March 16, 2016

Allison Thigpen, MPH
Health System Improvement Coordinator
Division of Health Planning
5th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

Re: Tennessee Department of Health's Request for an Addendum to the Application for a Certificate of Public Advantage

Dear Ms. Thigpen:

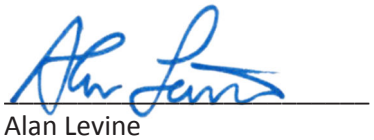
The following information is being provided in response to your letter dated February 29, 2016, relating to the Department of Health's request for an addendum to the application for issuance of a Certificate of Public Advantage ("COPA"). Specifically, we wish to address the Department's objectives and positions raised in your January 15, 2016, written in response to the "Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report" and identify where each objective/position is addressed in the COPA Application submitted on February 16, 2016. Each objective/position posed in your January 15th letter is set forth in its entirety in the attached Addendum together with the location in the Application where that objective/position is addressed. We have also provided an explanation about how the Application section responds to the Department's observations and positions where appropriate.

Additionally, we have included information about the recent announcement that Wellmont's Chief Financial Officer, Alice Pope, will be joining HonorHealth, addressed a technical correction in Section 6 of the Application and accompanying Exhibits, and provided full copies of Exhibits 11.4 - Attachment D and 11.4 - Attachment E.

We appreciate the opportunity to provide the Department with additional information that we hope will be helpful in reviewing the COPA Application. We would be happy to discuss any of this information or any questions that you, or your colleagues, may have.

Sincerely,

Mountain States Health Alliance
President &
Chief Executive Officer



Alan Levine

Wellmont Health System
President &
Chief Executive Officer

Bart Hove

Enclosure

CC: Valerie Nagoshiner
Malaka Watson
Jeff Ockerman

ADDENDUM #1 TO THE

APPLICATION

CERTIFICATE OF PUBLIC ADVANTAGE

STATE OF TENNESSEE

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: March 16, 2016

MARCH, 2016

Wellmont Health System ("Wellmont") and Mountain States Health Alliance ("Mountain States") (collectively referred to as the "Applicants") submitted an application (the "Application") to the Tennessee Department of Health on February 16, 2016 for issuance of a Certificate of Public Advantage ("COPA").

The Tennessee Department of Health (the "Department") has requested that the Applicants provide an addendum to the Application to address the Department's objectives and positions raised in the Department's January 15, 2016 letter, which was written in response to the "Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report."

Each objective/position posed in the Department's January 15th letter is set forth in its entirety below, together with the location in the Application where that objective/position is addressed. The Applicants have also provided an explanation about how that particular section (or sections) responds to the Department's observations and positions where appropriate (Section 1 below).

Additionally, the Applicants wish to formally notify the Department of Alice Pope's planned departure from Wellmont Health System (Section 2 below), addressed a technical correction in Section 6 of the Application and accompanying Exhibits (Section 3 below), and provided full copies of Exhibits 11.4 - Attachment D and 11.4 - Attachment E (Section 4 below).

SECTION 1: RESPONSE TO THE DEPARTMENT'S JANUARY 15, 2016 LETTER

Observation #1 - Geographic Service Area

The report does not include counties in Kentucky and North Carolina in the geographic service area while the Letter of Intent, submitted September 16, 2015, does include these counties.

Department Position:

Consistent with department rule, "[i]f the proposed geographic service area differs from the service areas where the parties have conducted business over the five (5) years preceding the application, a description of how and why the proposed geographic area differs and why changes are proposed" is required.

The department notes the Kentucky and North Carolina counties are regularly included in business documents detailing the service area of Mountain States Health Alliance. Unless the application, when it is submitted, includes a reasonable justification to exclude the Kentucky and North Carolina counties, the department will consider these counties, which are contiguous to counties with facilities of the New Health System, to be included in the service area.

Applicants' Response:

As the Department is aware, "geographic service area" is not defined in either the Tennessee COPA statute[24] or regulations.[25] A healthcare geographic service area may be defined in different ways, including by patient origin data, location of services, geographic features, political boundaries, population, and/or health resources. Since the Tennessee COPA statute and regulations do not define "geographic service area," the Applicants looked to the regulatory language for guidance. Tennessee Rules section 1200-38-01-.02(2)(a)(7) states:

> If the proposed geographic service area differs from the service areas where the parties have conducted business over the five (5) years preceding the Application, a description of how and why the proposed geographic service area differs and why changes are proposed; [*emphasis added*]

For purposes of completing the COPA Application, the Applicants have interpreted the "proposed geographic service area" to mean the geographic area where the Applicants propose to conduct business as the New Health System.

The Applicants have historically served *patients* from a twenty-nine county area, which includes counties in Tennessee, Virginia, Kentucky, and North Carolina. While the Applicants serve patients from twenty-nine counties in Tennessee, Virginia, North Carolina, and Kentucky, Wellmont and Mountain States only have facilities and locations in Tennessee and Virginia. All of the Wellmont and Mountain States physical facilities and provider locations are located in Tennessee or Virginia and are subject to state regulations only in these two states. To the extent the Applicants draw some patients from adjacent North Carolina and Kentucky counties, these patients are served at the Applicants' facilities and provider locations in Tennessee and Virginia.

Section 5 of the Application provides a detailed description of the proposed geographic service area, not limited to the boundaries of the State of Tennessee. While the Applicants recognize that "geographic service area" may be defined in different ways, the Applicants have defined the "proposed geographic service area" in the COPA Application as the twenty-one counties in Tennessee and Virginia where the Applicants propose to conduct business as the New Health System. This twenty-one county area is inclusive of the Tennessee and Virginia counties in which the Applicants have locations and facilities and serve residents, and all locations and providers that will be under the control of the Applicants and subject to any regulation under the COPA or Cooperative Agreement. This 21-county area is inclusive of the vast majority of the population served by the Applicants, whether commercial, Medicare, Medicaid, or uninsured.

[24] Tennessee Code Section 68-11-1301 et seq.
[25] Tenn. Comp. R. & Regs 1200-38-01-.01 et seq.

Since Wellmont and Mountain States have only operated facilities in Tennessee and Virginia over the five years preceding the application, the proposed geographic service area for the COPA Application does not differ from the service areas where the Applicants have conducted business over the five years preceding the Application.

The Department correctly notes that the two Kentucky counties and six North Carolina counties are regularly included in business documents detailing the service area of Mountain States Health Alliance. As explained above, a healthcare "service area" may be defined in different ways. Both Wellmont and Mountain States have served *patients* from a twenty-nine county area that includes counties in Tennessee, Virginia, Kentucky, and North Carolina. However, Wellmont and Mountain States only have facilities in Tennessee and Virginia. As shown in the tables below, which is based on the same discharge data used in the Application and published by Tennessee and Virginia, patients from the six North Carolina counties identified in the 29-county area account for one half of one percent (0.5%) of the combined patient discharges. Patients from the two Kentucky counties identified in the 29-county area account for less than one half of one percent (0.4%) of the combined patient discharges. Ninety-eight percent (98%) of the combined patient discharges come from the proposed geographic service area - the 21 counties in Tennessee and Virginia.

	With MDC 19 and 20					
Patient County	MSHA	WHS	Combined	MSHA %	WHS %	Combined %
Total	59,594	35,810	95,404	100.0%	100.0%	100.0%
Proposed 21 County Geographic Service Area*	58,441	35,075	93,516	98.1%	97.9%	98.0%
Extended Service Area - NC**	456	35	491	0.8%	0.1%	0.5%
Extended Service Area - KY***	129	267	396	0.2%	0.7%	0.4%
All Other Counties	568	433	1,001	1.0%	1.2%	1.0%

	Without MDC 19 and 20					
Patient County	MSHA	WHS	Combined	MSHA %	WHS %	Combined %
Total	53,822	34,514	88,336	100.0%	100.0%	100.0%
Proposed 21 County Geographic Service Area*	52,835	33,828	86,663	98.2%	98.0%	98.1%
Extended Service Area - NC**	443	34	477	0.8%	0.1%	0.5%
Extended Service Area - KY***	123	263	386	0.2%	0.8%	0.4%
All Other Counties	421	389	810	0.8%	1.1%	0.9%

Notes:
Excludes DRG 795
Excludes Takoma Regional Hospital
*Includes the 21 counties and 2 independent cities across Tennessee and Virginia
**Includes the following six North Carolina counties: Ashe, Avery, Madison, Mitchell, Watauga, and Yancey
***Includes the following two Kentucky Counties: Harlan and Letcher

For the reasons stated above, the Applicants believe it is appropriate to define the geographic service area for purposes of the COPA Application as the twenty-one counties in Tennessee and Virginia.

Observation #2 - Prevention Services for all Categories of Payers

The description in the report of prevention services for all categories of payers lacks detail. For example, substance abuse prevention is the only specific example provided.

Department Position:

It is the department's position that, for the application to be deemed complete, prevention services will need to be more specifically enumerated. Consistent with department rule, the Cooperative Agreement must detail the "[p]roposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term population health improvements...."[26]

Applicants' Response:

In Sections 11.i and 11.j of the Application, the Applicants outline their commitments to improving community health through investment of not less than $75 million over ten years in science and evidence-based population health improvement. Specifically, on pages 86-88 of the Application, the Applicants address the use of cost savings to fund prevention services across all payer groups. The Applicants interpret "such as" in the regulations cited by the Department to indicate that the proposed use of cost savings may be used for these types of programs or other types of programs that are designed to achieve long-term population health improvements. The Applicants expect that low or no-cost services such as screening programs and disease management programs will be essential elements of the plan to achieve long-term population health improvements as outlined in the Application. Additionally, the Applicants believe that focusing these low or no-cost programs for specific populations will likely yield the greatest long-term population health improvements. For example, immunization programs for children are well-established and well-funded in the region. However, improvements could be made with respect to immunization programs for pneumonia, flu, and HPV by targeting specific populations to help achieve greater results. The Applicants intend to invest in population health improvement efforts that generate more focused and meaningful value-based spending in the region. The sections of the Application addressing this position are included below for reference:

[26] Tennessee Department of Health Rule 1200-38-01-.02(2)(a)13(ix)(II).

- Proposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term population health improvements.

  RESPONSE: The New Health System is committed to improving community health through investment of not less than $75 million over ten years in science and evidence-based population health improvement. Combining the region's two major health systems in an integrated delivery model is the best way to identify regional priorities, collaborate with payers to identify cost drivers and areas of need for improvement and to invest the resources it will take to effect material improvements. These efforts will provide resources that may be invested in more focused and meaningful value-based spending in the region – spending that helps 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. The New Health System would commence this process by preparing a comprehensive community health improvement plan that identifies the key strategic health issues for improvement over the next decade. The health improvement plan would be prepared in conjunction with the public health resources at ETSU. The process has already commenced through the four Community Health Work Groups described herein. Population health improvement funding may be committed to the following initiatives, as well as others based upon the 10-year plan for the region.

  - ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.

  - ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.

  - ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.

- ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.

The Parties believe that prevention services, such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services, are all essential ingredients in achieving population health improvements and maintaining a population's long-term health and wellness. Certain counties in the service area have achieved noteworthy performance in specific areas. For example, the Northeast region[27] ranks among the best in Tennessee in immunizations, and Sullivan County ranks well in mammograms. However, as a general rule, the health status of the service area population is in need of significant improvement. Targeted efforts to address immunizations and preventive screenings are expected to be explicitly derived from the MAPP community health improvement process outlined in this Application. The Parties intend to address chronic disease management as part of the "Helping Adults Live Well" strategy outlined in this Application. Specific plans regarding drug and alcohol abuse services are detailed in **Section 8.H** of this Application. It is anticipated that the Community Health Work Groups, the Advisory Groups appointed by the Commissioner, and the agreed-upon Health Index will reflect specific actions and strategies in connection with a broad range of prevention services, including immunizations, mammograms, chronic disease management and drug and alcohol abuse services. Further, the Parties believe there are significant opportunities to partner with all categories of payers to create effective systems of care for best practice preventative services and to extend those services to both economically and geographically underserved populations through effective collaboration with Federally Qualified Health Centers, charity care clinics, health departments and others. In addition, Mountain States operates drop-by Health Resources Centers which support chronic disease prevention and management in Kingsport and Johnson City and Wellmont owns and operates mobile health buses that are equipped to offer immunizations, cardiovascular and cancer screenings, mammograms, and physicals along with

[27] The Northeast region includes the following counties: Carter, Greene, Hancock, Hawkins, Johnson, Unicoi, and Washington. The rate represents the percent of 24-month-old children in Tennessee that have completed their required immunization series. The rate ranges from a high of 93% to a low of 65.3%. Tennessee Immunization Program, Tennessee Department of Health. "Results of the 2013 Immunization Status Survey of 24-Month-Old Children in Tennessee. *See* https://tn.gov/assets/entities/health/attachments/ImmunizationSurvey2013.pdf *accessed* February 4, 2016.

health education and coaching resources to engage with populations for effective behavior change and the extension of disease management resources. Mobile strategies will allow reach into populations with both economic and geographic barriers and can be further supplanted by a host of health IT and telemedicine strategies which are envisioned to be developed as part of the long-range community health improvement plan. Both organizations operate nurse call centers which are able to engage with populations for the development of wellness and prevention coaching and disease management programming to help overcome geographic and social barriers.

- Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

  RESPONSE: The savings realized by reducing duplication and improving coordination will stay within the region and be reinvested in ways that benefit the community substantially, including:

  Access to Health Care and Prevention Services. Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Cooperative Agreement will enable the hospitals to continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding. The New Health System will commit at least $140 million over ten years toward certain specialty services. It will also commit to create new capacity for residential addiction recovery services; 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; ensure recruitment and retention of pediatric sub-specialists; and develop pediatric specialty centers and emergency rooms in Kingsport and Bristol, with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals. These initiatives would not be sustainable in the region without the financial support created by the merger.

Observation #3 - Equity

The explanation of how the New Health System will provide equitable health services with respect to maintaining quality and competition within the service area needs further explanation.[28] The department acknowledges the report includes a discussion of access to services in rural areas.

[28] Tennessee Department of Health Rule 1200-38-01-.02(2)(a)12(iii).

Still, the document primarily focuses on contracts with health plans and does not discuss the impact of the proposed merger on other payers and their respective populations, including Medicaid and Medicare populations and people without insurance.

Department Position

Consistent with department rules, the application should include policies that specifically address Medicaid and Medicare populations and people without insurance.[29] Moreover, the population health improvement plan detailed in the application should cover all residents in the geographic service area.

Applicant's Response:

As noted in Section 11.g.iii.III of the COPA Application, Wellmont and Mountain States are the primary providers for Medicare and Medicaid in the region, and operate the primary system of access for children. Additionally, the primary location for inpatient mental health services for the uninsured and Medicaid population are housed within Mountain States. As part of the COPA Application, the Applicants provided the State with the current Charity Care and related policies of both Wellmont and Mountain States in the following exhibits:

Exhibit 8.4 - Attachment A	Mountain States' Charity Care Policy
Exhibit 8.4 - Attachment B	Mountain States' Credit and Collection Policy - Patient Accounts
Exhibit 8.4 - Attachment C	Mountain States' Collection Agency Process - Fiscal Services
Exhibit 8.4 - Attachment D	Mountain States' Code of Ethics and Business Conduct
Exhibit 8.5 - Attachment A	Wellmont's Patient Bill of Rights
Exhibit 8.5 - Attachment B	Wellmont's Charity Care Policy and Related Policies
Exhibit 8.5 - Attachment C	Wellmont Bad Debt, Bankruptcy, Small Balance Write-Off and Return Mail Policy

As explained on pages 73-76 of the Application, the New Health System will continue to remain committed to these populations, a commitment neither system can make without the proposed merger. If the COPA is granted, the Applicants intend for the New Health System to adopt policies that are substantially similar to the existing policies of both Applicants and consistent with the IRS's final 501(r) rules. The New Health System is a shell entity at this point with no authority to implement charity care or other policies that would govern the operations of the merged enterprise. However, as evidence of the Applicant's commitment to implement similar policies if the COPA is granted, the Applicants have committed in the executed

[29] Tennessee Department of Health Rule 1200-38-01-.02(2Xa)13(vii)(III)III[A-D].

Cooperative Agreement that the New Health System will adopt policies that are substantially similar to the existing policies of both Applicants.[30]

To further address the Department's interest in the New Health System's provision of equitable health services, the Applicants address each category of patients on pages 74-76 of the Application. This section is included below for reference:

> Medicare. Many of the "Helping Adults Live Well" strategies discussed in this Application will be designed specifically for the Medicare senior population and dual eligible population. Medicare hospital and physician pricing is determined by government regulation and is not a product of competition or the marketplace. As a result, the merger is not expected to impact the cost of care to Medicare beneficiaries, but access to and quality of services are expected to improve. Additionally, through care coordination models implemented as part of value based arrangements, it is expected that use rates will be favorably affected, and savings to the Medicare program will result. The many strategies contained within this Application, including implementation of a Common Clinical IT Platform, will be key factors in succeeding within the value-based Medicare environment.
>
> Medicaid. Many of the population health strategies detailed in this Application, such as child maternal health, will directly benefit the Medicaid population, and thus, the program. Also, the New Health System will seek innovative value-based models with the commercial payers that serve as intermediaries to the state Medicaid programs. Such models may include care management/shared savings, integrated mental health services and development of access points of care for the Medicaid and uninsured populations. It is widely known that simply having a Medicaid card does not equate to access. The intent of the New Health System is to ensure an organized care delivery model which optimizes the opportunity for access in the lowest cost, most appropriate setting. Importantly, these opportunities become more likely when the New Health System has the scale in terms of the number of lives it is managing. This should be an attractive feature for the states and to those payers acting as intermediaries with the states.
>
> Uninsured Population. As described in **Section 8.G** of this Application, both Parties currently provide significant amounts of charity care to the vulnerable populations in the Geographic Service Area and will continue to do so in the future. If the COPA is granted, the Parties intend that the New Health System will adopt a charity care policy that is substantially similar to the existing policies of both Parties. The uninsured

[30] *See* COPA Application **Exhibit 11.1**, Master Affiliation Agreement and Plan of Integration By and Between Wellmont Health System and Mountain States Health Alliance, Section 1.02 “Community Benefit."

population will also be the target of several inter-related health strategies outlined in this 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. The Parties intend to work with charitable clinics in the area to improve access for the uninsured population to patient-centered medical homes, federally qualified health centers, and other physician services. 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.

All categories of payers and the uninsured. Additionally, for all patients covered by all categories of payers and the uninsured, the New Health System will:

- Develop effective strategies to reduce the over-utilization and unnecessary utilization of services, particularly high-cost services such as emergency department care. This better-managed, more proactive approach will be developed in collaboration with a host of community-based resources and will be consistent with the CMS Accountable Health Communities model. Under this model, both traditional health care resources and societal resources are considered in tandem. Recognizing that factors such as transportation, educational attainment, food availability, housing, social support and other factors play a key role in health care access and outcomes, effective program development will include opportunities to help high-utilizers of care gain awareness of available resources, provide navigational access to those resources, and ensure systems of contact and collaboration exist and are effective.

- Develop with the State and community stakeholders Key Focus Areas for population health investment and intervention. These index categories will apply regardless of payer and the priorities for programming and intervention will be based on the communities where the need/impact will be greatest. The Parties intend to account for geographic gaps and disparities by aiming resources or strategies at specific populations, which will be outlined in the long-term community health improvement plan. Where payers have existing care management programs in place, the New Health System will work with payers to increase compliance for effective prevention and disease management programs. The Parties strongly believe that the New Health System must provide opportunities for prevention, navigation, and disease management, and must connect individuals, regardless of their coverage status, to community-based resources if the regional population health management initiative is to be successful.

Observation #4 - Health of the Region and Population Health Disparities

The identification and discussion of population health disparities is limited. While the report briefly highlights differences in health behaviors and outcomes among geographic entities, the report does not discuss other groups that often experience health disparities, e.g., racial/ethnic minority, rural and urban, age and gender disparities. The department also notes the report does not address physical activity, one of the Tennessee State Health Plan "Big Three +1" health issues (physical inactivity, obesity, tobacco use and substance abuse). As you know, evidence indicates physical activity, independent of its effect on weight, has substantial benefits for health.

Department Position

For an application to be deemed complete, granular detail is needed regarding factors that influence the health and health disparities of counties, communities, and groups within them, particularly as it relates to the applicants' current assessment of existing trends and long-term population health outcomes.

The department also notes that, should a COPA be issued, the New Health System will be responsible for population health in the region for an indefinite period of time. The department is interested in additional longitudinal plans and New Health System expectations for regional population health improvement after the initially-proposed ten year period.

Applicants' Response:

In Section 8.A of the Application, the Applicants address the significant health care challenges that face the population of the geographic service area. As outlined on page 30, a 2015 Tennessee Department of Health report, *Drive Your County to the Top Ten*,[31] found that:

- All Tennessee counties in the Geographic Service Area exceed the national average for smoking
- The state level obesity rate exceeds the national average, and several counties within the Geographic Service Area have obesity rates of more than thirty percent (30%).
- Three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for frequency of low birthweight births and
- Three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for teen pregnancy rates.

[31] "2015 Drive Your County to the Top Ten", Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. Available here: https://www.tn.gov/health/topic/specialreports

Table 8.1 on page 31 of the Application reports key statistics on the population in the counties within the Geographic Service Area, including metrics for obesity, smoking, childhood poverty, and death rates due to drug poisoning. Full County Health Rankings for all Tennessee and Virginia Counties and Independent Cities located in the Geographic Service Area are attached to the Application as Exhibit 8.1A and 8.1B. Table 8.1 is provided below for reference.

Table 8.1 from the COPA Application

Service Area Health Rankings By State, County or City	Overall State or County Health Rank	Percentage of Adults Reporting Fair or Poor Health	Percentage Of Adults That Are Obese	Percentage of Adults Who Are Currently Smokers	Percentage of Children In Poverty	Drug Poisoning Mortality Rate per 100,000 Population
Tennessee	43rd	19%	32%	23%	27%	16
Carter	48/95	23%	29%	31%	34%	20
Cocke	88/95	27%	31%	21%	41%	21
Greene	59/95	21%	32%	29%	30%	22
Hamblen	54/95	26%	30%	23%	29%	27
Hancock	93/95	29%	30%	40%	45%	42
Hawkins	64/95	26%	35%	26%	31%	26
Johnson	44/95	26%	31%	28%	38%	11
Sullivan	36/95	22%	33%	26%	28%	17
Unicoi	68/95	26%	30%	23%	29%	24
Washington	19/95	19%	31%	24%	24%	17
Virginia	21st	14%	28%	18%	16%	9
Buchanan	132/133	29%	29%	30%	33%	37
Dickenson	130/133	31%	29%	32%	28%	53
Grayson	74/133	20%	32%	22%	29%	Not Reported
Lee	116/133	29%	29%	25%	39%	14
Russell	122/133	29%	35%	25%	26%	32
Scott	114/133	23%	34%	28%	27%	14
Smyth	123/133	29%	31%	22%	26%	15
Tazewell	133/133	29%	30%	21%	23%	37
Washington	82/133	19%	32%	24%	21%	13
Wise	129/133	24%	32%	33%	28%	38
Wythe	85/133	27%	30%	24%	22%	18

University of Wisconsin Population Health Institute. County Health Rankings 2015.
Accessible at www.countyhealthrankings.org

The Applicants specifically addressed the health priorities of the State in the discussion of the "Big Three Plus One" health issues (physical inactivity, obesity, tobacco abuse and substance abuse) on pages 31-35. As noted in the Application, these four health issues are particularly significant challenges for the Geographic Service Area and are associated with other health challenges and conditions that are responsible for higher health care utilization.

The Applicants' discussion of the "Big Three Plus One" issues from the Application are included below for reference:

> Physical Inactivity & Obesity
>
> Obesity and physical inactivity are mutually reinforcing public health concerns. Tennessee's state level obesity rate exceeds the national average. While most of the Tennessee counties in the 21-county geographic service area have obesity rates lower than the state average, Hawkins and Sullivan Counties are exceptions at 35% and 33% respectively. All of the Tennessee counties in the geographic service area exceed the state average for physical inactivity (30%). Most notably, Unicoi County has a physical inactivity rate of 37.0% and Hancock County has a physical inactivity rate of 39.4%. Measures for Virginia counties in the service area reflect challenges as well.
>
> Tobacco Abuse
>
> The "2015 Drive Your County to the Top Ten" report[32] published by the Tennessee Department of Health Division of Policy, Planning, and Assessment State Department of Health demonstrates that all of the Tennessee counties in the 21-county geographic service area exceed the national average for smoking, and seven of the ten Tennessee counties exceed the state average for smoking. In particular, Hancock County and Carter County are at the high end of the range with smoking rates that exceed 30%.
>
> Substance Abuse
>
> Substance abuse is a key priority of the Tennessee Department of Health and a significant concern in this region. Of the ten Tennessee counties in the geographic service area, nine exceed the state average in the number of deaths due to drug poisoning per 100,000 population. Of particular note is Hancock County, which has the highest drug poisoning mortality rate in the state. Addressing substance abuse is one of the highest priorities of the New Health System, with efforts to address the specific needs of this population as well as improve access to, and coordination of care at, healthcare facilities for substance abuse patients.

[32] "2015 Drive Your County to the Top Ten", Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. Available here: https://www.tn.gov/health/topic/specialreports

Table 8.2 reports key statistics on the population in the counties in the 21-county area for the "Big Three +1" health issues, including metrics for physical inactivity, obesity, tobacco use, and substance abuse. Red shading indicates that the County scores worse than the state average for that particular metric.

	Physical Inactivity Score[33]	Obesity[34]	Tobacco Abuse[35]	Substance Abuse Score[36]
Tennessee Average	30%	32%	23%	16
Carter County	32%	29%	31%	20
Cocke County	36%	31%	21%	21
Greene County	36%		29%	22
Hamblen County	33%	30%	23%	27
Hancock County	39%	30%	40%	42
Hawkins County	35%	35%	26%	26
Johnson County	34%	31%	28%	11
Sullivan County	35%	33%	26%	17
Unicoi County	37%	30%	23%	24
Washington County	30%	31%	24%	17
Virginia Average	22%	28%	18%	9
Buchanan	28%	29%	30%	37
Dickenson	32%	29%	32%	53
Grayson	30%	32%	22%	Not reported
Lee	27%	29%	25%	14
Russell	36%	35%	25%	32
Scott	35%	34%	28%	14
Smyth	23%	31%	22%	15
Tazewell	31%	30%	21%	37
Washington	30%	32%	24%	13
Wise	38%	32%	33%	38
Wythe	27%	30%	24%	18

* Red shading indicates that a County's score exceeds the state average.

[33] Physical Inactivity: Percentage of adults aged 20 and over reporting no leisure-time physical activity. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, available at http://www.countyhealthrankings.org/

[34] Adult Obesity: Percentage of adults that report a BMI of 30 or more. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, available at http://www.countyhealthrankings.org/

[35] Adult Smoking: Percentage of adults who are current smokers. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, available at http://www.countyhealthrankings.org/

[36] Substance Abuse: Drug Poisoning Mortality Rate per 100,000 Population Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, available at http://www.countyhealthrankings.org/

> The Parties share the State's concern about these four significant health issues and are aware of the acute challenges present in this region. The Parties intend for these four issues to be key areas of focus within the scope of the current Community Input Work Groups, as well as included in the Advisory Groups that will work to define the health index for the geographic service area.

The Applicants acknowledge that the New Health System will be responsible for population health in the region for an indefinite period of time. As a result, the New Health System has proposed a plan for development of the Index of Public Advantage and Community Health Improvement that includes input from community stakeholders and the State as outlined in Section 11.j of the Application. Additionally, the Applicants have set forth a proposal for development of this Index in Table 11.7, which identifies the proposed five Key Focus Areas in which the New Health System is committed to investing in community health improvement and which the Applicants propose be included in the Commitment to Community Health Annual Report. Within each Key Focus Area, the Applicants have identified specific Health Concerns that pose an important challenge and priority for health in this region that are aligned with health challenges and priorities identified by the states. The Applicants have also identified a common national measure and a reliable source of data used to track each county's status relative to this Health Concern. These measures provide for comparison with other areas in the states or nationally. The Applicants have proposed a representative investment, intervention or performance improvement that could be implemented by the New Health System to address a specific Health Concern. It is proposed that these be identified in partnership with the State and with regional stakeholders over time as part of the MAPP Community Health Improvement Process described earlier and that several investments, interventions or performance improvements are likely to be necessary to address each concern across the Geographic Service Area. The relevant Accountability Mechanism the Applicants believe reflects the New Health System's performance related to the investment, intervention, or performance improvement is also identified for each Health Concern. The Applicants have proposed a representative progress measure that could be used to measure progress in the Geographic Service Area for this health concern, and finally, the Applicants have identified County level disparities for each Health Concern as measured by the counties in the Geographic Service Area in Tennessee and Virginia that have the lowest/poorest measure. This recognizes the states' concerns that specific areas may warrant particular attention or intervention.

The Applicants seek to engage the COPA Index Advisory Group and the State in the final determination of the measures to be included in the Health Index. The Applicants expect to be held accountable for the commitments outlined in the Application and believe it is the goal of all those involved that the population health of the Geographic Service Area will improve with the New Health System's commitment of substantial resources and improved coordination of new and existing health programs.

Observation #5 - Duplication of Services

As noted in the report, MSHA and WHS currently have "expensive duplications of costs" and plan to reduce duplications post-merger through delivery model integration and "job displacement."[37] Limited detail of these plans is provided.

The department also notes that most other hospital mergers (including the merger of St. Joseph's Hospital and Memorial Mission Hospital in 1995 supervised by the State of North Carolina through a COPA) result in the reduction of the number of full-time equivalent positions.

Department Position:

Pursuant to department rule, the application must include "economic metrics that detail anticipated efficiencies in operating costs and shared services to be gained through the Cooperative Agreement."[38]

To ascertain how efficiencies in operating costs and shared services could potentially impact population health and health care, the department needs additional detail to evaluate the potential benefits and disadvantages of these plans to achieve these cost savings. Specifically, the department will require a good faith estimate of the number of full-time equivalent positions estimated to be eliminated each year, or if none, other plans to achieve stated efficiencies.

Applicants' Response

Section 11.i of the Application details the anticipated efficiencies in operating costs and shared services the Applicants expect to gain through the Cooperative Agreement. As noted on pages 81-82 of the Application, 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. The New Health System, by aligning Wellmont and Mountain State's individual efforts in key service areas, will be able to drive cost savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services. The Applicants commissioned FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm ("FTI Consulting"), to specifically perform an economies and efficiencies analysis regarding the proposed savings and efficiencies to address this question in the Application. As detailed on pages 82-84 of the Application, the economies

[37] Wellmont Health System and Mountain States Health Alliance. Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report. January 2016. p. 8-9.

[38] Tennessee Department of Health Rule 1200-38-01-.02(2)(a)13(ix).

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 findings of the FTI Consulting Report are addressed in the Application on pages 82-83 and copied below for reference:

1. Non-Labor Efficiencies. The Parties have comparable size, and each has multiple facilities. Their purchasing needs are similar, including 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. The larger, combined enterprise of the New Health System will be able to generate significant purchasing economies. These non-labor efficiency savings would include

    - Harmonization to a Common Clinical IT platform
    - Consolidation of purchased services (Blood/Blood products, Anesthesia, Legal, Marketing, Executive Recruitment, etc.)
    - Reductions in unnecessary duplication of Call Pay
    - Reductions in Locum Tenens and use of “Registry Staff”
    - Renegotiations of service, maintenance, and other contracts
    - Reductions in the duplication of subscriptions, memberships, licenses and other similar payments and
    - Added economies and efficiencies gained from the larger size of the New Health System.

    The Parties have identified potential savings from the merger in the areas of non-labor expenses totaling approximately $70 million annually that would not be possible but for the merger. The Non-Labor Efficiencies is "a reasonable estimate" of what can be achieved by the combination. It is characterized by FTI Consulting, and the Parties, as neither "conservative" nor "optimistic."

2. Labor Efficiencies. The workforce is the lifeblood of a health care organization, and the competition for the labor force will remain intense, both locally and regionally. As stated in **Section 6** herein, the majority of outpatient services will not be controlled by the New Health System, and other very significant inpatient providers are located nearby. Thus, the New Health System will remain competitive as it relates to salary and benefit offerings, and will be committed to the ongoing development of its workforce. As discussed in **Section 11.f**, the Parties are committed to their existing workforces and the New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions

within the New Health System. However, with time, including through attrition, the New Health System will reduce 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. The Parties have identified potential savings from the merger in labor expenses totaling approximately $25 million annually. These savings could extend across a variety of departments and areas:

- Administration;
- Biomedical Engineering;
- Patient Access/Registration;
- Finance and Accounting;
- Health Information Management;
- Human Resources;
- Facilities and Maintenance;
- Security;
- Supply Chain; and
- Other departments and areas.

It is very important to note, however, that a significant portion of these savings would be reinvested through financial commitments in the development of the many new programs and services outlined in this Application, including new clinical offerings, behavioral health services, community health improvement initiatives, and academics and research. While national trends in health care will apply in this region and could negatively impact the workforce over time, the Parties strongly believe the net effect of the merger on the health care workforce in the region will be positive rather than negative.

These Labor Efficiencies are considered "conservative" since the savings discussed do not include any clinical personnel, and the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in **Section 11.h.ii**, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

3. Clinical Efficiencies. 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. To ensure that the care delivery decisions of the New Health System are aligned with the interests of the community, the New Health System will adopt a comprehensive Alignment Policy (discussed in **Section 11.h.ii**) that will allow the New Health System to utilize a rigorous, systematic method to evaluate the potential merits and adverse effects related to access, quality and service for patients and make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The clinical efficiencies generated by the Alignment Policy will result in operating efficiencies, improved quality and improved access that would not be accomplished without the merger. The anticipated clinical efficiencies generated by the New Health System are largely driven by the New Health System's ability to align duplicative health care services for better care delivery. Cost-saving and efficiency opportunities for the New Health System include consolidation of the area's two Level I Trauma Centers, consolidation of specialty pediatrics services, repurposing acute care beds and consolidation of certain co-located ambulatory facilities. The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately $26 million annually. Much like the Labor Efficiencies, the Clinical Efficiencies are considered "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in **Section 11.h.ii**, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

The potential savings identified here are limited to the estimated dollar savings from the realignment of services and clinical efficiencies, and do not include the potentially significant benefits that are expected to be achieved through improved access, quality, and care in the optimal locations for access to care that will directly benefit these communities.

The Applicants wish to specifically address the Department's questions about workforce. As detailed on page 83, the Applicants are committed to their existing workforces and the New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions within the New Health System. However, with time, including through attrition, the New Health System will reduce 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. The Applicants do not anticipate any merger-related reductions in force that would trigger federal or state notification obligations. At this time, the Applicants believe that the workforce adjustments can primarily be handled through reassignment of duties and normal attrition.

Additionally, in Section 11.f, beginning on page 67 of the Application, the Applicants address the State's questions about the impact of the merger on the service area's health care industry workforce. The Applicants' expect to achieve substantial efficiencies and reduce unnecessary duplication of services, but it is not anticipated that the overall clinical workforce in the region will decrease significantly. Demand for health professionals is generally driven by patient volumes and varies across the market from time to time. The Applicants recognize that health care workers are in great demand in this particular region, and retaining and developing excellent health professionals in the region will be of utmost importance to the New Health System to ensure the highest clinical quality.

Observation #6 - Reinvestment of Cost Savings

The report does not state whether the estimated $450 million re-investment of cost-savings is a conservative or optimistic projection. The report also does not allow the reader to discern the estimate of the intervals and amounts of savings and subsequent reinvestments planned over the proposed ten year period.

Department Position

To allow the department to evaluate this aspect of public benefit, the application should include a good faith estimate of the expected annual expenditures in each reinvestment category that will be realized each year.

Applicants' Response:

The Applicants addressed this objective in Section 11.i of the Application in the discussion of the anticipated efficiencies in operative costs and shared services the Applicants expect to gain through the Cooperative Agreement. Specifically, the Applicants would like to draw your attention to the following:

At the end of "Non-Labor Efficiencies" section on page 82, the Applicants state:

> The Non-Labor Efficiencies is "a reasonable estimate" of what can be achieved by the combination. It is characterized by FTI Consulting, and the Parties, as neither "conservative" nor "optimistic."

At the end of the "Labor Efficiencies" section on pages 83-84, the Applicants state:

> These Labor Efficiencies are considered "conservative" since the savings discussed do not include any clinical personnel, and the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in Section 11.h.ii, the labor and clinical savings require an institutional process among the stakeholders in the

> community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

At the end of the "Clinical Efficiencies" section on page 84, the Applicants state:

> The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately $26 million annually. Much like the Labor Efficiencies, the Clinical Efficiencies are considered "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in Section 11.h.ii, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.
>
> The potential savings identified here are limited to the estimated dollar savings from the realignment of services and clinical efficiencies, and do not include the potentially significant benefits that are expected to be achieved through improved access, quality, and care in the optimal locations for access to care that will directly benefit these communities.

SECTION 2: DEPARTURE OF ALICE POPE, WELLMONT'S CHIEF FINANCIAL OFFICER

On March 8, 2016, Wellmont Health System announced that Alice Pope, the system's executive vice president and chief financial officer, will become the new chief financial officer for HonorHealth in Scottsdale, Arizona. Pope will continue serving in her Wellmont leadership position, which she has held for 3 ½ years, for the next 60 days and will assist in a smooth transition. She has worked for Wellmont for 16 years, steadily advancing to positions of increasing responsibility. The timing of Pope's announcement was, in part, to allow strategic decisions to be made for Wellmont and for the new health system that would result from the proposed merger of Wellmont and Mountain States Health Alliance if the Application is approved.

In the term sheet and applications for a Certificate of Public Advantage in Tennessee and cooperative agreement in Virginia, Pope was designated to serve as the proposed new health

system's chief financial officer. The chief financial officer position for the proposed new health system will be evaluated by both Applicants given Pope's departure and the Applicants will notify the Department of any decisions by the Applicants that may affect the executive leadership structure of the New Health System or the COPA Application. The change is not expected to impact the proposed merger itself.

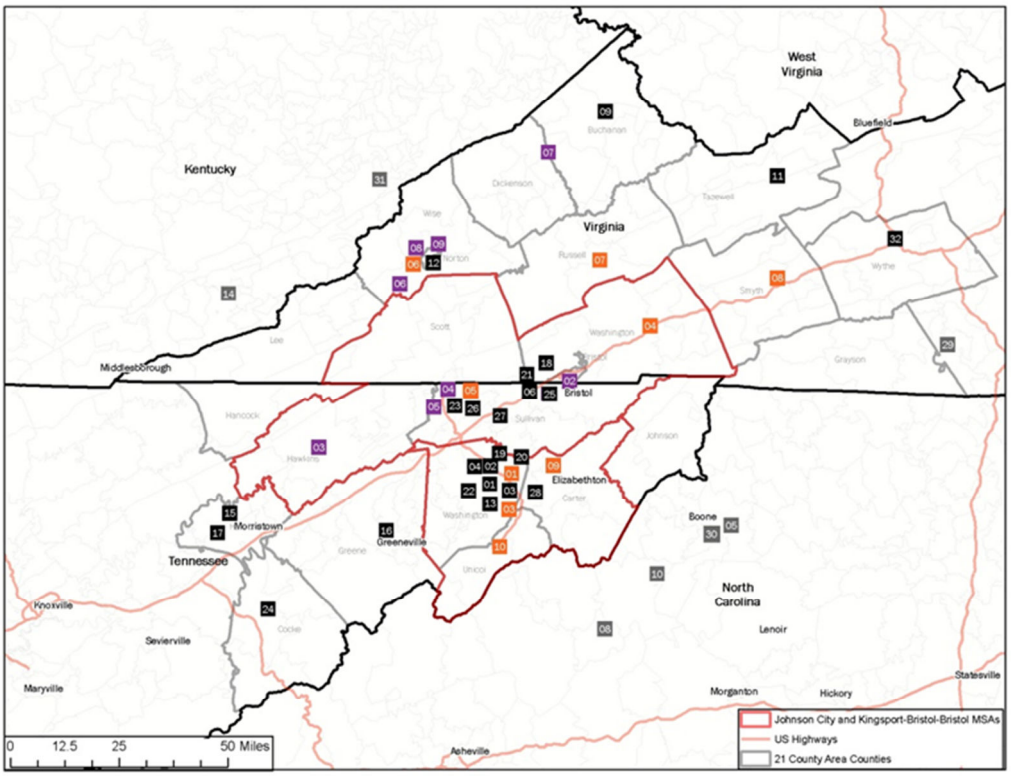
SECTION 3: TECHNICAL CORRECTION TO SECTION 6 OF THE COPA APPLICATION AND ACCOMPANYING EXHIBITS

Section 6 of the Application and Exhibit 6.1D list the Ambulatory Surgical Center Locations and Counts, by System. Among the Ambulatory Surgical Center Locations listed in the Application is the State of Franklin OB/GYN, which is listed as performing surgery in an ASC setting. It has come to the Applicants' attention that the State of Franklin OB/GYN performs in-office surgical procedures but does not have an Ambulatory Surgical Center. To correct this oversight, the Applicants wish to remove the State of Franklin OB/GYN from the list of ASCs. This change will affect the following four sections of the Application:

1) Application Section 6 - pages 25-26

- Delete the following:

> Wellmont and Mountain States each have ambulatory surgery centers ("ASCs")[24] in the area, but fifty-seven percent (57%) are competing facilities. The locations of all area ASCs are shown in Figure 6.3 below. Exhibit 6.1D lists all ASCs serving the Geographic Service Area.[25]
>
> Figure 6.3 – Map of Location of Ambulatory Surgical Centers[26]



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[24] ASCs include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities.

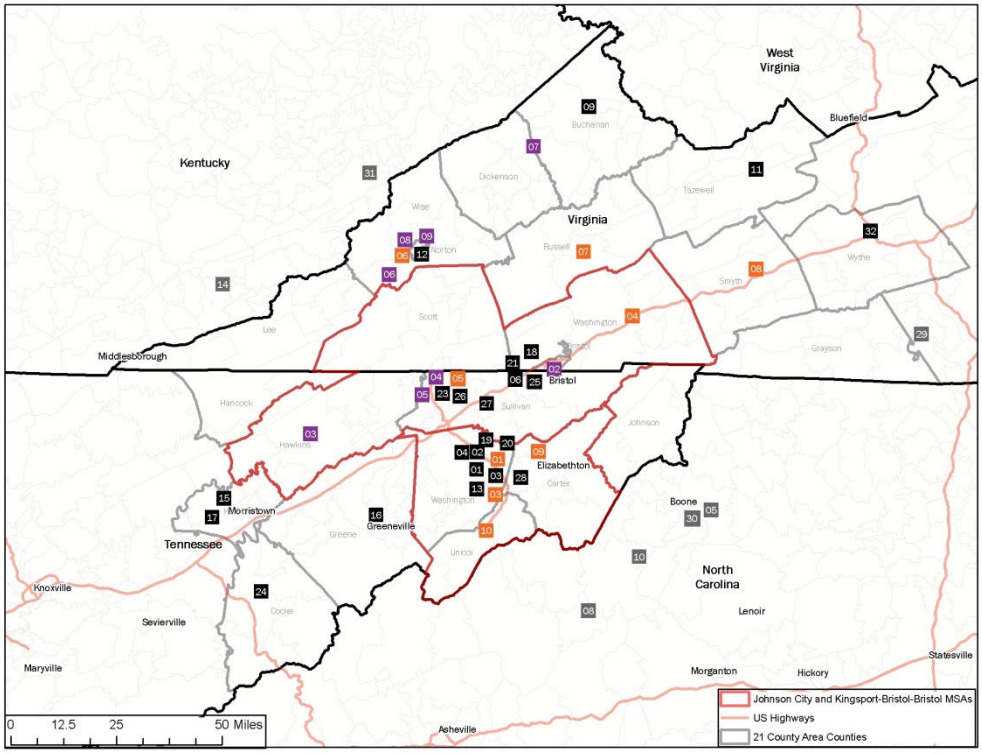
[25] The outpatient facilities listed in Exhibit 6.1D include the outpatient facilities located in the Geographic Service Area and serving the Geographic Service Area.

[26] An enlarged version of the map and the legend are attached as Exhibit 6.1D.

- Replace it with:

Wellmont and Mountain States each offer outpatient surgery services[24] in the area, but fifty-five percent (55%) of the outpatient surgical facilities in the area are operated by competitors of Wellmont and Mountain States. The locations of all area outpatient surgical facilities are shown in **Figure 6.3** below. **Table 11.5** and **Exhibit 6.1A** break out the count and share for each category of outpatient surgical facilities while **Exhibit 6.1D** lists all outpatient surgical facilities serving the Geographic Service Area.[25]

Figure 6.3 – Map of Location of Outpatient Surgical Facilities[26]



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[24] Outpatient surgery services include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities.

[25] The outpatient surgical facilities listed in Exhibit 6.1D include the outpatient surgical facilities located in the Geographic Service Area and serving the Geographic Service Area.

[26] An enlarged version of the map and the legend are attached as Exhibit 6.1D.

2) Application Table 11.5

- Delete the following:

Table 11.5 - Shares of Outpatient Facilities by System

Service Type	WHS & MSHS Combined %	Mountain States	Mountain States-NsCH Affiliate	Wellmont	Non-Managed Joint Venture	All Other	Total
Pharmacy	1.4%	5	0	0	0	349	**354**
Fitness Center	0.0%	0	0	0	0	98	**98**
XRAY	28.3%	14	0	12	0	66	**92**
Nursing Home	7.6%	3	0	2	0	61	**66**
Physical Therapy	6.6%	1	0	3	0	57	**61**
Home Health	16.7%	8	0	2	0	50	**60**
Rehabilitation	39.5%	9	0	8	0	26	**43**
CT	51.2%	12	0	10	0	21	**43**
MRI	43.9%	11	0	7	0	23	**41**
Surgery - Endoscopy	45.2%	9	0	5	0	17	**31**
Urgent Care	50.0%	8	0	8	0	16	**32**
Surgery - Hospital-based	46.7%	9	0	5	0	16	**30**
Dialysis Services	0.0%	0	0	0	0	25	**25**
Wellness Center	14.3%	2	0	1	0	18	**21**
Surgery - ASC	50.0%	2	0	3	4	9	**18**
Chemotherapy	55.6%	4	1	5	0	8	**18**
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	**16**
Radiation Therapy	54.5%	3	0	3	0	5	**11**
Cancer Center	54.5%	3	0	3	0	5	**11**
Weight Loss Center	14.3%	0	0	1	0	6	**7**
Community Center	0.0%	0	0	0	0	6	**6**
Cancer Support Services	0.0%	0	0	0	0	1	**1**
Women's Cancer Services	100.0%	0	0	1	0	0	**1**

Note: Wellmont and Mountain States provide cancer support services at their cancer centers.

- Replace it with:

TABLE 11.5 - SHARES OF OUTPATIENT FACILITIES BY SYSTEM

Service Type	WHS & MSHS Combined %	Mountain States	Mountain States-NsCH Affiliate	Wellmont	Non-Managed Joint Venture	All Other*	Total
Pharmacy	1.4%	5	0	0	0	349	**354**
Fitness Center	0.0%	0	0	0	0	98	**98**
XRAY	28.3%	14	0	12	0	66	**92**
Nursing Home	7.6%	3	0	2	0	61	**66**
Physical Therapy	6.6%	1	0	3	0	57	**61**
Home Health	16.7%	8	0	2	0	50	**60**
Rehabilitation	39.5%	9	0	8	0	26	**43**
CT	51.2%	12	0	10	0	21	**43**
MRI	43.9%	11	0	7	0	23	**41**
Surgery - Endoscopy	45.2%	9	0	5	0	17	**31**
Urgent Care	50.0%	8	0	8	0	16	**32**
Surgery - Hospital-based	46.7%	9	0	5	0	16	**30**
Dialysis Services	0.0%	0	0	0	0	25	**25**
Wellness Center	14.3%	2	0	1	0	18	**21**
Surgery - ASC	60.0%	2	0	3	4	6	**15**
Chemotherapy	55.6%	4	1	5	0	8	**18**
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	**16**
Radiation Therapy	54.5%	3	0	3	0	5	**11**
Cancer Center	54.5%	3	0	3	0	5	**11**
Weight Loss Center	14.3%	0	0	1	0	6	**7**
Community Center	0.0%	0	0	0	0	6	**6**
Cancer Support Services	0.0%	0	0	0	0	1	**1**
Women's Cancer Services	100.0%	0	0	1	0	0	**1**

Note: Wellmont and Mountain States provide cancer support services at their cancer centers.

3) Application Exhibit 6.1 - Attachment A

- Delete the following:

A. All Outpatient Facilities

Service Type	WHS & MSHS Combined %	Mountain States	Mountain States-NsCH Affiliate	Wellmont	Non-Managed Joint Venture	All Other	Total
Pharmacy	1.4%	5	0	0	0	349	**354**
Fitness Center	0.0%	0	0	0	0	98	**98**
XRAY	28.3%	14	0	12	0	66	**92**
Nursing Home	7.6%	3	0	2	0	61	**66**
Physical Therapy	6.6%	1	0	3	0	57	**61**
Home Health	16.7%	8	0	2	0	50	**60**
Rehabilitation	39.5%	9	0	8	0	26	**43**
CT	51.2%	12	0	10	0	21	**43**
MRI	43.9%	11	0	7	0	23	**41**
Surgery - Endoscopy	45.2%	9	0	5	0	17	**31**
Urgent Care	50.0%	8	0	8	0	16	**32**
Surgery - Hospital-based	46.7%	9	0	5	0	16	**30**
Dialysis Services	0.0%	0	0	0	0	25	**25**
Wellness Center	14.3%	2	0	1	0	18	**21**
Surgery - ASC	50.0%	2	0	3	4	9	**18**
Chemotherapy	55.6%	4	1	5	0	8	**18**
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	**16**
Radiation Therapy	54.5%	3	0	3	0	5	**11**
Cancer Center	54.5%	3	0	3	0	5	**11**
Weight Loss Center	14.3%	0	0	1	0	6	**7**
Community Center	0.0%	0	0	0	0	6	**6**
Cancer Support Services	0.0%	0	0	0	0	1	**1**
Women's Cancer Services	100.0%	0	0	1	0	0	**1**

- Replace it with:

A. All Outpatient Facilities

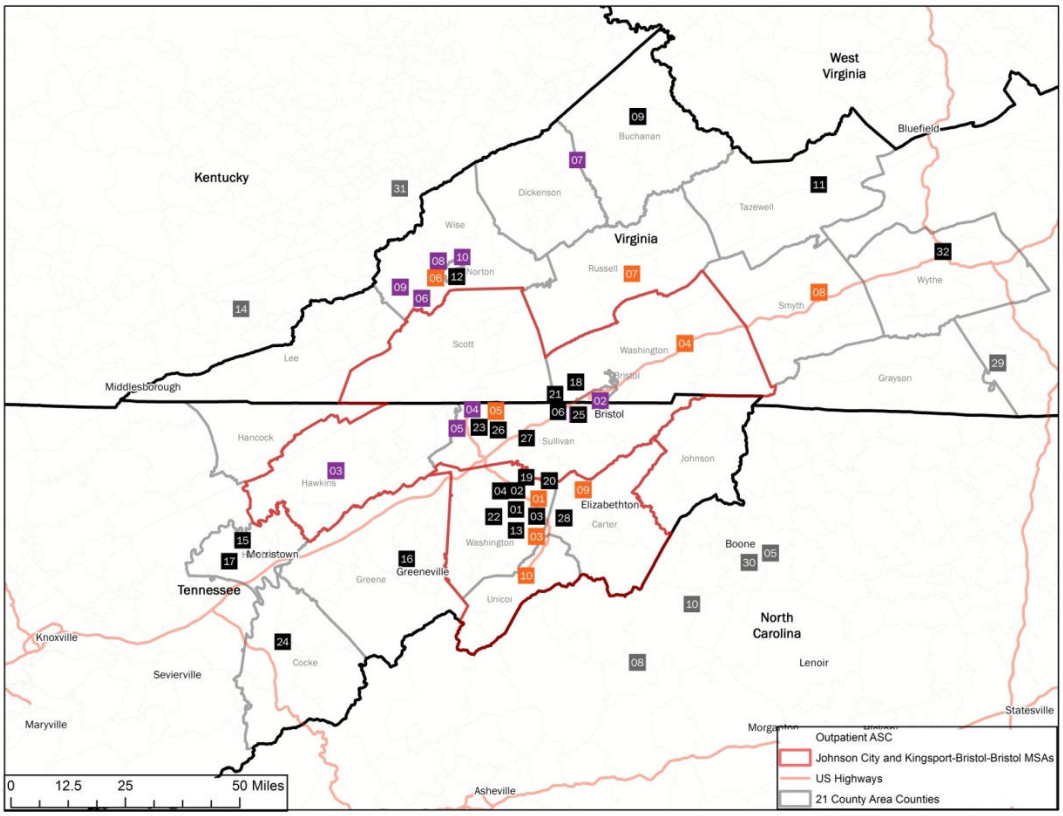
Service Type	WHS & MSHS Combined %	Mountain States	Mountain States-NsCH Affiliate	Wellmont	Non-Managed Joint Venture	All Other*	Total
Pharmacy	1.4%	5	0	0	0	349	**354**
Fitness Center	0.0%	0	0	0	0	98	**98**
XRAY	28.3%	14	0	12	0	66	**92**
Nursing Home	7.6%	3	0	2	0	61	**66**
Physical Therapy	6.6%	1	0	3	0	57	**61**
Home Health	16.7%	8	0	2	0	50	**60**
Rehabilitation	39.5%	9	0	8	0	26	**43**
CT	51.2%	12	0	10	0	21	**43**
MRI	43.9%	11	0	7	0	23	**41**
Surgery - Endoscopy	45.2%	9	0	5	0	17	**31**
Urgent Care	50.0%	8	0	8	0	16	**32**
Surgery - Hospital-based	46.7%	9	0	5	0	16	**30**
Dialysis Services	0.0%	0	0	0	0	25	**25**
Wellness Center	14.3%	2	0	1	0	18	**21**
Surgery - ASC	60.0%	2	0	3	4	6	**15**
Chemotherapy	55.6%	4	1	5	0	8	**18**
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	**16**
Radiation Therapy	54.5%	3	0	3	0	5	**11**
Cancer Center	54.5%	3	0	3	0	5	**11**
Weight Loss Center	14.3%	0	0	1	0	6	**7**
Community Center	0.0%	0	0	0	0	6	**6**
Cancer Support Services	0.0%	0	0	0	0	1	**1**
Women's Cancer Services	100.0%	0	0	1	0	0	**1**

*All Other may include competing facilities located outside of the Geographic Service Area yet serving patients from the Geographic Service Area.

4) Application Exhibit 6.1 - Attachment D

- Delete the following:

D. Ambulatory Surgical Centers



Ambulatory Surgical Centers Outpatient Facilities

Wellmont

01	Bristol Regional Medical Center
02	Bristol Surgery Center
03	Hawkins County Memorial Hospital
04	Holston Valley Medical Center
05	Holston Valley Sugery Center, LLC
06	Lonesome Pine Hospital
07	Sapling Grove ASC
08	Takoma Regional Hospital *(Independent)**
09	Wellmont Loesome Pine Hospital
10	Wellmont Mountain View Regional Medical

MSHA

01	Franklin Woods Community Hospital
02	Indian Path Medical Center
03	Johnson City Medical Center
04	Johnston Memorial Hospital
05	Kingsport Ambulatory Surgery Center
06	Norton Community Hospital
07	Russell County Medical Center
08	Smyth County Community Hospital
09	Sycamore Shoals Hospital
10	Unicoi County Community Hospital

All Other Facilities

01	East Tennessee Ambulatory Surgery Center, LLC**
02	Johnson City Eye Surgery Center**
03	Mountain Empire Surgery Center, LP**
04	TriCities Laser Center**
05	Appalachian Gastroenterology
06	Appalachian Orthopaedic Associates, PC
07	Ashe Memorial Hospital
08	Blue Ridge Regional Hospital
09	Buchanan General Hospital
10	Cannon Memorial Hospital
11	Carilion Tazewell Community Hospital
12	Clinch Valley Medical Center
13	Endoscopy Center of Northeast Tennessee, PC
14	Harlan ARH Hospital
15	Lakeway Regional Hospital
16	Laughlin Memorial Hospital
17	Morristown-Hamblen Healthcare System
18	Mountain Empire Cataract and Eye Surgery Center
19	PMA Surgery Center, LLC
20	Reeves Eye Surgery Center
21	Renaissance Surgery Center
22	State of Frankin OB/GYN Specialists
23	Sullivan Digestive Center
24	Tennova Healthcare - Newport Medical Center
25	The Endoscopy Center of Bristol
26	The Regional Eye Surgery Center
27	Tri Cities Gastroenterology
28	Tri-Cities Outpatient Surgery, LLC
29	Twin County Regional Hospital
30	Watauga Medical Center
31	Whitesburg ARH Hospital
32	Wythe County Community Hospital

* Wellmont sold Takoma Regional Hospital ("Takoma") to Adventist Health System in 2014. Wellmont has publicly announced its plan to repurchase Takoma. However, as of the date of this filing, the transaction has not yet closed and may not close. The Parties anticipate that, if Takoma is acquired by Wellmont before the COPA is granted, that Takoma would be included in the COPA.

** Non-Managed Joint Venture

Ambulatory Surgical Center Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
Total	**Total**			**17**	**31**	**30**
Wellmont	Bristol Regional Medical Center	Sullivan	TN		X	X
Wellmont	Bristol Surgery Center	Sullivan	TN	X		
Wellmont	Hawkins County Memorial Hospital	Hawkins	TN		X	X
Wellmont	Holston Valley Medical Center	Sullivan	TN		X	X
Wellmont	Holston Valley Surgery Center, LLC	Sullivan	TN	X		
Wellmont	Lonesome Pine Hospital	Wise	VA			X
Wellmont	Sapling Grove ASC	Sullivan	TN	X		
Wellmont	Wellmont Lonesome Pine Hospital	Wise	VA		X	
Wellmont	Wellmont Mountain View Regional Medical	Wise	VA		X	X
Wellmont	**Total**			**3**	**5**	**5**
Mountain States	Franklin Woods Community Hospital	Washington	TN		X	X
Mountain States	Indian Path Medical Center	Sullivan	TN		X	X
Mountain States	Johnson City Medical Center	Washington	TN		X	X
Mountain States	Johnston Memorial Hospital	Washington	VA	X	X	X
Mountain States	Kingsport Ambulatory Surgery Center	Sullivan	TN	X		
Mountain States	Norton Community Hospital	Wise	VA		X	X
Mountain States	Russell County Medical Center	Russell	VA		X	X
Mountain States	Smyth County Community Hospital	Smyth	VA		X	X
Mountain States	Sycamore Shoals Hospital	Carter	TN		X	X
Mountain States	Unicoi County Community Hospital	Unicoi	TN		X	X
Mountain States	**Total**			**2**	**9**	**9**
Non-Managed Joint Venture	East Tennessee Ambulatory Surgery Center, LLC	Washington	TN	X		
Non-Managed Joint Venture	Johnson City Eye Surgery Center	Washington	TN	X		
Non-Managed Joint Venture	Mountain Empire Surgery Center, LP	Washington	TN	X		

Ambulatory Surgical Center Locations and Counts, by System

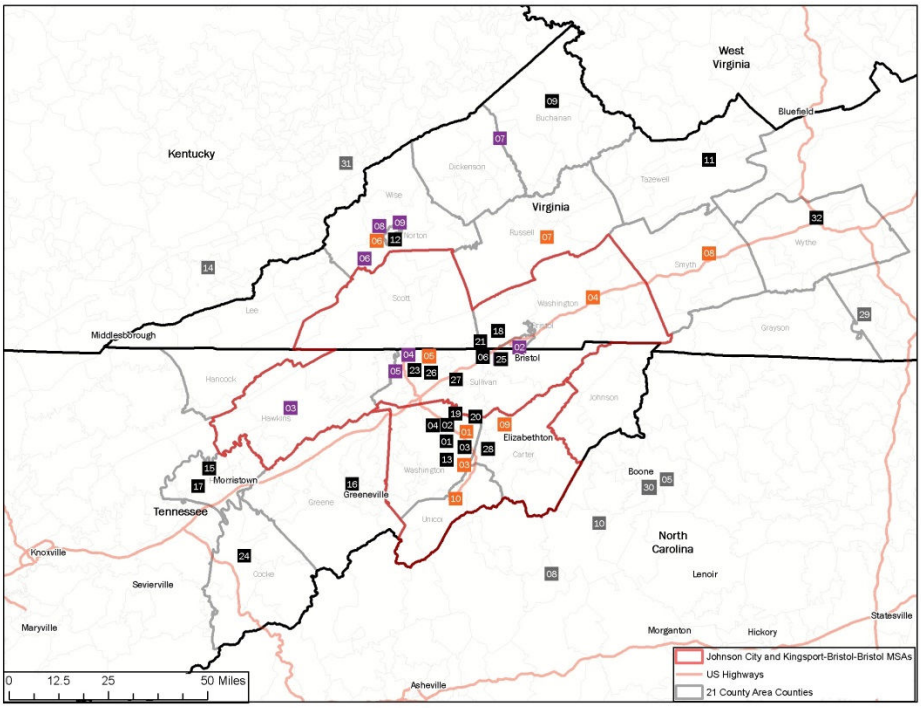
System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
Non-Managed Joint Venture	TriCities Laser Center	Washington	TN	X		
Non-Managed Joint Venture	**Total**			**4**	**0**	**0**
All Other	Appalachian Gastroenterology	Watauga	NC		X	
All Other	Ashe Memorial Hospital	Ashe	NC		X	X
All Other	Blue Ridge Regional Hospital	Mitchell	NC		X	X
All Other	Buchanan General Hospital	Buchanan	VA		X	X
All Other	Cannon Memorial Hospital	Avery	NC		X	X
All Other	Carilion Tazewell Community Hospital	Tazewell	VA			X
All Other	Clinch Valley Medical Center	Tazewell	VA		X	X
All Other	Endoscopy Center of Northeast Tennessee, PC	Washington	TN		X	
All Other	Harlan ARH Hospital	Harlan	KY		X	X
All Other	Lakeway Regional Hospital	Hamblen	TN		X	X
All Other	Laughlin Memorial Hospital	Greene	TN		X	X
All Other	Morristown-Hamblen Healthcare System	Hamblen	TN		X	X
All Other	Mountain Empire Cataract and Eye Surgery Center	Sullivan	TN	X		
All Other	PMA Surgery Center, LLC	Washington	TN	X		
All Other	Reeves Eye Surgery Center	Washington	TN	X		
All Other	Regional Surgical Services	Tazewell	VA	X		
All Other	Renaissance Surgery Center	Sullivan	TN	X		
All Other	State of Franklin OB/GYN Specialists	Washington	TN	X		
All Other	Sullivan Digestive Center	Sullivan	TN		X	
All Other	Takoma Regional Hospital	Greene	TN			X
All Other	Tennova Healthcare - Newport Medical Center	Cocke	TN		X	X
All Other	The Endoscopy Center of Bristol	Sullivan	TN		X	
All Other	The Regional Eye Surgery Center	Sullivan	TN	X		

Ambulatory Surgical Center Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
All Other	Tri Cities Gastroenterology	Sullivan	TN		X	
All Other	Tri-Cities Outpatient Surgery, LLC	Washington	TN	X		
All Other	Twin County Regional Hospital	Grayson	VA			X
All Other	Watauga Medical Center	Watauga	NC		X	X
All Other	Whitesburg ARH Hospital	Letcher	KY		X	X
All Other	Wythe County Community Hospital	Wythe	VA			X
All Other	**Total**			**8**	**17**	**16**

- Replace it with:

D. Outpatient Surgical Facilities*



* Outpatient Surgical Facilities include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities. These facilities are included in the map and table.

Outpatient SurgicalFacilities

Wellmont

01	Bristol Regional Medical Center
02	Bristol Surgery Center
03	Hawkins County Memorial Hospital
04	Holston Valley Medical Center
05	Holston Valley Surgery Center, LLC
06	Lonesome Pine Hospital
07	Sapling Grove ASC
08	Takoma Regional Hospital *(Independent)**
09	Wellmont Mountain View Regional Medical

MSHA

01	Franklin Woods Community Hospital
02	Indian Path Medical Center
03	Johnson City Medical Center
04	Johnston Memorial Hospital
05	Kingsport Ambulatory Surgery Center**
06	Norton Community Hospital
07	Russell County Medical Center
08	Smyth County Community Hospital
09	Sycamore Shoals Hospital
10	Unicoi County Community Hospital

All Other Facilities

01	East Tennessee Ambulatory Surgery Center, LLC***
02	Johnson City Eye Surgery Center***
03	Mountain Empire Surgery Center, LP***
04	TriCities Laser Center***
05	Appalachian Gastroenterology
06	Appalachian Orthopaedic Associates, PC
07	Ashe Memorial Hospital
08	Blue Ridge Regional Hospital
09	Buchanan General Hospital
10	Cannon Memorial Hospital
11	Carilion Tazewell Community Hospital
12	Clinch Valley Medical Center
13	Endoscopy Center of Northeast Tennessee, PC
14	Harlan ARH Hospital
15	Lakeway Regional Hospital
16	Laughlin Memorial Hospital
17	Morristown-Hamblen Healthcare System
18	Mountain Empire Cataract and Eye Surgery Center
19	PMA Surgery Center, LLC
20	Reeves Eye Surgery Center
21	Renaissance Surgery Center
23	Sullivan Digestive Center
24	Tennova Healthcare - Newport Medical Center
25	The Endoscopy Center of Bristol
26	The Regional Eye Surgery Center
27	Tri Cities Gastroenterology
28	Tri-Cities Outpatient Surgery, LLC
29	Twin County Regional Hospital
30	Watauga Medical Center
31	Whitesburg ARH Hospital
32	Wythe County Community Hospital

* Wellmont sold Takoma Regional Hospital ("Takoma") to Adventist Health System in 2014. Wellmont has publicly announced its plan to repurchase Takoma. However, as of the date of this filing, the transaction has not yet closed and may not close. The Parties anticipate that, if Takoma is acquired by Wellmont before the COPA is granted, that Takoma would be included in the COPA.

** Managed Joint Venture

*** Non-Managed Joint Venture

Outpatient Surgical Facility Types, Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
Total	**Total**			**15**	**31**	**30**
Wellmont	Bristol Regional Medical Center	Sullivan	TN		X	X
Wellmont	Bristol Surgery Center	Sullivan	TN	X		
Wellmont	Hawkins County Memorial Hospital	Hawkins	TN		X	X
Wellmont	Holston Valley Medical Center	Sullivan	TN		X	X
Wellmont	Holston Valley Surgery Center, LLC	Sullivan	TN	X		
Wellmont	Lonesome Pine Hospital	Wise	VA		X	X
Wellmont	Sapling Grove ASC	Sullivan	TN	X		
Wellmont	Wellmont Mountain View Regional Medical	Wise	VA		X	X
Wellmont	**Total**			**3**	**5**	**5**
Mountain States	Franklin Woods Community Hospital	Washington	TN		X	X
Mountain States	Indian Path Medical Center	Sullivan	TN		X	X
Mountain States	Johnson City Medical Center	Washington	TN		X	X
Mountain States	Johnston Memorial Hospital	Washington	VA	X	X	X
Mountain States	Kingsport Ambulatory Surgery Center**	Sullivan	TN	X		
Mountain States	Norton Community Hospital	Wise	VA		X	X
Mountain States	Russell County Medical Center	Russell	VA		X	X
Mountain States	Smyth County Community Hospital	Smyth	VA		X	X
Mountain States	Sycamore Shoals Hospital	Carter	TN		X	X
Mountain States	Unicoi County Community Hospital	Unicoi	TN		X	X
Mountain States	**Total**			**2**	**9**	**9**
Non-Managed Joint Venture	East Tennessee Ambulatory Surgery Center, LLC	Washington	TN	X		
Non-Managed Joint Venture	Johnson City Eye Surgery Center	Washington	TN	X		
Non-Managed Joint Venture	Mountain Empire Surgery Center, LP	Washington	TN	X		

Outpatient Surgical Facility Types, Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
Non-Managed Joint Venture	TriCities Laser Center	Washington	TN	X		
Non-Managed Joint Venture	**Total**			**4**	**0**	**0**
All Other	Appalachian Gastroenterology	Watauga	NC		X	
All Other	Ashe Memorial Hospital	Ashe	NC		X	X
All Other	Blue Ridge Regional Hospital	Mitchell	NC		X	X
All Other	Buchanan General Hospital	Buchanan	VA		X	X
All Other	Cannon Memorial Hospital	Avery	NC		X	X
All Other	Carilion Tazewell Community Hospital	Tazewell	VA			X
All Other	Clinch Valley Medical Center	Tazewell	VA		X	X
All Other	Endoscopy Center of Northeast Tennessee, PC	Washington	TN		X	
All Other	Harlan ARH Hospital	Harlan	KY		X	X
All Other	Lakeway Regional Hospital	Hamblen	TN		X	X
All Other	Laughlin Memorial Hospital	Greene	TN		X	X
All Other	Morristown-Hamblen Healthcare System	Hamblen	TN		X	X
All Other	Mountain Empire Cataract and Eye Surgery Center	Sullivan	TN	X		
All Other	PMA Surgery Center, LLC	Washington	TN	X		
All Other	Reeves Eye Surgery Center	Washington	TN	X		
All Other	Renaissance Surgery Center	Sullivan	TN	X		
All Other	Sullivan Digestive Center	Sullivan	TN		X	
All Other	Takoma Regional Hospital	Greene	TN			X
All Other	Tennova Healthcare - Newport Medical Center	Cocke	TN		X	X
All Other	The Endoscopy Center of Bristol	Sullivan	TN		X	
All Other	The Regional Eye Surgery Center	Sullivan	TN	X		
All Other	Tri Cities Gastroenterology	Sullivan	TN		X	

Outpatient Surgical Facility Types, Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
All Other	Tri-Cities Outpatient Surgery, LLC	Washington	TN	X		
All Other	Twin County Regional Hospital	Grayson	VA			X
All Other	Watauga Medical Center	Watauga	NC		X	X
All Other	Whitesburg ARH Hospital	Letcher	KY		X	X
All Other	Wythe County Community Hospital	Wythe	VA			X
All Other	**Total**			**6**	**17**	**16**

** Kingsport Ambulatory Surgery Center is a Managed Joint Venture.

SECTION 4: EXHIBITS 11.4 - ATTACHMENT D AND 11.4 - ATTACHMENT E

Certain exhibits were withheld from the Application because they contained competitively sensitive or confidential information of the Applicants. Among the exhibits withheld were Exhibit 11.4 - Attachment D - Mountain States Covenant Compliance Certificates for the Last Five Years and Exhibit 11.4 - Attachment E - Mountain States Officer's Certificate Accompanying the Independent Auditor's Report for FY10 to FY14.

After further discussions with counsel, Mountain States has determined that these two exhibits (11.4 - Attachment D and 11.4 - Attachment E) should be filed publicly with the Department. The Applicants have attached these exhibits to this Addendum #1 for review by the Department.

The Applicants support the Department's commitment to transparency in reviewing the Application and will continue to work with counsel, the Department, and the Tennessee Attorney General's office to make all information required for the Application available to the Department while respecting federal antitrust laws.