RESPONSES TO QUESTIONS
SUBMITTED APRIL 22, 2016
BY
TENNESSEE DEPARTMENT OF HEALTH
IN CONNECTION WITH
APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE

Submitted by: Mountain States Health Alliance
Wellmont Health System
Date: July 13, 2016

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SUBMITTED APRIL 22, 2016

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TENNESSEE DEPARTMENT OF HEALTH

IN CONNECTION WITH

APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: July 13, 2016

Additional Request from the Department of Health
Submitted April 22, 2016

Mountain States Health Alliance and Wellmont Health System Response

I. INCOMPLETE (1)

a. Services Offered by Other Providers

Tenn. Comp. R. & Regs. 1200-38-01-. 02(2)(a)8

Revise the lists of services and products in Application Section 11, Exhibit 6, and Addendum #1 Section 3 to reflect the following changes:

i. **Limit services and products provided to those within the geographic service area;**[1]

RESPONSE: The Parties have attached the information requested above as Exhibit 1, which shows the hospitals providing inpatient services to residents of the Geographic Service Area, and limits the hospitals to only those physically located within the Geographic Service Area. The Parties have several concerns about excluding competitors not physically located in the proposed 21-county Geographic Service Area from the assessment of alternatives and competitive constraints on the Parties. These alternatives are relatively large in number and include major academic medical centers (AMCs) offering an array of services, including more advanced tertiary and quaternary services, specialty hospitals (such as psychiatric facilities), and community hospitals located in adjacent areas. These provide alternatives for commercially insured and other patients. There is clear evidence of market share overlap in these areas despite the existence of state or other political borders. Wellmont and Mountain States believe that the relevant competitive impact coming from organizations physically located outside the proposed 21-county Geographic Service Area is small. However, to the extent it is measurable, the Parties believe it is more accurate to include all competitive impact when analyzing competition within and the effect of the proposed transaction in the proposed 21-county Geographic Service Area. We respectfully suggest that, while exclusion of out-of-area competitors may be one interpretation of the rule, evaluation of post-merger effects should take into consideration responses to any alleged anticompetitive pricing and any repositioning that hospitals and payers may undertake, which would tend to start with identification of those additional competitors. As a result, the Parties respectfully request that the services and product information contained in their original Application dated February 16, 2016 be included in the record so that it is available for analysis.

[1] Pursuant to department rule, identification of services offered by other providers and the corresponding market share calculations should be limited to the geographic service area identified in the application. The application identifies the geographic service area (GSA) as a 21 -county area that includes ten (10) Tennessee and eleven (11) Virginia counties. In contrast, Application Section 6, Exhibit 6, and Addendum #1 Section 3 include products from competitors located outside this 21-county GSA.

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- Exhibit 1 - Services Provided by Other Providers Limited to Services and Products Provided by Facilities Physically Located in the Geographic Service Area to Those within the Geographic Service Area

ii. **Revise classification of facilities to reflect substitutable services or products;**[2]

RESPONSE: Outpatient facility listings have been revised to exclude five facilities. We have attempted to identify any center that expressly limits services and have considered the examples provided. We note that many ASCs have the ability to expand operations beyond current services by bringing on additional physicians/surgeons, and that overly narrow service lines may overstate competitive issues. A revised list of facilities to reflect substitutable services or products is attached as Exhibit 2.

INDEX OF DOCUMENTS:

- Exhibit 2 - Revised Classification of Facilities to Reflect Substitutable Services or Products

iii. **Provide information on the structure of physician practices to calculate the appropriate market share.**[3]

RESPONSE: The Parties are calculating the appropriate market share for physician practices as requested and will provide this information to the Department as soon as possible.

INDEX OF DOCUMENTS:

- Exhibit 3 - Information on the Structure of Physician Practices (to be provided in a subsequent response)

iv. **Identify physicians under an exclusive contract or arrangement with either applicant or a subsidiary of either applicant.**

RESPONSE: The list of physicians under an exclusive contract or arrangement with either applicant or a subsidiary of either applicant will be provided under CID to the Attorney General's Office.

[2] A facility is the method of delivery for the product but is not necessarily itself the product. For example, gastroenterology, orthopedic, and eye surgery centers are not substitutable (i.e., a patient with eye issues would not consider accessing the former two surgery centers). Consequently, these facilities cannot be listed under the same product or used to calculate a market share.

[3] The market power of a single physician is not equal to the bargaining power of a physician group. Therefore, in Exhibit 6.1-E, the number of physician groups and their size (i.e. number of doctors) by specialty and county is required.

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- Exhibit 4 - Physicians Under an Exclusive Contract (considered confidential information and will be subsequently filed)

b. Description of the Competitive Environment
Tenn. Comp. R. & Regs. 1200-38-01-.02(2) (a) 13 (v)

Recalculate market shares using appropriate geographic market and output measures.[4]

RESPONSE: The Parties have attached the information requested above as Exhibit 5, which presents shares based on discharges in the Geographic Service Area. As noted above in Section I(a)(i), the Parties have concerns about excluding competitors not physically located in the proposed 21-county Geographic Service Area from the evaluation of competition and from share measures. These competitors represent alternatives for payers, patients, and their physicians; the data and information show that physicians are referring patients for a large array of services out of the Geographic Service Area to several hospitals, including the leading AMCs and hospitals in Tennessee and Virginia for commercially insured and other payers. These alternatives are very relevant to evaluation of the transaction; retaining and regaining volumes locally with an enhanced integrated delivery network and improved care models are important goals of .the proposed transaction. To accomplish this, the Parties will have every incentive to improve quality and deliver care in cost-effective and high value fashion. As a result, the Parties respectfully request that the market share information contained in the original Application dated February 16, 2016 be included in the record so that it is available for analysis.

INDEX OF DOCUMENTS:

- Exhibit 5 - Recalculation of Market Shares

c. Cooperative Agreement - EXHIBIT 11.1
Tenn. Comp. R. & Regs. 1200-38-01-. 02(2) (a) J 3

i. **Provide a copy of the nonbinding April 2, 2015 Term Sheet referenced in the Master Affiliation Agreement and Plan of Integration, page 1 paragraph 6.**

RESPONSE: A copy of the nonbinding April 2, 2015 Term Sheet is attached as Exhibit 6.

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[4] See Incomplete Item I.a.

- Exhibit 6 - Copy of the Nonbinding April 2, 2015 Term Sheet

ii. **Provide the following exhibits referenced in the Master Affiliation Agreement, page 56:**

1. **Exhibit C-l: Interim Parent Company Articles and Interim Parent Company Bylaws.**

RESPONSE: The Interim Parent Company Articles are attached as Exhibit 7. The Interim Parent Company Bylaws are attached as Exhibit 8.

INDEX OF DOCUMENTS:

- Exhibit 7 - Interim Parent Company Articles
- Exhibit 8 - Interim Parent Company Bylaws

2. **Exhibit C-3: Amended Parent Company Articles.**

RESPONSE: The Amended Parent Company Articles will not be adopted until at or shortly before the closing. The only two changes that will be made to the current Interim Parent Company Articles are (1) to change the principal place of business to the office location selected by the Parties and (2) to change the name from "Newco" to the permanent name selected by the Parties.

3. **Exhibit C-4: Amended Parent Company Bylaws.**

RESPONSE: The Amended Parent Company Bylaws will not be adopted until at or shortly before the closing. A draft of the Amended Parent Company Bylaws is attached as Exhibit 9.

INDEX OF DOCUMENTS:

- Exhibit 9 - Amended Parent Company Bylaws

II. **INCOMPLETE (2)**

a. Potential Disadvantages

Tenn. Comp. R. & Reg. 1200-38-01-.02(2) (a)3 (iv)

Identify any potential disadvantages that may result from the Cooperative Agreement.

RESPONSE: A detailed explanation of any potential disadvantages that may result from the Cooperative Agreement and how the Parties have proposed to address these potential disadvantages is attached as Exhibit 10. The Parties have also included an explanation of each of the likely benefits resulting from the agreement to be weighed against the potential disadvantages. By way of overview, we note that the agreement

provides a unique opportunity to create a fully integrated patient-centric healthcare delivery network with common infrastructure supporting technologies and care models, coordinated care, and needed investments in population health in the largely rural communities characteristic of the Geographic Service Area. These represent advantages and consumer and community benefits that are unlikely to occur absent this transaction.

INDEX OF DOCUMENTS:

- Exhibit 10 - Benefits and Potential Disadvantages that may Result from the Cooperative Agreement

b. Geographic Service Area
Tenn. Comp. R. & Regs. 1200-38-01-. 02(2)(a) 7

Detail whether the New Health System intends to increase its market share in the following counties: Harlan and Letcher in Kentucky; and Ashe, Avery, Madison, Mitchell, Watauga, and Yancey in North Carolina.

RESPONSE: The New Health System does not intend to increase its market share in Harlan and Letcher in Kentucky; or Ashe, Avery, Madison, Mitchell, Watauga, and Yancey in North Carolina.

c. Insurance Contracts / Proposed use of any Cost Savings to Reduce Prices Borne by Insurers and Consumers [5]
Tenn. Comp. R. & Regs. 1200-38-01-.02(2) (a) 13 (vii) (111)1 II
Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)13(ix)(I)

i. **Provide the number of current insurance contracts that represent less than 2% of patient services revenue.**

RESPONSE: Wellmont has sixty-eight current insurance contracts that each represent less than 2% of patient services revenue. A list of these sixty-eight insurance contracts (in alphabetical order) is provided as Exhibit 11.

Mountain States has one hundred sixty-one current insurance contracts that each represent less than 2% of patient services revenue. A list of these one hundred sixty-one insurance contracts (in alphabetical order) is provided as Exhibit 12.

INDEX OF DOCUMENTS:

- Exhibit 11 - List of Wellmont's Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue
- Exhibit 12 - List of Mountain States' Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue

[5] See Application pp. 46 and 47.

ii. **Identify any potential insurers that would represent less than 2% of patient services revenue that do not currently contract with either system.**

RESPONSE: The Parties are not aware of any insurer that is active in the area that would represent less than 2% of patient services revenue and does not currently contract with either system.

iii. **Detail the percent of current insurance contracts that have fixed rate increases as written. Provide the amount and timing of these currently planned fixed rate increases. You may aggregate these rates separately for MSHA and Wellmont if you include the mean and standard deviation of the planned fixed rates.**

RESPONSE: Less than six percent of Mountain States' current insurance contracts have fixed rate increases as written. Sixteen percent of Wellmont's current insurance contracts have fixed rate increases as written.

The amounts and timing of Wellmont's and Mountain States' respective currently planned fixed rate increases will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 13 - Mountain States' Currently Planned Fixed Rate Increases (considered confidential information and will be subsequently filed)
- Exhibit 14 - Wellmont's Currently Planned Fixed Rate Increases (considered confidential information and will be subsequently filed)

iv. **Provide the negotiated rate increases for the past five years. These increases should be calculated using the same methodology proposed in the commitment to not increase negotiated rates for hospital, physician or non-hospital outpatient services by more than the hospital or medical care Consumer Price Index minus 0.25%.**

RESPONSE:

The negotiated rate increases for the past five years calculated using the same methodology proposed in the commitment to not increase negotiated rates for hospital, physician, or non-hospital outpatient services will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 15 - Mountain States' Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient Services (considered confidential

information and will be subsequently filed)

- Exhibit 16 - Wellmont's Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient Services (considered confidential information and will be subsequently filed)

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

RESPONSE: For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%.

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

The Parties have proposed that this provision only apply to contracts with negotiated rates and should not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, the Parties have proposed that baseline rates or estimated reimbursement for inpatient and outpatient services for an expiring contract at the point of its expiration be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes for subsequent years.

Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of a natural disaster or other extraordinary circumstances beyond the New Health System's control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index.

Following approval of the COPA, if the New Health System and a Principal Payer[6] are unable to reach agreement on a negotiated rate, the New Health System agrees to mediation as a process to resolve any disputes.

[6] The Application defines "Principal Payers" as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

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

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

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

vi. **Detail how the New Health System will handle price setting for uninsured or private pay patients.**

RESPONSE: The New Health System will continue to treat all patients with dignity, compassion, and high-quality care standards regardless of their social status or ability to pay. The New Health System's charity care policy will comply with all state and federal regulations in regard to charity care and essential hospital access and will be consistent with the New Health System's role as a public benefit, not-for-profit, tax-exempt corporation. The policy will be published, and all patients will be advised of their ability to access services under the policy. The policy will apply at the time of service delivery rather than after collection attempts have been made. Patients will have no barriers to receiving needed care. The New Health System will place no dollar limits on the amount of charity care it will provide and commits to providing a charity care policy that incorporates the best elements of the current policies of each Applicant. In fact, the New Health System's charity care policy will increase the benefit for charity care above and beyond what either of the Applicants currently provide. The new policy will provide a 100% discount for inpatient hospital and clinic services to patients with incomes below 225% of the Federal Poverty Level. In addition, all patients may apply for financial assistance and/or payment plans based on their ability to pay. Currently, the highest threshold used by the Applicants for a 100% discount for these services is 200% of the

Federal Poverty Level, with a sliding scale applying to certain patients.

Uninsured individuals who do not qualify under the charity care policy will receive a discount off hospital charges based on their ability to pay. This discount will comply with Section 501(r) of the Internal Revenue Code, and the rules and regulations relating to that Section, governing not-for-profit organizations, and payment provisions will be based on the specific circumstances of each individual/family. The New Health System will seek to connect individuals to coverage when possible. It is the goal of the New Health System to provide services to members of the community in a manner that is compassionate, fair, and reasonable and that does not result in an undue financial burden.

The New Health System will take other steps to benefit needy patients. One of the New Health System's stated goals is to reduce unnecessary utilization of high cost emergency department and inpatient services by uninsured individuals. So-called "super-utilizers" of health care consume a disproportionate level of health care resources and often have co-existing medical conditions coupled with addiction and mental health issues and social resource needs.

The New Health System will design an effective case management model for this "super-utilizer" population, once identified, that is proactive. Elements of the program will include social needs screening and assessment (transportation, food and housing insecurity, high risk behaviors or environments, etc.), connection to primary care preferably in a patient-centered medical home model for disease management, connection to health care and social resource navigators and community health workers, and connection to medication assistance. The New Health System will also provide resources for individuals who are ready to receive intervention for unhealthy behaviors that contribute to poor health. Findings from previously conducted model programs will be used to inform and create the overall plan. Partnerships with regional Federally Qualified Health Centers, Rural Health Centers, Health Departments, and charity clinics will be essential.

For individuals who agree to comply with certain requirements such as following physician prescriptions and orders, keeping scheduled appointments, participating in appropriate screenings, and participating in education related to chronic conditions or healthy lifestyles, the New Health System will provide guaranteed access to program services and medical care and the discount for services will be increased substantially.

This model can be a precursor to other population health models which can apply to other high-utilizer populations and may even be a source for translational research studies to result in best practice program development—especially in rural environments.

d. Common Clinical IT and Health Information Exchange

Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a) 10

i. **Provide your anticipated 10-year timeline with milestones for development and implementation for both the Common Clinical IT platform, connectivity for information exchange and quality measurement reporting. At a minimum, the timeline should include targeted objectives for each year following the formation of the New Health System, including target dates for the following activities:**

1. **Behavioral health capability. If your chosen Clinical IT system does not currently include a behavioral health module, detail your plans here, including integration or interoperability of electronic behavioral health record systems from third-party vendors.**

2. **Integration of systems and / or linkage of records (medical, lab, pharmacy, diagnostic, and referral / scheduling).**

3. **Migration and / or archiving of pre-existing records.**

4. **Training for new users (System and non-System providers).**

5. **Patient access to information.**

6. **Capabilities for collecting, analyzing and reporting quality outcomes (clinical, cost, patient satisfaction, etc.) for providers (System and non-System).**

RESPONSE: If the COPA is approved, the Parties expect the New Health System to assess each party's existing electronic health records computer platform(s), including third party systems, hardware, software, computer infrastructure, etc., to determine the roadmap to bring the New Health System onto a Common Clinical IT Platform, as described in the Application. This assessment is expected to take at least six months after the New Health System is formed. Until this full assessment is completed, a detailed timeline and cost estimate cannot be determined. However, a high-level timeline for implementation of the Common Clinical IT Platform is included as Exhibit 17 for reference.

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Exhibit 17 - Anticipated 10-Year Timeline

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

non-System providers, along with estimates for any revenue projected to be realized from any services offerings related to these capabilities.

RESPONSE: The estimates for how and when the $150 million investment in a Common Clinical IT Platform and Health Information Exchange will be allocated, including but not limited to the amount designated for the Common Clinical IT Platform, the amount designated for connectivity with non-System providers, population health management and quality reporting capabilities is attached as Exhibit 18.

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- Exhibit 18 - Estimates for How and When the $150 Million Investment in a Common Clinical IT Platform and Health Information Exchange will be Allocated

iii. **Describe the current commitment and timeframe for participation of both MSHA and Wellmont in OnePartner, the operational regional health information exchange. Also describe the options and plans for future participation (e.g., continued participation or acquisition of OnePartner, participation with a competing HIE provider, or development of a competing service offering).**

RESPONSE: A description of both Parties' use of health information exchanges ("HIEs") with information showing the current system used by each party, including current usage, how information is shared, fees or costs paid to use the system and the number of other providers currently using the system, how the records are shared, and the extent of patient records included in the exchange is attached as Exhibit 19.

Both Wellmont and Mountain States are currently participating in OnePartner. It is expected that the New Health System will meaningfully participate in a health information exchange, however, specific details about which health information exchange the New Health System will participate in have not been decided at this time.

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- Exhibit 19 - Current Commitment and Timeframe for Participation of both MSHA and Wellmont in OnePartner

e. **Total Cost Resulting from Cooperative Agreement**
Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a) 15

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

Provide documentation of the availability of the necessary funds.

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

Expense Category	Expense Incurred as of June 15, 2016
Communication Services	$1,129,408
Consulting Services	$2,260,548
COPA Fees*	$104,958
Due Diligence Services	$2,497,435
Legal Services	$10,496,155

* COPA Services include the filing fees and expenses that have been paid to the Southwest Virginia Health Authority and the Tennessee Department of Health.

f. **Description of Financial Performance**
Tenn. Comp. R. & Regs. 1200-30-01-02(2)(a) 13(vii)

i. **The description and summary of financial performance of Wellmont and MSHA does not adequately detail all components noted by department rule.**

RESPONSE: Application Exhibits 11.4 Attachments D and E were submitted in Addendum #1 to the COPA Application on March 17, 2016. Exhibit 11.5 Attachment D was submitted by Wellmont to the Attorney General's Office under CID on May 12, 2016.

ii. **Provide additional detail on the activities to be funded by the following proposed community reinvestment: 1) the $75 million investment in population health improvements; 2) the $140 million to expand mental health, addiction recovery, substance abuse prevention programs; and 3) the $85 million to develop and grow academic and research opportunities.[7]**

RESPONSE: As explained in the Application, the Parties have committed to reinvesting savings over the next ten years in the following categories:

- $75 million towards population health improvements
- $140 million towards the expansion of needed services which includes:
  - $85 million for mental health and addiction recovery
  - $27 million for pediatric sub-specialty access
  - $28 million for rural health access; and
- $85 million to develop and grow academic and research

[7] Requests for additional detail regarding the $150 million investment in Common Clinical IT and a Health Information Exchange are detailed in Incomplete Section II.d.

opportunities.

Additional detail on the activities to be funded by the proposed community reinvestment is attached as Exhibit 20.

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- Exhibit 20 - Additional Detail on the Proposed Community Reinvestment

iii. **Complete the "Year-by-Year Summary" that requests an estimate of the year-by-year timing of reinvestments and cost savings. (See Attachment 1)**

RESPONSE: The New Health System commits to using reinvestments and cost savings to implement programs and strategies to reduce tobacco use, obesity rates, physical inactivity, drug poisoning deaths and neonatal abstinence syndrome in the Geographic Service Area, as outlined in the template Community Health Improvement Plan, attached as Exhibit 21. The "Year-by-Year Summary" that provides an estimate of the year-by-year timing of these reinvestments and cost savings is attached as Exhibit 22.

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- Exhibit 21 - Template Community Health Improvement Plan
- Exhibit 22 - Year-by-Year Summary

iv. **Provide an updated amount of net expenditures on community health improvement, health professions education, and research as detailed on your most recent IRS Form 990 Schedule H.[8]**

RESPONSE: Below are the net expenditures on community health improvement, health professions education, and research for Mountain States and Wellmont based on each organization's 2015 IRS Form 990 Schedule H.

	Mountain States	Wellmont
Community Health Education and Outreach	$4,113,567	$5,761,249
Health Professions Education	$9,276,052	$5,748,416
Research	$237,449	$140,715

v. **Detail whether a $75 million investment in population health over ten years represents an increase in spending over that of past community health**

[8] As non-profit hospitals, MSHA and Wellmont already provide some level of community benefit. The department notes that in 2012 MSHA and Wellmont had net expenditures of $10.8 million on community health improvement and $18.9 million on health professions education and research.

investment, and if so, provide an estimate of the aggregate planned population health investment.

RESPONSE: Should the COPA be granted, the investment in population health set forth in the Application represents a net increase of $75 million in aggregate over that of past community health investment for the ten year period following the creation of the New Health System.

vi. **Detail whether an $85 million investment in research and training over ten years represents an increase in spending over that of past research and training investment, and if so, provide an estimate of the aggregate planned research and teaching investment.**

RESPONSE: Should the COPA be granted, the investment in research and training set forth in the application represents a net increase of $85 million in aggregate over the past research and training investment for the ten year period following the creation of the New Health System.

vii. **Compare and contrast the type of programs currently funded by Community Benefit spending, particularly in the categories above, with the planned investment over the next ten years.**

RESPONSE: The Community Benefit spending reported in the Parties' IRS Form 990s and annual reports represent investments in social responsibility efforts which are outside of their clinical core functions. The financial value of the Parties' current Community Benefit spending will serve as a baseline for the new incremental investments the Parties have proposed under the COPA, subject to adjustment for the most current financial performance of the combined systems to ensure the community benefit spending reflects current market conditions.

The Parties' current Community Benefit spending also represents the substantial investments made by our health systems to provide charity care to those in need or to fund uncollectable payments for medical services. It includes investments made by each health system and their respective foundations to improve the delivery of health care and quality of life in the region. This includes providing financial support to outside organizations whose work aligns with the Parties' efforts to improve the overall health status and economic vitality of the region. As explained in the Application, the Parties' plans for incremental investments under the COPA may increase support for certain current efforts as well as fund new efforts.

The Parties' current Community Benefit spending includes investments in graduate medical education, including residency slots and the internal infrastructure required to support them. The current Community Benefit spending also includes investments in direct support for health professions training along with internships and preceptor work associated with allied health professional training. At any given point, the two health systems are serving

one thousand plus students collectively and supporting their ability to learn in the clinical environment. Again, the investments the Parties plan to make as a part of the COPA will be over and above these current levels of Community Benefit.

In addition to workforce education and training, the Parties currently support many regional efforts to improve community health. Examples of this work include programs sponsored by the two health systems, such as the Mountain States' Morning Mile walking program for area children and Wellmont's Project Fit America program to provide outdoor exercise play equipment and curriculum to schools. Both organizations also support third-party efforts such as Healthy Kingsport, regional YMCA/YWCA programs, Girls and Boys Clubs, and many more organizations and programs which are designed to be catalysts for health improvement. Once the community health improvement goals are agreed upon with the state, the Parties will work collaboratively with local stakeholders to leverage existing programs that are operating successfully and support the establishment of new programs where gaps exist.

By the third year, the reinvestments in community benefit funded through the efficiencies gained by the proposed merger will double the current level of community benefit spending of the Parties as outlined in their most recent 990s and will approach a consistent rate of at least 2.5 times the current level by year five. This increase in community benefit spending will be in addition to the substantial financial support the New Health System will offer patients through the provision of charity care and self-pay discounts.

viii. **Provide the audited financial statement on MSHA as of June 30, 2015. (See Exhibits 11.4-F)**

RESPONSE: The audited financial statement on MSHA as of June 30, 2015 is attached as Exhibit 23.

INDEX OF DOCUMENTS:

- Exhibit 23 - Audited Financial Statement on MSHA as of June 30, 2015

ix. **On April 06, 2015, Fitch Ratings placed on Rating Watch Evolving the 'BBB+' rating for Health and Educational Facilities Board of Johnson City, TN, revenue bonds issued on behalf of MSHA and parity debt issued on behalf of MSHA listed in April 06, 2015 press release. Provide the current status regarding Fitch's Rating Watch. (See Exhibits 11.4-H)**

RESPONSE: Mountain State's current Fitch Ratings Watch is attached as Exhibit 24.

INDEX OF DOCUMENTS:

- Exhibit 24 - Mountain State's current Fitch Ratings Watch

g. Efficiencies in Operating Costs and Shared Savings

Tenn. Comp. R. & Regs. 1200-30-01-. 02 (a) 13(ix)

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

RESPONSE: The report prepared by FTI Consulting, Inc. that details the assumptions used in calculating the proposed economies and efficiencies of the proposed merger will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 25 - FTI Consulting Report (considered confidential information and will be subsequently filed)

III. GENERAL COMMENTS

a. **Detail how an additional layer of governance (i.e., the parent company) benefits the organization.**

RESPONSE: The creation of the New Health System as the sole member, and essentially the "holding company", of the currently existing corporations of Wellmont and Mountain States is critical to preserving the cash flow of the combined entity. If the Parties were to merge one of the existing corporations (Wellmont Health System/Mountain States Health Alliance) into the other, that would be considered a change of ownership by the Centers for Medicare and Medicaid Services ("CMS").

A change of ownership requires that CMS issue new provider numbers. The process of applying for and receiving new provider numbers takes between three and six months, during which time CMS will not pay for services rendered at the hospitals undergoing a change in ownership. Approximately one-half (1/2) to two-thirds (2/3) of the cash flow from the involved hospitals would be withheld during this three to six month period of time due to the level of government-paid patient volumes seen at those hospitals. While CMS will ultimately pay for such services after new provider numbers are issued, the interruption of such a significant amount of the cash flow for the New Health System would be crippling. By putting the New Health System in place, the merger is not considered a change of ownership by CMS, thereby avoiding a debilitating cash-flow interruption. Primary governance functions of the New Health System will account for the majority of all governance activities since the New Health System will become the sole member of the existing Wellmont and Mountain States entities. The current organizations will limit governance to those essential functions that need to be retained for basic corporate oversight. Thus, the new structure will not create any significant redundancy of governance functions.

b. **Provide an organizational chart that shows the resulting institution.**

RESPONSE: Exhibit 26 includes an organizational chart that shows the resulting New Health System.

INDEX OF DOCUMENTS:

- Exhibit 26 - Organizational Chart

c. **Clarify the amount of current debt and what is proposed in debt repayment and/or incurring additional debt as a result of this proposal.**

RESPONSE: Exhibit 27 shows the current debt for Mountain States as of third quarter FY2016. Exhibit 28 shows the current debt for Wellmont as of third quarter of FY2016. The assumption on debt repayment in the FTI model is: the repayment schedules for both organizations will remain the same. However, the Parties currently project, based on current market conditions, that significant savings opportunities exist for restructuring debt. The savings have not been incorporated into the model because the Parties cannot accurately predict the amount of savings that could be achieved at the time the transaction closes.

The FTI model assumes that NewCo will not incur any additional debt as a result of the transaction.

INDEX OF DOCUMENTS:

- Exhibit 27 - Mountain States' Q3 FY2016 Financials and Maximum Annual Debt Service Coverage Ratio
- Exhibit 28 - Wellmont's Third Quarter FY2016 Financial Statements

d. **Provide details regarding severance packages, including but not limited to, timing of implementation and dollar amount. Include details of severance packages currently being paid. (See Application p. 61)**

RESPONSE: Details regarding each Party's severance packages will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 29 - Details Regarding Mountain States' Severance Packages (considered confidential information and will be subsequently filed)

- Exhibit 30 - Details Regarding Wellmont's Severance Packages (considered confidential information and will be subsequently filed)

e. **Provide proposed employment agreements mentioned in the application.**

RESPONSE: The proposed employment agreements mentioned in the Application will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 31 - Proposed Employment Agreements with New Health System

(considered confidential information and will be subsequently filed)

f. **Describe the proposed performance parameters that will be used to measure employee performance.**

RESPONSE: The New Health System will implement a set of performance standards that incentivize all team members to pursue objectives to increase clinical quality, improve the patient experience, and achieve the financial goals of the New Health System. These parameters will be established based on annual goals which will be approved by the governing board once the New Health System is established. These parameters will be communicated clearly and proactively to team members. Overall performance will also be evaluated against the efforts of individual employees to contribute to the achievement of the New Health System's mission, vision, and values.

g. **The resulting board appears to be comprised of nine (9) members, of which only eight (8) will be voting members. Identify and/or detail how the board would deal with a 4/4 vote.**

RESPONSE: As noted in the Application,[9] the New Health System will be governed exclusively by its board of directors, which is the fiduciary board responsible for the delivery of quality care in consideration of the needs of the communities served by the system. The board of directors of the New Health System will be composed of fourteen (14) voting members, as well as two (2) ex-officio voting members and one ex-officio non-voting member.

Wellmont and Mountain States will each designate six (6) members to serve on the initial board of directors of the New Health System. In addition, Wellmont and Mountain States will jointly select two (2) members of the initial New Health System board, who will not be incumbent members of either Party's board of directors. The two (2) ex-officio voting members will be the New Health System Executive Chairman/President and the New Health System Chief Executive Officer. The sole ex-officio non-voting member will be the then-current President of ETSU.

Pursuant to the Bylaws of the New Health System, to be approved, actions of the Board of Directors require the affirmative vote of at least a majority of the voting directors at a meeting at which a quorum is present. Therefore, tie votes would result in disapproval of the motion under consideration by the board.

h. **Provide the Physician Needs Assessment from Niswonger Children's Hospital and detail how recruitment strategy will differ post-merger.**

RESPONSE: The Physician Needs Assessment for Niswonger Children's Hospital will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

[9] *See* Application Section 11(b).

- Exhibit 32 - Physician needs Assessment from Niswonger Children's Hospital (considered confidential information and will be subsequently filed)

IV. INCONSISTENCIES

The applicants should address the inconsistencies noted below.

Exhibit 11.4, pages 3 and 5 (Adobe pgs. 709 and 711/2578)	**The Statement of Operations summary for the fiscal year ended June 30, 2014 did not always appear to agree with amounts presented on the financial statement included in the application (Exhibit 11.4, Attachment F). For example, the summary reported net patient revenue decreased by $3.8 million; however, the audited financial statement (Adobe pg. 1538/2578) reflected a decrease of $4.96 million. Additionally, the Balance Sheet summary for the fiscal year ended June 30, 2014 stated that part of the reason for the increase in assets was due to an increase in patient receivables; however, the Consolidated Balance Sheet (page 1536/2578) reflected a decrease in patient accounts receivable of approximately $3 million from the prior year.**

RESPONSE: Internal financial packages were used to provide the calculations in the summary provided in the Application. Mountain States has attached calculations to demonstrate the variances in the REVISED summary (attached). All changes have been bolded. The variance between the internal financials and audited financials and explanations for the changes in the summary are:

A. The internal financials do not have eliminations for Mountain States' employee health plan. These eliminations (1) reduce net revenue and (2) reduce benefit expense. The benefit eliminations are included in the audited financials. The summary has been revised to include the benefit eliminations amounts.

B. The internal financial package includes incentive pay as a non-operating expense. The audited financials classify incentive pay in salaries and wages. The summary reflects incentive pay in non-operating expenses.

C. The FY2012 internal financial package includes the loss on early extinguishment of debt as a non-operating expense. The audited financials classify the loss as an expense in the prior year in the new audited format for FY2013. The summary reflects the loss on extinguishment as non-operating and the loss on extinguishment is therefore excluded from the income from operations calculation.

D. The FY2015 audited financials include an elimination for Mountain State's owned Medicare Advantage insurance plan. These eliminations (1) reduce net revenue and (2) reduce medical cost. This elimination was not done in FY2014. The FY2014 audited financials have been revised to be comparable. The summary has been revised to reflect these benefit eliminations.

The summary was written before Mountain State's final FY2015 audited financials were

issued. Therefore, the summary was based on preliminary unaudited results. The summary has been updated to reflect the final audited results for FY2015.

From time to time, items may be reclassified in Mountain States' audited financial statements. When comparing prior years, the numbers may not match exactly due to the reclassifications. These reclassifications are completed in order to make the financial statements comparable.

For example, in FY2012, per new accounting guidance, bad debt expense was included as a deduction from net revenue. Also, revenue associated with Mediserve Durable Medical Equipment was classified as Other Revenue instead of Patient Revenue. The FY2011 audited financials were revised to be consistent with the new FY2012 classification. The summary has been revised to reflect these changes. The FY2012 comparison is based on the FY2012 audited financial as compared to the FY2011 audited financial adjusted for the bad debt expense and durable medical equipment revenue reclassifications.

In FY2013, the format of Mountain States' audited financial was changed. There is no differentiation between operating and non-operating revenue and expenses. The audited results for FY2013 to FY2015 are attached as Exhibit 33 in a comparable format that was used for FY2011 and FY2012.

INDEX OF DOCUMENTS:

- Exhibit 33 - Audited Results for FY2011 to FY2015

Exhibit 11.5 - Attachment C Wellmont EMMA - Annual Disclosures for 2011 to 2015 and Material Event Disclosures (as listed on page 126) (Adobe pg. 128/2578)	**The exhibit was not included in the application.** **This exhibit was not included in the list of excluded information on page 119; therefore, it appears to have been omitted from the application in error.**

RESPONSE: Exhibit 11.5 - Attachment C was inadvertently omitted from the Application. It is attached to this response as Exhibit 34.

INDEX OF DOCUMENTS:

- Exhibit 34 - Exhibit 11.5 - Attachment C Wellmont EMMA - Annual Disclosures for 2011 to 2015

Exhibit 11.8, page 2 (Adobe pg. 2500/2578)	**The "Timing and Phases of Efficiency Assumptions" section stated that no efficiency savings are projected to be implemented in whole or in part until the FYE 6/17; however, the "Preliminary Efficiencies" Model Income Statement appeared to reflect savings of $41,144 over the "Baseline" model for the FYE 6/16 (i.e., savings of $21,632 in medical supplies and drugs, $5,651 in purchased services, $1,002 in maintenance and utilities, and $12,859 in other).**

RESPONSE: The "Timing and Phases of Efficiency Assumptions" description included savings that could be negotiated on day one. Since these contract changes would occur at the start of the merger FTI assumed the impact would be immediate. In the "Baseline" model, FTI has updated the timing in the second run of the model to start FYE 6/17 which reflects the current anticipated timeline. The updated Financial Model is attached as Exhibit 35.

INDEX OF DOCUMENTS:

- Exhibit 35 - Updated Financial Model

Exhibit 11.8, page 9 (Adobe pg. 2507/2578)	**It appears, for the forecasted columns of the "Baseline" Model Balance Sheet, total net assets should equal the prior year ending net assets balance plus revenues in excess of expenses reported on the operating statement on the previous page. However, the total net assets balances reported on the "Baseline" Model Balance Sheet in the 2016 through 2020 columns did not equal this. The difference appears to be related to the income attributable to non-controlling interests.**

RESPONSE: For the forecasted columns of the "Baseline" Model Balance Sheet, the assumptions in the baseline were that the Company post-merger would have to payout each Joint Venture entity's interest, while currently the separate hospitals do not appear to make those distributions and allow each Joint Venture entity to maintain the cash balance. The total net asset balances reported in the Baseline Model Balance Sheet in the 2016 through 2020 columns have been updated to match the baseline assumption, that the Joint Venture entities do not make distributions and retain the cash. See attached Exhibit 35.

Exhibit 11.8, pages 12 and 13 (Adobe pgs. 2510-11/2578)	**On the "Preliminary Efficiencies" Model Cash Flows, the cash flows from financing activities included amounts for each year for payments made related to income attributable to non-controlling interest. However, it appears the "Preliminary Efficiencies" Model Balance Sheet on the previous page reflected this amount as part of net assets each year (i.e., the non-controlling interest component of net assets increased each year by the amount of income attributable to non- controlling interest).**

RESPONSE: See explanation immediately above. The updated Financial Model is attached as Exhibit 35.

Exhibit 11.8 - pages 10 and 13	**The amounts reflected for Payments on LTD and liabilities (net of interest) on the "Baseline" and "Preliminary Efficiencies" Model Statement of Cash Flows**

(Adobe pgs. 2508 and 2511/2578)	**were not consistent with amounts disclosed in the debt service schedules presented in the most recent financial statements included in the application. The financial model notes referenced a "Debt Schedule" (page 6) which may provide explanation; however, this schedule was not included with the model. It was expected that the LTD and liabilities payments would agree with debt service amounts presented in the notes to the financial statements (Exhibits 11.4, Attachment F and 11.5, Attachment B) (Adobe pgs. 1559 and 2421/2578).**

RESPONSE: The original financial model did not include an assumption that the New Health System would pay down particular tranches of debt. The assumption was that the New Health System would refinance each tranche as it became due. Additionally, one of the goals of this exercise was not to disclose any of the specific detail of information that each individual health system would be able to use to gain a greater insight into the other health system's financial performance. If FTI used specific debt schedules from each health system then the health systems would have been able to extrapolate competitively sensitive information.

INDEX OF DOCUMENTS

Exhibit 16 Wellmont's Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient Services
To be submitted pursuant to CID.

Exhibit 17 Anticipated 10-Year Timeline

Exhibit 18 Estimates for How and When the $150 Million Investment in a Common Clinical IT Platform and Health Information Exchange will be Allocated

Exhibit 19 Current Commitment and Timeframe for Participation of both MSHA and Wellmont in OnePartner

Exhibit 20 Additional Detail on the Proposed Community Reinvestment

Exhibit 21 Template Community Health Improvement Plan

Exhibit 22 Year-by-Year Summary

Exhibit 23 Audited Financial Statement on MSHA as of June 30, 2015

Exhibit 24 Mountain State's current Fitch Ratings Watch

Exhibit 25 FTI Consulting Report
To be submitted pursuant to CID.

Exhibit 26 Organizational Chart

Exhibit 27 Mountain States' Q3 FY2016 Financials and Maximum Annual Debt Service Coverage Ratio

Exhibit 28 Wellmont's Third Quarter FY2016 Financial Statements

Exhibit 29 Details Regarding Mountain States' Severance Packages
To be submitted pursuant to CID.

Exhibit 30 Details Regarding Wellmont's Severance Packages
To be submitted pursuant to CID.

Exhibit 31 Proposed Employment Agreements with New Health System
To be submitted pursuant to CID.

Exhibit 32 Physician needs Assessment from Niswonger Children's Hospital
To be submitted pursuant to CID.

Exhibit 33 Audited Results for FY2011 to FY2015

Exhibit 34 Exhibit 11.5 - Attachment C Wellmont EMMA - Annual Disclosures for 2011 to 2015

Exhibit 35 Updated Financial Model

Exhibit 1

Services Provided by Other Providers Limited to Services and Products Provided by Facilities Physically Located in the Geographic Service Area to Those within the Geographic Service Area

Services Provided by Other Providers Limited to Services and Products Provided by Facilities Physically Located in the Geographic Service Area to Those within the Geographic Service Area

Hospital Name	Hospital Affiliation	Total Discharges
Total		119,282
Total 21-County Hospitals		108,392
Total Non 21-County Hospitals		10,890
Share Outside 21 County-Area		9.1%
WELLMONT HANCOCK COUNTY HOSPITAL	WHS	179
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WHS	1,012
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	WHS	1,160
WELLMONT LONESOME PINE HOSPITAL	WHS	1,704
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WHS	13,000
WELLMONT HOLSTON VALLEY MEDICAL CENTER	WHS	16,773
DICKENSON COMMUNITY HOSPITAL	MSHA	5
JOHNSON COUNTY COMMUNITY HOSPITAL	MSHA	14
WOODRIDGE PSYCHIATRIC HOSPITAL	MSHA	32
QUILLEN REHABILITATION HOSPITAL	MSHA	491
UNICOI COUNTY MEMORIAL HOSPITAL, INC.	MSHA	757
RUSSELL COUNTY MEDICAL CENTER	MSHA	1,313
SMYTH COUNTY COMMUNITY HOSPITAL	MSHA	1,753
NORTON COMMUNITY HOSPITAL	MSHA	3,120
SYCAMORE SHOALS HOSPITAL	MSHA	3,167
FRANKLIN WOODS COMMUNITY HOSPITAL	MSHA	5,138
INDIAN PATH MEDICAL CENTER	MSHA	5,939
JOHNSTON MEMORIAL HOSPITAL	MSHA	8,123
JOHNSON CITY MEDICAL CENTER	MSHA	22,983
CARILION TAZEWELL COMMUNITY HOSPITAL	Other	543
BUCHANAN GENERAL HOSPITAL	Other	1,041
WYTHE COUNTY COMMUNITY HOSPITAL	Other	1,801
TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL	Other	1,820
TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER	Other	2,011
TAKOMA REGIONAL HOSPITAL	Other	2,270
LAUGHLIN MEMORIAL HOSPITAL, INC.	Other	3,225
CLINCH VALLEY MEDICAL CENTER	Other	4,102
MORRISTOWN-HAMBLEN HEALTHCARE SYSTEM	Other	4,916

Exhibit 2

Revised Classification of Facilities to Reflect Substitutable Services or Products

Revised Classification of Outpatient Facilities to Reflect Substitutable Services or Products

Service Type	WHS & MSHA Combined %	Mountain States	Mountain States-NsCH Affiliate	Wellmont	Non-Managed Joint Venture	All Other*	Total
Pharmacy	1.7%	5	0	0	0	297	302
Fitness Center	0.0%	0	0	0	0	82	82
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	9.1%	3	0	2	0	50	55
Physical Therapy	7.8%	1	0	3	0	47	51
Home Health	19.6%	8	0	2	0	41	51
Rehabilitation	39.5%	9	0	8	0	26	43
CT	59.5%	12	0	10	0	15	37
MRI	52.9%	11	0	7	0	16	34
Surgery - Endoscopy	58.3%	9	0	5	0	10	24
Urgent Care	57.1%	8	0	8	0	12	28
Surgery - Hospital-based	58.3%	9	0	5	0	10	24
Dialysis Services	0.0%	0	0	0	0	20	20
Wellness Center	18.8%	2	0	1	0	13	16
Surgery - ASC	66.7%	2	0	3	3	4	12
Chemotherapy	62.5%	4	1	5	0	6	16
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	16
Radiation Therapy	60.0%	3	0	3	0	4	10
Cancer Center	60.0%	3	0	3	0	4	10
Weight Loss Center	14.3%	0	0	1	0	6	7
Community Center	0.0%	0	0	0	0	3	3
Cancer Support Services	0.0%	0	0	0	0	1	1
Women's Cancer Services	100.0%	0	0	1	0	0	1

*Excluded 3 facilities under ASC and 2 under Urgent Care
ASCs excluded - The Regional Eye Surgery Center, Reeves Eye Surgery Center, and Johnson City Eye Surgery Center; Urgent Care Centers excluded - Patmos EmergiClinic and Doctors Care

Exhibit 3

Information on the Structure of Physician Practices

This Exhibit will be provided in a subsequent response.

Exhibit 4

Physicians Under an Exclusive Contract

To be submitted pursuant to CID.

Exhibit 5

Recalculation of Market Shares

Recalculation of Shares in NEWCO Geographic Service Area for Hospitals Located in Area

Hospital Name	Hospital Affiliation	Total	Shares of Total Discharges	Shares of WHS and MSHA Discharges	Shares of Hospitals in 21-County Area
Total		119,282	100.0%		
Total 21-County Hospitals		108,392	90.9%		
Total Non 21-County Hospitals		10,890	9.1%		
Share Outside 21 County-Area		9.1%			
WELLMONT HANCOCK COUNTY HOSPITAL	WHS	179	0.2%	0.2%	0.2%
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WHS	1,012	0.8%	1.2%	0.9%
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	WHS	1,160	1.0%	1.3%	1.1%
WELLMONT LONESOME PINE HOSPITAL	WHS	1,704	1.4%	2.0%	1.6%
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WHS	13,000	10.9%	15.0%	12.0%
WELLMONT HOLSTON VALLEY MEDICAL CENTER	WHS	16,773	14.1%	19.4%	15.5%
DICKENSON COMMUNITY HOSPITAL	MSHA	5	0.0%	0.0%	0.0%
JOHNSON COUNTY COMMUNITY HOSPITAL	MSHA	14	0.0%	0.0%	0.0%
WOODRIDGE PSYCHIATRIC HOSPITAL	MSHA	32	0.0%	0.0%	0.0%
QUILLEN REHABILITATION HOSPITAL	MSHA	491	0.4%	0.6%	0.5%
UNICOI COUNTY MEMORIAL HOSPITAL, INC.	MSHA	757	0.6%	0.9%	0.7%
RUSSELL COUNTY MEDICAL CENTER	MSHA	1,313	1.1%	1.5%	1.2%
SMYTH COUNTY COMMUNITY HOSPITAL	MSHA	1,753	1.5%	2.0%	1.6%
NORTON COMMUNITY HOSPITAL	MSHA	3,120	2.6%	3.6%	2.9%
SYCAMORE SHOALS HOSPITAL	MSHA	3,167	2.7%	3.7%	2.9%
FRANKLIN WOODS COMMUNITY HOSPITAL	MSHA	5,138	4.3%	5.9%	4.7%
INDIAN PATH MEDICAL CENTER	MSHA	5,939	5.0%	6.9%	5.5%
JOHNSTON MEMORIAL HOSPITAL	MSHA	8,123	6.8%	9.4%	7.5%
JOHNSON CITY MEDICAL CENTER	MSHA	22,983	19.3%	26.5%	21.2%
CARILION TAZEWELL COMMUNITY HOSPITAL	Other	543	0.5%		0.5%
BUCHANAN GENERAL HOSPITAL	Other	1,041	0.9%		1.0%
WYTHE COUNTY COMMUNITY HOSPITAL	Other	1,801	1.5%		1.7%
TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL	Other	1,820	1.5%		1.7%
TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER	Other	2,011	1.7%		1.9%
TAKOMA REGIONAL HOSPITAL	Other	2,270	1.9%		2.1%
LAUGHLIN MEMORIAL HOSPITAL, INC.	Other	3,225	2.7%		3.0%
CLINCH VALLEY MEDICAL CENTER	Other	4,102	3.4%		3.8%
MORRISTOWN-HAMBLEN HEALTHCARE SYSTEM	Other	4,916	4.1%		4.5%
UNIVERSITY OF TENNESSEE MEDICAL CENTER	Other	1,764	1.5%		
CARILION MEDICAL CENTER	Other	1,159	1.0%		
TENNOVA HEALTHCARE-PHYSICIANS REGIONAL MEDICAL CEN	Other	1,045	0.9%		
UNIVERSITY OF VIRGINIA MEDICAL CENTER	Other	862	0.7%		
VANDERBILT UNIVERSITY HOSPITALS	Other	856	0.7%		
All Other		5,204	4.4%		

Exhibit 6

Copy of the Nonbinding April 2, 2015 Term Sheet

TERM SHEET

This term sheet is intended for discussion purposes only and does not constitute and will not give rise to any legally binding obligation on the part of any party to these discussions or any affiliates of any party to these discussions. None of the parties to these discussions or any of their respective affiliates shall be legally bound with respect to the transactions contemplated by this term sheet unless and until such parties have executed and delivered to each other definitive, binding written agreements in respect of such transactions.

NON-BINDING PROVISIONS	
I. **Transaction Structure**	A. Wellmont and Mountain States shall adopt a statement of Shared Vision and Guiding Principles consistent with the statements attached as Exhibit A to this term sheet. B. The form of transaction will be the formation of a new entity which will serve as the parent of Wellmont Health System ("Wellmont") and Mountain States Health Alliance ("Mountain States") (the "Transaction"). C. Wellmont and Mountain States will cause a new, not for profit, tax exempt corporation to be incorporated in Tennessee ("Newco"). Newco shall be established as an independent not for profit, Tennessee corporation which shall be governed by a Board of Directors composed of residents from the Tri-Cities area of Tennessee and Virginia as set forth below. D. Wellmont and Mountain States collectively (the "Parties") will amend, modify or revise their respective articles and bylaws to designate Newco as the sole corporate member of each of the Parties.
II. **Timing and Due Diligence**	A. The Parties will mutually agree on a time schedule for conducting and completing due diligence and negotiating the Definitive Agreement, it being contemplated that such actions will be completed within one hundred fifty (150) days following signing of this term sheet. B. Subject to the "Protocols on Information Sharing" section below, each of Mountain States and Wellmont shall use reasonable efforts to provide access to the information, employees or contractors requested by the other Party on a timely basis and shall provide to the other Party reasonable access to its facilities upon prior notice. C. Neither Party (nor such Party's representatives) will contact the employees or other personnel of the other Party (including without limitation members of the medical staffs of such Party's hospitals, and no inspection will be conducted, without such Party first coordinating such inspection or contact with, in the case of Wellmont, Gary Miller, Esq. or his designees and in the case of Mountain States, Tim Belisle, Esq. or his designees.
III. **Governance - Board of Directors**	A. After execution of this term sheet or similar legal document, Wellmont and Mountain States will, at the appropriate and mutually agreed upon time, jointly engage third party consultants to assist with the selection, development, education and various other tasks related to establishing and integrating the Newco Board, as well as a third party consultant to conduct a culture audit of the two organizations in order to better inform

the Newco Board on how best to integrate the two organizations from a human relations and cultural standpoint.

B. Upon execution of this term sheet or similar legal document, Wellmont and Mountain States will each nominate an equal number of their existing board members to become members of the pre-closing Joint Board Task Force. Further, the CEOs of Wellmont and Mountain States will each serve on the Joint Board Task Force. The total number of members of the Joint Board Task Force will not exceed 14. This Joint Board Task Force will oversee the pre-closing activities of the Integration Council. Given the significance of issues to be managed pre-closing, it is highly desirable the individuals who are selected to serve on the Joint Board Task Force also be those who will ultimately serve on the Newco Board.

C. The initial Newco governing board will be comprised of 14 voting members, as well as two ex-officio voting members and one (1) ex-officio non-voting member. The two ex-officio voting members shall be the Newco Executive Chairman/President and the Newco Chief Executive Officer.

1. The Newco Chief Executive Officer will serve as a voting member of the Newco Board for not longer than two (2) years. At the conclusion of the Chief Executive Officer's two (2) year term, the Chief Executive Officer will rotate off the Newco Board. Upon rotation of the Chief Executive Officer off of the Newco Board, the initial Wellmont designees to the Newco Board (as described in Section D. below) shall appoint a new member to the Newco Board to replace the Chief Executive Officer. The initial term of this new Board member shall be three (3) years, with the opportunity to serve on additional three (3) year term.
2. The one ex-officio non-voting member shall be the then current President of East Tennessee State University.
3. The Board shall include not less than 4 licensed physicians who are members of the medical staff of one or more Newco-affiliated hospitals, with at least two (2) physicians from each legacy system. The total Newco board shall be composed of a maximum of sixteen (16) voting members.
4. Should there be a change in the Executive Chairman/President within the first twenty-four (24) months, for any reason, it is the intent of both Parties to define a process for inclusion in the Definitive Agreement that would maintain the balance of the Newco Board between the legacy systems.

D. Wellmont and Mountain States will each designate 6 members to serve on the initial board of Newco. Wellmont and Mountain States will jointly select 2 members of the initial Newco board, who will not be incumbent members of either Party's board.

E. The initial members of the Newco board will be selected with the goals of

(1) obtaining a broad range of competencies, skills and experience relevant to the governance of a large healthcare system and (2) ensuring broad representation from the region, employer and patient communities served by Newco. Both organizations agree the ultimate goal is for Newco to be governed by a board that is competency-based and utilizing industry best practices.

F. The initial Newco board appointments will be for staggered terms, with 6 members having a term of two (2) years, four (4) board members with terms of three (3) years, and four (4) board members with terms of four (4) years. The two (2) Board members jointly appointed by the initial Wellmont and Mountain States members shall be in the class with an initial four-year term. The initial board members may serve their initial terms and one additional three-year term. Thereafter, limits on the number of terms of service for board members who succeed the initial board members will be agreed upon and set forth in the Newco bylaws to be adopted at the closing. For the first four years, the staggered terms shall be constructed so that legacy Board members from Wellmont and Mountain States will roll off the Board in equal numbers. If a legacy member resigns or is removed from office during his or her initial term, the person appointed to that position shall come from the same legacy organization and shall serve the unexpired term. Any renewal terms shall be subject to customary board governance policies and procedures.

G. As and after the initial board terms expire, the Newco board will be self-perpetuating. Newco bylaws will provide that Board members will be subject to term limits as discussed above.

H. The Newco board will have the ultimate fiduciary duties and governing role for the key business decisions, activities and management of the new health system. The Newco Board shall adopt governance best practices, including periodic performance evaluation. The governance best practices shall be further enumerated in the Newco bylaws.

I. The Definitive Agreement shall provide for an Executive Chairman (see Section IX *infra*) and a Vice Chairman/Lead Independent Director (to be nominated by Wellmont and affirmed by the non-management members of the Joint Board Task Force and named in the Definitive Agreement) whose responsibilities will be substantially similar to the description attached as Exhibit B to this term sheet. The term of the initial Vice Chairman/Lead Independent Director will be two years after the closing.

J. The Officer and Executive Committee positions of the Newco Board will be defined in the initial Newco Bylaws to be adopted in accordance with the Definitive Agreement. There will be 4 Board Officer positions to be filled as follows: Executive Chair, Vice Chair, Treasurer, and Secretary. Additionally, there will initially be two at-large members of the Executive Committee.

K. Upon closing of the Transaction and the constitution of the Newco Board, the existing Wellmont and Mountain States Boards may be delegated certain responsibilities by the Newco Board, such as credentialing,

	subsidiary and joint-venture oversight, and implementation of Newco Board decisions as required to transition to one governance structure. It is anticipated that the Wellmont Board and Mountain States Board will be dissolved at such time that the Newco Board makes the decision to do so, but not later than 24 months after the closing of the Transaction, with their functions, authority and responsibilities transferred to the Newco Board and its Committees. It is also anticipated that during the transition period between closing and dissolution of each board, the existing Wellmont Board and Mountain States Board will have delegated responsibility for the following: 1. Medical staff credentialing and oversight as those functions currently are outlined in each organization's bylaws; 2. Official business of any subsidiary corporation subject to Newco Board's final authority as sole Member over such decisions; and 3. Regulatory oversight such as those requirements contained within the accreditation standards for hospitals and all other subsidiary services.
IV. **Governance - Board Subcommittees**	A. Board committees will also be established with initial membership of equal representation by and from the Parties. B. Likely committees will include: Executive, Audit; Finance; Legal/ Regulatory/Compliance; Quality; Human Resources; Governance; Investments; and Nominating. C. The final committee structure, committee charters, initial membership, and initial chairs of each will be mutually agreed upon and defined in the Definitive Agreement. D. The Executive Chairman/President of Newco will be an ex-officio, non-voting member of the Nominating Committee. The Nominating Committee charter will establish the criteria for selecting future board and committee members.
V. **Supermajority Items**	A. For a period of time post-Transaction, not to exceed two (2) years, certain board actions will require approval by a supermajority (defined as two-thirds) vote. B. The specific list of actions requiring supermajority approval will be identified in the Definitive Agreement, but will include the following: 1. Amendments to Newco charter and bylaws; 2. Sale of substantially all of the assets of Newco, or merger of Newco with or into another entity; 3. Sale or closure of any hospital; 4. Debt incurrence above an amount to be set forth in the Newco bylaws; 5. Decision to file bankruptcy or insolvency proceedings or to seek

	appointment of a receiver for Newco or key members of its group(s) obligated to repay long-term debt; and 6. Discontinuing major clinical services, to be defined in the Definitive Agreement, at a Newco affiliated hospital.
VI. **Hospital and Affiliate Governance**	A. Subject to the provisions of any existing joint-venture and other contractual agreements, the governing boards of all hospitals and other affiliates will be appointed by, and serve at the pleasure of, the Newco board. The Newco Board shall have final authority as sole Member of Newco's ownership interest in any hospital, joint-venture or partnership. B. Except as provided below, the existing governing boards of hospitals and affiliates as of the Transaction closing will continue to serve unless replaced by the Newco board. C. To the degree any of the Boards of any subsidiary or wholly owned corporations of Wellmont and Mountain States have membership constituted to include Board members of Wellmont or Mountain States, such board composition shall be amended such that there is equal representation from Wellmont and Mountain States Board members. D. The composition of the boards of the respective physician organizations of Wellmont and Mountain States will be approved by the Newco Board. E. The charters of the Wellmont and Mountain States foundations will require that their respective funds as of the Transaction closing must be used consistent with the intent of the original donors thereof.
VII. **Integration Council**	A. As legally appropriate after the execution of this term sheet or similar legal document, the Parties will establish an Integration Council comprised of ten to twelve (10-12) members. The Integration Council will have responsibility for retaining an independent consultant to undertake a comprehensive analysis of the clinical, operational and financial functions of Wellmont and Mountain States to (1) identify, substantiate and quantify the cost-savings and quality-enhancement opportunities achievable specifically from the Transaction and (2) describe the timeline and integration plan for achieving these opportunities. The Integration Council will engage, on a regular basis, with this consultant for periodic reports on his/her analysis and supply information as needed to further the analysis, and prepare the Parties for integration to ensure the realization of Newco's clinical, operational and financial potential post-Transaction. The objective of the Integration Council is to ensure a system approach that best serves the needs of the community and region based on objective information. B. Integration Council members may include operating executives, finance executives, legal executives and physician executives. Physician, nurse and other clinical and administrative leaders, shall be called upon to provide input and support to the Integration Council. The Integration Council will be composed of an equal number of representatives from Wellmont and Mountain States. There shall be at least four (4) members of the

	Integration Council who shall be physicians, with two (2) representatives from each of Wellmont and Mountain States. At least one (1) of each health system's physician representatives on the Integration Council shall be a physician in independent practice from each system. C. Wellmont and Mountain States may jointly engage additional third party consultants to advise the Integration Council, as needed. D. After the execution of this term sheet or similar legal document and until the Transaction closing date, the Integration Council will report to the Joint Board Task Force, to be comprised of existing Wellmont and Mountain States Board members, and the CEOs of Wellmont and Mountain States, acting in a transaction committee role. E. All of the activities of the Integration Council prior to Transaction close shall be reviewed and advised in advance by legal counsel to ensure compliance with all applicable legal and regulatory restrictions. F. The Integration Council shall develop a draft Newco policy outlining the process for consolidating services and facilities, which policy shall include but not be limited to cultural integration, timetables for actions, input from physicians impacted, and notices to staff and community. The draft policy shall be submitted to the Newco board for approval. Post-Transaction, the Integration Council will cease operations and its functions shall be assumed by the Newco management team. G. The Parties will mutually agree and define in the Definitive Agreement the ongoing activities, terms of service and scope of the Integration Council within Newco post-Transaction.
VIII. **Clinical Council**	A. Promptly after the Transaction closing, Newco commits to the development of a physician-led Clinical Council (composed of appropriate balances of private physicians, group practice physicians and employed physicians) to guide, oversee and assist in implementation of the plan to integrate clinical activities, service lines and business units, and to advise on any appropriate further clinical integrative actions post-implementation that would result in added growth, operational efficiencies and advancements in patient care. Post-closing, the initial Clinical Council will equally represent physicians whose primary practice venue is Wellmont or Mountain States. B. The Clinical Council will include Newco management representatives but will be composed primarily of physician representatives. The Clinical Council will report to the Chief Medical Officer of Newco. The Chair of the Clinical Council will be a physician member of the active medical staff(s) of one or more Newco-affiliated hospitals, will serve on the Quality Committee of the Newco Board, and will provide ongoing reports on the activities of the Clinical Council to the Newco Board through the Quality Committee function of the Board. C. Among other duties, it is anticipated the Clinical Council will work on areas, among others, such as establishing a common standard of care,

	common credentialing, consistent multidisciplinary peer review, where appropriate, and quality performance standards
IX. **Newco Management**	A. The initial management team ("Initial Management Team") of Newco shall be as follows: • Executive Chairman/President: Alan Levine o The Executive Chairman/President will be the senior officer of the organization. The evaluation of the Executive Chairman/President's performance will reside with the Newco Board. • Chief Executive Officer: Bart Hove o The Chief Executive officer will report to the Executive Chairman/President. • Chief Operating Officer: Marvin Eichorn o The Chief Operating Officer will report to the Chief Executive Officer. • Chief Financial Officer: Alice Pope o The Chief Financial Officer will report to the Chief Executive Officer. The position description for the Executive Chairman/President shall be substantially similar to the position description attached as Exhibit C to this Term Sheet and ensure the position is the most senior officer of Newco. The Joint Board Task Force will develop and approve the Executive Chairman/President's contract for inclusion as an exhibit to the Definitive Agreement, and to be executed by the Newco Board upon the closing of the Transaction • Concurrently with the process for development of the Contract with the Executive Chairman/President, the Executive Chairman/President shall, on behalf of the Joint Board Task Force, negotiate an employment agreement with the Chief Executive Officer for ratification by the Joint Board Task Force. This contract will be included as an exhibit to the Definitive Agreement, and will be executed by the Executive Chairman/President and Chief Executive Officer upon the closing of the Transaction. The position description for the Chief Executive Officer shall be substantially similar to the position description attached as Exhibit D to this Term Sheet. • The Chief Executive Officer, in consultation with the Executive Chairman/President, will then develop job descriptions for the remaining Initial Management Team members for inclusion as an exhibit to the Definitive Agreement. B. The Executive Chairman/President and the Chief Executive Officer of

	Newco will begin the process of assembling the Newco management team (comprised of the direct reports to the Executive Chairman/President and the Chief Executive Officer other than the Initial Management Team), which shall be presented to the Newco Board for approval after the closing. It is anticipated that the Newco management team will be composed of representatives from each Party and will not be composed of the management team from a single Party. C. Upon signing of this term sheet or similar legal document, Wellmont and Mountain States will identify to each other those senior executives with whom each has executed, or will execute, retention and severance agreements. D. It is in the best interest of Newco that the corporate headquarters are easily accessible and conveniently located. Within 2 years of closing, the Newco Board will direct that the Newco Senior Management Team evaluate the most suitable, cost-effective and appropriate location of the corporate headquarters and to make a recommendation to the Board for consideration and approval. The Newco corporate headquarters shall not be located on the campus of any Newco affiliated hospital.
X. **Employees**	A. Newco and affiliates will continue employment of (or, as appropriate, extend offers of employment to) all active employees of the Parties upon substantially similar terms and conditions with respect to base salaries and wages, job duties, titles and responsibilities that are currently provided to such employees immediately prior to close, except that certain positions which are identified as synergies may be eliminated. Normal employment practices, including terminations and reductions in force, will be unaffected. B. Newco will honor prior service credit under each Parties' employee plans for purposes of eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States, and will waive any eligibility requirement or pre-existing condition limitation for persons covered under each Parties' employee benefit plans. Newco will provide all employees credit for accrued vacation. C. Newco will work as quickly as practicable after closing to address any required actions with respect to differences in salary/ pay rates and employee benefit structures with a goal of creating consistency throughout the merged health system wherever feasible.
XI. **Medical Staff**	A. Newco is committed to a pluralistic, physician-led medical staff model that embraces the strengths of private practice, group practice and employed physicians. B. The medical staff members in good standing immediately prior to Transaction closing will maintain their medical staff privileges at the Parties' facilities where such privileges are maintained, subject to the medical staff

	bylaws then in effect. C. Subject to completion of due diligence, Newco will continue all existing contracts with physicians, including employment agreements, at least until the initial expiration of such contracts. D. All medical staff bylaws of each legacy system will remain in effect until such time as Newco and each respective medical staff develop and approve a new or modified set of medical staff bylaws, should new or modified medical staff bylaws be deemed necessary.
XII. **Existing Affiliations**	A. Newco will initially maintain the Wellmont and Mountain States joint ventures, affiliations and other outsourced contracts/relationships existing at close. B. Opportunities to optimize such structures will continue to be evaluated by the Newco board and the Integration Council post-Transaction. C. Prior to closing the Transaction any potential conflicts arising under such arrangements that are caused by the Transaction shall, subject to prior advice of counsel, be identified and reviewed by the Integration Council and the Joint Board Task Force. Recommendations by the Integration Council for post-closing actions by Management or Newco Board will be reported to the Board and Counsel.
XIII. **Information Technology**	A. The Definitive Agreement will provide that all Newco hospitals will fully integrate into the EPIC information system currently used by Wellmont.
XIV. **Insurance Platforms**	A. As soon as practicable after closing, Newco will review the structure of the existing insurance platforms of Wellmont and Mountain States and work to spread risk, reduce costs and realize efficiencies that result from the Transaction
XV. **Philanthropic Gifts**	A. Newco will honor the intent of all gifts, bequests, grants and donations provided to either Mountain States or Wellmont by a donor to be used for charitable purposes by a tax-exempt organization.
XVI. **Community Benefit**	A. Newco commits to operate in accordance with the "community benefit standards" as they apply to 501c(3) hospital non-profit corporations, including, without limitation, the (i) acceptance of all Medicare and Medicaid patients, (ii) acceptance of all emergency patients without regard to ability to pay, (iii) maintenance of an open medical staff, (iv) provision of public health programs of educational benefit to the community, and (v) general promotion of public health, wellness, and welfare to the community through the provision of health care at a reasonable cost. B. The Definitive Agreement will commit Newco to maintaining the Parties' existing or equivalent community benefit and education programs and services at close. C. In the context of supporting the Certificate of Public Advantage, Newco will conduct, in partnership with East Tennessee State University and other Academic partners, as appropriate, a detailed public health needs

	assessment in order to identify and prioritize measurable health needs and initiatives. Such initiatives may include, but not be limited to: • The establishment of a long-term strategy for improving the health status of the region served by the merged system that supports both the Tennessee and Virginia state health plans; • Improvement of behavioral health services, mental health, addiction recovery, and services for people with developmental disabilities; • Enhancement of programs to reduce drug abuse in the region, specifically among women in child-bearing years; • Establishment of programs to improve health literacy; • Development of programs to improve child wellness – physical and emotional; • Growth of medical research programs; and • Expansion of academic opportunities, to include, but not be limited to, expansion of new fellowships and other opportunities to allow physicians and allied health professionals to train and serve in health professional shortage areas within the region. D. Newco will abide by policies and provisions of charity care that are no less generous than the policies of the Parties at the time of the Transaction closing, subject to changes in law, policy or regulation as applicable.
XVII. **Naming/ Branding**	A. The Parties will work to mutually agree to the renaming and rebranding of Newco. Upon signing of this term sheet, Wellmont and Mountain States will mutually agree upon and jointly retain a firm to advise and assist them with the rebranding strategy. The rebranding strategy will have goals of establishing a single identity for the merged system that communicates its mission and clearly informs all members of the regional community of the new name, logo(s), and the mission of the merged system.
XVIII. **Approvals; Termination**	A. The execution and delivery of the Definitive Agreement are conditioned on the receipt of all necessary consents and approvals of the appropriate governing boards of Mountain States and Wellmont. Furthermore, it is anticipated that the Definitive Agreement will provide that the consummation of the Transaction will be conditioned upon: 1. The receipt of all material consents of third parties, if any, necessary under material agreements of the Parties for consummation of the Transaction contemplated under the Definitive Agreement; 2. The filing of all notices and the receipt of all approvals and consents, as required from governmental authorities (including, if applicable, the Attorneys General of the States of Tennessee and Virginia); 3. The termination of any waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended; and

	4. The satisfaction of such other conditions as are mutually acceptable to the Parties or are legally required. B. It is the intent of both Parties, upon execution of the Definitive Agreement, that both Parties will take all reasonable steps necessary to close the Transaction. Notwithstanding the foregoing, both Parties recognize there may be circumstances of federal and/or state government action or inaction, or extraordinary external factors, that may give rise to the conclusion that the Transaction may be imperiled or it is no longer reasonable to pursue closing of the Transaction. Consequently, the Definitive Agreement shall articulate circumstances upon which either Party may unilaterally terminate the Transaction.
XIX. **COPA**	A. Without limiting the approvals described above, simultaneously with the negotiation of the Definitive Agreement, the Parties will negotiate a "cooperative agreement" as defined in the Tennessee Hospital Cooperation Act of 1993 (the "Act"). B. Following execution of the Definitive Agreement, the Parties will apply to the Tennessee Department of Health to obtain, and follow the procedures under the Act for obtaining, a certificate of public advantage (the "Tennessee COPA") to govern the cooperative agreement as provided in the Act. C. At the appropriate time, the Parties shall apply to the Virginia Attorney General, or other appropriate state agency or entity, for a consent order or other appropriate state approvals regarding Newco Virginia operations on substantially the same terms as the Tennessee COPA (the "Virginia Consent Order"). D. Subject to the provisions articulated in Section XVIII, Paragraph B above, each Party shall use good faith efforts to obtain the Tennessee COPA and other regulatory approvals necessary to closing of the Transaction. The Definitive Agreement will provide that receipt of the Tennessee COPA and the Virginia Consent Order, or comparable approval, on terms satisfactory to the respective Wellmont and Mountain States Boards, in their reasonable discretion, is a condition to the Parties' respective obligations to complete the Transaction.
BINDING PROVISIONS	
XX. **Confidentiality and Disclosure**	A. The Parties have previously entered into a confidentiality agreement dated April 2, 2014 (the "Confidentiality Agreement"). In addition to the provisions contained in that agreement, except as and to the extent required by law, without the prior written consent of the other Party, neither Mountain States nor Wellmont shall, and each shall direct its representatives not to, directly or indirectly, make any public comments, statement or communication with respect to, or otherwise disclose or permit the disclosure of the existence of discussions regarding a possible Transaction or any of the terms, conditions or aspects of the Transaction proposed in this term sheet except in the manner provided by the

	Confidentiality Agreement. The timing, content and context of any announcements, press releases, public statements, or reports and related matters incident to the matters referenced in this term sheet, or its existence, will be determined in advance by the mutual written consent of the Parties. Further, the Parties will advise each other of communications to their employees and medical staff relating to the Transaction prior to the communication of the same.
XXI. **Protocols on Information Sharing**	A. The Parties recognize that disclosure of certain information may raise unique legal concerns due to the proximity of the Parties' operations and facilities ("Competitive Sensitive Information"). Such Competitive Sensitive Information may include, but is not limited to, information about prices, pricing formulas, costs, rates of provider compensation, strategy or intentions regarding contracting with any provider or purchaser, fee schedules, managed care contracts, premium rates, compensation or benefits information relating to employees, recruitment of medical professionals or others, future expansion plans involving clinical services or pertaining to physicians, and any non-public marketing or strategic planning documents or other competitively sensitive documents relating to a party's future plans. The Parties will only disclose Competitive Sensitive Information in accordance with law as agreed to in advance by the Parties' and their respective legal counsel and to that end, the Parties may enter into one or more protective agreements or develop other arrangements to address the review of such Competitive Sensitive Information to ensure compliance with applicable law.
XXII. **Transaction Expenses; Exclusive Negotiations**	In view of the substantial time and expense involved in obtaining required regulatory approvals, due to the innovative nature of the Transaction: A. With respect to the expenses of the Tennessee COPA (including experts and the Wellmont counsel fees), the Virginia Consent Order and other expenses arising out of this term sheet and the Transaction (collectively referred to as "Expenses"), whether or not the Transaction or any part thereof shall close, Mountain States shall bear 70% of the Expenses, while Wellmont shall bear 30% of the Expenses. B. In consideration of the Parties' significant investment of time and expense in connection with the transactions contemplated by this term sheet, from the date of execution of this term sheet or similar legal document until written termination of negotiations are received by the other Party, neither Party may, without the written approval of the other Party, make or solicit offers for, or hold discussions or negotiations or enter into any agreement with respect to, (a) the sale, lease or management of any of its hospitals or any material portion of its assets or any ownership interest in any entity owning any of its hospitals or any material portion of its assets, (b) any reorganization, merger, consolidation, management agreement, member substitution or joint venture involving any of its hospitals or any material portion of its assets, or (c) any other transaction in which a person or group other than the other Party would acquire the right, directly or indirectly, to

	control the governing board of, direct the operations of, establish governing or operating policies for, and/or own, lease or otherwise acquire the right to use or control, any of such Party's hospitals or any material portion of its assets (the "Exclusive Negotiations Covenant").
XXIII. **Nature of Term Sheet**	A. The Parties agree that, except for Sections XX-XXIV hereof, this Term Sheet is not intended to be a binding agreement and shall not give rise to any obligations between the Parties. B. Further, due to the complexity of the proposed transaction, it is the expressed intention of the parties that, except for the provisions of Sections XX-XXIV, no binding contractual agreement shall exist between them unless and until Mountain States and Wellmont (and any other necessary parties) shall have executed and delivered a Definitive Agreement, which shall contain the provisions outlined above and the representations, warranties, and other terms and conditions customary in this type of transaction, all of which must be acceptable to all parties in their sole discretion (including, without limitation, contingencies for all necessary regulatory approvals). Any Party may for whatever reason terminate this term sheet and further negotiations by written notice to the other Party. In such event, there shall be no liability between any of the Parties as a result of the execution of this term sheet, any acts or omissions of the parties or their representatives in connection with the proposed transaction, any action taken in reliance on this term sheet, or such termination, except as set forth in Sections XX-XXIV hereof. Notwithstanding the foregoing, termination by either party of this term sheet shall not terminate or otherwise affect the obligations the parties may have to each other pursuant to the Confidentiality Agreement, and pursuant to any separate agreement entered into with respect to Competitive Sensitive Information. C. Prior to execution, this term sheet shall be approved by the Board of Directors of both Wellmont and Mountain States.
XXIV. **Governing Law**	A. The Transaction definitive documents shall be governed by and construed in accordance with the laws of the State of Tennessee without reference to principles of conflicts of law. Wellmont counsel shall prepare the initial drafts of definitive documents.

(signatures on the following page)

IN WITNESS WHEREOF, the parties hereto have caused this term sheet to be executed in multiple originals by their duly authorized officers, all as of the date first above written.

COPY

MOUNTAIN STATES HEALTH ALLIANCE

By: _____
Barbara Allen
Chair

By: _____
Alan Levine
President and CEO

WELLMONT HEALTH SYSTEM

By: _____
Roger Leonard
Chairman

By: _____
Bart Hove
President and CEO

COPY

Exhibit A

Shared Vision and Guiding Principles

A Shared Vision for Regional Healthcare

It is the shared vision of our boards that Wellmont Health System and Mountain States Health Alliance come together as equal partners to develop a brand new health system for our region with a new leadership structure, a new board, a new name, and a new kind of vision. This new leadership structure and board will work to unite the resources of both systems with one common purpose—to become one of the best regional health systems in the nation..

As one of the largest health systems and employers in the state of Tennessee, this new system will—

- Establish new unifying mission, vision, and values statements that honor our heritage and charter our future
- Be one of the strongest health systems in the country, known for outstanding clinical outcomes and superior patient experiences
- Be one of the best health system employers in the country and one of the most attractive health systems for physicians and employee team members
- Create new models of joint physician and administrative leadership to shape the future of healthcare in our region through substantial physician influence and direction
- Partner with physicians to achieve better quality at lower cost for patients, businesses, and payers
- Achieve long-term financial stability and sustainability through wise stewardship of resources, avoidance of waste, and sound fiscal management
- Advance high-level services so that more people can receive the care they need close to home
- Be a national model for rural healthcare delivery and rural access to care
- Work with regional educational and allied health partners to identify health gaps and disparities and effectively meet community health needs
- Create an efficient, high quality healthcare system that attracts employers to our region and creates long-term economic opportunity
- Build new population health models and leverage electronic health records and community engagement programs to reduce unhealthy behaviors and improve the overall health status of our region
- Work with academic partners, in particular East Tennessee State University, in new ways to bolster medical school and allied health programs and attract research investments
- Establish innovative philanthropic partnerships for healthcare advancement

To accomplish these objectives, we will seek to build shared vision with our team members and physicians and invest in their success. As a health system of choice, the new system will benchmark

against the best health systems in the nation to create an environment that advances our team members and physicians.

Our integration should be methodical and intentional, guided by achieving clear value for the community, our team members, and our physicians. A substantial period of initial assessment will be needed and will result in a long-term strategic vision for the new system. During the assessment and planning period, it will be important to maintain clinical services in our current communities and move forward to address any access gaps across the region. We commit to open communication through rotating quarterly town hall meetings and other methods to keep our communities and physicians informed about our plans and our progress.

Working together, focused solely on what is in the best interests of our physicians, team members, patients, and communities we will set a new standard for healthcare excellence and bring unprecedented value to our region guided by the principles that follow.

Guiding Principles for a New Regional Health System

Beyond a shared vision to develop one of the best health systems in the nation, the new not for profit health system created by the merger of Wellmont Health System and Mountain States Health Alliance will be guided by the following principles and will develop strategic plans to deliver on them.

Mission, Vision, and Strategy

- Exhibit common values and a compelling vision for healthcare delivery in the region
- Achieve cultural integration across key stakeholder groups and embody a culture of collaboration
- Demonstrate commitment to the Triple Aim of improving the patient experience through enhanced quality and satisfaction, improving the health of populations and reducing the per capita cost of healthcare

Patients

- Demonstrate a commitment to first class patient experiences and broad community support for programs and services
- Improve and advance the overall health status of patients and communities served, including both healthcare and wellness services, to improve their ability to stay well
- Commit to serving all people in each community—including those with and without the ability to pay
- Develop regional community health needs assessments and implementation plans and update these annually to ensure healthcare gaps and disparities are addressed
- Keep the best interest of patients at the center of everything we do, delivering exceptional value and high quality outcomes

- Facilitate patient access to their preferred physicians
- Create the best practice environment for the physicians who care for our patients
- Maintain and further develop highly specialized medical services

Physicians

- Support and strengthen our valued community of independent physicians as well as currently employed physicians for the benefit of high-quality patient outcomes
- Create an environment and culture that is attractive to highly qualified physicians and that places equal value on the roles of both independent and employed physicians
- Ensure all physicians have the resources needed to access clinical information and collaborate in the best interest of patients
- Broaden expertise and resources to enhance local medical staff leadership and professional development
- Commit to physician leadership at all levels of system and local administration

Employees

- Maintain or improve compensation and benefits for employees to levels that are competitive in comparable markets throughout the Southeastern United States and maintain the tenure of employees for eligibility and other purposes
- Create industry leading educational and professional development programs, including continuing education and clinical education
- Create an employment environment that will attract and retain highly qualified clinical and administrative talent in service to our communities

Clinical Programs, Service, and Quality

- Develop cohesive resources to effectively coordinate the provision of services across the system and ensure seamless access to high quality, cost-effective healthcare services
- Seek to improve primary care access and develop NCQA, level 3 patient-centered medical homes
- Effectively manage rural facilities and align tertiary resources to ensure timely access to appropriate care
- Expand clinical trial programs in heart, cancer, and other areas
- Design a seamless regional care continuum across a full spectrum, including pre and post acute care

Management & Operations

- Seek opportunities to leverage economies of scale for operational efficiency in corporate management and back office functions
- Enhance clinical support functions that will advance service excellence and quality outcomes
- Leverage any unique capabilities, assets, and programs to maximize effectiveness and efficiency
- Develop proficiency in implementation and management processes and protocols to redesign care, reduce variation, and systematically improve outcomes while lowering cost

Investment and Innovation

- Endeavor to remain on the forefront of future developments in healthcare technology
- Develop effective purchasing and financing systems to improve overall cost of capital
- Achieve and maintain an improved approach to overall financial management, resulting in improved finances and bond ratings
- Build a comprehensive Epic platform to support clinical integration, population health management, and connectivity
- Achieve sufficient financial security to ensure commitment of capital and investment in new services, technology, and facilities.

Population Health Management

- Focus on the purposeful development of a care management/population health model
- Support advancement of population health management locally through quality incentive and risk-bearing payment arrangements, among other appropriate mechanisms
- Develop necessary informatics and analytic systems to support partnerships with payers and employers in new compensation and insurance models.

Governance

- Instill industry leading governance structures and practices that effectively represent the communities we serve and showcase physician leadership
- Ensure the system possesses the resources, talent, and technology needed to thrive both in the current and the emerging healthcare industry

Exhibit B

COPY

Description of the Vice Chair/Lead Independent Director Position

Charter of the Vice Chair/Lead Independent Director

The Vice Chair/Lead Independent Director coordinates the activities of the other non-management Directors, and performs such other duties and responsibilities as the Board of Directors may determine.

The specific responsibilities of the Vice Chair/Lead Independent Director are as follows:

Presides at Executive Sessions

- Presides at all meetings of the Board at which the Executive Chairman/President is not present, including executive sessions of the independent Directors.

Calls Meetings of Independent Directors

- Has the authority to call meetings of the independent Directors.

Conducts Evaluation of Executive Chairman/President

- Ensures independent Director evaluation of the Executive Chairman/President by the Board, including an annual evaluation of his or her performance and compensation.

Functions as Liaison with the Executive Chairman/President

- Serves as liaison between the independent Directors and the Executive Chairman/President.

Approves appropriate provision of information to the Board such as board meeting agendas and schedules

- Approves meeting information sent to the Board relating to agendas and actions items, including the quality, quantity and timeliness of such information.
- Setting the Board's approval of the number and frequency of Board meetings, and approves meeting schedules to assure that there is sufficient time for discussion of all agenda items.

Authorizes Retention of Outside Advisors and Consultants

- Authorizes the retention of outside advisors and consultants who report directly to the Board of Directors on board-wide issues upon approval of the Governance Committee.

Constituent Communication

- If requested by constituent groups, ensures that he/she is available, when appropriate, for consultation and direct communication.

Exhibit C

COPY

Description of the Executive Chairman/President Position

Executive Chairman/President

Leadership

- Leadership of the board; ensuring the board's effectiveness and engagement in all aspects of its role and, in conjunction with the Vice Chair, setting of its agenda.
- Directing activities which serve to promote the mission.
- Consistent with the shared vision statement, setting the direction for the organization by shaping the vision, setting the strategy, and leading critical negotiations with potential partners.
- Shaping a positive culture: setting the standards, modeling Newco's values, to include a focus on 'system-ness' and value-based performance, research and academics, and innovation.
- In conjunction with the Chief Executive Officer: building leadership capability of the management team; selecting, developing and motivating key leaders and high potential talent to ensure future leadership is capable of meeting current and future organizational needs and is held accountable for system-wide performance.
- Promoting the highest standards of corporate governance.

Meeting

- Chairing board meetings.
- In conjunction with the Vice Chair, ensuring the board's effectiveness in all aspects of its role, including regularity and frequency of meetings.
- In conjunction with the Vice Chair, setting the board agenda, taking into account the issues and concerns of all board members. The agenda should be forward looking, concentrating on strategic matters.
- Ensuring that the directors receive accurate, complete, timely and clear information, and are advised of all likely future developments and trends, to enable the board to take sound decision and promote the success of the company.

Directors

- Facilitating the effective contribution of directors and encouraging active engagement by all members of the board.
- Ensuring constructive relations among the directors and between the directors and management.
- Building and maintaining an effective competency based and complementary board, and with the Nomination Committee, initiating change and planning succession in board appointments subject to the bylaws and board approval.

Induction, Development and Performance Evaluation

- Ensuring new directors are oriented, and provided adequate opportunity to on-board.
- Ensuring that the development needs of directors are identified and met. The directors should be able to continually update their skills, knowledge, and familiarity with the company.
- In conjunction with the Vice Chair, identifying the development needs of the board as a whole to enhance its overall effectiveness as a team and to ensure it receives board education consistent with industry standards for a system of the size and scope of Newco.

- Ensuring the performance of the board, its committees and individual directors is evaluated periodically through the Board Governance Committee, and acting on the results of such evaluation.

Relations with Stakeholders

- Ensuring effective communication with all stakeholders, financial institutions, the public and government/regulatory agencies. Serve as the Chief Spokesperson for the Organization with appropriate delegation of authority to the CEO on operational matters.
- Representing Newco to Federal, State and local governing bodies and, either in person or through a designee, serve as Chief Spokesperson and advocate for the interests of Newco and on healthcare issues in general.
- Maintaining and promoting Newco's public image and reputation.

Direct Reports

The direct reports to the Executive Chairman/President include:

- Chief Executive Officer
- Compliance and Audit (dual reporting responsibility to the Executive Chairman/President and also to Chair of Audit Committee)
- General Counsel (dual reporting to the Executive Chairman/President and to the board.
- Corporate Communications
- System Development/Philanthropy
- Strategic Planning

Other Responsibilities

The Executive Chairman/President shall:

- Uphold the highest standards of integrity.
- Ensuring effective implementation of board decisions.
- Ensuring the long-term sustainability of the business through coordination with Newco Board and Management Team.

The Executive Chairman/President is accountable to, and reports to the Newco Board.

The Executive Chairman/President is also responsible for the following:

- Enhancement of external affiliations and relationships.
- Implementing and oversight of compliance with Certificate of Public Advantage or other regulatory agreements.
- Regular review of the operational performance of the company.
- Responsible to the Newco Board for ensuring the provision of the highest quality of patient care and customer service in all Newco facilities and business units.
- Responsible for management of the organization's debt.
- Aligning the organization: continuing to drive the integration of Newco to create a cohesive, responsive organization by eliminating redundancies, capitalizing on economies of scale, and fostering a system mentality.

Exhibit D

COPY

Description of the Chief Executive Officer Position

Chief Executive Officer

Leadership

- The Chief Executive Officer of Newco reports to the Executive Chairman/President and is the senior executive in charge of all business operations of the Newco organization. This executive position requires a combination of operational excellence and system administrative skills and must be attentive to enhanced financial performance in a physician-empowered culture. It is expected that the CEO is adroit in physician relations, physician recruitment and retention.

- This position requires visionary leadership and plays a vital role in creating, implementing and executing the strategy in conjunction with the Executive Chairman/President. Of paramount importance, this position requires the incumbent to establish credibility with employees, physicians, payors, providers and community leaders. The CEO is expected to raise the health system's visibility and reputation in the communities it serves in conjunction with the Executive Chairman/President.

- The CEO position serves as the principal operational leader for the organization and is responsible for driving forward Newco's vision to be the best healthcare delivery system in the region in conjunction with the Executive Chairman/President. This position is the champion for Newco's continued emphasis on "systemness" across the care delivery continuum, to achieve not only its quality and safety goals, but also to increase operational efficiency and provide a consistent point of service contact for its patients.

Major Responsibilities

- Possess a professional and personal adherence to the values, mission and philosophy of the Newco organization.

- Expand on the legacy of the quality and safety of patient care services across the system.

- Working closely with the Executive Chairman/President to lead the ongoing review of the current strategic plan and development of future strategic plans; ensure the plan supports the organization's goal of clinical excellence, while at the same time considers the appropriate business model for the medical staff and strategic service opportunities for growth and addresses revenue generation to sustain ongoing growth. Realize the goal of an integrated health system that leverages the advantages of a multi-state and multimarket health.

- In conjunction with the Executive Chairman/President, build a high performance culture characterized by decisiveness, accountability and compassion.

Direct Reports

- Chief Operating Officer
- Chief Financial Officer

And the following subject to development of a final organizational chart.

- Chief Medical Officer
- Vice President of Human Resources
- President of Physician Organization

Exhibit 7

Interim Parent Company Articles

BILL GARRETT, Davidson County
Trans:T20150077661 CHARTER
Recvd: 09/11/15 15:50 5 pgs
Fees:7.00 Taxes:0.00
20150911-0092693

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Newco, Inc.
STE 800
211 COMMERCE ST
NASHVILLE, TN 37201-1817

September 11, 2015

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

SOS Control # :	**000814276**	Formation Locale:	TENNESSEE
Filing Type:	Nonprofit Corporation - Domestic	Date Formed:	09/11/2015
Filing Date:	09/11/2015 3:14 PM	Fiscal Year Close:	12
Status:	Active	Annual Report Due:	04/01/2016
Duration Term:	Perpetual	Image # :	B0126-8290
Public/Mutual Benefit:	Public		
Business County:	DAVIDSON COUNTY		

Document Receipt

Receipt # : 002230945	Filing Fee:	$100.00
Payment-Check/MO - BAKER, DONELSON, BEARMAN, CALDWELL & BERKOWITZ, NASHVILI		$100.00

Registered Agent Address:
CLAIRE C. HALTOM
STE 800
211 COMMERCE ST
NASHVILLE, TN 37201-1817

Principal Address:
STE 800
211 COMMERCE ST
NASHVILLE, TN 37201-1817

Congratulations on the successful filing of your **Charter** for **Newco, Inc.** in the State of Tennessee which is effective on the date shown above. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee. Please visit the Tennessee Department of Revenue website (apps.tn.gov/bizreg) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and recieve it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

Processed By: Kelli Wiggins

ARTICLES OF INCORPORATION

OF

NEWCO, INC.

The undersigned nonprofit corporation acting pursuant to the provisions of the Tennessee Nonprofit Corporation Act, Tennessee Code Annotated, Section 48-51-101, et seq. (the "Act"), adopts the following Articles of Incorporation pursuant to Tennessee Code Annotated, Section 48-52-102:

ARTICLE I.

CORPORATE NAME

The name of the corporation is Newco, Inc. (the "Corporation").

ARTICLE II.

TYPE OF CORPORATION

The Corporation is a public benefit corporation.

ARTICLE III.

INCORPORATOR

The name, address and zip code of the incorporator is Claire C. Haltom, 211 Commerce Street, Suite 800, Nashville, TN 37201.

ARTICLE IV.

REGISTERED AGENT AND OFFICE

The registered office of the Corporation is 211 Commerce Street, Suite 800, Nashville, Tennessee 37201, Davidson County, and its registered agent at that address is Claire C. Haltom.

ARTICLE V.

PRINCIPAL OFFICE

The street address and zip code of the principal office of the Corporation is 211 Commerce Street, Suite 800, Nashville, Tennessee 37201.

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2831265-000041 09/11/2015

ARTICLE VI.

NONPROFIT STATUS

The Corporation is not for profit.

ARTICLE VII.

MEMBERS

The Corporation will not have members.

ARTICLE VIII.

PURPOSES

The purposes for which this Corporation is organized are as follows:

(a) It is intended that the Corporation will qualify at all times as an organization exempt from federal income tax under Sections 501(a) and 501(c)(3) of the Internal Revenue Code of 1986, including any amendments that may be made from time to time (the "Code"), and that it will qualify at all times as an organization to which deductible contributions may be made pursuant to Sections 170, 642, 2055 and 2522 of the Code. The Corporation is organized and will be operated exclusively for charitable, scientific, and educational purposes within the meaning Section 501(c)(3) of the Code, including the business of developing, owning and operating inpatient hospitals, clinics, physician practices, other healthcare services, and other services, businesses and activities for the overall purpose of promoting health and providing quality health care services to a broad cross section of the community. In accomplishment of such purposes, the Corporation shall be organized, and at all times operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of the not for profit corporations of which it is a member, provided that such not for profit corporations (i) qualify at all times as organizations exempt from federal income tax under Section 501(c)(3) of the Code and (ii) are described in Section 509(a)(1) or 509(a)(2) of the Code.

(b) Notwithstanding the other provisions of these Articles of Incorporation, the Corporation shall only conduct or carry on activities permitted to be conducted or carried on by an organization exempt under Section 501(c)(3) of the Code, and by any organization contributions to which are deductible under Section 170(c)(2) of the Code.

(c) The Corporation may do any and all things hereinabove set forth, and all things usual, necessary or proper in furtherance of or incidental to the purposes of the Corporation.

ARTICLE IX.

LIMITATIONS ON POWERS

As a means of accomplishing the purposes for which it is organized, the Corporation shall have the rights and powers now or later conferred upon corporations not for profit by the Act and the laws of the State of Tennessee, limited in certain respects as follows:

(a) The Corporation shall neither have nor exercise any power, nor shall it directly or indirectly engage in any activity, that would (1) prevent it from obtaining and maintaining exemption from federal income taxation as a corporation described in Section 501(c)(3) of the Code, (2) prevent it from obtaining and maintaining the status of a corporation contributions to which are deductible under Section 170(c)(2) of the Code, or (3) cause it to lose such exemption or status.

(b) The Corporation shall not be operated for the primary purpose of carrying on a trade or business for profit.

(c) No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its directors, officers, or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of its corporate purposes.

(d) Except as may be permitted from time to time under Section 501 of the Internal Revenue Code, no substantial part of the activities of the Corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation; nor shall it in any manner or to any extent participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for public office; nor shall the Corporation engage in any activities that are unlawful under applicable federal, state, or local laws.

ARTICLE X.

LIMITATION OF DIRECTOR LIABILITY

To the fullest extent that the laws of the State of Tennessee as it exists on the date hereof permits the limitation or elimination of the liability of directors, no director of the Corporation shall be personally liable to the Corporation for monetary damages for breach of fiduciary duty as a director. If the Act is amended after approval of these Articles of Incorporation to authorize corporate action further eliminating or limiting personal liability of directors, then the liability of a director of the Corporation shall be eliminated or limited to the fullest extent permitted by the Act, as amended, without the requirement for further amendment of these Articles of Incorporation.

ARTICLE XI.

DISSOLUTION

Upon the dissolution of the Corporation, and pursuant to the laws of the State of Tennessee:

(a) All liabilities and obligations of the Corporation shall be paid and discharged, or adequate provisions shall be made therefore; and

(b) All remaining assets of the Corporation shall be distributed to one or more charitable, scientific, literary or educational organizations which are not for profit, and which qualify under the provisions of Section 501(c)(3) of the Code, and which, if practical, are engaged in affairs substantially similar to those of the Corporation, or to the State of Tennessee or any governmental subdivision thereof exclusively for public purposes all as shall be determined by the Board of Directors of the Corporation. In default of any such determination, all remaining assets shall be disposed of by a court of competent jurisdiction in the county in which the principal office of the Corporation is then located exclusively for charitable, scientific, literary, or educational purposes, or to one or more organizations that are organized and operated exclusively for such purposes, as such court determines.

CERTIFICATION

IN WITNESS WHEREOF, these Articles of Incorporation are hereby executed and filed with the Secretary of State of the State of Tennessee, as of September 11, 2015, to be effective immediately.

Claire C. Haltom, Incorporator

Exhibit 8

Interim Parent Company Bylaws

BYLAWS

OF

NEWCO, INC.

ARTICLE I
NAME, PURPOSE, AND PRINCIPAL PLACE OF BUSINESS

Section 1. **Name.** The name of this Corporation is Newco, Inc. (hereinafter referred to as the "Corporation").

Section 2. **Purposes**. It is intended that the Corporation will qualify at all times as an organization exempt from federal income tax under Sections 501(a) and 501(c)(3) of the Internal Revenue Code of 1986, including any amendments that may be made from time to time (the "Code"), and that it will qualify at all times as an organization to which deductible contributions may be made pursuant to Sections 170, 642, 2055 and 2522 of the Code. The Corporation is organized and will be operated exclusively for charitable, scientific, and educational purposes within the meaning Section 501(c)(3) of the Code, including the business of developing, owning and operating inpatient hospitals, clinics, physician practices, other healthcare services, and other services, businesses and activities for the overall purpose of promoting health and providing quality health care services to a broad cross section of the community. In accomplishment of such purposes, the Corporation shall be organized, and at all times operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of the not for profit corporations of which it is a member, provided that such not for profit corporations (i) qualify at all times as organizations exempt from federal income tax under Section 501(c)(3) of the Code and (ii) are described in Section 509(a)(1) or 509(a)(2) of the Code.

ARTICLE II
MEMBERS

The Corporation shall have no members.

ARTICLE III
BOARD OF DIRECTORS

Section 1. **Duties**. The business and affairs of the Corporation shall be governed exclusively by its Board of Directors. The Board of Directors shall be responsible for ensuring high quality delivery of health care and human services to the communities served by the Corporation and the Corporation's subsidiaries. The Board of Directors may delegate certain authorities to subsidiary boards. Any authorities not specifically delegated are reserved to the Board of Directors of the Corporation.

Section 2. **Composition**. The Corporation's Board of Directors shall consist of four (4) directors, two (2) of whom shall be appointed by Mountain States Health Alliance, ("MSHA"), and two (2) of whom shall be appointed by Wellmont Health System ("Wellmont"); provided, however, that all Directors shall be persons who are deemed to be independent community directors in accordance with Internal Revenue Service guidance for organizations that are exempt from federal income tax under Code Section 501(c)(3) and which provide hospital services or other health care services or serve as supporting organizations to tax exempt health care services providers; provided, further, in order to satisfy the requirements for an organization supervised or controlled in connection with organizations described in Code Section 509(a)(1) or (2), as

described in Code Section 509(a)(3)(B)(ii), at all times all of the Corporation's directors will also be directors of MHSA and directors of Wellmont.

Section 3. Terms.

The Directors shall serve for a term of two (2) years commencing immediately following his or her respective appointment and continuing until their respective successors shall have been appointed and qualified.

Section 4. Vacancies. Vacancies arising in positions on the Board of Directors (whether by resignation, death, expiration of term of office, termination, removal, increase in Board size, or other reason) shall be filled by the corporation which appointed the Director vacating the position.

Section 5. Removal. Directors may be removed without cause by the corporation which appointed the Director to be removed.

Section 6. Resignation. A director may resign at any time by delivering written notice of resignation to the Corporation's Secretary. Resignation is effective when notice is delivered unless the notice specifies a later effective date, in which case such date shall be the effective date.

Section 7. Confidentiality and Fiduciary Duty of Loyalty, Care and Obedience.. Each director shall maintain the strict confidentiality of all information discussed or received in connection with any meeting of the Board of Directors and any committee meeting, whether such information is oral, written or preserved in any other form. No Director shall use any information gained through or in connection with his or her capacity as a director in any manner which might create, directly or indirectly, any form of personal benefit unless such usage is consistent with and done in compliance with the Corporation's policies regarding Conflicts of Interest. Each Director shall, at all times, exercise loyalty, care and obedience to the fiduciary responsibilities entrusted to the Director on behalf of the Corporation.

ARTICLE IV
OFFICERS OF THE CORPORATION

Section 1. Officers. The officers of the Corporation shall consist of a President, a Secretary, and a Treasurer. Except as provided below, all officers of the Corporation shall be elected by, and shall serve at the pleasure of, the Board of Directors. A duly appointed officer may appoint one (1) or more officers or assistant officers.

Section 2. Resignation. An officer may resign at any time by delivering written notice of resignation to the Corporation's President or Secretary. Resignation is effective when the notice is delivered unless the notice specifies a later effective date, in which case such date shall be the effective date.

ARTICLE V
POWERS AND DUTIES OF THE OFFICERS.

Section 1. **President**. Subject to the oversight of the Board of Directors, the President of the Corporation shall have general supervision, direction and control of the business and affairs of the Corporation and shall have the general powers and duties of management usually vested in persons in similar positions. In such capacity, the President shall report to the Board of Directors. The President, or his/her designee, may execute all promissory notes, mortgages, deeds, contracts and other instruments. The President shall have such other duties and authority as may be prescribed elsewhere in these Bylaws or from time to time by the Board of Directors.

Section 2. **Secretary**. The Secretary shall cause to be kept the minutes of all meetings of the Board of Directors and of any committee. He or she shall cause to be given all notices provided for in these Bylaws. He or she shall have custody of the seal of the Corporation and shall affix the same, attested by his or her signature, to all instruments required to be under the seal of the Corporation. He or she shall have the duties, power and responsibilities of the secretary of a Corporation under the laws of the State of Tennessee and shall perform such other duties as may be prescribed by the Board of Directors.

Section 3. **Treasurer**. The Treasurer shall be the official custodian of all funds and securities of the Corporation, and shall deposit, or cause to be deposited, same in such banks or other depositories as the Board of Directors may designate or approve. He or she shall have the duties, power and responsibilities of the treasurer of a Corporation under the laws of the State of Tennessee and shall perform such other duties as may be prescribed by the Board of Directors.

ARTICLE VI
MISCELLANEOUS

Section 1. **Corporate Seal**. The Board of Directors may provide a seal for the Corporation in the form approved by the Board of Directors.

Section 2. **Fiscal Year**. The fiscal year of the Corporation shall begin on the first day of July of each year.

ARTICLE VII
NOTICE

Whenever under the provisions of the Act, the Charter, or these Bylaws notice is required to be given to any director, officer, or committee member of the Corporation, it shall not be construed to require personal notice, but such notice, unless required to be in writing, may be given by telephone or electronic mail and, if given in writing, may be given either personally or by facsimile, or by depositing the same in a post office or letter box in a postpaid, sealed wrapper., in either case addressed to such director, officer, or committee member at his or her address as the same appears in the records of the Corporation; and the time when the same shall be so mailed or faxed, shall be deemed to be the time of the giving of such notice.

ARTICLE VIII
INDEMNIFICATION

Section 1. **Indemnification of Officers and Directors**. The Corporation shall indemnify an individual made a party to a proceeding, criminal or civil, because he or she is or was an officer or director (whether voting or non-voting) of the Corporation against liabilities and expenses incurred in the proceeding to the fullest extent permitted by the Act. The Corporation shall make advances for expenses incurred or to be incurred in the proceeding as provided for in the Act.

Section 2. **Indemnification of Employees and Agents**. The Corporation may indemnify an individual made a party to a proceeding, criminal or civil, because he or she is or was an employee or agent of the Corporation against liabilities and expenses incurred in the proceeding to the extent determined appropriate by the Board of Directors consistent with the provisions of the Act. The Corporation may make advances for expenses incurred or to be incurred in the proceeding to the extent determined appropriate by the Board of Directors consistent with the provisions of the Act.

Section 3. **Insurance**. The Corporation shall have the power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee, or agent of another Corporation, partnership, joint venture, trust, or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have the power or would be required to indemnify him or her against such liability under the provisions of this Article.

Section 4. **Nonexclusivity**. The rights of indemnification and advancement of expenses granted pursuant to this Article shall not be deemed exclusive of any other rights to which an officer, director, employee, or agent seeking indemnification or advancement of expenses may be entitled, pursuant to the Act, Tennessee statutory or case law, the Corporation's Charter, these Bylaws, a resolution of the Board of Directors, or an agreement or arrangement providing for indemnification; provided, however, that no indemnification may be made to or on behalf of any officer, director, employee, or agent, if a judgment or other final adjudication establishes that such indemnification is prohibited by Section 48-58-502 of the Act or any successor statutory provision.

Section 5. **Statutory Immunities**. Nothing contained in this Article VIII shall be construed to prejudice or otherwise diminish the limitations, immunities and other protections available to the directors and officers of the Corporation (including a director of a Hospital Board) pursuant to Section 48-58-601 of the Act or any successor statutory provision.

ARTICLE IX
CONFLICTS OF INTEREST

The Board of Directors shall adopt and maintain a Conflict of Interest Policy applicable to all members of the Board, Board Committees, officers of the Corporation, and key management personnel. The policy shall require the annual completion and submission of an acknowledgement and disclosure statement, as well as a confidentiality agreement applicable to all business of the Board of Directors.

Exhibit 9

Amended Parent Company Bylaws

AMENDED AND RESTATED

BYLAWS

OF

NEWCO, INC.

Table of Contents

Page

Table of Contents

ARTICLE I
NAME AND PURPOSE,

Section 1. **Name.** The name of this Corporation is Newco, Inc. (hereinafter referred to as the "Corporation").

Section 2. **Purposes.** It is intended that the Corporation will qualify at all times as an organization exempt from federal income tax under Sections 501(a) and 501(c)(3) of the Internal Revenue Code of 1986, including any amendments that may be made from time to time (the "Code"), and that it will qualify at all times as an organization to which deductible contributions may be made pursuant to Sections 170, 642, 2055 and 2522 of the Code. The Corporation is organized and will be operated exclusively for charitable, scientific, and educational purposes within the meaning Section 501(c)(3) of the Code, including the business of developing, owning and operating inpatient hospitals, clinics, physician practices, other healthcare services, and other services, businesses and activities for the overall purpose of promoting health and providing quality health care services to a broad cross section of the community. In accomplishment of such purposes, the Corporation shall be organized, and at all times operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of the not for profit corporations of which it is a member, provided that such not for profit corporations (i) qualify at all times as organizations exempt from federal income tax under Section 501(c)(3) of the Code and (ii) are described in Section 509(a)(1) or 509(a)(2) of the Code.

ARTICLE II
MEMBERS

The Corporation shall have no members.

ARTICLE III
BOARD OF DIRECTORS

Section 1. **Duties**. The business and affairs of the Corporation shall be governed exclusively by its Board of Directors. The Board of Directors shall be responsible for ensuring high quality delivery of health care and human services to the communities served by the Corporation and the Corporation's subsidiaries, with such responsibilities including, but not being limited to:

(a) the establishment, approval and review of policies necessary for the governance of the Corporation, including delegations of authority, establishment and Board approval of the strategic plan, the provision of quality patient care and the appropriate allocation of personnel, resources and assets;

(b) the establishment, approval and review of policies and procedures, or the appropriate delegation of authority for such policies and procedures, for the effective delivery of healthcare services within the Corporation's affiliated Hospitals and ancillary facilities including appropriate Medical Staff bylaws and competency standards, nursing practice standards, and regulatory standards for care delivery;

(c) the approval of the Corporation's annual operating budget;

(d) the approval of long-term capital expenditure budgets which address the Corporation's anticipated capital needs;

(e) the regular review of the Corporation's financial performance vis-a-vis its annual operating budgets and capital budgets, and the adjustment or modification of such budgets from time to time as circumstances require;

(f) the establishment of policies sustaining performance improvement, risk management and quality programs with appropriate assessment of effectiveness of each program;

(g) the regular review of the Corporation's Corporate Compliance Plan, its implementation, and observance;

(h) the oversight of fulfillment of the community benefit purpose of the Corporation;

(i) at the end of the Integration Period, conduct a review to determine whether retaining the Executive Chair/President and Vice Chair/Lead Independent Director structure, or converting to an independent Chair and Chief Executive Officer structure, is necessary or desirable in the best interest of the Corporation and its mission and purpose.

The Board of Directors may delegate certain authorities to subsidiary boards. Any authorities not specifically delegated are reserved to the Board of Directors of the Corporation.

The Board of Directors, in fulfilling its governance role, will ensure meaningful participation by management, clinical and physician leadership and any advisors deemed appropriate by the Board of Directors. The Board of Directors shall require the implementation of such systems and procedures as will foster effective communication by and among the administrative and departmental staffs, the Medical Staffs, and the Board of Directors.

At least one (1) time each fiscal year, the Board of Directors shall meet to assess the performance of the Board of Directors and the Corporation's progress toward executing its strategic plan and achieving its stated goals and objectives. Where appropriate, such review process shall include an assessment and adjustment of the Corporation's long-range, strategic, and operational plans and policies, as well as the Corporation's budget, fiscal position, and allocation of resources, in light of the Corporation's stated business purposes and mission statement.

(j) **Composition (Integration Period)**. During the Integration Period, the Corporation's Board of Directors shall consist of not more than seventeen (17) voting directors, sixteen (16) of whom shall be appointed on the Closing Date. Two of the voting directors shall be the Executive Chair/President of the Corporation and the Chief Executive Officer of the Corporation, each of whom who shall serve as a voting ex-officio director, subject in the case of the Chief Executive Officer, to the limitations in Sections 2 and 3 below. The voting directors who are not serving ex officio shall be and are divided into two (2) Category J Directors, six (6) Category W Directors and six (6) Category M Directors. The voting directors who are not serving ex officio shall be and are divided further into three classes, designated Class I, Class II and Class III. Class I and Class II initially each shall consist of two (2) Category M Directors and two (2) Category W Directors. Class III initially shall consist of two (2) Category J Directors, two (2) Category M Directors, and two (2) Category W Directors. At least two (2) Category M Directors and two (2) Category W Directors shall be physicians who are members of the active medical staff of at least one of the

Corporation's affiliated Hospitals; provided, however, that, at all times, the majority of the Board of Directors shall consist of members who are deemed to be independent community directors in accordance with Internal Revenue Service guidance for organizations that are exempt from federal income tax under Code Section 501(c)(3) and which provide hospital services or other health care services or serve as supporting organizations to tax exempt health care services providers; provided, further, in order to satisfy the requirements for an organization supervised or controlled in connection with organizations described in Code Section 509(a)(1) or (2), as described in Code Section 509(a)(3)(B)(ii), at all times all of the Corporation's directors will also be directors of Mountain States Health Alliance and directors of Wellmont Health System. In addition, the person serving from time to time as the President of East Tennessee State University shall serve as a non-voting ex-officio director.

(k) **Composition (Post-Integration Period)**. Except for the purposes of Section 3(b)(ii) below, upon the expiration of the Integration Period the division of the Board of Directors into Categories J, M and W shall cease, but the terms and the designation into Classes of the persons then serving as Directors shall not be affected thereby. After the expiration of the Integration Period the Corporation's Board of Directors shall consist of not more than seventeen (17) voting directors, one of whom shall be the Executive Chair/President of the Corporation who shall serve as a voting ex-officio director. The sixteen (16) voting directors who are not serving ex officio shall be and are divided into three classes, designated: Class I, Class II and Class III; provided, in order to satisfy the requirements for an organization supervised or controlled in connection with organizations described in Code Section 509(a)(1) or (2), as described in Code Section 509(a)(3)(B)(ii), at all times all of the Corporation's directors will also be directors of Mountain States Health Alliance and directors of Wellmont Health System. In addition, the person serving from time to time as the President of East Tennessee State University shall serve as a non-voting ex-officio director.

(l) **Qualifications.** In the selection of directors, appropriate consideration shall be given to an individual's competencies, skills and perspectives and the individual's ability to commit the time necessary to devote to a director's duties. Consideration shall also be given to the inclusion of a variety of business, health-related, and consumer perspectives among the various members of the Board of Directors, with a goal of achieving (i) a geographic and demographic diversity among the members and (ii) a mix of competencies, skills and perspectives as determined by the Board from time to time to be necessary or desirable

(m) **Orientation.** The Board shall adopt a policy ensuring appropriate orientation of new Board and Board Committee members.

(n) **Additional Independent Director.** During the Integration Period, the Board of Directors may choose to elect a person to serve as the Additional Independent Director, who may be in addition to the sixteen (16) persons appointed on the Closing Date. If elected, the Additional Independent Director will be a Category J Director and appointed to Class III.

Section 2. Terms.

Generally, each director shall serve for a term of three (3) years ending on the date of the third annual meeting of directors following the annual meeting of directors at which such director was elected. For purposes of this section, the Closing Date shall be deemed the date of the initial annual meeting and initial election of directors. Notwithstanding the generally applicable terms of office, each director initially appointed to Class I shall serve for an initial term expiring at the

Corporation's second annual meeting of directors following the Closing Date; each director initially appointed to Class II shall serve for an initial term expiring at the Corporation's third annual meeting of directors following the Closing Date; and each director initially appointed to Class III (including the Additional Independent Director, if elected) shall serve for an initial term expiring at the Corporation's fourth annual meeting of directors following the Closing Date; provided, that the term of each director shall continue until the election and qualification of a successor and be subject to such director's earlier death, resignation or removal. Ex-officio directors shall serve for a term that is commensurate with their term of office in the ex-officio position which creates membership on the Corporation's Board of Directors, except that the Chief Executive Officer of the Corporation shall cease to serve as a voting ex-officio director on the second anniversary of his or her initial appointment.

Elected directors may serve no more than two (2) consecutive three (3) year terms. An initial appointment as a Class I, Class II, or Class III Director shall be deemed a 3-year term for the purpose of this consecutive term limitation.

Section 3. Vacancies.

(a) In General. Except as set forth in subsection (b) of this Section 3, vacancies arising in positions on the Board of Directors (whether by resignation, death, expiration of term of office, termination, removal, increase in Board size, or other reason) shall be filled by the Board of Directors based upon nominations presented by the Governance/Nominating Committee. In submitting its nominations, the Governance/Nominating Committee shall endeavor to propose nominees who possess the skill sets identified in Article III, Section 1 of these Bylaws taking into account the skill mix of the persons then serving on the Board of Directors.

(b) Integration Period and Initial Vacancies.

(i) During the Integration Period, any vacancy among the Category M Directors or Category W Directors shall be filled by a vote of the majority of the remaining Category M or Category W Directors, as the case may be. During the Integration Period, any vacancy among the Category J Directors, including the Additional Independent Director, if nominated by the Governance/Nominating Committee, shall be filled by a person approved by the vote of a majority of each of the Category M Directors and the Category W Directors, voting as two classes.

(ii) Notwithstanding Section 1(k) above, after the Integration Period, and until the fourth anniversary of the closing of the affiliation transaction between Wellmont Health System and Mountain States Health Alliance, any vacancy among the Category M Directors or Category W Directors shall be filled by a vote of the majority of the Board of Directors upon the nomination of a replacement by the remaining Category M or Category W Directors, as the case may be, and shall consider the appropriate competencies determined to be desirable by the Board of Directors.

(iii) The Category W Directors shall appoint, by majority vote, a person to serve as a Class I, Category W Director to replace the Chief Executive Officer of the Corporation when he or she shall cease to serve as a voting ex-officio director as provided in Section 2 above.

(iv) In the event of a separation between the Corporation and the Executive Chair/President during the Integration Period:

A. The Category M Directors shall nominate one Director to serve as the Acting Chair of the Board of Directors, which nominee shall be subject to election by a majority vote of the Board of Directors. The Acting Chair shall assume the powers and responsibilities of the Executive Chair/President as Chair of the Board of Directors and will not have operating responsibilities.

B. The Chief Executive Officer shall immediately become a non-voting ex-officio director.

C. The Board may choose to appoint an interim President to assume the management responsibilities of the Executive Chair/President. The Board shall follow industry best practices in developing a process for selection of a permanent replacement for the Executive Chair/President.

D. The Board shall conduct a review to determine whether retaining the Executive Chair/President and Vice Chair/Lead Independent Director structure, or converting to an independent Chair and Chief Executive Officer structure, is necessary or desirable in the best interest of the Corporation and its mission and purpose.

Section 4. **Removal**. Voting and non-voting directors may be removed by a majority vote (as described below in Section 5) of the Board of Directors only for cause. For purposes of these Bylaws, "for cause" shall mean: (i) failure to satisfy the attendance requirements for directors set forth below in Section 7; (ii) continuous disruptive behavior as determined by the Board of Directors in its reasonable judgment; (iii) conviction of a felony or a crime of moral turpitude; (iv) incapacity, inability, or unwillingness to perform the duties and responsibilities of a director, as determined by the Board of Directors in its reasonable discretion; (v) engagement by a director in an activity, arrangement, or transaction which would result in a material conflict with his or her position as a director of the Corporation or the Corporation's interests or purposes, as determined by the Board of Directors in its reasonable discretion; (vi) a breach of the duty of confidentiality as such duty is set forth below in Section 9, or as such duty may otherwise be provided for or defined from time to time in the Corporation's internal policies or by action of the Board of Directors, or (vii) such other activity, event, or reason determined to constitute cause by the Board of Directors in its reasonable discretion.

Section 5. **Actions of the Board.**

(a) Majority and Super-Majority Votes. Except as otherwise set forth below, actions of the Board of Directors shall require the affirmative vote of a majority of the voting directors at a meeting at which a quorum is present. For purposes of these Bylaws, a quorum of the Board of Directors shall be a majority of the voting directors. Notwithstanding the foregoing, until the second anniversary of the closing of the affiliation transaction between Wellmont Health System and Mountain States Health Alliance, the following actions may be taken by the Board of Directors only upon the affirmative vote of a majority of the directors then in office, which must include a majority of the Category M Directors and a majority of the Category W Directors, each voting as a class (referred to herein as a "super-majority vote"):

(i) Amendments to the Charter or Bylaws of the Corporation, including amendments to the duties of the Executive Chair/President or the Vice Chair/Lead Independent Director as set forth in these Bylaws.

(ii) Sale or closure of any of the Hospitals;

(iii) Adoption of a plan of dissolution for the Corporation;

(iv) Sale or other transfer of all or substantially all of the Corporation's assets;

(v) Entering into a plan of merger or consolidation of the Corporation with or into an unrelated entity;

(vi) Incurrence of any indebtedness, guarantees, or capital lease obligations exceeding $100 million in the aggregate during any fiscal year, other than trade payables and other short-term liabilities in the ordinary course of business;

(vii) Discontinuation of major service lines where any such discontinuation would render the service unavailable in that community.

(viii) Any decision to file a petition requesting or consenting to an order for relief under the federal bankruptcy laws, or other actions with respect to the Corporation or any member of its obligated group as a result of insolvency or the inability to pay debts generally as such debts become due.

Section 6. **Meetings**. The Board of Directors shall hold an annual meeting in the month of June of each year. The Board shall hold regular meetings on not less than a quarterly basis. Special meetings shall be held as called by the Executive Chair/President or the Vice Chair/Lead Independent Director, or as requested by any three (3) directors in writing to the Secretary of the Corporation. Any actions of the Board of Directors to be taken at a meeting may be taken without a meeting if all voting directors consent in writing (which shall include electronic mail) to taking such action without a meeting. Directors may participate in any meeting of the Board of Directors by means of a conference telephone or similar communications equipment through which all persons participating in the meeting can hear each other. Participation by such means shall constitute presence in person at such meeting.

Section 7. **Attendance Requirements**. Each voting director shall be required to attend at least seventy-five percent (75%) of all scheduled meetings during any fiscal year (annual, regular, or special), unless otherwise excused by the Executive Committee. Failure to attend seventy-five percent (75%) of all scheduled meetings or failure to attend three (3) consecutive meetings shall constitute cause for removal as a voting director.

Section 8. **Resignation**. A director may resign at any time by delivering written notice of resignation to the Corporation's Secretary. Resignation is effective when notice is delivered unless the notice specifies a later effective date, in which case such date shall be the effective date.

Section 9. **Confidentiality and Fiduciary Duty of Loyalty, Care and Obedience.**. Each director shall maintain the strict confidentiality of all information discussed or received in connection with any meeting of the Board of Directors and any committee meeting, whether such

information is oral, written or preserved in any other form. Unless otherwise expressly authorized by Board action or by the Executive Chair/President, or unless disclosure is otherwise made by the Corporation through authorized action such as approved press releases or public statements, no director shall disclose, discuss or otherwise disseminate any information relating to the actions, deliberations and decisions of the Board of Directors and any committee of the Board of Directors. In any situation where comment or discussion is permitted, such comment or discussion shall extend only so far as is consistent with the degree of authorization. Further, no director shall use any information gained through or in connection with his or her capacity as a director in any manner which might create, directly or indirectly, any form of personal benefit unless such usage is consistent with and done in compliance with the Corporation's policies regarding Conflicts of Interest. Each Director shall, at all times, exercise loyalty, care and obedience to the fiduciary responsibilities entrusted to the Director on behalf of the Corporation. Each director shall execute an annual written acknowledgement of his or her duties of confidentiality, loyalty, care and obedience and such acknowledgements shall be kept in the official records of the Corporation.

ARTICLE IV
OFFICERS OF THE CORPORATION

Section 1. **Officers**. The officers of the Corporation shall consist of an Executive Chair/President, a Vice Chair/Lead Independent Director, a Chief Executive Officer (the "CEO"), a Secretary, a Treasurer, and such officers as the Board of Directors shall elect or appoint. The offices of Executive Chair/President, Vice Chair/Lead Independent Director, Secretary, and Treasurer shall be held by directors (collectively, the "Board Officers").

Section 2. **Terms of Office**. Except for the Executive Chair/President and the CEO, who shall each hold their offices for so long as their employment by the Corporation to serve in those positions continues, the Board Officers shall serve two (2) year terms. A Board Officer may serve no more than two (2) consecutive two (2) year terms in the same office. Nothing contained in these Bylaws shall be construed to constitute a contract of employment. Other than the limitations applicable to Board Officers, there shall be no limit as to the number of consecutive terms corporate officers may serve. Each Board officer shall hold office until his or her successor is duly elected and qualified.

Section 3. **Election, Removal and Vacancies**.

(a) Except as provided below, all officers of the Corporation shall be elected by, and shall serve at the pleasure of, the Board of Directors. Nominations for Board Officer positions shall be submitted by the Governance/Nominating Committee. Nominees for Board Officer positions shall be Directors. Removal of any officer shall be without prejudice to the contract rights, if any, of the officer; provided, however, that election of an officer itself shall not create any contractual rights.

(b) During the Integration Period, the successor to the person serving as the initial Vice Chair/Lead Independent Director shall be nominated by a majority vote of the Category W Directors, and elected by the non-management members of the Board of Directors. The individuals elected to serve as Treasurer and Secretary during the Integration Period shall be elected as follows: one from among the Category W members and one from the Category M members.

Section 4. **Resignation**. An officer may resign at any time by delivering written notice of resignation to the Corporation's Secretary. Resignation is effective when the notice is delivered unless the notice specifies a later effective date, in which case such date shall be the effective date.

ARTICLE V
POWERS AND DUTIES OF THE OFFICERS.

Section 1. **Executive Chair/President**. The Executive Chair/President shall have the powers usually vested in the office of Chair of a Board of Directors, the powers usually vested in the office of President of a Corporation, and as the most senior officer of the Corporation, shall have the powers and duties set forth in the written employment agreement entered into by the Corporation with the Executive Chair/President and any amendments thereto. He or she shall preside at all meetings of the Board of Directors, unless he or she is unable to attend. He or she shall see that all orders and resolutions of the Board of Directors are carried into effect. He or she shall perform all other duties required of him or her by the laws of the State of Tennessee. The Board of Directors shall periodically evaluate the performance of the Executive Chair/President in the context of the Corporation's progress toward and attainment of the Corporation's strategic and business goals and objectives as established from time to time by the Board. The Executive Committee, or another committee specifically appointed by the Board, shall conduct such performance reviews. The Executive Chair/President shall, at least annually, evaluate the performance of the CEO and the other officers reporting to him or her.

Section 2. **Vice Chair/Lead Independent Director**. In the absence or disability of the Executive Chair/President, the Vice Chair/Lead Independent Director shall exercise only those powers and shall perform only the duties of the Executive Chair/President with respect to the Executive Chair/President's role as the Chair of the Board of Directors, and not any of the powers and duties of the Executive Chair/President as the President and most senior officer the Corporation. Additionally, he or she shall have the duties set forth in Exhibit A attached hereto.

Section 3. **Chief Executive Officer**. The Chief Executive Officer (the "CEO") shall be appointed by Executive Chair/President. Any employment agreement with respect to the CEO shall be ratified by a majority vote of the Board of Directors. The Chief Executive Officer will report to the Executive Chair/President and shall have the powers and duties set forth in the written employment agreement entered into by the Corporation with the Chief Executive Officer and any amendments thereto. The CEO shall, at least annually, evaluate the performance of the officers reporting to him or her.

Section 4. **Vice Presidents**. To the extent any Vice President is to act as an officer of the Corporation, the Board of Directors shall confirm such responsibilities as an officer of the Corporation through resolution or other form of approval. Each such Vice President shall be responsible for executing and carrying out such duties, instructions, objectives and orders as may be established by the Executive Chair/President or CEO from time to time.

Section 5. **Secretary**. The Secretary shall cause to be kept the minutes of all meetings of the Board of Directors and of the Executive Committee. He or she shall cause to be given all notices provided for in these Bylaws. He or she shall have custody of the seal of the Corporation and shall affix the same, attested by his or her signature, to all instruments required to be under the seal of the Corporation. He or she shall have the duties, power and responsibilities of the secretary

of a Corporation under the laws of the State of Tennessee and shall perform such other duties as may be prescribed by the Board of Directors.

Section 6. **Treasurer**. The Treasurer shall be the official custodian of all funds and securities of the Corporation, and shall deposit, or cause to be deposited, same in such banks or other depositories as the Board of Directors may designate or approve. He or she shall have the duties, power and responsibilities of the treasurer of a Corporation under the laws of the State of Tennessee and shall perform such other duties as may be prescribed by the Board of Directors.

ARTICLE VI
SIGNATURE AND ENDORSEMENTS OF NOTES, CHECKS, ETC.

Section 1. **Signatures**. All notes, checks, bonds, and other promises to pay money shall be signed by an officer or other individual authorized by the Board of Directors.

Section 2. **Endorsements and Sales of Securities**. Checks, drafts, notes, and other negotiable instruments payable to the Corporation or to its order shall be endorsed for collection or deposit by an officer or other individual authorized by the Board of Directors. Stocks, bonds, or other securities owned by the Corporation may be sold or transferred upon signature of an officer or other individual authorized by the Board of Directors.

ARTICLE VII
COMMITTEES

Section 1. **Designation**. The Board of Directors may, from time to time, establish such standing and special committees as it deems advisable and in the best interests of the Corporation. All committee actions are advisory to the Board of Directors, unless the Board of Directors, through resolution, has delegated any authority to a committee it deems advisable; provided, however, that no committee may:

(a) Take any action required by Article III, Section 6, to be taken by a super-majority vote of the Board of Directors;

(b) Authorize distributions; or

(c) Elect, appoint, or remove directors or fill vacancies on the Board of Directors or any committee thereof.

Section 2. **Committee Members**. Other than members of the Executive Committee, whose members shall be members of the Board of Directors, Board committees may be composed of non-directors. Members of a committee may be designated as voting or non-voting ex-officio members. The Executive Chair/President shall recommend committee members, and presiding officers/chairs, for standing committees annually for consideration by the Governance/Nominating Committee. The Governance/Nominating Committee shall consider the recommendations of the Executive Chair/President, and make nominations to the Board of Directors, which shall, by majority vote, elect the committee membership. Each committee member shall serve for a one (1) year term, or on such other basis and for such other terms as set forth by the Board of Directors. The Board of Directors may remove any committee member with or without cause. Vacancies on a committee, due to death, resignation, expiration of term, or removal shall be filled by the Board of

Directors in the manner prescribed in this section. Committee members shall serve until their successors are duly elected and qualified. For the initial committee appointments, the Governance/Nominating Committee shall ensure equal numbers of individuals from existing committees of the Boards of Directors of Wellmont Health Systems and Mountain States Health Alliance. For purposes of this section, initial committee appointments shall mean only the first appointment of the individual selected to serve upon the Closing Date and shall not apply to any vacancies thereafter.

Section 3. **Voting and Quorum Requirements**. Except as otherwise limited by the Board of Directors, all actions of a committee shall require the affirmative vote of a majority of the voting members of the committee at a meeting at which a quorum is present. A majority of the voting members shall constitute a quorum. Any actions of a committee to be taken at a meeting may be taken without a meeting if all voting members of the committee consent in writing, to include electronic mail, to taking such action without a meeting. Members may participate in any meeting of the Committee by means of a conference telephone or similar communications equipment through which all persons participating in the meeting can hear each other. Participation by such means shall constitute presence in person at such meeting. Each Committee shall hold such meetings as it deems appropriate, or as directed by the Board. Each Committee member shall be required to attend seventy-five percent (75%) of all scheduled meetings (regular or special) during any fiscal year, unless otherwise excused by the chair of the Committee. Failure to attend seventy-five percent (75%) of all scheduled meetings or three (3) consecutive scheduled meetings shall constitute cause for removal as a member of such Committee.

Section 4. **Standing Committees**. The Corporation's Board of Directors shall have the following standing committees: Executive; Audit and Compliance; Finance; Quality, Service and Safety, Executive Compensation, Community Benefit, Workforce and Governance/Nominating. The Board of Directors may establish such other committees as it deems necessary or appropriate from time to time. Committee Chairs shall be members of the Board of Directors. The Executive Chair/President and CEO may not serve as Chair of standing committees, except that as provided in subsection (a)(i) below the Executive Chair/President shall serve as the presiding officer of the Executive Committee. Non-voting ex-officio members may serve as Committee Chairs upon the conclusion of the Integration Period. Each standing committee and any committee created by the Board of Directors shall establish and maintain a charter describing its duties in detail, shall regularly review and propose revisions to its charter in light of industry best practices, and shall present such charter and any proposed revisions for review and approval by the Board of Directors.

(a) **Executive Committee**.

(i) **Composition**. The Executive Committee shall be comprised of both voting and non- voting members. The voting members shall be the Executive Chair/President, the Vice Chair/Lead Independent Director, the Treasurer, and the Secretary of the Corporation, and two at-large members. The CEO of the Corporation shall be a non-voting ex-officio member of the Executive Committee. The Executive Chair/President shall serve as the presiding officer of the Executive Committee. The initial at-large members of the Executive Committee serving during the Integration Period shall be one Class W Director and one Class M Director.

(ii) **Powers and Duties**. The Executive Committee shall have and exercise the full authority and have all the powers and duties of the Board of Directors except as otherwise limited by the Act, the Board of Directors, or these Bylaws. The Executive Committee may

transact the business of the Corporation in urgent situations during the periods between meetings of the Board of Directors; provided that any action taken shall not conflict with the policies and expressed wishes of the Board of Directors. Matters of major importance shall be referred to the entire Board of Directors unless the urgency of the situation does not permit delay. The Executive Committee shall report any action taken between meetings to the Board of Directors as soon as practicable.

(iii) **Review of Executive Chair/President.** The Executive Committee, or another committee as expressly determined by the Board of Directors, is charged with the responsibility of evaluating the Executive Chair/President. The Executive Compensation Committee shall be charged with the responsibility of approving the compensation of the Executive Chair/President. The Executive Committee shall provide its evaluation of the Executive Chair/President to the Executive Compensation Committee for its consideration, in addition to any other factors considered by the latter , in setting compensation of the Executive Chair/President. The Lead Independent Director shall ensure a mechanism is established for input by the full Board of Directors on the evaluation of the Executive Chair/President, and that feedback is provided to the Executive Chair/President. As it relates to his or her compensation or performance evaluation, the Executive Chair/President shall not participate in the evaluative deliberations of the Executive Committee or the Executive Compensation Committee other than to provide information, answer questions and receive feedback.

(b) **Audit and Compliance Committee**. The Audit and Compliance Committee shall: (a) ensure the integrity of the Corporation's financial reporting and audit procedures, including engagement of an independent public accounting firm to conduct an annual certified audit and examination of the Corporation's financial reporting and controls; (b) ensure financial controls are adequate to protect the integrity of the Corporation's financial assets; (c) report, as needed, to the Board of Directors, any issues related to financial controls and recommend any changes deemed necessary by the committee; (d) monitor the Corporation's compliance program and make any recommendations related to compliance risk and (e) approve the compliance policies. The Corporation's Chief Compliance Officer and Senior Audit Director shall report jointly to the Executive Chair/President and to the Audit and Compliance Committee, and any reports shall be provided to both. The Audit Committee shall be comprised of membership that includes individuals with audit and public accounting experience. The Governance/Nominating Committee shall seek to nominate a Chair of the Audit and Compliance Committee who is experienced in accounting and audit oversight, subject to the requirement that committee chairs must be members of the Board of Directors. The membership of the Audit and Compliance Committee shall be constituted by individuals who are independent as defined by the IRS Form 990.

(c) **Finance Committee**. The primary responsibilities of the Finance Committee are to develop and recommend operating and capital budgets to the Board of Directors, and to monitor the ongoing financial performance of the Corporation.

(d) **Quality, Service and Safety Committee**.

(i) The Board of Directors has the ultimate responsibility for quality patient care and authority for maintaining a Performance Improvement and Risk Management Program. The Board of Directors may delegate certain functions of this program to the Executive Chair/President, or to the respective community boards of each hospital (the " Community Boards"), together with the authority for action under limitations described in this section. The Quality, Service and Safety

Committee is charged with the responsibility of ensuring these functions are administered, and reporting to the Board of Directors.

A. The Quality, Service and Safety Committee shall require the medical staffs and staffs of the various departments/services of the hospitals to implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying and resolving problems and for identifying opportunities to improve patient care.

B. The Board of Directors, through the Quality, Service and Safety Committee, the Executive Chair/President and CEO, shall fully support performance improvement activities and mechanisms. The Board, through the Executive Chair/President, shall also provide for adequate resources and support systems for the performance improvement functions related to patient care and safety.

C. The Quality, Service and Safety Committee shall assess the effectiveness of the performance improvement program on an annual basis, and shall re-endorse or recommend revisions to the program as necessary. These recommendations shall be made to the Board of Directors, which shall timely consider the recommendations, and either endorse or make changes to the program.

(ii) The Medical Staffs of the various affiliated hospitals, through their elected officers, departments, committees, and individual members shall make a commitment to actively participate in the performance improvement program by developing indicators to be used for screening, evaluating and utilizing clinical judgment concerning identified problems or opportunities to improve care. Findings shall be reported to the Board of Directors through the Quality, Service and Safety Committee. Priority shall be given to those aspects of care which are high-volume, high-risk or problem-prone.

A. Department Chairmen are responsible for assuring the implementation of a planned and systemic process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the departments and the clinical performance of all individuals with clinical privileges in those departments. When important problems in patient care and clinical performance or opportunities to improve care are identified, action shall be taken and the effectiveness of such action taken evaluated.

B. The presidents of the respective medical staffs shall facilitate and coordinate medical staff involvement in the performance improvement program and shall serve as advisor to the respective Community Board on performance improvement matters.

C. The respective Community Boards may delegate oversight of the hospital-wide performance improvement program as it pertains to the medical staff to the executive committee of the medical staff.

(iii) The Executive Chair/President, through the CEO, is responsible for implementation of the performance improvement program as it concerns non-physician professionals and technical staff and patient care units. The Executive Chair/President shall actively support the performance improvement program by the provision of adequate resources.

(iv) The Executive Chair/President may delegate necessary functions to the CEO to ensure, system-wide, that all functions related to performance improvement, risk management and improvement in the clinical aspects of care are prioritized, performed, and that relevant information about the effectiveness of these functions is reported to the Quality, Service and Safety Committee.

(v) At all times during the Integration Period, the Chair of the Quality, Service and Safety Committee shall be a physician member of the Board of the Corporation.

(e) **Executive Compensation.** The Executive Compensation Committee shall be composed of members who are independent in accordance with Internal Revenue Service guidance for organizations that are exempt from federal income tax under Code Section 501(c)(3) and which provide hospital services or other health care services or serve as supporting organizations to tax exempt health care services providers. The Committee shall evaluate and approve compensation, and changes to compensation, for the Executive Chair/President. The Committee shall consider and approve the compensation for the Chief Executive Officer, any executive vice president or senior vice president based upon the recommendation of the Executive Chair/President. Evaluations by the Executive Chair/President or CEO of the performance of any executive vice president or senior vice president shall be made available if requested by the Executive Compensation Committee for its use in consideration of the recommended adjustment to compensation. In evaluating compensation, the committee shall satisfy the Rebuttable Presumption of Reasonableness standards as promulgated by the Internal Revenue Service as amended from time to time.

(f) **Community Benefit and Population Health.** The Community Benefit Committee's responsibilities shall include: (1) extending and strengthening the Corporation's community benefit programs and services, (2) review community benefit strategies and performance to assure adequate financial and human investments are maintained, (3) monitor the community benefit reporting to ensure integrity of the information, (4) ensure compliance with community benefit standards imposed by regulatory agencies, (5) ensure public recognition of community benefit activities and community value through periodic reports to the community, (6) review of population health initiatives, and (7) oversight of compliance by the Corporation with the terms of any Certificate of Public Advantage to which the Corporation is subject. The committee shall report its findings and recommendations to the Board.

(g) **Governance/Nominating Committee.**

(i) The Governance/Nominating Committee shall be responsible for ensuring there is an effective process for filling board and committee positions, and that timely recommendations are made for the Board of Directors to consider. This committee shall also consider, from time to time, issues of governance, including review of bylaws, rules, and regulations, and establishing governance goals. The Governance/Nominating Committee shall also consider and recommend education and other resources for enhancement of Board performance, and shall lead the annual Board self-evaluation. The Executive Chair/President shall be an ex-officio member of the Governance/Nominating committee. Upon the creation of vacancies on the Board or on committees of the Board, the Executive Chair/President shall collaborate with the members of the

Board of Directors to facilitate recommendations to the Governance/Nominating Committee for consideration. The Executive Chair/President shall not vote on matters relating to nominations, but may vote on governance matters.

(ii) At its discretion, the Governance/Nominating Committee shall evaluate the advisability of adding to the Board of Directors one additional voting director, who, among other qualifications as determined by the Governance/Nominating Committee, shall (i) be a nationally recognized, independent health care expert, (ii) not residing in the Northeast Tennessee or Southwest Virginia region, (iii) who provides incremental value to the Board of Directors through competencies or relationships not then available to the Board of Directors, and (iv) who has not been previously engaged by or with Wellmont Health System or Mountain States Health Alliance nor has been involved in a financial, business, investment or family relationship with the Executive Chairman/President or CEO of the health system (the "Additional Independent Director"). If the Governance/Nominating Committee determines that the Additional Independent Director is advisable, it shall undertake a search process to fill that position whose nomination the Governance/Nominating Committee is prepared to submit to the Board of Directors.

(h) **Workforce Committee**. The Workforce Committee shall provide recommendations to the Board of Directors on matters relating to the workforce of the Corporation, including, but not limited to, matters relating to: (1) implementation of workforce plans for recruitment and retention, (2) policies which support the workforce plan, (3) education and professional development of the clinical workforce, (4) competence of the workforce, (5) policies and practices related to a safe and productive workplace, (6) benefits, and (7) any opportunities related to the facilities of the Corporation becoming and remaining the health care workplace of choice.

Section 5. Clinical Council. A physician-led clinical council will be maintained, composed of independent, privately practicing physicians as well as physicians employed by the Corporation or its subsidiaries or affiliates. The Clinical Council will include representatives of management, but the majority will be composed by physicians. The Clinical Council will report to the Chief Medical Officer of the Corporation, or to the senior officer of the Corporation if there is no Chief Medical Officer. The Chair of the Clinical Counsel will be a physician member of the active medical staff(s) of one or more affiliated hospitals, will serve on the Quality, Service and Safety Committee of the Board, and will provide ongoing reports on the activities of the Clinical Council to the Board through the Quality, Service and Safety Committee of the Board. Among other duties assigned to it from time to time, the Clinical Council will endeavor to establish a common standard of care, credentialing standards, consistent multidisciplinary peer review where appropriate and quality performance standards. The Clinical Council will provide input on issues related to clinical integration, and shall support the goals established by the Board of Directors. The Clinical Council members serve at the pleasure of the Board of Directors and may be removed with or without cause.

ARTICLE VIII
MEMBER CORPORATION BOARDS

Section 1. Appointment. The Corporation is the sole member of Mountain States Health Alliance and Wellmont Health System (the "Subsidiary Corporations"). The Corporation's Board of Directors shall also serve as the Board of Directors of each of the Subsidiary Corporations pursuant to the Amended and Restated Bylaws of each Subsidiary Corporation.

Section 2. **Delegation of Authority.** Subject to limitations prescribed exclusively by the Board of Directors, the board of directors of each Subsidiary Corporation shall perform the following duties: (i) oversee the relationship of each Hospital owned by the Subsidiary Corporation with its physicians and other medical providers, including administration of the credentialing and disciplinary process applicable to such Hospital's medical staff, (ii) assure compliance by the Hospitals owned by the Subsidiary Corporation with the accreditation standards promulgated by the Joint Commission, and (iii) govern the business and affairs of the Subsidiary Corporation, subject to the limitations set forth in these bylaws and the Articles of Incorporation the Subsidiary Corporation. The board of directors of each Subsidiary Corporation shall provide reports to the Board of Directors regarding actions taken pursuant to the delegation of duties specified above in a manner prescribed by the Board of Directors. The board of directors of each Subsidiary Corporation is authorized to exercise the powers, authority and responsibilities set forth in this Section 2 pursuant to this delegation by the Board of Directors of the Corporation. Any powers not specifically delegated in this Section 2 are reserved to the Board of Directors of the Corporation.

ARTICLE IX
MISCELLANEOUS

Section 1. **Corporate Seal**. The Board of Directors may provide a seal for the Corporation in the form approved by the Board of Directors.

Section 2. **Fiscal Year**. The fiscal year of the Corporation shall begin on the first day of July of each year.

ARTICLE X
NOTICE

Whenever under the provisions of the Act, the Charter, or these Bylaws notice is required to be given to any director, officer, or committee member of the Corporation, it shall not be construed to require personal notice, but such notice, unless required to be in writing, may be given by telephone or electronic mail and, if given in writing, may be given either personally or by facsimile, or by depositing the same in a post office or letter box in a postpaid, sealed wrapper., in either case addressed to such director, officer, or committee member at his or her address as the same appears in the records of the Corporation; and the time when the same shall be so mailed or faxed, shall be deemed to be the time of the giving of such notice.

ARTICLE XI
INDEMNIFICATION

Section 1. **Indemnification of Officers and Directors**. The Corporation shall indemnify an individual made a party to a proceeding, criminal or civil, because he or she is or was an officer or director (whether voting or non-voting) of the Corporation, including a director of a Hospital Board, against liabilities and expenses incurred in the proceeding to the fullest extent permitted by the Act. The Corporation shall make advances for expenses incurred or to be incurred in the proceeding as provided for in the Act.

Section 2. **Indemnification of Employees and Agents**. The Corporation may indemnify an individual made a party to a proceeding, criminal or civil, because he or she is or was an employee or agent of the Corporation against liabilities and expenses incurred in the proceeding

to the extent determined appropriate by the Board of Directors consistent with the provisions of the Act. The Corporation may make advances for expenses incurred or to be incurred in the proceeding to the extent determined appropriate by the Board of Directors consistent with the provisions of the Act.

Section 3. **Insurance**. The Corporation shall have the power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the Corporation (including a director of a Hospital Board), or is or was serving at the request of the Corporation as a director, officer, employee, or agent of another Corporation, partnership, joint venture, trust, or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have the power or would be required to indemnify him or her against such liability under the provisions of this Article.

Section 4. **Nonexclusivity**. The rights of indemnification and advancement of expenses granted pursuant to this Article shall not be deemed exclusive of any other rights to which an officer, director, employee, or agent seeking indemnification or advancement of expenses may be entitled, pursuant to the Act, Tennessee statutory or case law, the Corporation's Charter, these Bylaws, a resolution of the Board of Directors, or an agreement or arrangement providing for indemnification; provided, however, that no indemnification may be made to or on behalf of any officer, director, employee, or agent, if a judgment or other final adjudication establishes that such indemnification is prohibited by Section 48-58-502 of the Act or any successor statutory provision.

Section 5. **Statutory Immunities**. Nothing contained in this Article X shall be construed to prejudice or otherwise diminish the limitations, immunities and other protections available to the directors and officers of the Corporation (including a director of a Hospital Board) pursuant to Section 48-58-601 of the Act or any successor statutory provision.

ARTICLE XII
CONFLICTS OF INTEREST

The Board of Directors shall adopt and maintain a Conflict of Interest Policy applicable to all members of the Board, Board Committees, Officers of the Corporation, and key management personnel. The policy shall require the annual completion and submission of an acknowledgement and disclosure statement, as well as a confidentiality agreement applicable to all business of the Board of Directors.

ARTICLE XIII
VOLUNTEER AND AUXILIARY ORGANIZATIONS

Volunteer and Auxiliary organizations may, with the approval of the Board of Directors of the Corporation, perform nonprofessional services within the affiliated entities which further the purposes and interests of the Corporation. Such volunteer organizations, in discharging their functions, shall cooperate closely with management of the affiliated entity and the Board of Directors or its designee. Such cooperation may include a requirement for production of reports or information relevant to the services and benefit being provided. The activities of the volunteer or auxiliary organizations shall, if the Corporation's Board of Directors deems proper and necessary, be carried out under bylaws adopted by such organizations, and such bylaws and any amendments thereto shall be subject to revision by, and approval of, the Board of Directors or its designee. The

Board of Directors may require Board of Directors approval of appointments to the Board of any Volunteer or Auxiliary Organization.

ARTICLE XIV
AMENDMENTS

Section 1. **Periodic Review of Bylaws**. The Board of Directors shall cause these Bylaws to be reviewed annually to determine whether any amendments or revisions are necessary or desirable from a legal, regulatory or operational standpoint when considered in light of best industry or nonprofit organization practices. The Governance/Nominating Committee shall conduct such review and make recommendations to the Board of Directors..

Section 2. **Amendments**. Subject to Article III, Section 5 above, these Bylaws may be altered, amended, or repealed, and new Bylaws may be adopted, by the Board of Directors at any meeting, whether annual, regular, or special, by a majority vote of the voting directors serving on the Board of Directors. A full statement of the proposed amendment, or amendments, to these Bylaws shall be set forth in the notice of each such meeting.

ARTICLE XV
DEFINITIONS

For purposes of these Bylaws, the following terms shall have the following meanings:

"Category J Directors" means those directors initially appointed jointly by Mountain States Health Alliance and Wellmont Health System pursuant to the Master Affiliation Agreement and Plan of Integration dated as of February 15, 2016, by and between Wellmont Health System and Mountain States Health Alliance (the "Affiliation Agreement"), and their successors as appointed in accordance with the Bylaws of the Corporation.

"Category M Directors" means those directors initially appointed by Mountain States Health Alliance pursuant to the Affiliation Agreement, and their successors as appointed in accordance with the Bylaws of the Corporation.

"Category W Directors" means those directors initially appointed by Wellmont Health System pursuant to the Affiliation Agreement, and their successors as appointed in accordance with the Bylaws of the Corporation.

"***Closing Date"*** means of the closing date pursuant to the Affiliation Agreement.

"Integration Period" means the period beginning on the Closing Date and ending on the second anniversary of the Closing Date.

Exhibit A

Description of the Vice Chair/Lead Independent Director Position

Charter of the Vice Chair/Lead Independent Director

The Vice Chair/Lead Independent Director coordinates the activities of the other non-management Directors, and performs such other duties and responsibilities as the Board of Directors may determine.

The specific responsibilities of the Vice Chair/Lead Independent Director are as follows:

Presides at Executive Sessions

- Presides at all meetings of the Board at which the Executive Chair/President is not present, including executive sessions of the independent Directors.

Calls Meetings of Independent Directors

- Has the authority to call meetings of the independent Directors.

Conducts Evaluation of Executive Chair/President

- Ensures the Executive Committee, or another committee as determined by the Board, conducts an annual review of the performance of the Executive Chair/President, with such review being approved by the non-management members of the Board of Directors.
- Ensures annual compensation review of the Executive Chair/President by the Executive Compensation Committee upon the completion of the annual performance review of the Executive Chair/President.

Functions as Liaison with the Executive Chair/President

- Serves as liaison between the independent Directors and the Executive Chair/President.

Approves appropriate provision of information to the Board such as board meeting agendas and schedules

- Approves meeting information sent to the Board relating to agendas and actions items, including the quality, quantity and timeliness of such information.
- Setting the Board's approval of the number and frequency of Board meetings, and approves meeting schedules to assure that there is sufficient time for discussion of all agenda items.

Authorizes Retention of Outside Advisors and Consultants

- Authorizes the retention of outside advisors and consultants who report directly to the Board of Directors on board-wide issues upon approval of the Governance Committee.

Exhibit 10

Benefits and Potential Disadvantages that may Result from the Cooperative Agreement

Exhibit 10

Benefits and Potential Disadvantages

The proposed transaction involves several key features that differentiate the assessment of its overall advantages and disadvantages from a more traditional hospital merger. These include:

- The specific geography, which is largely rural, and the population served, including their current and anticipated health needs. Population growth in many of the rural communities has been negative,[1] and projections demonstrate flat-to-no population growth against a backdrop of significant downward pressure on inpatient utilization. In many rural hospitals, where the census is below 30, this is a substantial threat to viability under the status quo environment;
- The implications of those health needs on the economic vitality and sustainability of the workforce and competitiveness of the region for Tennessee and more generally; and the overall economic health and wellbeing of the communities in eastern Tennessee;
- The resources and assets needed to efficiently and effectively meet health needs of this diverse population, including the uninsured, Medicaid, Medicare, and commercial populations, now and in the future. Assets and resources include physicians, clinics, outpatient facilities, and inpatient hospital facilities, and the alignment and location of the right assets and resources in the best locations to serve the population;
- The current configuration of the healthcare delivery systems in the area as compared to the efficient and effective configuration of delivery systems – by type of facility and also integration across facilities;
- The supporting infrastructure and investments to manage and improve population health, clinical services, care delivery, and services to improve patient experience and care, outcomes, and address needed priorities at lower and sustainable costs; examples include physician leadership and best practices, clinical coordination and integration, and IT/EHR capabilities across the area and care locations;
- Alignment of the healthcare delivery systems with new payment models and metrics and with payers to establish contracts and methods that seek improved outcomes, access, and reduced costs – increasingly, payers seek contracts with better measures of reduced total medical costs and improved outcomes, not just lower unit prices;
- The likely alternatives to the proposed transaction, including status quo and alternatives;
- The context in which the transaction occurs – namely, a COPA model with specific commitments, conditions, and requirements of the Parties with active supervision by the State.

How do these features differentiate the merger review of the advantages and disadvantages of the proposed transaction from a more traditional merger?

A traditional merger review tends to focus on the predicted and likely effect of the proposed transaction on prices facing commercial health plans and whether these effects are likely to be anticompetitive. The expected benefits of the transaction are often examined with regard to expected merger-specific cost reductions (efficiencies) and gains from realignment of inpatient hospital resources/services, including some consideration of expected quality effects. Costs and benefits have traditionally been evaluated with regard to the implications of predicted prices or

[1] *See* United States Census Bureau Statistics for County Population, percent change - April 1, 2010 to July 1, 2015, available at: http://www.census.gov/quickfacts/table/PST045215/00.

quality effects on patient populations, payers, and/or employers based on future medical costs of inpatient services and their impact on premiums, co-pays and deductibles. The analyses are typically predicated on models that assume that the current marketplace *is at a competitive equilibrium* and that, but-for the merger, competition between two or more independent health systems for commercial contracts would achieve lower prices and higher quality. Generally, these analyses assume away any need for transformational or substantial change in the organization of care delivery by providers and that the assessment of competitive effects on commercial payers can largely be conducted without reference to Medicaid, Medicare, or uninsured populations.

The COPA context is fundamentally different, and the features of this transaction and of the geographic region set out above yield a substantially different advantages/disadvantages calculation for the proposed transaction. Briefly, some of those differences include:

- *Transactions subject to COPA, including this transaction, are a unique set*. They fundamentally involve transactions with major systemic risks to the healthcare delivery system and the merging hospitals, the communities, and the population if they *do not* proceed. These systemic risks and the associated weight of public advantages created are balanced with some antitrust risks under a permitted merger and further mitigated through active supervision by the state. COPA transactions are very likely to include those where the "but-for" world – the world without the proposed transaction or with alternative purchasers -- reduces the potential antitrust risks yet yields very limited, if any, gains or may even yield a substantial reduction in benefits relative to the status quo. For example, in this case, the proposed transaction occurs in an area with multiple challenges and where sustainable competition between two large independent systems is not the most efficient or highest value outcome.
- *The implication is that COPA analysis weighs heavily the collective advantages of the transaction, the collective disadvantages, the practicality of the alternatives to the transaction, and the particular means to assure that the known advantages are achieved and known disadvantages are mitigated or limited substantially by the benefits*.
- *The transaction addresses all populations across all communities*. The benefits to be achieved in terms of enhanced access, reduced costs, improved patient and population experience, quality and outcomes adhere to far more than commercially insured populations. The COPA context values very highly the gains to all populations, patients and residents, from the transaction and not just commercially insured patients – measures of the advantages of the transaction include broader populations, longer term benefits, and improved care and experience across the area, rather than narrower evaluation of specific commercial populations with shorter term quality or price effects.
- *The COPA context provides for the translation of cost-savings and efficiencies into specific commitments, resources and investments to be made by the Parties.* This provides the incentive to achieve the savings, not otherwise likely to occur, and to commit specific resources in specific ways to benefit the overall community and population health. This provides the opportunity for the specific commitments and investments to be directly aligned with community priorities and needs (e.g., investments in new clinics, in new services, in specific population health initiatives) with metrics and methods for reporting and tracking. Investments may also include expedited and area-wide or system-wide clinical initiatives, infrastructure and alignment of care that are part of the commitments made to integrate and align the two competing systems
- *The COPA context provides for mechanisms to keep pricing within a competitive range, using market-based methods that rely on known contracting mechanisms; and contracting terms and*

conditions that might be derived from competition. The COPA essentially provides an enforceable mechanism to ensure that pricing under negotiated agreements will change at a rate not to exceed the upper limits of what might occur in the absence of the transaction.

This section addresses how the proposed transaction between Wellmont and Mountain States – when evaluated with this broader and more appropriate COPA-specific advantage/disadvantage framework – results in material and measurable benefits that far outweigh potential disadvantages.

Benefits of the Proposed Merger

In evaluating the potential benefits of a cooperative agreement, the department shall consider whether the following benefits may result from the cooperative agreement:

(A) Enhancement of the quality of hospital and hospital-related care provided to Tennessee citizens;

Situation: Steadily increasing financial pressures on Wellmont and Mountain States require ever-increasing efficiency in order to maintain the excellent level of care historically provided by both systems. Under the proposed merger, the New Health System will be significantly better equipped to deliver enhanced services and improve the overall quality of health care through a fully integrated system of care that utilizes a common clinical IT platform, a regional health information exchange, a system-wide clinical council, and enhanced quality reporting.

Background: As noted in the Application, the two health systems currently have expensive, duplicative healthcare resources that are allocated inefficiently. A merger would enable elimination of unnecessary duplication to capture large cost savings and realign resources to improve access and quality. The evidence shows there are two additional pressures which drive the necessity for consolidation and reduction in avoidable and unnecessary duplicative cost in order to sustain quality and access. Population stagnation in the region combined with downward pressure on inpatient use rates and downward pressure on government and commercial growth in reimbursement rates create limiting factors even as costs for labor and supplies continue to grow.

In fact, there is a triad of pressures including population trends, use rates and reimbursement. The key areas served by the combined system have seen, and will see, little to no population growth. For instance, Sullivan County and Washington County increased by less than 1 percent, Carter decreased by 1.6 percent, Johnson decreased by 2.3 percent, Unicoi decreased by 2.5 percent, and Hancock decreased by 3.6 percent.[2] The Virginia counties have seen even worse declines, with Smyth decreasing by 2.3 percent, Russell decreasing by 3.5 percent, and Wise and Scott counties decreasing by 4.2 and 4.5 percent respectively.[3]

Combining the stagnant population with expected decreasing hospital inpatient use rates will have a serious adverse effect on the health systems. If the Parties remain separate, this will create a shift in the cost structure to a higher percentage of costs being deployed for fixed corporate, rather than clinical, purposes, since each system would be required to sustain duplicative corporate functions and the fixed cost associated with these functions. Consolidation

[2] *Id.*
[3] *Id.*

of the two systems enables a substantial reduction in fixed overhead cost. For instance, the current inpatient use rates in the region, which are 126 per 1,000 population, are higher than the current national range of 106 per 1,000. Given the increasing strategy by payers of shifting to risk-based contracting for physicians, the stated desire of payers to reduce inpatient utilization and the shift to increased use of outpatient services, it is expected that the region's inpatient use rates will decline. Assuming a 2015 population for the 21-county Geographic Service Area of 960,019,[4] if the current use rates decline to the top of the national range, this would represent a decline of somewhere between 15,000 and 16,000 discharges.[5] If use rates decline to the lower end of the range, the decline would be as many as 34,000 discharges.[6]

Declines of this magnitude can be offset by population growth, which has occurred in certain areas in the country. In those instances, declining use rates may not mean significant volume declines in hospitals. But in a rural area, where many hospitals are operating at lower volume, it is difficult for hospitals to sustain their efforts with such significant declines in volume. Low population growth and declining use rates are intrinsic to the outlook for this region and there will be a high correlation between declining use rates and actual volume decline in the region's hospitals collectively. Already, many of these hospitals have negative operating margins. Without the COPA, it is likely some of these hospitals will fail. Declining volume in the larger hospitals, combined with the duplicative costs each system will continue to bear, will decrease the ability of those hospitals to financially support the smaller hospitals. It is important to note that if some of these hospitals were to fail, it could potentially lead to reduced access for consumers, and even reduced choice if a hospital were to close. Through the Parties' commitment to utilize synergies to sustain these access points, the COPA provides a rational approach to managing service provision and capacity and the alignment of the combined system based on the needs of the communities.

In addition to these challenges, fixed rate increases in Medicare, commercial plans and Medicare Advantage plans are simply no longer reliable. For the coming federal fiscal year, the region faces yet another decrease in the Area Wage Index. This decrease is despite the fact that the region has the second lowest wage index in the United States. This represents a decrease in federal reimbursement, which cascades to most of the commercial payers.

What is potentially left are two independent systems with significant duplication of fixed administrative cost structures, lower inpatient volumes, and significant clinical duplication dedicated to supporting capacity that may no longer be needed. All of this is combined with a revenue stream which does not support growth in capital investment or even sustainability of the current cost structures.

The Parties believe quality will suffer in this status quo environment as the systems lose their capacity to capitalize or face substantially higher costs for doing so. Remaining separate, the two systems will not have the ability to standardize, eliminate variation and take advantage of scale. These limitations on capital will lead to decreased efforts to diversify the specialties which may

[4] The population estimate is for the 21-county service area. Sg2 Market Demographics: Population Trends (2016).
[5] This estimate assumes a decrease in inpatient utilization in the 21-county service area from the current rate of 126/1,000 to 110/1,000.
[6] This estimate assumes a decrease in inpatient utilization in the 21-county service area from the current rate of 126/1,000 to 90/1,000.

be needed, but do not generate significant revenue, such as pediatrics, and other medical specialties which, ironically, help reduce the demand for inpatient utilization when they are available in the market.

Numerous studies have shown that critical mass in volume leads to better outcomes.[7] Reduced fragmentation, clinical scale and elimination of variation all become important factors in reducing cost and improving quality. A combined system that is able to utilize the tools and protocols described in the Application is better positioned to use this scale to achieve these desired outcomes than two separate systems would be able to do in a declining admission, population stagnant environment. As outlined elsewhere in this document, another option is for each system to join larger out-of-market systems. Such a system does not have the ability to realign in-area capacity and resources to the benefit of the local economies and community and to improve efficiency and sustainability of care to serve substantial local population health needs of Medicare, Medicaid, uninsured, and commercial patients in largely rural communities.

Assessment: In addition to maintaining the scale needed as a counter to population stagnation and decreasing usage rates, to achieve enhanced quality of hospital and hospital-related services, the New Health System should adopt, implement and fund technology, policies, and programs that are not possible for the two separate and competing health systems to accomplish. This should include the following essential components:

- Common Clinical IT Platform: A Common Clinical IT Platform will allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care and will also facilitate the development and increased adoption of best practices and evidence-based medicine implemented by the New Health System. Availability of immediate system-wide alerts and "hard-coding" best practice protocols for clinical pathways has been demonstrated to enhance overall quality by reducing the risk of clinical variation and lowering the cost of care by decreasing duplication of health care services. The cost of implementation of a Common Clinical IT Platform is built into the capital model for the New Health System. Standardized order sets, collection of data and standardization of data sharing with physicians are all benefits that would be immediately achieved with the Common Clinical IT Platform once fully implemented. While some might argue that the two systems, remaining independent, could collaborate on these issues, the Parties strongly disagree. Even if Mountain States were to acquire the EPIC system independently, the IT systems would not be identical, and patients would continue to have two records – one for Wellmont and one for Mountain States. Protocols between the two systems would not be identical and the accountability structure (i.e., the Boards of Directors) would remain separate. There would be little incentive for physicians, who remain competitive, to share information. The collection of data for academic studies and research purposes would be

[7] *See High-volume trauma centers have better outcomes treating traumatic brain injury*, Tepas, Joseph J. III MD; Pracht, Etienne E. PhD; Orban, Barbara L. PhD; Flint, Lewis M. MD, Journal of Trauma and see Acute Care Surgery, January 2013, available at: http://www.ncbi.nlm.nih.gov/pubmed/23271089. *Relationship between trauma center volume and outcomes*, Avery B. Nathens, MD, PhD, MPH; Gregory J. Jurkovich, MD; Ronald V. Maier, MD; David C. Grossman, MD, MPH; Ellen J. MacKenzie, PhD; Maria Moore, MPH; Frederick P. Rivara, MD, MPH, Journal of American Medical Association, March 2001, available at: http://jama.jamanetwork.com/article.aspx?articleid=193615.

further complicated by the need to navigate two separate systems with separate protocols and data sharing capabilities.

- Region-Wide Health Information Exchange - A region-wide health information exchange that includes the New Health System, independent providers, medical groups and facilities in an effective collaborative model will encourage and support patient and provider connectivity to the New Health System's integrated information system. Though a health information exchange does not have the ability to achieve the level of clinical integration possible through a common electronic medical record system, it is an important component for the management of shared patients between physicians, hospitals, and outpatient settings especially for the avoidance of unnecessary duplication of testing and care coordination to close care gaps. Among other benefits, the seamless sharing of this information will reduce unnecessary cost, mitigate risk to patients and enable improved productivity among providers. After the transaction, the New Health System will commit financial resources to the utilization of an effective health information exchange. These incremental resources will contribute to the sustainability of an effective health information exchange model.

- System-Wide Clinical Council - System-level clinical councils have the ability to drive clinical effectiveness, manage change, and evaluate initiatives through physician leadership and expertise. Best practice and local feedback demonstrates that the New Health System should establish a Clinical Council composed of independent physicians as well as physicians employed by the New Health System or its subsidiaries or affiliates—including those physicians that practice in hospitals as well as those that practice primarily in outpatient environments. Further, the Clinical Council should be supported by other clinicians, subject matter experts, and senior management. This group should report frequently to the board of the New Health System through the Chief Medical Officer to facilitate the board's responsibility for quality improvement. Nationally, clinical councils are effective in establishing common standards of care, credentialing standards, consistent multidisciplinary peer review where appropriate and quality performance standards and best practices. For the New Health System, the Clinical Council should also provide input on issues related to clinical integration and support the goals established by the Board of Directors of the New Health System.

- Quality Reporting - Effective quality reporting is an essential component of any integrated clinical system with accountability to the community. This calls for complete transparency on quality measures with respect to the performance of the New Health System on a common and comprehensive set of measures readily available for consumers. This will impact choice and further incentivize the provision of high-quality care. Increased transparency will provide consumers with information to make better health care decisions. For meaningful comparison, this reporting system should include CMS core measures including patient experience scores for each facility within thirty days of reporting the data to CMS. The reporting system should also provide benchmarking data against the most recently available CMS data so the public can evaluate and monitor how the New Health System facilities compare against hospitals across the state and nation in a manner that is more "real time" than currently available and as far in advance of the federal agency reporting as possible.

The Parties believe quality will not diminish under the COPA and point to the experience of Mission Health in Asheville as support for this position. Mission Health was granted a COPA in

1995 and has been recognized nationally for its low cost and high quality health care. For seven years in a row, Mission has been named a Top 100 hospital, and for three years in a row, has been named a top 15 health system in the nation. Under the COPA, quality at Mission has been sustained and costs are lower relative to their peers. According to data provided by the State of North Carolina, the costs for health care services at Mission have been sustained at a lower level than its peers in the state. In fact, Mission Health has been recognized as one of the best examples in the country of health systems that have successfully achieved higher quality while maintaining low costs.[8]

Competition was reduced in Asheville by the merger, but, because of the implementation of the COPA and state supervision over Mission's commitments, health care costs have remained low and health care quality has improved. The Parties note that the U.S. Department of Justice and the North Carolina Attorney General's Office recently took legal action against another health system in North Carolina (Carolinas HealthCare). The legal action alleges anticompetitive behavior by Carolinas Healthcare which could increase pricing and reduce consumer choice.[9] The claims made against Carolinas Healthcare have never been made by a federal or state agency against Mission Health. The Parties note that the anticompetitive behaviors that Carolinas Healthcare has allegedly engaged in are explicitly prohibited by the COPA regulating Mission Health, and Mission has not engaged in such behaviors. The Parties have proposed commitments in their Application that are similar to the Mission Health commitments. These are intended to prohibit the anticompetitive behaviors that triggered the federal and state action against Carolinas Healthcare. The Parties believe such commitments, when properly supervised, reduce the likelihood of the behavior alleged by the Department of Justice in the Carolinas Healthcare case, and protect high quality and low cost.

Recommendation: To ensure that enhanced quality of hospital and hospital-related care is provided to Tennessee citizens under the merger, Mountain States and Wellmont have proposed the following commitments to be actively supervised by the state:

- The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.
- The New Health System will participate meaningfully in the exchange of health information open to community providers.
- The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.
- The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully in the Application.

[8] *See* "Mission One of Ten Hospitals Named for 'Doing It Right,'" *Mission Health Scope*, August 7, 2009, available at: http://www.mission-health.org/sites/default/files/document-library/1292_0.pdf (accessed July 12, 2016).
[9] See " State and feds say Carolinas HealthCare drove up costs by curbing competition," *The Charlotte Observer*, June 9, 2016, available at: http://www.charlotteobserver.com/news/local/article82726402.html (accessed July 12, 2016).

- The New Health System will collaborate with independent physician groups to develop a local, region-wide clinical services network to share data, best practices, and efforts to improve outcomes for patients and the overall health of the region.

(B) Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities;

Situation: The Parties believe that it will be increasingly difficult to continue financially supporting rural facilities over the long-term without the savings the proposed merger would create. Continued access to appropriate hospital-based and clinical services is a driving impetus for the Cooperative Agreement. The COPA is the only means to achieve the efficiencies necessary to sustain rural facility operations and preserve and enhance access to quality care in geographical proximity to the communities traditionally served by those facilities.

Background: Health care services offered by rural hospitals in the United States are increasingly at risk of closure. According to the University of North Carolina Sheps Center, seventy-six rural hospitals have closed since 2010, including eight in Tennessee and one in Virginia.[10]

Providers throughout the nation, including Wellmont and Mountain States, are faced with reduced payment for services, services moving from the inpatient to the outpatient setting, and higher patient out-of-pocket costs due to increased copayments and deductibles which have led to more hospital bad debt. The challenges are intensified in the Parties' service area of Northeast Tennessee and Southwest Virginia, a rural area with extremely low Medicare payment rates, high volumes of Medicaid and uninsured populations, and significant health care challenges.[11]

As presented in Tables 5.2 and 5.3 of the COPA Application, many of the Parties' rural hospitals have an average daily census of twenty patients or less. Currently, most rural hospitals operated by Wellmont and Mountain States operate with negative or very low operating margins, representing challenges to the capitalization and, ultimately, the survival of these hospitals.

Last year alone, Mountain States and Wellmont collectively invested more than $19.5 million to ensure that inpatient services would remain available at the following rural hospitals: Smyth County Community Hospital, Russell County Medical Center, Unicoi County Memorial Hospital, Johnson County Community Hospital, Dickenson Community Hospital, Hawkins County Memorial Hospital, Hancock County Hospital, Lonesome Pine Hospital, and Mountain View Regional Medical Center.

In the current resource-constrained, status-quo environment, these hospitals face an uncertain future with respect to their viability, and, in fact, may be in peril. A recent report estimates 673

[10] *See 76 Rural Hospital Closures: January 2010 – Present*, The Cecil G. Sheps Center for Health Services Research at the University of North Carolina, *available at*: https://www.shepscenter.unc.edu/programs-projects/ruralhealth/rural-hospital-closures/ (accessed July 13, 2016). Ten rural hospitals have closed since the COPA Application was filed in February, 2016, including two rural hospitals in Tennessee.

[11] County-level data for the region is available at 2015 "Drive Your County to the Top Ten," Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. Available at: https://www.tn.gov/health/topic/specialreports/.

rural hospitals are vulnerable or at risk for closure nationwide.[12] The existing threat to these hospitals is substantial, which affects not only patients' access to local care in geographic proximity to their homes, but also affects the economic vitality of these communities.

These rural facilities are supported by three regional tertiary hospitals located along major highways that connect the rural markets to the Tri-Cities. These hospitals—Johnson City Medical Center, Bristol Regional Medical Center, and Holston Valley Medical Center—serve distinct patient bases in a hub and spoke model to distinct rural geographies. Each of these hospitals provides an array of high-level services that are essential to the greater Tri-Cities region of Northeast Tennessee and Southwest Virginia communities they serve. They are also major regional teaching facilities with a variety of academic partners in Virginia and Tennessee. The financial support for these rural hospitals is generated largely by the tertiary facilities. As stated earlier in this document, population stagnation and decreased inpatient use rates will increasingly challenge these hospitals' ability to continue supporting rural facilities as redundant, duplicative costs remain.

Assessment: The COPA is a mechanism for ensuring that the efficiencies from the merger will be used to ensure sustained access to care for these communities. *Without the Cooperative Agreement and the commitments in the COPA, there is no comparable assurance from the two health systems*. The Parties believe the evidence supports the assertion that these hospitals are threatened as population stagnates and financial support from the tertiary facilities become increasingly difficult to sustain. The commitment to keep these facilities open and to preserve access to existing healthcare services in these rural markets creates a public advantage that does not exist today and that cannot exist without the merger. This commitment also mitigates the risk that healthcare services will not be maintained in reasonable geographical proximity to the communities served by these hospitals. The timeframe associated with this commitment should acknowledge that healthcare services are constantly evolving locally and nationally and some repurposing of existing facilities may be needed to meet specific community needs, some of which are not necessarily being met today. The commitment should also address retention of high-level tertiary services in a teaching hospital environment at the region's existing tertiary hospitals.

Recommendation: In order to preserve hospital facilities in geographical proximity to the communities traditionally served by those facilities, Mountain States and Wellmont have proposed the following commitments to be actively supervised by the state:

- All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.

[12] *See* 2016 Rural Relevance: Vulnerability to Value. A Hospital Strength INDEX Study. Ivantage. Accessed on June 13 at https://tinyurl.com/j3gaatc.

- The New Health System will maintain the three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available in close proximity to where the population lives.

(C) Gains in the cost-efficiency of services provided by the hospitals involved;

Situation: The existing competitive dynamic between Wellmont and Mountain States has led to expensive duplication of equipment and facilities. The merger would allow the New Health System to achieve greater cost efficiencies through various organizational and administrative efficiencies, including non-labor efficiencies, labor efficiencies, clinical efficiencies, and the opportunity to consolidate technology resources on a Common Clinical IT Platform.

Background: Federal and state regulatory agencies impose significant cost constraints on all hospital providers. Medicare and Medicaid payment rates are non-negotiable and are often applied as benchmarks by other payers. Medicare costs are regulated through the Medicare Wage Index. In Northeast Tennessee and Southwest Virginia, payment rates remain lower because the local Medicare Wage Index is one of the lowest in the nation. With a payer mix for the regional health systems that is approximately 70% Medicare, Medicaid, and Medicare managed care, this wage index serves as a fundamental regulator of health care costs.[13]

Assessment: The proposed Cooperative Agreement complements federal and state efforts to contain costs and promote cost efficiency in several ways.

Through the Cooperative Agreement and the commitments in the COPA, the two health systems will be able to avoid unnecessary duplication of services. By integrating their efforts in key service areas, the Parties will avoid duplicative costs and will be able to operate these facilities and services more efficiently, with better quality and with enhanced patient outcomes. One example of duplicative services the New Health System can potentially consolidate is the area's two Level I Trauma Centers, which are expensive to maintain and redundant in a region with low population density. No other region in Tennessee operates two Level I Trauma Centers.

Consolidation of these programs into a single facility is projected to result in cost savings. Significantly, studies have shown that higher-volume trauma centers result in better patient outcomes.[14] Thus, a consolidation is not only likely to result in lower cost, but it is also likely to result in improved outcomes. Other cost-saving and efficiency opportunities include consolidation of specialty pediatric services, repurposing acute care beds and consolidation of certain co-located facilities. This repurposing will lead to higher volumes in the acute care and other consolidated facilities, and thus, better efficiency. The quality of care is also expected to improve since studies indicate quality is generally better in higher volume environments.[15]

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[13] *See* Application Exhibit 5.1C for a breakdown of payers in the Geographic Service Area.

[14] *See High-volume trauma centers have better outcomes treating traumatic brain injury*, Tepas, Joseph J. III MD; Pracht, Etienne E. PhD; Orban, Barbara L. PhD; Flint, Lewis M. MD, Journal of Trauma and see Acute Care Surgery, January 2013, available at: http://www.ncbi.nlm.nih.gov/pubmed/23271089. *Relationship between trauma center volume and outcomes*, Avery B. Nathens, MD, PhD, MPH; Gregory J. Jurkovich, MD; Ronald V. Maier, MD; David C. Grossman, MD, MPH; Ellen J. MacKenzie, PhD; Maria Moore, MPH; Frederick P. Rivara, MD, MPH, Journal of American Medical Association, March 2001, available at: http://jama.jamanetwork.com/article.aspx?articleid=193615.

[15] *Id*.

Access is also expected to improve because the repurposed facilities may be able to add services that could not be previously supported in an environment of duplication and low capacity.

Recommendation: To ensure the merger results in gains in the cost-efficiency of services provided by the hospitals involved, Wellmont and Mountain States have committed to achieve at least $95 million in annual efficiencies by the end of the fifth year of operation. The potential savings are limited to the estimated dollar savings from the realignment of resources and certain clinical efficiencies, but do not include the potentially significant benefits that the Parties expect to achieve through improved access, quality, and care in the best locations that will directly benefit these communities.

(D) Improvements in the utilization of hospital resources and equipment;

Situation: Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thus contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and the realignment of services to reduce overutilization of inpatient services in the region and stem the pace of health care cost growth for patients, employers and insurers.

Background: Collectively, Wellmont and Mountain States serve a region with one of the highest inpatient use rates. Currently, for every 1,000 people in the region, 126 are admitted to the hospital annually, compared to a national average of 106 admissions per 1,000. The current lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region which contributes to the overutilization of costly inpatient services. Unnecessary duplication of high cost services contributes to this trend. A major factor in the accumulation of nearly $1.5 billion of debt, and the redundant costs borne by the market, has been the duplication of services and programming by Wellmont and Mountain States as separate systems. These costs must be covered through clinical revenues and that contributes to higher costs.

Moreover, providers throughout the nation, including Wellmont and Mountain States, are faced with reduced payment for services, services moving from the inpatient to the outpatient setting, higher patient out-of-pocket costs due to increased copayments and deductibles (resulting in additional declining revenue to the hospitals as the deductibles are increasingly uncollectable by hospitals), and a variety of other pressures stemming from an understandable frustration with the cost of health care. The challenges are intensified in the Parties' service area of Northeast Tennessee and Southwest Virginia, a rural area with extremely low Medicare payment rates, high volumes of Medicaid and uninsured populations, and significant health care challenges. In the coming years, inpatient utilization rates are projected to decline, while fixed infrastructure costs remain.

Assessment: Combining the region’s two major health systems in an integrated delivery model is the best way to avoid the most expensive duplications of cost and enable the New Health System to reduce overutilization of inpatient services and stem the pace of healthcare cost growth for patients, employers and insurers. These efforts will enable the creation of a regionally integrated health system, with a comprehensive regional health information exchange, that will help reduce unnecessary utilization. This integrated delivery model will not

be possible as long as the two health systems duplicate one another in an environment of increasingly scarce resources.

Because of their regional proximity and high levels of duplication, the Cooperative Agreement will enable the two health systems to avoid unnecessary duplication and over-utilization thereby containing costs, achieving greater efficiency and improving utilization of high-cost hospital services. By integrating their efforts in key service areas, the Parties will avoid duplicative costs and will be able to operate these facilities and services more efficiently, with better quality and with enhanced patient outcomes.

One example of how the integrated delivery system could reduce the utilization of hospital resources is behavioral health. According to the American Hospital Association, one in four Americans experiences a behavioral health issue or substance abuse disorder each year, with the majority of those also experiencing physical health conditions or chronic diseases that complicate care needs. Thus, these patients typically have higher levels of health care utilization. It has been estimated that medical costs for treating those patients with chronic medical and comorbid mental health/substance use disorder conditions can be 2-3 times as high as for those who do not have a mental health/substance abuse disorder. Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thereby contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and a regionally integrated delivery model to support the development of effective behavioral health and substance abuse that reduces unnecessary hospital utilization.

These efforts could not be undertaken in the absence of the merger due to a variety of factors, including the need to share proprietary information, the fact that reduction in duplication of resources would absolutely not occur without the merger and the significant commitment of resources to be made by the Parties. Specifically, the Parties have committed to investing millions of dollars in new behavioral health community-based services, residential addiction recovery services, and a Common Clinical IT Platform that are needed to create an integrated system and would not be possible without the merger. Moreover, commitments relating to pricing, consolidation of services, standardization of practices, and procedures, would raise significant antitrust concerns if undertaken together by two independent hospital systems.

In order to most efficiently utilize hospital resources, important relationships must be developed across a continuum of community-based resources, primary care, intensive outpatient care, and inpatient care to appropriately address the utilization of hospital resources. In fact, effective systems of care and provider resources in the outpatient environment and the community go a long way in reducing the need for acute hospitalization or emergency department use. Though the New Health System will work to ensure appropriate inpatient resources exist, the development of outpatient systems of care, coordinated systems of care in the community, sufficient provider and specialized counseling resources, and residential recovery services will help manage the utilization of hospital resources.

Recommendation: To ensure the merger results in improvement in the utilization of hospital resources and equipment, the New Health System has proposed certain commitments which can only be funded through the cost-containment, cost-efficiency, improved utilization, and avoidance of unnecessary duplication derived from the merger. These commitments include the

adoption of a Common Clinical IT Platform for electronic medical records among the combined nineteen hospitals, employed physicians and related services and facilitation of a community health information exchange between participating community providers in the region. This combination will help ensure that providers have the information they need to make high-quality treatment decisions, reduce unnecessary duplication of services, enhance documentation and improve the adoption of standardized best practices. Patient information will be more portable, removing barriers to patient choice and improving patients' access to their own health information. A more fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, post-acute care and outpatient services resulting in a better patient experience and more effective and efficient care.

The New Health System has also proposed creation of a local clinical network which would partner the health system with the physician community in sharing data, best practices, standardization of care models and reduction of unnecessary utilization.

(E) Avoidance of duplication of hospital resources;

Situation: A major factor in the accumulation of nearly $1.5 billion of debt, and the redundant costs borne by the market, has been the duplication of services and programming by Wellmont and Mountain States as separate health care systems. The significant ongoing duplication of health care services and costs in the region cannot be avoided without a consolidation. Funding the population health, access to care, enhanced health services, and other commitments described in the Application would be impossible without the efficiencies and savings created by the merger. By aligning Wellmont's and Mountain States' efforts in key service areas, the New Health System will drive cost-savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services.

Background: Wellmont and Mountain States have competed with each other in certain areas and with other health care providers since the formation of the two systems in the late 1990s. A result has been the unnecessary duplication of hospital resources that has not added value. By eliminating the duplication of hospital resources and investing in what evidence has shown will help make this region healthier, the Parties believe the New Health System will be able to control costs and make healthcare more affordable.

Assessment: Combining the region’s two major health systems in an integrated delivery model is the best way to avoid the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high quality services moving forward. These efforts will provide savings that may be invested in higher-value activities in the region to help expand currently absent but necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. These new levels of development and job creation will not be possible as long as the two health systems duplicate one another in an environment of increasingly scarce resources.

The Applicants commissioned FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm ("FTI Consulting"), to identify the unnecessary duplication of hospital

resources and perform an economies and efficiencies analysis regarding the proposed savings and efficiencies that would be gained by the merger. As detailed on pages 82-84 of the Application, the economies analysis was divided into three major segments. Segment One was the efficiencies and savings that could be achieved in the area of purchased services (the "Non-Labor Efficiencies"). Segment Two was the savings and efficiencies that could be achieved by aligning the two system's health work forces (the "Labor Efficiencies"). Segment Three was the efficiencies and savings that could be achieved by clinical alignment (the "Clinical Efficiencies").

The Parties have identified potential savings from the merger in the following areas that would not be possible but for the merger:

- Non-Labor Efficiencies
    - How the Merger Would Help: Cost-savings can be achieved through operational efficiencies. Examples include combined purchasing and use of a non-medical items such as laundry and food services, and clinical-related items such as physician clinical preference items, implantable devices, therapeutics, durable medical equipment, and pharmaceuticals.
    - Estimated Savings from the Avoidance of Duplication: The Parties have identified potential savings from the merger in non-labor expenses totaling approximately $70 million annually.
- Labor Efficiencies
    - How the Merger Would Help: The New Health System will reduce workforce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system.
    - Estimated Savings from the Avoidance of Duplication: The Parties have identified potential savings from the merger in labor expenses totaling approximately $25 million annually.
- Clinical Efficiencies
    - How the Merger Would Help: The alignment of clinical operations of two previously independent hospital systems into a merged entity can yield improved outcomes, reduced costs of care and related efficiencies, and improve sustainability of the most effective levels of services at the right locations.
    - Estimated Savings from the Avoidance of Duplication: The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately $26 million annually.

Further, the extensive commitments described in the Application to improve access to health care and quality of health care could not be achieved without the combination and would not be effectively enforced absent an active state supervision program mandated by Virginia and Tennessee law.

Recommendation: To ensure the merger results in the avoidance of duplication of hospital resources, the New Health System has proposed certain commitments that would eliminate the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high quality services. Specifically, Wellmont and Mountain States have committed to achieve at least $95 million in annual efficiencies by the end of the fifth year of operation. The potential savings are limited to

the estimated dollar savings from the realignment of resources and certain clinical efficiencies, but do not include the potentially significant benefits that the Parties expect to achieve through improved access, quality, and care in the best locations that will directly benefit these communities. By eliminating duplications, and the costs associated with those duplications, the New Health System will be able to re-direct those resources to maintaining and improving quality rather than duplicating services that result in excess capacity or underutilization. These efforts will provide resources that can be invested in more value-based spending in the region – spending that helps expand (and where absent, implement) necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. Enhancing the coordination, integration, sustainability and development of new models of care delivery across the community improves the health of this region's residents and the economy of its communities.

(F) Demonstration of population health improvement of the region served according to criteria set forth in the agreement and approved by the department;

RESPONSE: The population served by Mountain States and Wellmont has long had more significant health challenges than the population in the United States generally. The area served by the Parties has significantly higher rates of many chronic conditions such as obesity, diabetes, heart disease, and cancer.[16] Behavioral issues prevalent in the community, such as drug use, smoking, and poor nutrition, have made these conditions particularly difficult for health care providers to address in a meaningful way.

The New Health System commits to implementing programs and strategies to reduce tobacco use, obesity rates, physical inactivity, drug poisoning deaths and neonatal abstinence syndrome in the Geographic Service Area, as outlined in the template Community Health Improvement Plan, attached as Exhibit 21 to these Responses. Suggested short-term and intermediate-term outcome metrics are included in the template Community Health Improvement Plan. Because of limitations and lags in current federal and state population health data sources, especially at the county level, the Parties expect that final metrics and targets will be agreed upon with the Tennessee Department of Health. In order to make data actionable, new or augmented data collection efforts may be necessary. The "Year-by-Year Summary" that provides an estimate of the year-by-year timing of these reinvestments and cost savings is attached as Exhibit 22. All of these efforts recognize that ultimately, individual and community health and well-being are not primarily driven by health care services, but instead by income, education, family and community support, personal choices, genetics and the environment.

The New Health System expects to work collaboratively with the State to determine which specific interventions will be implemented where. While many evidence based programs exist to reduce tobacco use, obesity, drug poisoning, etc., it may not be possible to implement these locally without modification due to workforce, transportation or other infrastructure constraints.

[16] County-level data for the region is available at 2015 "Drive Your County to the Top Ten," Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. Available at: https://www.tn.gov/health/topic/specialreports/.

Combining two strong health systems aligned with other providers along the care continuum as well as stakeholders in the community creates a unique opportunity to direct resources in a coordinated way and tackle these longstanding, expensive problems that reduce quality of life for so many of the state's most vulnerable citizens and communities.

(G) The extent to which medically underserved populations have access to and are projected to utilize the proposed services; and

Situation: Some residents in Northeast Tennessee and Southwest Virginia have acceptable access to many services, but other areas are substantially underdeveloped or lacking services altogether. Wellmont and Mountain States anticipate significantly improved access to health care services under the Cooperative Agreement and the commitments set forth in the COPA. The Cooperative Agreement will enable the hospitals to improve access to medically underserved populations through charitable care programs as well as continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding. The COPA will ensure that the New Health System is held accountable for the commitments the Parties have made to the state.

A recent *60 Minutes* story highlighted Wise County, Virginia as an example of gaps in access to care for non-hospital services and misplaced resources.[17] Wise County has a population of 47,000 people that is steadily declining - yet there are three full service hospitals in the county, each with a census below 30. The reporter told the story of uninsured patients with chronic health conditions who aren't able to access the primary care services they need. Resources that could be spent on lower cost primary care and disease management initiatives are tied up in three acute care hospitals. How does this happen? Unfortunately, the incentives are improperly aligned. Today, hospitals in Wise County, and many other rural areas, are incentivized to provide acute care services, invest in physicians who perform high-cost procedures, and expand services for competitive reasons, even if they are duplicative. Yet, the fundamental health care needs of the population are not being met. The resources are there, but there is no organized incentive to change the model to address the needs of the region. The COPA creates this incentive. By eliminating irrational competition, the New Health System will be able to reduce unnecessary cost, and refocus its resources to provide access for the medically underserved. Shifting physical resources and personnel to needed outpatient services (including mental health and substance abuse services), case management services, and health management services will ultimately result in a healthier population and contribute to economic improvement, including a more sustainable health care workforce and a more employable overall workforce.

Background: Populations are medically underserved in this region for lack of insurance and lack of providers. Wellmont and Mountain States currently provide significant amounts of charity care to uninsured and underinsured populations in the Geographic Service Area[18] and will continue to do so in the future in accordance with IRS guidelines for not-for-profit hospitals. In fact, the New Health System's charity care policy will increase the benefit for charity care above and beyond what either of the Parties currently provide. The new policy will provide a 100%

[17] *See On the road with the Health Wagon*, 60 Minutes, March 24, 2016, available at: http://www.cbsnews.com/videos/on-the-road-with-the-health-wagon (accessed July 10, 2016).

[18] In fiscal year 2015, Wellmont provided $72,940,011 in uncompensated care. See Wellmont's IRS Form 990 for fiscal year 2015.

discount for inpatient hospital and clinic services to patients with incomes below 225% of the Federal Poverty Level. In addition, all patients may apply for financial assistance and/or payment plans based on their ability to pay. Currently, the highest threshold used by the Applicants for a 100% discount for these services is 200% of the Federal Poverty Level, with a sliding scale applying to certain patients.

The New Health System will take other steps to benefit needy patients. One of the New Health System's stated goals is to reduce unnecessary utilization of high cost emergency department and inpatient services by uninsured individuals. So-called "super-utilizers" of health care consume a disproportionate level of health care resources and often have co-existing medical conditions coupled with addiction and mental health issues and social resource needs.

The New Health System will design an effective case management model for this "super-utilizer" population, once identified, that is proactive. Elements of the program will include social needs screening and assessment (transportation, food and housing insecurity, high risk behaviors or environments, etc.), connection to primary care preferably in a patient-centered medical home model for disease management, connection to health care and social resource navigators and community health workers, and connection to medication assistance. The New Health System will also provide resources for individuals who are ready to receive intervention for unhealthy behaviors that contribute to poor health. Findings from previously conducted model programs will be used to inform and create the overall plan. Partnerships with regional Federally Qualified Health Centers, Rural Health Centers, Health Departments, and charity clinics will be essential.
For individuals who agree to comply with certain requirements such as following physician prescriptions and orders, keeping scheduled appointments, participating in appropriate screenings, and participating in education related to chronic conditions or healthy lifestyles, the New Health System will provide guaranteed access to program services and medical care and the discount for services will be increased substantially.

This model can be a precursor to other population health models which can apply to other high-utilizer populations and may even be a source for translational research studies to result in best practice program development—especially in rural environments. The Parties believe this is a significant advantage that will offset any potential disadvantage that results from the reduction in competition. Reduced pricing and improved quality and access to services are key to this particular commitment.

Both systems also subsidize physicians, services and facilities in areas that lack medical care. But there are still considerable unmet needs. As neither Tennessee nor Virginia is a Medicaid expansion state, the number of uninsured will persist and as high deductible health plans grow, the number of effectively under-insured will continue to rise beyond current levels.

As far as services, mental health, substance abuse and specialty pediatric services are three areas the Parties have identified as priority for investment. These services have not been developed for two primary reasons: first, because patient volumes are disaggregated between the two health systems, and neither system has the critical mass necessary to support the service, and second, because the size of the serviced population is not sufficient to fully support full-time specialists.

Assessment: To address the uninsured populations that need access to affordable health care, will comply with all state and federal regulations in regard to charity care and essential hospital access and will be consistent with the New Health System's role as a public benefit, not-for-profit, tax-exempt corporation. The new policy will provide a 100% discount for inpatient hospital and clinic services to patients with incomes below 225% of the Federal Poverty Level. In addition, all patients may apply for financial assistance and/or payment plans based on their ability to pay. Currently, the highest threshold used by the Applicants for a 100% discount for these services is 200% of the Federal Poverty Level, with a sliding scale applying to certain patients.

Uninsured individuals who do not qualify under the charity care policy will receive a discount off hospital charges based on their ability to pay. This discount will comply with Section 501(r) of the Internal Revenue Code, and the rules and regulations relating to that Section, governing not-for-profit organizations, and payment provisions will be based on the specific circumstances of each individual/family. The New Health System will seek to connect individuals to coverage when possible.

As detailed in the Application, the New Health System intends to partner with, or support, existing community based charity clinics along with rural health clinics and Federally Qualified Health Centers ("FQHCs") to help people access the care they need rather than creating new charity clinics. There are many effective charity care clinics and programs already operating in the region, and the New Health System believes that partnering with or supporting these established programs will be the best use of community resources. An established network of care options will be especially important as the New Health System seeks to enroll indigent or uninsured high-use, high need individuals in the "super-utilizer" accountability model mentioned in Response #7. Under this program and the regional network of primary care providers, the New Health System will encourage individuals to participate more actively in their health and to employ prevention and disease management strategies so that high cost health care utilization can be avoided. Effective management of the health of this population in partnership with charity care clinics and FQHCs along with social agencies and others will reduce the cost of health care in the region overall and allow the New Health System to keep costs lower for everyone. These efforts will help ensure that the uninsured population has a front door for non-emergent care and seeks care at the appropriate locations. The New Health System intends to create an organized delivery model for the uninsured which relies upon the medical home as the key entry point, and which also encourages individual responsibility for determinants of poor health.

The uninsured population will also be the target of several inter-related health strategies outlined in the Application. For example, the Parties intend to encourage all uninsured individuals to seek coverage from the federal health marketplaces from plans offered in the service area – Wellmont currently holds an active federal grant for these navigator services, Mountain States does not.

In addition, the proposed partnership is committed to efforts to improve overall health services to the medically underserved areas. In cooperation with the College of Public Health at East Tennessee State University ("ETSU"), the Parties launched the region's most substantial community health improvement assessment effort to date. Four Community Health Work Groups were created to specifically focus on medical needs of the medically underserved,

identify the root causes of poor health in this region, and identify actionable interventions the New Health System can target to achieve a generational shift in health trends. The Parties jointly sponsored and funded these four Work Groups only as part of the Parties' goal to improve health care services through the Cooperative Agreement.

The Community Health Work Groups met during the Fall of 2015 in public meetings throughout Northeast Tennessee and Southwest Virginia to seek community input. The meetings were led by subject matter experts and included business and community leaders from throughout the region who represent a broad variety of experience and perspectives. The meetings were also staffed by members of Mountain States and Wellmont along with master's and doctoral-level students from ETSU. ETSU was engaged jointly by the Parties to analyze the community input received at these Community Health Work Group meetings and to develop a 10-year plan for addressing these community health opportunities for improvement.

As key access points increase, the Parties expect additional utilization from medically underserved populations to increase also. Additionally, as the New Health System's charity care policy becomes more generous and more widely known, the New Health System will be able to engage with the uninsured population in a way that proactively connects people to services – including primary care, health management services, and social needs navigation functions. While utilization is expected to increase overall, the Parties do expect there to be a shift, however, from higher cost inpatient and emergency department use to lower cost outpatient use and utilization of health management services.

Recommendation: The Cooperative Agreement will allow the hospitals to redirect efficiencies to continue to support programs and services that do not currently exist or are now unprofitable and otherwise may have to be reduced or cancelled due to lack of funding. To ensure the merger results in improved access to health care for the medically underserved under the Cooperative Agreement, Wellmont and Mountain States have proposed the following commitments to be included in the COPA and actively supervised by the state:

- The New Health System commits to spending at least $140 million over ten years pursuing specialty services as detailed below which otherwise would not be sustainable in the region without the financial support of the transaction.
- The New Health System commits to creating new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.
- The New Health System commits to ensuring recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment.
- The New Health System commits to development of pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting as close to patients' homes as possible.
- The New Health System commits to development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference.

- Implementation of an organized care delivery model for the uninsured which would provide significantly higher pricing discounts to individuals who agree to participate meaningfully in an organized accountability model which guarantees access and lower pricing in return for improved individual health behaviors among the uninsured population.

(H) Any other benefits that may be identified.

Situation: In addition to the benefits identified above, Wellmont and Mountain States expect the Cooperative Agreement to result in additional benefits for the region. These benefits will include: increased behavioral health and substance abuse services, enhanced health IT capabilities, robust academic and research partnerships, and a commitment to workforce development. The Parties will be held accountable for their commitments through the COPA.

Background: Both systems are committed to maintaining the viability and vitality of regional assets in order to ensure access, manage the future costs of healthcare for local employers, and address the serious health issues affecting the Geographic Service Area. Given the multitude of challenges faced by the two systems, combined with the consolidation that is occurring throughout the industry among hospitals, physician groups, insurance companies and even health information technology companies, it is clear that neither Wellmont nor Mountain States will be able to remain independent moving forward. Given this reality, two options exist: merge locally to capture large merger-specific efficiencies and quality-enhancement opportunities through an integrated, locally governed regional health system or independently merge with large healthcare systems, located and controlled from outside the region – a step that would not come close to achieving the merger-specific benefits of a Wellmont-Mountain States integration. The proposed transaction, by far, positions the region to achieve the greatest level of public advantage and cost containment.

Assessment: In addition to the other benefits listed above, Wellmont and Mountain States expect the Cooperative Agreement to result in the following benefits for the Geographic Service Area:

- Behavioral Health and Substance Abuse Services. Behavioral health and substance abuse issues are a major health factor in the geographic area served by the Parties, and there are currently significant gaps in the continuum of care related to these issues. As part of the public benefit associated with the merger, and the $140 million commitment, the New Health System is prepared to make major investments in programs and partnerships that will help to address these issues. The societal cost associated with mental illness and substance abuse is extensive, and, given that the single largest diagnosis related to regional inpatient admissions is psychoses, these issues merit priority attention. Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thereby contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and a regionally integrated delivery model to support the development of effective behavioral health and substance abuse resources to provide high-quality, well-coordinated, and more proactive care.

The Parties recognize that important relationships must be developed across a continuum of community-based resources, primary care, intensive outpatient care, and inpatient care. In fact, effective systems of care and provider resources in the outpatient environment and the community will contribute to reducing the need for acute hospitalization or emergency department use. Though the New Health System will work to ensure appropriate inpatient resources exist, the main focus of development in this area will be outpatient systems of care, coordinated systems of care in the community, sufficient provider and specialized counseling resources, and residential recovery services. The New Health System will work within the existing framework of resources and partnerships across the region to identify needs associated with this area as well as gaps in service offerings. The Parties expect to identify a more integrated care model similar to what is outlined by the Agency for Healthcare Research and Quality ("AHRQ") for the region through the efforts of the Community Health Work Groups. That model includes primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care addressing mental health, substance abuse conditions, health behaviors, life stressors and crisis, stress-related physical symptoms, and ineffective patterns of health care utilization. The work of AHRQ and other evidence-based best practices will be used as a guide to support the development of regional services in a model that is coordinated, co-located, and integrated to overcome the disparate and disconnected manner in which individuals are currently treated. The New Health System will support a network of care resources across the region in partnership with agencies such as Frontier Health, Highlands Community Services, the regional rural health centers and Federally Qualified Health Centers, faith-based organizations, and health departments. Together with these partnership networks, the care resources associated with the New Health System, including primary care networks, emergency department networks, and inpatient behavioral health, will position the system to positively impact the development of this continuum of resources in an unprecedented way.

- Enhanced Health IT Capabilities. The Cooperative Agreement will allow the New Health System to leverage its integrated technology systems, combined with data from within the community to better coordinate population health efforts. By creating a "single team" approach, the combined system will promote collaboration across inpatient and outpatient care environments, engage patients, and manage health care data to promote healthier living and manage chronic care conditions.

- Academic and Research Partnerships. A hallmark initiative enabled by the proposed merger is the development of an enhanced academic medical system which can help transform health care delivery and address health care needs, access, experience, and economic well-being of the local community in the near term as well as long term. The proposed merger provides funds generated through merger efficiencies, some of which the Parties will invest in the development of research and academic enhancement to bring specific health care and economic benefits to the community. The Parties intend for the academic health system to be a focal point for health care and population health research specific to the issues and needs of the communities served by the New Health System in Tennessee and Virginia to focus strategies for interventions and improvements in health and health care delivery. The investments made possible by merger efficiencies, and their specific applications in research and development, faculty,

expanded services and training can also contribute to the economic vitality of the area as well as the improved ability to attract medical professionals and business endeavors, thereby benefiting the communities with overall health and economic wellbeing.

- Workforce Development. In addition to developing academic and research programs that attract talent to the region, the New Health System intends to attract and retain employees by being competitive with neighboring health systems. The Parties believe that by carrying through on the commitments in the Application, the New Health System will become a nationally recognized model which will attract highly talented team members and physicians who want to be part of a health care solution not necessarily offered elsewhere.

Recommendation: Wellmont and Mountain States anticipate significant benefits from the merger, including increased behavioral health and substance abuse services, enhanced health IT capabilities, improvement in the quality and availability of health care services, robust academic and research partnerships, and a commitment to workforce development. To ensure these benefits outweigh any potential disadvantages associated with the transaction, Mountain States and Wellmont make the following commitments:

- Behavioral Health and Substance Abuse Services
    - As part of its $140 million commitment, the New Health System will create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region. This service is not broadly available without sufficient capacity, and there are no plans by any entity to develop and build an integrated residential treatment facility. This benefit would not occur but for the transaction.
    - The New Health System will develop community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements.
- Enhanced Health IT Capabilities
    - The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.
    - The New Health System will commit to participate meaningfully in a health information exchange open to community providers.
- Academic and Research Partnerships
    - The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than $85 million over 10 years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty.
    - With its academic partners in Tennessee and Virginia, the New Health System will develop and implement a ten-year plan for post graduate training of physicians, nurse practitioners, physician assistants, and other allied health professionals in the region.
    - The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a 10-year plan

for investment in research and growth in the research enterprise within the region.

- Workforce Development
    - The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.
    - The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures.
    - The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.

Potential Disadvantages of the Proposed Merger

The department's evaluation of any disadvantages attributable to any reduction in competition likely to result from the agreement shall include, but need not be limited to, the following factors:

(A) The extent of any likely adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed healthcare organizations, or other healthcare payers to negotiate appropriate payment and service arrangements with hospitals, physicians, allied healthcare professionals, or other healthcare providers;

Background: Depending on the facts, mergers can "enable the merged firm to reduce its costs and become more efficient, which, in turn, may lead to lower prices, higher quality products [or services], or investments in innovation."[19] Tennessee's COPA law recognizes these principles as they apply to healthcare mergers through the list of potential advantages identified in the statute. Also under certain facts, mergers can result in market power, which can be exercised by raising price, reducing quality or slowing innovation.[20] The COPA law's list of potential disadvantages reflects this principle as well.

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

The major payer mix for the proposed Geographic Service Area of the New Health System (Application Exhibit 5.1-C) is:

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

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

The combined inpatient share in the proposed Geographic Service Area for the New Health System is approximately 73 percent. The combined facilities share for outpatient services (Application Exhibit 6.1-A to 6.1-D) ranges between 0 percent and 55.6 percent depending on

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

the specialty. Combined, the New Health System will employ approximately 30 percent of the physicians in the proposed Geographic Service Area (Application Exhibit 6.1-E).

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

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

Recommendation: In order to prevent the New Health System's ability to exercise any increased market or bargaining power achieved through the merger that could adversely impact the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other healthcare payers to negotiate appropriate payment and service arrangements with hospitals, physicians, allied healthcare professionals or other healthcare providers, the Parties have proposed that the following commitments be included in the COPA and be actively supervised by the State:

1. *The New Health System will negotiate in good faith with Principal Payers[21] to include the New Health System in health plans offered in the service area on commercially reasonable terms and rates (subject to the limitations herein). The New Health System would agree to resolve through mediation any disputes in health plan contracting.*

   How this commitment would prevent the potential disadvantage: This commitment by the New Health System would prevent the New Health System from rejecting in-network participation for payers constituting more than two percent of the New Health System's revenue if terms and rates offered were commercially reasonable (a judgment itself subject to the State's active supervision). Because the New Health System would be required to negotiate in good faith with all Principal Payers who offer commercially reasonable terms, or risk violation of the terms of the COPA, the New Health System

[21] For purposes of the Application and this Response, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

would have no leverage to demand anticompetitive rates. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA. In addition, any disputes in health plan contracting between the New Health System and the Principal Payers would be subject to mediation. Mediation consists of confidential negotiations facilitated by a third-party neutral whose role is limited to helping parties arrive at a mutually agreeable resolution to the dispute. Mediation is less expensive than litigation and less time-consuming. The Parties believe the commitment to mediation will help expeditiously resolve any disputes that arise with Principal Payers in order to minimize the impact a dispute may have on covered beneficiaries.

2. *The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.*

   How this commitment would prevent the potential disadvantage: This commitment would prevent the New Health System from requiring payers to contract with the merged entity exclusively in the proposed Geographic Service Area. The result is that consumers will continue to have network choices beyond the New Health System and providers will have an alternative to contracting solely with the New Health System or its network. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

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

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

The Parties believe that including these commitments in the COPA will prevent the New Health System from exercising any possible market or bargaining power achieved through the merger to adversely impact the ability of health maintenance organizations, preferred provider

organizations, managed health care organizations or other healthcare payers to negotiate appropriate payment and service arrangements with hospitals, physicians, allied healthcare professionals or other healthcare providers. The Parties presume that, to ensure the disadvantage is prevented, the State will actively supervise these commitments through annual reporting requirements.

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

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

Assessment: Although the merger will eliminate competition between the Parties, the COPA is the mechanism created by the Legislature to allow beneficial mergers while ensuring through active state supervision that consumers retain those benefits. Through this statutory authority, the State is able to protect its citizens from anticompetitive activity and simultaneously allow the New Health System to address the region's major population health issues and related healthcare challenges.

As noted above, the combined facilities share for outpatient services (Application Exhibit 6.1-A to 6.1-D) ranges between 0 percent and 55.6 percent depending on the specialty. Combined, the New Health System will employ approximately 30 percent of the physicians in the proposed Geographic Service Area (Application Exhibit 6.1-E). The merger of Mountain States and Wellmont will not create a concentrated market involving any physician or outpatient services. The Parties acknowledge that for general acute care inpatient services, the merger creates a relatively concentrated proposed Geographic Service Area.

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

Recommendation: In order to prevent the New Health System from reducing competition among or for physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with, hospitals in a way that results in disadvantages, the Parties have proposed that the following commitments be included in the COPA and be actively supervised by the State:

1. *The New Health System will maintain open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors.*

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

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

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

3. *Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.*

   How this commitment would prevent the potential disadvantage: Exclusive contracting has the potential to reduce competition by requiring physicians to render services only at facilities of the New Health System. Restricting the practice of independent physicians

to the New Health System's hospitals and other facilities has the potential to reduce the number of referrals in the proposed Geographic Service Area available to competing providers, and reduce the labor supply of physicians necessary for these providers to operate in the market. In order to ensure compliance with this commitment, the Parties have proposed that the commitment be actively supervised by the State through annual reports attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

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

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

5. *The New Health System will participate meaningfully in a health information exchange open to community providers.*

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

6. *The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.*

   How this commitment would prevent the potential disadvantage: A health system that achieves increased market share or bargaining power through a merger could potentially obtain labor at more favorable terms and wage rates than in an otherwise competitive market for the purchase of labor. Such an outcome is not likely for the New Health System due to at least two factors, in addition to this commitment: 1) the low

area wage index that the region is currently assigned by the federal government creates competition for labor from outside the Geographic Service Area, and the merger will not reduce this competition 2) the New Health System will not have a dominant share in the outpatient and physician services market which are attractive alternative employment options for hospital staff.

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

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

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

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

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

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

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

1. *The New Health System will maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available in close proximity to where the population lives.*

   How this commitment would prevent the potential disadvantage: In order to ensure higher-level services are available in close proximity to where the population lives, the New Health System will commit to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol. This commitment ensures that the three hospitals which have traditionally served as the hubs for high-level services, Johnson City Medical Center, Bristol Regional Medical Center and Holston Valley Medical Center, will remain available as tertiary referral centers to the patient population. This commitment would be actively supervised by requiring the New Health System to file an

annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

2. *Maintenance of open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors*

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

3. *For all Principal Payers, the New Health System will reduce existing commercial contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement; and, for subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index. If following such approval the New Health*

System and a Principal Payer are unable to reach agreement on a negotiated rate, the New Health Systems agrees to mediation as a process to resolve any disputes.

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

4. *The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.*

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

   To ensure that a reduction in competition between facilities does not decrease the incentive for increased quality and value of care, the Parties have committed to seeking out the alignment of reimbursements with quality and value measures. Federal and state governments are increasingly tying reimbursement, and reimbursement growth, to performance by measuring quality, patient experience and utilization/total cost of care. Commercial health plans and managed Medicare and Medicaid plans are following Medicare's lead. Not only will increased value based payments limit the ability of the New Health System to increase price based on a dominant market position, these payments will drive the New Health System towards improved quality and enhanced patient experience. Since an increasing number of payers with value-based systems

reward appropriate utilization, it will be difficult for the New Health System to make up lost revenue from the price controls detailed above in Section C.3 by inappropriately increasing utilization. *This commitment ensures that the New Health System will actively pursue quality and value based payments* and the State will actively supervise this commitment by requiring the New Health System to report progress toward this goal on an annual basis.

5. *The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.*

   How this commitment would prevent the potential disadvantage: To further ensure that a reduction in competition between facilities does not decrease the quality of care in the region, the Parties have proposed a commitment to report quality measures in a timely and easy to understand manner for use by patients, employers and insurers. Public and proprietary reporting of quality data is increasingly being used by patients, employers and insurers to make decisions about what providers provide the best value. Not only are patients utilizing data on quality to decide what provider to use, employers and insurers are increasingly using similar quality data to decide how to tier or narrow their networks to incentivize the use of high-value providers or to exclude low-value providers all together. This commitment ensures that the New Health System will be held accountable by the State and the public for its quality performance. The State will actively supervise this commitment by requiring the New Health System to comply with its quality reporting obligations on an annual basis.

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

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

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

Status Quo. The two systems could continue to compete with each other, which is the status quo. However, in a Geographic Service Area that has one of the lowest Medicare Wage Indices in the country, negligible population growth and contains fourteen Health Professional Shortage Areas,[22] the status quo has produced a combined debt service of

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

$1.5 billion, bond ratings below A grade, and significant restrictions on the availability of capital to invest in the upkeep of existing infrastructure. With a continued decline in the rate of hospital admissions per capita, the status quo alternative is likely to result in significant reductions in staff, services, and rural facilities to maintain operating margins. While maintaining the status quo may be less restrictive to competition, it would not result in any of the benefits that would be made possible by the merger if the COPA is granted. In fact, maintaining the status quo is likely to result in significant disadvantages for the community and the health of the region.

Joint Ventures: Most of the efficiencies identified by the New Health System could not be undertaken under Joint Venture arrangements. Because integration would be partial, not full, meaningful reduction in unnecessary duplication, and the cost-savings and other associated benefits of the merger, would be sharply limited. To the extent there is integration, the Parties would need to share proprietary information, requiring the setting up of complex firewalls and other protections to protect against spillover of competitively sensitive information into areas outside the joint venture. In the past, the Parties have attempted to collaborate with respect to quality improvement methodologies and related projects, but these efforts have been unsuccessful due to the restrictive competitive environment. Specifically, the Parties, as competitors, have been unable to share proprietary information and have lacked a common clinical information system. A joint venture would eliminate the incentive for the Parties to move towards a Common Clinical IT Platform due to the significant investments both Parties have made towards their individual IT systems. Commitments relating to pricing, consolidation of services, standardization of practices, and procedures, would also raise significant antitrust concerns if undertaken together by two independent hospital systems in a joint venture arrangement. The Parties have exhausted their joint venture options in the current competitive market. As a result, the COPA is needed for the Parties to realize the benefits made possible by the merger.

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

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

If Wellmont and Mountain States are not allowed to merge under the COPA, both systems would continue their independent searches for partners outside the region. A merger by either Party with an out-of-market system would not require a COPA and would likely not trigger the same antitrust scrutiny. In this case, there is a reasonable concern that a merger by either Party with an out-of-market system could result in price

increases for consumers since the out-of-market partner would be free to leverage any bargaining position without State supervision.[23]

Other deleterious effects could result from the merger by either Party with an out-of-market system. Specifically, local governance over health care operations would likely be lost. Well-paying jobs in the region may decrease as corporate business functions would be eliminated locally and centralized out-of-market. Any efficiencies gained from an out-of-market merger would likely be sent out of the region to two new corporate parents instead of being reinvested in public health, behavioral health, and academics and research as the Parties have committed to under the COPA. Finally, a merger with an out-of-market system by either Party would likely result in the potential loss of access to health care in rural areas. As described in the Application, providing services in rural areas is often unprofitable, and it would be very difficult to maintain rural healthcare services in the long term without the commitments made by the two Parties under the COPA. In short, while a merger by either Party with an out-of-network system may be viewed as a less restrictive alternative to the merger of Wellmont and Mountain States, none of the benefits or efficiencies described in the Application would be likely to result from such an out-of-market merger. In fact, the unsupervised merger of either Party with an out-of-market system is likely to result in far more disadvantages for consumers and the community than a merger of Wellmont and Mountain States that is actively supervised by the State.

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

The COPA provides a unique mechanism for Wellmont and Mountain States to merge under active state supervision. This structure allows the State to replace competition with regulatory oversight of the New Health System's compliance with the mutually agreed enforceable commitments that benefit the community. Ongoing, active supervision by the State ensures that the benefits of the merger continue to outweigh any potential disadvantages and that the State's policies underlying the issuance of the COPA are fulfilled.

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

Exhibit 11

List of Wellmont's Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue

CONTRACT LISTING - Less than 2% Net Revenue

CONTRACT	CONTRACTING PARTY
Aetna	PHO
Amera-Net	PHO
American PPO	PHO
Amerigroup	WHS (System)
Anthem Healthkeepers HMO SNF	MVRMC
Anthem Med Advantage SNF	MVRMC
Anthem PAR/PPO SNF	MVRMC
Anthem	Hospice
BCBST TennCare	ASC's
BCBST TennCare	WHS Hospitals
BCBST Medical Service Agreement	Hospice
BCBST TennCare	Hospice
Beacon Health (Value Options)	BRMC/Ridgeview
Beech Street	PHO
Carolina Steel	PHO
Cigna Behavioral Health	BRMC/Ridgeview
Cigna Behavioral Health	WMA - contracts with each behavioral health provider
Commonwealth of VA Dept of Rehab	BR/HV/LPH/MVRMC
Corvel Corporation	PHO
Coventry Healthcare of Virginia	PHO
Coventry National Network	WHS Facilities
Employer's Choice Network	WHS Hospitals in VA
Evolutions Healthcare Systems	PHO
Galaxy Health Network	PHO
HealthNet Federal Services (Veterans)	WHS Hospitals in VA
HealthNet Federal Services (TriCare)	WHS Hospitals in VA
HealthNet Federal Services	WMA
HealthNet Federal Services	WCS
HealthSpring Medicare Advantage	Wexford House
Humana Tricare Prime	WHS Hospitals/Hospice
Humana Tricare	WMA
Humana Tricare	WCS
Integrated Medical Solutions	PHO
INTotal Health	PHO
LifeSynch	WMA
King University	PHO
Magellan Behavioral Health	BRMC/Ridgeview
MCA Level Funding Plan	PHO
MHNet Behavioral Health	BRMC/Ridgeview
Mountain Empire PACE	WHS Hospitals/Hospice
Mountain Empire PACE	WMA
Multiplan	PHO
NovaNet	PHO

Optima Health Medicaid	WHS
Optima Health Medicaid	WMA
Optima Health Medicaid	WCS
Pittston Preferred	PHO
Prime Health Services	PHO
Provider Select	PHO
Scott County School Board	PHO
SelectNet Plus	PHO
Takoma Regional Hospital	PHO
The Initial Group	PHO
The United Company	PHO
TriCare for Life	Wexford House
TriWest Healthcare Alliance	WHS (System)
United Behavioral Health Commercial	BRMC/Ridgeview
United Behavioral Health Commercial	WMA - contracts with each behavioral health provider
United Behavioral Health TennCare	BRMC/Ridgeview
United Behavioral Health TennCare	WMA
UHC Community Plan	WHS Facilities
UHC Community Plan	WMA
UHC Community Plan	WCS
UHC Community Plan	Wexford House
USA MCO	PHO
Veterans Evaluation Services	WHS Hospitals
Virginia Premier	PHO
WellCare Medicare Advantage	PHO
Wellmont Health System	PHO

Exhibit 12

List of Mountain States' Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue

Mountain States Health Alliance
Payers that Represent Less than 2% of Patient Service Revenue

Total Number of Payers **161**

Payor	Product	Mountain States Health Alliance Contracting Party
Allied National, Inc.		Mountain States Managed Care, Inc.
Amerigroup Virginia, Inc.	VA Medicaid	ISHN, LLC
Anthem Health Plans of Virginia, Inc.	Medicaid Integration Participation Attachment	MSHA Home Health - VA and Kingsport Home Health
Anthem Health Plans of Virginia, Inc.	Medicaid Integration Participation Attachment	MSHA SNF - NCH & SCCH
Anthem Health Plans of Virginia, Inc.	Medicaid Integration Participation Attachment	Mediserve Medical Equipment, Inc. and Community Home Care, Inc.
Anthem Health Plans of Virginia, Inc.	Medicaid Integration Participation Attachment	MSHA Hospice - VA and Kingsport Home Health
Anthem Health Plans of Virginia, Inc.	Medicare Advantage	Johnston Memorial Hospital; Dickenson Community Hospital; Norton Community Hospital; Smyth County Community Hospital; Mountain States Health Alliance d/b/a Russell County Medical Center, and Mountain States Health Alliance d/b/a Indian Path Medical Center
Anthem Health Plans of Virginia, Inc.	Medicare Integration Participation Attachment	MSHA Home Health - VA and Kingsport Home Health
Anthem Health Plans of Virginia, Inc.	Medicare Integration Participation Attachment	Mediserve Medical Equipment, Inc. and Community Home Care, Inc.
Anthem Health Plans of Virginia, Inc.	Medicare Integration Participation Attachment	MSHA SNF - NCH & SCCH
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	Blue Ridge
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	Johnston Memorial Hospital; Dickenson Community Hospital; Norton Community Hospital; Smyth County Community Hospital; Mountain States Health Alliance d/b/a Russell County Medical Center, and Mountain States Health Alliance d/b/a Indian Path Medical Center
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	Mediserve Medical Equipment, Inc. and Community Home Care, Inc.
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	MSHA Home Health - VA and Kingsport Home Health

Payor	Product	Mountain States Health Alliance Contracting Party
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	MSHA Hospice - VA and Kingsport Home Health
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	MSHA SNF - NCH & SCCH
Anthem Health Plans of Virginia, Inc.	VA Medicaid	Johnston Memorial Hospital; Dickenson Community Hospital; Norton Community Hospital; Smyth County Community Hospital; Mountain States Health Alliance d/b/a Russell County Medical Center, and Mountain States Health Alliance d/b/a Indian Path Medical Center
Anthem Health Plans of Virginia, Inc.	Medicare	Blue Ridge
Anthem Health Plans of Virginia, Inc.	VA Medicaid	Blue Ridge
Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	HMO Medicaid Participation Attachment – Non-Acute	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Medicare Advantage Participation Attachment – Non-Acute	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Medicare Medicaid Dual Integration	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
Appalachian Agency for Senior Citizens	AllCare for Seniors	Mountain States Health Alliance d/b/a Dickenson Community Hospital
Appalachian Agency for Senior Citizens	AllCare for Seniors	Johnston Memorial Hospital
Appalachian Agency for Senior Citizens	AllCare for Seniors	Mountain States Health Alliance d/b/a Russell County Medical Center
Appalachian Agency for Senior Citizens		Dickenson Community Hospital
Appalachian Agency for Senior Citizens		Norton Community Hospital
Appalachian Agency for Senior Citizens		Norton Community Physician Services Corporation
Appalachian Agency for Senior Citizens		Mountain States Health Alliance dba Russell County Medical Center

Payor	Product	Mountain States Health Alliance Contracting Party
Appalachian Agency for Senior Citizens		Russell County Medical Center dba Riverside Community Medical Clinic
Beech Street Corporation		Mountain States Health Alliance
Beech Street Corporation		Blue Ridge Medical Management
Beech Street Corporation		APP
Benefit Plan Administrators, Inc.		Smyth County Community Hospital
Benefit Resources, Inc.		Russell County Medical Center
Blue Ridge Job Corp Center		Smyth County Community Hospital
BlueCross BlueShield of Tennessee Inc.	Dual Eligible Special Needs Plan	Participating TennCare Provider (BRMMC)
BlueCross BlueShield of Tennessee Inc.	Dual Eligible Special Needs Plan	Participating TennCare Provider (Facilities and KDS)
Bluegrass Family Health, Inc.		Unicoi County Memorial Hospital
CareCentrix		Mountain States Health Alliance dba MCHC
Centurion		Mountain States Health Alliance
CHA Provider Network, Inc.		Norton Community Hospital
Christian Care Centers of Johnson City, Inc.		Mountain States Health Alliance
CIGNA Behavioral Health, Inc.		Mountain States Health Alliance
Commonwealth of Virginia Department of Health, Office of Family Heath Services		Smyth County Community Hospital
Commonwealth of Virginia Department of Rehabilitative Services		Smyth County Community Hospital
Commonwealth of Virginia, Department of Mental Health, Mental Retardation and Substance Abuse Services		Smyth County Community Hospital
Commonwealth of Virginia, Virginia Department of Health, Cumberland Plateau Health District	Breast & Cervical Cancer Program	Russell County Medical Center
Comp Management of Virginia, Inc.		Norton Community Hospital
Corphealth, Inc. d/b/a LifeSynch	Psych Commercial	Facility and Physician
Corvel Healthcare Corporation	Corvel Commercial/WC	Mountain States Health Alliance
Corvel Healthcare Corporation	Corvel Commercial/WC	Kingsport Ambulatory Surgery Center, LLC dba Kingsport Day Surgery
Corvel Healthcare Corporation	Physician Agreement - Commercial/WC	Blue Ridge Medical Management Corporation

Payor	Product	Mountain States Health Alliance Contracting Party
Cumberland Mountain Community Services, Dickenson County Behavioral Health Services, Highlands Community Services, Mount Rogers Community Services, New River Valley Community Services, Planning District 1 Behavioral Health Services	Psychiatric Service Agreement	Russell County Medical Center
Dickenson County Behavioral Health Services	Behavioral Health Services Agreement	Russell County Medical Center
Division of Rehabilitation Services of the Tennessee Department of Human Services		Mountain States Health Alliance
EvaluMed		Not specified; mentions “Mountain States Health Alliance physical therapist” and “Managed Care”
First Health Group Corp.		Mountain States Health Alliance - TN Facilities
First Health Group Corp.		Norton Community Hospital
Fortified Provider Network		Johnston Memorial Hospital
Frontier Health, Inc./PD 1	Psychiatric	Russell County Medical Center
Galaxy Health Network		Russell County Medical Center
Galaxy Health Network		Unicoi County Memorial Hospital
Gateway Health Alliance, Inc.		Dickenson Community Hospital, Norton Community Hospital, Smyth County Community Hospital, Mountain States Health Alliance d/b/a Russell County Medical Center (includes rates for facility and physician)
Gateway Health Alliance, Inc.		Southwest Virginia Health Network - JMH PHO(includes rates for both physicians and facility)
Grayson Nursing & Rehabilitation Center- Skilled Nursing Facility		Smyth County Community Hospital, Inc.
Health Payors Organization, LTD.		Johnson City Medical Center Hospital, Inc.
Highlands Community Services	Psychiatric	Russell County Medical Center
Holston Distributing Inc	Ancillary Agreement - WC	Mountain States Health Alliance
Horizon Health EAP Services, Inc.		Mountain States Health Alliance dba Sycamore Shoals Hospital
Horizon Health EAP Services, Inc.		Mountain States Health Alliance dba Johnson City Medical Center (dba Woodridge Psychiatric Hospital)

Payor	Product	Mountain States Health Alliance Contracting Party
Horizon Health EAP Services, Inc.		Blue Ridge Psychiatry/Woodridge Hospital Physicians
Hospice of Southwest Virginia		Smyth County Community Hospital
Humana Government Business, Inc. d/b/a Humana Military		Mountain States Health Alliance (Unicoi Locations)
Humana Health Plan, Inc.	Commercial	Mountain States Health Alliance
Humana Insurance Company, Humana Health Plan, Inc.	Commercial	Blue Ridge Medical Management
Humana Military Health Services, Inc.		Mountain States Health Alliance
Integrated Medical Solutions, LLC	USP Lee County	Mountain States Health Alliance (IPMC & NCH)
INTotal Health, LLC (formerly known as Amerigroup Virginia, Inc.)	VA Medicaid	ISHN, LLC - Physicians
ISHN - Optima/Sentara	Optima/Sentara Mediciad	Blue Ridge Medical Management
ISHN - Optima/Sentara	Optima/Sentara Mediciad	Facilities
ISHN - Optima/Sentara		Mountain States Health Alliance (Kingsport Day Surgery Center, Dickenson Community Hospital, Franklin Woods, Indian Path, Johnson City Medical, Woodridge Hospital, Johnson County Community Hospital, Johnston Memorial Hospital, Norton Community Hospital, Russell County Medical Center, Smyth County Community Hospital, Sycamore Shoals, Quillen Rehabilitation, Niswonger Children's Hospital)
ISHN - Optima/Sentara		Blue Ridge Medical Management
Ivy Hall Nursing Home, Inc.		Mountain States Health Alliance
Johnston & Associates, Inc.		Mountain States Health Alliance - WC TN & VA Diagnostic
Johnston & Associates, Inc.		Mountain States Health Alliance - TN WC Rehab
Johnston & Associates, Inc.		Mountain States Health Alliance VA WC Rehab
KDM, Inc. dba Durham-Hensley Health and Rehabilitation		Mountain States Health Alliance
Lakebridge Medical Investors, LLC dba Lakebridge Health Care Center		Mountain States Health Alliance
Magellan Behavioral Health, Inc.	Commercial	Blue Ridge Medical Management Corporation

Payor	Product	Mountain States Health Alliance Contracting Party
Magellan Behavioral Health, Inc.	Medicaid	Blue Ridge Medical Management Corporation
Magellan Behavioral Health, Inc.	Commercial	Mountain States Health Alliance
Magellan Behavioral Health, Inc.	Medicaid	Mountain States Health Alliance
Managed Health Network, Inc.		Russell County Medical Center, Inc.
Medcost,Inc.		Johnston Memorial Hospital
Medical Control Network Solutions, Inc.		Norton Community Hospital
Medical Network, Inc.		Sycamore Shoals
Mental Health Associates, Inc.		ISHN, LLC
Modern Chevrolet		Russell County Medical Center
Mountain Empire Older Citizens, Inc.	PACE	Norton Community Hospital Home Health
Mountain Empire Older Citizens, Inc.	PACE	Norton Community Physicians Services
Mountain Empire Older Citizens, Inc.	PACE	Norton Community Hospital
Mountain Empire Older Citizens, Inc.	PACE	Community Home Care, Norton Community Hospital
MultiPlan, Inc.	Commercial	Blue Ridge Medical Management
MultiPlan, Inc.	Commercial	Facility
MVP Health Plan, Inc., MVP Select Care, Inc. and MVP Affiliates	Medicare PPO	Mountain States Health Alliance and Blue Ridge Medical Management
National Preferred Provider Network, Inc.		Southwest Virginia Health Network (JMH & Physicians)
National Preferred Provider Organization (Unicare)		Russell County Medical Center & Johnston Memorial
Novanet, Inc.	Medical	MSHA Hospitals
Novanet, Inc.	Medical	KDS
Novanet, Inc.	Medical	BRMMC, Norton Community Physician Services, Abingdon Physician Partners, Dickenson Medical Associates, Dickenson Community Hospital ER Physicians, Smyth County Community Hospital ER Physicians, Smyth County Community Hospital Physicians, Russell County Medical Center ER Physicians, Russell County Medical Center Physicians, Johnston Memorial Hospital Physicians

Payor	Product	Mountain States Health Alliance Contracting Party
Novanet, Inc.	Workers' Comp	BRMMC, Norton Community Physician Services, Abingdon Physician Partners, Dickenson Medical Associates, Dickenson Community Hospital ER Physicians, Smyth County Community Hospital ER Physicians, Smyth County Community Hospital Physicians, Russell County Medical Center ER Physicians, Russell County Medical Center Physicians, Johnston Memorial Hospital Physicians
Novanet, Inc.	Workers' Comp	Kingsport Day Surgery
Novanet, Inc.	Workers' Comp	Mountain States Health Alliance
Optimum Choice, Inc		Russell County Medical Center, Inc.
Physician Services, LC	4Most Health	Facility & Physician
Pittston Coal		Russell County Medical Center
Preferred Care	USA Care Plan	Facility
Prime Health Services, Inc.		Blue Ridge Medical Management Corporation
Prime Health Services, Inc.		Facilities
Private Healthcare Systems, Inc.		Physician
Private Healthcare Systems, Inc.		Mountain States Health Alliance
Public Risk Services, Inc. /The Pool		Mountain States Health Alliance
Roan Highlands Medical Investors, LLC dba Roan Highlands Nursing Center		Mountain States Health Alliance
Russell County Detention Center		Russell County Medical Center
SelectNet Plus, Inc. (Accorida National)		Russell County Hospital
Seven Corners, Inc.	USP Lee County	Mountain States Health Alliance
Southern Health Services, Inc.	VA Medicaid	ISHN, LLC (MSHA & MSMG)
Southwest Virginia Mental Health Institute		Smyth County Community Hospital
State Of Tennessee Department of Health	Tennessee Department of Health, Communicable & Environmental Diseases and Emergency Preparedness, HIV/STD Programs , Ryan White Part B Program	Unicoi County Memorial Hospital
Tennessee Department of Health	Breast and Cervical Screenings	Unicoi County Memorial Hospital
Tennessee Department of Health	CEDEP Program (Ryan White)	Johnson City Medical Center - Facilities to be determined based on vendor forms
Tennessee Department of Health	Mammography Screening Program	Mountain States Health Alliance
The Infant Toddler Connection of Mount Rogers		Smyth County Community Hospital
The Initial Group		APP

Payor	Product	Mountain States Health Alliance Contracting Party
The Initial Group		APP
The Initial Group, Inc.		ISHN, LLC
Three Rivers Provider Network		Hospital Affiliation – Johnston Memorial Hospital
Three Rivers Provider Network, Inc.		JMH physicians
TriWest Healthcare Alliance Corp.		Mountain States Health Alliance
Trustees of the UMWA 1992 (and 1993) Benefit Plan;		Mountain States Health Alliance d/b/a Russell County Medical Center Home Health
Trustees of the UMWA 1992 (and 1993) Benefit Plan;		Norton Community Hospital
Trustees of the United Mine Workers of America Combined Benefit Fund, the Trustees of UMWA 1992 Benefit Plan , the Trustees of the UMWA 1993 Benefit Plan and the Trustees of the UMWA Prefunded Benefit Plan		Mountain States Health Alliance dba Russell County Medical Center
UMWA Health and Retirement		Mountain States Managed Care, Inc. (TN Facilities)
United Behavioral Health, Inc.	Commerical & Medicare	Mountain States Health Alliance d/b/a Sycamore Shoals Hospital and Woodridge Psychiatric Hospital
United Behavioral Health, Inc.	TennCare	Mountain States Health Alliance d/b/a Sycamore Shoals Hospital and Woodridge Psychiatric Hospital
United Mine Workers of American, Combined Benefit Fund, UMWA 1992 Benefit Plan, UMWA 1993 Benefit Plan		Blue Ridge Medical Management Corporation
United Payors and United Providers, Inc.		Sycamore Shoals, Quillen, Franklin Woods and KDS
USA Health Network Company, Inc.		JMH
USA Health Network Company, Inc.		JMH Physicians
USA Managed Care Organization, Inc.		Norton Community Hospital
USA Managed Care Organization, Inc.		Smyth County Community Hospital
USA Managed Care Organization, Inc.		Mountain States Health Alliance
USA Managed Care Organization, Inc.		APP
Value Options, Inc.	Commerical	Mountain States Health Alliance dba Woodridge Psychiatric Hospital and Sycamore Shoals

Payor	Product	Mountain States Health Alliance Contracting Party
Value Options, Inc.	TriCare Provider Agreement	Mountain States Health Alliance dba Woodbridge Psychiatric Hospital
Virginia Department of Health	Sterilization Program	Smyth County Community Hospital
Virginia Department of Health, Mount Rogers health district	Virginia Department of Health Office of Purchasing and General Services Standard Contract - Every Women's Life	Johnston Memorial Hospital, Inc.
Virginia Health Network, Inc.		Mountain States Health Alliance & Physicians
Virginia Premier Health Plan, Inc.		ISHN, LLC - Base Agreement (Facilities & Physicians)
Windsor Health Plan, Inc.		Unicoi County Memorial Hospital, Inc. & Nursing Home

Exhibit 13

Mountain States' Currently Planned Fixed Rate Increases

To be submitted pursuant to CID.

Exhibit 14

Wellmont's Currently Planned Fixed Rate Increases

To be submitted pursuant to CID.

Exhibit 15

Mountain States' Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient Services

To be submitted pursuant to CID.

Exhibit 16

Wellmont's Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient Services

To be submitted pursuant to CID.

Exhibit 17

Anticipated 10-Year Timeline

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

Exhibit 18

Estimates for How and When the $150 Million Investment in a Common Clinical IT Platform and Health Information Exchange will be Allocated

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

Exhibit 19

Current Commitment and Timeframe for Participation of both MSHA and Wellmont in OnePartner

RESPONSE:

- ***Description of the health information exchanges ("HIE") currently used by each party***

    - Wellmont
        - Wellmont is currently an acute data contributor to OnePartner.
        - As an acute data contributor, Wellmont provides the following information to OnePartner:
            - Demographics
            - Encounters
            - Labs
            - Diagnoses
            - Procedures and
            - Radiology.
        - The initial cost to set up the interface with OnePartner was $63,500.
        - There are annual fees of $9,800 for Wellmont to continue sending information to OnePartner.
        - The cost for each provider to be able to access the information in the HIE is $149 per physician per month.
        - As of July, 2016, a group of Wellmont physicians have access to OnePartner as collaborators rather than simply contributors.
        - The only patient information available within the HIE is the 18 data points identified below. The patient information can be viewed and printed when the provider is accessing the HIE.

    - Mountain States
        - Mountain States is currently an acute data contributor to OnePartner under a five year agreement set to expire on December 31, 2019.
        - As an acute data contributor, Mountain States provides the following information to OnePartner:
            - Demographics
            - Encounters
            - Labs
            - Diagnoses
            - Procedures and
            - Radiology.
        - Clinical documents are scheduled to go-live in July 2016. For acute hospitals the clinical documents will include history and physical, progress notes (SOAP), consults, procedure notes, and discharge summaries. For ambulatory surgery centers, the clinical documents will include office visit assessments, post- op visit notes, ER follow up notes, and prenatal visit notes.
        - Mountain States Medical Group is currently testing ambulatory data on-boarding with OnePartner and will be complete by the end of August 2016. Once on-board, Mountain States Medical Group is expected to provide

Demographics, Encounters, Vitals, Labs, Diagnoses, Procedures, Problems, Allergies, Medications, Immunizations, Clinical Documents to OnePartner for all patients treated by the Group's 375 providers and mid-levels.

- Mountain States' current financial commitment to OnePartner is $98,000.
- Initial setup cost to connect to OnePartner was $53,500. Mountain States pays $8,900 per year for five years for access to the OnePartner data.
- In addition to exchanging 11,432,731 data transactions with OnePartner, Mountain States has had a broad range of experiences with data sharing arrangements.
- Currently, other data sharing partners include:
  - State of Franklin Health Associates : 373,673 data transactions
  - Inpatients Consultants: 289,760 data transactions
  - Medical Practice Management: 162,384 data transactions
  - East Tennessee State University: 69,502 data transactions.
- Mountain States also currently send Immunization data, and is in final testing for exchanging Syndromic Surveillance data, to the state of Tennessee. In addition, Mountain States currently sends Immunization and Syndromic Surveillance data to the Virginia Connect HIE.
- Mountain States was a Veterans Administration proof of concept, pilot and demonstration partner in the development of the Direct Messaging platform and has recently undertaken initial conversations with the Veterans Administration for potential inclusion with their Virtual Lifetime Electronic Record (VLER) program.
- Finally, Mountain States is actively working with Tennessee's Healthcare Innovation Initiative to develop a community case management tool.

- ***Description of the OnePartner HIE***
  - OnePartner is a for-profit limited liability company owned by physicians in northeast Tennessee.
  - OnePartner is exclusively a physician Regional Health Information Exchange available to providers located in Northeast Tennessee and Southwest Virginia.
  - It is operationalized through the use of a product named dbMotion. dbMotion is a context aware computer application that when deployed and integrated with a OnePartner collaborator's EMR, provides access to the OnePartner patient record from the practicing physician's EMR workstation.
  - Access to OnePartner is available through an online portal: https://provider.onepartnerhie.com.
  - Before accessing the OnePartner HIE data, a participating entity must sign a collaborator agreement, meet the criteria in the agreement, pay a subscription fee of $150-200 per month per provider, and meet the minimum standards for participating providers. They must also sign a Business Associate Agreement and a Data Sharing Agreement.
  - The information fields available in the OnePartner HIE are limited to the following:

    - Name
    - Demographics
    - Active Allergies
    - Current Medications
    - Problem List (Current Problems)
    - Problem List (Resolved Problems)
    - Recent Visits
    - Immunizations
    - History (Medical and Surgical)
    - History (Family)
    - History (Social)
    - Last Recorded Vital Signs
    - Progress Notes
    - Plan of Care
    - Functional Status
    - Recent Results
    - PCP
    - Custodial/Source Organization

- These 18 components are sent to the HIE unless a patient affirmatively opts-out and requests that their information not be included.
- Once on the system, HIE data can be printed and can be brought into the participating entity's EMR only if they have certain computer capabilities on their end.
- According to OnePartner, over the last four years:
    - the number of providers providing data is currently greater than 1,000
    - the number of providers viewing data is approximately 400
    - there are 654,083 unique patients have been entered into the database.
- Based on information provided by OnePartner, the top contributing providers are Mountain States, Holston Medical Group, and State of Franklin Health Associates.
- Again, based on information provided by OnePartner, the top accessors of data are Holston Medical Group, State of Franklin Health Associates, and Qualuable Medical Professionals.

Exhibit 20

Additional Detail on the Proposed Community Reinvestment

Below is a description of the activities to be funded by the proposed community reinvestment by category. It should be noted that the timing of spending for each category is an estimate and may vary depending upon market circumstances. Also, some spending may cross into multiple categories. For example, as noted below, pediatric sub-specialty access may include specific mental health services. As a result, it has not yet been determined which category would be "credited" with that expenditure.

The $75 million investment in population health improvements:

RESPONSE: Additional detail on this incremental investment is provided in the proposed template Community Health Improvement Plan included separately as Exhibit 21 and the annual estimate of reinvestment from efficiencies, also provided separately as Exhibit 22. As explained in the Application, the Parties believe that including the Department, the local departments of health, the Community Health Work Groups, the Advisory Groups, and other community stakeholders in finalizing the proposed Index Categories, Key Focus Areas, and Accountability Mechanisms will lead to greater community buy-in and adaptation of the population health improvement process. Once the community health improvement goals are agreed upon with the state under the COPA, the exact programmatic investments – including location and timing – will be determined in order to most effectively leverage existing programs which operate successfully in the region and fill gaps in service offerings and funding needs where existing programs do not adequately cover the community health needs.

The $140 million to expand needed services:

RESPONSE: The $140 million spending referenced in the Application falls into three major categories: mental health and addiction recovery ($85 million), pediatric sub-specialty access ($27 million) and rural health access ($28 million). Additional detail on the incremental investment for these services is provided in the proposed template Community Health Improvement Plan included separately as Exhibit 21. Annual spending estimates for these services are included in the annual estimate of reinvestment from efficiencies that is included separately as Exhibit 22. These latter two categories of spending, pediatric sub-specialty access and rural health access, will support the provision of new services which would not otherwise generate sufficient revenue for the New Health System to offer, but are necessary to address specific health and health care needs and reduce patient travel time. These expenditures will be guided by physician needs assessments updated every three years in each sub-market within the Geographic Service Area.

The $85 million to develop and grow academic and research opportunities:

RESPONSE: Additional detail on the spending associated with academic and research opportunities is provided in the annual estimate of reinvestment from efficiencies, provided separately as Exhibit 22. In regard to the sub-categories of spending on research infrastructure, increasing residency and training slots, creating new specialty training opportunities, and adding faculty—the Parties believe these plans must be developed together with their academic partners in Tennessee and Virginia. This process will include the development of a ten-year plan

for post-graduate training of physicians, nurse practitioners, and physician assistants along with other allied health professions. The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a ten-year plan for investment in health research and growth in the health research enterprise within the region. It is not possible for the Parties to develop these plans without the integral involvement of their academic partners in Tennessee and Virginia, and the Parties expect this process will take at least a year for these plans to be fully developed.

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

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

Exhibit 21

Template Community Health Improvement Plan

Template Community Health Improvement Plan

Ensure Strong Starts for Children 1/2	Short-term Outcomes	Intermediate Outcomes	Long-term Expected Health Impact				
			Heart	**Cancer**	**Diabetes**	**Behavioral Health**	**Infant Mortality**
Reduce Childhood Obesity		Reduction in percent children classified as "overweight"	X	X	X		
• Increase rates of breastfeeding ▪ Program Example: *Baby Friendly Hospital Initiative*	Increased rate of breastfeeding at 6 months		X	X	X		X
• Increase physical activity ▪ Program Example: *Morning Mile; Project SPARK*	Increased rate of children achieving the recommend level of weekly physical activity		X	X	X		
• Increase healthy eating ▪ Program Example: *#LiveSugarFreed campaign*	Decreased amount of weekly sugary beverage consumption in children		X	X	X		
Decrease Tobacco Use in Youth		Decreased rates of "current" use of tobacco	X	X	X	X	X
• Expand anti-smoking campaigns ▪ Program Example: *#UNSMOKABLE*	Reduced rate of past year smoking initiation or "ever" smoked		X	X	X	X	X
Decrease Opioid Abuse in Youth		Decreased reported past month non-medical use of pain relievers				X	X
• Decrease diversion ▪ Program Example: *Drug return kiosks*	Milligrams of prescription painkillers removed from circulation					X	X
• Expand anti-opioid campaigns ▪ Program Example: *Above the Influence*	Reduced rate of "ever" tried					X	X
Increase 3rd Graders reading at Grade Level		Increased percentage of 3rd graders scoring "proficient" on TCAP reading assessment	X	X	X	X	X
• Increase read aloud opportunities ▪ Program Example: *Bear Buddies; Nurse Family Partnership*	Increased percentage of "at-risk" K-2 students paired with a Bear Buddy reading mentor		X	X	X	X	X

Ensure Strong Starts for Children 2/2	Short-term Outcomes	Intermediate Outcomes	Long-term Expected Health Impact				
			Heart	**Cancer**	**Diabetes**	**Behavioral Health**	**Infant Mortality**
Decrease Pre-term Births		Decreased pre-term birth rate				X	X
• Increase effectiveness of pre-natal care ▪ Program Example: *Nurse Family Partnership; Centering Pregnancy; 17-P utilization*	Increased percentage high-risk women participating in program					X	X
• Decrease tobacco use among pregnant women ▪ Program Example: *ACOG 5 As Behavioral Intervention; Baby and Me; SMART Moms*	Increased percentage of pregnant female participants completing nicotine abstinence programs					X	X
• Decrease NAS births ▪ Program Example: *Residential treatment for opioid addicted pregnant women*	Decreased percentage of births with NAS					X	X
• Increase birth spacing ▪ Program Example: *Post-partum LARC insertion*	Increased average/median months between pregnancy in high-risk women					X	X

Help Adult Live Well in the Community	Short-term Outcomes	Intermediate Outcomes	Long-term Expected Health Impact				
			Heart	**Cancer**	**Diabetes**	**Behavioral Health**	**Infant Mortality**
Decrease Adult Obesity		Decreased adult obesity rate	X		X		
• Increase Physical Activity ▪ Program Example: *YMCA Diabetes Prevention Program*	Decreased percentage of adults reporting no physical activity within past month		X	X	X		
• Increase Healthy Eating ▪ Program Example: *YMCA Diabetes Prevention Program*	Improvement in the Healthy Eating Index measure of dietary quality		X	X	X		
Decrease Adult Tobacco Use		Decreased rates of "current" tobacco use	X	X	X	X	X
• Increase cessation treatment ▪ Program Example: *Screening and Physician Counseling*	Improved score on tobacco-related HEDIS measures in the New Health System.		X	X	X	X	X
• Expand successful mass-reach health communication interventions ▪ Program Example: *CDC's Tips From Former Smokers*	Increased population awareness in anti-smoking awareness and attitudes over survey baseline		X	X	X	X	X
Increased Early Detection of Chronic Disease		Decreased early mortality from heart disease, diabetes, suicide, cancer, infant mortality	X	X	X	X	X
• Increase population screening ▪ Program Example: *Screening and Physician Counseling; SBIRT; Mobile Health Unit Deployment*	Improved score on screening-related HEDIS measures in the New Health System.		X	X	X	X	X

Promoting a Drug Free Community	Short-term Outcomes	Intermediate Outcomes	Long-term Expected Health Impact				
			Heart	**Cancer**	**Diabetes**	**Behavioral Health**	**Infant Mortality**
Decrease Opioids In Circulation		Decreased reported past month non-medical use of pain relievers				X	X
• Decrease prescriptions written ▪ Program Example: *Choosing Wisely, CSMD*	Decreased morphine equivalents prescribed					X	X
Expand Environmental Prevention Strategies		Decreased reported past month non-medical use of pain relievers				X	X
• Increase multi-sector community collaborations ▪ Program Example: *Tennessee Community Prevention Coalitions*	Increased number of counties in the GSA with an active Community Prevention Coalition					X	X
Expand supportive services		Decreased reported past month non-medical use of pain relievers				X	X
• Increase supportive housing ▪ Program Example*: Oxford House*	Expanded number of units available in drug-free supportive housing.					X	X

Decrease Avoidable ED Use for High-Need High-Utilization Uninsured Individuals	**Short-term Outcomes**	**Intermediate Outcomes**	**Long-term Expected Health Impact**				
			Heart	**Cancer**	**Diabetes**	**Behavioral Health**	**Infant Mortality**
Increase use of ED alternatives		Reduction in avoidable ED and Inpatient Admissions in High-Need High-Use population	X	X	X	X	
• Increase use of primary, BH and specialty-care services ▪ Program: *Project Access, Free-clinics*	Increased utilization of primary care and specialty services by High-Need High-Risk population		X	X	X	X	
• Increase use of home-based health services ▪ Program Example: *Community Paramedics, Community Health Workers*	Increased utilization of home-based health services by High-Need High-Risk population		X	X	X	X	
Expand supportive services		Reduction in avoidable ED and Inpatient Admissions in High-Need High-Use population	X	X	X	X	
• Increase use of case management ▪ Programs example: *SC Medicaid Healthy Outcomes Program*	Increased percentage of High-Need High Utilizing population in active case management		X	X	X	X	
• Decrease transportation barriers ▪ Programs example: *Transportation vouchers*	Decrease “no-show” rate in High-Need High Utilization population		X	X	X	X	

Improve Access to Behavioral Health	Short-term Outcomes	Intermediate Outcomes	Long-term Expected Health Impact				
			Heart	**Cancer**	**Diabetes**	**Behavioral Health**	**Infant Mortality**
Increased Screening for Depression and Substance Abuse		Increased use of behavioral health treatment services				X	X
• Increased screening at sites of care ▪ Program Example: *SBIRT*	Increase in the rates of SBIRT administration					X	X
Reduce Unnecessary Psychiatric Admissions		Decreased psychiatric ER and inpatient admissions.				X	X
• Expand community based outpatient treatment ▪ Program Example: *Assertive Community Treatment*	Increased percentage of individuals with SMI/SUD participating in community-based treatment					X	X
• Expand crisis management services ▪ Program Example: *Mobile Crisis Teams*	Increased percentage of crisis calls responded to by crisis management teams versus law enforcement					X	X
Increase number of individuals with SUD in recovery		Increased percentage of individuals participating in active recovery				X	X
• Expand continuum of treatment options ▪ Program Example: *Medically Monitored Detox, Residential Treatment, Outpatient Treatment*	Increased capacity in full continuum of treatment services for individuals living with SUD					X	X

Exhibit 22

Year-by-Year Summary

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Expanded Health Care Services	Behavioral Health Services	$ 1,000,000	$ 4,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	**$ 85,000,000**
	Children's Services	1,000,000	2,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	**27,000,000**
	Rural Health Services	1,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	**28,000,000**
Health Research & Graduate Medical Education	Academics & Research	3,000,000	5,000,000	7,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	**85,000,000**
Community Health Improvement	Strong Starts for Children; Helping Adults Live Well; Supporting a Drug Free Community; Decreasing High Utilization by the Uninsured	1,000,000	2,000,000	5,000,000	7,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	**75,000,000**

$ 300,000,000

Exhibit 23

Audited Financial Statement on MSHA as of June 30, 2015

MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Information)

Years Ended June 30, 2015 and 2014

PYA
Certified Public Accountants

MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Information)
(Dollars in Thousands)

Years Ended June 30, 2015 and 2014

PERSHING YOAKLEY & ASSOCIATES, P.C.
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PYA
Certified Public Accountants

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Mountain States Health Alliance and its subsidiaries (the Alliance), which comprise the consolidated balance sheets as of June 30, 2015 and 2014, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the 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 accounting principles generally accepted in the United States of America; 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 misstatements, whether due to fraud or error.

Auditor's 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 auditor's 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 Alliance'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 Alliance'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 Mountain States Health Alliance and its subsidiaries as of June 30, 2015 and 2014, and the results of their operations, changes in net assets, and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplemental information is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Pershing Yoakley & Associates PC

Knoxville, Tennessee
October 28, 2015

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets
(Dollars in Thousands)

	June 30, 2015	June 30, 2014
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	**$ 79,714**	$ 59,185
Current portion of investments	**19,598**	25,029
Patient accounts receivable, less estimated allowances for uncollectible accounts of $73,805 in 2015 and $47,853 in 2014	**162,256**	161,318
Other receivables, net	**33,286**	45,502
Inventories and prepaid expenses	**33,969**	30,838
TOTAL CURRENT ASSETS	**328,823**	321,872
INVESTMENTS, less amounts required to meet current obligations	**694,542**	648,475
PROPERTY, PLANT AND EQUIPMENT, net	**847,089**	881,429
OTHER ASSETS		
Goodwill	**156,596**	156,613
Net deferred financing, acquisition costs and other charges	**24,755**	25,841
Other assets	**53,040**	48,350
TOTAL OTHER ASSETS	**234,391**	230,804
	$ 2,104,845	$ 2,082,580

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets - Continued
(Dollars in Thousands)

	June 30, 2015	June 30, 2014
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	**$ 18,159**	$ 18,648
Current portion of long-term debt and capital lease obligations	**40,286**	30,618
Accounts payable and accrued expenses	**100,301**	87,126
Accrued salaries, compensated absences and amounts withheld	**72,066**	72,181
Estimated amounts due to third-party payers, net	**4,781**	10,463
TOTAL CURRENT LIABILITIES	**235,593**	219,036
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	**1,031,661**	1,075,069
Estimated fair value of derivatives	**2,541**	10,603
Estimated professional liability self-insurance	**8,461**	8,957
Other long-term liabilities	**38,683**	35,974
TOTAL LIABILITIES	**1,316,939**	1,349,639
COMMITMENTS AND CONTINGENCIES - Notes D, F, G, and M		
NET ASSETS		
Unrestricted net assets		
Mountain States Health Alliance	**583,287**	541,979
Noncontrolling interests in subsidiaries	**191,118**	178,547
TOTAL UNRESTRICTED NET ASSETS	**774,405**	720,526
Temporarily restricted net assets		
Mountain States Health Alliance	**13,303**	12,204
Noncontrolling interests in subsidiaries	**71**	84
TOTAL TEMPORARILY RESTRICTED NET ASSETS	**13,374**	12,288
Permanently restricted net assets	**127**	127
TOTAL NET ASSETS	**787,906**	732,941
	$ 2,104,845	$ 2,082,580

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations
(Dollars in Thousands)

	Year Ended June 30,	
	2015	***2014***
Revenue, gains and support:		
Patient service revenue, net of contractual allowances and discounts	**$ 1,116,954**	$ 1,046,767
Provision for bad debts	**(127,519)**	(122,642)
Net patient service revenue	**989,435**	924,125
Premium revenue	**32,184**	10,683
Net investment gain	**17,016**	50,703
Net derivative gain	**13,890**	3,219
Other revenue, gains and support	**36,571**	62,457
TOTAL REVENUE, GAINS AND SUPPORT	**1,089,096**	1,051,187
Expenses and losses:		
Salaries and wages	**345,155**	340,589
Physician salaries and wages	**80,279**	77,636
Contract labor	**5,416**	4,282
Employee benefits	**77,306**	69,173
Fees	**120,691**	115,606
Supplies	**176,050**	163,699
Utilities	**16,775**	17,052
Medical costs	**18,383**	6,633
Other	**81,477**	79,980
Loss on early extinguishment of debt	**-**	4,622
Depreciation	**67,210**	69,437
Amortization	**1,557**	1,742
Interest and taxes	**43,697**	44,392
TOTAL EXPENSES AND LOSSES	**1,033,996**	994,843
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	**$ 55,100**	$ 56,344

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Changes in Net Assets
(Dollars in Thousands)

Year Ended June 30, 2015

	Mountain States Health Alliance	*Noncontrolling Interests*	*Total*
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	$ 41,008	$ 14,092	$ 55,100
Pension and other defined benefit plan adjustments	(178)	(152)	(330)
Net assets released from restrictions used for the purchase of property, plant and equipment	478	-	478
Repurchases of noncontrolling interests, net	-	(1,014)	(1,014)
Distributions to noncontrolling interests	-	(355)	(355)
INCREASE IN UNRESTRICTED NET ASSETS	41,308	12,571	53,879
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	3,663	69	3,732
Net assets released from restrictions	(2,564)	(82)	(2,646)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	1,099	(13)	1,086
INCREASE IN TOTAL NET ASSETS	42,407	12,558	54,965
NET ASSETS, BEGINNING OF YEAR	554,310	178,631	732,941
NET ASSETS, END OF YEAR	$ 596,717	$ 191,189	$ 787,906

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Changes in Net Assets - Continued
(Dollars in Thousands)

Year Ended June 30, 2014

	Mountain States Health Alliance	*Noncontrolling Interests*	*Total*
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	$ 48,058	$ 8,286	$ 56,344
Pension and other defined benefit plan adjustments	194	194	388
Net assets released from restrictions used for the purchase of property, plant and equipment	3,313	-	3,313
Noncontrolling interest in acquired subsidiary	-	914	914
Distributions to noncontrolling interests	-	(461)	(461)
INCREASE IN UNRESTRICTED NET ASSETS	51,565	8,933	60,498
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	4,693	88	4,781
Net assets released from restrictions	(5,265)	(56)	(5,321)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	(572)	32	(540)
INCREASE IN TOTAL NET ASSETS	50,993	8,965	59,958
NET ASSETS, BEGINNING OF YEAR	503,317	169,666	672,983
NET ASSETS, END OF YEAR	$ 554,310	$ 178,631	$ 732,941

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	Year Ended June 30,	
	2015	*2014*
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase in net assets	**$ 54,965**	$ 59,958
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	**69,242**	71,789
Provision for bad debts	**127,519**	122,642
Loss on early extinguishment of debt	**-**	4,622
Change in estimated fair value of derivatives	**(7,718)**	2,761
Equity in net income of joint ventures, net	**(79)**	(369)
Loss (gain) on disposal of assets	**(2,192)**	(3,489)
Amounts received on interest rate swap settlements	**(6,172)**	(5,980)
Capital Appreciation Bond accretion and other	**2,780**	2,629
Restricted contributions	**(3,732)**	(4,781)
Pension and other defined benefit plan adjustments	**330**	(388)
Increase (decrease) in cash due to change in:		
Patient accounts receivable	**(128,457)**	(115,380)
Other receivables, net	**12,303**	(11,880)
Inventories and prepaid expenses	**(3,131)**	959
Trading securities	**(39,873)**	(46,451)
Other assets	**(3,128)**	(2,492)
Accrued interest payable	**(489)**	(1,058)
Accounts payable and accrued expenses	**16,745**	(6,666)
Accrued salaries, compensated absences and amounts withheld	**(115)**	8,006
Estimated amounts due to third-party payers, net	**(5,682)**	(16,312)
Estimated professional liability self-insurance	**(496)**	199
Other long-term liabilities	**2,379**	16,425
Total adjustments	**30,034**	14,786
NET CASH PROVIDED BY OPERATING ACTIVITIES	**84,999**	74,744
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property, plant and equipment and property held for expansion	**(44,569)**	(64,424)
Acquisitions, net of cash acquired	**-**	(4,256)
Purchases of held-to-maturity securities	**(1,417)**	(5,978)
Net distribution from joint ventures and unconsolidated affiliates	**4,859**	661
Proceeds from sale of property, plant and equipment and property held for resale	**2,654**	2,858
NET CASH USED IN INVESTING ACTIVITIES	**(38,473)**	(71,139)

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows - Continued
(Dollars in Thousands)

	Year Ended June 30, 2015	2014
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt and capital lease obligations, including deposits to escrow	**(36,210)**	(38,768)
Payment of acquisition and financing costs	**-**	(3,826)
Proceeds from issuance of long-term debt and other financing arrangements	**-**	11,916
Net amounts received on interest rate swap settlements	**6,172**	5,980
Restricted contributions received	**4,041**	5,376
NET CASH USED IN FINANCING ACTIVITIES	**(25,997)**	(19,322)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	**20,529**	(15,717)
CASH AND CASH EQUIVALENTS, beginning of year	**59,185**	74,902
CASH AND CASH EQUIVALENTS, end of year	**$ 79,714**	$ 59,185
SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:		
Cash paid for interest	**$ 38,982**	$ 40,546
Cash paid for federal and state income taxes	**$ 917**	$ 854
Construction related payables in accounts payable and accrued expenses	**$ 5,034**	$ 8,604
Assets contributed into joint venture	**$ 8,668**	$ -
Supplemental cash flow information regarding acquisitions:		
Assets acquired, net of cash	**$ -**	$ 12,715
Liabilities assumed	**-**	(8,459)
Acquisitions, net of cash acquired	**$ -**	$ 4,256

During the year ended June 30, 2014, the Alliance refinanced previously issued debt of $318,385.

NOTE A--ORGANIZATION AND OPERATIONS

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, Unicoi, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The primary operations of the Alliance consist of eleven acute and specialty care hospitals.

The Alliance's accompanying consolidated financial statements include all assets, liabilities, revenues, expenses, and changes in net assets attributable to the noncontrolling interests in the following subsidiaries:

- Smyth County Community Hospital and Subsidiary - the Alliance holds an 80% interest
- Norton Community Hospital and Subsidiaries - the Alliance holds a 50.1% interest
- Johnston Memorial Hospital, Inc. and Subsidiaries - the Alliance holds a 50.1% interest

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices, real estate and ambulatory surgery centers and provides other healthcare services to individuals in Tennessee and Virginia.

The Alliance is a 99.9% shareholder of Integrated Solutions Health Network, LLC, a for-profit entity that owns a for-profit insurance company and an accountable care organization and administers a provider-sponsored health care delivery network,

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc., a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation: The accompanying consolidated financial statements include the accounts of the Alliance and its consolidated subsidiaries after elimination of all significant intercompany accounts and transactions.

Use of Estimates: The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America 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. Actual results could differ from these estimates.

Cash and Cash Equivalents: Cash and cash equivalents include all highly liquid investments with a maturity of three months or less when purchased. Cash and cash equivalents designated as assets limited as to use or uninvested amounts included in investment portfolios are not included as cash and cash equivalents.

Investments: Investments include trading securities and held-to-maturity securities. Within the trading securities portfolio, all debt securities and marketable equity securities with readily determinable fair values are reported at fair value based on quoted market prices. Investments without readily determinable fair values are reported at estimated fair market value utilizing observable and unobservable inputs. Investments which the Alliance has the positive intent and ability to hold to maturity are classified as held-to-maturity and are stated at amortized cost. Realized gains and losses are computed using the specific identification method for cost determination. Interest and dividend income is reported net of related investment fees.

Management evaluates whether unrealized losses on held-to-maturity investments indicate other-than-temporary impairment. Such evaluation considers the amount of decline in fair value, as well as the time period of any such decline. Management does not believe any investment classified as held-to-maturity is other-than-temporarily impaired at June 30, 2015.

Investments in joint ventures are reported under the equity method of accounting, which approximates the Alliance's equity in the underlying net book value. Other assets include investments in joint ventures of $5,180 and $1,364 at June 30, 2015 and 2014, respectively. During 2015, the Alliance contributed assets into a joint venture which owns and operates a rehabilitation hospital.

Inventories: Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market with cost determined by first-in, first-out method.

Property, Plant and Equipment: Property, plant and equipment is stated on the basis of cost, or if donated, at the fair value at the date of gift. Generally, depreciation is computed by the straight-line method over the estimated useful life of the asset. Equipment held under capital lease obligations is amortized under the straight-line method over the shorter of the lease term or estimated useful life. Amortization of buildings and equipment held under capital leases is shown as a part of depreciation expense and accumulated depreciation in the accompanying consolidated financial statements. Renewals and betterments are capitalized and depreciated over their useful life, whereas costs of maintenance and repairs are expensed as incurred.

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.

The Alliance reviews capital assets for indications of potential impairment when there are changes in circumstances related to a specific asset. If this review indicates that the carrying value of these assets may not be recoverable, the Alliance estimates future cash flows from operations and the eventual disposition of such assets. If the sum of these undiscounted future cash flows is less than the carrying amount of the asset, a write-down to estimated fair value is recorded. The Alliance did not recognize any impairment losses during 2015 and 2014.

Other assets include property held for resale and expansion of $19,316 and $20,793, respectively, at June 30, 2015 and 2014. Property held for resale and expansion primarily represents land contributed to, or purchased by, the Alliance plus costs incurred to develop the infrastructure of such land. Management annually evaluates its investment and records non-temporary declines in value when it is determined the ultimate net realizable value is less than the recorded amount. No such declines were identified in 2015 and 2014.

Goodwill: Goodwill is evaluated for impairment at least annually. The Alliance comprises a single reporting unit for evaluation of goodwill. Management performed an evaluation of goodwill for impairment considering qualitative and quantitative factors and does not believe the goodwill to be impaired as of June 30, 2015 and 2014. Management's estimates utilized in the evaluation contain significant estimates and it is reasonably possible that such estimates could change in the near term.

Deferred Financing, Acquisition Costs and Other Charges: Other assets include deferred financing, acquisition costs and other charges of $24,755 and $25,841 at June 30, 2015 and 2014, respectively. Deferred financing costs are amortized over the life of the respective bond issue using the average bonds outstanding method.

Derivative Financial Instruments: The Alliance is a party to various interest rate swaps. These financial instruments are not designated as hedges and have been presented at estimated fair market value in the accompanying Consolidated Balance Sheets as either current or long-term liabilities, based upon the remaining term of the instrument.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims and are recorded at the estimated net present value of such claims. Other long-term liabilities include contributions payable and obligations under deferred compensation arrangements, a defined benefit pension plan, a post-retirement employee benefit plan as well as other liabilities which management estimates are not payable within one year.

Net Patient Service Revenue/Receivables: Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts, including estimated retroactive adjustments under reimbursement agreements with third-party payers.

Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The Alliance's revenue recognition policies related to self-pay and other types of payers emphasize revenue recognition only when collections are reasonably assured.

Patient accounts receivable are reported net of both an estimated allowance for uncollectible accounts and an estimated allowance for contractual adjustments. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, Medicaid, TennCare and other third-party payment programs. Current operations include a provision for bad debts in the Consolidated Statements of Operations estimated based upon the age of the patient accounts receivable, historical writeoffs and recoveries and any unusual circumstances (such as local, regional or national economic conditions) which affect the collectibility of receivables, including management's assumptions about conditions it expects to exist and courses of action it expects to take. The primary uncertainty lies with uninsured patient receivables and deductibles, co-payments or other amounts due from individual patients. Additions to the allowance for uncollectible accounts result from the provision for bad debts. Patient accounts written off as uncollectible are deducted from the allowance for uncollectible accounts.

For uninsured patients that do not qualify for charity care, the Alliance recognizes revenue on the basis of discounted rates under the Alliance's self-pay patient policy. Under the policy, a patient who has no insurance and is ineligible for any government assistance program has their bill reduced to the amount which generally would be billed to a commercially insured patient. The Alliance's policy does not require collateral or other security for patient accounts receivable. The Alliance routinely accepts assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans or policies.

Charity Care: The Alliance accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the Alliance and various guidelines outlined by the Federal Government. These policies define charity as those services for which no payment is anticipated and, as such, charges at established rates are not included in net patient service revenue. Charges forgone, based on established rates, totaled $85,988 and $109,550 during 2015 and 2014, respectively. The estimated direct and indirect cost of providing these services totaled $17,953 and $24,011 in 2015 and 2014, respectively. Such costs are determined using a ratio of cost to charges analysis with indirect cost allocated.

In addition to the charity care services, the Alliance provides a number of other services to benefit the poor for which little or no payment is received. Medicare, Medicaid, TennCare and State indigent programs do not cover the full cost of providing care to beneficiaries of those programs. The Alliance also provides services to the community at large for which it receives little or no payment.

Excess of Revenue, Gains and Support Over Expenses and Losses: The Consolidated Statements of Operations and the Consolidated Statements of Changes in Net Assets includes the caption Excess of Revenue, Gains and Support Over Expenses and Losses (the Performance Indicator). Changes in unrestricted net assets which are excluded from the Performance Indicator, consistent with industry practice, include contributions of long-lived assets or amounts restricted to the purchase of long-lived assets, certain pension and related adjustments, and transactions with noncontrolling interests.

Income Taxes: The Alliance is classified as an organization exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code. As such, no provision for income taxes has been made in the accompanying consolidated financial statements for the Alliance and its tax-exempt subsidiaries. The Alliance's taxable subsidiaries are discussed in Note L. The Alliance has no significant uncertain tax positions at June 30, 2015 and 2014. At June 30, 2015, tax returns for 2011 through 2014 are subject to examination by the Internal Revenue Service.

Temporarily and Permanently Restricted Net Assets: Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. When a donor or time restriction expires; that is, when a stipulated time restriction ends or purpose restriction is fulfilled, 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. The Alliance's policy is to net contribution and grant revenues against related expenses and present such amounts as a part of other revenue, gains and support in the Consolidated Statements of Operations. Permanently restricted net assets have been restricted by donors to be maintained by the Alliance in perpetuity.

Premium Revenue: Premium revenue include premiums from individuals and the Centers for Medicare & Medicaid Services (CMS). CMS premium revenue is based on predetermined prepaid rates under Medicare risk contracts. Premiums are recognized in the month in which the members are entitled to health care services. Premiums collected in advance are deferred and recorded as unearned premium revenue. Premium deficiency losses are recognized when it is probable that expected future claim expenses will exceed future premiums on existing contracts. Management evaluated the need for a premium deficiency reserve and recorded an estimated reserve of $2,000 at June 30, 2015 and 2014.

Medicare Shared Savings Program (MSSP): The Alliance participates in CMS's Medicare Shared Savings Program which is designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. Accountable care organizations participating in the program are assigned beneficiaries by CMS and are entitled to share in the savings if they are able to lower growth in Medicare Parts A and B fee-for-service costs while meeting performance standards on quality of care. Utilizing statistical data and the

methodology employed by CMS, management estimated and recognized $2,857 and $5,425 of shared savings in 2015 and 2014, respectively.

Electronic Health Record (EHR) Incentives: The American Recovery and Reinvestment Act of 2009 (ARRA) provides for incentive payments under the Medicare and Medicaid programs for certain hospitals and physician practices that demonstrate meaningful use of certified EHR technology. The incentive payments are calculated based upon estimated discharges, charity care and other input data and are recorded upon the Alliance's attainment of program and attestation criteria. The incentive payments are subject to regulatory audit. During the years ending June 30, 2015 and 2014, the Alliance recognized EHR incentive revenues of $1,883 and $18,269, respectively. EHR incentive revenues are included in other revenue, gains and support in the accompanying Consolidated Statements of Operations. The Alliance incurs both capital expenditures and operating expenses in connection with the implementation of its various EHR initiatives. The amount and timing of these expenditures does not directly correlate with the timing of the Alliance's receipt or recognition of the EHR incentive payments.

Medical Costs: The cost of health care services is recognized in the period in which services are provided. Medical costs include an estimate of the cost of services provided to members by third-party providers, which have been incurred but not reported.

Subsequent Events: The Alliance evaluated all events or transactions that occurred after June 30, 2015, through October 28, 2015, the date the consolidated financial statements were available to be issued. During this period management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2015 consolidated financial statements, other than as disclosed in Note P.

Reclassifications: Certain 2014 amounts have been reclassified to conform with the 2015 presentation in the accompanying consolidated financial statements.

New Accounting Pronouncements: In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers*. Under ASU 2014-09, recognition of revenue occurs when a customer obtains control of promised goods or services in an amount that reflects the consideration which the entity expects to receive in exchange for those goods or services. In addition, the accounting standard requires disclosure of the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The standard is effective for fiscal years beginning after December 15, 2017. Management is currently evaluating the impact of adopting the accounting standard.

(Dollars in Thousands)

NOTE C--INVESTMENTS

Assets limited as to use are summarized by designation or restriction as follows at June 30:

	2015	2014
Designated or restricted:		
Under safekeeping agreements	$ 8,221	$ 8,220
By Board to satisfy regulatory requirements	1,529	6,759
Under bond indenture agreements:		
For debt service and interest payments	53,812	55,123
For capital acquisitions	8,507	16,127
	72,069	86,229
Less: amount required to meet current obligations	(19,598)	(25,029)
	$ 52,471	$ 61,200

Assets limited as to use consist of the following at June 30:

	2015	2014
Cash and cash equivalents	$ 49,665	$ 54,437
U.S. Government and agency securities	19,757	28,518
Corporate and foreign bonds	860	2,354
Municipal obligations	1,787	920
	$ 72,069	$ 86,229

Held-to-maturity securities (other than assets limited as to use) are carried at amortized cost and consist of the following at June 30:

	2015	2014
Cash and cash equivalents	$ 2,781	$ 220
Corporate and foreign bonds	30,967	35,131
Municipal obligations	5,765	3,408
	$ 39,513	$ 38,759

Held-to-maturity securities had gross unrealized gains and losses of $98 and $425, respectively, at June 30, 2015 and $206 and $456, respectively, at June 30 2014. At June 30, 2015, the Alliance held securities within the held-to-maturity portfolio with a fair value and unrealized loss of $12,710

(Dollars in Thousands)

and $359, respectively, which had been at an unrealized loss position for over one year. At June 30, 2014, the Alliance held securities within the held-to-maturity portfolio with a fair value and unrealized loss of $13,513 and $456, respectively, which had been at an unrealized loss position for over one year. At June 30, 2015, the contractual maturities of held-to-maturity securities were $10,020 due in one year or less, $16,580 due from one to five years and $12,913 due after five years.

Trading securities consist of the following at June 30:

	2015	2014
Cash and cash equivalents	$ 20,789	$ 50,623
U.S. Government and agency securities	76,167	69,805
Corporate and foreign bonds	95,726	96,749
Municipal obligations	23,330	21,409
U.S. equity securities	5,419	1,868
Mutual funds	293,983	253,301
Alternative investments	87,144	54,761
	$ 602,558	$ 548,516

The net investment gain is comprised of the following for the years ending June 30:

	2015	2014
Interest and dividend income, net of fees	$ 13,894	$ 12,074
Net realized gains on the sale of securities	9,260	15,311
Change in net unrealized gains on securities	(6,138)	23,318
	$ 17,016	$ 50,703

The Alliance is a member of Premier Inc.'s (Premier) group purchasing organization and holds Class B Units which are convertible into cash or Class A common stock over a seven year vesting period. The Alliance records an investment relative to the estimated fair value of its Class B units, $14,724 and $14,713 at June 30, 2015 and 2014, respectively. In addition, as the vesting period is tangential to the Alliance's continued participation in the group purchasing contract, the Alliance recorded a liability equivalent to the estimated fair value of the Class B units, which is included within other long-term liabilities in the Consolidated Balance Sheets. The liability is being amortized as a vendor incentive over the vesting period. During 2015 and 2014, the Alliance recognized $4,045 and $2,933, respectively, related to the vendor incentive which is included within other revenue, gains and support in the Consolidated Statements of Operations.

(Dollars in Thousands)

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is subject to an enforceable master netting arrangement in the form of an ISDA agreement with Bank of America, Merrill Lynch (BofAML). The ISDA agreement requires that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. As of June 30, 2015 and 2014, the Alliance was not required to post additional collateral. Under the terms of this agreement, offsetting of derivative contracts is permitted in the event of default of either party to the agreement.

The following is a summary of the interest rate swap agreements at June 30, 2015 and 2014:

Notional Amount	*Termination*	*Counterparty*	*Current Payments:* *Receive*	*Pay*	*Estimated Fair Value* *2015*	*2014*
$170,000	4/2026	BofAML	1.14%	0.00%	$ 5,205	$ 3,089
$95,000	4/2026	BofAML	1.14%	0.00%	2,929	1,748
$173,030	4/2034	BofAML	1.16%	0.00%	884	(1,884)
$82,055	7/2033	BofAML	67% USD-LIBOR-BBA	0.312% + USD-SIFMA	(8,253)	(9,365)
$50,000	7/2038	BofAML	67% (USD-LIBOR-BBA + 0.15%)	USD-SIFMA	(3,351)	(4,210)
$19,400	7/2018	BofAML	4.50%	1.05% + USD-SIFMA	48	63
$4,293	7/2015	First Tennessee Bank	0.00%	USD-LIBOR-BBA	(3)	(44)
					$ (2,541)	$ (10,603)

The Alliance recognized net settlement income on the interest rate swap agreements of $6,172 and $5,980 in 2015 and 2014, respectively.

(Dollars in Thousands)

NOTE E--PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment consist of the following at June 30:

	2015	2014
Land	$ 60,337	$ 60,722
Buildings and leasehold improvements	766,089	760,853
Property and improvements held for leasing	83,582	80,824
Equipment and information technology infrastructure	733,315	700,748
Buildings and equipment held under capital lease	249	340
	1,643,572	1,603,487
Less: Allowances for depreciation and amortization	(815,105)	(757,641)
	828,467	845,846
Construction in progress	18,622	35,583
	$ 847,089	$ 881,429

Accumulated depreciation and amortization on property and improvements held for leasing purposes is $29,520 and $27,500 at June 30, 2015 and 2014, respectively. Net interest capitalized was $925 and $1,533 for the years ended June 30, 2015 and 2014, respectively.

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS

Long-term debt and capital lease obligations consist of the following at June 30:

Description	*Rate as of June 30, 2015*	*Outstanding Balance 2015*	*2014*
2013 Hospital Revenue and Refunding Revenue Bonds:			
$61,180 variable rate tax-exempt term bond, due August 2031	1.15%	$ 327,785	$ 328,665
$47,970 variable rate tax-exempt term bond, due August 2032	0.93%		
$13,350 variable rate tax-exempt term bond, due August 2038	1.15%		
$89,370 variable rate tax-exempt term bonds, due August 2042	1.12% - 1.23%		
$16,235 variable rate tax-exempt term bond, due August 2043	0.07%		
$99,680 variable rate taxable term bond due August 2043	0.12%		
2012 Hospital Revenue Bonds: (net of unamortized premium of $1,696 and $1,756 at June 30, 2015 and 2014, respectively)			
$55,000 fixed rate tax-exempt term bond, due August 2042	5.00%	56,696	56,756
2011 Hospital Revenue and Refunding and Improvement Bonds:			
$74,795 variable rate tax-exempt term bonds, due July 2033	0.08%	94,320	104,710
$19,525 variable rate tax-exempt term bond, due July 2033	1.11%		

(Dollars in Thousands)

Description	*Rate as of June 30, 2015*	*Outstanding Balance 2015*	*2014*
2010 Hospital Revenue Refunding Bonds: (net of unamortized premium of $1,441 and $1,523 at June 30, 2015 and 2014, respectively)			
$33,960 fixed rate tax-exempt serial bonds, through 2020	4.00% to 5.00%	173,271	180,993
$4,355 fixed rate tax-exempt term bond, due July 2023	5.00%		
$14,985 fixed rate tax-exempt term bond, due July 2025	5.38%		
$4,250 fixed rate tax-exempt term bond, due July 2028	5.50%		
$19,230 fixed rate tax-exempt term bond, due July 2030	5.63%		
$95,050 fixed rate tax-exempt term bonds, due July 2038	6.00% - 6.50%		
2009 Hospital Revenue Bonds: (net of unamortized discount of $2,176 and $2,267 at June 30, 2015 and 2014, respectively)			
$14,425 fixed rate tax-exempt term bonds, due July 2019	7.25%	117,264	119,813
$21,730 fixed rate tax-exempt term bonds, due July 2029	7.50%		
$83,285 fixed rate tax-exempt term bonds, due July 2038	7.75% - 8.00%		
2007B Taxable Hospital Revenue Bonds:			
$15,920 variable rate taxable term bond due July 2019	0.12%	15,920	19,515
2006 Hospital First Mortgage Revenue Bonds: (net of unamortized premium of $123 and $129 at June 30, 2015 and 2014, respectively)			
$3,965 fixed rate tax-exempt serial bonds, through 2019	5.00%	167,143	167,864
$7,375 fixed rate tax-exempt term bond, due July 2026	5.25%		
$20,505 fixed rate tax-exempt term bond, due July 2031	5.50%		
$135,175 fixed rate tax-exempt term bond, due July 2036	5.50%		
2001 Hospital First Mortgage Revenue Bond:			
$19,400 fixed rate tax-exempt term bond, due July 2026	4.50%	19,400	20,400
2000 Hospital First Mortgage Revenue and Refunding Bonds:			
$42,000 fixed rate tax-exempt term bond, due July 2026	8.50%	81,538	81,006
$39,538 fixed rate tax-exempt Capital Appreciation Bond, interest and principal due July 2026 through 2030	6.63%		
Capitalized lease obligations secured by equipment			
Various monthly principal and interest payments through December 2016	Various	350	806
Notes payable secured by real estate			
Paid-off in 2015	Various	-	5,542
Promissory notes secured by assets of certain subsidiaries			
Various monthly principal and interest payments through 2019	Various	1,705	1,944
Term note			
Monthly principal payments of $60 plus variable rate interest beginning November 2012 through September 2015; remaining principal due October 2015	1.17%	16,160	16,883
Notes payable secured by equipment			
Various monthly principal and interest payments through 2016	Various	395	790
		1,071,947	1,105,687
Less current portion		(40,286)	(30,618)
		$ 1,031,661	$ 1,075,069

Capital Appreciation Bonds: The Series 2000 Bonds include $14,680 of insured Capital Appreciation Bonds. Such bonds bear a 0% coupon rate and have a yield of 6.625% annually. The Alliance recognizes interest expense and increases the amount of outstanding debt each year based upon this yield. Total principal and interest due at maturity (2026 through 2030) is $93,675.

Other: Outstanding tax-exempt bond obligations that were insured under municipal bond insurance policies were $81,538 and $81,006 at June 30, 2015 and 2014, respectively. Under terms of these policies, the insurer guarantees the Alliance's payment of principal and interest. At June 30, 2015 and 2014, the Alliance held $206,630 and $212,360, respectively, in variable rate demand bonds with letter of credit support and $231,395 and $240,530, respectively, in variable rate bonds held under direct purchase agreements.

Early Redemption: Essentially all of the Alliance's bonds are subject to redemption prior to maturity, including optional, mandatory sinking fund and extraordinary redemption, at various dates and prices as described in the respective Bond indentures and other documents.

Derecognized Bonds: In previous years, the Alliance advance refunded debt by placing required funds in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments of the outstanding debt. Management, upon advice of legal counsel, believes the amounts deposited in such irrevocable trust accounts have contractually relieved the Alliance of any future obligations with respect to this debt. Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2015 due to previous advance refundings totaled $185,470.

The assets placed in the irrevocable trust accounts are also not recognized as assets of the Alliance. These assets consist primarily of various investments, as permitted by bond indentures and other documents, including United States Treasury obligations, an investment contract with MBIA Insurance Corporation (MBIA) in the original amount of $54,300, as well as the Series 2000C and 2000D Bonds which were purchased with the proceeds of the 2000A and 2000B Bonds specifically for the purpose of utilizing the Series 2000C and 2000D Bonds in the irrevocable trust. Therefore, certain of the assets held in the irrevocable trust accounts have future income streams contingent upon payments by the Alliance.

Financing Arrangements: The Alliance granted a deed of trust on Johnson City Medical Center and Sycamore Shoals Hospital to secure the payment of the outstanding bond indebtedness. The bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued. The Johnston Memorial Hospital, Inc. and Subsidiaries (JMH) Series 2011 Hospital Refunding and Improvement Revenue Bonds are secured by pledged revenues of JMH, as defined in the Credit Agreement.

(Dollars in Thousands)

Certain members of the Alliance and JMH are each members of separate Obligated Groups. The bond indentures, master trust indentures, letter of credit agreements and loan agreements related to the various bond issues and notes payable contain covenants with which the respective Obligated Groups must comply. These requirements include maintenance of certain financial and liquidity ratios, deposits to trustee funds, permitted indebtedness, use of facilities and disposals of property. These covenants also require that failure to meet certain debt service coverage tests will require the deposit of all daily cash receipts of the Alliance into a trust fund. Management has represented the Alliance and JMH are in compliance with all such covenants at June 30, 2015.

The scheduled maturities and mandatory sinking fund payments of the long-term debt and capital lease obligations (excluding interest), exclusive of net unamortized original issue discount and premium, at June 30, 2015 are as follows:

Year Ending June 30,		
2016	$	40,286
2017		24,112
2018		24,793
2019		25,926
2020		27,048
Thereafter		928,699
		1,070,864
Net premium		1,083
	$	1,071,947

NOTE G--SELF-INSURANCE PROGRAMS

The Alliance is substantially self-insured for professional and general liability claims and related expenses. The Alliance maintains a $25,000 umbrella liability policy that attaches over the self-insurance limits of $10,000 per claim and a $15,000 annual aggregate retention. The Alliance's insurance program also provides professional liability coverage for certain affiliates and joint ventures.

The Alliance is also substantially self-insured for workers' compensation claims in the State of Tennessee and has established estimated liabilities for both reported and unreported claims. The Alliance maintains a stop-loss policy that attaches over the self-insurance limits of $1,000 per occurrence. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

(Dollars in Thousands)

At June 30, 2015, the Alliance is involved in litigation relating to medical malpractice and workers' compensation and other claims arising in the ordinary course of business. There are also known incidents occurring through June 30, 2015 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Management has estimated and accrued for the cost of these unreported claims based on historical data and actuarial projections. The estimated net present value of malpractice and workers' compensation claims, both reported and unreported, as of June 30, 2015 and 2014 was $12,616 and $13,220, respectively. The discount rate utilized was 5% at June 30, 2015 and 2014.

Additionally, the Alliance is self-insured for employee health claims and recognizes expense each year based upon actual claims paid and an estimate of claims incurred but not yet paid. Such amount is included in accounts payable and accrued expenses in the Consolidated Balance Sheets.

NOTE H--NET PATIENT SERVICE REVENUE

Patient service revenue, net of contractual allowances and discounts, is composed of the following for the years ended June 30:

	2015	*2014*
Third-party payers	$ 965,865	$ 933,491
Patients	151,089	113,276
Patient service revenue	$ 1,116,954	$ 1,046,767

Patient deductibles and copayments under third-party payment programs are included within the patient amounts above.

The Alliance also provides services to uninsured and underinsured patients that do not qualify for financial assistance. Based on historical experience, a significant portion of uninsured and underinsured patients are unable or unwilling to pay the portion of their bill for which they are financially responsible, and a significant provision for bad debts is recorded in the period the services are provided.

The Alliance's allowance for doubtful accounts totaled $73,805 and $47,853 at June 30, 2015 and 2014, respectively. The allowance for doubtful accounts increased from 23% of patient accounts receivable, net of contractual allowances in 2014 to 31% of patient accounts receivable, net of contractual allowances in 2015. The increase is mainly related to the growing popularity of high-deductible insurance plans resulting in higher deductibles and out-of-pocket costs for patients. Management's estimate of the allowance for doubtful accounts is an estimate subject to change in the

near term. The provision for bad debts associated with the Alliance's ancillary service lines are not significant.

NOTE I--THIRD-PARTY REIMBURSEMENT

The Alliance renders services to patients under contractual arrangements with Medicare, Medicaid, TennCare and various other commercial payers. The Medicare program pays for inpatient services on a prospective basis. Payments are based upon diagnosis related group assignments, which are determined by the patient's clinical diagnosis and medical procedures utilized. The Alliance also receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid and other low income patients. Most Medicare outpatient services are reimbursed on a prospectively determined payment methodology. The Medicare program also reimburses certain other services on the basis of reasonable cost, subject to various prescribed limitations and reductions.

Reimbursement under the State of Tennessee's Medicaid waiver program (TennCare) for inpatient and outpatient services is administered by various managed care organizations (MCOs) and is based on diagnosis related group assignments, a negotiated per diem or fee schedule basis. The Alliance also receives additional supplemental payments from the State of Tennessee and Medicaid. These payments recognized totaled $10,386 and $10,860 for the years ended June 30, 2015 and 2014, respectively.

The Virginia Medicaid program reimbursement for inpatient hospital services is based on a prospective payment system using both a per case and per diem methodology. Additional payments are made for the allowable costs of capital. Payments for outpatient services are transitioning from cost-based reimbursement principles to a prospective payment system. Full implementation of this transition is expected to take place over multiple years.

Amounts earned under the contractual agreements with the Medicare and Medicaid programs are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The impact of final settlements of cost reports or changes in estimates increased net patient service revenue by $3,076 and $6,201 in 2015 and 2014, respectively.

Activity with respect to audits and reviews of the governmental programs in the healthcare industry has increased and is expected to increase in the future. No additional specific reserves or allowances have been established with regard to these increased audits and reviews as management is not able to estimate such amounts, if any. Management believes that any adjustments from these increased audits and reviews will not have a material adverse impact on the consolidated financial statements.

However, due to uncertainties in the estimation, it is at least reasonably possible that management's estimate will change in 2016, although the amount of any change cannot be estimated.

Participation in the Medicare program subjects the Alliance to significant rules and regulations; failure to adhere to such could result in fines, penalties or expulsion from the program. Management believes that adequate provision has been made for any adjustments, fines or penalties which may result from final settlements or violations of other rules or regulations. Management has represented that the Alliance is in substantial compliance with these rules and regulations as of June 30, 2015.

The Alliance has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, preferred provider organizations and employer groups. The basis for payment under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

NOTE J--EMPLOYEE BENEFIT PLANS

The Alliance sponsors a defined contribution retirement plan (the Plan) which covers substantially all employees. The Alliance makes contributions to the Plan under a stratified system, whereby the Alliance's contribution percentage is based on each employee's years of service. Employees of certain other subsidiaries are covered by other plans, although such plans are not significant. The total expense related to defined contribution plans for the years ended June 30, 2015 and 2014 was $15,601 and $13,850, respectively.

NCH maintains a frozen defined benefit pension plan and a frozen post-retirement employee benefit plan. The accrued unfunded pension liability was $1,806 and $2,086, and the accrued unfunded post-retirement liability was $6,307 and $5,857 at June 30, 2015 and 2014, respectively.

The Alliance sponsors a secured executive benefit program (SEBP) for certain key executives. Contributions to the plan by the Alliance are based on an annual amount of funding necessary to produce a target benefit for the participants at their retirement dates, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed $1,727 and $511 to the plan during 2015 and 2014, respectively. Other assets at June 30, 2015 and 2014 include $13,030 and $11,302, respectively, related to the Alliance's portion of the benefits which are recoverable upon the death of the participant. In addition, the Alliance sponsors a Section 457(f) plan for certain key executives. Contributions to the Section 457(f) plan during 2015 and 2014 were not significant.

NOTE K--CONCENTRATION OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia, a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local

(Dollars in Thousands)

residents and are insured under third-party payer agreements. Net patient service revenue from Washington County, Tennessee acute-care operations was approximately 52% of total net patient service revenue in 2015 and 2014.

The mix of receivables from patients and third-party payers based on charges at established rates is as follows as of June 30. The patient responsibility related to charges for which the third-party has not yet paid is included within the third-party payer categories.

	2015	*2014*
Medicare	41%	39%
Tenncare/Medicaid	15%	18%
Commercial	26%	28%
Other third-party payers	8%	8%
Patients	10%	7%
	100%	100%

Approximately 91% and 88% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2015 and 2014, respectively. Admitting physicians are primarily practitioners in the regional area.

The Hospital maintains bank accounts at various financial institutions covered by the Federal Deposit Insurance Corporation (FDIC). At times throughout the year, the Alliance may maintain bank account balances in excess of the FDIC insured limit. Management believes the credit risk associated with these deposits is not significant.

The Alliance routinely invests in investment vehicles as listed in Note C. The Alliance's investment portfolio is managed by outside investment management companies. Investments in corporate and foreign bonds, municipal obligations, money market funds, equities and other vehicles that are held by safekeeping agents are not insured or guaranteed by the U.S. government.

NOTE L--INCOME TAXES

BRMM and its subsidiaries file a consolidated federal tax return and separate state tax returns. As of June 30, 2015 and 2014, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of $30,700 and $27,085, respectively, related to operating loss carryforwards, which expire through 2033. At June 30, 2015 and 2014, BRMM had state net operating loss carryforwards of $75,619 and $74,191, respectively, which expire through 2029. The net operating loss carryforwards may be offset against future taxable income to the extent permitted by the Internal Revenue Code and Tennessee Code Annotated.

(Dollars in Thousands)

Net deferred tax assets related to these carryforwards and other deferred tax assets have been substantially offset through valuation allowances equal to these amounts. Income taxes paid relate primarily to state taxes for certain subsidiaries and federal alternative minimum tax.

NOTE M--OTHER COMMITMENTS AND CONTINGENCIES

Construction in Progress: Construction in progress at June 30, 2015 represents costs incurred related to various hospital and medical office building facility renovations and additions and information technology infrastructure. The Alliance has outstanding contracts and other commitments related to the completion of these projects, and the cost to complete these projects is estimated to be $30,508 at June 30, 2015. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

Employee Scholarships: The Alliance offers scholarships to certain individuals which require that the recipients return to the Alliance to work for a specified period of time after they complete their degrees. Amounts due are then forgiven over a specific period of time as provided in the individual contracts. If the recipient does not return and work the required period of time, the funds disbursed on their behalf become due immediately, and interest is charged until the funds are repaid. Other receivables at June 30, 2015 and 2014 include $7,095 and $8,685, respectively, related to students in school, graduates working at the Alliance and amounts due from others who are no longer in the scholarship program, net of an estimated allowance.

Operating Leases and Maintenance Contracts: Total lease expense for the years ended June 30, 2015 and 2014 was $7,414 and $7,901, respectively. Future minimum lease payments for each of the next five years and in the aggregate for the Alliance's noncancellable operating leases with remaining lease terms in excess of one year are as follows:

Year Ending June 30,		
2016	$	7,346
2017		4,614
2018		3,605
2019		3,279
2020		2,481
Thereafter		11,240
	$	32,565

NOTE N--FAIR VALUE MEASUREMENT

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2015 and 2014, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Alliance could realize in a current market exchange. The carrying value of substantially all financial instruments approximates fair value due to the nature or term of the instruments, except as described below.

Held-to-Maturity Securities: The estimated fair value of the Alliance's held-to-maturity securities at June 30, 2015 and 2014, is $39,186 and $38,508, respectively, and would be classified in level 2 of the fair value hierarchy (described below). The fair value is based on prices provided by the Alliance's investment managers and its custodian bank, which use a variety of pricing sources to determine market valuations.

Investment in Joint Ventures: It is not practical to estimate the fair market value of the investments in joint ventures.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Estimates of reported and unreported professional liability claims, pension and post-retirement liabilities are discounted to approximate their estimated fair value. It is not practical to estimate the fair market value of other long-term liabilities.

Long-Term Debt: The estimated fair value of the Alliance's long-term debt at June 30, 2015 and 2014, is $1,130,580 and $1,172,357, respectively, and would be classified in Level 2 in the fair value hierarchy. The fair value of long-term debt is estimated based upon quotes obtained from brokers for bonds and discounted future cash flows using current market rates for other debt. For long-term debt with variable interest rates, the carrying value approximates fair value.

FASB Accounting Standards Codification 820 establishes a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 - Inputs based on quoted market prices for identical assets or liabilities in active markets at the measurement date.

- Level 2 - Observable inputs other than quoted prices included in Level 1, such as quoted prices for similar assets and liabilities in active markets; quoted prices for identical or similar assets and liabilities in markets that are not active; or other inputs that are observable or can

(Dollars in Thousands)

- be corroborated by observable market data. The Alliance's Level 2 investments are valued primarily using the market valuation approach.

- Level 3 - Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Alliance's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Alliance's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the asset or liability.

The following table sets forth, by level within the fair value hierarchy, the financial instruments measured at fair value as of June 30, 2015 and 2014:

	Total	*Level 1*	*Level 2*	*Level 3*
June 30, 2015				
Cash and cash equivalents	$ 70,439	$ 70,439	$ -	$ -
U.S. Government and agency securities	88,083	88,083	-	-
Corporate and foreign bonds	96,586	-	96,586	-
Municipal obligations	23,329	-	23,329	-
U.S. equity securities	5,419	5,419	-	-
Mutual funds	293,983	212,323	81,660	-
Alternative investments	87,144	-	72,420	14,724
Total assets	$ 664,983	$ 376,264	$ 273,995	$ 14,724
Derivative agreements	$ (2,541)	$ -	$ -	$ (2,541)
June 30, 2014				
Cash and cash equivalents	$ 98,956	$ 98,956	$ -	$ -
U.S. Government and agency securities	90,474	90,474	-	-
Corporate and foreign bonds	99,103	-	99,103	-
Municipal obligations	21,409	-	21,409	-
U.S. equity securities	1,868	1,868	-	-
Mutual funds	253,301	177,067	76,234	-
Alternative investments	69,474	-	54,761	14,713
Total assets	$ 634,585	$ 368,365	$ 251,507	$ 14,713
Derivative agreements	$ (10,603)	$ -	$ -	$ (10,603)

Fair values for the Alliance's fixed maturity securities are based on prices provided by the Alliance's investment managers and its custodian bank, which use a variety of pricing sources to determine market valuations. Fair values of equity securities have been determined by the Alliance from market quotations.

Alternative Investments: The Alliance generally uses net asset value per unit as provided by external investment managers without further adjustment as the practical expedient estimate of the fair value of its alternative investment in a real estate fund. Accordingly, such values may differ from values that would have been used had an active market for the investments existed. The real estate fund invests primarily in U.S. commercial real estate. The Alliance may request redemption of all or a portion of its interests as of the end of a calendar quarter by delivering written notice to the fund managers at least 60 days prior to the end of the quarter. Such redemptions are subject to the capital requirements of the fund manager.

The Alliance's investment in Premier Class B units does not have a readily determinable fair value and have been reported at estimated fair market value. The significant unobservable inputs primarily relate to management's estimate of the discount for lack of marketability of 12%. Accordingly, such value may differ from values that would have been used had an active market for the investment existed and as such it has been classified in Level 3 of the fair value hierarchy.

Derivative Agreements: The valuation of the Alliance's derivative agreements is determined using market valuation techniques, including discounted cash flow analysis on the expected cash flows of each agreement. This analysis reflects the contractual terms of the agreement, including the period to maturity, and uses certain observable market-based inputs. The fair values of interest rate agreements are determined by netting the discounted future fixed cash payments (or receipts) and the discounted expected variable cash receipts (or payments). The variable cash receipts (or payments) are based on the expectation of future interest rates and the underlying notional amount. The Alliance also incorporates credit valuation adjustments (CVAs) to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. The CVA on the Alliance's interest rate swap agreements at June 30, 2015 and 2014 resulted in a decrease in the fair value of the related liability of $713 and $4,584, respectively.

A certain portion of the inputs used to value its interest rate swap agreements, including the forward interest rate curves and market perceptions of the Alliance's credit risk used in the CVAs, are unobservable inputs available to a market participant. As a result, the Alliance has determined that the interest rate swap valuations are classified in Level 3 of the fair value hierarchy. Due to the nature of these financial instruments, such estimates of fair value are subject to significant change in the near term.

(Dollars in Thousands)

The following tables provide a summary of changes in the fair value of the Alliance's Level 3 financial assets and liabilities during the fiscal years ended June 30, 2015 and 2014:

	Alternative Investment	*Derivatives, Net*
July 1, 2013	$ -	$ (8,185)
Total unrealized/realized losses	-	(2,761)
Net investment income	-	343
Additions	14,713	-
June 30, 2014	14,713	(10,603)
Total unrealized/realized gains	6,978	7,718
Net investment income	-	344
Settlements	(6,967)	-
June 30, 2015	$ 14,724	$ (2,541)

NOTE O--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION

The Alliance does not present expense information by functional classification because its resources and activities are primarily related to providing healthcare services. Further, since the Alliance receives substantially all of its resources from providing healthcare services in a manner similar to business enterprises, other indicators contained in these consolidated financial statements are considered important in evaluating how well management has discharged their stewardship responsibilities.

NOTE P--SUBSEQUENT EVENTS

The Alliance and Wellmont Health System (Wellmont) have agreed to exclusively explore the creation of a new, integrated and locally governed health system. Wellmont operates six hospitals and numerous outpatient care sites, serving communities in Northeast Tennessee and Southwest Virginia. Wellmont and the Alliance have filed a letter of intent (LOI) with the Tennessee Department of Health, indicating the organizations will submit an application for a Certificate of Public Advantage (COPA). The two organizations have submitted a similar letter of intent with the Southwest Virginia Health Authority, signaling their intent to request approval by the commonwealth of the anticipated cooperative agreement between the two systems. A COPA in Tennessee and the cooperative agreement approval process in Virginia will allow Wellmont and the Alliance to merge, with the states actively supervising the proposed new health system to ensure it complies with the provisions of the COPA intended to contain costs and sustain high quality, affordable care. The two organizations are in the process of finalizing a definitive agreement. The date for expected completion of the merger has not been set but will not occur before state approval has been granted.

Supplemental Information

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets
(Smyth County Community Hospital and Subsidiary and Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)

June 30, 2015

	Smyth County Community Hospital and Subsidiary	*Norton Community Hospital and Subsidiaries*
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 2,940	$ 6,798
Patient accounts receivable, less estimated allowances for uncollectible accounts	6,295	11,137
Other receivables, net	156	310
Inventories and prepaid expenses	1,079	2,061
Estimated amounts due from third-party payers, net	793	292
TOTAL CURRENT ASSETS	11,263	20,598
INVESTMENTS, less amounts required to meet current obligations	24,807	30,451
PROPERTY, PLANT AND EQUIPMENT, net	67,550	50,275
OTHER ASSETS		
Net deferred financing, acquisition costs and other charges	139	210
Other assets	741	-
TOTAL OTHER ASSETS	880	210
	$ 104,500	$ 101,534

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets - Continued
(Smyth County Community Hospital and Subsidiary and Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)

June 30, 2015

	Smyth County Community Hospital and Subsidiary	*Norton Community Hospital and Subsidiaries*
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	$ 12	$ 15
Current portion of long-term debt and capital lease obligations	134	110
Accounts payable and accrued expenses	2,323	6,245
Accrued salaries, compensated absences and amounts withheld	2,116	4,388
Payables to affiliates, net	342	89
TOTAL CURRENT LIABILITIES	4,927	10,847
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	15,830	20,985
Estimated professional liability self-insurance	442	632
Other long-term liabilities	1,178	8,200
TOTAL LIABILITIES	22,377	40,664
NET ASSETS		
Unrestricted net assets	82,114	60,734
Temporarily restricted net assets	9	136
TOTAL NET ASSETS	82,123	60,870
	$ 104,500	$ 101,534

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations and Changes in Net Assets
(Smyth County Community Hospital and Subsidiary and Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)

Year Ended June 30, 2015

	Smyth County Community Hospital and Subsidiary	*Norton Community Hospital and Subsidiaries*
UNRESTRICTED NET ASSETS:		
Revenue, gains and support:		
Patient service revenue, net of contractual allowances and discounts	$ 48,370	$ 78,667
Provision for bad debts	(5,332)	(8,546)
Net patient service revenue	43,038	70,121
Net investment gain	651	746
Other revenue, gains and support	1,745	2,576
TOTAL REVENUE, GAINS AND SUPPORT	45,434	73,443
Expenses and losses:		
Salaries and wages	17,289	23,681
Physician salaries and wages	257	6,043
Contract labor	170	567
Employee benefits	4,365	8,965
Fees	9,050	8,326
Supplies	5,349	8,793
Utilities	978	1,286
Other	4,348	7,753
Depreciation	4,289	4,489
Amortization	8	30
Interest and taxes	156	257
TOTAL EXPENSES AND LOSSES	46,259	70,190
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	(825)	3,253
Pension and postretirement liability adjustments	-	(305)
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	(825)	2,948

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations and Changes in Net Assets - Continued
(Smyth County Community Hospital and Subsidiary and Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)

Year Ended June 30, 2015

	Smyth County Community Hospital and Subsidiary	*Norton Community Hospital and Subsidiaries*
TEMPORARILY RESTRICTED NET ASSETS:		
Restricted grants and contributions	8	134
Net assets released from restrictions	(8)	(160)
DECREASE IN TEMPORARILY RESTRICTED NET ASSETS	-	(26)
INCREASE (DECREASE) IN TOTAL NET ASSETS	(825)	2,922
NET ASSETS, BEGINNING OF YEAR	82,948	57,948
NET ASSETS, END OF YEAR	$ 82,123	$ 60,870

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet
(Obligated Group and Other Entities)
(Dollars in Thousands)

June 30, 2015

	Obligated Group	*Other Entities*	*Eliminations*	*Total*
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	$ 47,025	$ 32,689	$ -	$ 79,714
Current portion of investments	19,598	-	-	19,598
Patient accounts receivable, less estimated allowance for uncollectible accounts	134,777	27,479	-	162,256
Other receivables, net	17,873	15,413	-	33,286
Inventories and prepaid expenses	25,427	8,542	-	33,969
TOTAL CURRENT ASSETS	244,700	84,123	-	328,823
INVESTMENTS, less amounts required to meet current obligations	458,373	236,169	-	694,542
EQUITY IN AFFILIATES	351,724	-	(351,724)	-
PROPERTY, PLANT AND EQUIPMENT, net	614,870	232,219	-	847,089
OTHER ASSETS				
Goodwill	152,600	3,996	-	156,596
Net deferred financing, acquisition costs and other charges	23,504	1,251	-	24,755
Other assets	44,738	8,302	-	53,040
TOTAL OTHER ASSETS	220,842	13,549	-	234,391
	$ 1,890,509	$ 566,060	$ (351,724)	$ 2,104,845

See note to supplemental information.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet – Continued
(Obligated Group and Other Entities)
(Dollars in Thousands)

June 30, 2015

	Obligated Group	*Other Entities*	*Eliminations*	*Total*
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accrued interest payable	$ 18,125	$ 34	$ -	$ 18,159
Current portion of long-term debt and capital lease obligations	22,040	18,246	-	40,286
Accounts payable and accrued expenses	80,408	19,893	-	100,301
Accrued salaries, compensated absences and amounts withheld	54,519	17,547	-	72,066
Payables to (receivables from) affiliates, net	15,314	(15,314)	-	-
Estimated amounts due to third-party payers, net	3,909	872	-	4,781
TOTAL CURRENT LIABILITIES	194,315	41,278	-	235,593
OTHER LIABILITIES				
Long-term debt and capital lease obligations, less current portion	1,012,167	19,494	-	1,031,661
Estimated fair value of derivatives, net	2,541	-	-	2,541
Estimated professional liability self-insurance	7,362	1,099	-	8,461
Other long-term liabilities	35,176	3,507	-	38,683
TOTAL LIABILITIES	1,251,561	65,378	-	1,316,939
NET ASSETS				
Unrestricted net assets				
Mountain States Health Alliance	583,287	344,360	(344,360)	583,287
Noncontrolling interests in subsidiaries	42,160	143,222	5,736	191,118
TOTAL UNRESTRICTED NET ASSETS	625,447	487,582	(338,624)	774,405
Temporarily restricted net assets				
Mountain States Health Alliance	13,303	12,966	(12,966)	13,303
Noncontrolling interests in subsidiaries	71	7	(7)	71
TOTAL TEMPORARILY RESTRICTED NET ASSETS	13,374	12,973	(12,973)	13,374
Permanently restricted net assets	127	127	(127)	127
TOTAL NET ASSETS	638,948	500,682	(351,724)	787,906
	$ 1,890,509	$ 566,060	$ (351,724)	$ 2,104,845

See note to supplemental information.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Operations
(Obligated Group and Other Entities)
(Dollars in Thousands)

Year Ended June 30, 2015

	Obligated Group	*Other Entities*	*Eliminations*	*Total*
Revenue, gains and support:				
Patient service revenue, net of contractual allowances and discounts	$ 925,979	$ 203,883	$ (12,908)	$ 1,116,954
Provision for bad debts	(104,724)	(22,795)	-	(127,519)
Net patient service revenue	821,255	181,088	(12,908)	989,435
Premium revenue	-	32,184	-	32,184
Net investment gain	12,486	4,530	-	17,016
Net derivative gain	13,195	695	-	13,890
Other revenue, gains and support	27,244	97,465	(88,138)	36,571
Equity in net gain of affiliates	716	10,275	(10,991)	-
TOTAL REVENUE, GAINS AND SUPPORT	874,896	326,237	(112,037)	1,089,096
Expenses:				
Salaries and wages	284,643	67,093	(6,581)	345,155
Physician salaries and wages	64,838	71,222	(55,781)	80,279
Contract labor	3,101	2,913	(598)	5,416
Employee benefits	66,881	17,443	(7,018)	77,306
Fees	97,754	35,093	(12,156)	120,691
Supplies	146,516	29,660	(126)	176,050
Utilities	12,981	3,798	(4)	16,775
Medical Costs	-	30,566	(12,183)	18,383
Other	61,323	26,524	(6,370)	81,477
Depreciation	51,307	15,903	-	67,210
Amortization	1,488	69	-	1,557
Interest and taxes	41,599	2,098	-	43,697
TOTAL EXPENSES	832,431	302,382	(100,817)	1,033,996
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	$ 42,465	$ 23,855	$ (11,220)	$ 55,100

See note to supplemental information.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Changes in Net Assets
(Obligated Group and Other Entities)
(Dollars in Thousands)

Year Ended June 30, 2015

	Obligated Group		*Total*	*Other Entities*		*Total*		
	Mountain States Health Alliance	*Noncontrolling Interests*	*Obligated Group*	*Mountain States Health Alliance*	*Noncontrolling Interests*	*Other Entities*	*Eliminations*	*Total*
UNRESTRICTED NET ASSETS:								
Excess of Revenue, Gains and Support over Expenses and Losses	$ 41,008	$ 1,457	$ 42,465	$ 13,832	$ 10,023	$ 23,855	$ (11,220)	$ 55,100
Pension and other defined benefit plan adjustments	(178)	(152)	(330)	(207)	(206)	(413)	413	(330)
Net assets released from restrictions used for the purchase of property, plant and equipment	478	-	478	478	-	478	(478)	478
Repurchases of noncontrolling interests, net	-	(1,000)	(1,000)	-	(14)	(14)	-	(1,014)
Distributions to noncontrolling interests	-	-	-	(458)	(355)	(813)	458	(355)
Net asset transfers	-	-	-	912	2,372	3,284	(3,284)	-
INCREASE IN UNRESTRICTED NET ASSETS	41,308	305	41,613	14,557	11,820	26,377	(14,111)	53,879
TEMPORARILY RESTRICTED NET ASSETS:								
Restricted grants and contributions	3,663	69	3,732	3,172	7	3,179	(3,179)	3,732
Net assets released from restrictions	(2,564)	(82)	(2,646)	(2,093)	(5)	(2,098)	2,098	(2,646)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	1,099	(13)	1,086	1,079	2	1,081	(1,081)	1,086
INCREASE IN TOTAL NET ASSETS	42,407	292	42,699	15,636	11,822	27,458	(15,192)	54,965
NET ASSETS, BEGINNING OF YEAR	554,310	41,939	596,249	341,817	131,407	473,224	(336,532)	732,941
NET ASSETS, END OF YEAR	$ 596,717	$ 42,231	$ 638,948	$ 357,453	$ 143,229	$ 500,682	$ (351,724)	$ 787,906

See note to supplemental information.

MOUNTAIN STATES HEALTH ALLIANCE

Note to Supplemental Information

Year Ended June 30, 2015

NOTE A--OBLIGATED GROUP MEMBERS

As described in Note F to the consolidated financial statements, the Alliance has granted a deed of trust on JCMC and SSH to secure the payment of the outstanding bonds. The bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued. The members pledged pursuant to the Amended and Restated Master Trust Indenture between Mountain States Health Alliance and the Bank of New York Mellon Trust Company, NA as Master Trustee include Johnson City Medical Center Hospital, Indian Path Medical Center, Franklin Woods Community Hospital, Sycamore Shoals Hospital, Johnson County Community Hospital, Russell County Medical Center, Unicoi County Memorial Hospital, Norton Community Hospital (hospital only), Smyth County Community Hospital (hospital only) and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group (Obligated Group).

The supplemental consolidating information includes the accounts of the members of the Obligated Group after elimination of all significant intergroup accounts and transactions. Certain other subsidiaries of the Alliance are not pledged to secure the payment of the outstanding bonds as they are not part of the Obligated Group. These affiliates have been accounted for within the Obligated Group based upon the Alliance's original and subsequent investments, as adjusted for the Alliance's pro rata share of income or losses and any distributions, and are included as a part of equity in affiliates in the supplemental consolidating balance sheet.

Exhibit 24

Mountain State's current Fitch Ratings Watch

FITCH MAINTAINS RATING WATCH EVOLVING ON MOUNTAIN STATES HEALTH ALLIANCE (TN) REV BONDS

Fitch Ratings-New York-28 March 2016: Fitch Ratings maintains the Rating Watch Evolving on Mountain States Health Alliance's (MSHA) outstanding debt. A full list of outstanding debt follows at the end of this release.

SECURITY

Bonds are secured by pledged assets and a mortgage on Johnson City Medical Center and Sycamore Shoals Hospital. There is a debt service reserve fund on certain series of debt.

KEY RATING DRIVERS

MERGER PROCEEDING: In April 2015, Fitch placed MSHA's 'BBB+' rating on Rating Watch Evolving in response to the announcement that MSHA and Wellmont Health System (WHS; rated BBB+; Rating Watch Evolving) had signed an agreement to explore a merger. The maintenance of the Rating Watch Evolving reflects the continuation of the merger process.

COPA SUBMITTED: The two organizations have jointly submitted Certificate of Public Advantage (COPA) applications to Tennessee and Virginia. The COPA applications are the official request to each of these states for the approval of the merger. A public comment and consideration process is currently underway, which will last for 120 days in Tennessee and 150 days in Virginia. The timelines for the public comment periods officially start with the applications being declared complete by the states, which has yet to happen.

OPERATIONS REMAIN STEADY: MSHA had a 2.3% operating margin in FY2015 (June 30 year end) and 2.4x debt service coverage; results for the six month Dec. 31, 2015 interim period are consistent with the year end results.

RATING SENSITIVITIES

COMPLETION OF PENDING TRANSACTION: Resolution of the Rating Watch will be tied to the completion of the merger process and the treatment of the debt of Mountain States Health Alliance post-transaction.

CREDIT PROFILE

Headquartered in Johnson City, Tennessee, MSHA was formed in 1998 from the acquisition of six hospitals in Tennessee from Columbia/HCA and has grown into a large regional health care system with 13 hospitals (1,699 licensed beds) and other related entities, primarily serving northeast Tennessee and southwest Virginia. MSHA has a membership interest (ranging from 50.1% - 80%) in three of the hospitals in the system (Smyth County Community Hospital, Norton Community Hospital, Johnston Memorial Hospital). In fiscal 2015 (June 30 year end), MSHA had total operating revenue of $1 billion.

Outstanding Debt:

--$55,000,000 Health and Educational Facilities Board of the City of Johnson City, Tennessee hospital revenue bonds (Mountain States Health Alliance), series 2012A;

--$5,250,000 Health and Educational Facilities Board of the City of Johnson City, Tennessee hospital revenue bonds, series 2009A;
--$166,300,000 Health and Educational Facilities Board of the City of Johnson City, Tennessee hospital first mortgage revenue bonds, series 2006A;
--$18,300,000 Health and Educational Facilities Board of the City of Johnson City, Tennessee hospital first mortgage revenue bonds, series 2001A;
--$34,645,000 Health and Educational Facilities Board of the City of Johnson City, Tennessee hospital first mortgage revenue refunding bonds, series 2000A;
--$27,840,000 Health and Educational Facilities Board of the City of Johnson City, Tennessee hospital first mortgage revenue bonds, series 2000C;
--$5,245,000 Industrial Development Authority of Smyth County hospital revenue bonds, series 2009B;
--$106,205,000 Industrial Development Authority of Washington County Virginia, hospital revenue bonds, series 2009C;
--$11,995,000 Mountain States Health Alliance taxable note, series 2000D.

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Additional information is available at 'www.fitchratings.com'.

Applicable Criteria
Revenue-Supported Rating Criteria (pub. 16 Jun 2014)
https://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=750012
U.S. Nonprofit Hospitals and Health Systems Rating Criteria (pub. 09 Jun 2015)
https://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=866807

METHODOLOGIES ARE AVAILABLE FROM THIS SITE AT ALL TIMES. FITCH'S CODE OF CONDUCT, CONFIDENTIALITY, CONFLICTS OF INTEREST, AFFILIATE FIREWALL, COMPLIANCE AND OTHER RELEVANT POLICIES AND PROCEDURES ARE ALSO AVAILABLE FROM THE 'CODE OF CONDUCT' SECTION OF THIS SITE. FITCH MAY HAVE PROVIDED ANOTHER PERMISSIBLE SERVICE TO THE RATED ENTITY OR ITS RELATED THIRD PARTIES. DETAILS OF THIS SERVICE FOR RATINGS FOR WHICH THE LEAD ANALYST IS BASED IN AN EU-REGISTERED ENTITY CAN BE FOUND ON THE ENTITY SUMMARY PAGE FOR THIS ISSUER ON THE FITCH WEBSITE.

Exhibit 25

FTI Consulting Report

To be submitted pursuant to CID.

Exhibit 26

Organizational Chart

Structure of Proposed Transaction

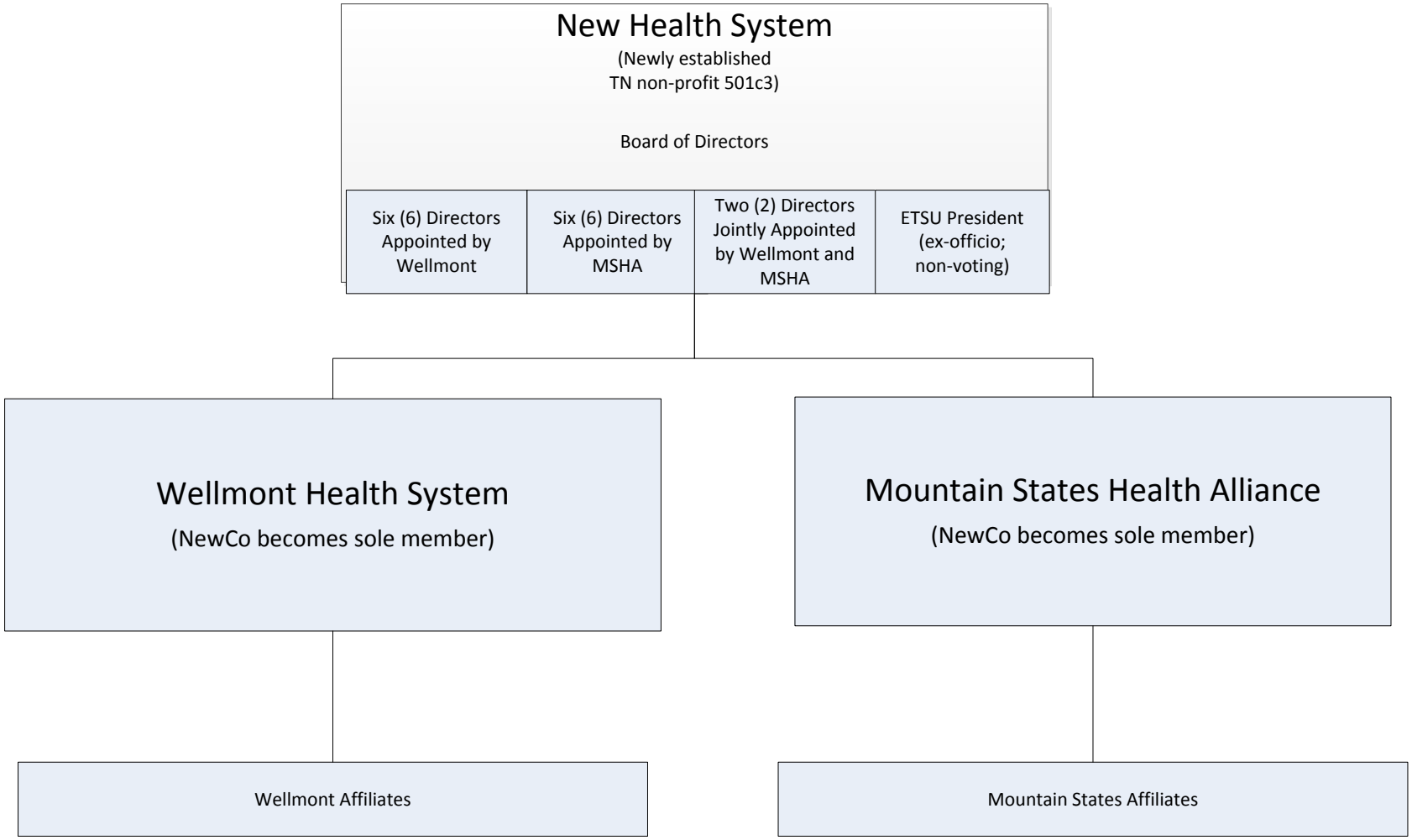

Exhibit 27

Mountain States' Q3 FY2016 Financials and Maximum Annual Debt Service Coverage Ratio

MOUNTAIN STATES HEALTH ALLIANCE

Fiscal Year 2016
Third Quarter ending March 31, 2016

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Comparative Balance Sheet

	March 31 2016	June 30 2015
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	72,030,451	79,713,574
Current Portion AWUIL	4,926,561	19,597,595
Accounts Receivable (Net)	167,367,087	162,255,802
Other Receivables	24,622,400	33,285,941
Due From Affiliates	527	(0)
Due From Third Party Payors	(0)	(0)
Inventories	28,889,682	26,646,561
Prepaid Expense	9,807,550	7,322,824
	307,644,257	328,822,296
ASSETS WHOSE USE IS LIMITED	40,413,113	52,470,955
OTHER INVESTMENTS	635,182,396	642,070,837
PROPERTY, PLANT AND EQUIPMENT		
Land, Buildings and Equipment	1,700,664,673	1,662,193,378
Less Allowances for Depreciation	864,005,602	815,104,790
	836,659,071	847,088,588
OTHER ASSETS		
Pledges Receivable	2,696,746	3,260,254
Long Term Compensation Investment	25,476,423	25,284,264
Investments in Unconsolidated Subsidiaries	7,633,537	5,179,805
Land / Equipment Held for Resale	4,631,959	4,631,959
Assets Held for Expansion	16,050,303	14,684,441
Investments in Subsidiaries	0	0
Goodwill	156,577,573	156,596,125
Deferred Charges and Other	23,799,887	24,754,992
	236,866,427	234,391,841
TOTAL ASSETS	2,056,765,266	2,104,844,518
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable and Accrued Expense	85,981,790	92,133,309
Accrued Salaries, Benefits, and PTO	58,380,188	72,064,537
Claims Payable	9,262,484	8,167,693
Accrued Interest	9,221,428	18,159,055
Due to Affiliates	(0)	22
Due to Third Party Payors	9,392,866	4,781,320
Current Portion of Long Term Debt	24,223,026	40,286,349
	196,461,781	235,592,285
OTHER NON CURRENT LIABILITIES		
Long Term Compensation Payable	12,405,257	12,250,293
Long Term Debt	1,010,013,749	1,031,660,759
Estimated Fair Value of Interest Rate Swaps	2,406,251	2,540,682
Deferred Income	27,222,996	15,259,244
Professional Liability Self-Insurance and Other	20,701,865	19,635,356
	1,072,750,119	1,081,346,335
TOTAL LIABILITIES	1,269,211,900	1,316,938,620
NET ASSETS		
Restricted Net Assets	13,959,809	13,502,164
Unrestricted Net Assets	575,587,131	583,215,057
Noncontrolling Interests in Subsidiaries	198,006,425	191,188,677
	787,553,366	787,905,897
TOTAL LIABILITIES AND NET ASSETS	2,056,765,266	2,104,844,518

Mountain States Health Alliance
Statement of Revenue and Expense
As of March 31, 2016 and March 31, 2015

	FY16 Q3	FY15 Q3	FY16 YTD	FY15 YTD
Revenue, Gains and Support				
Patient service revenue, net of contractual allowances and discounts	287,153,198	292,064,611	873,720,869	840,390,491
Provision for bad debts	(34,267,588)	(41,498,739)	(105,013,659)	(100,375,420)
Net patient service revenue	252,885,610	250,565,872	768,707,210	740,015,071
Other operating revenue	8,279,397	9,054,733	26,266,620	26,926,979
TOTAL REVENUE, GAINS AND SUPPORT	261,165,007	259,620,605	794,973,830	766,942,050
Expenses:				
Salaries and wages	88,789,529	85,302,622	266,531,590	252,527,296
Physician salaries and wages	21,260,390	17,673,074	62,244,324	56,840,825
Contract Labor	1,449,654	1,453,093	4,777,566	4,252,570
Employee Benefits	19,200,042	20,296,987	56,516,782	54,797,671
Fees	30,714,896	28,814,408	94,424,150	85,093,729
Supplies	44,744,925	44,489,808	135,099,445	131,846,120
Utilities	3,836,319	3,984,507	12,205,231	12,634,273
Medical Costs	(25,147)	(165,957)	(460,945)	(377,513)
Other Expense	20,472,197	20,495,116	64,254,429	60,554,391
Depreciation	16,537,420	16,796,866	49,604,782	50,634,568
Amortization	362,002	362,218	1,113,880	1,174,794
Interest & Taxes	10,888,905	10,766,373	32,972,067	32,931,495
TOTAL EXPENSES	258,231,132	250,269,115	779,283,302	742,910,219
OPERATING INCOME	2,933,875	9,351,490	15,690,528	24,031,831
Nonoperating gains (losses):				
Interest and dividend income	1,983,485	1,751,383	9,334,975	8,696,424
Net realized gains (losses) on the sale of securities	111,912	233,899	352,552	387,543
Change in net unrealized gains on securities	2,013,412	8,950,340	(19,166,946)	(7,519,476)
Derivative related income	1,550,522	1,534,217	4,664,195	4,633,485
Loss on extinguishment of LTD / derivatives	0	0	0	0
Change in estimated fair value of derivatives	(1,833,072)	4,708,408	(124,617)	6,749,512
Gain (loss) on discontinued operations	(2,655,942)	(840,457)	(6,815,529)	(5,626,091)
Other nonoperating gains (losses)	(1,273,282)	(1,519,753)	(3,212,265)	(1,683,812)
Noncontrolling interests in subsidiaries	(2,996,534)	(5,565,027)	(6,986,224)	(8,867,717)
NET NONOPERATING GAINS	(3,099,498)	9,253,010	(21,953,859)	(3,230,133)
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	(165,623)	18,604,500	(6,263,330)	20,801,698
EBITDA	27,442,362	32,881,395	96,718,962	106,345,229

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)

UNAUDITED QUARTERLY DISCLOSURE - FY 2016 - Third Quarter ending March 31, 2016

Historical Maximum Annual Debt Service Coverage

Calculation:	Third Quarter ending March 31, 2016	Twelve Months ending March 31, 2016
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	$ (345,964)	$ 32,371,179
Plus depreciation expense	$ 16,537,419	$ 66,180,541
Plus amortization expense	$ 362,001	$ 1,496,076
Plus interest expense	$ 10,888,905	$ 43,745,099
Subtotal	27,442,362	143,792,895
Annualized quarterly total income available for debt service	x 4	n/a
Total income available for debt service	109,769,448	143,792,895
Maximum annual debt service	67,638,000	67,638,000
Maximum annual debt service coverage	1.6	2.1

Exhibit 28

Wellmont's Third Quarter FY2016 Financial Statements

Wellmont Health System and Affiliates

Consolidated Balance Sheets as of
March 31, 2016 and June 30, 2015

Consolidated Statements of Operations and Changes in Net Assets
and Statements of Cash Flows for the Quarters and Fiscal Years to Date ended
March 31, 2016 and March 31, 2015

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

Wellmont Health System
Management Discussion and Analysis
For the Quarter and Fiscal Year to Date ended March 31, 2016

Volumes:

Quarter ended March 31, 2016 versus quarter ended March 31, 2015:

Inpatients were down 253 or 3.1% and observation patients increased by 812 or 22.6% (so total "patients in a bed" increased 559 or 4.7%) as we continue to transition to value based payments while facing the challenge of increasingly prevalent high deductible plans in our area. Emergency room visits were up 5.2%, surgeries were up 2.9%, and deliveries were down 6.9%. Physician office visits were up 15% including urgent care visits which were up 55.2%, due to Wellmont now having eight urgent care centers.

Fiscal Year to Date (Three Quarters):

Inpatients were down 1,180 or 4.7% and observation patients increased 2,377 or 22.4% (so total "patients in a bed" increased 1,197 or 3.4%) as we continue to transition to value based payments while facing the challenge of increasingly prevalent high deductible plans in our area. Emergency room visits were up 2.8%, surgeries were down 3.4%, and deliveries were down 4.8%. Physician office visits were up 10.5% including urgent care visits which were up 42.9%, due to Wellmont now having eight urgent care centers.

Statement of Operations:

Quarter ended March 31, 2016 versus quarter ended March 31, 2015:

Net patient service revenue increased $13.2 million or 6.9% from the same quarter last year due to (a) an overall 3.1% increase in gross revenue and (b) improved cash receipts. Other revenue decreased $1.4 million primarily as a result of zero Electronic Health Record Meaningful Use amounts earned during the quarter being $1.0 million below the prior year amounts of $1.0 million due to reduced payments from lower volumes and the scheduled annual decreases in the program's payments.

Salaries and benefits increased $5.7 million or 5.8% due primarily to (a) the increase in physician office visits and (b) an increase in employee health plan costs. Supplies increased $1.8 million or 4.4% primarily due to higher infusion volumes. Purchased services increased $5.1 million or 30.1% primarily due to potential merger expenses. Interest expense decreased $0.3 million or 6.7% due to scheduled reductions in debt. Depreciation was essentially unchanged. All other expenses decreased $1.3 million primarily due (a) lower professional and general liability expense from improved actuarial reports and (b) planned elimination of maintenance and pre-Epic systems.

Income from operations of $1.1 million was above the same quarter last year by $0.8 million. Net income (loss) (shown as "Revenues and gains in excess of expenses and losses

attributable to Wellmont Health System") of $(8.7 million) was below the same quarter last year by $11.0 million due primarily to realized investment losses from a portfolio rebalance.

Fiscal Year to Date (Three Quarters):

Net patient service revenue increased $16 million or 2.7% compared to the prior fiscal year to date due to (a) an overall 1.6% increase in gross revenue and (b) the successful implementation of ICD-10 and improved cash receipts. Other revenue decreased $3.0 million primarily as a result of (a) $0.1 million of Electronic Health Record Meaningful Use amounts earned being $2.5 million below the prior year amounts of $2.6 million due to reduced payments from lower volumes and the scheduled annual decreases in the program's payments, (b) blood bank revenue reductions of $0.4 million due to the loss of a significant contract.

Salaries and benefits increased $7.9 million or 2.7% due primarily to (a) the increase in physician office visits and (b) an increase in employee health plan costs. Supplies were flat. Purchased services increased $8.7 million or 15.3% primarily due to potential merger expenses. Interest expense decreased $1.6 million or 12.2% due to scheduled reductions in debt and the effect of the 2014 refinancing activities. Depreciation was essentially unchanged. All other expenses decreased $3.2 million primarily due to (a) lower professional and general liability expense from improved actuarial reports and (b) planned elimination of maintenance and pre-Epic systems.

Income from operations of $7.0 million was above the prior fiscal year to date by $1.6 million. Net income (shown as "Revenues and gains in excess of expenses and losses attributable to Wellmont Health System") of $11.3 million was below the prior fiscal year to date by $2.5 million due to realized investment losses from a portfolio rebalance.

Balance Sheet and Ratios:

The only significant changes in the balance sheet were (a) normal liquidation of fiscal year end accounts payable and accrued expenses (b) decrease in assets limited as to use resulting from unrealized losses on the investment portfolio.

The debt to capitalization ratio, debt service coverage ratio, and days cash on hand were all relatively unchanged.

Wellmont Health System and Affiliates

The following table sets forth selected historical utilization statistics for the quarters and fiscal years to date ended March 31, 2016 and March 31, 2015.

	FY16 QTR 3	FY15 QTR 3	FY16 YTD	FY15 YTD
Hospital Statistics:				
Acute Discharges	8,038	8,291	23,885	25,065
Observation Patients	4,398	3,586	12,998	10,621
Patients in Bed	12,436	11,877	36,883	35,686
Patient Days	35,452	38,164	104,013	110,918
Average Length of Stay (Days)	4.41	4.60	4.35	4.43
Daily Census including Observations	438	464	425	444
Emergency Room Visits	44,184	41,999	136,546	132,891
Deliveries	469	504	1,496	1,572
Surgical Cases:				
Inpatient	2,209	2,257	6,634	6,886
Outpatient	5,916	5,642	17,843	18,464
Total Surgical Cases	8,125	7,899	24,477	25,350
Physician Office Visits	131,434	114,255	383,951	347,588
including Urgent Care Visits	25,053	16,147	67,649	47,348

The following table shows the percentage of gross patient service revenue by payor for the fiscal year to date ended March 31, 2016 and the fiscal year ended June 30, 2015.

	FY16 YTD	FY15 All Year
Medicare	28.1%	30.0%
Medicare Managed Care	26.5%	24.2%
Medicaid	11.9%	11.7%
Managed Care/Other	28.2%	27.9%
Self	5.3%	6.2%
	100.0%	100.0%

Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of March 31, 2016 and June 30, 2015
(Dollars in Thousands)(Unaudited)

	As of 3/31/16	As of 6/30/15
Assets		
Current assets:		
Cash and cash equivalents	$62,427	$ 48,866
Assets limited to use that are required for current liabilities	3,677	3,651
Patient accounts receivable	104,716	112,299
Other receivables	10,494	11,238
Inventories	17,344	19,981
Prepaid expenses & other current assets	7,776	9,979
Total current assets	206,434	206,014
Assets limited as to use, net of current portion	414,776	424,864
Land, buildings and equipment, net	463,370	484,569
Other assets:		
Long-term investments	25,490	27,964
Investments in affiliates	7,143	7,214
Deferred debt expense, net	4,005	4,217
Goodwill, net	51,546	51,583
Other	526	525
	88,710	91,503
Total assets	$ 1,173,290	$ 1,206,950
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	$18,130	$ 18,626
Accounts payable and accrued expenses	84,065	101,871
Estimated third-party payor settlements	13,119	12,987
Current portion of other long-term liabilities	5,910	7,660
Total current liabilities	121,224	141,144
Long-term debt, less current portion	465,062	480,187
Other long-term liabilities, less current portion	40,966	39,097
Total liabilities	627,252	660,428
Net assets:		
Unrestricted	534,865	535,632
Temporarily restricted	6,946	6,960
Permanently restricted	1,325	1,323
Noncontrolling interests	2,902	2,607
Total net assets	546,038	546,522
Commitments and contingencies		
Total liabilities and net assets	$ 1,173,290	$ 1,206,950

Wellmont Health System and Affiliates
Consolidated Statements of Operations and Changes in Net Assets
The quarters and fiscal years to date ended March 31, 2016 and March 31, 2015
(Dollars in Thousands)(Unaudited)

	FY16 QTR 3	FY15 QTR 3	FY16 YTD	FY15 YTD
Revenue:				
Net patient service revenue less provision for bad debts	$ 203,749	$ 190,535	$ 601,562	$ 585,489
Other revenue	4,224	5,581	13,470	16,459
Total revenue	207,973	196,116	615,032	601,948
Expenses:				
Salaries and benefits	103,655	97,962	299,739	291,805
Medical supplies and drugs	43,226	41,418	126,626	126,701
Purchased services	22,159	17,029	65,357	56,663
Interest	3,892	4,170	11,703	13,329
Depreciation and amortization	14,237	14,179	42,865	43,141
Maintenance and utilities	8,154	9,519	27,272	29,725
Lease and rental	3,975	3,874	11,946	11,389
Other	7,603	7,646	22,552	23,856
Total expenses	206,901	195,797	608,060	596,609
Income from operations	1,072	319	6,972	5,339
Nonoperating gains (losses):				
Investment income	(9,579)	2,376	4,793	11,679
Derivative valuation adjustments	38	726	72	1,134
Loss on refinancing	-	-	-	(1,389)
Nonoperating gains (losses), net	(9,541)	3,102	4,865	11,424
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	(8,469)	3,421	11,837	16,763
Discontinued operations	-	(691)	-	(2,188)
Revenues and gains in excess of expenses and losses	(8,469)	2,730	11,837	14,575
Income attributable to noncontrolling interests	(258)	(496)	(549)	(793)
Revenues and gains in excess of expenses and losses attributable to Wellmont Health System	(8,727)	2,234	11,288	13,782
Other changes in unrestricted net assets:				
Change in net unrealized gains (losses) on investments	15,432	3,206	(16,024)	(14,395)
Net assets released from restrictions for additions to land, buildings, and equipment	737	1,187	3,969	2,328
Increase (decrease) in unrestricted net assets	7,442	6,627	(767)	1,715
Changes in temporarily restricted net assets:				
Contributions	1,481	488	4,610	2,375
Net assets released from temporary restrictions	(1,116)	(1,498)	(4,624)	(3,131)
Increase (decrease) in temporarily restricted net assets	365	(1,010)	(14)	(756)
Changes in permanently restricted net assets:				
Permanently restricted contributions and investment income	-	-	2	3
Increase (decrease) in permanently restricted net assets	-	-	2	3
Changes in noncontrolling interests:				
Income attributable to noncontrolling interests	258	496	549	793
Distributions to noncontrolling interests	(116)	(337)	(254)	(612)
Increase (decrease) in noncontrolling interests	142	159	295	181
Change in net assets	7,949	5,776	(484)	1,143
Net assets, beginning of period	538,089	546,197	546,522	550,830
Net assets, end of period	$ 546,038	$ 551,973	$ 546,038	$ 551,973

Wellmont Health System and Affiliates
Consolidated Statement of Cash Flows
The fiscal years to date ended March 31, 2016 and March 31, 2015
(Dollars in Thousands)(Unaudited)

	FY16 YTD	FY15 YTD
Cash flows from operating activities:		
Change in net assets	$ (484)	$ 1,143
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	42,865	43,141
Net realized and unrealized (gains) losses on investments	11,231	2,716
Derivative valuation adjustments	(72)	(1,134)
(Gain) loss on sale of fixed assets	(416)	(542)
Loss on refinancing	0	1,389
Increase (decrease) in cash due to changes in:		
Accounts Receivable	7,583	6,368
Inventories	2,637	(870)
Prepaid expenses and other current assets	2,577	5,157
Accounts payable and accrued expenses	(15,092)	(29,683)
Net decrease (increase) in other assets	757	16,997
Net cash provided by operating activities	51,586	44,682
Cash flows from investing activities:		
Purchases of property, plant and equipment, net	(23,965)	(31,402)
Transfer (to)/from Bond and Self-Insurance funds	1,561	(857)
Transfer (to)/from Board funds	0	0
Net cash (used) in investing activities	(22,404)	(32,259)
Cash flows from financing activities:		
Proceeds from long term debt	0	22,415
Repayment of long term debt	(15,621)	(33,789)
Net cash provided (used) in financing activities	(15,621)	(11,374)
Increase (decrease) in cash and cash equivalents	13,561	1,049
Cash and cash equivalents, beginning	48,866	30,674
Cash and cash equivalents, ending	$ 62,427	$ 31,723

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

		3/31/16	6/30/15
Capitalization			
Current portion of long-term debt		$ 18,130	$ 18,626
Short-term notes payable		-	-
Long-term debt, less current portion	A	465,062	480,187
Total debt		483,192	498,813
Unrestricted net assets	B	534,865	535,632
Other net assets		11,173	10,890
Total net assets		546,038	546,522
Long-term debt plus Unrestricted net assets	A+B	$ 999,927	$ 1,015,819
Long-term debt to Capitalization	A/(A+B)	0.465	0.473
Debt Service Coverage			
Revenue and gains in excess of expenses and losses (12 months)		$ 12,869	$ 15,363
Add back:			
Depreciation and amortization (12 months)		58,293	58,569
Interest expense (12 months)		16,131	17,757
(Gain) loss on refinancing (12 months)		-	1,389
(Gain) loss from discontinued operations (12 months)		4,908	2,720
Total income available for debt service per Master Trust Indenture	C	92,201	95,798
Maximum annual debt service	D	$ 42,972	$ 43,009
Debt Service Coverage Ratio per Master Trust Indenture	C/D	2.15	2.23
Days Cash on Hand			
Unrestricted cash		$ 62,427	$ 48,866
Unrestricted investments:			
Capital improvements		373,396	382,902
Long-term investments		25,490	27,964
Less illiquid investments		(26,248)	(28,051)
	E	435,065	431,681
Operating expenses (12 months)		817,487	806,035
Less depreciation and amortization		(58,293)	(58,569)
Total cash expenses		759,194	747,466
Number of days in the period		366	365
Daily cash operating expenses	F	$ 2,074	$ 2,048
Days cash on hand	E/F	209.7	210.8

Exhibit 29

Details Regarding Mountain States' Severance Packages

To be submitted pursuant to CID.

Exhibit 30

Details Regarding Wellmont's Severance Packages

To be submitted pursuant to CID.

Exhibit 31

Proposed Employment Agreements with New Health System

To be submitted pursuant to CID.

Exhibit 32

Physician needs Assessment from Niswonger Children's Hospital

To be submitted pursuant to CID.

Exhibit 33

Audited Results for FY2011 to FY2015

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations

	2015	2014	2013	2012	2011
Revenue, gains and support:					
Net patient service revenue, net of contractual allowances and discounts	$ 1,116,954,225	$ 1,050,425,742	$ 1,045,244,653	$ 1,075,050,313	$ 1,062,122,920
Provision for bad debts	(127,519,531)	(122,641,687)	(112,497,088)	(122,917,014)	(116,248,346)
	989,434,694	927,784,055	932,747,565	952,133,299	945,874,574
Other operating revenue	73,345,726	71,043,732	64,140,484	39,406,853	24,868,175
TOTAL REVENUE, GAINS AND SUPPORT	1,062,780,420	998,827,787	996,888,049	991,540,152	970,742,749
Expenses:					
Salaries and wages	345,155,144	340,589,134	355,589,870	358,607,181	342,208,116
Physician salaries and wages	80,279,380	77,636,096	74,257,857	65,706,003	59,248,825
Contract labor	5,415,831	4,282,340	3,941,874	6,375,067	5,963,696
Employee benefits	77,306,084	69,173,499	74,589,762	69,599,641	67,138,834
Fees	120,691,188	115,606,412	105,890,846	97,958,613	85,918,931
Supplies	176,049,710	163,698,766	162,955,174	170,186,051	168,261,321
Utilities	16,775,020	17,052,090	16,857,010	17,289,136	17,300,381
Medical costs	18,382,989	10,292,244	1,039,401	-	-
Other	81,477,121	79,979,993	80,211,445	76,285,343	69,647,165
Depreciation	67,210,326	69,436,735	78,941,071	73,059,635	87,499,468
Amortization	1,556,991	1,741,757	2,259,537	2,245,327	2,559,141
Interest and taxes	43,695,597	44,391,756	43,202,890	45,902,804	44,152,737
TOTAL EXPENSES	1,033,995,381	993,880,822	999,736,737	983,214,801	949,898,615
OPERATING INCOME (LOSS)	28,785,039	4,946,965	(2,848,688)	8,325,351	20,844,134
Nonoperating gains (losses):					
Interest and dividend income	13,893,945	12,073,668	13,880,727	15,212,951	16,224,492
Net realized gains (losses) on the sale of securities	9,260,235	15,310,531	3,073,768	(2,594,831)	1,956,855
Net unrealized gains on securities	(6,137,785)	23,317,890	24,024,957	(2,884,095)	22,168,047
Derivative related income	6,171,935	5,979,869	6,661,242	7,514,566	5,072,334
Loss on early extinguishment of debt	-	(4,622,060)	-	(2,636,010)	-
Change in estimated fair value of derivatives	7,718,028	(2,761,314)	456,715	(6,197,514)	23,048,906
Other nonoperating gains (losses)	(4,590,695)	2,097,601	14,318,127	11,235,840	(2,652,743)
NET NONOPERATING GAINS (LOSSES)	26,315,663	51,396,185	62,415,536	19,650,907	65,817,891
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	$ 55,100,702	$ 56,343,150	$ 59,566,848	$ 27,976,258	$ 86,662,025

Exhibit 34

Exhibit 11.5 - Attachment C Wellmont EMMA - Annual Disclosures for 2011 to 2015

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

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

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

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

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

###

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WELLMONT HEALTH SYSTEM'S BOARD CHAIRMAN, CEO ISSUE STATEMENTS

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

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

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

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

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

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

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

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

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

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

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

###

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

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

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

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

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

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

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

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

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

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

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

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

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

###

FOR IMMEDIATE RELEASE 1/5/10

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

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

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

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

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

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

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

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

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

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

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

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

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

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

###

FOR IMMEDIATE RELEASE 2/1/10

WELLMONT NAMES BOB BURGIN INTERIM CEO

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

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

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

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

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

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

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

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

He and his wife have two grown children.

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

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

# # #

FOR IMMEDIATE RELEASE **6/4/10**
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WELLMONT NAMES ACCOMPLISHED EXECUTIVE MARGARET 'DENNY' DENARVAEZ PRESIDENT AND CEO

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

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

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

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

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

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

(MORE)

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

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

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

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

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

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

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

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

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

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

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Wellmont Health System

Denny DeNarvaez

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

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

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

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

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

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

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

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

MATERIAL EVENT NOTICE

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

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

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

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

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

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

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

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

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

WELLMONT HEALTH SYSTEM

Dated: August 21, 2014

FOR IMMEDIATE RELEASE 8/2/12

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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FOR IMMEDIATE RELEASE 1/9/14

WELLMONT HEALTH SYSTEM LAUNCHES PROCESS TO ASSESS STRATEGIC OPTIONS FOR FUTURE

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

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

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

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

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

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

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

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

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

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

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

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

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

About Wellmont Health System

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

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

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FOR IMMEDIATE RELEASE:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

About Wellmont Health System

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

About Mountain States Health Alliance

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

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Wellmont Health System and Affiliates

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

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

Wellmont Health System

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

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

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

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

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

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

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

Wellmont Health System

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

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

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

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

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

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

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

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

Wellmont Health System and Affiliates

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

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

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

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

Volumes:

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

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

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

Statement of Operations:

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

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

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

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

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

Fiscal 2011 versus fiscal 2010:

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

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

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

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

Balance Sheet:

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

Wellmont Health System and Affiliates

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

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

Wellmont Health System and Affiliates

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

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

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

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

Volumes:

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

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

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

Statement of Operations:

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

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

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

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

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

Fiscal 2012 versus fiscal 2011:

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

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

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

Balance Sheet:

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

Wellmont Health System and Affiliates

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

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

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

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

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

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

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

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

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

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

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

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

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

Wellmont Health System and Affiliates

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

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

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

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

Volumes:

Quarter:

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

Fiscal Year:

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

Statement of Operations:

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

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

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

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

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

Fiscal Year:

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

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

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

Balance Sheet:

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

Wellmont Health System and Affiliates

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

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

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

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

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

	As of 6/30/13	As of 6/30/12
Assets		
Current assets:		
Cash and cash equivalents	$ 55,958	$ 44,930
Assets limited to use that are required for current liabilities	5,061	4,372
Patient accounts receivable	107,029	108,265
Other receivables	17,995	23,805
Inventories	18,361	17,862
Prepaid expenses & other current assets	8,949	7,462
Total current assets	213,353	206,696
Assets limited as to use, net of current portion	375,709	339,030
Land, buildings and equipment, net	474,730	458,048
Other assets:		
Long-term investments	28,628	36,633
Investments in affiliates	31,874	32,646
Deferred debt expense, net	5,178	5,419
Goodwill, net	15,096	17,090
Other	547	651
	81,323	92,439
Total assets	$ 1,145,115	$ 1,096,213
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	$ 15,002	$ 11,913
Accounts payable and accrued expenses	84,300	81,243
Estimated third-party payor settlements	7,157	15,535
Current portion of other long-term liabilities	6,198	5,782
Total current liabilities	112,657	114,473
Long-term debt, less current portion	475,946	459,654
Other long-term liabilities, less current portion	41,567	54,060
Total liabilities	630,170	628,187
Net assets:		
Unrestricted	503,934	458,218
Temporarily restricted	6,927	5,739
Permanently restricted	1,311	1,304
Noncontrolling interests	2,773	2,765
Total net assets	514,945	468,026
Commitments and contingencies		
Total liabilities and net assets	$ 1,145,115	$ 1,096,213

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

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

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

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

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

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

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

Wellmont Health System and Affiliates

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

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

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

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

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

Volumes:

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

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

Fiscal Year:

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

Statement of Operations:

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

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

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

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

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

Fiscal Year:

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

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

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

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

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

Balance Sheet and Ratios:

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

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

Wellmont Health System and Affiliates

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

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

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

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

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

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

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

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

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

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

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

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

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

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

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

Wellmont Health System and Affiliates

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

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

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

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

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

Overview:

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

Volumes:

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

Statement of Operations:

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

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

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

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

Fiscal Year:

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

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

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

Balance Sheet and Ratios:

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

Wellmont Health System and Affiliates

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

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

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

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

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

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

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

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

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

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

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

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

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

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

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

Exhibit 35

Updated Financial Model

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

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

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

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

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

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