

APPLICATION

CERTIFICATE OF PUBLIC ADVANTAGE

STATE OF TENNESSEE

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: February 16, 2016

FEBRUARY, 2016

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1. EXECUTIVE SUMMARY

REQUEST: The Executive Summary shall include:

- (i) Goals for change to be achieved by the Cooperative Agreement;
- (ii) Benefits and advantages to parties and the public including but not limited to:
 - (I) Population health;
 - (II) Access to health care and prevention services; and
 - (III) Health care operating costs, including avoidance of capital expenditures, reduction in operating expenditures and improvements in patient outcomes.
- (iii) Description of how the Cooperative Agreement better prepares and positions the parties to address anticipated future changes in health care financing, organization and accountability initiatives; and
- (iv) Potential disadvantages of the Cooperative Agreement.

RESPONSE: Wellmont Health System ("Wellmont") and Mountain States Health Alliance ("Mountain States") (collectively, the "Parties") are formally submitting this application to the Tennessee Department of Health to request the issuance of a Certificate of Public Advantage ("COPA") under Tennessee Code Section 68-11-1301 *et seq.*

The Process.

Two years ago, Wellmont began an internal evaluation of Wellmont's strategic and financial position, industry trends, and the organization's goals for the future of health care within its service area. Wellmont entered the process from a position of clinical strength and relative financial stability, but recognized that it needed to be prepared for financial pressures, regulatory mandates, and imperatives for change. The important and increased need for investment in population health, management of information and measurable improvement in cost and quality, combined with continued downward pressure on reimbursement from government and commercial payers compelled the Wellmont Board to thoroughly evaluate its strategic options. Wellmont's Board evaluated all reasonable options with the objective of sustaining community assets vital to the region while achieving high quality patient care at the lowest possible cost. Wellmont was not alone. Hospital systems throughout the nation have undergone strategic options reviews, with many choosing a traditional merger or consolidation in hopes of surviving in this challenging environment – an environment which has seen

more than 60 rural hospitals close since 2010.¹ Four of Wellmont's six hospitals are rural, and have below 50 staffed beds, each with a daily census ranging from 3 to 13. Seven of the Mountain States hospitals are rural, and have below 50 staffed beds, each with a census ranging from 1 to 35. The overwhelming number of assets between the two systems are rural.

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.

After a thorough evaluation, Wellmont's Board of Directors and leadership team ultimately determined that Wellmont's future would be best served through a strategic alignment with another health care system. In April 2014, Wellmont began a strategic options process to further consider alternatives to fulfill its long-term health care mission through potential alignment options. Wellmont issued requests for proposals from organizations interested in strategic alignment and received substantial interest and a number of proposals from a variety of sophisticated health systems, including Mountain States. Based on inquiries, the health system issued twenty-two requests for proposals and received nine proposals from other health systems. After 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, Wellmont entered into a term sheet with Mountain States in April, 2015 to exclusively explore the creation of a new, integrated and locally governed health system (the "New Health System").

Wellmont and Mountain States have a history of competition dating back to the formation of the two health systems in the late 1990s, and the decision to form the New Health System is not based on a traditional merger approach. This merger is contingent on the granting of a Certificate of Public Advantage by the State of Tennessee and a Letter Authorizing a Cooperative Agreement by the Commonwealth of Virginia (collectively the "State Agreements"). Without the State Agreements, the proposed consolidation of Wellmont and Mountain States, would likely be challenged under state and federal antitrust laws. The Parties believe that this merger is the only model that

¹ See *66 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/rural-health/rural-hospital-closures/> (accessed January 25, 2016).

effectively maintains local governance, provides a unique opportunity to sustain and integrate health care delivery for residents into a high-quality and cost-effective system, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in the region, and invests those dollars in the improved health of this region while also preserving local jobs.

The Goals to be Achieved by the Cooperative Agreement.

The Parties' goal in pursuing the merger is to reduce cost growth, improve the quality of health care services and access to care, including the patient experience of care, and enhance overall community health in the region. Under approved State Agreements, savings realized through the merger, by reducing duplication and improving coordination, will remain within the region and be reinvested in ways that significantly benefit the community through the addition of new services and capabilities, improved choice and access, effective management of costs and investment in improving the quality of health care and economic development in the region. All of these investments will be devoted to Northeast Tennessee and Southwest Virginia to focus on improving the health of this region's residents and the economy of its communities. As examples, the New Health System will:



Invest not less than \$75 million over ten years in population health improvements, committed through a regional ten-year plan



Invest not less than \$140 million over ten years to expand mental health, addiction recovery, and substance abuse prevention programs; develop both healthcare- and community-based resources for children's health across the region; meet regional physician needs and address service gaps and preserve and expand rural services and access points



Invest not less than \$85 million over ten years to develop and grow academic and research opportunities, support post-graduate healthcare training, and strengthen the pipeline and preparation of nurses and allied health professionals



Invest approximately \$150 million over ten years to facilitate the regional exchange of health information among participating providers and to establish an electronic health record system within the New Health System that ensures a common platform and interoperability among its hospitals, physicians, and related services

The Benefits and Advantages of the Cooperative Agreement.

- **Population Health.** The New Health System is committed to creating a new integrated delivery system designed to significantly enhance community health through the investment of not less than \$75 million over ten years in population health improvement. The New Health System would commence the population health improvement process by preparing a comprehensive community health improvement plan that identifies the key strategic health issues for its focus over the next decade. The health improvement plan would be prepared in conjunction with the public health resources available at East Tennessee State University. The funding may be committed to the following initiatives, as well as others, based upon the 10-year action 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.²
 - ***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.
- **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 allow the hospitals the opportunity to continue to offer programs and services that are now unprofitable and otherwise may have to be reduced or cancelled due to lack of funding. The New

² In May 2010, the Annie E. Casey Foundation published *Early Warning: Why Reading by the End of Third Grade Matters*, which summarized the research basis for focusing on grade-level reading proficiency as an essential step toward increasing the number of children who succeed academically, graduate from high school on time and do well in life and the workforce. <http://www.aecf.org/resources/early-warning-confirmed/>.

Health System will commit to spending at least \$140 million over ten years pursuing specialty services. Specifically, the New Health System will 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.

- Improving Health Care Value. 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 merger offers the New Health System the opportunity to use resources derived from efficiencies and a regionally integrated delivery model to reduce overutilization of inpatient services in the region and stem the pace of health care cost growth for patients, employers and insurers. To ensure that merger-derived savings realized by reducing duplication and improving coordination will stay within the region and be reinvested in ways that substantially benefit the community by the addition of new services and capabilities, the New Health System is prepared to make significant commitments related to pricing, consolidation of services, and standardization of practices, all of which are described in more detail in this Application.
- Investment in Health Research and Graduate Medical Education. The New Health System will work with its academic partners to commit not less than \$85 million over ten years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty – all critical to sustaining an active and competitive training program. Partnerships with academic institutions will enable research-based and academic approaches to the provision of these services. These initiatives would not be sustainable in the region without the financial support created by the merger.
- Avoidance of Duplication of Hospital Resources. Combining these two health systems in an integrated delivery model is the only effective 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 produce 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 by adding research opportunities. The coordination, integration, sustainability and development of new models of care delivery made possible by the merger will lead to better health for local residents and a stronger local economy.

- Improvements in Patient Outcomes. The region served by the Parties faces significant health care challenges. A key goal of the Cooperative Agreement is to enable the Parties to sustain and enhance services and improve the quality of health care and patient outcomes. The New Health System is committed to implementing a common clinical information technology platform (the "Common Clinical IT Platform") to allow providers in the New Health System the ability to obtain full access to patient records quickly at point of care, supporting the regional exchange of health information to encourage and support patient and provider connectivity to the New Health System's integrated information system, establishing a system-wide physician-led clinical council responsible for implementing quality performance standards across the New Health System, and publicly reporting extensive quality measures with respect to the performance of the New Health System, to promote transparency and further incentivize the provision of high quality care. These commitments will result in the investment of approximately \$150 million over ten years to ensure a Common Clinical IT Platform and interoperability among the New Health System's hospitals, physicians, and related services.
- Preservation of Hospital Facilities in Geographical Proximity to the Patients They Serve. The Parties recognize that it will be increasingly difficult to continue supplementing rural facilities over the long-term without the savings the proposed merger would create. Continued access to appropriate hospital-based services in the rural areas of these communities is a significant priority and a driving impetus for the Cooperative Agreement. Last year alone, Mountain States and Wellmont collectively invested over \$19.5 million to ensure that inpatient services continued to remain available in these smaller communities. To address this, the New Health System will commit that all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. To ensure higher-level services are available in close proximity to where the population lives, the New Health System will also commit to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol. The proposed Cooperative Agreement is the only means to achieve the efficiencies and generate the resources needed to sustain rural hospital operations in these areas and thus enhance access to quality care in our rural communities.

- Enhanced Behavioral Health & Substance Abuse Services. In the region the Parties serve, behavioral health problems and substance abuse are prevalent, imposing an extensive societal cost that warrants priority attention. The largest diagnosis related to regional inpatient admissions is psychoses, yet significant gaps exist in the continuum of care devoted to these issues. As part of the public benefit associated with the merger, the New Health System commits to make major investments in programs and partnerships to help address and ameliorate behavioral and addiction problems.

How the Cooperative Agreement Best Positions the Parties to Address Anticipated Future Changes in Health Care Financing, Organization and Accountability Initiatives.

Wellmont and Mountain States believe the formation of the New Health System will greatly accelerate the move from volume-based health care to value-based health care. The Affordable Care Act, which was enacted in 2010, is moving providers away from the fee-for-service reimbursement system toward a risk-based model that rewards improved patient outcomes and incentivizes the provision of higher-value care at a lower cost. However, the movement to value-based payment requires comprehensive provider networks to form and contract for the total care of patients for a defined population. The formation of the New Health System will align the region's hospitals and related entities into one seamless organization, working together to enter into value-based contracts. As evidence of its commitment to move towards risk-based payment, the New Health System is willing to: include provisions for improved quality and other value-based incentives for all Principal Payer³ contracts; discuss risk-based models with its Principal Payers for some portion of each Principal Payer's business; and commit to having a risk-based model in place within two years after the closing of the transaction (the "Closing"), subject to payer interest.

Potential Disadvantages of the Cooperative Agreement.

The Parties do not foresee any adverse impacts on population health, quality, access, availability or cost of health care to patients and payers as a result of the Cooperative Agreement. Rather, the Parties foresee the Cooperative Agreement resulting in significant benefits as detailed in this Application.

³ For purposes of this Application, "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.

A Unique Solution for a Unique Region.

Northeast Tennessee and Southwest Virginia disproportionately suffer from serious health issues.⁴ The cost of this poor health is not sustainable. This region is a unique geographic area that requires a unique solution. With the approvals of Tennessee and Virginia under the State Agreements, savings realized by reducing duplication and improving coordination will remain within the region and be reinvested in ways that substantially benefit the community. These benefits will include new services and capabilities, improved choice and access; more effective management of health care costs, and strategic investments to address the region's most vexing health problems while spurring its economic development.

The merger of Wellmont and Mountain States is a unique opportunity to create a long-lasting legacy of improved health for this region with positive effects on the local economy.

⁴ 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/>.

2. IDENTIFICATION OF THE PARTIES

REQUEST: Provide the names of each party to the Application and the address of the principal business office of each party.

RESPONSE:

Legal Name of Applicant #1.

Mountain States Health Alliance
FEIN: 62-0476282

Address of Principal Business Office for Applicant #1.

Alan Levine, President & CEO
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604

Legal Name of Applicant #2.

Wellmont Health System
FEIN: 62-1636465

Address of Principal Business Office for Applicant #2.

Bart Hove, President & CEO
1905 American Way
Kingsport, Tennessee 37660

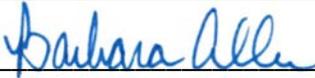
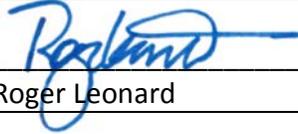
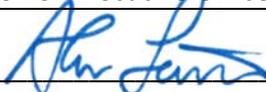
Throughout this Application, the parties listed above are referred to individually as a "Party" and collectively as the "Parties."

3. VERIFIED STATEMENT

REQUEST: Provide a verified statement signed by the Chairperson of the Board of Directors and Chief Executive Officer of each party to the Application; or, if one or more of the Applicants is an individual, signed by the individual Applicant; attesting to the accuracy and completeness of the enclosed information.

RESPONSE: The undersigned hereby verifies that:

- a. it is the intent of the parties to enter into the Cooperative Agreement as presented in this application;
- b. the parties hereby apply for a Certificate of Public Advantage to govern the Cooperative Agreement; and
- c. that the information included in this application and all attachments is accurate and complete to the best of our knowledge and belief and that it is our intent to carry out the proposed agreement.

Mountain States Health Alliance Chairman of the Board	Wellmont Health System Chairman of the Board
 Barbara Allen	 Roger Leonard
Mountain States Health Alliance President & Chief Executive Officer	Wellmont Health System President & Chief Executive Officer
 Alan Levine	 Bart Hove

4. PRIOR HISTORY OF APPLICANTS

REQUEST: Provide a description of the prior history of dealings between the parties to the Application, including, but not limited to, their relationship as competitors and any prior joint ventures or other collaborative arrangements between the parties.

RESPONSE:

Description of Mountain States Health Alliance

Mountain States Health Alliance (“Mountain States”) is a Tennessee non-profit corporation based in Johnson City, Tennessee. It traces its roots back over one hundred years, and became a system in 1998 when the then Johnson City Medical Center Hospital, Inc., a one-hospital organization, acquired from the former Columbia-HCA six hospitals located in upper East Tennessee, thus forming Mountain States. In 2006 Mountain States acquired a membership interest in Smyth County Community Hospital in Marion, Virginia, which began Mountain States’ journey as a multi-state health care system. Since 2006, Mountain States has acquired or become a member of four other hospitals in the Southwest Virginia region.

Throughout its multi-state service area, Mountain States functions as an integrated delivery system. Its thirteen hospitals collectively offer a range of services from the most basic primary level of care through two critical access facilities to highly advanced tertiary levels of care such as Level I trauma, open heart and radiation oncology. Through its for-profit subsidiaries, Mountain States employs approximately four hundred physicians and mid-level providers throughout the region. Also, Mountain States, either directly or through its for-profit subsidiaries, provides an array of outpatient and/or post-acute care services, including: pharmacy; home health; hospice; durable medical equipment; diagnostics; skilled nursing/nursing home; and rehabilitation. Additionally, Mountain States owns and operates the region’s only children's hospital: Niswonger Children's Hospital.

Mountain States’ hospitals provide services with a total licensed bed complement of 1,669 beds⁵ but with an average daily census of 734 for FY2013. The Tennessee hospitals owned and/or operated by Mountain States are: Johnson City Medical Center; Niswonger Children's Hospital;⁶ Indian Path Medical Center; Franklin Woods Community Hospital; Sycamore Shoals Hospital; Unicoi County Memorial Hospital; Johnson County Community Hospital; and Woodridge Hospital.⁷ Mountain States also has a joint venture with HealthSouth to operate Quillen Rehabilitation Hospital where 26 rehab beds

⁵ This number includes Mountain States' general acute care beds, psychiatric beds, rehab beds, nursing home beds and skilled nursing beds.

⁶ Niswonger Children’s Hospital is licensed under Johnson City Medical Center.

⁷ Woodridge Hospital is also licensed under Johnson City Medical Center.

currently exist. In Virginia, Mountain States owns and/or operates: Johnston Memorial Hospital; Smyth County Community Hospital; Russell County Medical Center; Norton Community Hospital and Dickenson Community Hospital. Mountain States also holds an ownership interest in a number of joint venture entities, primarily for the purpose of providing ambulatory surgical services. None of these joint ventures include Wellmont Health System.

Description of Wellmont Health System

Wellmont Health System (“Wellmont”) is a Tennessee non-profit corporation based in Kingsport, Tennessee, and provides health care services in Northeast Tennessee and Southwest Virginia. Wellmont was formed in July 1996 with the merger of Bristol Memorial Hospital, now known as Bristol Regional Medical Center, in Bristol, Tennessee and Holston Valley Medical Center in Kingsport, Tennessee. Since that time, Wellmont has grown to include four additional rural hospitals, an integrated physician network and several ambulatory sites. Wellmont hospitals offer a broad scope of services, including community-based acute care to highly specialized tertiary services including two trauma centers, comprehensive heart care and cancer care.

Wellmont owns and operates an integrated health care delivery system providing inpatient, outpatient and other health care services at multiple locations in Northeast Tennessee and Southwest Virginia. Currently, Wellmont owns and operates five acute care hospital facilities and one critical access hospital with a total of 1,011 licensed beds but with an average daily census of 430 for FY2013. The Tennessee hospitals owned/operated by Wellmont in Tennessee include: Holston Valley Medical Center; Bristol Regional Medical Center; Hawkins County Memorial Hospital; and Hancock County Hospital. In Virginia, Wellmont owns and/or operates: Mountain View Regional Medical Center and Lonesome Pine Hospital.

Wellmont also, directly or indirectly, controls, owns or is affiliated with various nonprofit and for-profit corporations and other organizations that currently provide health care and health care-related services throughout the service area.

History of Dealings between the Parties

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. Prior to the merger of Holston Valley and Bristol Regional into Wellmont and the acquisition of HCA hospitals by Johnson City Medical Center, which formed Mountain States, those three tertiary facilities were viewed largely as serving their individual cities and adjacent areas. Since the formation of the two systems, each system subsequently acquired smaller primary and secondary facilities, and has served a region composed of twenty-one counties in southwestern Virginia and northeastern Tennessee. The two systems offer essentially equivalent levels of services in their respective tertiary and

secondary hospital facilities. In addition, both systems have historically affiliated with separate air ambulance services and operate competing Level I Trauma Centers. In addition, Wellmont has a Level II Trauma Center located in Northeast Tennessee, which is the only region of the state having more than one Level I trauma center. Although there is some overlap in the primary market areas of the three large tertiary facilities, the main overlap in competitive services has occurred in two areas: (1) Wise County, Virginia, where Wellmont owns two secondary acute care hospitals and Mountain States owns one hospital; and (2) Kingsport, Tennessee, where Mountain States' secondary acute care facility Indian Path Medical Center competes with Holston Valley Medical Center, Wellmont's largest tertiary facility.

In the early 2000s, Wellmont applied for and initially was awarded a certificate of need ("CON") to construct a secondary hospital facility in Johnson City, but that CON was overturned following a challenge to the CON by Mountain States. Wellmont's 2007 CON application for a free-standing Emergency Room to be located on the northern boundary of Johnson City was denied following opposition by Mountain States. Beginning in 2012, Wellmont and Mountain States competed in a public contest for the acquisition of Unicoi County Memorial Hospital; ultimately, Mountain States acquired that facility in 2013.

The Parties have attempted to collaborate with respect to quality improvement methodologies and related projects but have been unsuccessful due to the competitive environment, the inability to share proprietary information, and the lack of a common clinical information system.

There have also been examples of cooperative arrangements between the Parties as follows:

- In 2004, the foundations for the two systems worked together to start the first regional Susan G. Komen affiliate.
- For several years now, hospitals from both systems have been members of the Northeast/Sullivan Healthcare Coalition to utilize annual grant funds from the Tennessee Department of Health to prepare the region for disasters and health emergencies. The two health systems are currently alternating annually as fiscal agents for the \$250,000 per year in grant funds for this project.
- Since 2008, Wellmont has provided blood services to certain Mountain States facilities through its blood bank, the Marsh Regional Blood Center.
- The two systems collaborated in 2014 in their joint responses to the Ebola awareness and preparedness campaigns and have jointly sponsored other community health awareness efforts, such as the Healthy Kingsport initiative.

- Recently, Wellmont has added Indian Path Medical Center as a satellite site to its Orthopedic Residency Program and has allowed Mountain States/Norton Community Hospital Internal Medicine residents the opportunity to complete their endocrinology rotations at Bristol Regional Medical Center.
- Also, the two systems are currently working together to provide an Antibiotic Stewardship educational program for providers and the community.
- In addition, in cooperation with the College of Public Health at East Tennessee State University ("ETSU") and in connection with the parties' goal to improve health care services through a cooperative agreement, the parties have jointly sponsored and funded the region's most substantial community health improvement assessment effort to date. Four Community Health Work Groups have been created to specifically focus on the health needs in the region, including Mental Health and Addiction, and Healthy Children and Families. Numerous public meetings have been held to seek community input. Mutual efforts directly related to this proposed merger are discussed more fully herein in **Section 8.G**.

5. PROPOSED GEOGRAPHIC SERVICE AREA

REQUEST: Provide a detailed description of the proposed geographic service area, not limited to the boundaries of the State of Tennessee. If the proposed geographic service area differs from the service areas where the parties have conducted business over the five years preceding the Application, a description of how and why the proposed geographic service area differs and why changes are proposed.

RESPONSE: The proposed Geographic Service Area takes into consideration the counties principally served by the Parties, including the following counties: Carter, Cocke, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington in Tennessee; Ashe, Avery, Madison, Mitchell, Watauga, and Yancey in North Carolina; Harlan and Letcher in Kentucky, and Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe in Virginia. These counties represent the service areas where the Parties have conducted business over the five years preceding the Application. These counties are inclusive of the areas from which the Parties draw and serve the majority of patients. While the Parties serve patients from twenty-nine counties in Tennessee, Virginia, North Carolina, and Kentucky, the patients only receive services from Wellmont and Mountain States at facilities and locations in Tennessee and Virginia, as the Wellmont and Mountain States physical facilities and provider locations are all in those two states and are subject to state regulations only in these states. To the extent the Parties draw some patients from adjacent North Carolina and Kentucky counties, these patients are served at the Parties' facilities and provider locations in Tennessee and Virginia.

In defining the Geographic Service Area for purposes of this Application and specifically for responses to a broad range of questions that request a single geographic area, the Parties believe it appropriate to focus on an area of the twenty-one counties in Tennessee and Virginia.⁸ This is inclusive of the Tennessee and Virginia counties in which the Parties have locations and facilities and serve residents, and all locations and providers that will be under the control of the Parties and subject to any regulation under the COPA or Cooperative Agreement. This area is inclusive of most of the population, whether commercial, Medicare, Medicaid, or uninsured, served by the Parties.

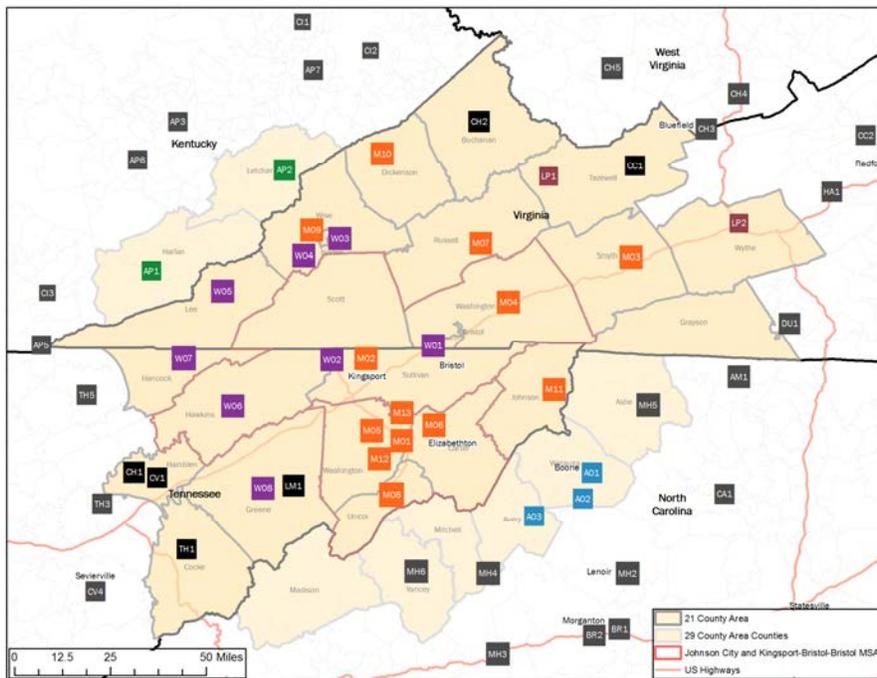
The Parties expect that the benefits of the transaction will primarily accrue in the Tennessee and Virginia counties and will likely extend to residents and communities in the adjacent North Carolina and Kentucky communities primarily through their access of services in Tennessee and Virginia. These benefits are likely to derive substantially from the changes made possible by the transaction at the facilities and provider locations of

⁸ These 21 counties are: Carter, Cocke, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington in Tennessee and Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe (including the Independent Cities of Bristol and Norton) in Virginia.

the New Health System located in Tennessee and Virginia, as well as the investments made by the New Health System in this region.

For purposes of the analyses in this Application, including share analysis and identification of competitors, the Parties focus on the twenty-one county area in Virginia and Tennessee principally served by the Parties, including the independent cities of Bristol and Norton in Virginia (the "Independent Cities"), and refer to this area throughout the Application as the "Geographic Service Area." **Figure 5.1** is the map of the Geographic Service Area indicating the location of hospitals and highlights the twenty-one (21) counties in Tennessee and Virginia.

Figure 5.1 - Map of the Geographic Service Area⁹



Rural Population: The Geographic Service Area within Virginia and Tennessee has a population over 960,000. Its largest cities are Bristol, Kingsport, and Johnson City. In the

⁹ An enlarged version of the map and the legend are attached as **Exhibit 5.1**. Wellmont closed Lee Regional Medical Center ("LRMC") in 2013. The Lee County Hospital Authority purchased the LRMC building from Wellmont in 2015 with plans to reopen the hospital as an independent facility. LRMC is no longer a Wellmont facility and, if reopened, it would not be included in the COPA. 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. For purposes of this map, Takoma (W08) is counted as one of the independent hospitals. The Mountain Home VA Medical Center is also located in the Geographic Service Area but is not shown on this map. The Parties compete with this facility for the recruiting and hiring of staff, but do not compete with this facility for patients. The patients that may seek treatment at the Mountain Home VA Medical Center are limited to those individuals that meet certain government-established criteria.

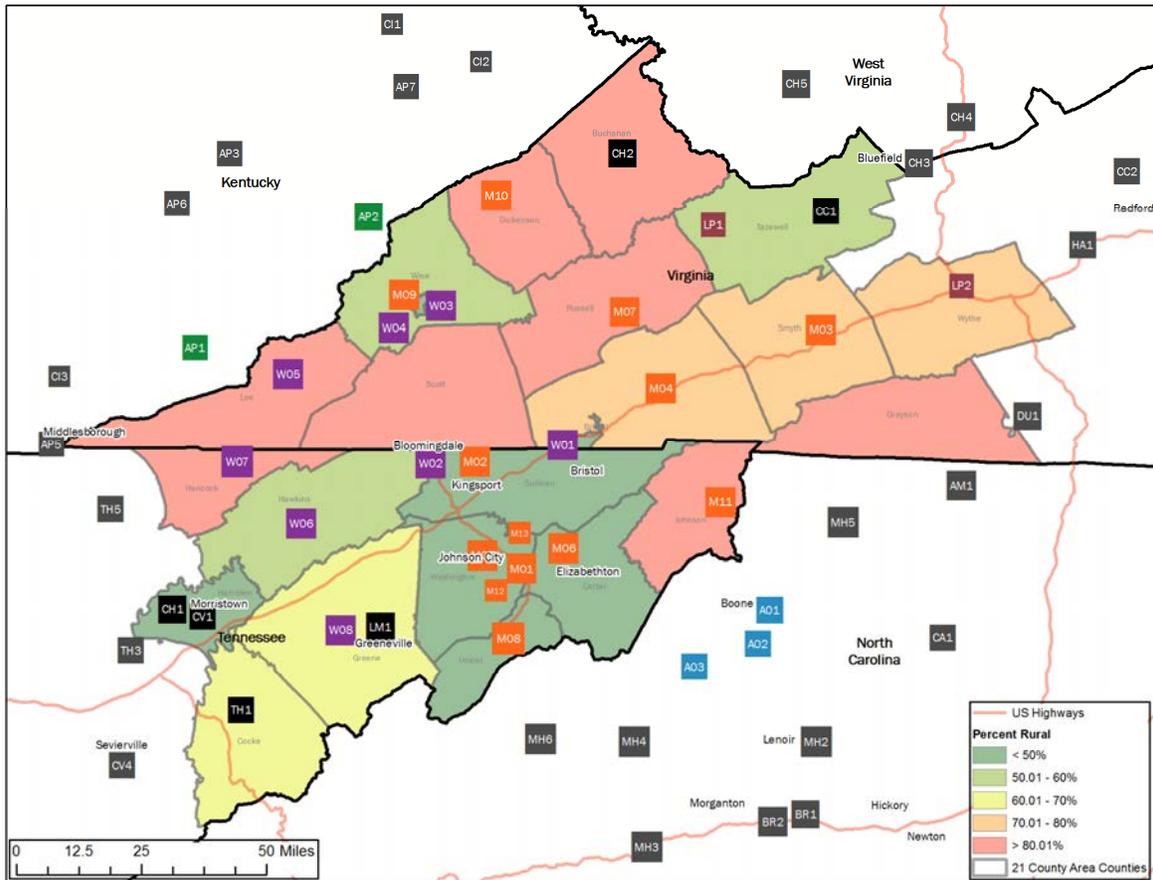
Geographic Service Area, over 500,000 residents (52%) live in areas defined as rural. **Table 5.1** provides data on population, the proportion of the county/Independent Cities in the Geographic Service Area classified as rural, and the total “rural” population.¹⁰ The data reveal that many of the counties/Independent Cities in the Geographic Service Area served by Wellmont and Mountain States are predominantly rural. Even in the two most populous counties (Washington and Sullivan Counties in Tennessee) a quarter or more of the population resides in rural areas. In total, sixteen of the counties in the Geographic Service Area (excluding the Independent Cities) are more than 50% rural, and in five counties virtually all of the population is classified as rural. **Figure 5.2** is a map with counties shaded by proportion of the population that is rural; it indicates that most of the Virginia counties are predominantly rural, as are all but a few counties in and around Sullivan and Washington Counties in Tennessee.

Table 5.1 – Geographic Service Area Statistics

County Name	Total Population	Percent Rural	Rural Population
Grand Total	962,309	52.0%	500,270
Hancock, TN	6,819	100.0%	6,819
Buchanan, VA	24,098	100.0%	24,098
Dickenson, VA	15,903	100.0%	15,903
Grayson, VA	15,533	99.9%	15,514
Lee, VA	25,587	99.6%	25,475
Russell, VA	28,897	88.2%	25,483
Johnson, TN	18,244	85.2%	15,546
Scott, VA	23,177	82.1%	19,034
Smyth, VA	32,208	75.3%	24,248
Wythe, VA	29,235	75.3%	22,023
Washington, VA	54,876	71.7%	39,333
Cocke, TN	35,662	67.5%	24,083
Greene, TN	68,831	65.2%	44,874
Hawkins, TN	56,833	57.9%	32,884
Wise, VA	41,452	56.7%	23,491
Tazewell, VA	45,078	51.9%	23,390
Unicoi, TN	18,313	44.7%	8,180
Carter, TN	57,424	41.0%	23,524
Washington, TN	122,979	26.4%	32,493
Sullivan, TN	156,823	25.6%	40,086
Hamblen, TN	62,544	21.9%	13,680
Norton City, VA	3,958	2.6%	102
Bristol City, VA	17,835	0.0%	7

¹⁰ All reported measures were obtained from the US Department of Health and Human Services' Area Health Resource File, a dataset that compiles data collected by other entities; available at: <http://ahrf.hrsa.gov/>. Total Population is from the U.S. Census Bureau's 2010 Census Redistricting Data (Public Law 94-171) Summary File. Rural residency is available from the Census of Population and Housing: Summary File 1 (SF1) Urban/Rural update.

Figure 5.2 - Percentage of Population in Rural Areas



Characteristics of Hospitals: Many of the Parties' hospitals are small, rural, have only a few beds and experience a very small average daily census. The service area and comparative statistics for Wellmont and Mountain States hospitals are attached in **Exhibit 5.1**. It illustrates that many Wellmont and Mountain States hospitals have a narrow service area (defined as comprising relatively few zip codes from which the hospital draws 75-90% of its patients), low staffed bed count and very low average daily census. Several of these hospitals have experienced declines in admissions, occupancy rates and average daily census over the last few years. Moreover, there is very little overlap in the geographic service areas of the smaller Wellmont hospitals and the smaller Mountain States hospitals.

Tables 5.2 and 5.3 demonstrate that licensed bed capacity is a poor measure of actual bed utilization. Most Mountain States and Wellmont hospitals have staffed beds that are well below their licensed bed capacity, and some of those hospitals, have relatively low occupancy rates for staffed beds.

- **Wellmont Bed Size and Average Daily Census:** As of 2013¹¹, four of the six operating Wellmont hospitals have fewer than fifty staffed beds, and an average daily census from only three to thirteen patients per day. The largest of these small hospitals (Hawkins County Memorial Hospital) has an occupancy rate of only nineteen percent (19%).
- **Wellmont Occupancy Rates:** Occupancy rates fell over the period FY10-FY13 at both Holston Valley and Mountain View Regional. The average daily census and patient days have declined by more than fifty percent (50%) since FY10 at Lonesome Pine.

Table 5.2 - Wellmont Hospitals (2013)

Hospital	Staffed Beds	Licensed Beds	Staffed Beds Occupancy	Licensed Beds Occupancy	Average Daily Census
Holston Valley	339	505	66.4%	44.6%	225
Bristol Regional	261	312	65.0%	54.4%	170
Hawkins County	46	50	18.7%	17.2%	9
Lonesome Pine	21	60	49.6%	17.4%	10
Mountain View Regional	18	74	69.5%	16.9%	13
Hancock County	10	10	30.9%	30.9%	3

- **Mountain States Bed Size and Average Daily Census:** As of 2013, seven Mountain States hospitals have fifty or fewer staffed beds (three have fewer than ten staffed beds) and an average daily census ranging from thirty-five to less than one patient per day on average. Four other Mountain States hospitals have between seventy-four and one hundred twelve staffed beds and an average daily census ranging from forty-two to sixty-five patients.
- **Mountain States Occupancy Rates:** Several Mountain States hospitals have low staffed bed occupancy rates. The average daily census at the Dickenson Community and Johnson County Community hospitals has been less than one each year since FY10.

¹¹ These numbers do not include Takoma Regional Hospital in the Wellmont numbers. Takoma was sold by Wellmont in 2014.

Table 5.3 - Mountain States Hospitals (2013)

Hospital	Staffed Beds	Licensed Beds	Staffed Beds Occupancy	Licensed Beds Occupancy	Average Daily Census
Johnson City ¹²	497	501	69.3%	68.7%	344
Indian Path	168	239	37.4%	26.3%	63
Johnston Memorial	112	116	58.3%	56.3%	65
Woodridge Psychiatric	80	84	76.0%	72.4%	61
Franklin Woods	77	80	54.1%	52.1%	42
Sycamore Shoals	74	121	57.0%	34.9%	42
Norton Community	50	129	70.5%	27.3%	35
Russell County	49	78	58.5%	36.7%	29
Smyth	44	44	48.1%	48.1%	21
Quillen Rehabilitation ¹³	26	26	77.8%	77.8%	20
Unicoi County	7	48	169.7%	24.7%	12
Dickenson Community	2	25	1.6%	0.1%	<1
Johnson County	2	2	6.0%	6.0%	<1

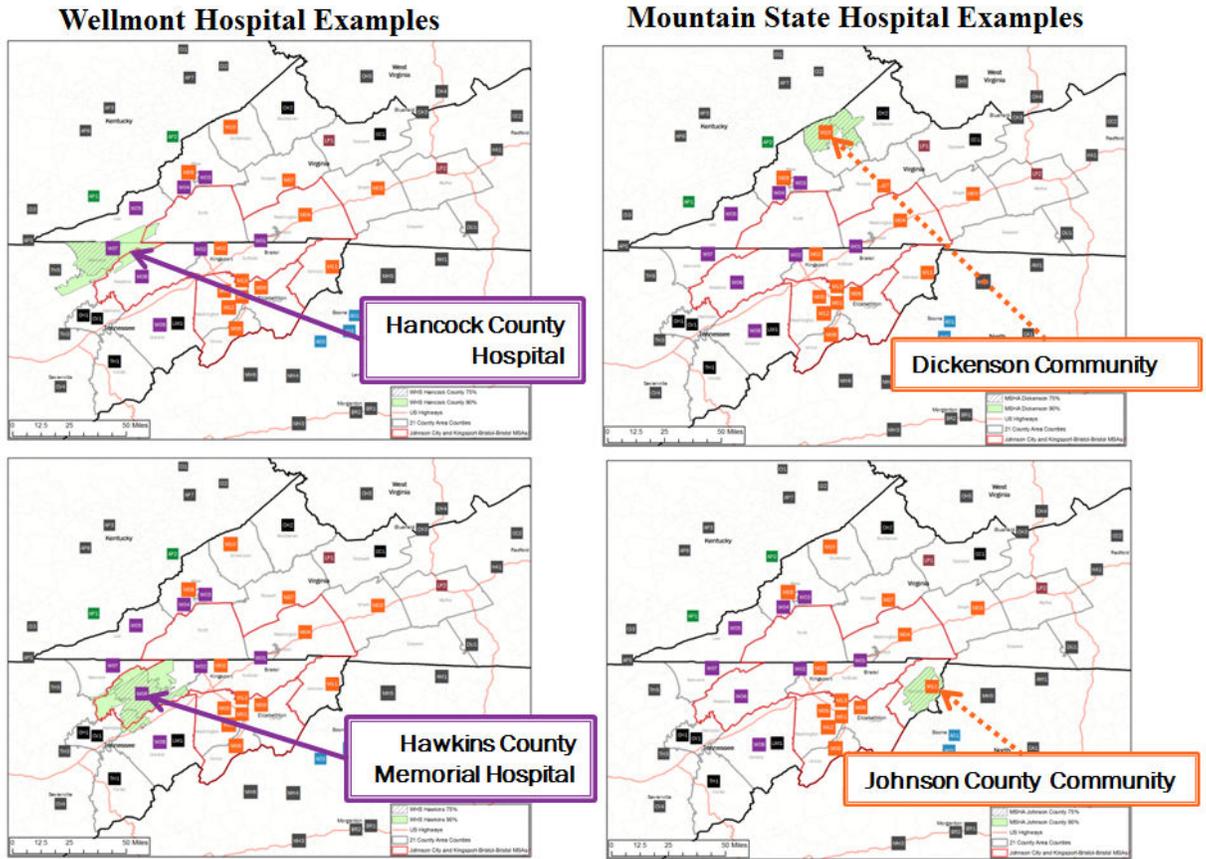
Service Areas: Several of the smaller Wellmont and Mountain States hospitals have narrow, non-overlapping service areas. The maps in **Figure 5.3** below show the 75% and 90% draw areas for certain Wellmont and Mountain States hospitals.¹⁴ Dickenson Community's 75% and 90% draw areas comprise only three ZIP codes and Johnson County Community's 75% and 90% draw areas consist of only a single zip code. In general, Wellmont hospitals tend to be on the western side of the Geographic Service Area and Mountain States hospitals tend to be in the northeast, south or southeast areas.

¹² Niswonger Children's Hospital operates as a unit of Johnson City Medical Center and its data is included in the Johnson City Medical Center reported data.

¹³ Mountain States has a minority interest in a joint venture with HealthSouth to operate Quillen Rehabilitation Hospital where 26 rehab beds currently exist.

¹⁴ **Exhibit 5.1** contains the methodology and maps for the 75% and 90% draw areas for each hospital, based on CY2014 discharge data for all payers for Tennessee and Virginia; the 75% area is depicted by cross-hatched areas.

Figure 5.3 - Draw Area Maps



Assessment of Inpatient Services in the Geographic Service Area

Wellmont and Mountain States obtain the majority of their inpatient discharges from the Geographic Service Area, an area served by other hospitals physically located in the area as well as by hospitals located outside of the area. Share analyses of general acute care inpatients in this area were calculated for the New Health System and for its competing hospitals and are shown in **Exhibit 5.2**.¹⁵ There are numerous competing hospitals that collectively account for approximately twenty-five percent (25%) of current discharges of residents in the Geographic Service Area.

The combined share of Wellmont and Mountain States, however, obscures the fact that the majority (58%)¹⁶ of their combined share is accounted for by three hospitals -- Bristol Regional, Holston Valley, and Johnson City Medical Center. Each of the other

¹⁵ Share analyses are based on discharges by hospitals for the Geographic Service Area. **Exhibit 5.2** provides shares calculated excluding DRG 795 and inclusive or exclusive of MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use or Induced Mental Disorders). The percentage holds for both.

¹⁶ This percentage is lower when MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use or Induced Mental Disorders) are excluded from the calculation.

Wellmont and Mountain States hospitals, most of which are very small and located in outlying areas,¹⁷ *individually* has very low patient volume and contributes very little to the Parties' combined shares - typically just one to two percent (1-2%) per hospital. The collective volume of these hospitals obscures their very small size and patient volumes thereby overstating any competitive significance.

Some residents of the Geographic Service Area leave the region to receive specialized care. The top three service lines with the largest proportion of outmigration volume from the Geographic Service Area are Mental Diseases, Circulatory, and Musculoskeletal. When patients leave the Geographic Service Area for medical care, they most frequently go to the University of Tennessee Medical Center in Knoxville and Carilion Medical Center in Roanoke, Virginia. Peninsula Hospital in Louisville, Tennessee, receives the largest outmigration for Mental Diseases.

As a result of the Cooperative Agreement, the Parties plan to provide new and enhanced services that will better serve local patients who currently leave the Geographic Service Area for health care and encourage in-migration by patients who reside outside the area. The proposed merger will produce savings that will be used to support specialty services such as behavioral health and pediatric subspecialties that otherwise could not be supported in a region of this size, geography and population density. These are discussed more fully below.

¹⁷ The next largest share contributors are Johnston Memorial Hospital and Indian Path Medical Center, which contribute 8.7% and 6.4% respectively.

6. SERVICES BEING OFFERED BY OTHER PROVIDERS IN THE GEOGRAPHIC SERVICE AREA

REQUEST: Identify whether any services or products of the proposed Cooperative Agreement are currently being offered or capable of being offered by other providers or purchasers in the geographic service area described in the Application.

RESPONSE: As described in more detail below, the Parties' provision of general inpatient services, physician services, and outpatient services are also currently offered or capable of being offered by other providers in the service area. In fact, independent providers offer the majority of physician services (70%) and outpatient services (over 50%).

Inpatient Services. Nine general acute care hospitals in the Geographic Service Area are not operated by Wellmont or Mountain States: Clinch Valley Medical Center, Wythe County Community Hospital, Carilion Tazewell Community Hospital, Lakeway Regional Hospital, Buchanan General Hospital, Morristown-Hamblen Healthcare System, Newport Medical Center, Takoma Regional Medical Center, and Laughlin Memorial Hospital.

The general inpatient services currently offered by Wellmont and Mountain States are offered by, or capable of being offered by, other hospitals located in the Geographic Service Area, with the exception of certain high-level tertiary care services such as trauma and neonatal intensive care.

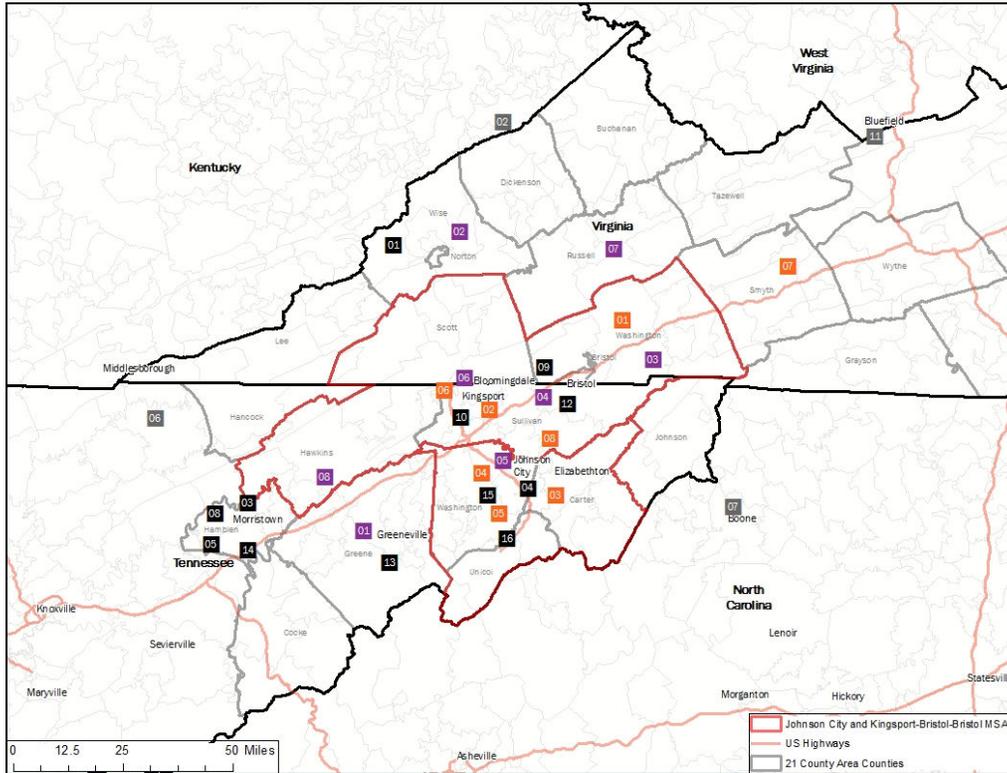
The proposed merger will produce savings to be used to support specialty services such as behavioral health and pediatric subspecialties that otherwise could not be supported in a region of this size, geography and population density. These are discussed more fully below.

Outpatient Facilities. The Geographic Service Area also contains a number of competing, independent outpatient facilities, along with independent nursing homes, assisted living facilities and skilled nursing facilities. **Exhibit 6.1A** provides the numbers and shares of outpatient facilities serving the Geographic Service Area as organized in broad categories.¹⁸ Wellmont and Mountain States together account for less than fifty percent (50%) of the outpatient facilities in twenty-one of the thirty-two categories provided, including Physical Therapy (6.6%) and Nursing Homes (7.6%). Outpatient services including urgent care, imaging, and ambulatory surgery centers have many independent alternatives, which are identified in **Exhibit 6.1A** and whose locations are shown on maps in **Figures 6.1-6.3**. Of the thirty-two urgent care centers in the service area, Mountain States and Wellmont collectively operate sixteen of them; fifty percent (50%) of the urgent care centers are competitor facilities. **Exhibit 6.1B** contains a list of all urgent care facilities serving the Geographic Service Area.¹⁹

¹⁸ The outpatient facilities listed in **Exhibit 6.1A** include the outpatient facilities located in the Geographic Service Area and serving the Geographic Service Area.

¹⁹ The outpatient facilities listed in **Exhibit 6.1B** include the outpatient facilities located in the Geographic Service

Figure 6.1 – Map of Locations of Urgent Care Facilities²⁰



The Geographic Service Area contains imaging facilities, including providers of CT, MRI, and X-Ray services. Wellmont and Mountain States each offers at least one type of these imaging services, but over seventy percent (70%) of all imaging facilities in the service area are operated by competitors. Wellmont and Mountain States together account for about half of the CT and MRI capabilities in the Geographic Service Area, and a much smaller percentage of X-Ray capabilities. A breakdown is provided in [Table 6.1](#) and locations are depicted on the map in [Figure 6.2](#). [Exhibit 6.1C](#) lists all CT/MRI capabilities serving the Geographic Service Area.²¹

Area and serving the Geographic Service Area.

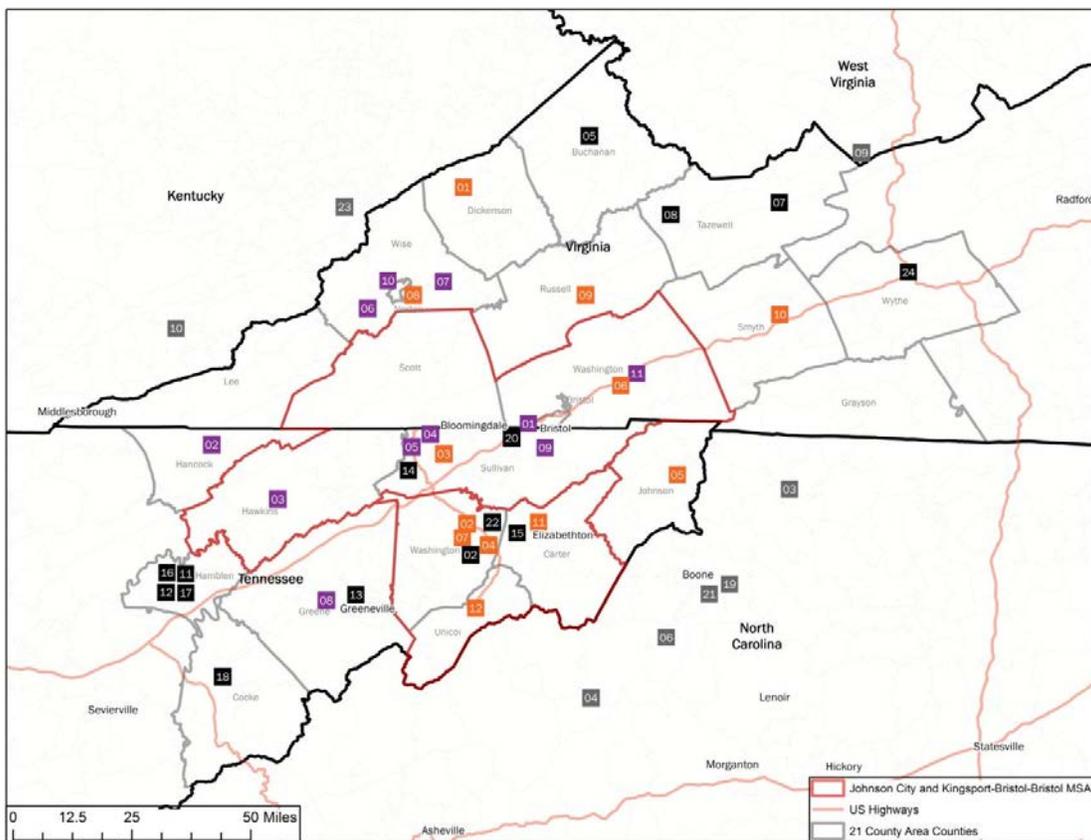
²⁰ An enlarged version of the map and the legend are attached as [Exhibit 6.1B](#).

²¹ The outpatient facilities listed in [Exhibit 6.1C](#) include the outpatient facilities located in the Geographic Service Area and serving the Geographic Service Area.

Table 6.1 – Medical Imaging Facilities and System Affiliation in the Geographic Service Area

System Affiliation	Total Facilities ²²	% of Total	CT Capabilities	MRI Capabilities	X-Ray Capabilities
Total	119		43	41	92
Wellmont	18	15.1%	10	7	12
Mountain States	15	12.6%	12	11	14
All Other	86	72.3%	21	23	66

Figure 6.2 – Map of Location of CT/MRI Facilities²³



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

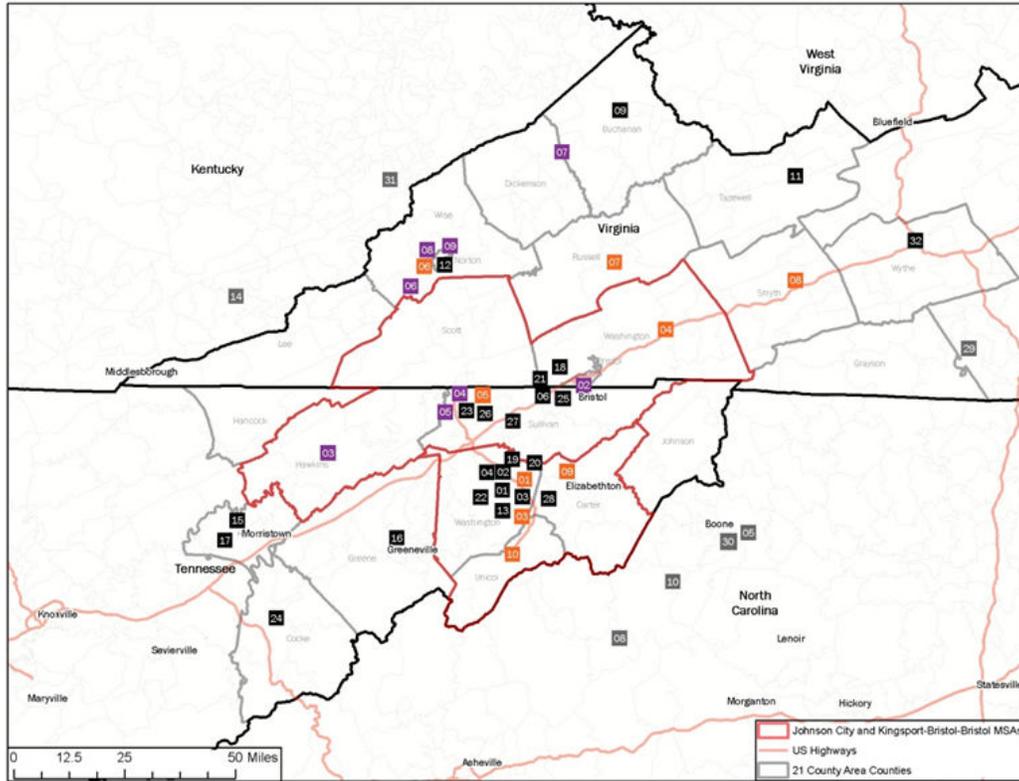
²² Facilities may have CT, MRI, and/or X-ray capabilities co-located at a single location which are counted separately.

²³ An enlarged version of the map and the legend are attached as **Exhibit 6.1C**.

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

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 Centers²⁶



Physician Services. A large number of independent physicians in the Geographic Service Area offer the physician services currently offered by Wellmont and Mountain States through their respective employed (or affiliated) physicians.

Exhibit 6.1E provides data on the number of physicians employed by Wellmont and employed by or affiliated with Mountain States in each of several specialties (e.g., family practice). It also reports data on the number of independent physicians in each of these specialties; the total counts of physicians are based on all physicians with privileges at either or both of Mountain States and Wellmont.

The majority of physicians in the Geographic Service Area with privileges at Wellmont or Mountain States are independent. Approximately seventy percent (70%) of all practitioners in the Geographic Service Area are independent. Wellmont employs nine percent (9%); Mountain States employs seventeen percent (17%); and four percent (4%) of physicians are affiliated with Mountain States through staffing arrangements for

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**.

certain hospital-based services. Independent competitive alternatives exist in all nineteen physician specialties in which the Parties overlap. The combined share of independent physicians exceeds sixty-five percent (65%) in all specialties except Family Medicine, Orthopedic Surgery, Psychology, Psychiatry, Pain Management, Cardiothoracic Surgery, Pulmonology, Occupational Medicine, Hematology/Oncology, Cardiology, and Hospital Medicine, and is at least fifty percent (50%) in most specialties. Nearly sixty-five percent (65%) of Family Practice and Orthopedic physicians are independent.

Each physician specialty where there is an “overlap” between Wellmont and Mountain States includes competition from independent physicians. No overlap between the Parties exists in a large number of specialties and all of them have numerous competitive alternatives. There are relatively few specialties where the combined number of Mountain States and Wellmont employed physicians exceeds thirty-five percent (35%) of the total number of area physicians in that specialty. As is common across the country, certain specialties tend to have higher shares of employed physicians due to the nature of that medical practice. This includes hospitalists, cardiologists and hematologists/oncologists, although these specialties have a number of independent alternatives.

7. ASSURANCE OF CONTINUED COMPETITIVE OPERATION

REQUEST: Explain how the Cooperative Agreement will assure continued competitive and independent operation of the services or products of entities not a party to the Cooperative Agreement.

RESPONSE: Market power will not be gained as a result of the Cooperative Agreement. The New Health System will be actively supervised by Tennessee and Virginia officials. This supervision will ensure that the New Health System will act in furtherance of the public policies that underlie Tennessee’s Certificate of Public Advantage and Virginia’s Cooperative Agreement statutory and regulatory provisions. Moreover, as noted above, the New Health System will face competition from several independent general acute care hospitals, outpatient facilities, post-acute care facilities and physicians in the Geographic Service Area. These competitors will not be a party to the Cooperative Agreement and the Parties anticipate that they will continue to operate independently and competitively if the COPA is granted. Most outpatient medical services are delivered outside the hospital setting by independent physicians and other independent providers such as home health, lab, imaging, occupational medicine, hospice, long-term care services, skilled nursing, physical therapy, occupational therapy, pharmacy, counseling, and surgery centers. Wellmont and Mountain States are required to ensure patient choice when selecting these services and will continue these policies as a merged organization.

In order to ensure continued competitive and independent operation of the services and products of entities not a party to the agreement, the Parties are willing to enter into the following commitments.

COMMITMENTS

- The New Health System will negotiate in good faith with Principal Payers* 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). New Health System would agree to resolve through mediation any disputes in health plan contracting.
- The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.
- The New Health System will not engage in “most favored nation” pricing with any health plans.

* For purposes of this Application, "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.

Similarly, a large number of independent physicians in the community will not be a party to the Cooperative Agreement. Both Wellmont and Mountain States continue to value a robust and successful independent physician community. The New Health System intends to collaborate where possible with the independent physician community in procompetitive arrangements to build an array of service offerings that will be accessible throughout the region. To remove barriers to patient choice and promote open physician practice, the New Health System is prepared to make the following commitments.

COMMITMENTS

- 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.
- The New Health System will maintain open medical staff at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the New Health System's Board of Directors.
- The New Health System will commit to not engage in exclusive contracting for physician services, except for hospital-based physicians, as determined by the New Health System's Board of Directors.
- The New Health System will not require independent physicians to practice exclusively at the New Health System's hospitals and other facilities.
- The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.

8. STATEMENT ON PUBLIC ADVANTAGE

REQUEST: Provide a statement of whether there will be a Public Advantage or adverse impact on population health, quality, access, availability or cost of health care to patients and payers as a result of the Cooperative Agreement.

RESPONSE:

PUBLIC ADVANTAGE

A. Enhancement of the quality of hospital and hospital-related care provided to Tennessee citizens.

The region served by the Parties to the Cooperative Agreement faces significant health care challenges. For example, a 2015 Tennessee Department of Health report²⁷ finds 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%). According to the same report, 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. **Table 8.1** reports key statistics on the population of the counties in 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 as **Exhibit 8.1A** and **8.1B**.

²⁷ "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 - Geographic Service Area Health Rankings

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 State of Tennessee has identified the "Big Three Plus One" health issues (physical inactivity, obesity, tobacco abuse and substance abuse) as major health challenges for the state. These health issues are particularly significant challenges for the Geographic Service Area and are associated with other health challenges and conditions.

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 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" report²⁸ 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 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, health care facilities for substance abuse patients.

Table 8.2 reports key statistics on the population in the counties in the Geographic Service Area for the "Big Three Plus One" 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.

²⁸ "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>.

Table 8.2 - County-Level Data for Physical Inactivity, Obesity, Tobacco Abuse, and Substance Abuse in the Geographic Service Area

	Physical Inactivity Score ²⁹	Obesity ³⁰	Tobacco Abuse ³¹	Substance Abuse Score ³²
Tennessee Average	30%	32%	23%	16
Carter County	32%	29%	31%	20
Cocke County	36%	31%	21%	21
Greene County	36%	32%	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

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

²⁹ 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/>.

³⁰ 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/>.

³¹ 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/>.

³² 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/>.

four issues to be key areas of focus within the scope of the current Community Health Work Groups, as well as included in the Advisory Groups that will work to define the ongoing health index for the Cooperative Agreement.

These variables impose increased costs on employers, the government and society in general because the cost to manage the health of these populations is much higher and often reactive and acute, rather than proactive. Poor health leads to higher inpatient utilization. A major component of the change the New Health System seeks to impact is to improve the determinants of poor health that lead to unnecessary inpatient utilization, better manage the “super-utilization” of health resources and, through collaboration with payers, align the incentives to ensure appropriate utilization.

The region is materially affected by the federal policy of paying local hospitals based on one of the lowest Medicare Wage Indices in the nation. This leads to substantially lower reimbursement than peer hospitals in other states and in Tennessee for the exact same services. The low rates, combined with the expensive, unnecessary and inefficiently allocated duplicative health care resources currently existing in our region, make it difficult for the two systems to independently invest the resources required to meaningfully influence the variables that contribute to poor health. These factors confine the region’s health systems to the model that has led to higher cost in the first place.

Furthermore, there is projected continued downward pressure on reimbursement by government payers, as costs for labor and supplies, many of which are unnecessarily duplicative, continue to grow. By better coordinating the two systems, eliminating unnecessary duplicative cost, and creating a better focus on the drivers of poor health, the New Health System will make a material positive impact on the region's health care.

Thus, a key goal of the Cooperative Agreement is to better enable the Parties to sustain and enhance services and improve the quality of health care and health outcomes in the region. The specific initiatives of the Cooperative Agreement are summarized below, followed by a description of the Parties' specific commitments to achieve these goals and the resulting benefits:

- A fully integrated and interactive Common Clinical IT Platform will be implemented to enable ready access to patient records by physicians from any location in the New Health System. Implementation of this Common Clinical IT Platform requires sharing of highly proprietary information and commitment of significant resources by both systems, which would not be accomplished in the absence of a merger.
- The New Health System will participate meaningfully in an existing or new health information exchange to promote coordination among

community providers, including those providers not part of the New Health System. The regional health information exchange will facilitate the sharing of information, including highly proprietary information to the extent feasible, and a commitment of significant resources, which would not be accomplished in the absence of a merger.

- Management and clinical practice procedures and policies will be standardized to promote efficiency and higher standards of care on a consistent basis throughout the New Health System through a system-wide Clinical Council. It would not be possible for the two competing systems to standardize procedures and policies for best practices absent the merger. Such standardization to improve health care requires sharing of proprietary information and significant contribution of resources by both parties, as discussed below.
- Best practices will be used to develop standardized clinical protocols for care ("Clinical Pathways") to reduce clinical variation and overlap, shorten length of stay, reduce costs, and improve patient outcomes. The Cooperative Agreement will allow sharing of the clinical and financial information needed to integrate this process.
- The integration and coordination of clinical services made possible by the merger will free up resources that can be directed to develop new health care services and to enhance existing services, discussed more fully below. Clearly, the resources needed to achieve these goals would not be available in the absence of the merger.
- 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 herein.
- The New Health System's services and staff will be optimally located to improve productivity and ensure access.
- Clinical programs will be integrated to establish centers of excellence that coordinate and optimize care throughout the New Health System. Our three tertiary hub hospitals will serve not only as training sites for new physicians and allied health professionals, but will also utilize effective technology and cutting edge treatment in concert with translational research.

To enhance the quality of health care services provided in the region to achieve the above benefits, the Parties are willing to commit to the following:

- i. Migrate to a Common Clinical IT Platform
 - (a) The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.
 - (b) The Common Clinical IT Platform will allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care.
 - (c) The Common Clinical IT Platform will also facilitate the increased adoption of best practices and evidence based medicine implemented by the New Health System.
 - (d) The New Health System intends to use the Common Clinical IT Platform to provide immediate system-wide alerts and new protocols to improve quality of care.
 - (e) The New Health System expects the Common Clinical IT Platform to be utilized in ways that will help reduce the risk of clinical variation and lower the cost of care by decreasing duplication of health care services.

- ii. Support Regional Efforts For Establishment of a Region-Wide Health Information Exchange
 - (a) The New Health System will support development and operation of a region-wide health information exchange (the "Health Information Exchange") that will include independent providers, medical groups and facilities.
 - (b) The Health Information Exchange will encourage and support patient and provider connectivity to the New Health System's integrated information system.
 - (c) The New Health System will coordinate with third parties to establish the technology platform vendor for the Health Information Exchange and to provide key data security and relevant protocols to all users.
 - (d) The New Health System will utilize the Health Information Exchange to further facilitate better patient care and coordination of care, and to decrease the unnecessary duplication of health care services.

- iii. Establish System-Wide Clinical Council
 - (a) The New Health System will establish a system-wide, physician-led clinical council (the "Clinical Council").

- (b) The Clinical Council will be composed of independent physicians as well as physicians employed by the New Health System or its subsidiaries or affiliates. The Clinical Council will include representatives of management but the majority will be composed of physicians.
- (c) The Clinical Council may be supported by other clinicians, subject matter experts, and senior management.
- (d) The Chair of the Clinical Council will be a physician member of the active medical staff(s) of one or more New Health System hospitals. The Chair will serve on the Quality, Service and Safety Committee of the Board of Directors of the New Health System and will provide ongoing reports on the activities of the Clinical Council through the Quality, Service and Safety Committee of the Board.
- (e) The Clinical Council will be responsible for establishing a common standard of care, credentialing standards, consistent multidisciplinary peer review where appropriate and quality performance standards and best practices requirements for the New Health System.
- (f) The Clinical Council will also provide input on issues related to clinical integration, and shall support the goals established by the Board of Directors of the New Health System.
- (g) The Clinical Council will report to the Chief Medical Officer of the New Health System.

iv. Quality Reporting

- (a) The Parties affirm the need for complete transparency on quality measures with respect to the performance of the New Health System. The Parties will report on a common and comprehensive set of measures and protocols that will be part of the integrated delivery of care across the entire New Health System, as well as track and monitor opportunities to improve health and access to care at the right place and right time for consumers. Timely information will be available to the public, which will impact choice and further incentivize the provision of high quality of care. Increased transparency will provide consumers with information for their use to make better health care decisions.
- (b) The New Health System will commit to publicly reporting on its website the New Health System's CMS core measures³³ for each

³³ CMS Hospital Compare metrics are publicly available at: <https://data.medicare.gov/data/hospital-compare>. As

facility within thirty days of reporting the data to CMS. The New Health System will 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. Publicly reported CMS Hospital Compare measures, by category, along with the number of measures in each respective category are presented in **Table 8.3** below. These demonstrate the breadth of commitment by the Parties to provide comprehensive and timely information for benchmarking and for consumers.

indicated in **Table 8.1** herein, there are seventeen categories of measures and each category contains a set of measures. For example, Readmissions & Deaths is one of the 17 Hospital Compare measure categories. This category contains fourteen individual measures including, for example, AMI 30-day mortality rate, Pneumonia 30-day mortality rate, and the Rate of readmission after discharge (hospital-wide).

Table 8.3 - CMS Hospital Compare Measures

Measure Category	Number of Measures
Healthcare-associated infections(HAI)	6
Inpatient Psychiatric Facility Quality Reporting(IPFQR)Program	6
Outpatient Imaging Efficiency	6
Payment & value of care	4
Readmissions & deaths	14
Surgical Complications	7
Survey of patients' experiences(HCAHPS)	11
Timely and effective care- Blood Clot Prevention and Treatment	6
Timely and effective care- Children's Asthma	3
Timely and effective care- Emergency Department	7
Timely and effective care- Heart Attack or Chest Pain	9
Timely and effective care- Heart Failure	3
Timely and effective care- Pneumonia	1
Timely and effective care- Pregnancy and Delivery Care	1
Timely and effective care- Preventive Care	2
Timely and effective care- Stroke Care	8
Timely and effective care- Surgical Care Improvement Project	9

- The New Health System's results will be available on its website and reported several months earlier than CMS customarily makes the information available to the public. Currently, there is an approximate six-month lag between when core measures are reported to CMS and when CMS posts the information for the public. The New Health System intends to empower patient decision making by reporting core measures in advance of the federal agency reporting.
- CMS periodically changes the core measures it requires hospitals to report. To ensure patients have information on the latest CMS core measures, the New Health System will commit to include all current CMS core measures in its public reporting on the website, rather than a pre-defined set of measures chosen by the Parties.³⁴

³⁴ The New Health System will commit to using the same standards of reporting as CMS and reserves the right to not report those core measures that would not be reported by CMS (e.g. too few patients for the metric to be

- (c) The New Health System will commit to publicly reporting on its website measures of patient satisfaction for each facility within thirty days of reporting the data to CMS via the Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") reporting. The New Health System will also provide benchmarking data against the most recently available CMS patient satisfaction scores so the public has access to how the New Health System facilities compare against hospitals across the state.
- The New Health System's results will be available on its website and reported several months earlier than CMS customarily makes the information available to the public.
- (d) The New Health System will commit to publicly reporting on its website specific high priority measures for each facility annually, with relevant benchmarks. The high priority measures are set by CMS³⁵ and the Joint Commission and have in the past included:
- Central Line-Associated Bloodstream Infections,
 - Catheter-Associated Urinary Tract Infections, and
 - Ventilator Associated Pneumonia Infection Rates.
- (e) The New Health System will commit to publicly reporting on its website surgical site infection rates for each facility annually.
- (f) The New Health System will commit to publicly reporting on its website the ten most frequent surgical procedures performed (by number of cases) at each Ambulatory Surgery Center in the system annually. Studies have shown that facilities performing high volumes of a procedure may have better outcomes than those performing low volumes.³⁶ The New Health System intends to be transparent about the volume of procedures it performs and the outcomes related to those procedures.

statistically significant, protected health information concerns with the metric being reported, etc.).

³⁵ The New Health System will commit to using the same standards of reporting as CMS and reserves the right to not report those high priority measures that would not be reported by CMS (e.g. too few patients for the metric to be statistically significant, etc.).

³⁶ *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 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>.

(g) The New Health System will commit to improved transparency and reporting on high priority measures for quality and cost by reporting annually on its website the following information by facility, aggregated for the facility across the DRGs that comprise eighty percent (80%) of the discharges from the New Health System facilities:³⁷

- Severity adjusted cost/case;
- Length of stay;
- Mortality rate; and
- Thirty-day readmission rate.

(h) The New Health System will also commit to report these quality measures on its website for the top ten DRGs aggregated across the system annually. By reporting on these quality measures specific to each of the top 10 DRGs for the system as a whole, the New Health System is committing to a new level of transparency and accountability for care in the service lines that account for greatest usage by the population. The top 20 DRGs by system for 2014 are listed in **Table 8.4** below:

³⁷ Cost and utilization metrics could include broad measures such as: total medical cost per member per year, inpatient admissions per 1000, average length of stay, percentage readmissions within 30 days, ER visits per 1000, Evaluation and Management per 1000, Scripts per 1000. More detailed expenditure and utilization statistics could be presented for inpatient by treatment type (Medical, Surgical, Psychiatric/Substance Abuse, Maternity/Newborn, Non Acute & LTC), outpatient by treatment type (Surgery, ER, Home Health, DME, Lab, Radiation, Pharmacy, Other) and Providers (PCP, Specialist, Transportation, DME & Supplies, Spec Drugs & Injections, and Other). The report could include costs for the top 10 DRGs by volume, evaluation and management visits by group, Rx Utilization, top 20 Clinical Conditions by Medical Cost, and top 10 patients (identified by clinical condition) by cost.

Table 8.4 - Top DRGs by Health Systems, 2014

Top 20 Discharge DRGs for Combined MSHA and Wellmont, 2014			
No.	DRG	DRG Description	Total Discharges
1	885	PSYCHOSES	5,320
2	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	3,627
3	775	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	3,283
4	470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2,820
5	189	PULMONARY EDEMA & RESPIRATORY FAILURE	1,965
6	392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	1,950
7	603	CELLULITIS W/O MCC	1,716
8	194	SIMPLE PNEUMONIA & PLEURISY W CC	1,651
9	193	SIMPLE PNEUMONIA & PLEURISY W MCC	1,619
10	872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1,535
11	690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	1,423
12	794	NEONATE W OTHER SIGNIFICANT PROBLEMS	1,413
13	766	CESAREAN SECTION W/O CC/MCC	1,402
14	683	RENAL FAILURE W CC	1,342
15	291	HEART FAILURE & SHOCK W MCC	1,174
16	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1,147
17	292	HEART FAILURE & SHOCK W CC	1,063
18	247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	1,026
19	378	G.I. HEMORRHAGE W CC	966
20	765	CESAREAN SECTION W CC/MCC	948

Note: The table excludes normal newborns (DRG 795).

Source: Combined all-payor IP discharge data from Virginia State & Tennessee State, calendar year 2014

- (i) The New Health System will select a third-party vendor and provide the data for the vendor to analyze the severity adjusted measures and post them to the New Health System's website.

B. Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities.

Health care services offered by rural hospitals in the United States are at increasing risk of closure. According to the University of North Carolina Sheps Center, sixty-six rural hospitals have closed since 2010, including six in Tennessee and one in Virginia.³⁸ Wellmont and Mountain States each make substantial investments in order to maintain access to health care services in their rural communities. As presented in **Tables 5.2** and **5.3**, many of the Parties' rural hospitals have an average daily census of twenty patients or less.

³⁸ See *66 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/rural-health/rural-hospital-closures/> (accessed January 25, 2016).

Because of decreasing reimbursements and the other challenges mentioned earlier, it will be increasingly difficult to continue to sustain these facilities over the long-term without the savings the proposed merger would create. Continued access to appropriate hospital-based services in the rural areas of these communities is a significant priority and a driving impetus for the Cooperative Agreement.

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, Norton Community Hospital, Johnston Memorial 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. The existing threat to these hospitals is substantial, which affects not only access to care, but also the economic vitality of these communities.

The proposed Cooperative Agreement is a thoughtful mechanism for ensuring that the efficiencies from a merger that is actively supervised will be used to ensure sustained access to care for these communities. Without such a Cooperative Agreement, there is no comparable assurance. Specifically, the Parties commit to the following:

COMMITMENTS
<ul style="list-style-type: none">• 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.

COMMITMENTS

- 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.
- The New Health System will commit to the 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. The Parties expect the combined system to facilitate this goal by employing physicians primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding.

C. Gains in the cost containment and cost efficiency of services provided by the hospitals involved.

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.³⁹

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

Through the Cooperative Agreement, 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

³⁹ See [Exhibit 5.1C](#) for a breakdown of payers in the Geographic Service Area.

population density. No other region in Tennessee operates two Level I 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.⁴⁰ Thus, a consolidation would likely result in lower cost and 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.

The New Health System will also achieve greater cost efficiencies through various organizational and administrative efficiencies as described in **Section 11.i**. Such efficiencies include, among other things, non-labor efficiencies, labor efficiencies, clinical efficiencies, and the opportunity to consolidate technology resources on a Common Clinical IT Platform as described in **Section 8.A.i**.

Specifically, the Parties commit that the New Health System will achieve at least \$95 million in annual efficiencies by the end of the fifth year of operation. The potential savings identified here 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. Importantly, that work must be done only after significant study and assessment along with input from key stakeholders and physicians, guided by the Alignment Policy set forth in this document. The work must be orderly, methodical, and well communicated. While the efficiency numbers set forth above were established and validated by independent outside experts, only certain sample initiatives have been set forth in this document.

D. Improvements in the utilization of hospital resources and equipment.

In addition to reduced costs through improved efficiency and avoidance of waste and duplication, the New Health System will reduce overutilization of inpatient services in the region and stem the pace of health care cost growth for patients, employers and insurers. Currently, 126 patients for every 1,000 people in Tennessee⁴¹ are admitted to the hospital annually, compared to a national average of 106 admissions/1,000 population. The Parties believe the creation of

⁴⁰ 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 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>.

⁴¹ This figure is reported by the Kaiser Family Foundation for the state of Tennessee for 2013. Source: Kaiser Family Foundation's Hospital Admissions per 1,000 Population, available at: <http://kff.org/other/state-indicator/admissions-by-ownership/>.

a regionally integrated health system with a comprehensive regional health information exchange will help reduce unnecessary utilization.

The proposed merger will result in a Common Clinical IT Platform for electronic medical records among the combined nineteen hospitals, employed physicians and related services, and will facilitate a community health information exchange between participating community providers in the region, as described above. 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.

To reduce the pace of health care cost growth for patients, employers and insurers, while also investing in improving quality and patient service, the New Health System will make the following commitments.

COMMITMENTS

- 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.

* For purposes of this Application, "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.

COMMITMENTS

- 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 System agrees to mediation as a process to resolve any disputes.
- 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.
- 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 a health information exchange 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.

* For purposes of this Application, "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.

All of these efforts would not be undertaken in the absence of the merger due to a variety of factors, including the need to share proprietary information and the significant commitment of resources to be made by the Parties as part of 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. A likely alternative to the proposed Cooperative Agreement merger would be for each system individually to be purchased by larger health systems from outside the region. Such an alternative is unlikely to be actively supervised to ensure overriding community benefits and would not come close to achieving the same level of efficiencies, cost-savings and quality enhancement opportunities as the New Health System. It would also not be subject to rigorous rate regulation by state authorities, even though there are concerns that out-of-market acquirers may raise the acquired hospital's prices.

In the event of repeal or material modification of the Tennessee Certificate of Need law and/or the Virginia Certificate of Public Need law, the Parties – solely with respect to outpatient, physician, and additional non-hospital healthcare services (collectively, the “non-inpatient services”) – reserve the right for the New Health System to enter exclusive network and most-favored nation agreements with insurers, and to engage in any other competitive practices that comply with the antitrust laws regarding the non-inpatient services, notwithstanding the commitments stated in the Application.

E. Avoidance of duplication of Hospital resources.

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. 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. While any alternative model to this proposal would likely lead to significant job displacement in the region, the proposed merger would mitigate this impact through investment in new programs as outlined in this application.

The Parties also anticipate cost savings through capital cost avoidance. This includes avoiding duplication in select clinical areas, as well as foregoing planned duplicative strategic investments for initiatives that would no longer be warranted as a combined entity.

F. Demonstration of Population health improvement of the region served according to criteria set forth in the Cooperative Agreement and approved by the Department.

Wellmont and Mountain States are committed to creating a New Health System designed to improve community health. To accomplish this, the New Health System will commit to pursuing health improvements aligned with goals contained in the current Tennessee State Health Plan, the Virginia Health Innovation Plan (including the Lieutenant Governor’s Quality, Payment Reform, and HIT Roundtable and Virginia’s Plan for Well Being) and with regional collaborative health improvement goals such as those set forth in Healthier Tennessee and the Blueprint for Health Improvement and Health-Enabled Prosperity.

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. As the 2014 Tennessee Health Plan states, “We know that health care alone cannot make major improvements in population health. To make significant improvements, we need to understand what ‘being healthy’ and ‘staying healthy’ mean, and how to encourage our entire society to value health. In other words, we need to build a culture of health.”

The New Health System is committed to create a new integrated delivery system designed to improve community health through investment of not less than \$75 million over ten years in population health improvement. The New Health System would commence the population health improvement process with the preparation of a comprehensive community health improvement plan, identifying the key 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 population health improvement funding may be committed to the following initiatives, as well as others based upon the 10-year action plan for the region.

- i. ***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.

- ii. ***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.
- iii. ***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.
- iv. ***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 New Health System will also provide financial support to develop and sustain an Accountable Care Community effort across state lines for the region that will help address these and other issues identified by the community health improvement plan. As described in the section below, some of this work is already underway. Wellmont and Mountain States have worked with the College of Public Health at ETSU to organize four Community Health Work Groups to focus on the root causes of poor health in the region and identify actionable interventions for a generational shift in health trends. It is expected that the membership of these Community Health Work Groups could form the initial core of the Accountable Care Community structure.

G. The extent to which medically underserved population have access to, and are projected to utilize, the proposed services.

In cooperation with the College of Public Health at ETSU, the Parties have launched the region's most substantial community health improvement assessment effort to date. Four Community Health Work Groups have been 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. As described above, the Parties have 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 four Community Health Work Groups and the eight community leaders who are serving as chairpersons are set forth below:

- Mental Health & Addiction: Dr. Teresa Kidd, president and CEO of Frontier Health, and Eric Greene, senior vice president of Virginia services for Frontier Health;
- Healthy Children & Families: Dr. David Wood, chair of the department of pediatrics at ETSU, and Travis Staton, CEO of United Way of Southwest Virginia;
- Population Health & Healthy Communities: Dr. Randy Wykoff, dean of ETSU's College of Public Health, and Lori Hamilton, RN, director of healthy initiatives for K-VA-T Food City;
- Research & Academics: Dr. Wilsie Bishop, vice president for health affairs and chief operating officer of ETSU, and Jake Schrum, president of Emory & Henry College.

These Community Health Work Groups are jointly funded by the Parties. The charters and membership lists of each Work Group are attached as **Exhibit 8.2A and Exhibit 8.2B**⁴².

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. The extensive schedule of public meetings already conducted by these four Work Groups is attached as **Exhibit 8.3**.

ETSU has been 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.

Specifically, the 10-year plan will utilize the input received in the Community Health Work Group sessions in the following ways:

- Mental Health & Addiction Work Group: The Mental Health and Addiction Work Group is charged with evaluating the inventory of mental health and addiction services for adults and children in the

⁴² The membership list reflects all members of each Work Group as of January 25, 2016.

area. An important objective is to provide data and analysis that will assist the New Health System in developing an optimal structure to combat addiction and substance abuse, reduce the number of newborns born into addiction, and to reduce dependency on drugs and alcohol through improved access and support. The New Health System will use findings from this group to partner with the medical and social service community to combat addiction and support the next generation to achieve its potential.

- Healthy Children & Families: The Healthy Children and Families Work Group is charged with exploring the opportunities and necessary actions for structuring a comprehensive regional approach to child well-being in Northeast Tennessee and Southwest Virginia. The work group will produce a report that identifies the most prominent physical, behavioral, and social health problems affecting children in the region and explores their causes, taking into account the social and family support necessary to equip children to make the strongest possible start in their journey to adulthood.
- Population Health & Healthy Communities: The Population Health and Healthy Communities Work Group is charged with exploring opportunities and necessary actions to improve the overall health and well-being of Northeast Tennessee and Southwest Virginia by aligning and mobilizing public and private sector resources - schools, businesses, civic and faith groups; health care providers; government - around a core set of community health improvement goals in the areas of both health care delivery and social determinants of health. The New Health System will utilize the findings from this group to identify health care delivery goals that could be improved, including, but not limited to: increased vaccinations and screenings, improved integration of primary care, dental and mental health services, improved access to preventive and treatment services for persons with addictive disorders, and reductions in hospital acquired conditions.
- Research & Academics: The Research and Academics Work Group is charged with exploring the opportunity to improve health and economic growth in Northeast Tennessee and Southwest Virginia by enhancing professional recruitment and research-based funding under a new research and academics partnering strategy between the New Health System and regional academic institutions. The findings from this Work Group will be used by the New Health System and its research partners to interface with an effort to create an accountable care community – in particular, analyze what

infrastructure is needed to use the benefit of research to support the initiatives and priorities identified in the accountable care community model.

In addition to utilizing the Community Health Work Groups to identify the services most needed by the medically underserved population, 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. The charity care policy and related policies for Mountain States is attached as **Exhibit 8.4**. The charity care policy and related policies for Wellmont is attached as **Exhibit 8.5**. 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 and consistent with the IRS's final 501(r) rule.

H. Any other benefits that may be identified.

Behavioral Health and Substance Abuse. 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, 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.

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.⁴³ 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.⁴⁴

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

⁴³ American Hospital Association. (2012, January). Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Cost and Outcomes. Trendwatch. Chicago, IL: American Hospital Association. Available at: <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>.

⁴⁴ Economic Impact of Integrated Medical-Behavioral Healthcare. Milliman, Inc. April 2014. Available at: <http://integrationacademy.ahrq.gov/node/5950>.

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 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 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. In fact, this is a major focus of the assessment being performed with ETSU through one of the priority Community Health Work Groups. 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 have tremendous opportunities to 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.

Common Clinical IT Platform. 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. Specifically, the Parties are willing to commit as follows:

COMMITMENTS
<ul style="list-style-type: none">• 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.

Quality and Availability. The quality and availability of health care services will improve under the proposed Cooperative Agreement. Wellmont and Mountain States have been developing quality measurement systems independently of one another. Working together, the Parties believe they will be able to improve how quality is measured not only at their respective hospitals, but also throughout the region. Specifically, the Parties commit to the following:

COMMITMENTS
<ul style="list-style-type: none">• 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.

Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Parties intend to maintain community outreach programs, such as programs for the elderly and the very young, and be able to better afford to attract and retain top quality specialists in areas either not now offered or at risk of out-migration from either one or both hospital systems. For example, the proposed merger will produce savings which will be used to support specialty services such as behavioral health and pediatric subspecialties that otherwise could not be supported in a region of this size, geography and population density.

The Cooperative Agreement will allow the hospitals the opportunity to continue to offer programs and services that are now unprofitable and otherwise may have to be reduced or cancelled due to lack of funding. Specifically, the New Health System will commit to spending at least \$140 million over ten years pursuing specialty services including those outlined in the commitments below.

These initiatives would not be sustainable in the region without the financial support created by the merger.

COMMITMENTS
<ul style="list-style-type: none">• 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.• 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.• The New Health System will ensure recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children’s Hospital physician needs assessment.• The New Health System will develop pediatric specialty centers and Emergency Rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting in close proximity to patients’ homes.

The Parties do not foresee any adverse impacts on population health, quality, access, availability or cost of health care to patients and/or payers as a result of the Cooperative Agreement. The projects and commitments identified in this Application will clearly improve health care in the region.

The Parties and the State share a common interest in ensuring that the financial commitments set forth in this Application are maintained to achieve the longer-term population health goals for the region served by the New Health System. In the event of a natural disaster or other extraordinary circumstance beyond the New Health System’s control that would materially risk the financial or operational stability of the New Health System, the Parties may file an amended schedule and investment plan for the commitments to the State for approval. Such amended schedule or contingency plan will specify the financial or operational issues that warrant an amended schedule or contingency plan, and detail how the amended plan or contingency plan is consistent with the intended goals and priorities of the original commitments.

9. STATEMENT ON PROJECTED LEVELS OF COST, ACCESS TO HEALTH CARE, OR QUALITY OF HEALTH CARE

REQUEST: Provide a statement of whether the projected levels of cost, access to health care or quality of health care could be achieved in the existing market without the granting of a COPA; and, for each of the above, an explanation of why or why not.

RESPONSE: The significant ongoing duplication of services and costs cannot be avoided without a consolidation. Funding the population health, access to care, enhanced health services, and other commitments described in this 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 as further described in **Section 11.i**.

Further, the extensive commitments described herein 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. A merger by Wellmont or Mountain States with a different entity would fall well short of the New Health System's potential for realizing the major integrative efficiencies described herein, which, in turn, will help fund and sustain the Parties' unprecedented and enforceable commitments to health care cost control and quality improvement in the Geographic Service Area. The proposed consolidation of Wellmont and Mountain States, without a COPA, would likely implicate state and federal antitrust laws. As a result, the potential efficiencies and benefits identified in this Application could not be achieved in the existing market without the granting of a COPA.

10. REPORT USED FOR PUBLIC INFORMATION

REQUEST: Provide a report used for public information and education that is documented to have been disseminated prior to submission of the Application and submitted as part of the Application. The report must include the following:

- (i) A description of the proposed geographic service area, services and facilities to be included in the Cooperative Agreement;
- (ii) A description of how health services will change if the Application is accepted;
- (iii) A description of improvements in patient access to health care including prevention services for all categories of payers and advantages patients will experience across the entire service area regarding costs, availability or accessibility upon initiation of the Cooperative Agreement and/or findings from studies conducted by hospitals and other external entities, including health economists, clinical services and population health experts, that describe how proposed Cooperative Agreement plans are effective with respect to resource allocation implications; efficient with respect to fostering cost containment, including, but not limited to, eliminating duplicate services and future plans; and equitable with respect to maintaining quality and competition in health services within the service area, assuring patient access to and choice of insurers and providers within the health care system;
- (iv) Findings from service area assessments that describe major health issues and trends, specific population health disparities and comparisons to state and other similar regional areas proposed to be addressed;
- (v) Impact on the health professions workforce including long-term employment and wage levels and recruitment and retention of health professionals; and
- (vi) A record of community stakeholder and consumer views of the proposed Cooperative Agreement collected through a public participatory process including meetings and correspondence in which this report or its components were used.

RESPONSE: The Parties prepared the Pre-Submission Report attached as **Exhibit 10.1** to educate the public on the proposed merger and seek additional community input. The Pre-Submission Report was posted on the Parties' website on January 7, 2016 and the Parties publicized the release of the report through various news outlets. The community has been invited to submit comments and questions, through the Parties' website: <http://becomingbettertogether.org>. A record of community stakeholder and consumer views of the proposed Cooperative Agreement is attached as **Exhibit 10.2**.

11. SIGNED COPY OF THE COOPERATIVE AGREEMENT

RESPONSE: A signed copy of the Cooperative Agreement (referred to by the Parties as the “Master Affiliation Agreement and Plan of Integration By and Between Wellmont Health System and Mountain States Health Alliance”) is attached hereto as **Exhibit 11.1**.

- a. **REQUEST:** A description of any consideration passing to any person under the Cooperative Agreement including the amount, nature, source and recipient.

RESPONSE: No consideration will pass between the Parties under the Cooperative Agreement. In order to preserve the assembled workforce, the Parties intend to pay retention consideration to key employees. The executive officers of the New Health System will enter into employment agreements consistent with their duties and responsibilities. Their compensation will be fair market value as confirmed by an independent valuation firm and consistent with IRS guidelines, and a significant portion of compensation will be based on performance. At the commencement of the strategic options process, Wellmont instituted a retention policy for its key executives. Likewise, Mountain States adopted a retention policy as it commenced negotiation of the Cooperative Agreement. As a result of the Cooperative Agreement, some positions will be eliminated. Those positions will be entitled to customary severance associated with that position. The New Health System anticipates executing new employment agreements, service agreements, and vendor agreements once the COPA has been granted, but none have been executed to date.

The Cooperative Agreement involves no brokers or finders fees. No professionals advising Wellmont, Mountain States, or the New Health System on matters related to the Cooperative Agreement are being compensated on a contingency basis.

- b. **REQUEST:** A detailed description of any merger, lease, change of control or other acquisition or change in ownership of the assets of any party to the Cooperative Agreement.

RESPONSE: The Parties plan to cause a new, independent public benefit, not for profit, tax-exempt corporation to be incorporated in Tennessee (the "New Health System"). The New Health System would be governed by a Board of Directors composed of representatives from each legacy board, as well as new community members. The Parties would amend their respective articles and bylaws to designate the New Health System as the sole corporate member of each of the Parties.

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 New Health System's management team will be composed of current executives from both organizations. The board of directors of the New Health System will be composed of fourteen voting members, as well as two ex-officio voting members and one ex-officio non-voting member. Wellmont and Mountain States will each designate six members to serve on the initial board of the New Health System. Wellmont and Mountain States will jointly select two members of the initial New Health System board, who will not be incumbent members of either Party's board of directors. The two ex-officio voting members will be the New Health System Executive Chairman/President and the New Health System Chief Executive Officer. The ex-officio non-voting member will be the then current President of ETSU. The New Health System will have a new name and will be managed by an executive team with representatives from each organization serving in the following agreed-upon roles—Executive Chairman/President Alan Levine (currently Mountain States' CEO), CEO Bart Hove (currently Wellmont's CEO), Chief Operating Officer Marvin Eichorn (currently Mountain State's Chief Operating Officer) and Chief Financial Officer Alice Pope (currently Wellmont's Chief Financial Officer). Other senior management positions will be determined at a later date.

After the Closing, the Wellmont and Mountain States entities will continue in existence and the boards of both of those entities will be identical to the New Health System board. The New Health System board will oversee all of the assets and operations of the previously separate Parties and all of their respective Affiliates on the terms and conditions set forth in the Cooperative Agreement for the purpose of enhancing the provision of high quality and cost effective health care that such a unified structure will facilitate, and for the purpose of positioning the combined systems to adapt effectively to the changes taking place locally and nationally in the health care delivery and financing systems.

- c. **REQUEST:** A list of all services and products and of all service locations that are the subject of the Cooperative Agreement, including those not occurring within the boundaries of the State of Tennessee, and including, but not limited to, hospitals or other inpatient facilities, insurance products, physician practices, pharmacies, accountable care organizations, psychiatric facilities, nursing homes, physical therapy and rehabilitation units, home care agencies, wellness centers or services, surgical centers or services, dialysis centers or services, cancer centers or services, imaging centers or services, support services or any other product, facility or service.

RESPONSE: The Parties intend for the Cooperative Agreement to include all services, products, and service locations under the control of Mountain States and Wellmont at the time of execution of the Cooperative Agreement and for so long as those entities remain under the control of the New Health System.

- d. **REQUEST:** A description of each party’s contribution of capital, equipment, labor, services or other value to the transaction.

RESPONSE: The Parties intend for the Cooperative Agreement to include all assets, ownership interests, subsidiaries and controlled affiliated businesses currently owned or operated, in whole or in part, directly or indirectly, by the respective Parties at the time the COPA is granted. An organizational chart identifying all of the subsidiaries and affiliates of Mountain States is attached as **Exhibit 11.2**. An organizational chart identifying all of the subsidiaries and affiliates of Wellmont is attached as **Exhibit 11.3**.⁴⁵

- e. **REQUEST:** A description of the competitive environment in the parties’ geographic service area, including:

- (i) Identification of all services and products likely to be affected by the Cooperative Agreement and the locations of the affected services and products;

RESPONSE: Please see response to item 11.c.

- (ii) The parties’ estimate of their current market shares for services and products and the projected market shares if the COPA is granted;

RESPONSE: The Parties estimate their current share in the Geographic Service Area for general acute care inpatient services based on Calendar Year 2014 ("CY2014") discharge data⁴⁶ as follows:

Table 11.1 – Share of CY2014 Discharges, Current Systems⁴⁷

System	Total	Share of Total Discharges
Mountain States	58,441	45.6%
Wellmont	35,075	27.4%
Other	34,584	27.0%

⁴⁵ Wellmont has publicly announced its plan to repurchase Takoma Regional Hospital ("Takoma") in Greeneville, Tennessee. 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.

⁴⁶ Shares of the Geographic Service Area and for general acute care inpatient services were calculated using CY2014 discharge data for all Tennessee and Virginia hospitals. Shares were calculated defining general acute care services excluding normal newborns (DRG 795) and including (excluding) MDC 19 (Mental Diseases) and MDC 20 (Alcohol/Drug Use or Induced Mental Disorders). Tables detailing discharges by hospitals serving the Geographic Service Area, and hospitals in the Geographic Service Area, are in **Exhibit 5.2**.

⁴⁷ Shares for this table were calculated defining general acute care services excluding normal newborns (DRG 795).

Table 11.1 identifies the percentage of total discharges in the Geographic Service Area (exclusive of DRG 795) that are accounted for by Mountain States, Wellmont, or other health care systems. Share analyses demonstrate that three hospitals (Bristol Regional Medical Center, Holston Valley Medical Center, and Johnson City Medical Center) make up fifty-eight percent (58%) of the combined system's discharges.⁴⁸ Other Mountain States and Wellmont hospitals individually contribute less than one to two percent (1-2%) to the total discharge volume accounted for by their respective parent system.

If the COPA is granted and volumes in the Geographic Service Area remain consistent with CY2014 trends, then the Parties estimate the projected shares for general acute care inpatient services would be as follows in **Table 11.2**:

Table 11.2 – Share of CY 2014 Discharges, New Health System

System	Total	Share of Total Discharges
New Health System	93,516	73.0%
Independent Competitors	34,584	27.0%

Due to the large independent physician community in the Geographic Service Area, the Parties do not expect a material change in the shares for physician services. Approximately seventy percent (70%) of all practitioners in the Geographic Service Area are independent. Even in overlap specialties, there are substantial competitive alternatives as reflected in the number of independent physicians in the specialty. **Table 11.3**⁴⁹ provides share estimates for independent physicians, Wellmont, and Mountain States in the specialties in which there is an overlap. **Table 11.4** reports shares for specialties in which there is not an overlap – that is, where Mountain States and Wellmont do not each employ physicians.

⁴⁸ These three hospitals account for 42.3% of discharges by all hospitals in the Geographic Service Area.

⁴⁹ **Tables 11.3** and **11.4** are based on data and information provided by the Parties regarding physicians with admitting privileges at their hospitals and employed or affiliated physicians and the specialty of physicians.

Table 11.3 – Shares of Physicians in Overlapping Specialties, by System

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate ⁵⁰
Grand Total (Overlap/Non-Overlap)		2,142	70%	9%	17%	4%
Emergency Medicine	X	141	95%	1%	1%	3%
Neurology	X	75	91%	3%	4%	3%
Otolaryngology	X	21	90%	5%	5%	0%
Pediatrics	X	87	87%	3%	9%	0%
General Surgery	X	57	70%	7%	19%	4%
Internal Medicine	X	178	67%	19%	13%	1%
OB/GYN	X	81	67%	10%	23%	0%
Neurosurgery	X	20	65%	5%	25%	5%
Family Medicine	X	183	63%	16%	20%	1%
Orthopedic Surgery	X	68	63%	3%	32%	1%
Psychology	X	5	60%	20%	20%	0%
Psychiatry	X	30	57%	10%	33%	0%
Pain Management	X	6	50%	17%	17%	17%
Cardiothoracic Surgery	X	21	43%	38%	19%	0%
Pulmonology	X	37	38%	38%	19%	5%
Occupational Medicine	X	5	20%	40%	40%	0%
Hematology/Oncology	X	34	15%	44%	35%	6%
Cardiology	X	70	14%	49%	36%	1%
Hospital Medicine	X	123	14%	10%	58%	15%

⁵⁰ Mountain States Affiliate physicians are those physicians who are not employed by Mountain States but who do provide services to Mountain States through a contractual arrangement. To be conservative, these physicians are counted along with the Mountain States employed physicians in assessing the "overlap" between Mountain States and Wellmont.

Table 11.4 – Shares of Physicians in Non-Overlapping Specialties, by System

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate ⁵¹
Grand Total (Overlap/Non-Overlap)		2,142	70%	9%	17%	4%
Allergy and Immunology	-	5	100%	0%	0%	0%
Child Development	-	1	100%	0%	0%	0%
Colorectal Surgery	-	2	100%	0%	0%	0%
Dentistry	-	8	100%	0%	0%	0%
Hand Surgery	-	2	100%	0%	0%	0%
Maternal and Fetal Medicine	-	2	100%	0%	0%	0%
Neonatology	-	8	100%	0%	0%	0%
Ophthalmology	-	35	100%	0%	0%	0%
Optometry	-	1	100%	0%	0%	0%
Oral Surgery	-	11	100%	0%	0%	0%
Pathology	-	24	100%	0%	0%	0%
Pediatric Dentistry	-	7	100%	0%	0%	0%
Pediatric Emergency Medicine	-	3	100%	0%	0%	0%
Pediatric Gastroenterology	-	2	100%	0%	0%	0%
Pediatric Hematology Oncology	-	2	100%	0%	0%	0%
Pediatric Nephrology	-	1	100%	0%	0%	0%
Pediatric Pulmonology	-	1	100%	0%	0%	0%
Pediatric Surgery	-	1	100%	0%	0%	0%
Perfusionist	-	1	100%	0%	0%	0%
Physician Assistant	-	55	100%	0%	0%	0%
Plastic Surgery	-	13	100%	0%	0%	0%
Podiatry	-	20	100%	0%	0%	0%
Radiology	-	186	100%	0%	0%	0%
Rheumatology	-	6	100%	0%	0%	0%
Sports Medicine	-	3	100%	0%	0%	0%
Telemedicine	-	2	100%	0%	0%	0%
Teleradiology	-	10	100%	0%	0%	0%

⁵¹ Mountain States Affiliate physicians are those physicians who are not employed by Mountain States but who do provide services to Mountain States through a contractual arrangement. To be conservative, these physicians are counted along with the Mountain States employed physicians in assessing the "overlap" between Mountain States and Wellmont.

Table 11.4 – Shares of Physicians in Non-Overlapping Specialties, by System (Continued)

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate
Grand Total (Overlap/Non-Overlap)		2,142	70%	9%	17%	4%
Nurse Practitioner	-	89	98%	0%	2%	0%
CRNA	-	75	97%	0%	0%	3%
Anesthesiology	-	65	97%	0%	0%	3%
Nephrology	-	16	94%	0%	6%	0%
Gastroenterology	-	30	90%	0%	10%	0%
Unknown	-	9	89%	0%	11%	0%
Urology	-	23	87%	0%	13%	0%
Physical Medicine and Rehabilitation	-	11	82%	18%	0%	0%
Infectious Disease	-	10	80%	20%	0%	0%
Dermatology	-	6	67%	0%	33%	0%
Pediatric Critical Care	-	3	67%	0%	0%	33%
Palliative Care	-	2	50%	50%	0%	0%
Pediatric Cardiology	-	4	50%	50%	0%	0%
Pediatric Neurology	-	2	50%	0%	0%	50%
Surgical Oncology	-	2	50%	50%	0%	0%
Radiation Oncology	-	11	36%	64%	0%	0%
Oncology	-	7	29%	43%	0%	29%
Trauma Surgery	-	29	21%	0%	38%	41%
Critical Care	-	15	7%	0%	80%	13%
Behavioral Health	-	8	0%	0%	50%	50%
Endocrinology	-	4	0%	0%	50%	25%
Pediatric Endocrinology	-	1	0%	0%	0%	100%
Pediatric Hospital Medicine	-	6	0%	0%	0%	100%
Sleep Medicine	-	2	0%	0%	50%	50%
Urgent Care	-	58	0%	0%	86%	14%

A large number of independent providers of outpatient services compete in the Geographic Service Area. In many outpatient services, including imaging, surgery and urgent care, independent providers account for at least a fifty percent (50%) share. **Table 11.5⁵²** depicts counts and share numbers for categories of outpatient services based on the affiliation of the providers:

⁵² **Table 11.5** depicts the counts and shares for categories of outpatient services and is based on a listing provided by the Parties of outpatient facilities by type including names, locations, and affiliations.

Table 11.5 - Shares of Outpatient Facilities by System

Service Type	WHS & MSHS	Mountain States	Mountain States-	Wellmont	Non-Managed	All Other	Total
	Combined %		NsCH Affiliate		Joint Venture		
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.

- (iii) A statement of how competition among health care providers or health care facilities will be reduced for the services and products included in the Cooperative Agreement; and

RESPONSE: The Parties acknowledge that the merger will eliminate competition between Wellmont and Mountain States in certain areas. The benefits of the merger will far outweigh this loss of competition, due to the cost-savings, quality enhancement and improved access the merger will generate. In addition, significant benefits will result from the Parties' commitments outlined herein, all of which will be actively supervised by the States. Moreover, the New Health System will face significant competition from the independent hospitals and other health care providers located in its service area, and, increasingly, from more distantly located health systems. With enhanced access to cost and quality information, patients utilize their mobility and often leave the immediate service area for health care services in locations including Nashville, Asheville, Knoxville and Winston Salem. The parties expect this pattern to increase.

- (iv) A statement regarding the requirement(s) for any Certificate(s) of Need resulting from the Cooperative Agreement.

RESPONSE: No Certificate of Need will be required under the proposed Cooperative Agreement.

- f. **REQUEST:** Impact on the service area's health care industry workforce, including long-term employment and wage levels and recruitment and retention of health professionals.

RESPONSE: It is the objective of the New Health System to become one of the best health system employers in the nation and one of the most attractive health systems for physicians and employee team members. In order to achieve this objective, the Parties will conduct frequent employee and physician satisfaction and engagement assessments benchmarking with national organizations to achieve at least top quartile performance. The Parties will also build substantial partnerships beyond what currently exist with regional colleges and universities in Tennessee and Virginia that train physicians, nurses, and allied health professionals to ensure there is a strong pipeline of regional health professionals.

The Parties recognize that their workforce is mobile, and there are many opportunities both within the region and in nearby metropolitan areas for their team members. Thus, competitiveness of pay and benefits is critical to the New Health System's success. The New Health System is committed to its existing workforce. Therefore, when the New Health System is formed:

COMMITMENTS

- 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.

COMMITMENTS

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

The New Health System will 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 volume and varies across the market from time to time. Health care workers are in great demand in the region, and retaining and developing excellent health professionals in the region will be of utmost importance to ensure the highest clinical quality. Wages must remain competitive to attract top regional and national talent.

Further, significant investments must be made in the development of infrastructures and human resources for community health improvement, population health management, academics and research, and new high-level services. In addition to the significant ongoing base of clinical personnel, support staff, and physicians, all of these initiatives will serve to further develop the region's health care workforce and support the regional economy.

A hallmark initiative enabled by the proposed merger is the development of an enhanced academic medical center aligned in important ways with the New Health System in its efforts to transform health care delivery and to 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 an enhanced academic medical center to bring specific health care and economic benefits to the community. For example, the Parties, with their academic partners, plan to create new specialty fellowship training opportunities, build an expanded research infrastructure, add new medical and related faculty, and attract research funding, especially translational research, to address regional health improvement objectives. These efforts will benefit the community directly and indirectly, with expanded efforts to develop

research specific to the local communities' health care needs and issues. The Parties intend for the enhanced academic medical center 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 well-being.

In the current environment, Wellmont and Mountain States have been reducing the number of residency slots due to financial constraints. It is a goal of the New Health System to reverse this trend. Using savings obtained from merger-derived efficiencies, the New Health System will work with its academic partners and commit not less than \$85 million over ten years to increase residency and training slots, create new specialty fellowship training opportunities, build and sustain research infrastructure, and add faculty. These are all critical to sustaining an active and competitive training program. New local investment in this research and training infrastructure will attract additional outside investments. State and federal government research dollars often require local matching funds, and grant-making organizations such as the National Institutes of Health and private organizations such as pharmaceutical companies want to know that their research dollars are being appropriated to the highest quality and resourced labs and scientists. Specifically, the Parties commit to the following:

- | COMMITMENTS |
|---|
| <ul style="list-style-type: none">• With 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, and 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. |

g. **REQUEST:** Description of financial performance, including:

- (i) A description and summary of all aspects of the financial performance of each party to the transaction for the preceding five years including debt, bond rating and debt service and copies of external certified public accountants annual reports;

RESPONSE: See attached **Exhibit 11.4** for a description and summary of all aspects of the financial performance of Mountain States for the preceding five fiscal years. See attached **Exhibit 11.5** for a description and summary of all aspects of the financial performance of Wellmont for the preceding five fiscal years. The Mountain States Covenant Compliance Certificates (**Exhibit 11.4D**), the Mountain States Officer's Certificates accompanying Independent Auditor's Reports (**Exhibit 11.4E**), and the Wellmont External Auditor Management Letters (**Exhibit 11.5D**) are considered confidential information and will be subsequently filed.

- (ii) A copy of the current annual budget for each party to the Cooperative Agreement and a three year projected budget for all parties after the initiation of the Cooperative Agreement. The budgets must be in sufficient detail so as to determine the fiscal impact of the Cooperative Agreement on each party. The budgets must be prepared in conformity with generally accepted accounting principles (GAAP) and all assumptions used must be documented;

RESPONSE: The current annual budgets for Mountain States (**Exhibit 11.6**) and Wellmont (**Exhibit 11.7**) are considered competitively sensitive information under federal antitrust laws and will be subsequently filed. A five-year projected budget for the New Health System is attached as **Exhibit 11.8**.

- (iii) A detailed explanation of the projected effects including expected change in volume, price and revenue as a result of the Cooperative Agreement, including;

- I. Identification of all insurance contracts and payer agreements in place at the time of the Application and a description of pending or anticipated changes that would require or enable the parties to amend their current insurance and payer agreements;

RESPONSE: Please see attached **Exhibit 11.9** identifying all insurance contracts and payer agreements in place at the time of the Application for Mountain States. Please see attached **Exhibit 11.10** identifying all insurance contracts and payer agreements in place at the time of the Application for Wellmont.

While some of the payer agreements held by both Parties permit the termination of the agreement by the payer upon a change of control, the Parties do not intend to amend their current insurance and payer agreements in connection with completing the affiliation except as set forth herein. Going forward, the Parties intend the New Health System will negotiate with the payers in the ordinary course of business as each managed care contract comes up for renewal after the Closing.

- II. A description of how pricing for provider insurance contracts are calculated and the financial advantages accruing to insurers, insured consumers and the parties of the Cooperative Agreement, if the COPA is granted including changes in percentage of risk-bearing contracts;

RESPONSE: Like other health systems across Tennessee and the nation, the Parties negotiate with commercial health insurance providers for inclusion in the health insurance plans they offer to employers and individuals. Wellmont and Mountain States each approach these negotiations with the basic goal of agreeing on rates and terms that will enable the health systems to cover the cost of providing high quality health care while earning a reasonable margin to invest in maintaining and improving their facilities and expand their service offerings.

Any pricing limitations agreed to by the New Health System are intended to benefit employers and those who are shouldering the burden of what is projected to be increased overall health care costs in the coming years. This burden has increasingly fallen on consumers who have seen dramatic increases in the deductibles they are required to pay. Unregulated merged systems do not provide for limitations on commercial payment increases, which can negatively impact self-insured employers, employees and insurers who are managing risk. Conversely, the New Health System has committed to a reduction in price increases and set a new, lower cost trend for many third party payers. These pricing commitments are proposed so as to pass savings on to consumers through their chosen insurers resulting from the efficiencies the New Health System expects to achieve.

COMMITMENTS

- For all Principal Payers,* the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract 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.
- 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 result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable consumer price index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, New Health Systems agrees to mediation as a process to resolve any disputes

* For purposes of this Application, "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.

In addition, as a result of the merger, the Parties project that the merger will result in improved quality of care and enhanced clinical coordination. This capability will enable the system to participate meaningfully in various federal and commercial efforts to share risk and take advantage of the scalable ability of the New Health System to better manage the care for high cost, high utilization patients.

Through this effort, these changes will result in fewer hospitalizations and reduced lengths of stay when patients are hospitalized. Insurers and insured consumers will benefit through lower expenditures for inpatient care when patients spend less time in the hospital or are able to avoid hospitalizations altogether.

The Parties' intend to manage population health through the deployment of a research-based ten year plan that is focused on reducing the variables leading to chronic disease, improved clinical coordination, higher quality facilitated by the consolidation of services, and a shared information technology platform, among other things. All of these benefits strengthen the ability of the Parties to engage in risk-based contracting to a far greater extent than is currently the practice in the region. It is, therefore, the intent of the New Health System that future contractual arrangements with payers will be more focused on identification of the drivers of cost, with a shared objective of reducing unnecessary cost, and sharing the benefit of such successful initiatives.

III. The following policies:

- A. Policy that assures no restrictions to Medicare and/or Medicaid patients,
- B. Policies for free or reduced fee care for the uninsured and indigent,
- C. Policies for bad debt write-off; and
- D. Policies that assure parties to the Cooperative Agreement will maintain or exceed the existing level of charitable programs and services.

RESPONSE: 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 are housed within Mountain States. The New Health System will continue to remain committed to these populations, a commitment neither system can make without the proposed merger. The current charity and other related policies for both Mountain States and Wellmont are attached as **Exhibits 8.3 and 8.4**. If the COPA is granted, the Parties intend for the New Health System to adopt policies that are substantially similar to the existing policies of both Parties and consistent with the IRS's final 501(r) rules. As evidence of this commitment, the Parties have committed in the Cooperative Agreement that the New Health System will adopt policies

that are substantially similar to the existing policies of both Parties.⁵³ Specifically, the Parties intend to address each category of patients as follows:

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 population will also be the target of several inter-related health strategies outlined in

⁵³ See **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."

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.

IV. Identification of existing or future business plans, reports, studies or other documents of each party that:

A. Discuss each party's projected performance in the market, business strategies, capital investment plans, competitive analyses and financial projections including any documents prepared in anticipation of the Cooperative Agreement; and

B. Identification of plans that will be altered, eliminated or combined under the Cooperative Agreement or subsequent COPA.

RESPONSE: Information regarding existing and future business plans of Mountain States (**Exhibit 11.11**) and Wellmont (**Exhibit 11.12**) is considered competitively sensitive information under federal antitrust laws and will be subsequently filed.

h. **REQUEST:** A description of the plan to systematically integrate health care and preventive services among the parties to the Cooperative Agreement, in the proposed geographic service area, to address the following:

(i) A streamlined management structure, including a description of a single board of directors, centralized leadership and operating structure;

RESPONSE: Please see response to 11.b above.

(ii) Alignment of the care delivery decisions of the system with the interest of the community;

RESPONSE: A well-executed merger provides multiple opportunities to enhance care delivery and patient outcomes through the consolidation, integration, realignment and/or enhancement of clinical facilities and services (collectively the "Clinical Consolidation"). Clinical Consolidation can involve both concentration of services of a particular type in fewer locations and/or establishment of common protocols and systems across a common set of services with an ultimate goal of yielding improved outcomes, sustaining the most effective levels of services at the right locations, reducing costs of care, and related efficiencies. Where appropriate, these Clinical Consolidations are a standard and widely accepted mechanism for reducing unnecessary cost in health care,

improving quality, and ensuring the services and programs offered by a health care delivery system are continuously evaluated to ensure efficiency and the best outcome for patients.

As a means 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 that will allow the New Health System to utilize a rigorous, systematic method for evaluating the potential merits and adverse effects related to access, quality and service for patients and to make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The Alignment Policy will apply to the consolidation of any clinical facilities and clinical services where the consolidation results in a discontinuation of a major service line or facility such that any such discontinuation would render the service unavailable in that community. Additionally, for two years after the formation of the New Health System, a super-majority vote of the Board is required in the event a service is consolidated in a way that results in discontinuation of that service in a community. A copy of the Alignment Policy is attached as **Exhibit 11.13**.

A likely alternative to the proposed Cooperative Agreement merger would be for each system individually to be purchased by larger health systems from outside the region. Such an alternative is unlikely to be actively supervised to ensure overriding community benefit and would not come close to achieving the same level of efficiencies, cost-savings and quality enhancement opportunities as those proposed by the New Health System and outlined in this Application.

- (iii) Clinical standardization;

RESPONSE: A well-executed merger can also improve patient outcomes if it results in improved performance management processes to assist leaders in identifying where (and why) problems are occurring and how to implement best practices to coordinate care across the system. The New Health System is firmly committed to standardizing its management and clinical practice policies and procedures to promote efficiency and higher standards of care throughout the New Health System. As evidence of this commitment, the New Health System will establish a system-wide, physician-led Clinical Council in order to identify best practices that will be used to develop standardized clinical protocols and models for care across the New Health System. These standardized practices, models and protocols will help reduce error and overlap, shorten length of stay, reduce costs, and improve patient outcomes. The Cooperative Agreement will allow the New Health System to share the clinical and

financial information needed to integrate this process across the range of inpatient, outpatient, and physician services. The Clinical Council will be composed of independent, privately practicing physicians as well as physicians employed by the New Health System or its subsidiaries or affiliates as more fully described in **Section 8** herein. It would not be possible for the two competing systems to standardize procedures and policies for clinical best practices as effectively, or to develop such new care models, absent the merger.

Many of the initiatives to reduce variation and improve quality will be derived from new contracting practices designed to ensure collaboration between the New Health System and the payers. These practices will be designed to use the analytic strength of the payers to identify high cost services and processes, and then align the interest of the payer and the New Health System to reduce cost and improve the overall patient outcome. This approach to value-based purchasing will truly harness the intent of the changes in federal policy that encourage improved population health. From contracting to implementation, the objective is to identify where the opportunities for patient outcome improvement and cost reduction exist, and to then collaborate with physician leadership to execute legitimate and scalable strategies throughout the region to achieve the mutual objectives of the payer and the health delivery system.

- (iv) Alignment of cultural identities of the parties to the Cooperative Agreement; and

RESPONSE: There are many specific steps the Parties will take to align the cultural identities of the two organizations, including merging the executive leadership, establishing a board made up of equal representation from both legacy systems, agreeing on the appointment of new, independent board members with expertise in integration, implementation of a Clinical Council, bringing together key providers of both systems and implementing a single information technology platform that will be used to promote system-wide communication, cultural integration, and implement common clinical standards for improvement of patient quality.

The New Health System's board of directors and management team will be composed of current executives from both Wellmont and Mountain States.

- The board of directors of the New Health System will be comprised of fourteen voting members, as well as two ex-officio

voting members and one ex-officio non-voting member. Wellmont and Mountain States will each designate six members to serve on the initial board of the New Health System.

- Wellmont and Mountain States will jointly select two members of the initial New Health System board, who would not be incumbent members of either Party's board of directors.
- The two ex-officio voting members will be the New Health System Executive Chairman/President and the New Health System Chief Executive Officer. The ex-officio non-voting member will be the then current President of ETSU.
- The New Health System will have a new name and will be managed by an executive team with representatives from each organization serving in the following agreed-upon roles— Executive Chairman/President Alan Levine (currently Mountain States' CEO), CEO Bart Hove (currently Wellmont's CEO), Chief Operating Officer Marvin Eichorn (currently Mountain State's Chief Operating Officer) and Chief Financial Officer Alice Pope (currently Wellmont's Chief Financial Officer).
- All Board committees of the New Health System will be established with initial membership of equal representation from both legacy organizations. Likely committees will include: Executive, Finance; Audit and Compliance; Quality, Service and Safety; Executive Compensation; Workforce; Community Benefit; and Governance/Nominating.

Promptly after Closing, the New Health System will establish a physician-led Clinical Council (see **Section 8.A.iii**) to establish common standards of care, credentialing standards, quality performance standards and best practices. The initial Clinical Council will equally represent physicians whose primary practice venue is currently Wellmont or Mountain States.

As discussed in **Section 8.A.i**, the New Health System will adopt a Common Clinical IT Platform that will allow all providers in the New Health System to quickly obtain full access to patient records at the point of care and will be used for system-wide communication and monitoring of best practices and establishment of new protocols to improve quality of care.

The New Health System is committed to its current workforce and will honor prior service credit, address any differences in salary/pay rates and benefits, offer competitive salaries, and combine the best of each

hospital's career development programs as described more fully in **Section 11.f.**

Cultures will be further aligned by the increased emphasis on quality through the use of a common set of measures and protocols and the timely public reporting of many quality measures, as discussed in **Section 8.A.iv.** This combined emphasis on quality and public reporting of quality measures will significantly contribute to promoting a common culture emphasizing quality in the New Health System.

- (v) Implementation of risk-based payment models to include risk, a schedule of risk assumption and proposed performance metrics to demonstrate movement toward risk assumption and a proposed global spending cap for hospital services.

RESPONSE: Wellmont and Mountain States believe the formation of the New Health System will greatly accelerate the move from volume-based health care to value-based health care. The Affordable Care Act is moving providers away from the fee-for-service reimbursement system toward a risk-based model that rewards improved patient outcomes and incentivizes the provision of higher-value care at a lower cost. CMS has stated that its goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. However, the movement to value-based payment requires comprehensive provider networks to form and contract for the total care of patients in a defined population. The formation of the New Health System will align the region's hospitals and related entities into one seamless organization, working together to enter into value-based contracts. The scale created by the merger will foster opportunities for cost-savings and quality-enhancement through risk contracting to a degree neither system could come close to achieving independently.

The New Health System intends to discuss risk-based models with its Principal Payers for some portion of each Principal Payer's business. Those discussions would address both New Health System's and Principal Payer's willingness and ability to successfully implement risk-based models and over what time period. Additionally, the New Health System will commit to having at least one risk-based model in place within two years after Closing. No payer has historically expressed an interest in a global spending cap for hospital services in this region. However, after completing its clinical integration/alignment, the New Health System is willing to engage in those discussions if requested by a reputable payer, and assuming the New Health System is extended an actuarially sound

proposal.

As further evidence of its commitment to move towards risk-based payment, the New Health System is willing to commit to the following:

COMMITMENTS
<ul style="list-style-type: none">• 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 system.• Adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System. This fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, post-acute care and outpatient services and facilitate the move to value-based contracting.
<p>* For purposes of this Application, "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.</p>

i. **REQUEST:** A description of the plan, including economic metrics, that details anticipated efficiencies in operating costs and shared services to be gained through the Cooperative Agreement including:

- Proposed use of any cost savings to reduce prices borne by insurers and consumers;
- 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; and
- Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

RESPONSE: Funding the population health, access to care, enhanced health services, and other commitments described in this 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. The Parties have analyzed the anticipated efficiencies in three categories and calculated the following anticipated savings.

The Parties 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. 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 findings of the FTI Consulting Report are more fully discussed below.

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.

- Proposed use of any cost savings to reduce prices borne by insurers and consumers.

RESPONSE: To ensure that savings and benefits are passed on from the merged system to patients, employers and insurers, while also investing in improving quality and patient service, the New Health System will make the following commitments.

COMMITMENTS

- For all Principal Payers,* the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract 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.
- 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 result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable consumer price index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, New Health Systems agrees to mediation as a process to resolve any disputes

* For purposes of this Application, "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.

- 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 region⁵⁴ 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 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

⁵⁴ 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.

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.

Improving Health Care Value. 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. To ensure that savings realized by reducing duplication and improving coordination will remain within the region and be reinvested in ways that substantially benefit the community through new services and capabilities, the New Health System is prepared to make significant commitments related to pricing, consolidation of services, and standardization of practices which are described in more detail in this Application.

Investment in Health Research and Graduate Medical Education. The New Health System will commit not less than \$85 million over ten years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty – all critical to sustaining an active and competitive training program. These funds will enhance the Parties' academic partners' abilities to invest in additional research infrastructure, a significant benefit to the State of Tennessee and Commonwealth of Virginia. Additionally, partnerships with academic institutions in Tennessee and Virginia will enable research-based and academic approaches to the provision of the services the New Health System intends to invest to improve overall population health. These initiatives would not be sustainable in the region without the financial support created by the merger.

Avoidance of Duplication of Hospital Resources. Combining the region's two major health systems in an integrated delivery model is the best and most effective 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. 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.

Improvements in Patient Outcomes. The region served by the Parties to the Cooperative Agreement faces significant health care challenges. In this environment, a key goal of the Cooperative Agreement is to better enable the Parties to sustain and enhance services and improve the quality of health care and patient outcomes in the region. The New Health System will adopt a Common Clinical IT Platform to allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care, supporting the regional exchange of health information to encourage and support patient and provider connectivity to the New Health System's integrated information system, establishing a system-wide, physician-led clinical council responsible for implementing quality performance standards across the New Health System, and publicly reporting extensive quality measures with respect to the performance of the New Health System to promote transparency and further incentivize the provision of high quality care. These commitments will result in the investment of up to \$150 million over ten years to ensure a Common Clinical IT Platform and interoperability among the New Health System's hospitals, physicians, and related services.

Preservation of Hospital Facilities in Geographical Proximity to the Patients They Serve. The Parties recognize that it will be increasingly difficult to continue supplementing rural facilities over the long-term without the savings the proposed merger would create. Continued access to appropriate hospital-based and clinical services in the rural areas of these communities is a significant priority and a driving impetus for the Cooperative Agreement. Last year alone, Mountain States and Wellmont collectively invested over \$19.5 million to ensure that inpatient services continued to remain available in these smaller communities. To address this, the New Health System will commit that all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. In order to ensure higher-level services are available in close proximity to where the population lives, the New Health System will also commit to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol. The proposed Cooperative Agreement is the only means to achieve the efficiencies and generate the resources needed to sustain hospital operations in these areas across the region to preserve and enhance access to quality care in these rural communities.

Enhanced Behavioral Health & Substance Abuse Services. In the region the Parties serve, behavioral health problems and substance abuse are prevalent, imposing an extensive societal cost that warrants priority attention. The largest diagnosis related to regional inpatient admissions is psychoses, yet significant gaps exist in the continuum of care related to these services. As part of the public benefit associated with the merger, the New Health System commits to make major investments in programs and partnerships to help address and ameliorate behavioral and addiction problems. The New Health System will invest in the development of new capacity for residential addiction treatment with the goal of reducing the incidence of addiction in our region.

- j. **REQUEST:** Proposed Measures and suggested baseline values with rationale for each Measure to be considered by the Department in development of an Index. Proposed Measures are to be used to continuously evaluate the Public Advantage of the results of actions approved in the COPA through the Cooperative Agreements under active supervision of the Department. Measures should include source and projected trajectory over each of the first five years of the Cooperative Agreement and the trajectory if the COPA was not granted; Proposed Measures may include:
- (i) Improvements in the service area population's health that exceed Measures of national and state improvement;
 - (ii) Continuity in availability of services throughout the service area;

- (iii) Access and use of preventive and treatment health care services throughout the service area;
- (iv) Operational savings projected to lower health care costs to payers and consumers; and
- (v) Improvements in quality of services as defined by surveys of the Joint Commission.

RESPONSE: The region served by the Parties to the Cooperative Agreement faces significant health care challenges. For example, a 2015 Tennessee Department of Health report finds 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%). According to the same report, three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for frequency of low birth weight births and three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for teen pregnancy rates. **Table 8.1** reports key statistics on the population of the counties in the Geographic Service Area, including metrics for obesity, smoking, death rates due to drug poisoning and childhood poverty.

The Parties share the State's concern about health disparities in the region and are aware of the acute challenges present in the individual counties across the Geographic Service Area. As a result, the Parties propose that ongoing evaluation of the Public Advantage resulting from the merger take into consideration the New Health System's pursuit of the Institute of Health Improvement's Triple Aim goals, commonly considered the national standard for evaluation of health care effectiveness. The Triple Aim objectives are to improve population health, improve patient experience of care (quality and access), and manage the per capita cost of health care. In this application, the Parties have organized the necessary actions by the New Health System to pursue the Triple Aim objectives as follows:

- Improving Community Health
- Enhancing Health Care Services
- Expanding Access and Choice
- Improving Health Care Value: Managing Quality, Cost and Service
- Investment in Health Research and Graduate Medical Education
- Attracting and Retaining a Strong Workforce

In order to evaluate the public benefit provided by the New Health System on a continuous basis, the Parties propose that the Department adopt an **Index of Public Advantage and Community Health Improvement** comprised of five major categories:

- A. Commitment to Improve Community Health
- B. Enhanced Health Care Services
- C. Expanding Access and Choice
- D. Improving Health Care Value: Managing Quality, Cost and Service
- E. Investment in Health Research/Education and Commitment to Workforce

A description of each category and the accountability mechanisms the Parties propose the State consider for each category are outlined in detail in the following sections.

A. Commitment to Improve Community Health

Community health is affected by a complex variety of factors including genetic predisposition, behavioral patterns, social circumstances, environmental exposures, and access to quality health care. Because of the complex set of influences that shape community health and well-being, effective improvement strategies must be developed through a combination of evidence-based approaches and an understanding of local and regional culture, capacity and resources. Plans that are adopted “off the shelf” from elsewhere, without community buy-in and adaptation, have less chance of success. Although there are similarities with other parts of Tennessee and Virginia, the southern Appalachian mountain region of Northeast Tennessee and Southwest Virginia has a distinct culture, capacity and resource base that results in a unique set of health issues.

There are tremendously valuable assets, organizations and individuals highly motivated to address the underlying factors that affect the poor health status of our region. ETSU's College of Public Health and Quillen College of Medicine are both nationally recognized for their contributions to rural community health improvement, along with a host of other academic institutions throughout the region. In addition, municipalities, community organizations such as local United Way agencies and YMCAs, Healthy Kingsport, chambers of commerce, and health departments are highly motivated to work in new, focused ways to improve community health.

Much of the work and investment devoted to these efforts in the past, however, has lacked unified focus in combination with sustainable funding. While the Parties believe that motivated leadership and substantial investment from the New Health System will be transformational, they also believe that a sustainable collective impact model of community health improvement stands the best chance of creating long-standing health improvements.

To make sustained improvements in health, a portfolio of investments,

interventions and performance improvements designed to impact specific long-term goals at a variety of intervention and prevention levels is necessary. **Figure 11.1** depicts the National Association of County and City Health Officials Mobilizing for Action through Planning and Partnerships ("MAPP") process for community health improvement. MAPP suggests that it is critical for the New Health System, the State and local Departments of Health and the broad community of stakeholders to work together in an Accountable Care Community arrangement to formulate the appropriate investments, interventions and performance improvements to populate a robust and dynamic community health improvement portfolio. This process includes 1) defining a common vision and goals; 2) conducting comprehensive assessments of community health status and well as community and public health systems culture, capacity and resources; 3) prioritizing health issues; 4) formulating goals and strategies; and 5) evaluation and monitoring.

Figure 11.1 - Mobilizing for Action through Planning and Partnerships



Some progress has already been made. Several local, state and national analyses have identified the key health issues in our region and there is considerable overlap in their findings. Groups such as the Southwest Virginia Health Authority, Healthier Tennessee, and Healthy Kingsport have organized to collectively address these findings, and important relationships have been formed.

Additionally, in cooperation with the College of Public Health at ETSU, the Parties launched the region's most substantial community health improvement assessment effort in August. Four Community Health Work Groups have been 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. These workgroups are co-chaired by regional community leaders from both Tennessee and Virginia and are organized by Healthy Children and Families, Mental Health and Addiction, Population Health and Healthy Communities, and Research and Academics. The charters for these groups can be found in **Exhibit 8.2A**.

Analyzing the most current findings of the Tennessee State Health Plan, the Virginia Health Innovation Plan, Healthier Tennessee and the Southwest Virginia Blueprint for Health Improvement and Health-Enabled Prosperity, as well as initial feedback from the Community Health Work Groups organized by Mountain States and Wellmont, the Parties have identified five Key Focus Areas and several related Health Concerns in which the New Health System is committed to investing at least \$75 million over ten years in population health improvement.

- ***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.

- **Improve Access to Behavioral Health Services** through new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region; as well as community-based mental health resources, such as mental 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.

For the first category of the Index, the Parties propose an accountability mechanism for the commitment to improve community health that the New Health System has set forth in this Application. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted) in **Table 11.6**.

Table 11.6 - Proposed Commitment to Improve Community Health Measures

Index of Public Advantage and Community Health Improvement		
A. Commitment to Improve Community Health Measures		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	The New Health System is committed to creating a new integrated delivery system designed to improve community health through investment of not less than \$75 million over ten years in population health improvement.	Annual report to State attesting to progress towards compliance until \$75 million is invested.
2.	The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed-upon by the State and the New Health System in the COPA.	Commitment to Community Health Annual Report to State will attest to progress on the accountability mechanisms for each Key Focus Area as outlined in the COPA.
3.	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 herein.	Annual report to State attesting to compliance with reporting obligations as outlined in the COPA.

In addition to the Commitment to Community Health Annual Report, described in more detail below, the Parties will submit a yearly report to the State attesting to progress toward the creation of a new integrated delivery system through investment of not less than \$75 million and an annual report to the State attesting to compliance with the quality reporting obligations as outlined in the COPA.

The annual report to the State attesting to progress on the achievement of accountability mechanisms for each Key Focus Area (the "Commitment to Community Health Annual Report") would be developed as follows:

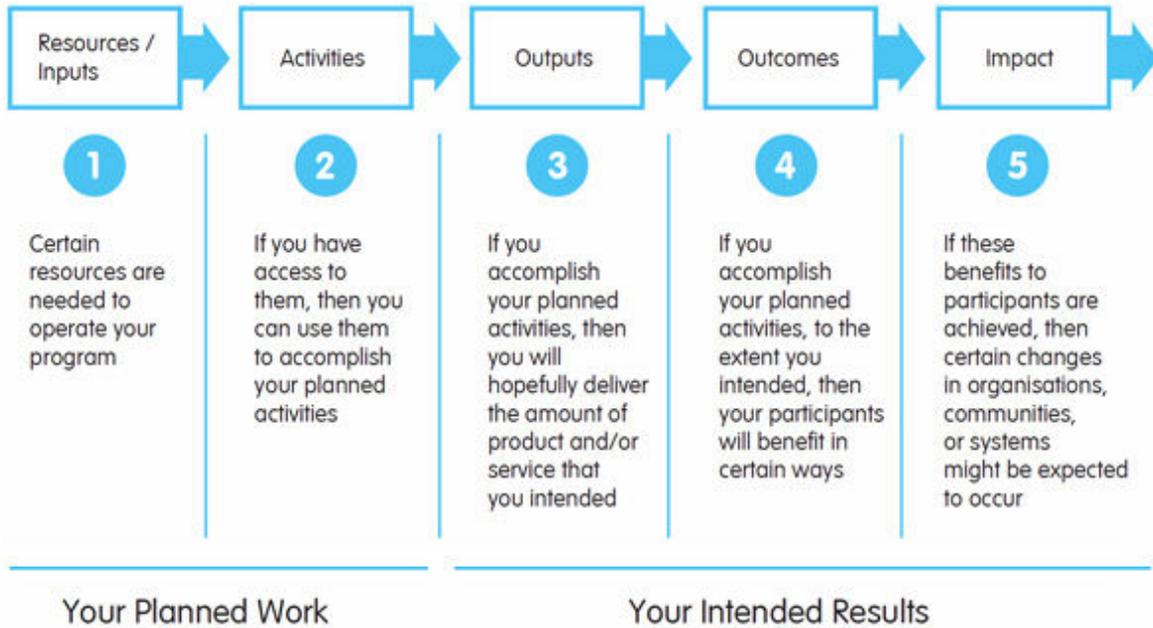
Proposal for Development of the Commitment to Community Health Annual Report

- As part of the State's process to determine the Application's completeness, the Department and the Parties will agree on the Key Focus Areas of the commitment to improve community health.
- After the Application is deemed complete, and during the Application review period, the New Health System and the Department, with input from community stakeholders (including the Department's Advisory Groups) will agree on a limited number of Health Concerns, Tracking Measures and relevant baselines within each Key Focus Area. Agreement on these specific Health Concerns for inclusion in the Commitment to Community Health Annual Report will serve as the guide for on-going development with the State and stakeholder community for the specific investments, interventions or performance improvements by the New Health System to improve community health in the region over the duration of the COPA.
- The COPA, if granted, will outline the specific Key Focus Areas, the individual Health Concerns, the Accountability Mechanisms, the Tracking Measures, and relevant baselines within each area agreed upon by the Department and the New Health System to be included in the Commitment to Community Health Annual Report.

Recognizing the complex interplay of inputs and activities in reaching desired population health outcomes, the Parties propose to use the Kellogg Foundation's Logic Model displayed in **Figure 11.2** for development of the Commitment to Community Health Annual Report Measures.

The evaluation of improvement in community health is complex and involves many factors, both short-term and long-term. Population health improvement programs can be characterized by their inputs, activities, outputs, outcomes, and impact. *Inputs* are the resources dedicated to or consumed by the program, including the human, financial, organizational, and community resources a program has available to direct toward doing the work. *Activities* are what the program does with its inputs to fulfill its mission. These include the processes, tools, events, technology, and actions that are an intentional part of the program implementation. *Outputs* are the direct products of program activities and may include types, levels and targets of services to be delivered by the program. *Outcomes* are the specific changes in program participants' behavior, knowledge, skills, status and level of functioning. *Impact* is the fundamental change occurring in organizations, communities or systems as a result of program activities often with longer-term time frames of 7 to 10 years.

Figure 11.2 - Logic Model for Evaluation



Under this model the State could evaluate progress toward *long-term* community health improvement outcomes under the COPA by measuring investments made in community health (Inputs) and the implementation of new programs or performance improvement (Activities). The State and the New Health System could track participation or service levels related to these programs and performance improvements (Outputs). Over time, the cumulative effect of these efforts is expected to result in the intended population health improvement (short and medium-term Outcomes and long-term Impact).

Table 11.7 identifies the proposed five Key Focus Areas in which the New Health System is committed to investing in community health improvement and which the Parties propose be included in the Commitment to Community Health Annual Report. Within each Key Focus Area, the Parties have identified specific Health Concerns (first column) that pose an important challenge and priority for health in this region; these are aligned with health challenges and priorities identified by the states. The second column identifies 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.

Column Three provides 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 fourth (highlighted) column provides the relevant Accountability Mechanism the parties believe reflects the New Health System's performance related to the investment, intervention, or performance improvement.

Column Five provides a representative progress measure that could be used to measure progress in the Geographic Service Area for this health concern.⁵⁵ The final two columns reference County level disparities 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.

⁵⁵ In addition to consideration of Triple Aim objectives, the Parties also have considered the categories of health measures for access, cost, health, and quality identified in the Institute of Medicine ("IOM") Vital Signs Core Measures; each of the several areas that these investment, intervention, or performance improvement would target are aligned with specific IOM Core Measures.

Table 11.7 - Sample Commitment to Community Health Annual Report

<i>Health Concern</i>	<i>Health Concern Tracking Measures in the TN & VA Service Area</i>	<i>Representative Investment, Intervention, or Performance Improvement</i>	<i>Representative Accountability Measures</i>	<i>Representative Progress Measures</i>	<i>Lowest Ranking Tennessee Counties in Geographic Service Area</i>	<i>Lowest ranking Virginia Counties in Geographic Service Area⁵⁶</i>	
Key Focus Area #1: Ensure Strong Starts for Children							
1.	Low Birth-Weight Babies	Low-birth weight rate per 100,000 population	Establish evidence-based Home Visitation Programs in certain high-risk counties ⁵⁷	Establish agreed- upon number of evidence-based Home Visitation Programs ⁵⁸ in specific counties by set date	Percentage of eligible women in high-risk communities participating in evidenced-based Home Visitation Programs	Johnson, Carter, Cocke ⁵⁹	Tazewell, Buchanan, Smyth ⁶⁰
2.	Neonatal Abstinence Syndrome	Percent of Births in New Health System with NAS	Establish residential treatment for pregnant woman with addiction in certain high-risk communities ⁶¹	Establish agreed-upon number of residential treatment programs for pregnant woman with addiction in specific counties by set date	Number of women in high-risk communities initiating residential treatment	Hancock, Hamblen, Hawkins ⁶²	Dickenson, Wise, Tazewell, Buchanan ⁶³

⁵⁶ This column is based on data that includes the Virginia counties and Independent Cities within the Geographic Service Area.

⁵⁷ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,4,5,8, and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

⁵⁸ Nurse Family Partnership is one example of a Department of Health and Human Services “evidenced based early childhood home visitation service delivery model.” Nurse Family Partnership is designed for first-time, low-income mothers and their children, from during pregnancy to when the child turns two. It includes face-to-face home visits by a registered nurse trained in the Nurse Family Partnership fidelity model.

⁵⁹ Tennessee: Percent of Low Birthweight. County Health Rankings. Accessed February 3, 2016.

⁶⁰ Virginia: Percent of Low Birthweight. County Health Rankings. Accessed February 3, 2016.

⁶¹ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,4,8,and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

⁶² As county-level Neonatal Abstinence Syndrome data is not currently available, adult drug poisoning deaths is used as a proxy measure. Tennessee: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

⁶³ As county-level Neonatal Abstinence Syndrome data is not currently available, adult drug poisoning deaths is used as a proxy measure. Virginia: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

Health Concern	Health Concern Tracking Measures in the TN & VA Service Area	Representative Investment, Intervention, or Performance Improvement	Representative Accountability Measures	Representative Progress Measures	Lowest Ranking Tennessee Counties in Geographic Service Area	Lowest ranking Virginia Counties in Geographic Service Area ⁵⁶	
3.	Childhood Obesity	Percent children w/ BMI >= 95th percentile of the sex-specific CDC BMI-for-age growth charts	Expand “Morning Mile” Program in certain high-risk communities ⁶⁴	Expand “Morning Mile ⁶⁵ ” Program through investment of an agreed-upon amount by set date	Number of children participating in Morning Mile in high-risk communities	Hawkins, Sullivan, Greene ⁶⁶	Russell, Scott, Grayson, Washington, Wise ⁶⁷
4.	Third Grade Reading Ability	Percent 3 rd graders reading at grade level	Expand “Bear Buddy” program ⁶⁸	Expand “BEAR Buddies ⁶⁹ ” program through investment of an agreed-upon amount by set date	Number of children participating in BEAR Buddies in TN & VA in high-risk communities	Hancock, Cocke, Carter ⁷⁰	Bristol City, Buchanan, Wythe ⁷¹

⁶⁴ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

⁶⁵ The Morning Mile is a before-school walking/running program that gives children the chance to start each day in an active way while enjoying fun, music and friends. The Morning Mile is currently sponsored in the Geographic Service Area by Mountain States. Additional Information is *available at*: <https://www.mountainstateshealth.com/medical-services/kohls-morning-mile>

⁶⁶ As county-level data on child obesity was not available, adult obesity rates were used as a proxy measure. Tennessee: Percent of Adult Obesity. County Health Rankings. Accessed February 3, 2016.

⁶⁷ As county-level data on child obesity was not available, adult obesity rates were used as a proxy measure. Grayson, Washington, and Wise are in a three-way tie having the third highest obesity rate among the counties in the service region. Virginia: Percent of Adult Obesity. County Health Rankings. Accessed February 3, 2016.

⁶⁸ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

⁶⁹ The BEAR (Being Engaged to Achieve Reading) Buddies program is a partnership between Niswonger Children’s Hospital and local schools designed to help children achieve early reading proficiency. BEAR Buddies pairs high school mentors with students in first, second or third grade who are six months or more behind in their reading level.

⁷⁰ Tennessee: TCAP District Level Results – 3rd through 8th Grade Reading Level. Percent Basic through Percent Advanced. Tennessee Department of Education. Accessed February 4, 2016.

⁷¹ Virginia: SOL Assessment – 3rd Grade English Reading Pass Rate for 2014 - 2015. Virginia Department of Education. Accessed February 4, 2016.

Health Concern	Health Concern Tracking Measures in the TN & VA Service Area	Representative Investment, Intervention, or Performance Improvement	Representative Accountability Measures	Representative Progress Measures	Lowest Ranking Tennessee Counties in Geographic Service Area	Lowest ranking Virginia Counties in Geographic Service Area ⁵⁶	
Key Focus Area #2: Help Adults Live Well in the Community							
1.	Premature death from Cardiovascular Disease	Age-Adjusted Death Rates for Diseases of the Heart per 100,000	Expansion of community-based smoking cessation programs in certain high-risk communities ⁷²	Expansion of community-based smoking cessation programs through investment of an agreed-upon amount by set date	Number of participants in smoking cessation programs in high-risk communities	Unicoi, Cocke, Hancock ⁷³	Tazewell, Smyth, Scott ⁷⁴
2.	Premature death from Diabetes	Age Adjusted Death Rates for Diabetes Mellitus per 100,000	Medical Staff Quality Improvement Project to reduce PQI Admissions for Diabetes Short-Term Complications ⁷⁵	Establish Medical Staff Quality Improvement Project to reduce PQI Admissions for Diabetes Short-Term Complications by set date	Number of Physicians participating in quality improvement project	Hamblen, Carter, Greene, Sullivan ⁷⁶	Scott, Smyth, Tazewell
3.	Premature death from Breast, Cervical, Colon and Lung Cancer	Age Adjusted Death Rates for Select Cancers per 100,000	Establish Faith-based screening campaigns for selected cancers (e.g. mammograms, prostate cancer) in specific high-risk counties ⁷⁷	Establish agreed-upon number of Faith-based screening campaigns in certain counties by set date	Number of parishioner screenings in high-risk counties	Hawkins, Cocke, Johnson ⁷⁸	Bristol City, Smyth, Buchanan ⁷⁹

⁷² This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,7,8,11, and 14. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

⁷³ "Ischemic Heart Disease in Tennessee." US Department of Health and Human Services' Area Health Resource File. Available at: <http://ahrf.hrsa.gov/>.

⁷⁴ "Ischemic Heart Disease in Virginia." US Department of Health and Human Services' Area Health Resource File. Available at: <http://ahrf.hrsa.gov/>.

⁷⁵ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,7,8,9,10, and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

⁷⁶ Tennessee: Diabetes Mortality Rate. US Department of Health and Human Services' Area Health Resource File. Available at: <http://ahrf.hrsa.gov/>. Greene and Sullivan counties tie for having the third highest rate among counties in the service area. Virginia: Diabetes Mortality Rate. US Department of Health and Human Services' Area Health Resource File. Available at: <http://ahrf.hrsa.gov/>.

⁷⁷ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,7,8,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

⁷⁸ Tennessee: Age Adjusted Mortality Rate from Breast, Cervical, Colon or Lung Cancer 2014. CDC Wonder Database. Accessed February 3, 2016.

Health Concern	Health Concern Tracking Measures in the TN & VA Service Area	Representative Investment, Intervention, or Performance Improvement	Representative Accountability Measures	Representative Progress Measures	Lowest Ranking Tennessee Counties in Geographic Service Area	Lowest ranking Virginia Counties in Geographic Service Area ⁵⁶
Key Focus Area #3: Promote a Drug-Free Community						
1.	Addiction to Prescription Pain-killers and illicit drugs	Addiction death rate per 100,000	Establish a regional residential addiction treatment program ⁸⁰	Establishment of a regional residential addiction treatment program by a set date	Number of individuals participating in residential addiction treatment	Hancock, Hamblen, Hawkins ⁸¹ Dickenson, Wise, Tazewell, Buchanan ⁸²
2.	Tobacco use in Teens	Percent of teens currently smoking	Expand evidence-based teen anti-smoking campaigns such as Teens Against Tobacco in certain high-risk counties ⁸³	Expand evidence-based teen anti-smoking campaigns such as Teens Against Tobacco through an agreed-upon investment by set date	Number of anti-smoking impressions in high-risk communities	Hancock, Carter, Greene ⁸⁴ Wise, Dickenson, Buchanan ⁸⁵
Key Focus Area #4: Decrease Avoidable Hospital Admission in the High-Utilizing Uninsured						
1.	Avoidable inpatient admission among the uninsured	PQI Admissions per 1,000 uninsured	Establish Integrated Care Management Program for Uninsured Community Super-Utilizers ⁸⁶	Establish agreed-upon number of Integrated Care Management Programs for Uninsured Community Super-Utilizers by set date	Number of Uninsured Community Super-Utilizers in Active Care Management	Hancock, Unicoi, Cocke ⁸⁷ Buchanan, Russell, Lee ⁸⁸

⁷⁹ Virginia: Age Adjusted Mortality Rate from Breast, Cervical, Colon or Lung Cancer, 2014. CDC Wonder Database. Accessed February 3, 2016.

⁸⁰ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,8,10,11, and 14. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

⁸¹ Tennessee: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

⁸² Virginia: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

⁸³ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 11,2,4,6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

⁸⁴ As county-level data on teen smoking was not available, adult smoking rates were used as a proxy. Tennessee: Percent of Adult Smoking. County Health Rankings. Accessed February 3, 2016.

⁸⁵ As county-level data on teen smoking was not available, adult smoking rates were used as a proxy measure. Virginia: Percent of Adult Smoking. County Health Rankings. Accessed February 3, 2016.

⁸⁶ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,6,7,8,9,10,11,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

<i>Health Concern</i>	<i>Health Concern Tracking Measures in the TN & VA Service Area</i>	<i>Representative Investment, Intervention, or Performance Improvement</i>	<i>Representative Accountability Measures</i>	<i>Representative Progress Measures</i>	<i>Lowest Ranking Tennessee Counties in Geographic Service Area</i>	<i>Lowest ranking Virginia Counties in Geographic Service Area⁵⁶</i>
Key Focus Area #5: Access to Behavioral Health Services						
1.	Access to community-based mental health treatment	Psychiatric Admissions through ER per 1,000 ER visits	Establish Crisis Receiving Centers in hospitals serving specific high-risk counties ⁸⁹	Establish an agreed-upon number of Crisis Receiving Centers in specific hospitals by set date	Number of individuals managed in Crisis Receiving Center.	Hancock, Cocke, Hamblen ⁹⁰ Wise, Dickenson, Tazewell ⁹¹

Representative Example:

If the State and the New Health System agree that one of the Key Focus Areas in the Commitment to Community Health Annual Report should be Ensuring Strong Starts for Children, one health concern the Parties suggest targeting is low birth-weight babies. The baseline for tracking this health concern would be the Low Birth Weight Rate per 100,000 population for specific counties within the Geographic Service Area. One investment, intervention, or performance improvement that the New Health System could undertake to address this health concern would be to establish evidence-based Home Visitation Programs in certain high-risk counties. The Representative Index Measures would reflect the New Health System's commitment to the State to establish an agreed-upon number of evidence-based Home Visitation Programs in certain counties by agreed-upon dates. The Progress Measures that could be used by the State and the New Health System to measure progress in addressing this health concern would be the percentage of eligible women in high-risk communities participating in evidenced-based Home Visitation Programs.

⁸⁷ As county-level data on avoidable admission among the uninsured was not available, preventable hospital stays for the Medicare population was used as a proxy. "Preventable Hospital Stays in Tennessee." County Health Rankings. Accessed February 3, 2016.

⁸⁸ As county-level data on avoidable admission among the uninsured was not available, preventable hospital stays for the Medicare population was used as a proxy. "Preventable Hospital Stays in Virginia." County Health Rankings. Accessed February 3, 2016.

⁸⁹ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3, and 8. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14.**

⁹⁰ As county-level data on psychiatric ER visits per 100,000 was not available, the percent of individuals reporting poor mental health was used as a proxy measure. Tennessee: Number of Poor Mental Health Days. County Health Rankings. Accessed February 3, 2016.

⁹¹ As county-level data on psychiatric ER visits per 100,000 was not available, the percent of individuals reporting poor mental health was used as a proxy measure. Virginia: Number of Poor Mental Health Days. County Health Rankings. Accessed February 3, 2016.

Periodic Review of the Commitment to Community Health Annual Report

The Parties recognize that population health is dynamic and the health challenges of a region will change over time. The Annual Report established when the COPA is granted should be periodically reviewed and updated to reflect these changes. The Parties propose that the initial Annual Report and its associated plan be established with the issuance of the COPA. On the fifth anniversary of the COPA, the New Health System and the State will evaluate the Annual Report to determine what adjustments, if any, need to be made to plan elements or accountability mechanisms. Once the New Health System and the State have agreed upon these changes, the updated elements of the Annual Report will go into effect on the sixth anniversary of the COPA for a period of five years. The Parties propose that the periodic review of the Annual Report be performed on the same intervals for as long as the COPA remains in effect.

B. Enhanced Health Care Services Measures

Some residents in Northeast Tennessee and Southwest Virginia have acceptable access to many services, but other areas are substantially underdeveloped or lacking services altogether. This is especially true for mental health, substance abuse and specialty pediatric services. 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.

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.

For the second category of the Index, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to enhance health care services. **Table 11.8** below indicates five areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

Table 11.8 - Proposed Enhanced Health Care Services Measures

Index of Public Advantage and Community Health Improvement		
B. Enhanced Health Care Services Measures		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	The New Health System commits to spending at least \$140 million over ten years pursuing specialty services which otherwise could not be sustainable in the region without the financial support.	Annual report to State attesting to progress towards compliance until \$140 million is invested.
2.	Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.	Annual progress reports and One-time report to State attesting to the creation of new capacity for residential addiction recovery services when complete.
3.	Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children’s Hospital physician needs assessment.	Report to State attesting to compliance after the third year after formation of the New Health System.
4.	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.	Annual report to State attesting to progress towards compliance until pediatric specialty centers and Emergency Rooms have been developed.
5.	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.	File the Comprehensive Physician Needs Assessment with the State every three years.

C. Expanding Access and Choice Measures

Investing in the development of new and expanded services is one way to improve access and choice in the region. Preserving services currently at risk and breaking down barriers for physicians to practice and patients to receive services where they choose is another. The New Health System is committed to both. By integrating the two systems, the Parties will help ensure that communities in the Geographic Service Area continue to have access to the care they need close to home and that care options are expanded rather than reduced.

For the third category of the Index, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to sustain and expand access and choice. **Table 11.9** below indicates six areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The

proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

Table 11.9 - Proposed Expanding Access and Choice Measures

Index of Public Advantage and Community Health Improvement		
C. Expanding Access and Choice Measures		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five (5) 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.	Annual report to State attesting to compliance for five years after formation of the New Health System.
2.	Maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available as closely as possible to where the population lives.	Annual report to State attesting to compliance.
3.	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	Annual report to State attesting to compliance.
4.	Commitment to not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.	Annual report to State attesting to compliance.
5.	Independent physicians will not be required to practice exclusively at the New Health System’s hospitals and other facilities.	Annual report to State attesting to compliance.
6.	The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.	Annual report to State attesting to compliance.

D. Improving Health Care Value: Managing Quality, Cost and Service Measures

In addition to achieving reduced costs through improved efficiency and avoidance of waste and unnecessary duplication, the merger will also specifically enable the New Health System to reduce overutilization of inpatient services and stem the pace of health care cost growth for patients, employers and insurers.

As evidence of their commitment to manage quality, cost, and service, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to improve health care value. **Table 11.10** below indicates ten areas where the Parties have made

commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

Table 11.10 - Proposed Improving Health Care Value: Managing Quality, Cost and Service Measures

Index of Public Advantage and Community Health Improvement		
D. Improving Health Care Value: Managing Quality, Cost and Service Measures		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	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.	Report to State after first contract year attesting to compliance.
2.	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.	Annual report to State attesting to compliance.

3.	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.	Annual report to State attesting to compliance.
4.	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.	Annual report to State attesting to compliance.
5.	The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.	Annual report to State attesting to progress towards compliance until the Common Clinical IT Platform is adopted.
6.	The New Health System will participate meaningfully in a health information exchange open to community providers.	Annual report to State attesting to compliance once health information exchange is fully established.
7.	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.	Annual report to State attesting to measurement of quality measures identified in Section 8(A)(iv) of the COPA Application.
8.	The New Health System will negotiate in good faith with Principal Payers* 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). New Health System would agree to resolve through mediation any disputes in health plan contracting.	Annual report to State attesting to compliance.
9.	The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.	Annual report to State attesting to compliance.
10.	The New Health System will not engage in "most favored nation" pricing with any health plans.	Annual report to State attesting to compliance.
* For purposes of this Application, "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.		

E. Investment in Health Research/Education and Commitment to Workforce

A cornerstone of the proposed merger is the expansion of the health-related research and academic capabilities of the region through additional funding and closer working relationships with East Tennessee State University and other academic partners in Tennessee and Virginia. The investments made possible by merger efficiencies, and their specific applications in research and development, faculty, and expanded services and training can also contribute to the economic vitality of the area and the improved ability to attract medical professionals and business endeavors; thereby benefiting the communities both with health and economic well-being.

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 becoming one of the best health system employers in the nation and one of the most attractive health systems for physicians and employee team members. 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 evidence of their commitments to invest in health research and education and to attract and retain a strong workforce, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to achieve these goals. The table below indicates six areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted) of **Table 11.11** below.

Table 11.11 - Proposed Investment in Health Education/Research and Commitment to Workforce Measures

Index of Public Advantage and Community Health Improvement		
E. Investment in Health Education/Research and Commitment to Workforce Measures		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	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.	Annual report to State attesting compliance.
2.	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, and physician assistants and other allied health professionals in the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.
3.	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.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.
4.	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.	Report to State attesting to compliance after the first year after formation of the New Health System.
5.	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.	Report to State attesting to compliance after the first year after formation of the New Health System.
6.	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.	Annual report to State attesting compliance.

Using the Index

The Parties anticipate that the Overall Achievement Score would be calculated annually and would be used by the State to objectively track the progress of the Cooperative Agreement over time to ensure Public Advantage. To calculate the Overall Achievement Score, the Parties propose that the State assign a "Satisfied" or "Not Satisfied" evaluation to each of the five categories of the Index and that the five categories be given equal weight in the scoring process. The score for each category will be the number of measures within that category successfully satisfied divided by the total number of measures within that category. The five category scores should be combined to determine the "Overall Achievement Score" for each year of active State supervision to ensure Public Advantage.

Representative Example:

For each of the five categories, the State would assign a "Satisfied" or "Not Satisfied" evaluation to the individual measures agreed upon by the New Health System and the State in the COPA as demonstrated in **Table 11.12** below. If the Parties agreed upon the following Index of Public Advantage and Community Health Improvement, the state would evaluate each individual accountability mechanism as follows:

Table 11.12 - Demonstration of Evaluation

	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
A. Commitment to Improve Community Health			
1.	The New Health System is committed to creating a new integrated delivery system designed to improve community health through investment of not less than \$75 million over ten years in population health improvement.	Annual report to State attesting to progress towards compliance until \$75 million is invested.	Satisfied
2.	The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed upon by the State and the New Health System in the COPA.	Annual report to State attesting to progress on the accountability mechanisms for each Key Focus Area as outlined in the COPA.	Satisfied
3.	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 herein.	Annual report to State attesting to compliance with reporting obligations as outlined in the COPA.	Satisfied

	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
B. Enhanced Health Care Services Measures			
1.	The New Health System commits to spending at least \$140 million over ten years pursuing specialty services which otherwise could not be sustainable in the region without the financial support.	Annual report to State attesting to progress towards compliance until \$140 million is invested.	Satisfied
2.	Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.	One-time report to State attesting to the creation of new capacity for residential addiction recovery services when complete.	Satisfied
3.	Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children’s Hospital physician needs assessment.	Report to State attesting to compliance after the third year after formation of the New Health System.	Satisfied
4.	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.	Annual report to State attesting to progress towards compliance until pediatric specialty centers and Emergency Rooms have been developed.	Satisfied
5.	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.	File the Comprehensive Physician Needs Assessment with the State every three years.	Satisfied
C. Expanding Access and Choice			
1.	All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five (5) 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.	Annual report to State attesting to compliance for five years after formation of the New Health System.	Satisfied
2.	Maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available as closely as possible to where the population lives.	Annual report to State attesting to compliance.	Satisfied

	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
3.	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	Annual report to State attesting to compliance.	Satisfied
4.	Commitment to not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.	Annual report to State attesting to compliance.	Satisfied
5.	Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.	Annual report to State attesting to compliance.	Satisfied
6.	The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.	Annual report to State attesting to compliance.	Satisfied
D. Improving Health Care Value: Managing Quality, Cost and Service			
1.	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.	Report to State after first contract year attesting to compliance.	Satisfied
2.	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	Annual report to State attesting to compliance.	Satisfied

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	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
	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.		
3.	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.	Annual report to State attesting to compliance.	Satisfied
4.	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.	Annual report to State attesting to compliance.	Satisfied
5.	The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.	Annual report to State attesting to progress towards compliance until the Common Clinical IT Platform is adopted.	Satisfied
6.	The New Health System will participate meaningfully in a health information exchange open to community providers.	Annual report to State attesting to compliance once health information exchange is fully established.	Satisfied
7.	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.	Annual report to State attesting to measurement of quality measures identified in Section 8(A)(iv) of the COPA Application.	Satisfied
8.	The New Health System will negotiate in good faith with Principal Payers* to include the New Health System in health plans offered in the service area on commercially reasonable terms and rates	Annual report to State attesting to compliance.	Satisfied

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	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
	(subject to the limitations herein). New Health System would agree to resolve through mediation any disputes in health plan contracting.		
9.	The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.	Annual report to State attesting to compliance.	Satisfied
10.	The New Health System will not engage in “most favored nation” pricing with any health plans.	Annual report to State attesting to compliance.	Satisfied
E. Investment in Health Education/Research and Commitment to Workforce			
1.	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.	Annual report to State attesting compliance.	Satisfied
2.	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, and physician assistants and other allied health professionals in the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.	Satisfied
3.	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.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.	Satisfied
4.	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.	Report to State attesting to compliance after the first year after formation of the New Health System.	Satisfied
5.	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.	Report to State attesting to compliance after the first year after formation of the New Health System.	Satisfied
6.	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.	Annual report to State attesting compliance.	Satisfied
* For purposes of this Application, "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.			

In this representative example, the Overall Achievement Score would be calculated as demonstrated in **Table 11.13** below:

Table 11.13 - Demonstration of Overall Achievement Scoring

Category	Measures Satisfied	Overall Achievement Score
A. Commitment to Improve Community Health	3/3	
B. Enhanced Health Care Services	5/5	
C. Expanding Access and Choice	6/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	10/10	
E. Investment in Health Research/Education and Commitment to Workforce	6/6	
Overall Achievement Score	30/30	100%

Continuing Public Advantage

The Parties propose that an Overall Achievement Score rounded to the nearest tenth of one point that equals seventy percent (70%) or above shall be considered clear and convincing evidence of the Public Advantage and the COPA shall continue in effect. An Overall Achievement Score rounded to the nearest tenth of one point that equals fifty percent (50%) up to seventy percent (70%) may be considered clear and convincing evidence of the Public Advantage depending upon the relative circumstances, and the State, at the Commissioner's discretion, may seek a modification to the Cooperative Agreement under the terms of the COPA. An Overall Achievement Score rounded to the nearest tenth of one point that is below fifty percent (50%) may be considered evidence, when considering the relative circumstances, that the Public Advantage of the COPA is no longer evident and the State, at the Commissioner's discretion, may begin action to terminate the COPA under the terms of the certification.

Due to the new and untested nature of the Index of Public Advantage and Community Health Improvement and the significant up-front and ongoing investments required for achieving community health improvement in the Geographic Service Area, it is critical that the Commissioner use proper discretion in determining whether the evidence of the Public Advantage is clear and convincing. Notwithstanding any provision to the contrary, the Commissioner shall consider any and all important public benefits, whether or not explicitly addressed in the Index of Public Advantage and Community Health Improvement. Further, the Commissioner shall have discretion to determine that

the clear and convincing standard has been achieved during a particular period even if the Overall Achievement Score falls below the parameters outlined.

Representative Examples:

Example 1. If the New Health System was able to satisfy most of the Index of Public Advantage and Community Health Improvement measures for a particular year, the scoring might appear as follows in **Table 11.14**:

Table 11.14 - Sample Scoring for Example 1

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	3/3	
B. Enhanced Health Care Services	5/5	
C. Expanding Access and Choice	5/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	9/10	
E. Investment in Health Research/Education and Commitment to Workforce	6/6	
Overall Achievement Score	28/30	93.3%

An Overall Achievement Score of 93.3% is considered clear and convincing evidence of the Public Advantage and the COPA would continue in effect.

Example 2. If the New Health System was not able to satisfy some of the Index of Public Advantage and Community Health Improvement measures for a particular year, the scoring might appear as follows in **Table 11.15**:

Table 11.15 - Sample Scoring of Example 2

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	2/3	
B. Enhanced Health Care Services	4/5	
C. Expanding Access and Choice	4/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	6/10	
E. Investment in Health Research/Education and Commitment to Workforce	3/6	
Overall Achievement Score	19/30	63.3%

An Overall Achievement Score of 63.3% may be considered clear and convincing evidence of the Public Advantage, depending upon the relative circumstances considered by the Commissioner. The New Health System would be given the opportunity to explain why any Measure has not been satisfied and the Commissioner would consider this information in deciding whether to exercise his or her discretion in seeking a modification to the Cooperative Agreement. After considering the Public Advantage and the explanations for why any Measure has not been satisfied, the State, at the Commissioner's discretion, may seek a modification to the Cooperative Agreement under the terms of the COPA.

Example 3. If the New Health System was not able to satisfy several Index of Public Advantage and Community Health Improvement measures for a particular year, the scoring might appear as follows in **Table 11.16**:

Table 11.16 - Sample Scoring of Example 3

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	2/3	
B. Enhanced Health Care Services	2/5	
C. Expanding Access and Choice	3/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	5/10	
E. Investment in Health Research/Education and Commitment to Workforce	2/6	
Overall Achievement Score	14/30	46.7%

An Overall Achievement Score of 46.7% may be considered evidence, depending on the relative circumstances, that the Public Advantage of the COPA is no longer evident. The New Health System would be given the opportunity to explain why any Measure has not been satisfied and the Commissioner would consider this information. The Commissioner would allow a reasonable period of time for a remediation plan to be developed, presented, accepted and implemented for re-evaluation. After considering the Public Advantage, the explanations for why any Measure has not been satisfied, and performance under the remediation plan, the State, at the Commissioner's discretion, may begin action to terminate the COPA under the terms of the certification. In deciding whether to take action to terminate the COPA under the terms of the certification, the Commissioner would have the authority to consider important public benefits that contribute to the Public Advantage even if those public benefits are not explicitly addressed in the Index of Public Advantage and Community Health Improvement.

Index of Public Advantage and Community Health Improvement Conclusion

The Parties believe that this Index of Public Advantage and Community Health Improvement proposal outlines a process for the New Health System to align its resources and commitments with the Triple Aim objectives to improve population health, improve patient experience of care (quality and access), and manage the per capita cost of health care in the region. At the same time, 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 these proposed Index Categories, Key Focus Areas, and Accountability Mechanisms will lead to greater community buy-in and adaptation of the population health improvement process. Ultimately, the Parties hope that this process will result in the highest chance of success for improving population health across our region.

12. EXPLANATION OF THE REASONS FOR THE EXCLUSION OF ANY INFORMATION

REQUEST: Provide an explanation of the reasons for the exclusion of any information set forth in section 1200-38-01-.02, the Application Process, including an explanation of why the item is not applicable to the Cooperative Agreement or to the parties.

RESPONSE: The Parties have excluded the following information from the Application because the information is considered confidential or competitively sensitive under federal antitrust laws. This information will be subsequently filed with the State.

Exhibit 11.4D Mountain States' Covenant Compliance Certificates

Exhibit 11.4E Mountain States' Officer's Certificates accompanying Independent Auditor's Reports

Exhibit 11.5D Wellmont's External Auditor Management Letters

Exhibit 11.6 Current Annual Budget for Mountain States

Exhibit 11.7 Current Annual Budget for Wellmont

Exhibit 11.11 Existing and Future Business Plans of Mountain States

Exhibit 11.12 Existing and Future Business Plans of Wellmont

13. DESCRIPTION OF THE TOTAL COST RESULTING FROM THE COOPERATIVE AGREEMENT

REQUEST: Provide a detailed description of the total cost resulting from the Cooperative Agreement, including, but not limited to, new costs for consultants, capital costs and management costs. The description should identify costs associated with the implementation of the Cooperative Agreement, including documentation of the availability of the necessary funds. The description should identify which costs are borne by each party.

RESPONSE: Commencing with the strategic options process, both Wellmont and Mountain States have incurred consultant and professional expenses in connection with the Cooperative Agreement. These services include business advisory, economist, legal, accounting and other professional services. Each Party has been responsible for its own legal and accounting services. The Parties have agreed to share certain consulting services, such as economist, public relations, and governance, and certain due diligence expenses. The Parties estimate merger-related expenses to be one-time expenses and to total in the aggregate approximately one half of one percent (0.5%) of the annual aggregate net revenue of the New Health System.

Because there is no consideration being exchanged in the transaction, there are no other fees that normally would apply, such as financing, contingency or lending fees. There are no capital expenditures required by the Cooperative Agreement. The Parties anticipate that the New Health System will make expenditures in connection with rebranding, the Common Clinical IT platform, population health, implementation of the health index, new services, and other items discussed more fully elsewhere in this Application.

14. TIMETABLE FOR IMPLEMENTATION OF THE COOPERATIVE AGREEMENT

REQUEST: Provide a timetable for implementing all components of the Cooperative Agreement.

RESPONSE: The Parties intend to follow the proposed timetable set out below for implementation of all components of the Cooperative Agreement:

Action	Date/Target Date
New Health System Articles of Incorporation Filed in Tennessee	September 11, 2015
COPA Letter of Intent Filed in Tennessee	September 16, 2015
Letter of Intent for a Letter Authorizing a Cooperative Agreement Filed in Virginia	September 16, 2015
Mountain States Board Approves Cooperative Agreement	December 15, 2015
Wellmont Board Approves Cooperative Agreement	January 6, 2016
COPA Pre-Submission Report Filed in Tennessee and Virginia	January 7, 2016
Cooperative Agreement is Executed by Both Parties	February 15, 2016
New Health System Interim Directors are Elected and Interim Bylaws are adopted	February 15, 2016
COPA Application Filed in Tennessee	February 16, 2016
Application for a Letter Authorizing a Cooperative Agreement Filed in Virginia	February 16, 2016
Tax-Exemption Application Filed for the New Health System	February 17, 2016 (Target Date)
Tennessee Public Benefit Hospital Sales and Conveyance Act Notice Submitted to the Tennessee Attorney General's Office	April 15, 2016 (Target Date)
Notice Of Disposition Of Assets By Nonprofit Healthcare Entity Submitted to the Virginia Attorney General's office	April 15, 2016 (Target Date)

Action	Date/Target Date
If the COPA is Granted in Tennessee and the Letter Authorizing the Cooperative Agreement is Granted in Virginia:	
New Health System Articles of Incorporation will be Amended	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
New Health System Bylaws will be Amended	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
New Health System Initial Directors are Elected	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
New Health System Board Officers are Elected	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
New Health System Initial Management Team is Elected	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
Wellmont Board will Adopt Amended and Restated Bylaws Making New Health System its Sole Member	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
Mountain States Board will Adopt Amended and Restated Bylaws Making New Health System its Sole Member	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
Cooperative Agreement Transaction Closes and New Health System Begins Operations	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)

15. PLAN OF SEPARATION

REQUEST: The Department shall require a Plan of Separation be submitted with the Application. The Plan of Separation shall be updated annually by the parties to the Cooperative Agreement. The parties shall provide an independent opinion from a qualified organization verifying the Plan of Separation can be operationally implemented without undue disruption to essential health services provided by the parties.

RESPONSE: The Plan of Separation will focus on a divestiture of assets and operations and any other actions that would be appropriate under then-current market circumstance, to restore, to the extent practicable, competitive conditions to their pre-consolidation state or otherwise remedy the competitive concerns identified. In planning the steps needed to accomplish this, the Parties and the consultant must consider the pre-consolidation competitive state and assess the relevant competitive factors currently applicable to each individual facility's local area, including patient flow patterns, utilization volumes, shares of local rival facilities and concentration levels. This exercise will take into account, for example, the fact that approximately half of the merging systems' current combined share of inpatient services in their combined service area is volume from three hospitals (Bristol Regional Medical Center, Holston Valley Medical Center and Johnson City Medical Center), and that each of these hospitals has an inpatient share in its own service area that is similar in size or larger. Most other hospitals in each system are in largely rural counties, offer fifty or fewer staffed beds and report an average daily census between one and three dozen patients. In only a minority of areas within the combined service area do the parties face each other with competing hospitals in close proximity to each other, and in various areas the parties have competition from third-party hospitals. Outpatient services competition has its own set of unique characteristics across different parts of the combined service area. The Plan of Separation will recommend divestitures and remedial steps, as applicable, designed to restore these competitive dynamics. Please see the Plan of Separation attached as **Exhibit 15.1.**

The Plan of Separation has been reviewed by FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm. FTI Consulting, Inc. has issued an opinion verifying that the Parties' Plan of Separation can be operationally implemented without undue disruption to essential health services provided by the Parties. A copy of the opinion is attached as **Exhibit 15.2.**

16. AUTHORIZED PERSONS TO RECEIVE NOTICES, REPORTS & COMMUNICATIONS

REQUEST: Provide the name, address and telephone number of the person(s) authorized to receive notices, reports and communications with respect to the Application.

RESPONSE: The individuals authorized to receive notices, reports and communications with respect to the Application are as follows:

For Mountain States:

Barbara Allen

Chairman of the Board
3300 Browns Mill Rd
Johnson City, TN 37604
423-282-4841

Alan Levine

President & Chief Executive Officer
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604
423-302-3423

Tim Belisle, Esq.

Senior Vice President-Compliance
Officer and General Counsel
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604
423-302-3394

J. Richard Lodge, Esq.

Bass Berry & Sims PLC
Counsel to Mountain States
150 Third Avenue South, Suite 2800
Nashville, TN 37201
615-742-6254

For Wellmont:

Roger Leonard

Chairman of the Board
102 Oakview Circle
Bristol, TN 37620
423-652-2204

Bart Hove

President & Chief Executive Officer
1905 American Way
Kingsport, Tennessee 37660
423-230-8219

Gary Miller, Esq.

Senior Vice President, Legal Affairs, and
General Counsel
1905 American Way
Kingsport, Tennessee 37660
423-230-8204

Richard G. Cowart, Esq.

Baker, Donelson, Bearman, Caldwell &
Berkowitz, P.C.
Counsel to Wellmont
211 Commerce Street, Suite 800
Nashville, TN 37201
615-726-5660

17. LIST OF EXHIBITS AND ATTACHMENTS

Exhibit Number	Description
Exhibit 5.1 - Attachment A	Service Area
Exhibit 5.1 - Attachment B	Hospital Draw Areas and Summary Statistics
Exhibit 5.1 - Attachment C	Geographic Service Area Payer Mix
Exhibit 5.2	Shares for New Health System
Exhibit 6.1 - Attachment A	Outpatient Facilities
Exhibit 6.1 - Attachment B	Urgent Care Centers
Exhibit 6.1 - Attachment C	CT/MRI Capabilities
Exhibit 6.1 - Attachment D	Ambulatory Surgical Centers
Exhibit 6.1 - Attachment E	Physician Services
Exhibit 8.1 - Attachment A	County Health Rankings for Tennessee Counties within the Geographic Service Area
Exhibit 8.1 - Attachment B	County Health Rankings for Virginia Counties and Independent Cities within the Geographic Service Area
Exhibit 8.2 - Attachment A	Work Group Charters
Exhibit 8.2 - Attachment B	Work Group Membership Lists
Exhibit 8.3	Schedule of Public Meetings Conducted by the Work Groups
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 Charity Care Policy and Related Policies
Exhibit 8.5 - Attachment B	Wellmont Patient Bill of Rights
Exhibit 8.5 - Attachment C	Wellmont Bad Debt, Bankruptcy, Small Balance Write-Off and Return Mail Policy
Exhibit 10.1	Pre-Submission Report
Exhibit 10.2	Record of Community Stakeholder and Consumer Views
Exhibit 11.1	Signed Copy of the Cooperative Agreement
Exhibit 11.2	Organizational Chart of Mountain States
Exhibit 11.3	Organizational Chart of Wellmont
Exhibit 11.4	Financial Summary for Mountain States
Exhibit 11.4 - Attachment A	Mountain States Bonds Official Statement for 2011 bonds

Exhibit Number	Description
Exhibit 11.4 - Attachment B	Mountain States Bonds Official Statement for 2012 bonds
Exhibit 11.4 - Attachment C	Mountain States Bonds Official Statement for 2013 bonds
Exhibit 11.4 - Attachment D	Mountain States Covenant Compliance Certificates for the Last Five Years
Exhibit 11.4 - Attachment E	Mountain States Officer's Certificate Accompanying the Independent Auditor's Report for FY10 to FY14
Exhibit 11.4 - Attachment F	Mountain States Audited Financial Statements for 2009 to 2014
Exhibit 11.4 - Attachment G	Mountain States EMMA – Annual Disclosures for 2010 to 2015 and Material Event Disclosures
Exhibit 11.4 - Attachment H	Mountain States - Rating Agencies
Exhibit 11.5	Financial Summary for Wellmont
Exhibit 11.5 - Attachment A	Wellmont 2011 Bonds Official Statement for 2011 bonds
Exhibit 11.5 - Attachment B	Wellmont Audits – External Audited Financial Statements for 2011 to 2014
Exhibit 11.5 - Attachment C	Wellmont EMMA – Annual Disclosures for 2011 to 2015 and Material Event Disclosures
Exhibit 11.5 - Attachment D	Wellmont External Auditor Management Letters for 2011 to 2014
Exhibit 11.5 - Attachment E	Rating Agencies – Fitch and Standard & Poor's Reports
Exhibit 11.6	Current Annual Budgets for Mountain States
Exhibit 11.7	Current Annual Budgets for Wellmont
Exhibit 11.8	Five Year Projected Budget for New Health System
Exhibit 11.9	Mountain States Insurance Contracts and Payer Agreements
Exhibit 11.10	Wellmont Insurance Contracts and Payer Agreements
Exhibit 11.11	Existing and Future Business Plans of Mountain States
Exhibit 11.12	Existing and Future Business Plans of Wellmont
Exhibit 11.13	Alignment Policy
Exhibit 11.14	Institute of Medicine Vital Signs Core Measures
Exhibit 15.1	Plan of Separation
Exhibit 15.2	Opinion on Plan of Separation

Exhibit 5.1

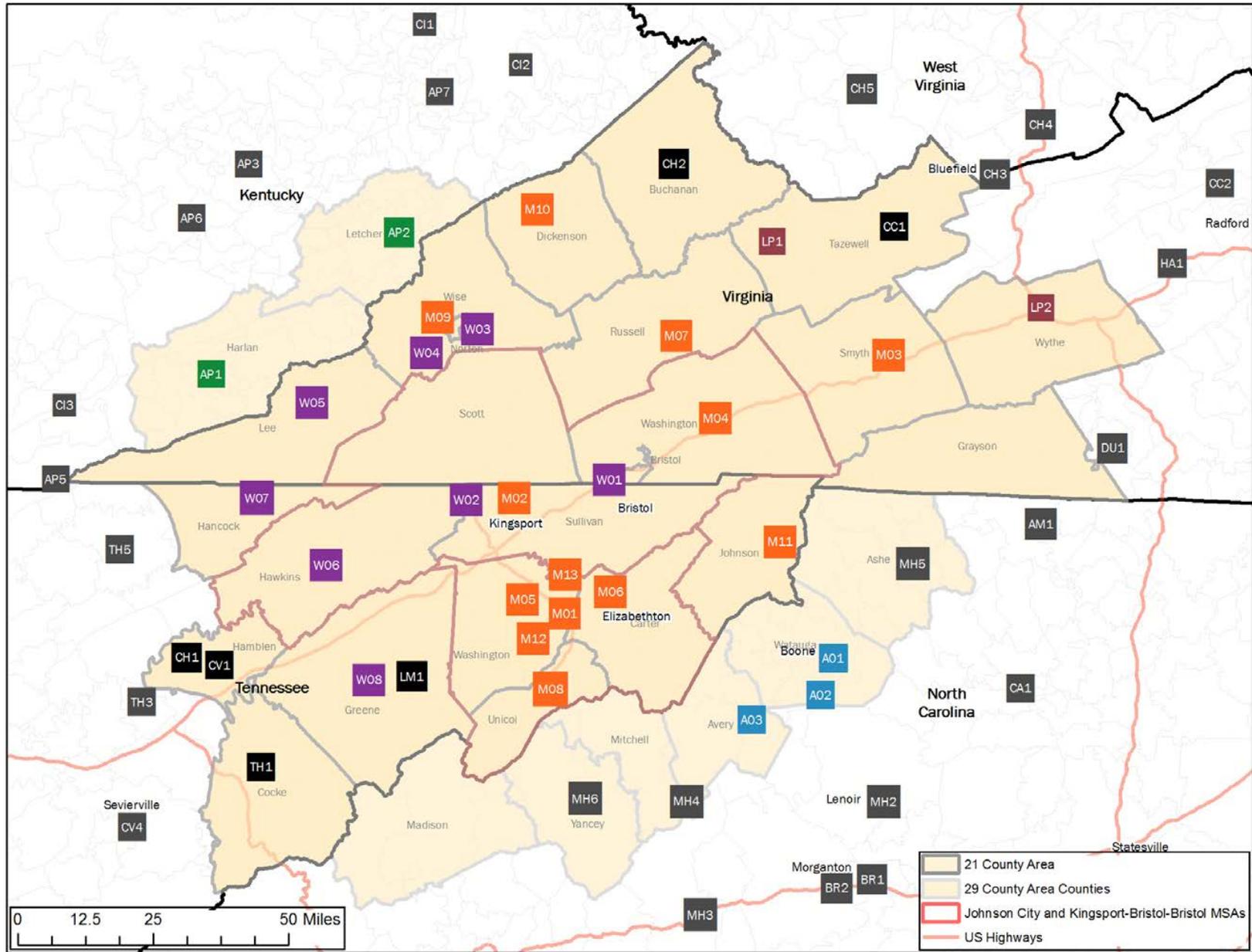
A. Service Area Definitions

Service areas were derived for each Wellmont and Mountain States hospital using patient discharge data for CY2014 from Tennessee and Virginia for all hospitals using standard methodologies for sorting zip codes from largest to smallest number of discharges:

Service areas were defined based on 75% and 90% discharge areas for general acute care patients (less normal newborns defined as DRG 795) and all payors. Service areas for Quillen and Woodridge were defined using the services they provide. Service areas are depicted for each hospital using maps and a table of the zip codes.

Summary statistics on licensed and staffed beds, occupancy and ADC were developed from reports filed by Wellmont and Mountain States with state agencies in Tennessee and Virginia¹; trend data are provided and summary statistics are reported for the latest available year (2013).

¹Sources: Tennessee Joint Annual Reports FY10-FY13; Virginia Health Information Reports FY10-FY13. The Tennessee Joint Annual Reports can be found at <https://apps.health.tn.gov/publicjars/default.aspx>. The Virginia Health Information Reports were provided by the Parties.



System	State	Hospital Name	Symbol	System	State	Hospital Name	Symbol	
Mountain States Health Alliance	TN	Johnson City Medical Center	M01	Community Health Systems, Inc.	TN	Lakeway Regional Hospital	CH1	
	TN	Indian Path Medical Center	M02		VA	Buchanan General Hospital	CH2	
	VA	Smyth County Community Hospital	M03		WV	Bluefield Regional Medical Center	CH3	
	VA	Johnston Memorial Hospital	M04		WV	Princeton Community Hospital	CH4	
	TN	Franklin Woods Community Hospital	M05		WV	Welch Community Hospital	CH5	
		TN	Sycamore Shoals Hospital	M06		TN	Fort Sanders Regional Medical Center	
		VA	Russell County Medical Center	M07	Covenant Health	TN	Morristown-Hamblen Healthcare System	CV1
		TN	Unicoi County Memorial Hospital	M08		TN	Parkwest Medical Center	
		VA	Norton Community Hospital	M09		TN	Peninsula Hospital	
		VA	Dickenson Community Hospital	M10		TN	LeConte Medical Center	CV4
		TN	Johnson County Community Hospital	M11	Tennova Healthcare	TN	Newport Medical Center	TH1
		TN	Woodridge Hospital	M12		TN	Physician Regional Medical Center	
		TN	Quillen Rehabilitation Hospital***	M13		TN	Jefferson Memorial Hospital	TH3
Wellmont Health System					TN	Turkey Creek Medical Center		
	TN	Wellmont Bristol Regional Medical Center	W01		TN	Claiborne County Hospital	TH5	
	TN	Wellmont Holston Valley Medical Center	W02		TN	Blount Memorial Hospital		
	VA	Mountain View Regional Medical Center	W03		TN	University of Tennessee Medical Center		
	VA	Wellmont Lonesome Pine Hospital	W04		TN	Laughlin Memorial Hospital	LM1	
	VA	Lee Regional Medical Center (Closed) *	W05		TN	East Tennessee Children's Hospital		
	TN	Wellmont Hawkins County Memorial Hospital	W06		TN	St. Jude Children's Research Hospital		
	TN	Wellmont Hancock County Hospital	W07					
	TN	Takoma Regional Hospital (Independent) **	W08	Blue Ridge HealthCare	NC	Valdese General Hospital	BR1	
Alliant Management Services	NC	Alleghany Memorial Hospital	AM1		NC	Grace Hospital	BR2	
Appalachian Regional Healthcare, Inc.	KY	Harlan ARH Hospital	AP1	Carolinas HealthCare System	NC	Wilkes Regional Medical Center	CA1	
	KY	Whitesburg ARH Hospital	AP2	Catholic Health Initiatives	KY	Saint Joseph - Martin	CI1	
	KY	Hazard ARH Regional Medical Center	AP3		KY	Pikeville Medical Center	CI2	
	KY	Williamson ARH Hospital			KY	Pineville Community Hospital Association	CI3	
	KY	Middlesboro ARH Hospital	AP5		KY	Highlands Regional Medical Center		
	KY	Mary Breckinridge ARH Hospital	AP6	Duke LifePoint Healthcare	VA	Twin County Regional Hospital	DU1	
	KY	McDowell ARH Hospital	AP7	HCA	VA	LewisGale Hospital at Pulaski	HA1	
Appalachian Regional Healthcare System	NC	Watauga Medical Center	A01	Mission Health System	NC	Caldwell Memorial Hospital	MH2	
	NC	Blowing Rock Hospital	A02		NC	McDowell Hospital	MH3	
	NC	Charles A. Cannon Memorial Hospital	A03		NC	Blue Ridge Regional Hospital	MH4	
LifePoint Hospitals, Inc.	VA	Clinch Valley Medical Center	LP1		NC	Ashe Memorial Hospital	MH5	
	VA	Wythe County Community Hospital	LP2		NC	Yancey Community Medical Center	MH6	
Carilion Clinic	VA	Carilion Tazewell Community Hospital	CC1	Vanderbilt Health	TN	Vanderbilt University Hospitals		
	VA	Carilion Giles Community Hospital	CC2					

*Wellmont closed Lee Regional Medical Center ("LRMC") in 2013. The Lee County Hospital Authority purchased the LRMC building from Wellmont in 2015 with plans to reopen the hospital as an independent facility. LRMC is no longer a Wellmont facility and, if reopened, it would not be included in the COPA.

**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.

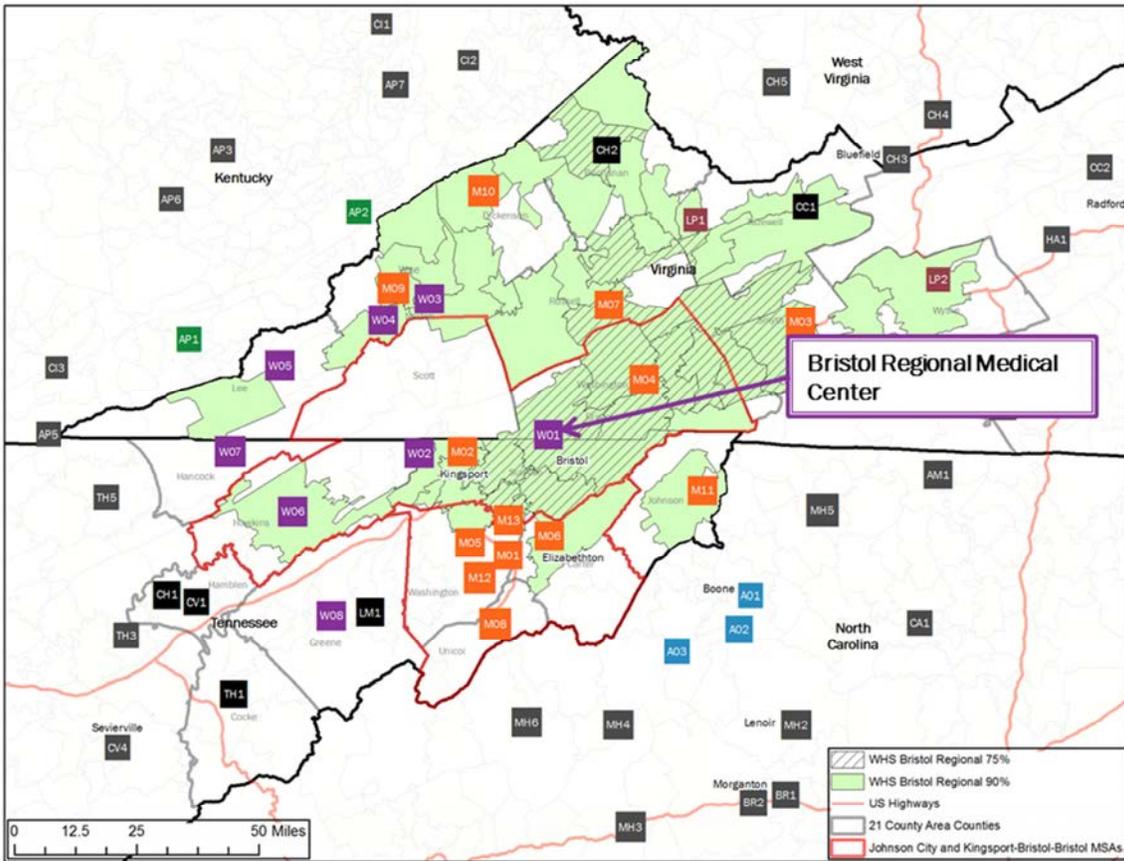
***Mountain States now has a joint venture with HealthSouth to operate Quillen Rehabilitation Hospital.

Some hospitals serving patients from the geographic service area are located outside the area depicted in the map. They are included in the legend for reference.

The Mountain Home VA Medical Center is also located in the Geographic Service Area but is not shown on this map. The Parties compete with this facility for the recruiting and hiring of staff, but do not compete with this facility for patients. The patients that may seek treatment at the Mountain Home VA Medical Center are limited to those individuals that meet certain government-established criteria.

B. Draw Area Maps and Summary Statistics

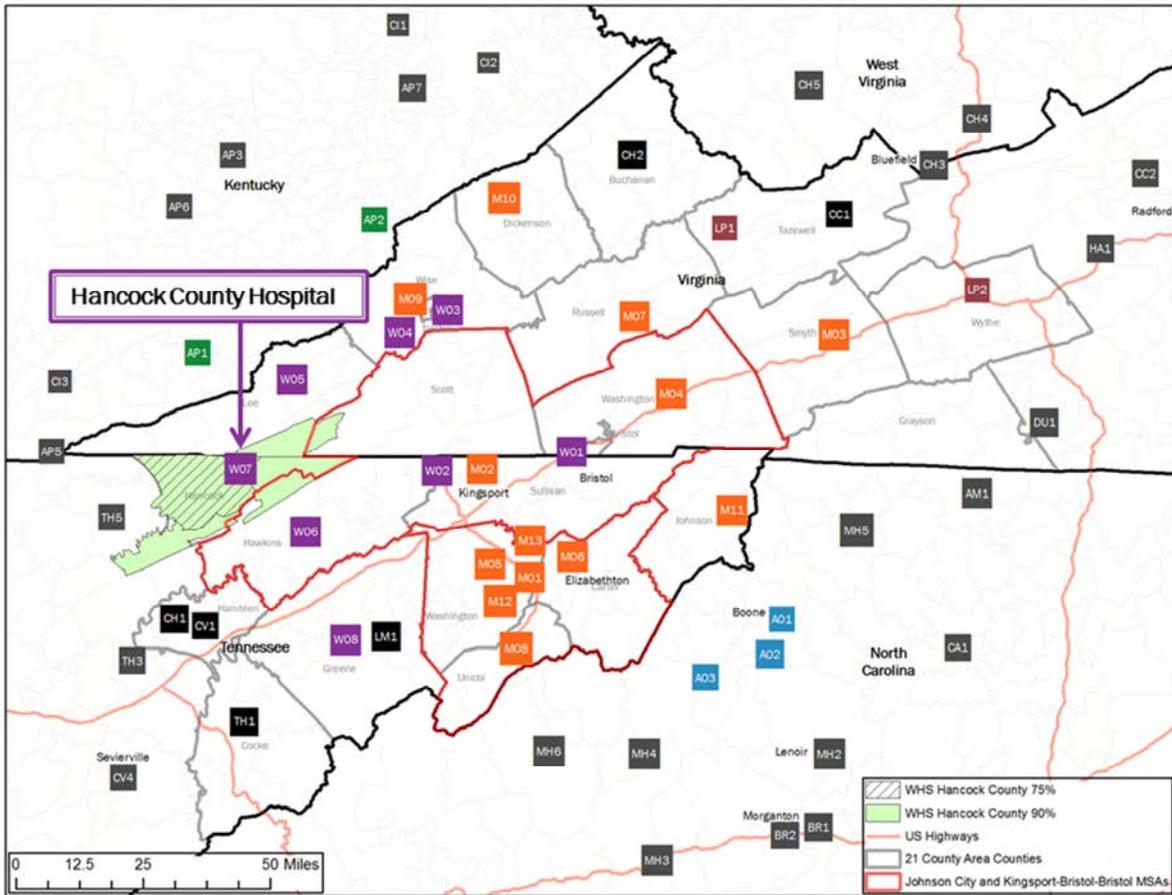
1. Bristol Regional Medical Center



Wellmont Bristol Regional Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	261	261	261	261
Licensed Beds	312	312	312	312
Staffed Beds Occupancy	64.2%	68.0%	66.6%	65.0%
Licensed Beds Occupancy	53.7%	56.9%	55.7%	54.4%
Average Daily Census	167	178	174	170
Patient Days	61,136	64,788	63,609	61,909
Discharges/Admissions	14,044	14,501	14,506	13,742
Average Length of Stay	4.4	4.5	4.4	4.5

Source: Tennessee Joint Annual Report FY10-FY13

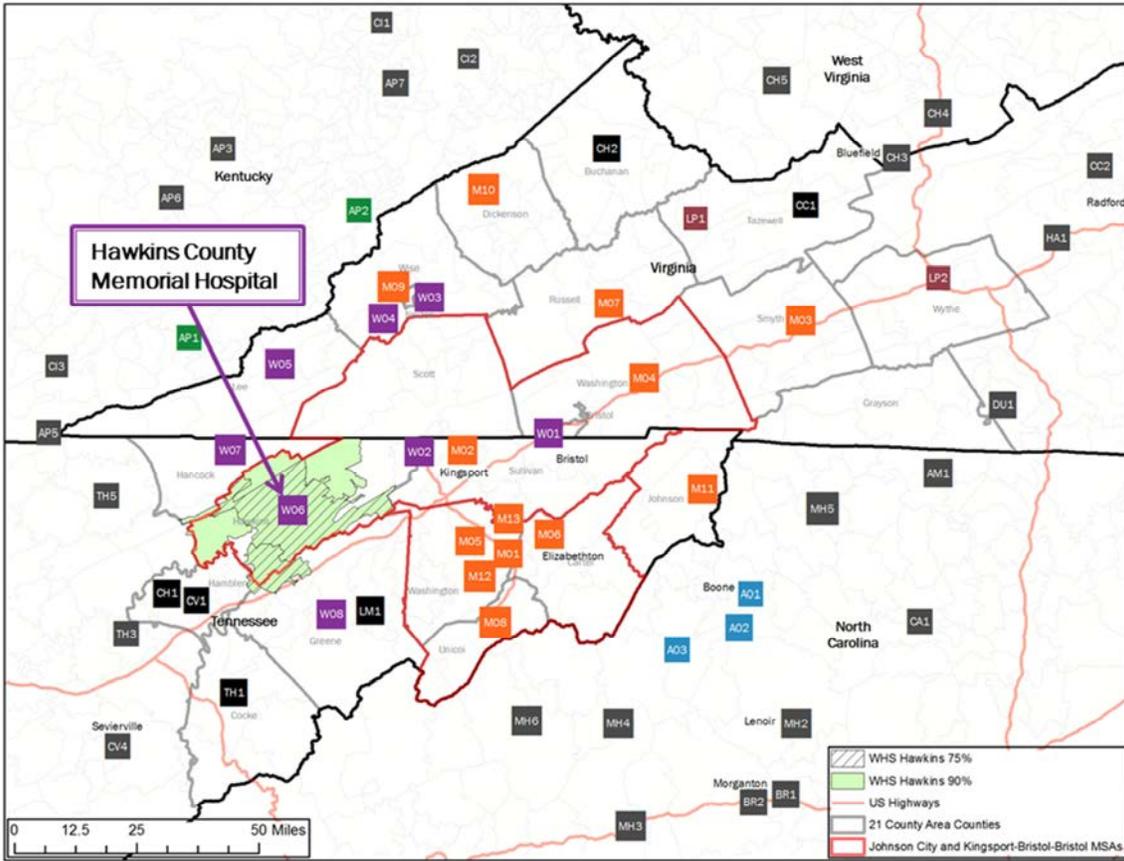
2. Hancock County Hospital



Wellmont Hancock County Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	10	10	10	10
Licensed Beds	10	10	10	10
Staffed Beds Occupancy	27.5%	22.1%	32.8%	30.9%
Licensed Beds Occupancy	27.5%	22.1%	32.8%	30.9%
Average Daily Census	3	2	3	3
Patient Days	1,003	808	1,199	1,127
Discharges/Admissions	327	245	261	242
Average Length of Stay	3.1	3.3	4.6	4.7

Source: Tennessee Joint Annual Reports FY10-FY13

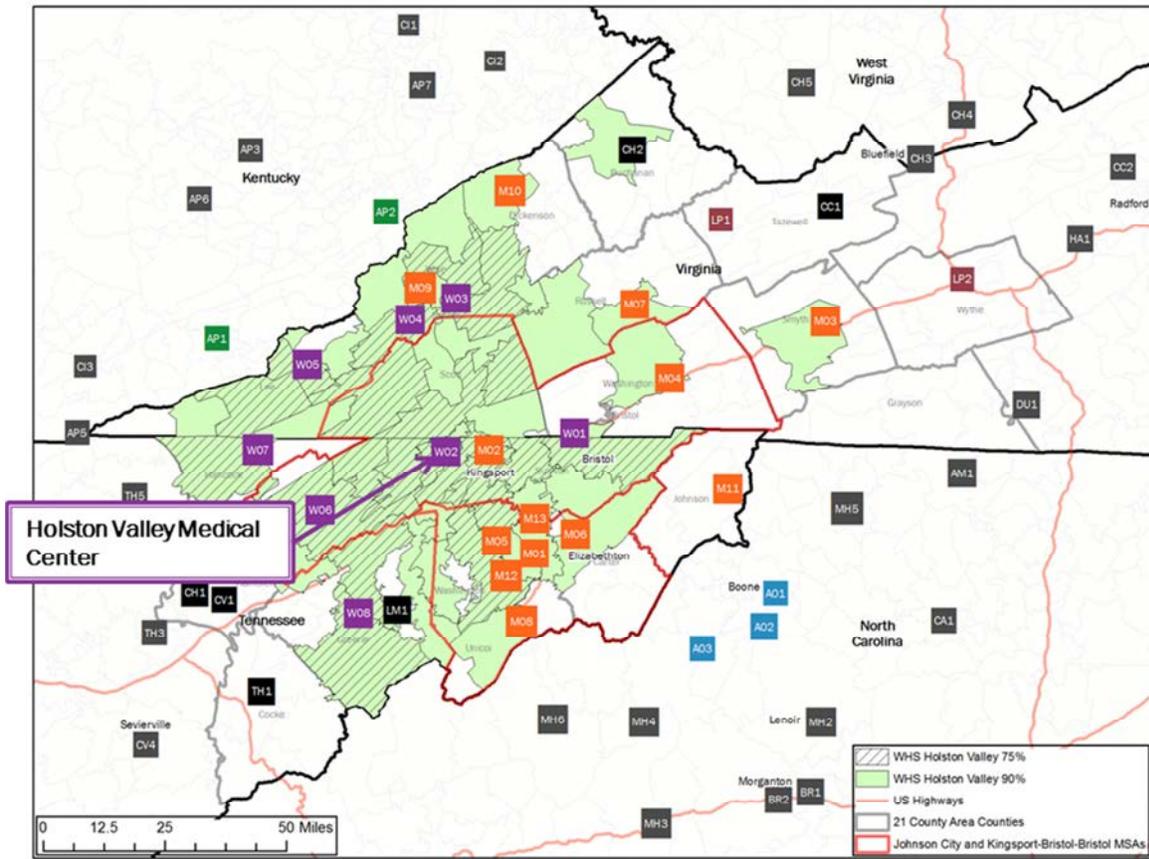
3. Hawkins County Memorial Hospital



Wellmont Hawkins County Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	46	46	46	46
Licensed Beds	50	50	50	50
Staffed Beds Occupancy	30.8%	30.7%	21.0%	18.7%
Licensed Beds Occupancy	28.3%	28.2%	19.3%	17.2%
Average Daily Census	14	14	10	9
Patient Days	5,165	5,153	3,530	3,139
Discharges/Admissions	1,710	1,603	1,291	1,241
Average Length of Stay	3.0	3.2	2.7	2.5

Source: Tennessee Joint Annual Reports FY10-FY13

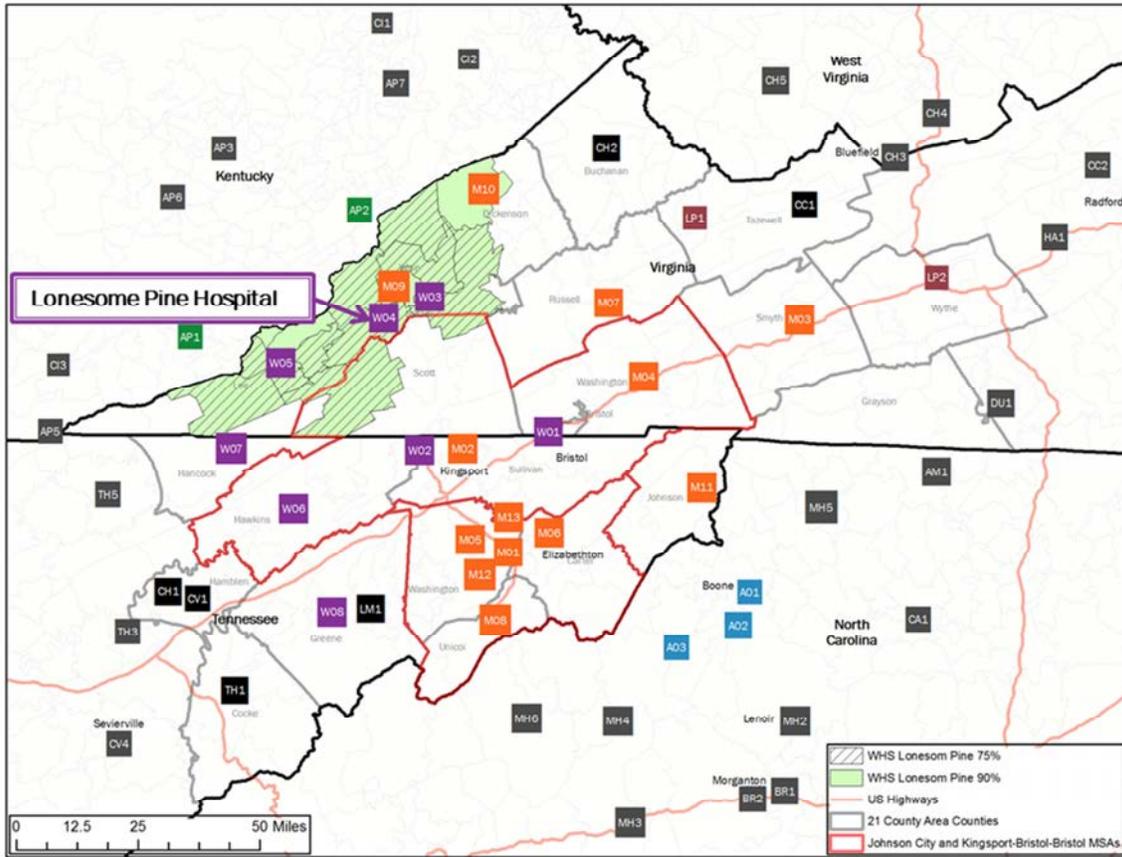
4. Holston Valley Medical Center



Wellmont Holston Valley Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	339	339	339	339
Licensed Beds	505	505	505	505
Staffed Beds Occupancy	69.1%	72.8%	69.9%	66.4%
Licensed Beds Occupancy	46.4%	48.9%	46.9%	44.6%
Average Daily Census	234	247	237	225
Patient Days	85,555	90,104	86,711	82,127
Discharges/Admissions	18,612	19,150	18,451	17,825
Average Length of Stay	4.6	4.7	4.7	4.6

Source: Tennessee Joint Annual Reports FY10-FY13

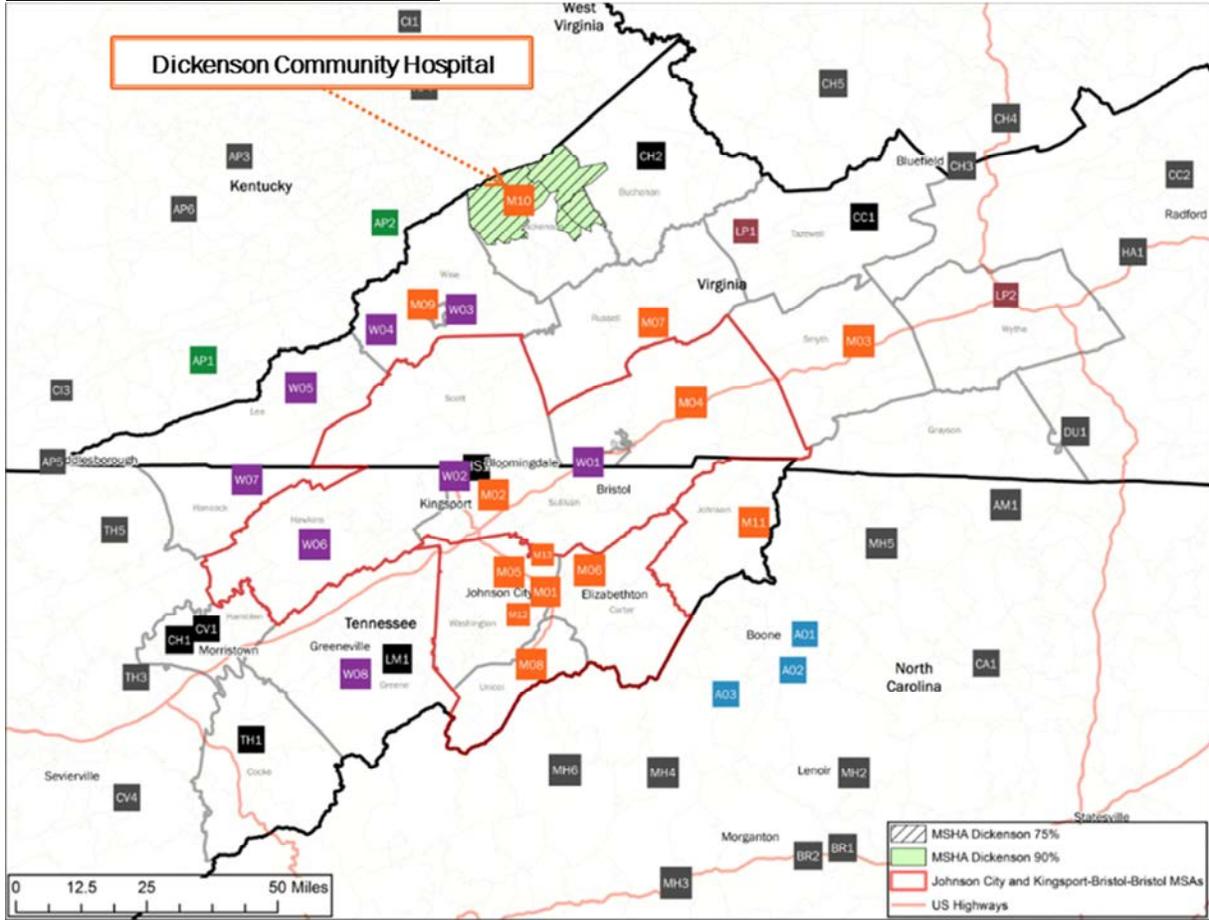
5. Lonesome Pine Hospital



Wellmont Lonesome Pine Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	48	48	60	21
Licensed Beds	60	60	60	60
Staffed Beds Occupancy	45.9%	42.6%	26.0%	49.6%
Licensed Beds Occupancy	36.7%	34.0%	26.0%	17.4%
Average Daily Census	22	20	16	10
Patient Days	8,041	7,455	5,715	3,799
Discharges/Admissions	2,529	2,392	1,955	1,484
Average Length of Stay	3.2	3.1	2.9	2.6

Source: Virginia Health Information Reports FY10-FY13

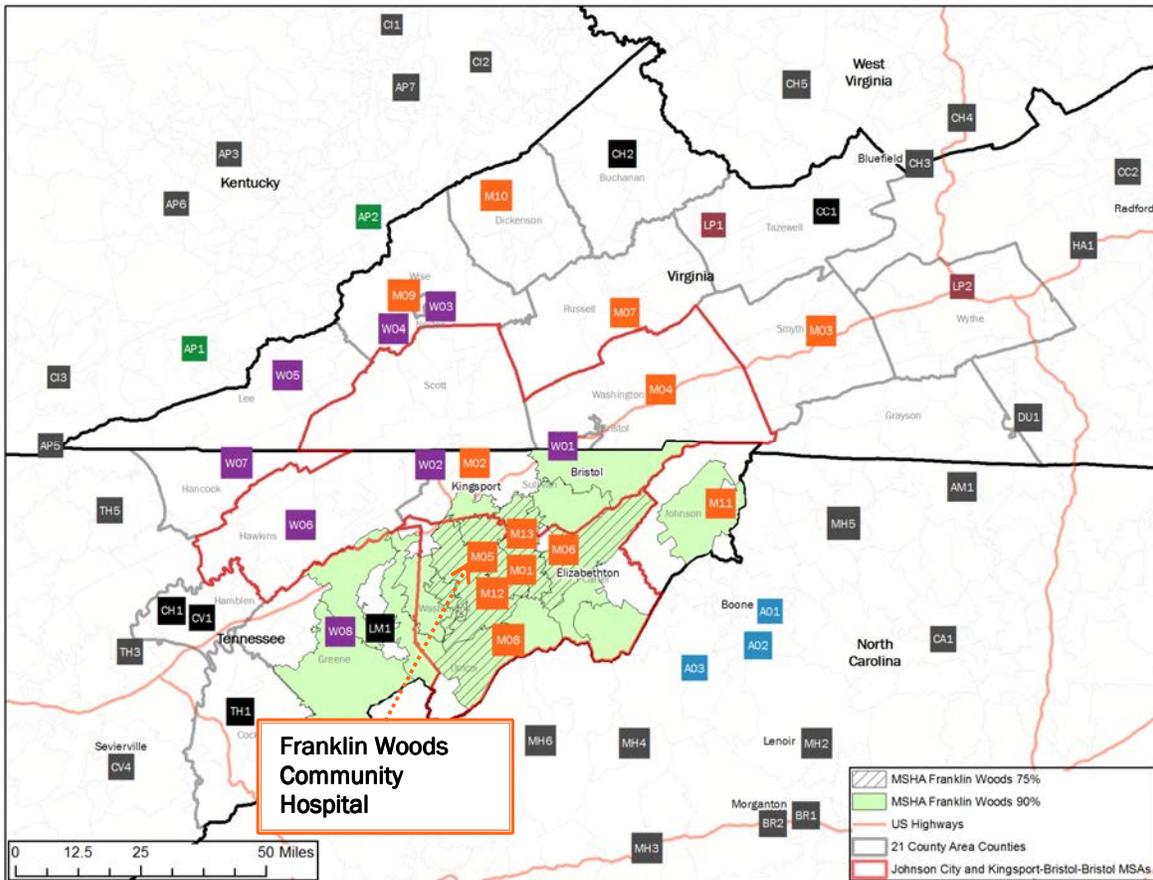
7. Dickenson Community Hospital



Mountain States Dickenson Community Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	1	2	1	2
Licensed Beds	25	25	25	25
Staffed Beds Occupancy	2.7%	0.3%	3.8%	1.6%
Licensed Beds Occupancy	0.1%	0.0%	0.2%	0.1%
Average Daily Census	0	0	0	0
Patient Days	10	2	14	12
Discharges/Admissions	8	1	11	9
Average Length of Stay	1.3	2.0	1.3	1.3

Source: Virginia Health Information Reports FY10-FY13

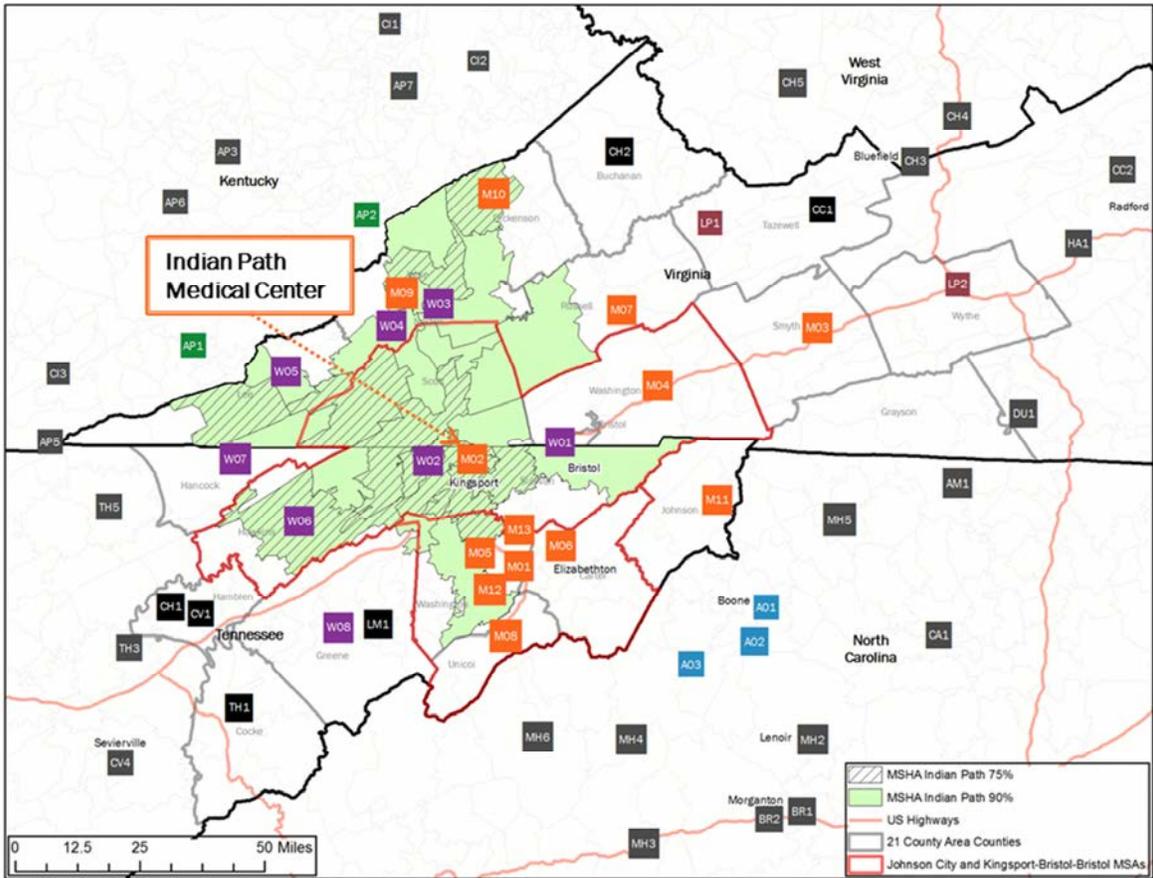
8. Franklin Woods Community Hospital



Mountain States Franklin Woods Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds		80	80	77
Licensed Beds		80	80	80
Staffed Beds Occupancy		50.0%	48.6%	54.1%
Licensed Beds Occupancy		50.0%	48.6%	52.1%
Average Daily Census		40	39	42
Patient Days		14,612	14,233	15,199
Discharges/Admissions		3,721	3,719	4,189
Average Length of Stay		3.9	3.8	3.6

Source: Tennessee Joint Annual Reports FY11-FY13

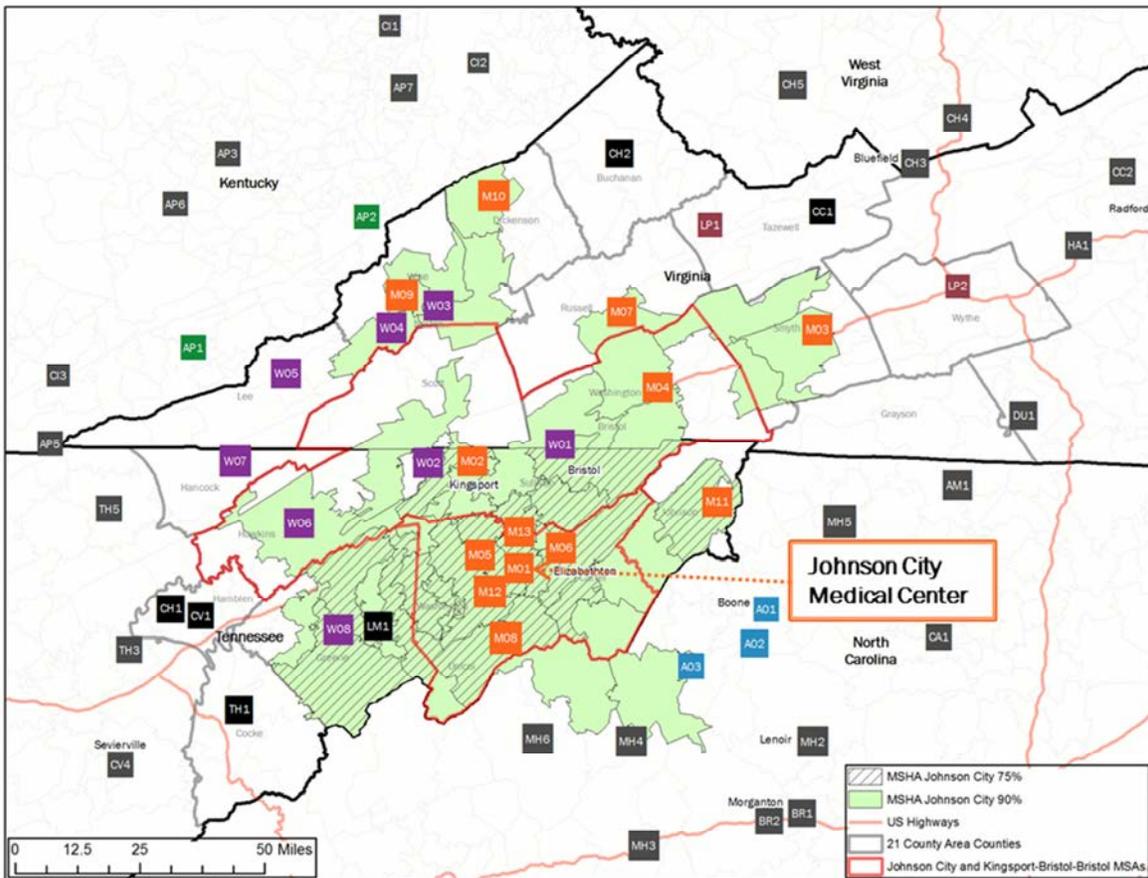
9. Indian Path Medical Center



Mountain States Indian Path Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	191	189	169	168
Licensed Beds	239	239	239	239
Staffed Beds Occupancy	40.9%	33.8%	39.5%	37.4%
Licensed Beds Occupancy	32.7%	26.7%	27.9%	26.3%
Average Daily Census	78	64	67	63
Patient Days	28,532	23,303	24,432	22,907
Discharges/Admissions	6,549	6,149	6,146	5,877
Average Length of Stay	4.4	3.8	4.0	3.9

Source: Tennessee Joint Annual Reports FY10-FY13

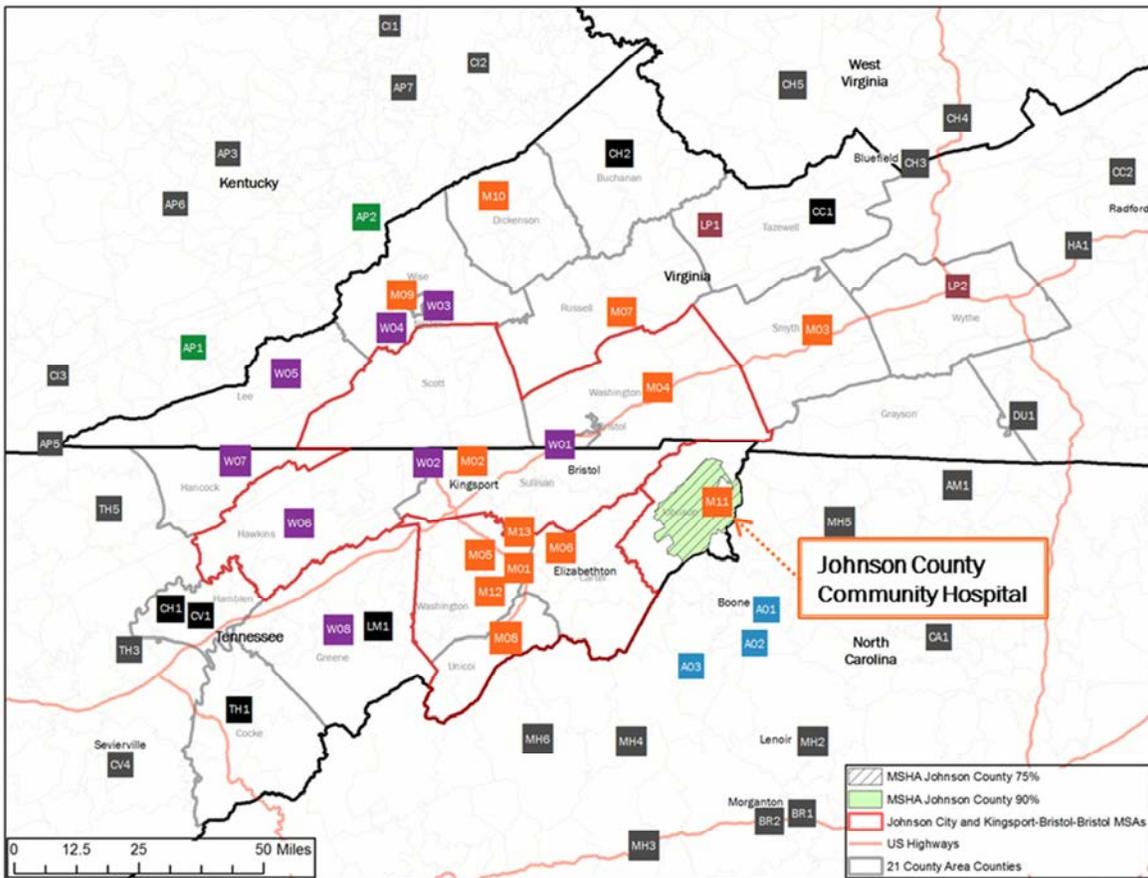
10. Johnson City Medical Center



Mountain States Johnson City Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	501	501	501	497
Licensed Beds	501	501	501	501
Staffed Beds Occupancy	75.8%	72.8%	72.4%	69.3%
Licensed Beds Occupancy	75.8%	72.8%	72.4%	68.7%
Average Daily Census	380	365	363	344
Patient Days	138,664	133,172	132,677	125,692
Discharges/Admissions	27,129	26,103	25,751	23,644
Average Length of Stay	5.1	5.1	5.2	5.3

Source: Tennessee Joint Annual Reports FY10-FY13

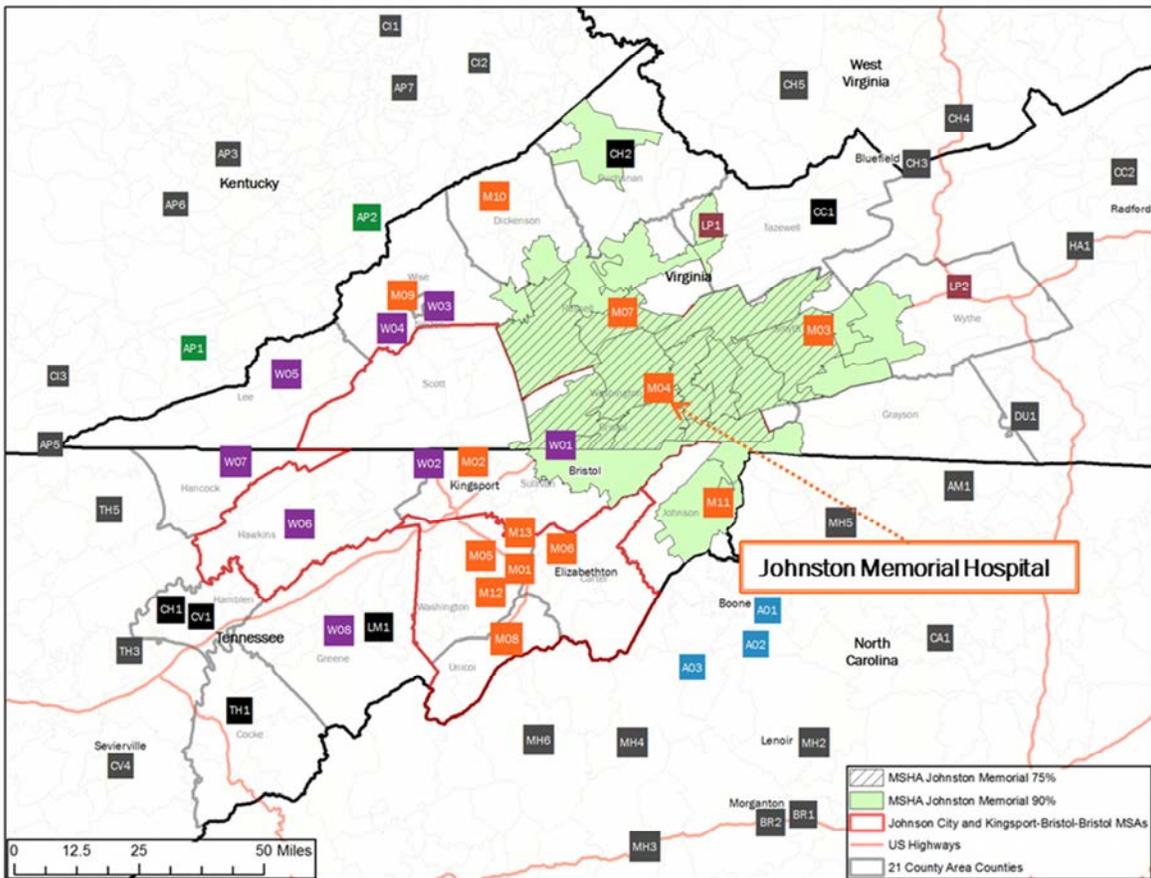
11. Johnson County Community Hospital



Mountain States Johnson County Community Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	2	2	2	2
Licensed Beds	2	2	2	2
Staffed Beds Occupancy	9.5%	5.9%	7.2%	6.0%
Licensed Beds Occupancy	9.5%	5.9%	7.2%	6.0%
Average Daily Census	0	0	0	0
Patient Days	69	43	53	44
Discharges/Admissions	29	20	26	23
Average Length of Stay	2.4	2.2	2.0	1.9

Source: Tennessee Joint Annual Reports FY10-FY13

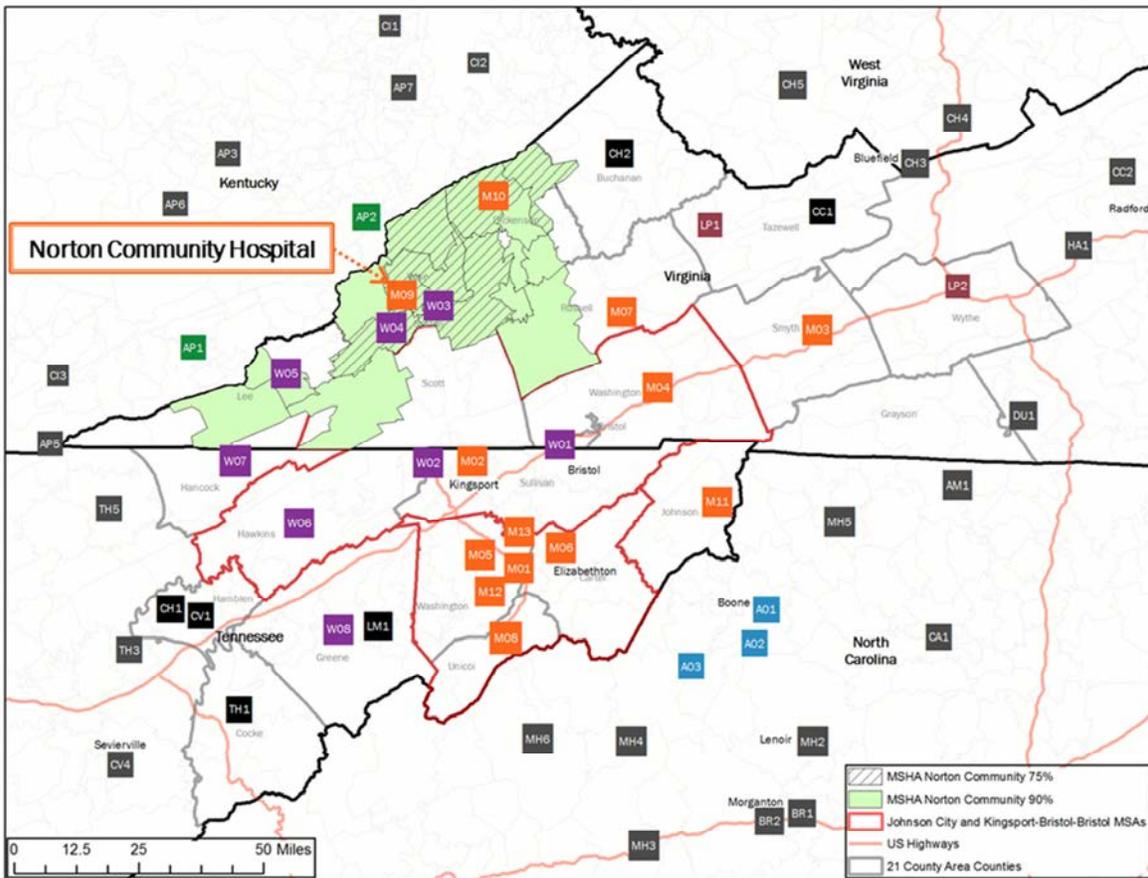
12. Johnston Memorial Hospital



Mountain States Johnston Memorial Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	100	116	116	112
Licensed Beds	135	116	116	116
Staffed Beds Occupancy	61.4%	51.6%	60.1%	58.3%
Licensed Beds Occupancy	45.5%	51.6%	60.1%	56.3%
Average Daily Census	61	60	70	65
Patient Days	22,427	21,866	25,511	23,822
Discharges/Admissions	5,883	6,156	7,053	7,215
Average Length of Stay	3.8	3.6	3.6	3.3

Source: Virginia Health Information Reports FY10-FY13

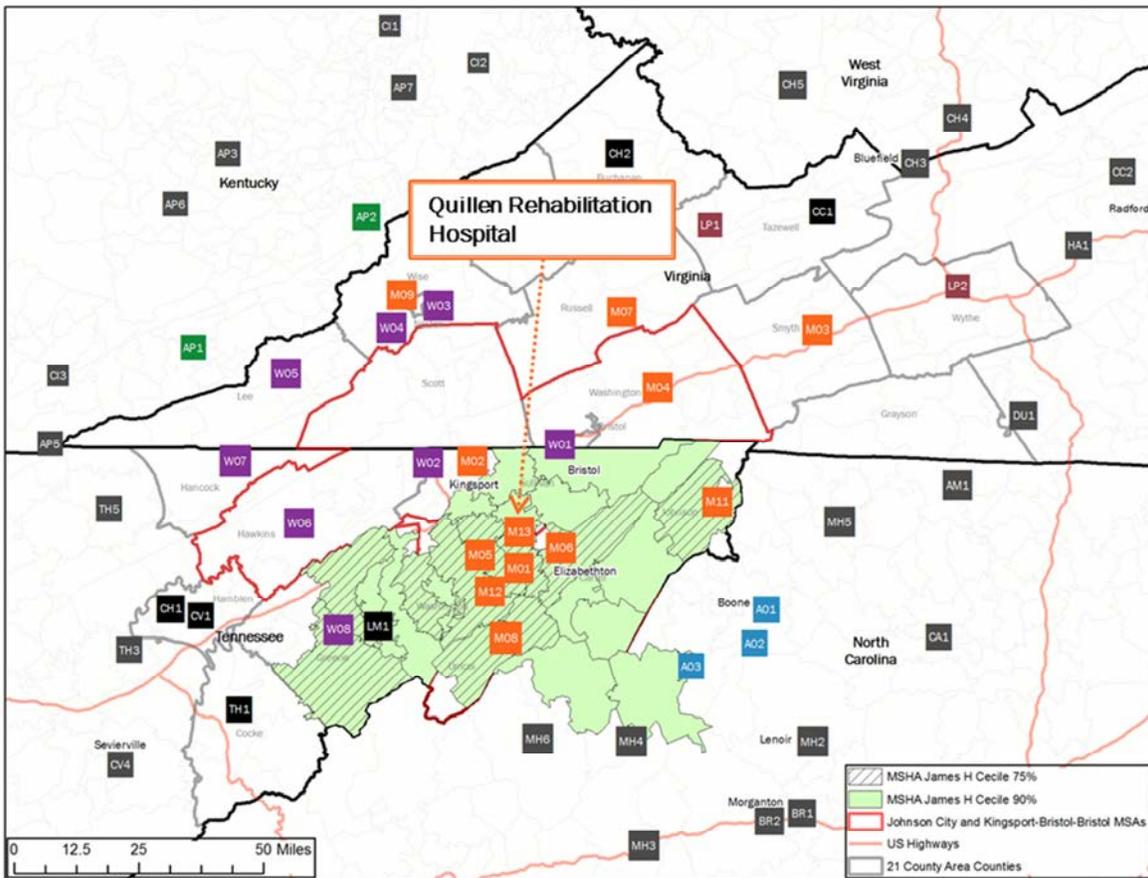
13. Norton Community Hospital



Mountain States Norton Community Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	40	40	50	50
Licensed Beds	129	129	129	129
Staffed Beds Occupancy	95.3%	94.9%	72.8%	70.5%
Licensed Beds Occupancy	29.6%	29.4%	28.2%	27.3%
Average Daily Census	38	38	36	35
Patient Days	13,916	13,858	13,320	12,859
Discharges/Admissions	4,308	4,375	4,149	3,685
Average Length of Stay	3.2	3.2	3.2	3.5

Source: Virginia Health Information Reports FY10-FY13

14. Quillen Rehabilitation Hospital

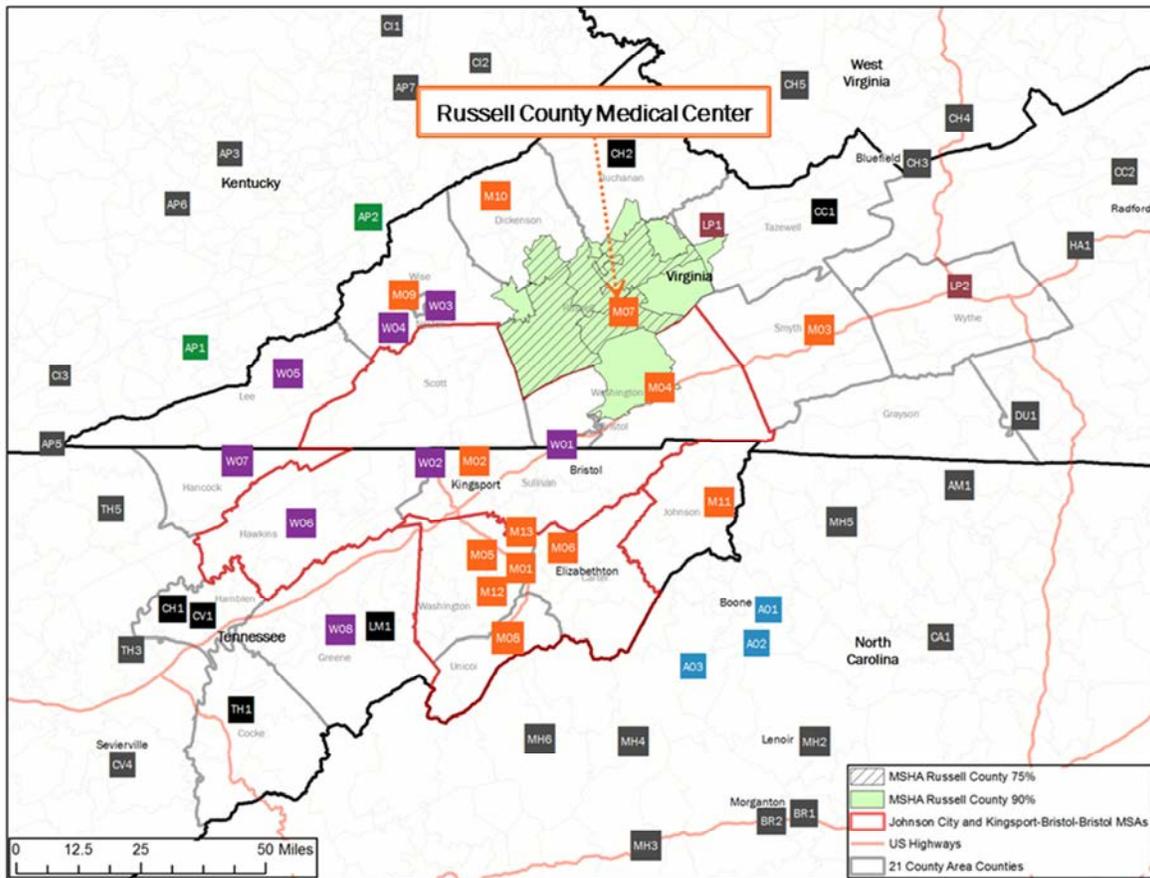


Mountain States James H. and Cecile C. Quillen Rehab Hospital Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds*	60	60	26	26
Licensed Beds	47	47	26	26
Staffed Beds Occupancy	45.3%	38.6%	81.0%	77.8%
Licensed Beds Occupancy	57.8%	49.3%	81.0%	77.8%
Average Daily Census	27	23	21	20
Patient Days	9,923	8,453	7,705	7,384
Discharges/Admissions	691	17,155	606	569
Average Length of Stay	14.4	12.9	12.7	13.0

*In FY10 and FY11, the number of staffed beds exceeds licensed beds because staffed beds include 13 separately licensed SNF beds co-located at Quillen Rehab Hospital.

Source: Tennessee Joint Annual Reports FY10-FY13

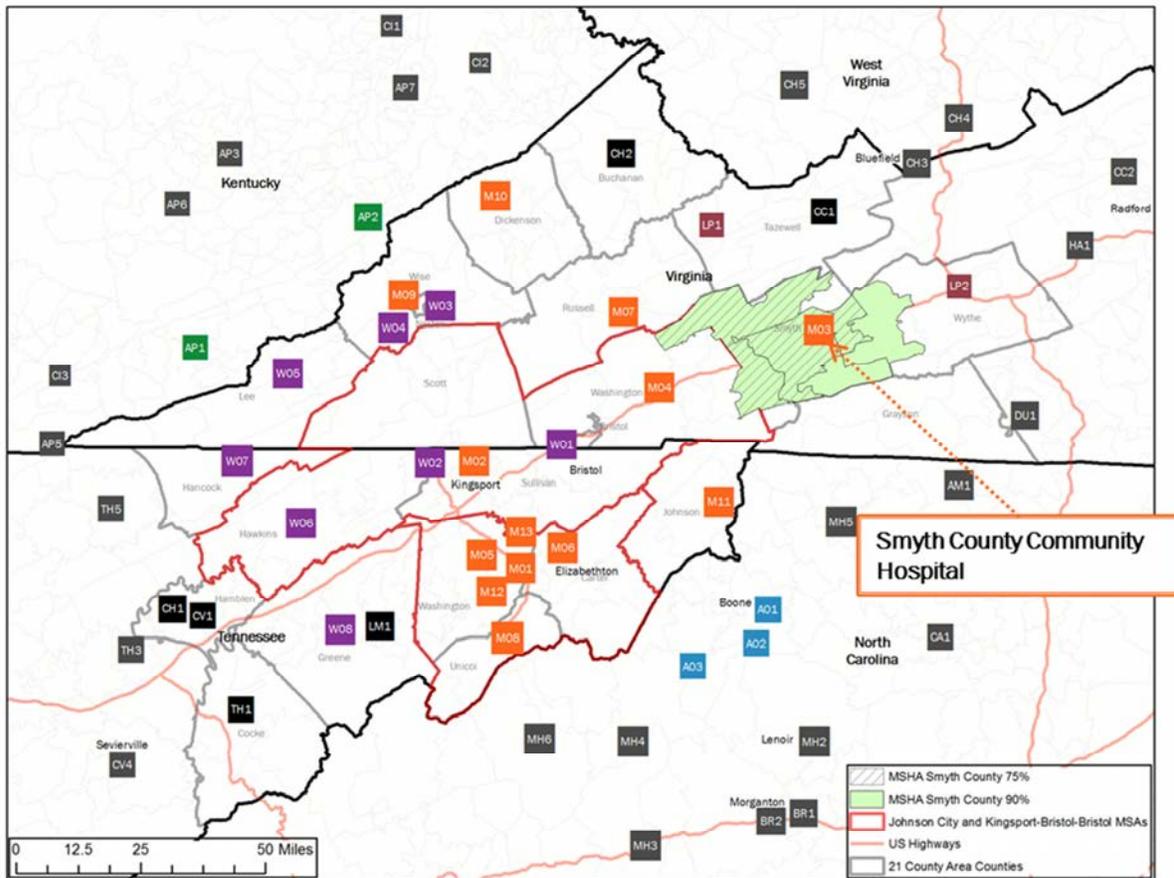
15. Russell County Medical Center



Mountain States Russell County Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	78	78	78	49
Licensed Beds	78	78	78	78
Staffed Beds Occupancy	44.9%	45.7%	43.3%	58.5%
Licensed Beds Occupancy	44.9%	45.7%	43.3%	36.7%
Average Daily Census	35	36	34	29
Patient Days	12,789	13,010	12,371	10,461
Discharges/Admissions	3,117	3,061	2,869	2,464
Average Length of Stay	4.1	4.3	4.3	4.2

Source: Virginia Health Information Reports FY10-FY13

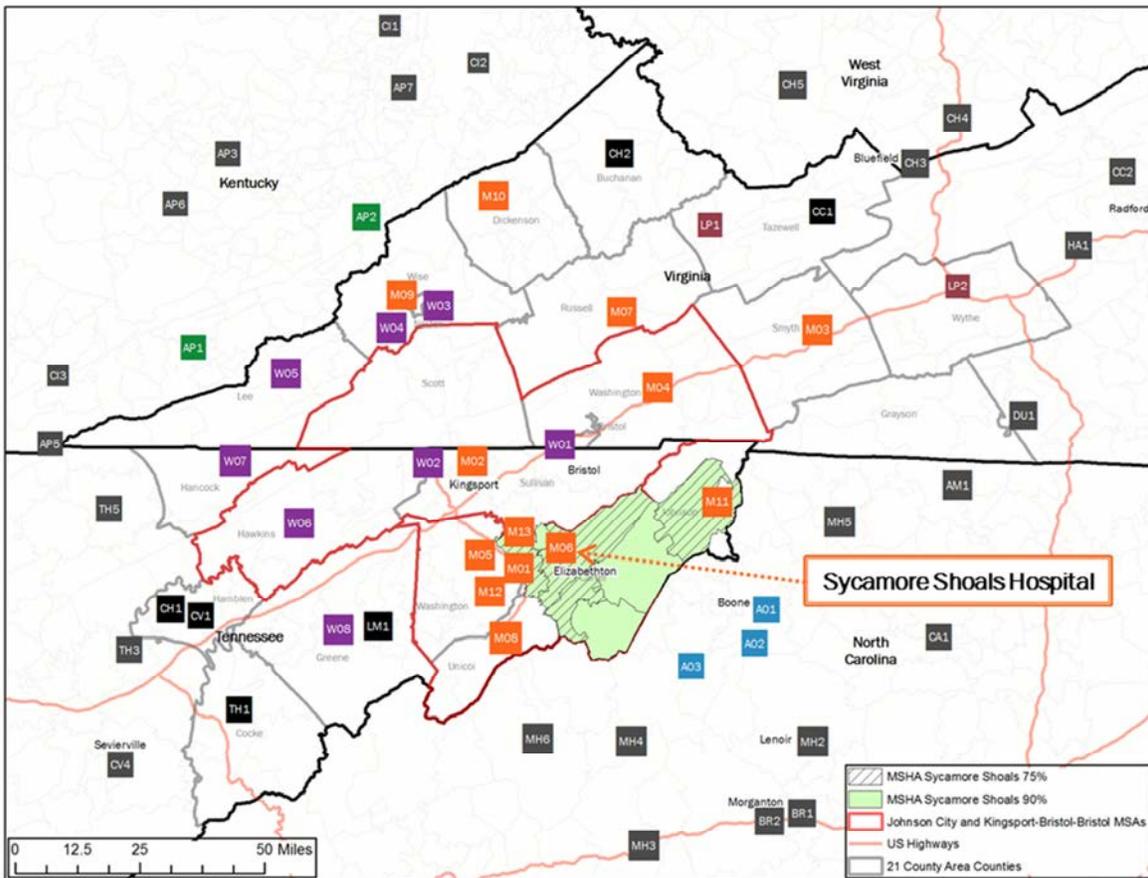
16. Smyth County Community Hospital



Mountain States Smyth County Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	54	44	44	44
Licensed Beds	170	170	139	44
Staffed Beds Occupancy	43.5%	51.3%	49.4%	48.1%
Licensed Beds Occupancy	13.8%	13.3%	15.6%	48.1%
Average Daily Census	23	23	22	21
Patient Days	8,569	8,234	7,951	7,729
Discharges/Admissions	2,498	2,275	1,962	1,713
Average Length of Stay	3.4	3.6	4.1	4.5

Source: Virginia Health Information Reports FY10-FY13

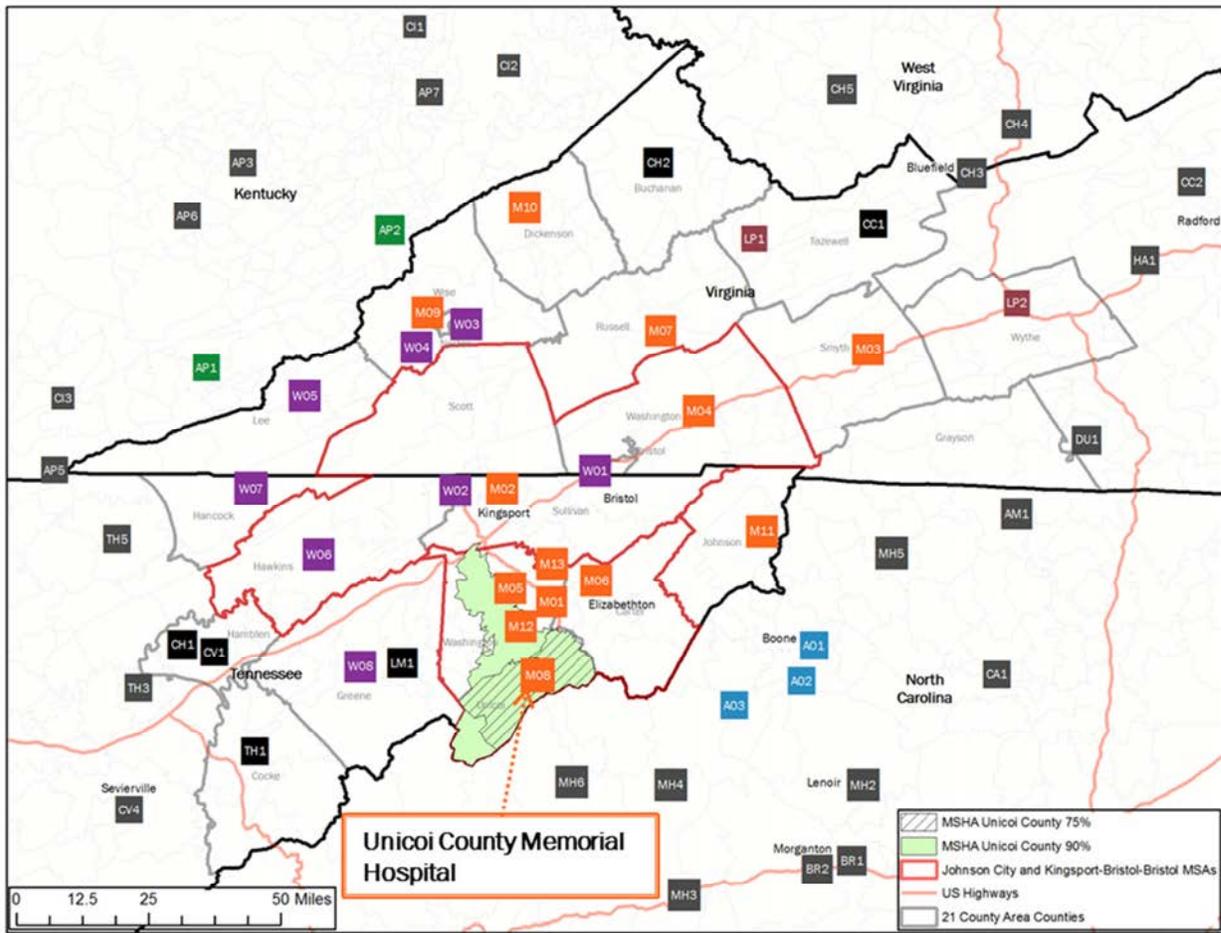
17. Sycamore Shoals Hospital



Mountain States Sycamore Shoals Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	79	79	79	74
Licensed Beds	121	121	121	121
Staffed Beds Occupancy	53.2%	53.1%	52.6%	57.0%
Licensed Beds Occupancy	34.7%	34.7%	34.3%	34.9%
Average Daily Census	42	42	42	42
Patient Days	15,334	15,299	15,206	15,398
Discharges/Admissions	3,448	3,640	3,673	3,430
Average Length of Stay	4.4	4.2	4.1	4.5

Source: Tennessee Joint Annual Reports FY10-FY13

18. Unicoi County Memorial Hospital

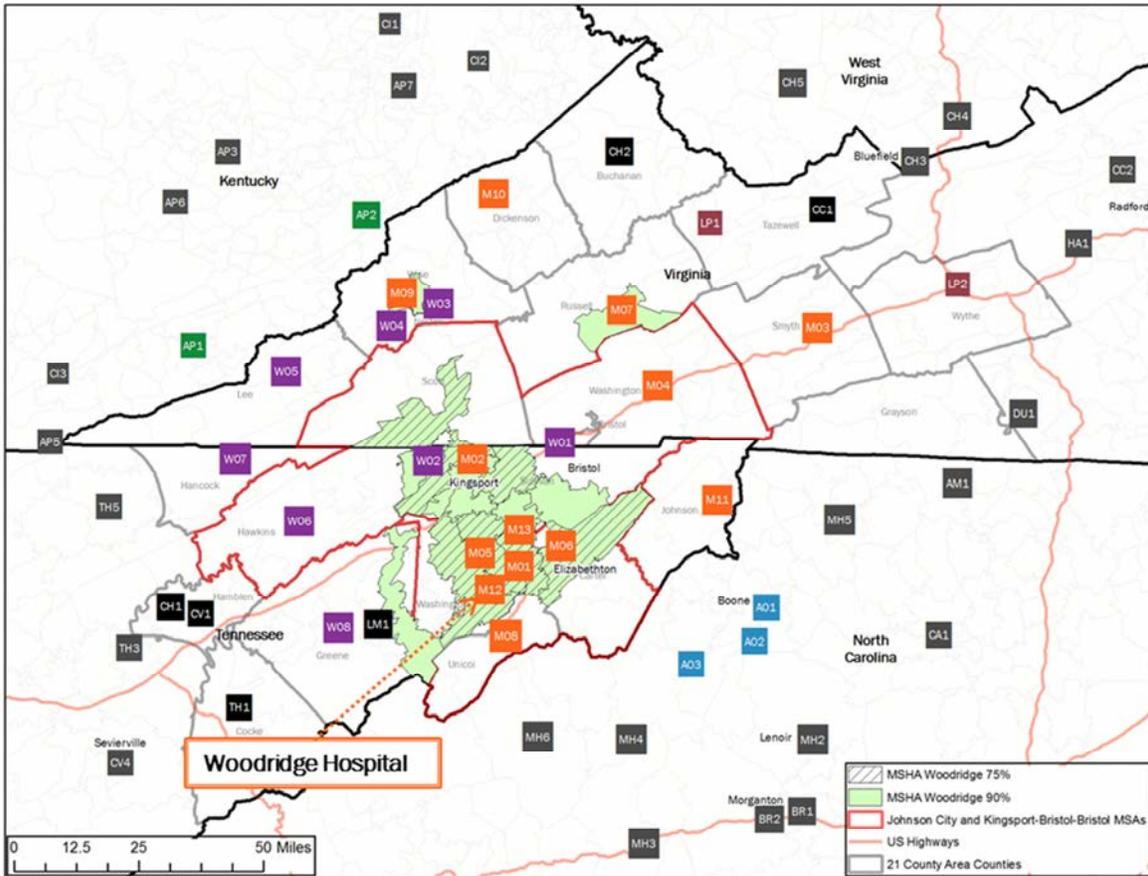


Mountain States Unicoi County Comparative Statistics

	FY2010	FY2011	FY2012	FY2013
Staffed Beds	25	10	7	7
Licensed Beds	48	48	48	48
Staffed Beds Occupancy	49.3%	126.6%	166.4%	169.7%
Licensed Beds Occupancy	25.7%	26.4%	24.3%	24.7%
Average Daily Census	12	13	12	12
Patient Days	4,499	4,622	4,262	4,336
Discharges/Admissions	1,223	1,221	1,098	1,060
Average Length of Stay	3.7	3.8	3.9	4.1

Source: Tennessee Joint Annual Reports FY10-FY13

19. Woodridge Hospital



Mountain States Woodridge Psychiatric Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	84	84	84	80
Licensed Beds	84	84	84	84
Staffed Beds Occupancy	63.8%	64.7%	69.4%	76.0%
Licensed Beds Occupancy	63.8%	64.7%	69.4%	72.4%
Average Daily Census	54	54	58	61
Patient Days	19,572	19,827	21,329	22,182
Discharges/Admissions	3,310	3,412	3,573	3,824
Average Length of Stay	5.9	5.8	6.0	5.8

Source: Tennessee Joint Annual Reports FY10-FY13

C. Geographic Service Area Payer Mix

For all discharges among residents living in the Geographic Service Area, payer mix was calculated from the 2014 inpatient discharge data.

Payer Class	Discharges	% of Discharges
Charity	1,328	1.1%
Commercial	21,027	17.5%
Government	1,142	0.9%
Medicaid	20,439	17.0%
Medicare	46,396	38.6%
Medicare HMO	17,726	14.7%
Missing	23	0.0%
Other	4,454	3.7%
Self Pay	7,495	6.2%
Worker's Comp	297	0.2%

Exhibit 5.2

Shares of the Geographic Service Area for general acute care inpatient services were calculated using Calendar Year 2014 discharge data for all Tennessee and Virginia hospitals using the Tennessee Hospital Discharge Data System and the Virginia Health Information's patient level database system.

A list of hospitals physically located in the Geographic Service Area is provided below. In addition, the table lists the top ten (10) out-of-area hospitals that serve patients in the Geographic Service Area.

Hospital Name	City	State
Wellmont Health System		
Wellmont Hancock County Hospital	Sneedville	TN
Wellmont Hawkins County Memorial Hospital	Rogersville	TN
Mountain View Regional Medical Center	Norton	VA
Wellmont Lonesome Pine Hospital	Big Stone Gap	VA
Wellmont Bristol Regional Medical Center	Bristol	TN
Wellmont Holston Valley Medical Center	Kingsport	TN
Mountain State Health Alliance		
Dickenson Community Hospital	Clintwood	VA
Johnson County Community Hospital	Mountain City	TN
Quillen Rehabilitation Hospital	Johnson City	TN
Unicoi County Memorial Hospital, Inc.	Erwin	TN
Smyth County Community Hospital	Marion	VA
Russell County Medical Center	Lebanon	VA
Norton Community Hospital	Norton	VA
Sycamore Shoals Hospital	Elizabethton	TN
Woodridge Psychiatric Hospital	Johnson City	TN
Franklin Woods Community Hospital	Johnson City	TN
Indian Path Medical Center	Kingsport	TN
Johnston Memorial Hospital	Abingdon	VA
Johnson City Medical Center	Johnson City	TN
Other Hospitals in the Geographic Service Area		
Takoma Regional Hospital	Greeneville	TN
Carilion Tazewell Community Hospital	Tazewell	VA
Buchanan General Hospital	Grundy	VA
Wythe County Community Hospital	Wytheville	VA
Tennova Healthcare-Lakeway Regional Hospital	Morristown	TN
Tennova Healthcare-Newport Medical Center	Newport	TN
Laughlin Memorial Hospital, Inc.	Greeneville	TN
Clinch Valley Medical Center	Richlands	VA
Morristown-Hamblen Healthcare System	Morristown	TN
Top 10 Hospitals Outside Geographic Service Area Serving Geographic Service Area Patients		
University Of Tennessee Medical Center	Knoxville	TN
Carilion Medical Center	Dayton	VA
Tennova Healthcare-Physicians Regional Medical Center	Knoxville	TN

Hospital Name	City	State
Vanderbilt University Hospitals	Nashville	TN
University Of Virginia Medical Center	Charlottesville	VA
Fort Sanders Regional Medical Center	Knoxville	TN
Carilion New River Valley Medical Center	Christiansburg	VA
Peninsula Hospital	Louisville	TN
East Tennessee Children's Hospital	Knoxville	TN
Twin County Regional Hospital	Galax	VA

Below are the aggregated system shares for Mountain States, Wellmont, and both combined. These shares are based on the hospital discharges including MDCs 19 and 20.

System	Total	Share of Total Discharges
Mountain States	58,441	45.6%
Wellmont	35,075	27.4%
Other	34,584	27.0%

System	Total	Share of Total Discharges
New Health System	93,516	73.0%
Independent Competition	34,584	27.0%

In the two tables below, Wellmont hospitals are highlighted in blue and Mountain States hospitals are highlighted in green. There are a number of independent hospitals located in the Geographic Service Area and these are highlighted in orange. There are a number of hospitals located outside of the Geographic Service Area used by patients in the area; the top several of these hospitals are shown (without highlighting).

Hospital and health system shares were calculated using a denominator of the total number of discharges of residents in the Geographic Service Area. An individual hospital's share is its total discharges of residents from the Geographic Service Area divided by the total number of area discharges. Health system shares are calculated as the sum of all of its hospitals' shares.

To estimate the share that a given Wellmont (Mountain States) hospital accounts for of the combined system share, its total discharges are shown as a percentage of the combined systems' discharges. These percentages are shown in the column labeled Shares of Wellmont and Mountain States Discharges.

Shares were calculated for general acute care services excluding normal newborns (DRG 795) and including/excluding MDC 19 and 20 and for all payers.

A. Inpatient (Including MDCs 19 and 20)

Hospital Name	Hospital Affiliation	Total	Shares of Total Discharges	Shares of Wellmont and Mountain States Discharges
Total		128,100	100.0%	
Total GSA Hospitals		115,691	90.3%	
Total Non-GSA Hospitals		12,409	9.7%	
Share Outside GSA		9.7%		
WELLMONT HANCOCK COUNTY HOSPITAL	Wellmont	181	0.1%	0.2%
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	Wellmont	1,025	0.8%	1.1%
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	Wellmont	1,168	0.9%	1.2%
WELLMONT LONESOME PINE HOSPITAL	Wellmont	1,712	1.3%	1.8%
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	Wellmont	14,158	11.1%	15.1%
WELLMONT HOLSTON VALLEY MEDICAL CENTER	Wellmont	16,831	13.1%	18.0%
DICKENSON COMMUNITY HOSPITAL	Mountain States	5	0.0%	0.0%
JOHNSON COUNTY COMMUNITY HOSPITAL	Mountain States	14	0.0%	0.0%
QUILLEN REHABILITATION HOSPITAL	Mountain States	491	0.4%	0.5%
UNICOI COUNTY MEMORIAL HOSPITAL, INC.	Mountain States	760	0.6%	0.8%
SMYTH COUNTY COMMUNITY HOSPITAL	Mountain States	1,779	1.4%	1.9%
RUSSELL COUNTY MEDICAL CENTER	Mountain States	1,957	1.5%	2.1%
NORTON COMMUNITY HOSPITAL	Mountain States	3,132	2.4%	3.3%
SYCAMORE SHOALS HOSPITAL	Mountain States	3,438	2.7%	3.7%
WOODRIDGE PSYCHIATRIC HOSPITAL	Mountain States	4,337	3.4%	4.6%
FRANKLIN WOODS COMMUNITY HOSPITAL	Mountain States	5,160	4.0%	5.5%
INDIAN PATH MEDICAL CENTER	Mountain States	5,972	4.7%	6.4%
JOHNSTON MEMORIAL HOSPITAL	Mountain States	8,182	6.4%	8.7%
JOHNSON CITY MEDICAL CENTER	Mountain States	23,214	18.1%	24.8%
CARILION TAZEWELL COMMUNITY HOSPITAL	Other	546	0.4%	
BUCHANAN GENERAL HOSPITAL	Other	1,048	0.8%	
WYTHE COUNTY COMMUNITY HOSPITAL	Other	1,809	1.4%	
TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL	Other	1,830	1.4%	
TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER	Other	2,028	1.6%	
TAKOMA REGIONAL HOSPITAL	Other	2,452	1.9%	
LAUGHLIN MEMORIAL HOSPITAL, INC.	Other	3,230	2.5%	
CLINCH VALLEY MEDICAL CENTER	Other	4,131	3.2%	
MORRISTOWN-HAMBLÉN HEALTHCARE SYSTEM	Other	5,101	4.0%	
UNIVERSITY OF TENNESSEE MEDICAL CENTER	Other	1,766	1.4%	
CARILION MEDICAL CENTER	Other	1,228	1.0%	
TENNOVA HEALTHCARE-PHYSICIANS REGIONAL	Other	1,047	0.8%	
VANDERBILT UNIVERSITY HOSPITALS	Other	874	0.7%	
UNIVERSITY OF VIRGINIA MEDICAL CENTER	Other	869	0.7%	
All Other		6,625	5.2%	

B. Inpatient (Excluding MDCs 19 and 20)

Hospital Name	Hospital Affiliation	Total	Shares of Total Discharges	Shares of Wellmont and Mountain States Discharges
Total		119,282	100.0%	
Total GSA Hospitals		108,392	90.9%	
Total Non-GSA Hospitals		10,890	9.1%	
Share Outside GSA		9.1%		
WELLMONT HANCOCK COUNTY HOSPITAL	Wellmont	179	0.2%	0.2%
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	Wellmont	1,012	0.8%	1.2%
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	Wellmont	1,160	1.0%	1.3%
WELLMONT LONESOME PINE HOSPITAL	Wellmont	1,704	1.4%	2.0%
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	Wellmont	13,000	10.9%	15.0%
WELLMONT HOLSTON VALLEY MEDICAL CENTER	Wellmont	16,773	14.1%	19.4%
DICKENSON COMMUNITY HOSPITAL	Mountain States	5	0.0%	0.0%
JOHNSON COUNTY COMMUNITY HOSPITAL	Mountain States	14	0.0%	0.0%
WOODRIDGE PSYCHIATRIC HOSPITAL	Mountain States	32	0.0%	0.0%
QUILLEN REHABILITATION HOSPITAL	Mountain States	491	0.4%	0.6%
UNICOI COUNTY MEMORIAL HOSPITAL, INC.	Mountain States	757	0.6%	0.9%
RUSSELL COUNTY MEDICAL CENTER	Mountain States	1,313	1.1%	1.5%
SMYTH COUNTY COMMUNITY HOSPITAL	Mountain States	1,753	1.5%	2.0%
NORTON COMMUNITY HOSPITAL	Mountain States	3,120	2.6%	3.6%
SYCAMORE SHOALS HOSPITAL	Mountain States	3,167	2.7%	3.7%
FRANKLIN WOODS COMMUNITY HOSPITAL	Mountain States	5,138	4.3%	5.9%
INDIAN PATH MEDICAL CENTER	Mountain States	5,939	5.0%	6.9%
JOHNSTON MEMORIAL HOSPITAL	Mountain States	8,123	6.8%	9.4%
JOHNSON CITY MEDICAL CENTER	Mountain States	22,983	19.3%	26.5%
CARILION TAZEWELL COMMUNITY HOSPITAL	Other	543	0.5%	
BUCHANAN GENERAL HOSPITAL	Other	1,041	0.9%	
WYTHE COUNTY COMMUNITY HOSPITAL	Other	1,801	1.5%	
TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL	Other	1,820	1.5%	
TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER	Other	2,011	1.7%	
TAKOMA REGIONAL HOSPITAL	Other	2,270	1.9%	
LAUGHLIN MEMORIAL HOSPITAL, INC.	Other	3,225	2.7%	
CLINCH VALLEY MEDICAL CENTER	Other	4,102	3.4%	
MORRISTOWN-HAMBLÉN HEALTHCARE SYSTEM	Other	4,916	4.1%	
UNIVERSITY OF TENNESSEE MEDICAL CENTER	Other	1,764	1.5%	
CARILION MEDICAL CENTER	Other	1,159	1.0%	
TENNOVA HEALTHCARE-PHYSICIANS REGIONAL	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 6.1

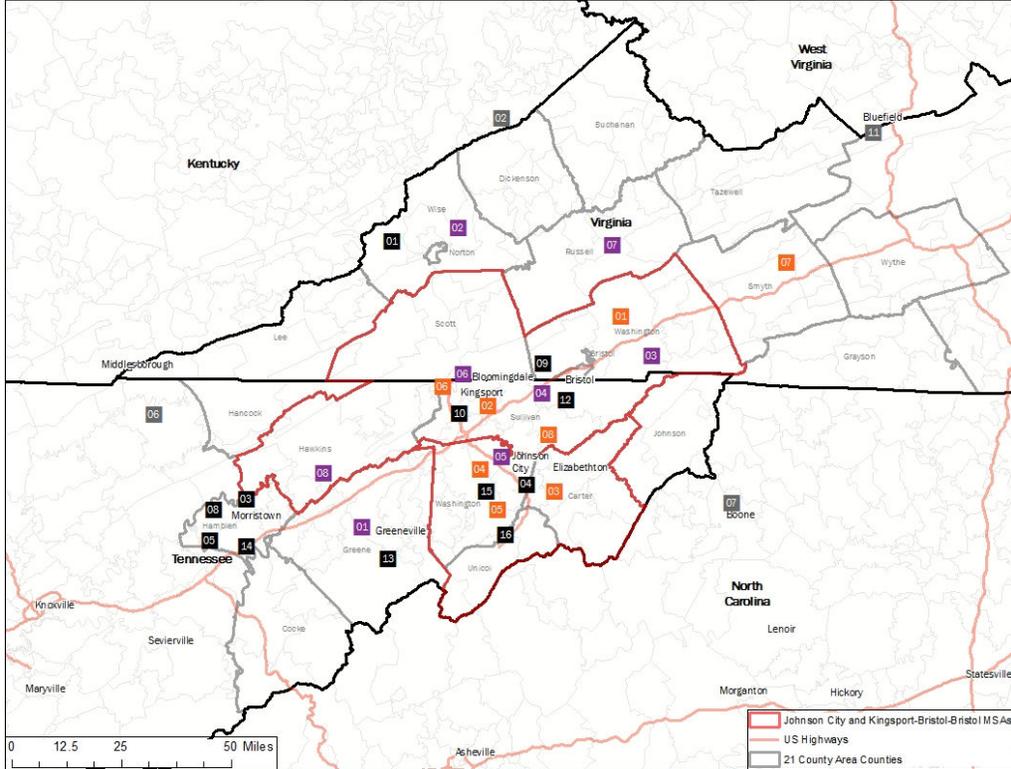
Outpatient analyses for the Geographic Service Area were conducted using counts of facilities for a variety of types of outpatient providers serving the area; these include out-of-area facilities. Facility-level data included the name, address, affiliation and type of service (e.g., ASC). A summary table for all categories of outpatient services is provided below and shows that for many services there is little or no overlap and that for the majority of services, independent providers account for a large share of total providers. In the few services in which there is higher share, there is no overlap. More detailed analyses were also conducted for three outpatient categories: urgent care, imaging facilities, and ambulatory surgery centers; and the tables below show that competing facilities account for 50% or greater share for each of these services. Maps show that these alternatives are located near those affiliated with Mountain States and Wellmont.

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

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

B. Urgent Care



Urgent Care Outpatient Facilities

Wellmont

- 01 Greenville Urgent Care
- 02 Wellmont Extended Hours Clinic - Norton
- 03 Wellmont Urgent Care - Abingdon
- 04 Wellmont Urgent Care - Bristol
- 05 Wellmont Urgent Care - Johnson City
- 06 Wellmont Urgent Care - Kingsport
- 07 Wellmont Urgent Care - Lebanon
- 08 Wellmont Urgent Care - Rogersville

MSHA

- 01 First Assist Urgent Care - Abingdon
- 02 First Assist Urgent Care - Colonial Heights
- 03 First Assist Urgent Care - Elizabethton
- 04 First Assist Urgent Care - Johnson City
- 05 First Assist Urgent Care - Jonesborough
- 06 First Assist Urgent Care - Kingsport
- 07 First Assist Urgent Care - Marion
- 08 First Assist Urgent Care - Piney Flats

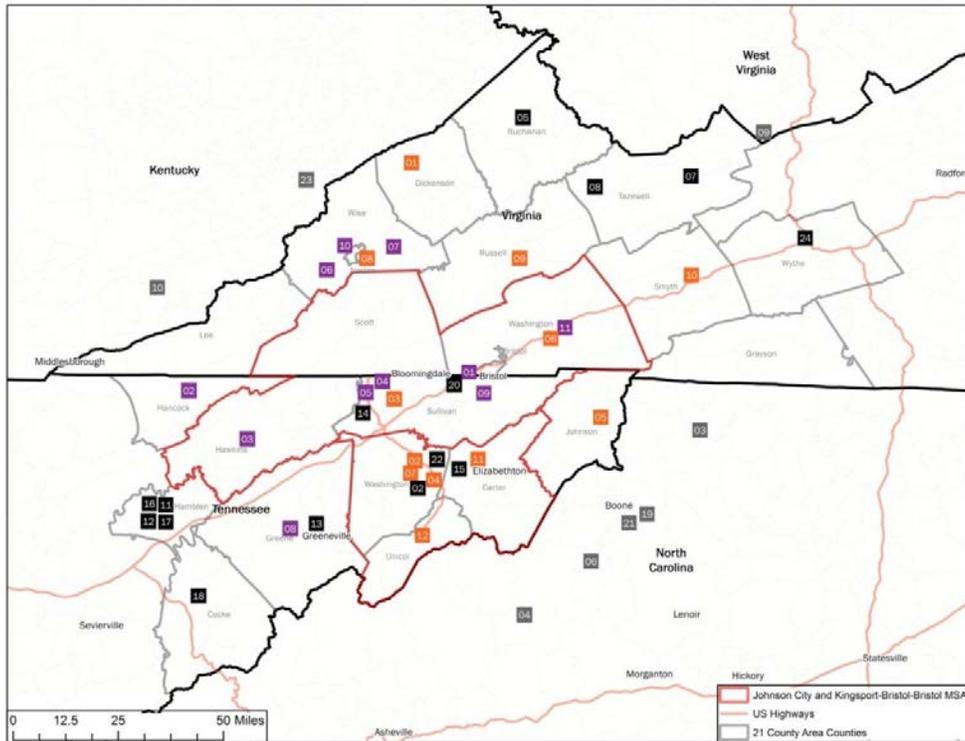
All Other Facilities

- 01 Appalachian After Hours Care
- 02 AppUrgent Care
- 03 College Park Medical Clinic
- 04 Doctors Care
- 05 Express Health Clinic-Morristown
- 06 Express Health Clinic-Newport
- 07 FastMed Urgent Care
- 08 HealthStar Urgent Care Clinic
- 09 Holston Medical Group Urgent Care-Bristol
- 10 Holston Medical Group Urgent Care-Kingsport
- 11 MedExpress Urgent Care-Bluefield
- 12 MedExpress Urgent Care-Bristol
- 13 Patmos EmergiClinic
- 14 Prompt Family Care
- 15 State of Franklin Healthcare Associates Walk-in Clinic
- 16 Urgent Care of Erwin

Urgent Care Facility Locations and Counts, by System

Affiliation	Facility Name	County	State
Total	Total	32	100.0%
Wellmont	Greeneville Urgent Care	Greene	TN
Wellmont	Wellmont Extended Hours Clinic - Norton	Wise	VA
Wellmont	Wellmont Urgent Care - Abingdon	Washington	VA
Wellmont	Wellmont Urgent Care - Bristol	Sullivan	TN
Wellmont	Wellmont Urgent Care - Johnson City	Washington	TN
Wellmont	Wellmont Urgent Care - Kingsport	Sullivan	TN
Wellmont	Wellmont Urgent Care - Lebanon	Russell	VA
Wellmont	Wellmont Urgent Care - Rogersville	Rogersville	TN
Wellmont	Total	8	25%
Mountain States	First Assist Urgent Care - Abingdon	Washington	VA
Mountain States	First Assist Urgent Care - Colonial Heights	Sullivan	TN
Mountain States	First Assist Urgent Care - Elizabethton	Carter	TN
Mountain States	First Assist Urgent Care - Johnson City	Washington	TN
Mountain States	First Assist Urgent Care - Jonesborough	Washington	TN
Mountain States	First Assist Urgent Care - Kingsport	Sullivan	TN
Mountain States	First Assist Urgent Care - Marion	Smyth	VA
Mountain States	First Assist Urgent Care - Piney Flats	Washington	TN
Mountain States	Total	8	25%
All Other	AppUrgent Care	Watauga	NC
All Other	Appalachian After Hours Care	Wise	VA
All Other	College Park Medical Clinic	Hamblen	TN
All Other	Doctors Care	Washington	TN
All Other	Express Health Clinic-Morristown	Hamblen	TN
All Other	Express Health Clinic-Newport	Cocke	TN
All Other	FastMed Urgent Care	Watauga	NC
All Other	HealthStar Urgent Care Clinic	Hamblen	TN
All Other	Holston Medical Group Urgent Care-Bristol	Sullivan	TN
All Other	Holston Medical Group Urgent Care-Kingsport	Sullivan	TN
All Other	MedExpress Urgent Care-Bluefield	Tazewell	VA
All Other	MedExpress Urgent Care-Bristol	Sullivan	TN
All Other	Patmos EmergiClinic	Greene	TN
All Other	Prompt Family Care	Hamblen	TN
All Other	State of Franklin Healthcare Associates Walk-in Clinic	Washington	TN
All Other	Urgent Care of Erwin	Unicoi	TN
All Other	Total	16	50%

C. CT/MRI



CT/MRI Capabilities		All Other Facilities	
Wellmont			
01	Bristol Regional Medical Center	01	Appalachian Orthopaedic Associates, PC**
02	Hancock County Hospital	02	Appalachian Orthopaedic Associates
03	Hawkins County Memorial Hospital	03	Ashe Memorial Hospital
04	Holston Valley Imaging Center, LLC	04	Blue Ridge Regional Hospital
05	Holston Valley Medical Center	05	Buchanan General Hospital
06	Lonesome Pine Hospital	06	Cannon Memorial Hospital
07	Southwest Virginia Cancer Center	07	Carilion Tazewell Community Hospital
08	Takoma Regional Hospital (<i>Independent</i>)*	08	Clinch Valley Medical Center
09	Volunteer Parkway Imaging Center	09	Community Radiology Of Virginia, Inc.
10	Wellmont Mountain View Regional Medical Center	10	Harlan ARH Hospital
11	Wellmont Urgent Care Abingdon	11	Healthstar Physicians, PC
MSHA		12	Lakeway Regional Hospital
01	Dickenson Community Hospital	13	Laughlin Memorial Hospital, Inc.
02	Franklin Woods Community Hospital	14	Meadowview Outpatient Diagnostic Center
03	Indian Path Medical Center	15	Medical Care, PLLC (Elizabethton)
04	Johnson City Medical Center	16	Medical Care, PLLC (Johnson City)
05	Johnson County Community Hospital	17	Morristown-Hamblen Hospital
06	Johnston Memorial Hospital	18	Newport Medical Center
07	Mountain States Imaging at Med Tech Parkway	19	Ortho-Carolina - Boone
08	Norton Community Hospital	20	Sapling Grove Outpatient Diagnostic Center
09	Russell County Medical Center	21	Watauga Medical Center
10	Smyth County Community Hospital	22	Watauga Orthopaedics, PLC
11	Sycamore Shoals Hospital	23	Whitesburg ARH Hospital
12	Unicoi County Memorial Hospital, Inc.	24	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.

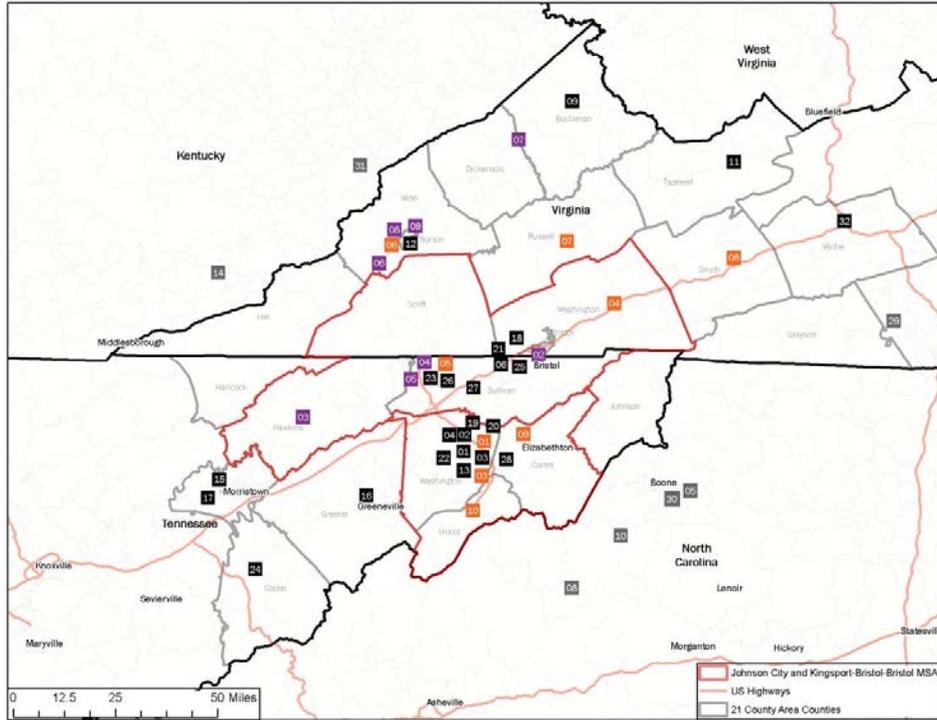
** Appalachian Orthopaedic Associates, PC is co-located with Bristol Regional Medical Center and is therefore not visible on the map

Imaging Capabilities Locations and Counts, by System

System Affiliation	Facility Name	County	State	CT Capabilities	MRI Capabilities
Total	Total	47	100%	43	41
Wellmont	Bristol Regional Medical Center	Sullivan	TN	X	X
Wellmont	Hancock County Hospital	Hancock	TN	X	
Wellmont	Hawkins County Memorial Hospital	Hawkins	TN	X	X
Wellmont	Holston Valley Imaging Center, LLC	Sullivan	TN	X	X
Wellmont	Holston Valley Medical Center	Sullivan	TN	X	X
Wellmont	Lonesome Pine Hospital	Wise	VA	X	X
Wellmont	Southwest Virginia Cancer Center	Wise	VA	X	
Wellmont	Volunteer Parkway Imaging Center	Sullivan	TN	X	X
Wellmont	Wellmont Mountain View Regional Medical Center	Wise	VA	X	X
Wellmont	Wellmont Urgent Care Abingdon	Washington	VA	X	
Wellmont	Total	10	21.3%	10	7
Mountain States	Dickenson Community Hospital	Dickenson	VA	X	
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	Johnson County Community Hospital	Johnson	TN	X	X
Mountain States	Johnston Memorial Hospital	Washington	VA	X	X
Mountain States	Mountain States Imaging at Med Tech Parkway	Washington	TN	X	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 Memorial Hospital, Inc.	Unicoi	TN	X	X
Mountain States	Total	12	25.5%	12	11
All Other	Appalachian Orthopaedic Associates, PC	Sullivan	TN		X
All Other	Appalachian Orthopaedic Associates	Washington	TN		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	X
All Other	Clinch Valley Medical Center	Tazewell	VA	X	X
All Other	Community Radiology Of Virginia, Inc.	Tazewell	VA	X	X
All Other	Harlan ARH Hospital	Harlan	KY	X	X
All Other	Healthstar Physicians, PC	Hamblen	TN	X	X
All Other	Lakeway Regional Hospital	Hamblen	TN	X	X

System Affiliation	Facility Name	County	State	CT Capabilities	MRI Capabilities
All Other	Laughlin Memorial Hospital, Inc.	Greene	TN	X	X
All Other	Meadowview Outpatient Diagnostic Center	Sullivan	TN	X	X
All Other	Medical Care, PLLC (Elizabethton)	Carter	TN	X	
All Other	Medical Care, PLLC (Johnson City)	Washington	TN	X	
All Other	Morristown-Hamblen Hospital	Hamblen	TN	X	X
All Other	Newport Medical Center	Cocke	TN	X	X
All Other	Ortho-Carolina - Boone	Watauga	NC		X
All Other	Sapling Grove Outpatient Diagnostic Center	Sullivan	TN	X	X
All Other	Takoma Regional Hospital	Greene	TN	X	X
All Other	Watauga Medical Center	Watauga	NC	X	X
All Other	Watauga Orthopaedics, PLC	Washington	TN		X
All Other	Whitesburg ARH Hospital	Letcher	KY	X	X
All Other	Wythe County Community Hospital	Wythe	VA	X	X
All Other	Total	25	53.2%	21	23

D. Ambulatory Surgical Centers²



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 Surgery Center, LLC
06	Lonesome Pine Hospital
07	Sapling Grove ASC
08	Takoma Regional Hospital (<i>Independent</i>)*
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
22	State of Franklin 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.

** Managed Joint Venture

*** Non-Managed Joint Venture

² ASCs include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities; these facilities are included in map and table.

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	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 ³	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		

³ Kingsport Ambulatory Surgery Center is a Managed Joint Venture.

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		
All Other	Tri Cities Gastroenterology	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 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

E. Physician Status by Specialty/Employment

Data were developed by specialty to identify physicians employed by Wellmont, employed by Mountain States (or affiliated with Mountain States) and independent physicians. Data on independent physicians were developed using names and specialties for physicians with admitting privileges at Wellmont and/or Mountain States hospitals. The Overlap Flag identifies specialties in which both systems employed physicians.

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate*
Grand Total (Overlap/Non-Overlap)		2,142	70%	9%	17%	4%
Emergency Medicine	X	141	95%	1%	1%	3%
Neurology	X	75	91%	3%	4%	3%
Otolaryngology	X	21	90%	5%	5%	0%
Pediatrics	X	87	87%	3%	9%	0%
General Surgery	X	57	70%	7%	19%	4%
Internal Medicine	X	178	67%	19%	13%	1%
Ob/GYN	X	81	67%	10%	23%	0%
Neurosurgery	X	20	65%	5%	25%	5%
Family Medicine	X	183	63%	16%	20%	1%
Orthopedic Surgery	X	68	63%	3%	32%	1%
Psychology	X	5	60%	20%	20%	0%
Psychiatry	X	30	57%	10%	33%	0%
Pain Management	X	6	50%	17%	17%	17%
Cardiothoracic Surgery	X	21	43%	38%	19%	0%
Pulmonology	X	37	38%	38%	19%	5%
Occupational Medicine	X	5	20%	40%	40%	0%
Hematology/Oncology	X	34	15%	44%	35%	6%
Cardiology	X	70	14%	49%	36%	1%
Hospital Medicine	X	123	14%	10%	58%	15%

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate*
Grand Total (Overlap/Non-Overlap)		2,142	70%	9%	17%	4%
Allergy and Immunology	-	5	100%	0%	0%	0%
Child Development	-	1	100%	0%	0%	0%
Colorectal Surgery	-	2	100%	0%	0%	0%
Dentistry	-	8	100%	0%	0%	0%
Hand Surgery	-	2	100%	0%	0%	0%
Maternal and Fetal Medicine	-	2	100%	0%	0%	0%
Neonatology	-	8	100%	0%	0%	0%
Ophthalmology	-	35	100%	0%	0%	0%
Optometry	-	1	100%	0%	0%	0%
Oral Surgery	-	11	100%	0%	0%	0%
Pathology	-	24	100%	0%	0%	0%
Pediatric Dentistry	-	7	100%	0%	0%	0%
Pediatric Emergency Medicine	-	3	100%	0%	0%	0%
Pediatric Gastroenterology	-	2	100%	0%	0%	0%
Pediatric Hematology Oncology	-	2	100%	0%	0%	0%
Pediatric Nephrology	-	1	100%	0%	0%	0%
Pediatric Pulmonology	-	1	100%	0%	0%	0%
Pediatric Surgery	-	1	100%	0%	0%	0%
Perfusionist	-	1	100%	0%	0%	0%
Physician Assistant	-	55	100%	0%	0%	0%
Plastic Surgery	-	13	100%	0%	0%	0%
Podiatry	-	20	100%	0%	0%	0%
Radiology	-	186	100%	0%	0%	0%
Rheumatology	-	6	100%	0%	0%	0%
Sports Medicine	-	3	100%	0%	0%	0%
Telemedicine	-	2	100%	0%	0%	0%
Teleradiology	-	10	100%	0%	0%	0%

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate*
Grand Total (Overlap/Non-Overlap)		2,142	70%	9%	17%	4%
Nurse Practitioner	-	89	98%	0%	2%	0%
CRNA	-	75	97%	0%	0%	3%
Anesthesiology	-	65	97%	0%	0%	3%
Nephrology	-	16	94%	0%	6%	0%
Gastroenterology	-	30	90%	0%	10%	0%
Unknown	-	9	89%	0%	11%	0%
Urology	-	23	87%	0%	13%	0%
Physical Medicine and Rehabilitation	-	11	82%	18%	0%	0%
Infectious Disease	-	10	80%	20%	0%	0%
Dermatology	-	6	67%	0%	33%	0%
Pediatric Critical Care	-	3	67%	0%	0%	33%
Palliative Care	-	2	50%	50%	0%	0%
Pediatric Cardiology	-	4	50%	50%	0%	0%
Pediatric Neurology	-	2	50%	0%	0%	50%
Surgical Oncology	-	2	50%	50%	0%	0%
Radiation Oncology	-	11	36%	64%	0%	0%
Oncology	-	7	29%	43%	0%	29%
Trauma Surgery	-	29	21%	0%	38%	41%
Critical Care	-	15	7%	0%	80%	13%
Behavioral Health	-	8	0%	0%	50%	50%
Endocrinology	-	4	0%	0%	50%	25%
Pediatric Endocrinology	-	1	0%	0%	0%	100%
Pediatric Hospital Medicine	-	6	0%	0%	0%	100%
Sleep Medicine	-	2	0%	0%	50%	50%
Urgent Care	-	58	0%	0%	86%	14%

*Mountain States Affiliate physicians are those physicians who are not employed by Mountain States but who do provide services to Mountain States through a contractual arrangement. To be conservative, these physicians are counted along with the Mountain States employed physicians in assessing the "overlap" between Mountain States and Wellmont.

Exhibit 8.1A
Health Rankings of Tennessee Counties within the Geographic Service Area

	Tennessee	Carter	Cocke	Greene	Hamblen	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington
Population	6,495,978	57,338	35,479	68,267	63,074	6,679	56,800	17,977	156,595	18,082	125,546
Health Outcomes		48	88	59	54	93	64	44	36	68	19
Length of Life		25	87	57	39	91	60	29	27	63	21
# Premature Deaths	90,439	917	741	1,278	985	163	999	293	2,566	360	1,805
Years of Potential Life Lost Rate (rate per 100,000)	8,696	8,846	12,132	10,276	9,510	13,805	10,433	9,058	8,978	10,604	8,403
Infant Mortality Rate	8.3	10.9	7.2	5.8	6.0		6.5		8.9		9.1
Child Mortality Rate	63.8	89.2	46.0	51.6	57.7		68.0		59.3	81.8	62.5
Quality of Life		81	86	63	76	84	67	68	55	65	28
% Poor or fair health	19	23	27	21	26	29	26	26	22	26	19
Poor physical health days	4.3	5.2	6.4	5.5	6.3	8.2	5.6	5.0	5.4	5.0	4.5
Poor mental health days	3.4	4.8	4.7	4.1	4.7		4.0	3.0	4.5	4.6	3.8
% Low birthweight	9.2	9.8	9.8	9.3	8.6	9.0	8.9	9.9	8.6	8.8	8.4
Health Factors		32	82	41	36	95	28	50	12	19	5
Health Behaviors		41	43	38	31	93	51	30	47	13	9
% Adult smoking	23	31	21	29	23	40	26	28	26	23	24
% Adult obesity	32	29	31	32	30	30	35	31	33	30	31

Exhibit 8.1A
Health Rankings of Tennessee Counties within the Geographic Service Area

	Tennessee	Carter	Cocke	Greene	Hamblen	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington
Food environment index	6.9	6.2	6.2	7.1	6.7	6.8	7.3	7.0	6.7	7.5	7.3
% Physical inactivity	30	32	36	36	33	39	35	34	35	37	30
% Access to exercise opportunities	70	82	74	44	65	4	36	100	77	100	72
% Excessive drinking	9	7		3			5		9		7
% Alcohol-impaired driving deaths	28	27	36	21	34	56	21	9	23	22	31
Sexually transmitted infections (rate per 100,000)	504	169	247	209	293	238	302	88	259	143	201
Teen births (rate per 1000)	47	49	69	48	66	50	51	60	49	45	33
Clinical Care		66	71	38	37	93	31	55	5	77	4
% Uninsured	16	17	18	17	19	17	16	18	15	17	17
PCP Ratio	1388:1	2868:1	1694:1	1496:1	1494:1	6720:1	3537:1	2262:1	754:1	1824:1	596:1
Dentists Ratio	1996:1	3373:1	5068:1	2528:1	1660:1	3340:1	5680:1	3595:1	1424:1	3616:1	1846:1
Mental Health Provider Ratio	786:1	3584:1	3942:1	1004:1	606:1		7100:1	2568:1	865:1	4521:1	345:1
Preventable hospital stays	73	94	114	82	87	181	82	74	86	117	82
% Diabetics	12	15	14	14	14	14	13	15	15	13	11

Exhibit 8.1A
Health Rankings of Tennessee Counties within the Geographic Service Area

	Tennessee	Carter	Cocke	Greene	Hamblen	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington
% Diabetic monitoring	86	84	86	83	87	86	88	82	90	82	89
% Mammogram screening	61.8	58.6	59.7	61.9	63.6	37.3	62.4	63.0	66.5	56.1	63.6
Social & Economic Factors		27	89	55	50	95	22	68	17	16	10
% High school graduation	87	93	94	95	87	78	95	93	92	98	93
% Some college	57.7	49.0	37.1	42.1	46.3	36.8	46.8	35.0	55.2	42.1	66.0
% Unemployment	8.2	8.6	10.8	10.6	8.9	12.3	8.0	9.9	7.5	8.9	7.3
% Children in poverty	27	34	41	30	29	45	31	38	28	29	24
Income Ratio	4.8	4.7	5.1	4.3	4.8	5.0	4.2	4.9	4.9	4.7	5.1
% Children in Single Parent homes	36	29	41	33	31	36	31	24	35	24	31
% Limited Access to Healthy Foods	8	15	10	4	11	1	8	5	14	3	6
Social associations	11.5	14.8	11.2	11.2	14.5	3.0	9.4	16.6	14.7	17.5	13.9
Violent crime (rate per 100,000)	621	206	670	385	526	429	256	476	530	167	415
Injury deaths	78	73	104	99	85	118	96	78	73	83	71
Physical Environment		3	42	9	8	63	19	4	7	1	23

Exhibit 8.1A
Health Rankings of Tennessee Counties within the Geographic Service Area

	Tennessee	Carter	Cocke	Greene	Hamblen	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington
Air pollution - particulate matter	13.8	13.0	13.2	13.1	13.2	13.1	13.1	13.0	13.0	13.1	13.1
% Drinking water violations	4	0	0	7	0	0	3	8	4	0	0
% Severe housing problems	15	13	17	11	13	17	10	13	11	10	15
% Driving alone to work	84	83	84	85	85	87	89	80	87	83	87
% Long commute - driving alone	32	28	39	27	21	43	34	36	24	28	22

Source: University of Wisconsin Population Health Institute. County Health Rankings 2015. *Available at:* www.countyhealthrankings.org

Exhibit 8.1B
Health Rankings of Virginia Counties and Independent Cities within the Geographic Service Area

	Virginia Mean	Bristol City	Buchanan	Dickenson	Grayson	Lee	Norton City	Russell	Scott	Smyth	Tazewell	Washington	Wise	Wythe
Population	8,260,405	17,341	23,597	15,486	15,161	25,185	4,017	28,264	22,640	31,652	44,103	54,907	40,589	29,344
Health Outcomes		111	132	130	74	116	89	122	114	123	133	82	129	85
Length of Life		122	131	127	69	105	97	119	118	106	132	80	124	65
# Premature Deaths	81,691	324	518	331	278	442	61	565	423	616	991	866	765	462
Years of Potential Life Lost Rate (rate per 100,000)	6,192	11,142	12,854	11,985	7,775	9,684	9,229	10,663	10,355	9,688	13,009	8,223	11,198	7,703
Infant Mortality Rate	7.2										6.3	8.8	7.3	
Child Mortality Rate	55.1	109.8	84.7			53.6		64.3	90.4	53.0	83.2	72.5	67.1	49.6
Quality of Life		79	131	130	81	121	72	122	105	132	133	84	127	101
% Poor or fair health	14		29	31	20	29		29	23	29	29	19	24	27
Poor physical health days	3.2		7.6	7.7	3.0	6.0		7.1	4.7	6.9	5.9	3.9	6.0	5.1
Poor mental health days	3.1		5.0	6.4	5.2	5.0		5.0	4.1	5.6	6.3	3.8	6.6	3.6
% Low birthweight	8.3	9.1	10.1	8.5	7.8	8.4	8.6	7.7	9.1	10.1	10.7	8.7	9.1	8.2
Health Factors		107	132	130	109	126	72	125	105	90	96	77	127	82
Health Behaviors		58	103	126	82	70	50	116	121	67	59	81	128	66

Exhibit 8.1B
Health Rankings of Virginia Counties and Independent Cities within the Geographic Service Area

	Virginia Mean	Bristol City	Buchanan	Dickenson	Grayson	Lee	Norton City	Russell	Scott	Smyth	Tazewell	Washington	Wise	Wythe
% Adult smoking	18		30	32	22	25		25	28	22	21	24	33	24
% Adult obesity	28	30	29	29	32	29	29	35	34	31	30	32	32	30
Food environment index	8.3	6.2	7.9	8.3	7.7	8.1	7.2	8.0	7.9	7.8	7.8	8.5	7.5	8.5
% Physical inactivity	22	24	28	32	30	27	24	36	35	23	31	30	38	27
% Access to exercise opportunities	81	97	27	47	45	53	99	43	48	77	52	69	75	71
% Excessive drinking	16					11					10		10	
% Alcohol-impaired driving deaths	31	25	28	70	33	23	0	23	15	28	23	31	28	7
Sexually transmitted infections (rate per 100,000)	427	311	63	300	125	110	344	151	123	183	156	141	340	215
Teen births (rate per 1000)	29	33	48	53	43	57	56	46	49	59	49	45	58	46
Clinical Care		127	133	130	121	131	28	132	111	86	129	93	128	89
% Uninsured	14	16	16	17	20	17	13	17	16	16	17	16	16	17
PCP Ratio	1344:1	2208:1	2982:1	3923:1	3037:1	2830:1	291:1	2032:1	2278:1	1586:1	1165:1	1577:1	2154:1	1625:1

Exhibit 8.1B
Health Rankings of Virginia Counties and Independent Cities within the Geographic Service Area

	Virginia Mean	Bristol City	Buchanan	Dickenson	Grayson	Lee	Norton City	Russell	Scott	Smyth	Tazewell	Washington	Wise	Wythe
Dentists Ratio	1611:1	2890:1	5899:1	15486:1	5054:1	3148:1	1004:1	9421:1	4528:1	1862:1	2940:1	1893:1	4059:1	2668:1
Mental Health Provider Ratio	724:1	1239:1	3933:1	3097:1	15161:1	1199:1	335:1	1229:1	1029:1	989:1	788:1	872:1	1194:1	489:1
Preventable hospital stays	55	110	182	130	75	135	126	160	106	77	130	90	126	70
% Diabetics	10	12	12	11	12	10	10	12	12	11	13	12	13	11
% Diabetic monitoring	87	84	83	85	88	83	91	87	91	88	84	87	86	87
% Mammogram screening	63.4	57.2	51.1	57.9	61.1	54.0	65.5	53.5	60.6	62.0	59.1	63.9	58.8	61.4
Social & Economic Factors		110	130	124	115	122	93	106	87	100	96	60	107	81
% High school graduation	83	73	76	83	83	83	93	81	88	84	74	86	83	82
% Some college	68.2	54.8	41.8	47.5	48.3	51.0	66.1	47.8	52.6	50.0	50.1	59.2	47.9	48.2
% Unemployment	5.5	7.8	9.8	10.0	9.7	9.1	8.7	8.7	7.4	8.4	7.0	6.9	8.8	7.0
% Children in poverty	16	36	33	28	29	39	37	26	27	26	23	21	28	22
Income Ratio	4.8	4.2	5.0	4.6	4.1	4.7	5.3	5.1	4.7	4.4	4.9	4.1	5.3	4.3
% Children in Single Parent homes	30	43	41	33	36	33	45	28	25	36	26	29	31	32

Exhibit 8.1B
Health Rankings of Virginia Counties and Independent Cities within the Geographic Service Area

	Virginia Mean	Bristol City	Buchanan	Dickenson	Grayson	Lee	Norton City	Russell	Scott	Smyth	Tazewell	Washington	Wise	Wythe
% Limited Access to Healthy Foods	4	15	3	0	6	0	7	3	5	4	7	4	5	2
Social associations	11.3	24.9	8.8	4.5	8.6	5.9	17.2	8.8	6.6	11.0	13.1	12.3	10.3	10.6
Violent crime (rate per 100,000)	200	331	145	106	122	131	91	130	109	193	134	104	158	109
Injury deaths	52	80	139	146	84	97	60	94	102	74	106	73	91	86
Physical Environment		124	116	92	55	133	102	109	128	93	78	81	113	75
Air pollution - particulate matter	12.7	13.0	13.0	13.0	13.0	13.1	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0
% Drinking water violations	2		0	0	0	29		0	24	3	0	0	11	4
% Severe housing problems	15	19	12	11	9	16	11	12	11	11	11	11	13	10
% Driving alone to work	77	82	88	84	82	85	89	86	84	87	84	85	84	85
% Long commute - driving alone	38	18	47	46	40	39	18	45	47	26	30	29	29	24

Source: University of Wisconsin Population Health Institute. County Health Rankings 2015. Available at: www.countyhealthrankings.org

Exhibit 8.2

Attachment A

Community Health Work Group Charters

Mental Health and Addiction Work Group

Charter

Purpose and Scope:

The Mental Health and Addiction Work Group will evaluate the inventory of mental health and addiction services for adults and children in the area. An important objective is to provide data and analysis that will assist the new proposed regional health system (“Newco”) in developing an optimal structure to combat addiction and substance abuse, reduce the number of newborns born into addiction, and to reduce dependency on drugs and alcohol through improved access and support. The findings of the work group will be a source of input into the development of Newco’s ten (10) year comprehensive community health improvement plan.

Deliverables:

The work group will produce a document for consideration by Newco that shall consider, but is not limited to, the following:

- Produce an inventory of regional outpatient, community and inpatient services available for adults and children;
- Receive input from physicians, mental health experts, addiction recovery experts and patients with respect to their experiences in the system, and suggestions for improved coordination and gaps in availability of services;
- Assess the national recommendations for best practices in community-based and residential mental health and addiction disorders, and discover opportunities for evolving the regional mental health delivery system toward the national best practices;
- Assess existing gaps in appropriate access points (especially in disadvantaged populations), quality, funding, and use of best practices;
- Identify opportunities to expand education and training for practitioners in mental health and addiction through existing partnerships with East Tennessee State University and potential new partnerships with other organizations;
- Review research-based protective factors and recommend solutions to minimize the initiation of drugs and alcohol in young people and promote mental health and well-being;
- Explore opportunities to better integrate primary care, mental health and addiction services, and to better coordinate care of individuals living with mental disorders and/or addiction across frequently used systems such as judicial, housing, medical and other welfare and family support services; and

- Identify opportunities for enhanced partnerships between Newco and East Tennessee State University, as well as potential new partnerships with other academic institutions, community-based providers and other organizations.

The work group's report will focus on achieving sustainable and measurable improvements in population health in the context of an accountable care community.

Schedule:

The work group will meet periodically at the call of the chair and as scheduled. The schedule shall include meetings which may be open to the public and announced in order to ensure public input in the process. The work group may invite presentations from organizations and individuals with expertise, and may also permit public comment. The work group may identify sub-committees which may meet more frequently to produce material for public review.

Reporting:

The Mental Health Work Group will provide its findings to the Integration Council.

Healthy Children and Families Work Group

Charter

Purpose and Scope:

The Healthy Children and Families Work Group will explore the opportunities and necessary actions for structuring a comprehensive regional approach to child well-being in Northeast Tennessee and Southwest Virginia. The work group will produce a report that identifies the most prominent physical, behavioral and social health problems affecting children in the region and explores their causes, taking into account the social and family supports necessary to equip children to make the strongest possible start in their journey to adulthood. The findings of the work group will be a source of input into the development of the proposed Newco's ten (10) year comprehensive community health improvement plan.

Deliverables:

The work group will produce a document for consideration by Newco that shall consider, but is not limited to, the following:

- Identify the top physical, behavioral and social health and well-being problems experienced by children in the region and explore their root causes;
- Identify gaps in education achievement among children in the region, assessing the impact of these gaps on their ability to thrive as healthy adults. Identify opportunities for how Newco can contribute to improving education achievement, particularly in the area of literacy and basic skills;
- Produce an inventory and gap analysis of past and current efforts that address regional:
 - Pediatric physical and behavioral health services and accessibility;
 - Health and social support services available for children with special needs, such as developmental disabilities and physical limitations; and
 - Social service and family and parenting supports available in the region (such as nurse family partnership, Healthy Start, etc.);
- Identify evidence-based best and promising practices in use regionally or elsewhere that may be replicated to improve children's health and well-being;
- Assess the relative ability of the region's public and private sector to improve health outcomes by addressing root causes through evidence-based best and promising practices;
- Identify opportunities to enhance children's health research, training, education, and service provision through existing partnerships with East Tennessee State University and potential new partnerships; and

- Prioritize improvement goals according to their relative importance to children's health and well-being, the commonality of impact across the region, the disparate impact on disadvantaged populations, and the ability of the community to reasonably make an impact on the goals in a sustainable timeframe.

The work group's report will focus on achieving sustainable and measurable improvements in population health in the context of an accountable care community, with prioritization on those areas most likely to be high impact in the region.

Schedule:

The work group will meet periodically at the call of the chair and as scheduled. The schedule shall include meetings which may be open to the public and announced in order to ensure public input in the process. The work group may invite presentations from organizations and individuals with expertise, and may also permit public comment. The work group may identify sub-committees which may meet more frequently to produce material for public review.

Reporting:

The Healthy Children and Families Task Force will provide its findings to the Integration Council.

Population Health and Healthy Communities Work Group

Charter

Purpose & Scope:

The Population Health and Healthy Communities Work Group will explore the opportunity and necessary actions to improve the overall health and well-being of Northeast Tennessee and Southwest Virginia (the “Region”) by aligning and mobilizing public and private sector resources – schools, businesses, civic and faith groups, health care providers, government – around a core set of community health improvement goals in the areas of both health care delivery and social determinants of health. Examples of health care delivery goals may include, but not be limited to: increased vaccinations and screenings, improved integration of primary care, dental and mental health services, improved access to services for persons with addictive disorders, and reductions in hospital acquired conditions. Examples of social determinant goals may include, but not be limited to: reduction in teen smoking or pregnancy, improvement of literacy and high school completion, enhanced coordination of services for low-income elderly, or improvements in the variables leading to type 2 diabetes in children.

The findings of the work group will be a source of input into the development of a ten (10) year comprehensive community health improvement plan to be adopted by the new proposed regional health system (“Newco”).

Deliverables:

The work group will produce a document for consideration by Newco that shall consider, but is not limited to, the following:

- Identify top health problems in the region and their root causes – both clinical and social – and the health and economic impact of these problems on various public- and private-sector organizations and on disadvantaged populations;
- Identify priorities for coordination of health services for the elderly, including opportunities to coordinate state and federal programs;
- Inventory past and current efforts in the region to address these problems and their root causes;
- Assess the relative ability of the public and private sector to improve health outcomes by addressing root causes – either individually or collectively – through implementation of evidence-based best practices;
- Prioritize improvement goals according to their relative importance to the community's health, the commonality of impact across sectors or the disparate impact on disadvantaged populations, and the ability of the community to reasonably make an impact on the goals in a sustainable timeframe;

- Identify community governance structures used elsewhere in the U.S. that have successfully implemented a health improvement strategy, and contemplate how those examples might inform a culturally appropriate structure for our region;
- Identify opportunities for the East Tennessee State University Academic Health Sciences Center and other academic, business, government and community partners to collaborate with Newco in the creation of an accountable care community.

Schedule:

The Population Health and Healthy Communities Work Group will meet periodically at the call of the chair and as scheduled. The schedule shall include meetings which may be open to the public and announced in order to ensure public input in the process. The work group may invite presentations from organizations and individuals with expertise, and may also permit public comment. The work group may identify sub-committees which may meet more frequently to produce material for public review.

Reporting:

The Population Health and Healthy Communities Work Group will provide its findings to the Integration Council.

Research and Academics Work Group

Charter

Purpose and Scope:

The Research and Academics Work Group will explore the opportunity to improve health and economic growth in Northeast Tennessee and Southwest Virginia (the “Region”) by enhancing professional recruitment and research-based funding under a new research and academics partnering strategy between the new proposed regional health system (“Newco”) and regional academic institutions, in particular East Tennessee State University. The findings of the work group will be a source of input into the development of Newco’s ten (10) year comprehensive community health improvement plan.

Deliverables:

The work group will produce a document for consideration by Newco that shall consider, but is not limited to, the following:

- Identify the fields in which academic institutions, in particular ETSU, can make superior contributions in research and medical education by collaborating with Newco and other community partners;
- Evaluate any institutional changes needed for ETSU and other academic institutions to support the collaborative opportunity with Newco to bolster academics and research;
- Identify institutional changes needed or structures required at Newco to support new and expanded research and undergraduate and graduate medical education opportunities with ETSU and other academic institutions;
- Identify potential long-term strategic research initiatives for Newco, ETSU, other academic institutions, and community collaboratives and estimate ways in which these research initiatives would enhance faculty recruitment and economic growth of the region; and
- Identify opportunities for Newco and its research partners to interface with an effort to create an accountable care community – in particular, what infrastructure is needed in order to use the benefit of research to assist with the priorities identified in the accountable care community model.

Schedule:

The work group will meet periodically at the call of the chair and as scheduled. The schedule shall include meetings which may be open to the public and announced in order to ensure public input in the process. The work group may invite presentations from organizations and individuals with expertise, and may also permit public comment. The work group may identify sub-committees which may meet more frequently to produce material for public review.

Reporting:

The Research and Academics Work Group will provide its findings to the Integration Council.

Exhibit 8.2

Attachment B

Community Health Work Group Membership Lists

Healthy Children & Families

Last Name	First Name	Employer	Title
Staton	Travis	United Way of Southwest Virginia	CEO
Wood	Dr. David	ETSU / Niswonger Children's Hospital	Chair, Department of Pediatrics / CMO
Angelopoulos	Dr. Theodore (Ted)	Emory & Henry School of Health Sciences	Professor
Bailey	Dr. Beth	ETSU, Dept. of Family Medicine	Professor and Director of Research
Baker	Dr. Katie	ETSU, Dept. of Community & Behavioral Health	Assistant Professor
Beilharz	Lisa	Boys and Girls Club of Kingsport	Chief Professional Officer
Carter	Lisa	Niswonger Children's Hospital	CNO, Interim CEO
Casteel	Tommy	Virginia Department of Social Services	Regional Director
Castro	Dr. Sandra	Niswonger Children's Hospital	Pediatric Emergency Physician
Collins	Dr. Melinda	Milligan, School of Sciences & Allied Health	Associate Dean
Counts	Dr. Melody	Virginia Department of Health, Cumberland Plateau District	District Director
Cox	Beth	Johnson City Schools	School Health Coordinator
DeVoe	Dr. Michael	ETSU Pediatrics	Director, Neonatology Professor and Vice Chair
Everhart	Aubrey	Appalachian Mountain Project Access	Executive Director
Feierabend	Margaret	Bristol Promise; Bristol City Council Member	Chairman (Bristol Promise)
Ferguson	Hugh	The First Bank & Trust Company	SVP/Energy Banker
Gendron	Dr. Richard	Holston Medical Group	Vice President, Pediatrician
Gouge	Dr. Natasha	MSMG Pediatrics	PhD Licensed Clinical Psychologist
Hale	Dr. Kim	ETSU, College of Education	Associate Dean/ Early Childhood Education
Holloway	Paula	Watauga Behavioral Health	Children & Youth Svcs Coord
Jaishankar	Dr. Gayatri	ETSU Pediatrics	Pediatrician
Kozinetz	Dr. Claudia	ETSU, Public Health	Professor and Chair, Department of Biostatistics and Epidemiology
Mabrey	Gary	Washington County/ Johnson City/ Jonesborough Chamber of Commerce	President & CEO
Midgett	Linda	People Incorporated of Virginia	Director, Community Services
Mobley	Julie	Integrated Solutions Health Network	Population Health Care Manager

**Healthy Children & Families
Steering Committee List**

Montgomery	Paul	Northeast State	VP, Access & Development
Myers	Dr. Pam	Highlands Pediatrics	Pediatrician
Perkins	James	Wellmont/Healthways	System Director Wellmont Diabetes Treatment Centers
Perry	Tim	Frontier Health	Director, Children's Outpatient Services
Pillion	Dr. Todd	Bristol Pediatric Dentistry	Pediatric Dentist
Polaha	Dr. Jodi	ETSU	Associate Professor Family Medicine
Powers	Catherine	ETSU	Professor of Nursing
Ratliff	Dr. Brian C.	Washington County Virginia Schools	Superintendent of Schools
Rhinehart	Beth	Bristol Chamber of Commerce	President /CEO
Robinson	Haydee	Dickenson County Schools	Superintendent
Robinson	Dr. Mike	Smyth County Virginia Schools	Superintendent of Schools
Skinner	Glen "Skip"	LENOWISCO Planning District Commission	Executive Director
Smith	Dr. Michael	ETSU, Dept. of Social Work	Department Chair
Stephens	Stephanie	Appalachian Association for the Education of Young Children	President
Stroud	Ellen		
Teague	Donna	Johnson County Community Hospital	LPN
Terry	Kathlyn	Appalachian Sustainable Development	Executive Director
Tipton	Lisa	Families Free	Executive Director
Thomas	Cynthia	TN Department of Health	Assistant Medical Director
Tweed Hill	Judy	Alpha Natural Resources	VP of Benefits
Wells	Conni	Mountain States Health Alliance	Patient/Family Driven Care Mgr
Werth	James	Stone Mountain Health Services, FQHC	Behavioral Health and Wellness Services Director
Wiley	Mary	Wellmont Hancock County Hospital	RN

Mental Health & Addiction
Steering Committee List

MENTAL HEALTH & ADDICTION

Last Name	First Name	Employer	Title
Greene	Eric	Frontier Health	Senior VP
Kidd	Dr. Teresa	Frontier Health	President and CEO
Abner	Dr. John Paul	Milligan College	Professor of OT & Psychology
Adler	Mike	Counseling and Consultation Services	Clinical Executive Director
Bailey	Marlene	Woodridge Hospital	Director, Behavioral Health Programs
Bangle	Rev. Jim	Retired Lutheran pastor, LCSW, Law Enforcement Chaplain	
Benedetto	Kathy	Frontier Health	SVP, Children & Youth Services
Bowen	Diane	Frontier Health	Director of Compliance and Performance Improvement
Chase	Anna	Mount Rogers CSB	Director of Youth and Family Services
Collins	Margie	City of Bristol, VA Circuit Court	Drug Court Coordinator
Fox	Jeff	Highlands Community Services	Executive Director
Gonder	Karen	Mountain States Health Alliance	Human Resources, retirement plans
Goodkin	Dr. Karl	ETSU, Dept. of Psychiatry	Chair
Griffith	Dr. Jay	ETSU, Dept. of Psychiatry & Behavioral Health	Training Program Director
Hagy	John	Russell County Medical Center	Director of Clearview Psychiatric Center
Holmes	Rebecca	Highlands Community Services	Clinical Director
Jessee	Dr. Randy	Frontier Health	Senior VP, Specialty Services
Jones	Kristie	Cumberland Mountain CSB	Director of MH Services
Keen	Doug	Wellmont Health System	Program Manager Department of Psychiatry
Ketron	Chris	NE State Community College	Adjunct Faculty
Larsen	Mark	Mount Rogers CSB	Director of Adult Behavioral Health Services
Lindenbusch	Sue	Wellmont Health System	SVP, oncology & behavioral health
Loyd	Dr. Stephen	VA Mountain Home	Associate Chief of Staff
McClaskey	Cynthia	SW VA Mental Health Institute	Director
Melton	Dr. Sarah	Gatton College of Pharmacy at ETSU	Associate Professor of Pharmacy Practice
Melton	Dr. Hughes	Mountain States Health Alliance	Director of GME Program

**Mental Health & Addiction
Steering Committee List**

Mills	Dr. Lori	Milligan College	Professor of Psychology
Moore	Elliott	Mountain States Health Alliance	VP, Government Relations
Moser	Dr. Michele	ETSU	Psychologist
Mullins-Potter	Karrie	Frontier Health	Peer Specialist, VA Operations
O'Dell	Sandy	Planning District One	Executive Director
Pack	Dr. Rob	ETSU	Assoc. Dean Academic Affairs
Page	Joe	Frontier Health	Senior VP, TN Adult Services
Plummer	Dr. Robert (Bob)	ETSU	AVP, University Advancement
Rainey	Alice	Retired	Member, SAGE: research group for examining needs and service gaps for seniors
Rice	Dr. Judy	ETSU College of Nursing	Interim Director, Graduate Programs
Richards	Scott	Emory & Henry College, School of Health Sciences; Mel Leamon Free Clinic of SWVA	Department Chair Family Practice / Psychiatric PA
Robshaw	Shannon	Technical Assistance Network for Children's Behavioral Health, University of Maryland	Consultant
Ross	Hon. Todd	Hawkins County, TN	Judge
Taylor	Ken	Frontier Health	Division Director, VA Child & Family Services
Testerman	Brenda	Frontier Health	VA Operations, MH Recovery Coach
Werth	James	Stone Mountain Health Services	Behavioral Health & Wellness Services Director
White	Lindy	Franklin Woods Community Hospital / Woodridge Hospital	CEO
Williams	Dr. Douglas	Mountain Empire Neurology Associates	Neurologist

Population Health & Healthy Communities
Steering Committee List

Population Health & Healthy Communities

Last Name	First Name	Employer	Title
Hamilton	Lori	K-VA-T Food City	Health Educator
Wykoff	Dr. Randy	ETSU College of Public Health	Dean
Belcher	Phil	Eastman Chemical Company	Health and Welfare Manager
Bishop	Marilyn	Mountain States Medical Group	Medical Director Occupational Medicine
Blackwelder	Dr. Reid	American Academy of Family Physicians	
Blevins	Shannon	UVA Wise	Dir., Economic Development
Brillhart	Catherine	City of Bristol	Councilwoman
Brock	Jenny	City of Johnson City	Commissioner
Buck	Linda	Rural Health Consortium	Director
Cantrell	Sue	SWVA Health Authority	LENOWISCO Health Director and Vice Chairman
Cook	Heather	Healthy Kingsport	Director
Counts	Melody	Cumberland Plateau Health District	District Health Director
Domst	Ronald	Johnston Memorial Hospital	Retired, Volunteer
Eastridge	Dr. Wesley	Mountain Region Family Medicine	Physician
English	Rebekah	NE TN Regional Health Department	Regional Director
Everhart	Aubrey	Appalachian Mountain Project Access	Executive Director
Farmer	Barbara	Pleasant View UMC; Wesley Clinic	Associate Pastor; Volunteer
Franko	Dr. John	ETSU	Family Medicine
Gail	Dick	AEP	Retired plant manager
Glass	Charlie	Greater Kingsport Family YMCA	Executive Director/CEO
Hammonds	Kristie	Frontier Health	SVP, Operations
Harris	Matthew	Mountain States Rehabilitation – JMH	Physical Therapist, Athletic Trainer
Holden	Dr. Lynn	King University	Dean, School of Nursing
Johnson	Stan	Great Body Company	Owner
Kent	Martin	United Company	President
Mayes	Gary	Sullivan County Health Department	Regional Director
Michael	Dr. Gary	Clinch River Health Services, Inc	Family Practice Physician

**Population Health & Healthy Communities
Steering Committee List**

Morgan	Ed	City of Abingdon	Mayor
Moulton	Dr. David	State of Franklin Healthcare Assoc.	
Nehring	Dr. Wendy	ETSU	College of Nursing
Perkins	James	Wellmont Health System	HVMC/BRMC Diabetes Treatment Center
Purdue	Malcolm	Stone Mt Health Services (FQHC)	Executive Director
Seligman	Dr. Morris	MSHA	EVP, CMO
Sensibaugh	David	Integrated Solutions Health Network	VP, integrated health management
Snodgrass	Dr. Jeff	Milligan College	Chair, Department of Occupational Therapy
Wiley	Mary	Wellmont Hancock County Hospital	RN

Research & Academics

Last Name	First Name	Employer	Title
Bishop	Dr. Wilsie	East Tennessee State University	VP for Health Affairs and COO
Schrum	Jake	Emory & Henry	President
Angelopoulos	Dr. Theodore (Ted)	Emory & Henry School of Health Sciences	Professor
Calvert	Linda	Northeast State	Director, WIA Grant & Bridge
Campbell	John	AccelNow	Executive Director
Campbell	Dr. Steve	Northeast State	VP for Business Affairs
Carmack	Duffy	Southwest VA Higher Ed Center	CFO/ Interim Director
Clark	Dr. Andy	ETSU	Professor of Clinical Nutrition Associate Dean of Research and Clinical Practice
Collins	Dr. Cathie	UVA Wise	Chair, Dept. of Nursing
Dawson	Dr. B. James	Lincoln Memorial University	President
Davis	Dr. Mary Lee	Michigan State University	Sr. Advisor, Dept. of Family & Community Medicine - emeritus
Dishner	Dr. Nancy	Niswonger Foundation	President & CEO
Drinnon	Dr. Joy	Milligan College	Director of Undergraduate Research/Professor of Psychology
Duncan	Dr. Bill	ETSU	Vice Provost for Research, Office of Sponsored Programs
Ehret	Charlene	James H. Quillen Veterans Administration Medical Center	Director
Fincher	Dr. Lou	Emory & Henry	Dean, School of Health Sciences
Fowler	Dr. Scott	Holston Medical Group	President
Fowlkes	Rachel	Southwest VA Higher Ed Center	Retiring Director
Gilliam	Dr. Janice	Northeast State Community College	President
Grandy	Joe (William)	Ferguson	General Manager
Greer	Dr. Bill	Milligan College	President & CEO
Henderson	Rebecca	Strategic Priorities Consulting	Consultant

**Research & Academics
Steering Committee List**

Henry	Donna	UVA Wise	Chancellor
Kendall	Martha	Johnston Memorial Hospital	Speech / Language Pathologist
Khoury	Dr. Amal	ETSU – Public Health	Chair, Dept of Health Svcs Mgt & Policy
Linville	Dr. David	ETSU	Associate Dean for GME
Lugo	Dr. Ralph	Gatton College of Pharmacy ETSU	Professor and Chair of Pharmacy Practice
Lura	Dr. Richard (Dick)	Milligan College	Professor of Chemistry
Mayhew	Dr. Susan	Appalachian School of Pharmacy	Dean
Means	Dr. Robert (Bob)	ETSU, Quillen College of Medicine	Dean
Melton	Dr. Hughes	Mountain States Health Alliance	Director of GME Program
Mitchell	Dr. Kathy	Virginia Highlands Community College	Dean, Nursing & Allied Health
Moody	Dr. Nancy	Tusculum College	President
Moorman	Dr. Jon	ETSU	Vice Chair, Research & Scholarship/Residency Program Director
Nida	Dr. Maurice	Wellmont Health System	Director, Osteopathic Medical Education / LMU adjunct professor of medicine
Niday	Pat	Mountain States Health Alliance	Chief Learning Officer
Ong	Dr. Han Chuan	King University	Dean, College of Arts & Sciences
Phillips	Dr. Kenneth	ETSU	Interim Assoc. Dean, Research
Pope	Pat	QSource (Quality Improvement Network for State of TN)	Practice Solution Advisor
Prill	Dr. Sue	Wellmont Cancer Center	Medical Director, Breast Center
Ray	Dr. Richard	King University	Interim President
Rinehart	Dr. Andrew	Glytec	Chief Medical Officer
Runnels	Dr. Clay	Mountain States Health Alliance	CMO, Washington County TN
Seligman	Dr. Morris	Mountain States Health Alliance	EVP, CMO
Shiple	Lindsey	ETSU Quillen College of Medicine	Student (Joint MD/MPH program)
Stepanov	Dr. Nonna	Mountain States Health Alliance	Director of Research
Tillman	Dr. Ken	ETSU - College of Nursing	Associate Dean of Academic Programs
Tooke-Rawlins	Dr. Dixie	Via College of Osteopathic Medicine	
Walker	Clay	NETWORKS Sullivan Partnership	CEO

Exhibit 8.3

Schedule of Public Meetings Conducted by the Community Health Work Groups

Community Input Work Groups
Steering Committee Meetings and Roundtable Meetings

Mental Health & Addiction Steering Committee *(Meetings held from 9:30am-Noon)*

- Thursday, August 20th, Millennium Centre, Johnson City
- Thursday, September 17th, Southwest Virginia Higher Education Center, Abingdon
- Wednesday, October 21st, Millennium Centre, Johnson City
- Thursday, November 19th, Southwest Virginia Higher Education Center, Abingdon
- Friday, December 18th, Millennium Centre, Johnson City

Healthy Children & Families Steering Committee *(Meetings held from 9:30am-Noon)*

- Tuesday, September 8th, Southwest Virginia Higher Education Center, Abingdon
- Tuesday, October 13th, Millennium Centre, Johnson City
- Tuesday, November 10th, Southwest Virginia Higher Education Center, Abingdon
- Tuesday, December 8th, Millennium Centre, Johnson City
- Tuesday, January 5th, Southwest Virginia United Way office (subcommittee meeting)
- Tuesday, January 12th, Southwest Virginia Higher Education Center, Abingdon

Population Health & Healthy Communities Steering Committee *(Meetings held from 9:30am-Noon)*

- Monday, August 24th, Southwest Virginia Higher Education Center, Abingdon
- Monday, September 28th, Millennium Centre, Johnson City
- Monday, October 26th, Southwest Virginia Higher Education Center, Abingdon
- Monday, November 16th, Millennium Centre, Johnson City
- Monday, January 18th, Southwest Virginia Higher Education Center, Abingdon

Research & Academics Steering Committee *(Meetings held from 9:30am-Noon)*

- Thursday, September 24th, Millennium Centre, Johnson City
- Thursday, 8th, Southwest Virginia Higher Education Center, Abingdon
- Wednesday, December 2nd, Millennium Centre, Johnson City
- Wednesday, January 13th, Southwest Virginia Higher Education Center, Abingdon
- Wednesday, January 27th, ETSU, (subcommittee meeting)

All Work Groups Meetings

- Monday, November 16, Millennium Centre, Johnson City, Topic: Accountable Care Communities *(9:00-10:30am)*
- Friday, December 18, Millennium Centre, Johnson City, Topic: Impact of Opioids on Appalachia *(9:30-11:30am)*
- Tuesday, February 2, Millennium Centre, Johnson City, Topic: Early Brain Development and Toxic Stress *(9:00-10:30am)*

Roundtable Meetings (*Meetings for Community Members; meetings held from 5:30-7:30pm*)

- Thursday, August 13th, Tennessee College of Applied Technology, 425 TN-91, Elizabethton, Tenn.
- Thursday, August 20th, Southwest Virginia Higher Education Center, One Partnership Circle, Abingdon, Va.
- Tuesday, September 15th, Holston Hills Community Golf Course (Multi-Purpose Room), Marion, VA
- Thursday, September 24th, Tennessee National Guard Armory, 615 South Main Street, Erwin, TN (Unicoi)
- Tuesday, September 29th, Russell County Conference Center, Lebanon, VA
- Thursday, October 1st, Food City Press Room, Kingsport, TN
- Tuesday, October 6th, Crooked Road Tech Center, Duffield, VA
- Thursday, October 15th, Bristol Motor Speedway, Bristol, TN
- Tuesday, October 20th, The Inn at Wise (Ballroom), Wise, VA
- Wednesday, October 21, United Way 2020 Summit with Robert Wood Johnson Foundation, Southwest Virginia Higher Education Center
- Thursday, October 22nd, Memorial Park Community Center, 510 Bert Street, Johnson City, TN

Exhibit 8.4

Attachment A

Mountain States' Charity Care Policy

Policy Manual:	Adminstration/Operational
Manual Section:	Fiscal Services - Policies
Policy Number:	CBO-400-011
Effective Date:	October 4, 2013
Supersedes:	February 2013
Reviewed Date:	September 12, 2013

I. TITLE: CHARITY POLICY – FISCAL SERVICES

II. PURPOSE:

To outline the guidelines that ensure MSHA reviews all requests for charity in a fair and equitable manner.

III. PATIENT-CENTERED CARE PRINCIPLES:

All team members are considered as caregivers.

IV. SCOPE:

Mountain States Corporate Billing Office (CBO) team members

V. FACILITIES/ENTITIES:

MSHA Corporate

Tennessee: FWCH, IPMC, JCCH, JCMC, QRH, SSH, WPH, Niswonger Children’s Hospital, Kingsport Day Surgery, IPMC Transitional Care, Princeton Transitional Care

Virginia: DCH, JMH, NCH, RCMC, SCCH, Clearview Psychiatric Unit, Francis Marion Manor Health & Rehabilitation

VI. DEFINITIONS:

Not Applicable

VII. POLICY:

A. Mountain States Health Alliance has established a strong mission to meet the medical needs of the communities it serves. It is the mission of Mountain States Health Alliance to:

1. Treat all patients equally- with dignity and respect
2. Evaluate all requests for financial assistance using established general guidelines while allowing for unique financial circumstances
3. Respond promptly to patient inquiries regarding their bills and requests for financial assistance
4. Ensure outside collection agencies follow hospital billing and collection guidelines
5. Follow a consistent collection protocol that ensures MSHA communicates with the patient regarding their financial liability prior to services being rendered

- B. Mountain States Health Alliance recognizes its obligation to provide quality health care to those who are unable to pay. Given the alliance's limited financial resources, this policy is designed to balance the hospital's obligation with its financial resources and to ensure that those receiving free or partially compensated care meet defined financial qualifications. All charity cases must be accompanied by a completed financial assistance form and supporting documentation.
1. Charity eligibility will be determined by review of the Financial Assessment Form, documents presented in support of the information on the Financial Assessment Form, and verification of assets.
 2. Charity eligibility determination will be made post-service and on an episodic basis with the exceptions outlined below:
 - a. Lactation consultations
 - i. If approved, the charity determination will be in effect for the duration of the breastfeeding of that child, which could encompass multiple encounters.
 - b. Oncology services
 - i. If approved, the charity determination will be in effect for six (6) months or duration of treatment regimens, whichever occurs first.
 - c. Appropriately referred Appalachian Mountain Project Access patient visits are extended 100% charity per contractual arrangement.
 - d. As of July 1, 2011, patient days covered by Tennessee Department of Mental Health grant are extended 100% charity per grant provisions.
 - e. High dollar implant cases may be pre-screened for charity prior to procedure.
 3. Charity eligibility encompasses the following patients: Patients with Medicaid eligibility after the date of service, patients that are deceased with no estate, patients with Virginia SLH funds exhausted and Medicaid eligible encounters where benefits limits have been exhausted.
 4. Mountain States Health Alliance charity guidelines are based on the National Poverty Guidelines for the applicable year.
 5. Charity awards are not based solely on income.
 - a. Unique financial circumstances are weighed and assets will be verified and these factors can change the category of eligibility.
 6. The decision as to the amount of charity write-off will be made by Customer Service Center supervision under the direction of the Customer Service Center Director.
 7. Elective or non life threatening procedures are not eligible for charity consideration.
 8. Charity determination may be retroactive for all dates of services, as determined by the screener at the time of the application.

9. Charity determinations are based on the current, outstanding balance of an account.
 - a. Any payments previously made to the account balance are not refunded.

LINKS:

National Poverty Guidelines

Chair, MSHA Board

Date

President and Chief Executive Officer, MSHA

Date

Exhibit 8.4

Attachment B

Mountain States' Credit and Collection Policy - Patient Accounts

Policy Manual:	Administration/Operational
Manual Section:	Fiscal Services - Policies
Policy Number:	ADM-400-018
Effective Date:	January 9, 2015
Supersedes:	February 2014
Reviewed Date:	January 8, 2015

I. TITLE: CREDIT AND COLLECTION POLICY – PATIENT ACCOUNTS

II. PURPOSE:

To outline general guidelines that allows for a fair and equitable system for credit and collection of payments from patients served by Mountain States Health Alliance.

III. SCOPE:

All team members

IV. FACILITIES/ENTITIES:

MSHA Corporate

Tennessee: FWCH, IPMC, JCCH, JCMC, QRH, SSH, UCMH, WPH, Niswonger Children’s Hospital, Princeton Transitional Care, Unicoi County Nursing Home

Virginia: DCH, JMH, NCH, RCMC, SCCH

V. DEFINITIONS:

- A. **Self-pay portion:** The amount owed by patients without insurance or deductible and co-payments required of patients with insurance coverage.
- B. **Non-emergent:** If the procedure being ordered is on the established non-emergent classification table or the diagnosis code supporting the order is on the non-emergent code list, the encounter would be deemed non-emergent.

VI. POLICY:

- A. Mountain States Health Alliance has established a strong mission to meet the medical needs of the communities it serves. It is the mission of Mountain States Health Alliance to:
 1. Treat all patients equally – with dignity and respect.
 2. Evaluate all requests for financial assistance using established general guidelines while allowing for unique financial circumstances.
 3. Respond promptly to patient inquiries regarding their bills and requests for financial assistance.
 4. Ensure outside collection agencies follow facility/entity billing and collection guidelines.
 5. Follow a strong collection program that enables Mountain States Health Alliance is able to communicate financial responsibility to the patient prior to

service.

- B. Mountain States Health Alliance (MSHA) has established sound guidelines to provide direction to team members in their interactions with patients and guarantors.
 - 1. Patients receiving services at MSHA facilities will be treated under the payment arrangement and financial options outlined in this policy.
 - 2. MSHA recognizes its obligation to provide quality health care to those who are unable to pay.
 - 3. In addition, MSHA provides financial counselors to help uninsured patients determine sources of payment for medical bills and to help patients determine eligibility for programs such as TennCare or Medicaid.
 - 4. Patients with no health insurance will receive a discount on their facility/entity bills at MSHA.

VII. PROCEDURE:

A. Payment arrangements

- 1. All patients will be required to submit coverage information prior to a service being rendered.
- 2. Mountain States Health Alliance will bill insurance carriers (including managed care plans) as dictated by contracts, after verification of benefits.

B. Pre-Admissions

- 1. Mountain States Health Alliance will pre-admit all patients when possible.
- 2. The method of payment will be verified prior to the patient's admission.

C. Non-Emergent Services

- 1. Patients scheduled for these services will be evaluated and informed of financial liability PRIOR to admission.
- 2. The patient will be required to either pay 50% of their estimated out-of-pocket liability or agree to monthly payment arrangements on the full estimated amount, with the first payment due before the service is rendered.
- 3. If satisfactory payment arrangements cannot be reached with the patient prior to the scheduled procedure time, the procedure will be postponed until acceptable payment arrangements can be established.

D. Emergent Services

- 1. Mountain States Health Alliance will perform these services for any patient regardless of their ability to pay.

E. Patient Financial Options

- 1. Mountain States Health Alliance provides the following guidelines for payment options.

2. Financial counselors are available to assist patients and their families with financial help, as needed.
3. The following payment options are available at Mountain States Health Alliance facilities:
 - a. **Cash Payments**
 - i. If payment at discharge is not possible, the patient and/or patient's family will be reminded that the balance is due within thirty (30) days of discharge or date of service.
 - b. **Credit Card Payments**
 - i. Mountain States Health Alliance will accept credit card payments for patient balances.
 - ii. Accepted cards are Visa, MasterCard, American Express and Discover.
 - c. **Pre-Service Pay Discounts**
 - i. A "pre-service pay" discount of up to 10% may be offered to patients if their liability is \$5000 or less.
 - ii. If the liability is greater than \$5000, a maximum discount of \$500 can be offered, using the steps outlined in the Financial Counselor Guidelines policy.
 - d. **Catastrophic High Dollar Inpatient Accounts**
 - i. In special circumstances, a discount in excess of the established discounting rates can be granted.
 - 1) When determining this discount, many factors will be taken into consideration including the cost of care rendered and the Medicare inpatient Diagnosis Related Group (DRG) rate.
 - ii. This offer requires the approval of the Vice President (VP) of Revenue Cycle.
 - e. **Insurance Company Requesting Audit**
 - i. A 5% discount can be offered to a non-contracted payer.
 - ii. The Managed Care department must be notified of any requests and included in negotiations.
 - iii. The account must be thoroughly documented to reflect all negotiations.
 - f. **Payment Arrangements**
 - i. Payment arrangements are available within the following guidelines:
 - 1) If the balance is less than \$500, the patient can make payments up to twenty (20) months, with a minimum monthly payment amount of \$25.00.

- a) Account must not be with a collection agency.
 - 2) If the balance is greater than \$500, the patient can make payments up to thirty-six (36) months but must make a minimum payment of \$50.00 per month.
 - a) Account must not be with a collection agency.
- g. Self Pay ED Visits
 - i. When possible, MSHA will provide an estimate of care rendered to self-pay patients before they leave the Emergency Department (ED).
 - ii. These estimated charges will be calculated at a higher discounted rate than our standard uninsured rate.
 - iii. The patient will have the option to pay this discounted amount in full at that time, pay the discounted amount in full within three (3) business days after the ED visit, or decline the offer.
 - iv. If declined, the patient will be responsible for all charges relating to the ED visit, after the standard uninsured discount is applied.
- h. **Exceptions to above**
 - i. In extenuating circumstances, the above may be deviated from by Revenue Cycle Senior Management.
- i. **Charity**
 - i. Mountain States Health Alliance recognizes its obligation to provide quality health care to those who are unable to pay.
 - ii. Refer to Charity Policy – Fiscal Services for detailed information on the MSHA charity guidelines.
- j. **Collection Agencies**
 - i. When it is determined that a patient has not responded to our requests for balance resolution, an account can be referred to an outside collection agency for collection assistance.

LINKS:

Charity Policy - Fiscal Services CBO-400-011

Financial Counselor - Contracted Medicaid Eligibility Guidelines CBO-400-010

President and Chief Executive Officer, MSHA

Date

Exhibit 8.4

Attachment C

Mountain States' Collection Agency Process - Fiscal Services

Policy Manual:	Administration/Operational
Manual Section:	Fiscal Services
Policy Number:	CBO-400-007
Effective Date:	April 11, 2014
Supersedes:	April 2013
Reviewed Date:	April 11, 2014

I. TITLE: COLLECTION AGENCY PROCESS – FISCAL SERVICES

II. PURPOSE:

To detail process of accounts placed with outside collection agencies.

III. PATIENT-CENTERED CARE PRINCIPLES:

All team members are considered as caregivers.

IV. SCOPE:

All MSHA Corporate Business Office (CBO) Team Members

V. FACILITIES/ENTITIES:

MSHA Corporate

Tennessee: FWCH, IPMC, JCCH, JCMC, QRH, SSH, UCMH, WPH, Niswonger Children’s Hospital, Kingsport Day Surgery, IPMC Transitional Care, Princeton Transitional Care, Unicoi County Nursing Home

Virginia: DCH, JMH, NCH, RCMC, SCCH, Clearview Psychiatric Unit, Francis Marion Manor Health & Rehabilitation, Norton Community Physicians Services (NCPS), Community Home Care (CHC)

BRMMC owned and managed practices

Home Health/Hospice

ISHN

VI. DEFINITIONS:

Not Applicable

VII. POLICY:

Accounts the CBO’s self pay collection unit is unable to successfully collect are placed with an outside collection agency on a regular basis.

VIII. PROCEDURE:

A. Monthly, accounts are transferred to the bad debt file on the Patient Accounts system and an electronic file of these accounts are sent to outside collection agencies for further collection efforts.

B. MSHA utilizes one (1) primary collection agency; one (1) secondary agency.

- C. Monthly, the agencies send electronic files to MSHA containing payments received in their office and posted in their system that day to MSHA accounts.
 - 1. These payments are applied to the patient's accounts on the Patient Accounts system.
- D. Daily, electronic payment files are sent back to the agencies from MSHA containing payments made at MSHA and posted to the patient's accounts.
 - 1. The agencies update this payment information back into their collection system.
- E. Monthly, the agencies send checks and remittances to the CBO detailing the total payments applied to the accounts in the month regardless of where the payments were made.
 - 1. These remittances list the paid amount, patient name, date of payment, amount due the agency and the amount due MSHA.
 - 2. The amount paid, amount due the agency and the amount due MSHA are totaled at the end of the remittance.
 - 3. The amount due the agency is the negotiated fee for services as outlined in the contracts.
 - 4. The remittances are balanced to the Patient Accounts system reports for accuracy.
 - 5. Check requests are submitted to Accounts Payable for the amounts verified due to the agencies and the payments are mailed by the Accounts Payable department.
- F. All accounts; regardless of primary payer classification, remain with the primary agencies as long as an acceptable payment arrangement has been established.
 - 1. Accounts deemed uncollectible by the agencies are closed and returned to MSHA.
 - a. Examples of uncollectible accounts are bankruptcies and deceased patients with no estate.
 - 2. These accounts are sent back via electronic file transfer and a credit adjustment to the account in Patient Accounts is posted to zero out the balance.
- G. Accounts that the primary agency has been unsuccessful in collecting are sent to a secondary agency for collection efforts.
 - 1. Reporting of payments and monthly billing of services occurs in the same manner at the primary agency process.

Vice President, Revenue Cycle, MSHA

Date

Exhibit 8.4

Attachment D

Mountain States' Code of Ethics and Business Conduct

Policy Manual:	Administration/Operational
Manual Section:	Board
Policy Number:	BD-000-006
Effective Date:	August 2, 2013
Supersedes:	June 2011
Reviewed Date:	July 8, 2013

I. TITLE: CODE OF ETHICS AND BUSINESS CONDUCT

II. PURPOSE:

To describe the ethical framework within which Mountain States Health Alliance conducts its patient care and business operations.

III. PATIENT-CENTERED CARE PRINCIPLES:

All team members are considered as caregivers.

IV. SCOPE:

All team members

V. FACILITIES/ENTITIES:

Tennessee: FWCH, IPMC, JCCH, JCMC, QRH, SSH, WPH, Niswonger Children’s Hospital, Kingsport Day Surgery, IPMC Transitional Care, Princeton Transitional Care

Virginia: DCH, JMH, NCH, RCMC, SCCH, Clearview Psychiatric Unit, Francis Marion Manor Health & Rehabilitation, Norton Community Physicians Services (NCPS), Community Home Care (CHC)

BRMMC, MSMG owned and managed practices

Home Health/Hospice

ISHN

VI. DEFINITIONS:

Not Applicable

VII. POLICY:

- A. Mountain States Health Alliance, its Board of Directors, Medical/Dental Staff, employees, and independent contractors conduct patient care according to the Patient-Centered Care Philosophy and all business operations in an ethical manner. Our behavior is guided by our mission, vision, and core values statements and the following general principles.
 - 1. We shall treat everyone with dignity, respect, and courtesy.
 - 2. All team members are considered as caregivers, and all caregivers cooperate with one another through a common focus on the best interests and personal goals of the patient.

3. Our primary commitment is to the health, safety, and rights of the patient, whether an individual, family, friends, group, or community.
4. Care is provided in a healing environment of comfort, peace, support, openness and honesty.
5. We shall provide services only to those patients for whom we can safely care within this organization, and no patient with a medical necessity will be turned away due to an inability to pay or for any other reason unrelated to patient care.
6. Care is customized and reflects patient needs, values, and choices and is based on continuous healing relationships, with the patient being the source of control for their care.
7. Patient confidentiality is preserved with knowledge and information being shared only among care partners, physicians, and other caregivers with a "need to know".
8. Caregivers owe the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
9. We shall adhere to a uniform standard of care throughout the organization.
10. We shall continuously seek to improve our skills and the quality of our care and add new technology in a prudent manner, while striving to cut costs.
11. We shall make clinical decisions on identified patient health care needs, not financial risks or incentives.
12. We shall abide by all professional standards, laws and regulations governing the operations of our organization, and we shall fairly and accurately represent ourselves and our capabilities.
13. We shall meet, or exceed, all standards and requirements imposed upon us by licensing and accrediting bodies.

VIII. PROCEDURE:

- A. The Code of Ethics and Business Conduct conveys the standards of ethical and legal behavior that is expected of all team members, Physicians/Allied Health Personnel, Independent contractors, and vendors.
- B. The Code of Ethics and Business Conduct booklet is provided to all new team members during orientation, to new vendors or independent contractors and is provided to all new Physicians/Allied Health Personnel.
 1. Individuals receiving a hard-copy of The Code of Ethics and Business Conduct must sign an acknowledgment of receipt or complete a computerized acknowledgment of receipt.
 2. The Code of Ethics and Business Conduct document is accessible at all times in electronic format on the MSHA Intranet.
- C. The Code of Ethics and Business Conduct is reviewed annually and modifications

are submitted to the Board for approval.

- D. All individuals subject to the Code of Ethics and Business Conduct are expected to adhere to the Standards.
 - 1. Failure to do so will result in disciplinary action up to and including termination of employment, removal from the Medical Staff or be excluded as a participating vendor.

LINKS:

Code of Ethics and Business Conduct – MSHA

Code of Ethics and Business Conduct – Norton Community Hospital

Chair, MSHA Board

Date

President and Chief Executive Officer, MSHA

Date

Exhibit 8.5

Attachment A

Wellmont's Patient Bill of Rights



Wellmont Health System

Effective: 03/2011
Approved: 10/2015
Last Revised: 10/2015
Custodian: Sharon Webb: ADMINISTRATIVE SECRETARY
Policy Area: Single Billing Office
Regulatory:
Applicability: Wellmont Health System

Charity Care

Policy Statement:

Wellmont Health System, a not-for-profit provider, recognizes its role in the community to provide medically necessary, quality care services to all people regardless of their ability to pay.

Wellmont Health System acknowledges its responsibility as a tax-exempt organization to provide medically necessary health care services for the community's uninsured or underinsured population. However, Wellmont Health System is also tasked with managing its resources in a fiscally sound manner and, therefore, sets forth the following charity care policy which is designed to help those who cannot afford to pay for those medically necessary health care services. This charity care policy is only applicable for services that are deemed to be medically necessary and non-elective. Charity care status will be granted to patients for 6 months. A new application will be required should the patient need coverage beyond 6 months.

Procedure:

Wellmont Health System proactively pursues patients who may be candidates for charity care through the following processes:

- Patients who walk-in or telephone the Business Office or a clinical office setting stating they are having problems paying their bills.
- Patients who are identified through telephone or statement collection procedures.
- Referrals from registration points that have identified possible indigent or charity situations.
- Inquiries from local charitable or religious organizations who call on behalf of patients seeking financial assistance.
- In-house social services whom, while working with patient or patient's family, has identified a financial need.
- All self-pay patients are referred to a Program Eligibility Specialist or to an outsourced agency that helps to qualify eligible patients for Medicaid and any known charitable programs.

Approval Process:

A charity care application is given or mailed to the patient/guarantor. The application shall include the following information:

- A. Proof of address
- B. Proof of total household income (copy of pay stubs, W-2's,) including copies of most recently filed tax return

- C. Complete current bank statements, checking, savings and investments
- D. Completed financial screening application

When a complete application is received, an applicant's income is verified and compared against federal poverty guidelines based on household size. (**Household** is defined as an individual, spouse, minor children under the age of 18 years which may include biological, step and adoptive children. Other persons living in the home, including friends and/or other relatives, etc. will not be counted as household members unless the person is included as a dependent on the income tax filing forms of the person requesting financial assistance or if the person requesting financial assistance is included as a dependent on the income tax filing forms of another household member.) The following applications can serve as a substitute WHS application:

- Friends in Need
- Rural Health Consortium
- Appalachian Mountain Project Access (AMPA),
- Healing Hands

Household income is defined as all wages, salary, tips, government benefits, pensions, support/alimony payments, roomer/boarder payments, work release checks, unemployment benefits, military allotments, regular contributions, and in-kind contributions.

In addition to household income, **assets** of the applicant will be considered including: property other than primary residence, life insurance if the cash surrender value exceeds \$10,000; retirement benefits in excess of \$10,000; other accounts such as certificates of deposit, money market accounts, stocks and savings accounts in excess of \$2,000. The charity care approval process will also include steps to insure that third party government assistance is not available to the patient (TennCare, Virginia Medicaid, Medicare Disability, etc).

Poverty Guidelines:

If the patient's or guarantor's income is below 200% of the poverty guidelines, the application will be approved for a 60 -100% write-off. Applications with income over 200% of the federal poverty guidelines will be denied assistance unless the Charity Care Committee or Administration approves otherwise based on extenuating circumstances.

These special circumstances could include patients who are between 200% and 400% of the federal poverty guidelines but whose account balance (after all insurances have processed or uninsured discount is applied) is equal to or greater than 50% of the patients total annual household income. The maximum a patient would be expected to pay to settle an account balance would be 15% of annual household income.

In addition to the above process, patient accounts which are unresolved are analyzed by a third party. The third party scores the accounts to determine if the patient qualifies for Presumptive Charity Care. If the patient qualifies, the account will be written off as Presumptive Charity Care.

UNINSURED: Regardless of a patient's income level, all patients who are uninsured will be entitled to the Uninsured Discount of 60%.

CHARITY CARE: Items that will not be discounted under Charity Care policy are:

- Hearing Aids
- Healthy Hearts
- Cosmetic Surgery
- Elective Procedures, defined by the WHS that are not deemed medically necessary.
- Does not apply to already discounted / negotiated services (eg. DOTS, CDLs)

- Evaluation and Management office CPT codes (place of service 11) are excluded from Charity Care discounts (99201-99215, 99381-99397, 99241-99245)
- Any account balances associated with Out-of-Network services
- Special promotions (eg, flu vaccine day, PSA test weekend, Mammography)
- Presumptive Charity Care
- HVMC Indigent clinic charges and related referrals to clinics will not be excluded from our charity policy.

For charity accounts, the uninsured discount will be reversed and the entire account balance will be adjusted off and classified as charity care (Bad Debt)

The applicant will be notified in writing of the committee's decision.

Scope:

All Wellmont Hospitals and Clinic Facilities

Regulatory Agency Standard(s):

N/A

History/Supersedes:

Replaces Financial Assistance/Charity Policy

Attachments:

No Attachments

Committee	Approver	Date
	Doris Young: Corporate Compliance Assistant	03/2011
	Christopher Spencer: VICE PRESIDENT REVENUE CYCLE	02/2014
	Alice Pope: EXECUTIVE VICE PRESIDENT AND SYSTEM CFO	04/2014
System Policy Task Force/Oversight Committee	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	08/2014
System Policy Stat Administrator	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	08/2014
	Christopher Spencer: VICE PRESIDENT REVENUE CYCLE	12/2014
	Alice Pope: EXECUTIVE VICE PRESIDENT AND SYSTEM CFO	12/2014
System Policy Approval & Oversight Committees	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	01/2015
	Christopher Spencer: VICE PRESIDENT REVENUE CYCLE	04/2015
	Alice Pope: EXECUTIVE VICE PRESIDENT AND SYSTEM CFO	09/2015
System Policy Approval & Oversight Committees	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	10/2015

Exhibit 8.5

Attachment B

Wellmont's Charity Care Policy and Related Policies



Wellmont Health System

Effective: 11/1993

Approved: 10/2015

Last Revised: 10/2015

Custodian: Janet Hazlewood: DIRECTOR
QUALITY ACCRED/RISK
MANAGEMENT

Policy Area: Risk Management

Regulatory:

Applicability: Wellmont Health System

Patient Bill of Rights

Policy Statement:

- A. Wellmont hospitals, as healthcare institutions, have the responsibility to patients, staffs, medical staffs, affiliated organizations, and the communities we serve to conduct business and patient care operations within a consistent ethical framework as defined by our mission, vision, values and related policies and documents.
- B. The ethical framework within which the staffs and physicians of Wellmont hospitals conduct all aspects of patient care and business operations is provided by the principles defined in our mission, vision and values:
1. **Mission:** We deliver superior health care with compassion.
 2. **Vision:** We will deliver the best health care anywhere.
 3. **Values:**
 - a. Integrity
 - b. Respect
 - c. Compassion
 - d. Empowerment
 - e. Innovation

Policy:

WELLMONT HEALTH SYSTEM PATIENT RIGHTS AND RESPONSIBILITIES

The Wellmont Health System advocates these patient rights and responsibilities without regard to gender or cultural, economic, educational or religious background or the source of payment for care and follows ethical behavior in its care, treatment, services and business practices. All Wellmont Health System personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patient rights.

As a patient you have the right to:

- Know and experience your rights and become informed of your rights as a patient in advance of, during, or when discontinuing the provision of care.

- Considerate, respectful, supportive care for your physical, psychological, social, emotional concerns and respect for your personal values and beliefs in an environment that preserves dignity and contributes to a positive self-image.
- Reasonable access to and continuity of your care
- Information concerning your diagnosis, condition, course of treatment including potential benefits and risks, and prospects for recovery including unanticipated outcomes, in terms that you can understand
- To be educated and participate actively in the development and implementation of the care plan and safe delivery of care including appropriate management of pain
- Participate in ethical issues that come up during your care and have such issues addressed
- Have a designated family member/representative participate in informed decisions about your health care, when appropriate
- Exclude any or all family members from participating in your care (this does not apply to unemancipated minors)
- Receive visitors and have a support person with you for emotional support
- Receive information regarding advance directives and generate advance directives and have them followed within the limits of the law and to receive medical care even if you do not have advance directives
- Express your wishes about foregoing, withholding or withdrawing resuscitative services and/or life sustaining treatments
- Have a family member or representative of choice, and personal physician notified of admission to the hospital with your consent
- Appropriate assessment and management of pain
- Know the names of your physicians and caregivers and their professional titles and status
- Request a change of health care provider or second opinion if desired
- Agree to and refuse treatment to the extent permitted by law and to be informed of the benefits, possible consequences of such action and of alternative treatments
- Be fully educated about the discomforts/risks/benefits, and to consent or refuse to participate in experimental treatment/research and also receive information about alternatives that might be helpful. You may refuse to participate and still receive other services. When participating in research investigation and clinical trials your rights shall be protected and respected and you will be given an explanation of the procedures to be followed
- Personal privacy and to receive care in a safe/secure environment
- Agree to and refuse for your picture to be used for any reason other than providing care
- Express spiritual beliefs and cultural practices and wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with diagnostic procedures or treatments
- Express concerns/dilemmas/grievances about your care to a nurse/employee or if needed to a member of management and to have these issues addressed and if possible resolved
- Confidentiality of all communications and your clinical records and access to the information in your medical record within the limits of the law
- Information provided with sensitivity regarding autopsy, organ and other tissue receipt/donation
- Freedom from all forms of abuse/harassment, neglect and exploitation
- Explanation of all charges for service and items on your bill
- Reasonable response to a request for services within the capacity of the health care facility
- Information about your continuing health care needs/options and planning for care after leaving the hospital as appropriate
- Information about rules and regulations affecting your care or conduct.

- Access to protective services (guardianship, advocacy services, conservatorship, adult and child protective services etc.)
- Pastoral and spiritual care
- Access to oral and written communication in your preferred language for discussing healthcare, such as, translators or special equipment for communication, if needed.
- When communication is restricted you and/or your family will be included in the process, including therapeutic effectiveness of the restriction.
- Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff
- Request and be informed of the existence of business relationships among the hospital, educational institutions, other health care providers or payors that may influence your treatment and care
- Be informed when the hospital cannot provide the care you request and be informed of your needs and alternatives for care
- Be transferred to another organization if necessary and medically advisable and the transfer is acceptable to the receiving organization

As a patient you are responsible to:

- Provide accurate and complete information regarding past and present medical problems, medications, and other matters pertaining to your health
- Follow medical instructions and health advice and discuss desired changes or concerns about your ability to comply
- Accept the consequences of your actions if you refuse treatment or do not follow instructions or advice
- Report changes in condition or symptoms or concerns regarding your care promptly
- Notify your caregiver if you do not understand information about your care or treatment or what is expected of you
- Act in a considerate, cooperative manner and respect the rights of others
- Choose whether you wish to be treated at a Wellmont Health System facility. For a medical non emergency, if your managed care organization does not cover the charges, you would be responsible for paying the bill
- Assure that your financial obligations for health care are fulfilled promptly
- Follow the rules and regulations of the health care facility
- Keep appointments and notify the hospital or physician if you cannot do so.
- Respect your personal property and that of other persons in the hospital and the hospital property
- Report any concerns regarding your care and/or any unexpected changes in your condition to the responsible practitioner.
- Ask questions when you do not understand what you have been told about your care or what you are expected to do.
- **Special Needs Patients**
 - ***If you feel special assistance is needed contact the Admissions Department, Case Management or Nursing Staff.***

Additionally, patients are encouraged to become active, involved and informed participants on the health care team. To help prevent health care errors, patients are urged to "Speak Up:"

Speak up if you have questions or concerns, and if you don't understand, ask again. It's your body and you have a right to know.

Pay attention to the care you are receiving. Make sure you're getting the right treatments and medications by the right health care professionals. Don't assume anything.

Educate yourself about your diagnosis, the medical tests you are undergoing, and your treatment plan

Ask a trusted family member or friend to be your advocate.

Know what medications you take and why you take them. Knowledge of your medications helps prevent medication errors.

Use a hospital, clinic, surgery center, or other type of health care organization that has undergone a rigorous on-site evaluation using established state-of-the-art quality and safety standards, such as that provided by The Joint Commission.

Participate in all decisions about your treatment. You are the center of the health care team

Wellmont Health System hospitals are accredited by Joint Commission on Accreditation of Healthcare Organizations. You may contact The Joint Commission at:

- - The Joint Commission
 - One Renaissance Blvd.
 - Oakbrook Terrace, IL 60181
 - Phone: 1-800-994-6610

In addition to the "Speak Up" reminders noted above, the American Hospital Association encourages patients and their families to follow the "Five Steps to Safer Health Care" listed below:

- A.
 1. **Ask questions if you have doubts or concerns.** Make sure you understand the answers. Choose a doctor you feel comfortable talking to. Take a relative or friend with you to help you ask questions and understand the answers.
 2. **Keep and bring a list of ALL the medicines you take.** Give your doctor and pharmacist a list of all the medicine that you take, including non-prescription medicines. Tell them about any drug allergies you may have. Ask about side effects and what to avoid while taking the medicine. Read the label when you get your medicine, including all warnings. Make sure your medicine is what the doctor ordered and know how to use it. Ask the pharmacist about your medicine if it looks different than you expected.
 3. **Get the results of any test or procedure.** Ask when and how you will get the results of tests or procedures. Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail. Call your doctor and ask for your results. Ask what the results mean for your care.
 4. **Talk to your doctor about which hospital is best for your health needs.** Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from. Be sure you understand the instructions you get about follow-up care when you leave the hospital.
 5. **Make sure you understand what will happen if you need surgery.** Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation. Ask your doctor, "Who will manage my care when I am in the hospital?" Ask your surgeon: Exactly what will you be doing? About how long will it take? What will happen after the surgery? How can I expect to feel during recovery? Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Scope:

All Wellmont Departments

History/Supersedes:

supersedes BRMC-AD-911-0003-PO, HVMC-AD-911-0046-PO, HCMH-W-SY-901-0056-PO, WHCH-W-SY-901-0056-PO, WLPH-W-SY-901-0056-PO.

Regulatory Agency Standard(s):

The Joint Commission Rights and Responsibilities of the Individual standards

CMS 42 CFR 482.13 - Condition of participation:Patient's Bill of Rights

Reference:

N/A

Attachments:

 [Patient Compliant and Grievance Resource](#)

Committee	Approver	Date
System Safety Committee	Marsha Helton: RN; Director Clinical Quality/Patient Safety	09/2012
	Tracey Moffatt: EXECUTIVE VP AND CHIEF OPERATING OFFICER	09/2012
	Margaret Denarvaez: PRESIDENT WHS	09/2012
	Doris Young: Corporate Compliance Assistant	09/2012
Risk Management SLDS Team	Melissa Mccall-Burton: DIR QUAL/RISK/MED STAFF	10/2015
	Gary Miller: EXECUTIVE VICE PRESIDENT, CHIEF GENERAL COUNSEL	10/2015
System Policy Approval & Oversight Committees	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	10/2015

Exhibit 8.5

Attachment C

Wellmont's Bad Debt, Bankruptcy, Small Balance Write-Off and Return Mail Policy



Wellmont Health System

Effective: 04/2014
Approved: 04/2014
Last Revised: 04/2014
Custodian: Sharon Webb: ADMINISTRATIVE
SECRETARY
Policy Area: Single Billing Office
Regulatory:
Applicability: Wellmont Health System

Wellmont Health System Bad Debt, Bankruptcy, Small Balance Write-Off and Return Mail Policy

Policy Statement:

It is the policy of Wellmont Health System to engage in routine collections of patient debt that is allowable and consistent with federal, state and local laws; transfer accounts in accordance with standard operating procedures to a collection entity separate from Single Billing Office, and list as bad debt without regard to patient type or financial class.

Policy:

The amounts uncollectible from non-Medicare guarantors are to be charged off as bad debt in the accounting period in which the accounts are deemed to be non-collectable. For Medicare purposes allowable bad debt is defined in the Provider Reimbursement Manual (PRM)

Section 302.2 - Allowable Bad Debts - "Allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set forth in Section 308. Allowable bad debts must relate of specific deductibles and coinsurance amounts.

Section 310.2 - If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date of the first bill is mailed to the beneficiary, may be deemed uncollectible.

The following 4 criteria as outlined in Section 308 must be met;

- 1. Debt is related to covered services and attributable to unpaid deductible and coinsurance amounts*
- 2. Reasonable collection efforts are made*
- 3. Debt is actually uncollectible when claimed as worthless*
- 4. There is no likelihood of future recovery*

Process:

A. Patient Balances

1. Non Medicare

- a. The Guarantor will receive 3 statements and a final notice. If the bill remains unpaid more than 90 days from the date it was first mailed to the guarantor, and reasonable collection attempts have failed, the account will be turned over to a collection agency.
 - i. Day 0: Statement
 - ii. Day 30: Statement
 - iii. Day 60: Statement
 - iv. Day 75: Final Notice Letter
 - v. Day 90: Collection Letter
- b. Day 90 account deemed bad debt and adjusted off as "Bad Debt".
- c. Day 90 account transferred to a collection agency.

2. Medicare

- a. Effective April 2005, CMS issued an updated stance on uncollectible Medicare bad debts. They cannot be claimed until closed by all collection agencies. In order to facilitate the process of collections, to appropriately manage the account receivable and to meet Medicare's bad debt audit guidelines the following procedures will apply:
 - i. Once final insurance payment is made the patient responsibility is due.
 - ii. The guarantor will receive 4 statements and a final notice. This process will take approximately 121 days. The only exception will be return mail. If a correct address cannot be obtained the account will be sent to the collection agency.
 - iii. Reasonable collection attempts will be made.
 - iv. After 121 days have passed the account will be moved to Bad Debt. At this point, the account will be transferred to a collection services agency.
 - v. When the account is deemed worthless it will be returned from the collection agency to be included in the Medicare bad debt log.

B. Bankruptcy

1. When notice is received that a patient has filed for Bankruptcy, a Bankruptcy Billing Indicator is placed on accounts.
 - a. Chapter 7 - All charges included in the bankruptcy are adjusted off as Bad Debt. All collection efforts are ceased
 - b. Chapter 11 - All charges included in the bankruptcy are adjusted off as Bad Debt and transferred to a collection agency.
 - c. Chapter 13 - All charges included in the bankruptcy are adjusted off as Bad Debt and transferred to a collection agency.

C. Return Mail

1. If unable to secure a current mailing address the account will then be turned over for collections.
 - a. Wellmont Health System considers the collection agency as an extension of their collection effort

D. Small Balance Write-Off

1. Personal account balance less than .99 will be adjusted off as "Small Balance Write-Off".

Reference(s):

N/A

Scope:

Wellmont Health System & Affiliates

Regulatory Agency Standard(s):

CMS Billing Manuals

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html>

History/Supersedes:

N/A

Attachments:

No Attachments

Committee	Approver	Date
	Christopher Spencer: VICE PRESIDENT REVENUE CYCLE	03/2014
	Alice Pope: EXECUTIVE VICE PRESIDENT AND SYSTEM CFO	04/2014
System Policy Task Force/Oversight Committee	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	04/2014
System PolicyStat Administrator	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	04/2014

Exhibit 10.1

Pre-Submission Report

Better Together



Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report

PREPARED BY

**Wellmont Health System &
Mountain States Health Alliance**

JANUARY 2016

About Our Systems



Wellmont Health System operates six hospitals and numerous outpatient care sites, serving communities in Northeast Tennessee and Southwest Virginia. Wellmont's mission is to deliver superior healthcare with compassion, and we consistently rank among the nation's best for high-quality outcomes and processes of care.



Mountain States Health Alliance operates 13 hospitals and numerous outpatient care sites across a 29-county, four-state region. Mountain States is committed to its mission of bringing loving care to healthcare – and we passionately pursue healing of the mind, body and spirit to meet the needs of the individuals and communities in our region.

A Letter to the Community from Our Boards

In April 2015, we jointly announced our desire to create a new approach to healthcare in our region by bringing our two organizations together to form a new, integrated and locally governed health system. We have been working diligently since then, meeting with both internal and external stakeholders and engaging in a meticulous process to be sure that we're taking the right path as we prepare to seek approval to come together.

Most importantly, we've had countless conversations with individuals throughout the community who are eager to see the health status of our region improve, and they're excited about what the future holds for these counties we call home.

The document you now hold is an important step in the final approval process, and we could not be more excited about the possibilities it represents. This report and the applications that will follow it are part of what sets our vision apart from the traditional mergers that are so common in the healthcare industry today. An important difference is that we're involving you, the public, and making enforceable commitments to create an organization that has a measurable, positive impact on our region.

We've put a lot of careful thought into the commitments in this document, because we know that the decisions we make together today are going to impact our children, our grandchildren and even our great-grandchildren for many generations to come. That's another reason we believe that joining together is the right thing to do, because it allows us to keep governance of our local healthcare here at home. There will always be difficult decisions to make as we continue to navigate the changing and challenging world of health care, and we would rather those decisions be made by people who live here and have a personal stake in the outcomes. A great many of you have told us that this is your wish, as well.

We are your neighbors, and we hear your voice. We will be accountable not only to the states that will supervise us, but also to you, our friends and family. We take seriously our responsibility to act in the best interest of the communities we serve.

As you read through the commitments outlined in this report, we hope you will feel - and share - our enthusiasm for the great things we can do together to help our region thrive. Thank you for your continued support, and know that we value your thoughts and opinions. Our process is not complete without your input, so please let us know your thoughts on this report or any other subject by communicating with us at www.BecomingBetterTogether.org. We hope that the more we share about our vision, the more we will all agree that we truly are better together.

Sincerely,



Bart Hove, *President and CEO*

Wellmont Health System



Roger Leonard, *Chair*

Wellmont Health System
Board of Directors



Alan Levine, *President and CEO*

Mountain States Health Alliance



Barbara Allen, *Chair*

Mountain States Health Alliance
Board of Directors

Purpose of the Report: Community Engagement and Feedback

This Pre-Submission Report provides the context for the proposed merger of Wellmont Health System and Mountain States Health Alliance to form a new health system (the “New Health System”), which was announced publicly in April 2015. Both systems have continuously sought to educate the public on the reasons for the merger, while also providing public opportunities for members of the community to provide input and ask questions. This transparency is not only the choice of the two organizations, it is also a requirement of the State of Tennessee and the Commonwealth of Virginia.

Wellmont and Mountain States have developed a formal process to collect community feedback. Immediately upon announcing the proposed merger, an informational website, www.BecomingBetterTogether.org, was created. This website provides information about the proposed merger, upcoming public events, frequently asked questions and a means to sign up for regular email updates and to submit questions. Frequently asked questions were answered on the website. The website link has been provided on collateral materials, and the public has been encouraged to ask questions. Questions may continue to be asked, and comments provided, by using the following link: www.BecomingBetterTogether.org



To date, Wellmont and Mountain States have participated in almost 40 scheduled community and media events that provided the public a chance to learn more and ask questions about the future of healthcare in the region. A record of the engagement to-date is included in this report as Attachment I. In addition, dozens of employee meetings and communications have been conducted throughout both organizations over the course of the last nine months, allowing substantive opportunities to ask questions and make comments.

Physician input has also been sought through medical staff and independent physician group meetings. In addition, both independent community physicians and physicians employed by each system have prominent leadership roles on the Integration Council and the Joint Board Task Force responsible for merger planning. Further venues for physician input are engrained in the original agreement between the two systems, which stipulates there will be a Clinical Council led by physicians, which reports through the Quality Committee of the new Board of Directors. It is the vision of the New Health System that physician input will be crucial to clinical and service-related issues after the completion of the merger. For more information on the Certificate of Public Advantage and Virginia Cooperative Agreement statutes and regulations, please see the following links:

[TENNESSEE COPA STATUTE \(TCA §68-11-1301 et seq.\)](#)

[TENNESSEE COPA REGULATIONS](#)

[VIRGINIA COOPERATIVE AGREEMENT STATUTE](#)

[VIRGINIA COOPERATIVE AGREEMENT REGULATIONS](#)

The Certificate of Public Advantage and Cooperative Agreement Process

This merger is contingent on the granting of a Certificate of Public Advantage by the State of Tennessee and a Cooperative Agreement with the Commonwealth of Virginia (“State Agreements”). Once granted, the State Agreements authorize Wellmont and Mountain States to merge and provide the framework for ensuring active supervision of the New Health System’s compliance with these agreements and the mutually agreed enforceable commitments that benefit the community. Active supervision ensures that the benefits of the merger continue to outweigh any potential disadvantages and that the Tennessee and Virginia policies underlying the issuance of the State Agreements are fulfilled. The states require that the New Health System maintain a Plan of Separation so that if the benefits of the merger no longer outweigh the disadvantages, the plan can be operationally implemented without undue disruption to essential health services.

Each state separately evaluates the potential benefits of its State Agreement, considers whether one or more of the following benefits might result from the State Agreement, and assesses whether the benefits outweigh possible disadvantages. These benefits generally include:

- » Enhancement of the quality of health and healthcare in the region
- » Preservation of healthcare facilities in geographical proximity to the communities traditionally served by those facilities
- » Gains in the cost-efficiency of services provided by the hospitals involved and prices paid by consumers
- » Improvements in the utilization of hospital resources and equipment
- » Avoidance of duplication of hospital resources

Background & Vision for the New Health System

Wellmont and Mountain States have served the health needs of residents in Northeast Tennessee and Southwest Virginia for decades. Both have invested in creating locally governed not-for-profit health systems to meet the unique needs of the region by providing a comprehensive array of services regardless of an individual's means of payment or ability to pay.

To move forward, the two systems have developed a comprehensive process to guide the design of the New Health System based on a shared vision, thoughtful analysis of current and future community health needs, significant feedback from the community, and oversight by both the State of Tennessee and Commonwealth of Virginia.

The vision of the proposed merger, which has been adopted by both Boards of Directors, sets forth that the New Health System will:

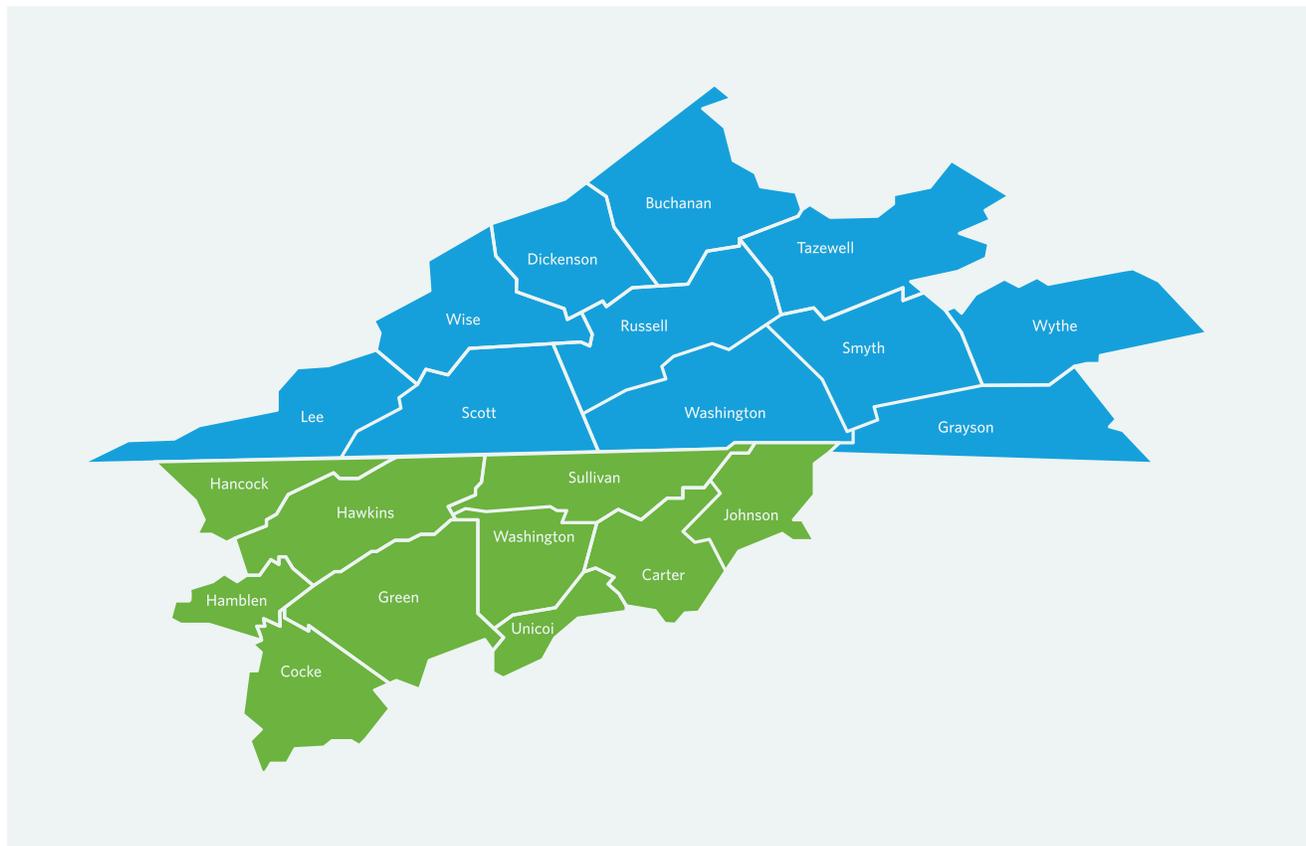
- » Establish new unifying mission, vision, and values statements that honor our heritage and charter our future;
- » Be one of the strongest health systems in the country, known for outstanding clinical outcomes and superior patient experiences;
- » Be one of the best health system employers in the 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 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; and
- » Establish innovative philanthropic partnerships for healthcare advancement

The New Health System will have a new name and be governed by a new sixteen-member Board of Directors. This new Board initially includes: six (6) members appointed by Wellmont, six (6) members appointed by Mountain States, the Executive Chairman/President, the Chief Executive Officer, two (2) jointly appointed members not currently associated with the governance of either system, and the President of East Tennessee State University as an ex-officio nonvoting member. The New Health System will be managed by a senior executive team with representatives initially selected from each organization: Executive Chairman/President Alan Levine from Mountain States, Chief Executive Officer Bart Hove from Wellmont, Chief Operating Officer Marvin Eichorn from Mountain States and Chief Financial Officer Alice Pope from Wellmont.

Service Area and Facilities

The New Health System will primarily serve the following counties: Carter, Cocke, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington in Tennessee and Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise and Wythe in Virginia.

All Wellmont and Mountain States inpatient, outpatient, clinic, and support facilities will be included in the Tennessee COPA and Virginia Cooperative Agreement with the exception of those where the health systems do not own a controlling interest. For a more detailed listing, please see Attachment II.



Rationale for the Merger

For more than a year, the Boards of Directors of Wellmont and Mountain States each deliberated on how to best navigate a challenging environment for hospitals. This environment has resulted in the closure of more than 60 rural hospitals in the nation since 2010.¹ In addition, hundreds of local hospitals have been acquired by large multistate health systems or for-profit healthcare companies that lack deep-rooted understanding of local community health needs and have fiduciary obligations unaligned with the health of the local economy.

The challenges faced by our local systems contribute uniquely to the rationale for the proposed merger.

There is a high concentration of services in our region with the third lowest Medicare Wage Index in the nation – leading to substantially lower reimbursement than peer hospitals in other states and in Tennessee for the same services. These challenges are intensified by a high proportion of Medicare, Medicaid, and uninsured patients. The two health systems have expensive, unnecessary



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. In addition, there is projected downward pressure on reimbursement by government payers as costs for labor and supplies continue to grow. Collectively, we serve a region with one of the highest inpatient use rates; moreover these rates are projected to decline, while our fixed infrastructure costs remain. Further, there are increasing challenges with recruitment and retention of physicians as physicians retire and the newly trained physician supply does not support the demand. All of these challenges undermine the long-term sustainability of both systems and their ability to continue as independent, locally governed organizations.

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 communities in which we live and serve. 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 Health System nor Mountain States Health Alliance 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 our 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.

Outside hospital systems entering the region by acquisition most likely would not be subject to substantial antitrust scrutiny and, therefore, would have little or no reason to seek a COPA or Cooperative Agreement.

¹University of North Carolina Sheps Center for Health Services Research, NC Rural Health Research Program.
<https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

As such, they are free to acquire our local hospitals and take merger-related savings and jobs out of our communities without facing a requirement or local accountability to make the investments in community health that our region desperately needs. In fact, to the extent an outside system achieves any savings, most would inure to the benefit of the outside system and the dollars would most likely leave the region. Even if a system commits to spending a certain amount of capital locally, the capital is typically derived from the cash flow of the local hospital.

The boards of Wellmont and Mountain States believe the purchase of our local health systems by larger systems from outside our region is more likely to increase costs, reduce access, and negatively impact jobs.

We believe our proposed alternative is better. It is the only model that maintains local governance, provides a unique opportunity to sustain and integrate healthcare delivery for our residents into a high-quality and cost-effective system, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in our region, and invests those dollars in the improved health of our region while also preserving local jobs.

The process of obtaining the State Agreements, as outlined in state laws that follow a legal doctrine upheld by the Supreme Court of the United States, respects state autonomy in the regulation of its healthcare delivery system. The State Agreements permit hospitals that meet statutory requirements to consolidate in accordance with the state's policy, as long as the elements of the State Agreement are supervised by the states and provide clear public benefit. The standard acquisition by hospitals entering from "out of market" does not generally include these types of enforcement mechanisms to protect consumers or ensure enhanced community benefit.



We believe a locally governed merger by far provides the best opportunity for the local communities to retain control of the health delivery system. Our board members are local business owners and leaders, retirees and parents, all deeply affected by the decisions related to the future of the delivery system. This model provides tangible benefits for the community. When decisions are made, they are being made by people who must live with the consequence or benefit of the decision. This is the bedrock of the not-for-profit hospital model, which both systems believe is in the best interest of our region.

A major factor in the accumulation of nearly \$1.5 billion of debt, and the redundant costs borne by the marketplace, has been the duplication of services and programming by Wellmont and Mountain States as separate systems. 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 produce 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. While consolidation will result in changes in the structure of the two organizations and displacement of some jobs, new development promises to create new job opportunities and advance the local economy. Enhancing the coordination, integration, sustainability and development of new models of care delivery across the community enhances health as well as economic well-being of the local economy, benefiting all. The benefit accrued to the community and resulting stimulus to the local economy will far outweigh any possible negative impact.

Through the State Agreements, the states of Tennessee and Virginia will be able to supervise the commitments the New Health System is making, which are described more fully herein. Further, the reinvested savings associated with the proposed merger provide compelling evidence that the resulting community benefit and public advantage will be substantial. These investments are described in more detail throughout the report. As examples, the New Health System will:



Invest not less than \$75 million over ten years in population health improvements, committed through a regional ten-year plan



Invest not less than \$140 million over ten years to expand mental health, addiction recovery, and substance abuse prevention programs; develop both healthcare- and community-based resources for children's health across the region; meet regional physician needs and address service gaps and preserve and expand rural services and access points



Invest not less than \$85 million over ten years to develop and grow academic and research opportunities, support post-graduate healthcare training, and strengthen the pipeline and preparation of nurses and allied health professionals



Invest approximately \$150 million over ten years to facilitate the regional exchange of health information among participating providers and to establish an electronic health record system within the New Health System that ensures a common platform and interoperability among its hospitals, physicians, and related services

Major Health Issues and Trends

According to the 2015 America's Health Rankings, Tennessee ranked 43rd and Virginia 21st in the U.S. for overall public health.² The county-level data in Table I, however, demonstrate that Northeast Tennessee and Southwest Virginia counties — the areas we serve — perform far worse than their state averages and are in fact among the unhealthiest counties in the United States. Based on County Health Rankings data published by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, the counties served by Wellmont and Mountain States rank among the worst in Virginia and Tennessee in several categories, notably in tobacco use, death due to drug poisoning and obesity.

Table I: Select Measures from County Health Rankings

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

² America's Health Rankings 2015 Annual Report.
<http://www.americashealthrankings.org/VA> and <http://www.americashealthrankings.org/TN>

Commitment to Improve Community Health

Wellmont and Mountain States are committed to creating a new health system designed to improve community health. To accomplish this, the New Health System will commit to pursuing health improvements aligned with goals contained within the current Tennessee State Health Plan, the Virginia Health Innovation Plan (including the Lieutenant Governor's Quality, Payment Reform, and HIT Roundtable and Virginia's Plan for Well Being) and with regional collaborative health improvement goals such as those set forth in Healthier Tennessee and the Blueprint for Healthy Appalachia. Additional local stakeholder input is being compiled by four Community Health Work Groups (mental health and addiction, healthy children and families, population health and healthy communities, and research and academics) organized by Wellmont and Mountain States.

All of these efforts recognize that income, education, family and community support, personal choices, genetics and the environment are key drivers of individual and community health and well-being. As the 2014 Tennessee Health Plan states, "We know that healthcare alone cannot make major improvements in population health. To make significant improvements, we need to understand what 'being healthy' and 'staying healthy' mean, and how to encourage our entire society to value health. In other words, we need to build a culture of health."

Yet each year, more of each employee paycheck, employer payroll and government budget is consumed by healthcare services, and less is invested in education, wage and job growth, public safety and other important investments. This is despite the fact the Institute of Medicine estimates that 30% of all healthcare service spending is wasted due to factors such as unnecessary and duplicative services, administrative burden, inefficient services, high prices, fraud and missed prevention opportunities.³

Hospitals and doctors have traditionally been paid to treat sick and injured patients. But Mountain States and Wellmont believe that redirecting savings identified from the merger into best-practice interventions aimed at the underlying causes of poor health in vulnerable populations will offer our best opportunity to improve the health of the overall population we serve. This requires a new approach that goes beyond the four walls of the health system and requires community collaboration and focus on a limited number of key problems and associated interventions. This necessitates both leadership and investment by the New Health System in partnership with many community stakeholders.

Fortunately, the region is primed for collaborative action to improve health in the form of a Regional (Northeast Tennessee-Southwest Virginia) Accountable Care Community (ACC). Successful ACC development requires multiple public and private stakeholders to commit to working collaboratively to advance the Triple Aim (better care, better health, and lower cost) in this region and to share the responsibility for the health of the community.



³IOM (Institute of Medicine). 2010. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington, DC: The National Academies Press. At Preface xvi and p.50

Several local, state and national analyses have identified the key health issues in our region, and there is considerable overlap in their findings. Groups such as the Southwest Virginia Health Authority, Healthier Tennessee, and Healthy Kingsport have organized to collectively address these findings, and important relationships have been formed. Consistent with federal objectives to better engage communities, in the Commonwealth of Virginia, the creation of Accountable Care Communities (ACCs) is an important strategy of Virginia's State Innovation Model Design awarded by the federal government.

To develop a comprehensive plan for the region which the New Health System can provide financial and other support, we propose adopting a community-driven strategic planning process between the New Health System, the state, and local Department of Health and an organized community of stakeholders, which will prioritize program strategies to meet defined community health improvement goals. This process would be guided by the National Association of County and City Health Officials' (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) framework displayed to the right.



Analyzing the most current output of the Tennessee State Health Plan, the Virginia Health Innovation Plan, Healthier Tennessee and the Blueprint for Healthy Appalachia, and the four Community Workgroups, Mountain States and Wellmont have identified as a starting point four key strategic issues in which we believe the New Health System may make regional investments using redirected savings from the merger or whereby the merger itself aids in the achievement of these goals.



The New Health System is committed to creating a new integrated delivery system designed to improve community health through investment of not less than **\$75 million** over ten years in population health improvement.

The New Health System would commence the population health improvement process with the preparation of a comprehensive community health improvement plan, identifying 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 East Tennessee State University. The funding may be committed to the following initiatives, as well as others as determined based upon the 10-year action 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 overprescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs.
- » **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 New Health System will also provide financial support to develop and sustain an Accountable Care Community effort across state lines for our region that will help address these and other issues identified through the community health improvement plan.



A Community Health Work Group held in the fall of 2015

Enhanced Healthcare Services

Some residents in Northeast Tennessee and Southwest Virginia have acceptable access to many services, but other areas are substantially underdeveloped or lacking services altogether. This is especially true for mental health, substance abuse and specialty pediatric services. 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.

Northeast Tennessee and Southwest Virginia are also victims of a flawed and antiquated federal funding program for Medicare, which depresses the reimbursement for our region relative to peer hospitals in other regions of the nation. The Medicare Wage Index adversely affects hospitals and doctors in our region, causing significant impediments to recruiting and retaining doctors, particularly specialists. For example, our hospitals are compensated at approximately 73 percent⁴ of the average wage index for treating the same patient, with the same condition, for which a treating hospital in San Jose, California, would be compensated at 178 percent of the average wage index.⁵ In the aggregate, this difference costs our region tens of millions of dollars annually in lower reimbursements, and has a substantial impact on physicians as well.



Providing these services is important and expensive. Why should rural families be required to expect less when it comes to access? Niswonger Children's Hospital, for example, continues to work to attract and support many subspecialties, but many families still travel significant distances to receive care. It is all too common that a child's illness forces families to split apart long-term or creates job loss as one parent must work while the other travels as a full-time caregiver. We don't believe these disparities should prevail and are prepared to make investments to ensure the most vulnerable have improved access.

Families and individuals suffering from the prescription drug addiction epidemic and other substance abuse disorders face even more difficult challenges. Funding has not kept up with needs and our local systems are overwhelmed. Families again face the difficult choice of splitting apart as loved ones must travel long distances to receive services, or even worse, can't find services at all or face long waits.

The proposed merger will produce savings which will be used to support specialty services such as behavioral health and pediatric subspecialties that otherwise couldn't be supported in a region of our size, geography and population density. In addition, the proposed merger will provide a unique opportunity for the New

⁴ This figure represents the average across Johnson City, TN and the Kingsport-Bristol-Bristol, TN-VA MSAs.

⁵ CMS Fiscal Year 2015 Wage Index Table, available here:
<https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/wageindex.html>

Health System to work with academic institutions in the region to increase training and recruitment of physicians and allied health professionals. Developing our own workforce connected with the region and likely to stay here long-term provides a strong supplement to recruitment efforts for other top-tier doctors, nurses and allied health professionals from other parts of the country.



The New Health System commits to spending at least \$140 million over ten years pursuing specialty services, outlined as follows, which otherwise could not be sustainable in the region without the financial support. Partnerships with academic institutions will enable research-based and academic approaches to the provision of these services.

- » Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.
- » 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.
- » Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment.
- » 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.
- » 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. We expect the combined system to facilitate this goal by employing physicians primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding.

Expanding Access and Choice

Investing in the development of new and expanded services is one way to improve access and choice in the region. Preserving services currently at risk and breaking down barriers for physicians to practice and patients to receive services where they choose is another. The New Health System is committed to both.

In the U.S., rural hospitals and healthcare providers are at increasing risk. According to the University of North Carolina Sheps Center, 61 rural hospitals have closed since 2010, including six in Tennessee and one in Virginia.⁶ Wellmont and Mountain States each make substantial investments in order to maintain access to health care services in their rural communities.

Last year alone, Mountain States and Wellmont collectively invested over \$19.5 million to ensure that inpatient services continued to remain available in these smaller communities. This does not include significant additional capital investments.

Mountain States Rural Hospitals:

- » Smyth County Community Hospital
- » Russell County Medical Center
- » Unicoi County Memorial Hospital
- » Johnson County Community Hospital
- » Dickenson Community Hospital
- » Norton Community Hospital
- » Johnston Memorial Hospital

Wellmont Rural Hospitals:

- » Hawkins County Memorial Hospital
- » Hancock County Hospital
- » Lonesome Pine Hospital
- » Mountain View Regional Medical Center

For the reasons discussed above, it will be increasingly difficult to continue sustaining these facilities over the long-term without the savings the proposed merger would create. Protecting and increasing patient choice is important to Mountain States and Wellmont. By integrating our two systems, we will help ensure that our communities continue to have access to the care they need close to home and that care options are expanded rather than reduced. Currently, more than one-quarter of inpatient admissions in the region occur at hospitals other than those owned by the two systems. Most outpatient medical services are actually delivered outside the two systems by independent physicians and other independent providers such as home health, lab, imaging, occupational medicine, hospice, long-term care services, skilled nursing, physical therapy, occupational therapy, pharmacy, counseling, and surgery centers. Wellmont and Mountain States are required to ensure patient choice when selecting these services and will continue these policies as a merged organization.

⁶University of North Carolina Sheps Center for Health Services Research, NC Rural Health Research Program.
<https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

After the merger, patient choice of hospitals will increase. Currently, some patients are limited to either Wellmont or Mountain States hospitals because of constraints in insurance networks. Similarly, many doctors are limited to practice in certain hospitals by contract. In each of these examples, patient choice is limited in the current environment. As another example, in some areas of the region, patients are often referred to hospitals farther away than more local hospitals, because the closer hospitals are part of the competing system. This inconvenience exists because of the continuum of care and physician relationships that arise between the facilities and because of transfer patterns from community hospitals to tertiary centers within the same system. Through the proposed merger, a more comprehensive and fully integrated regional network will improve patient choice and convenience, as these barriers would be removed.

Both Wellmont and Mountain States continue to value a robust and successful independent physician community. The New Health System intends to collaborate with the independent physician community where possible to build an array of service offerings which will also be accessible throughout the region.



The New Health System will invest in the development of expanded services while preserving services currently at risk through the following commitments.

- » All hospitals in operation at the effective date of the merger will remain operational as clinical and healthcare institutions for at least five (5) years. After this time, the New Health System will continue to provide access to healthcare 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 healthcare 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.
- » Maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available as closely as possible to where the population lives.
- » 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.
- » Commitment to not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.
- » Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.
- » The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.

Improving Healthcare Value: Managing Quality, Cost and Service

In addition to achieving reduced costs through improved efficiency and avoidance of waste and unnecessary duplication, the merger will also specifically enable the New Health System to reduce overutilization of inpatient services and stem the pace of healthcare cost growth for patients, employers and insurers. Currently, 126 patients for every 1,000 people in Tennessee are admitted to the hospital annually, compared to a national average of 106 admissions/1,000 population.⁷ We believe a regionally integrated health system, with a comprehensive regional health information exchange, will help reduce unnecessary utilization.

The proposed merger will also result in a common platform for electronic medical records among the merging systems' combined nineteen hospitals, many employed physicians and related services and will facilitate a community health information exchange between participating community providers in the region. This 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 patient access to their own health information. A more 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 merger will also allow for better clinical integration as the combined system reduces unnecessary variation in standards of care created by the simple fact that the two systems operate separately in silos and from the independent physician community. Given the significant pressure on health systems and independent physicians to deliver higher-quality care and service from Medicare and commercial payers, a unified merged system working with the independent physician community will be able to more rapidly adopt and disseminate best practices.

⁷ Kaiser Family Foundation, Hospital Admissions per 1,000 Population by Ownership Type. (2013)
<http://kff.org/other/state-indicator/admissions-by-ownership/>



The New Health System will reduce cost through improved efficiency and avoidance of waste and duplication, as well as reduce the pace of healthcare cost growth for patients, employers and insurers through the following commitments:

- » For all Principal Payers,* the New Health System will reduce existing commercial-contracted fixed-rate increases by 50% for the first full contract year following the first contract year after the formation of the New Health System.
- » 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%.
- » The United States Government has stated that its goal is to have 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 non government 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 system.
- » 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.
- » Adopt a common clinical information technology platform as soon as reasonably practical after the formation of the New Health System.
- » Participate meaningfully in a health information exchange open to community providers.
- » Establish annual priorities related to quality improvement and publicly report these quality measures in an easy-to-understand manner for use by the patients, employers and insurers.
- » Negotiate in good faith with Principal Payers* to include the New Health System in health plans offered in the service area, on commercially reasonable terms and rates (subject to certain limitations). The New Health System would agree to resolve through mediation any disputes in health plan contracting.
- » Not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.
- » Not engage in “most-favored-nation” pricing with any health plans.

* “Principal Payers” are defined as those commercial payers who provide more than two percent (2%) of the New Health System’s total net revenue

Investment in Health Research and Graduate Medical Education

A cornerstone of the proposed merger is the expansion of the health related research and academic capabilities of the region through additional funding and closer working relationships with East Tennessee State University and other academic partners in Tennessee and Virginia. The region is fortunate that Quillen College of Medicine, Lincoln Memorial University DeBusk College of Osteopathic Medicine, the Virginia College of Osteopathic Medicine, and Virginia Tech excel at educating physicians who choose to practice primary care and in rural areas.

Yet, due to financial constraints, Wellmont and Mountain States have reduced the number of residency slots in their respective systems to train these graduate physicians. Multiple studies have shown that physicians tend to locate their practice close to where they train in residency. And increasingly important to the primary care workforce are nurse practitioners and physician assistants trained at schools such as Emory & Henry, Milligan College and the ETSU School of Nursing. Unlike physician programs, historically little funding has been available for these programs from the federal and state governments.

By investing funds generated through merger efficiencies, the New Health System will increase residency and training slots, create new specialty fellowship training opportunities, build research infrastructure, and add faculty - all critical to sustaining an active and competitive training program. New local investment in this research and training infrastructure will attract additional outside investments. State and federal government research dollars often require local matching funds, and grant-making organizations such as the National Institutes of Health and private organizations such as pharmaceutical companies want to know that their research dollars are being appropriated to the highest-quality and resourced labs and scientists.



The New Health System will work with its academic partners 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 as outlined below - all critical to sustaining an active and competitive training program.

- » With academic partners in Tennessee and Virginia, the New Health System will develop and implement a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.
- » Work closely with East Tennessee State University (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.

Attracting and Retaining a Strong Workforce

Our workforce is mobile, and there are many opportunities both within the region and in nearby metropolitan areas for our team members. Thus, competitiveness of our pay and benefits is critical to our success. We believe certain federal policies, which have adversely affected the region's wage index, have also contributed to relocation out of market as being a primary cause of turnover. As such, the New Health System's biggest competitor for labor will continue to be regional systems located out of the immediate market. Additionally, with the Veteran's Administration hospital and services located in-region, as well as the multitude of outpatient services offered by local competition, there will be incentives for the new system to remain locally competitive for talent.

In addition, staffing is generally driven by volume. As such, if the demand for nurses, technicians and other clinical staff diminishes in the future, it will not be due to the merger but rather to the ongoing transformation of the healthcare industry. As outlined in this document, new programs to improve community health will be added and funded, all of which will need exceptional talent.

In addition to being competitive for labor, and mitigating the local impact on jobs, we are also committed to our existing workforce – our neighbors and friends who are the strength of our two organizations. We recognize that our workforce is mobile, and there are many opportunities both within the region and in nearby metropolitan areas for our team members. Thus, competitiveness of pay and benefits is critical to the New Health System's success.



Therefore, when the New Health System is formed:

- » 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 offer competitive compensation and benefits for its employees to support our vision to be one of the strongest health systems in the country and one of the best health system employers in the country.
- » 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.

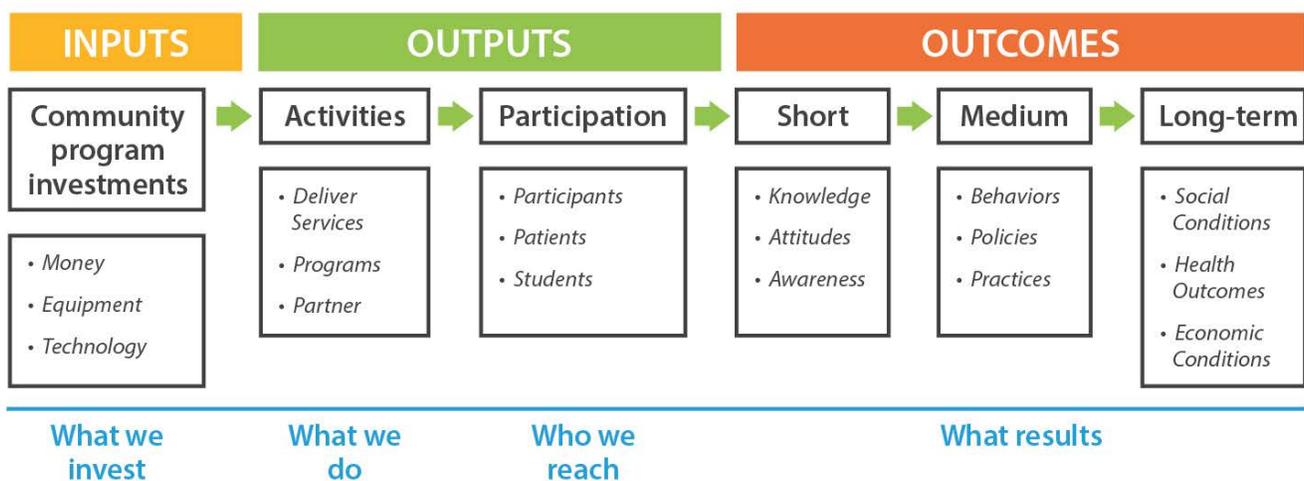
Measuring Progress

It is ultimately the goal of the New Health System to achieve the Institute of Health Improvement’s Triple Aim, commonly considered the national standard for evaluation of healthcare effectiveness. As part of our applications for a COPA in Tennessee and Cooperative Agreement in Virginia, we propose that ongoing evaluation of the public advantage resulting from the merger be based on the New Health System’s pursuit of the Triple Aim objectives to improve population health, improve patient experience of care (quality and access), and manage the per capita cost of healthcare in the region.

Before the Tennessee COPA and Virginia Cooperative Agreement is granted, each State and the New Health System should agree on key health concerns as well as a limited number of long-term health outcomes for tracking within four strategic area of focus: strong starts for children, living well in the community, promoting a drug-free community and decreasing avoidable inpatient and ER use by high need-high cost uninsured individuals. As an important component of the evaluation of each application, each State will separately establish advisory groups made up of stakeholders from the area to recommend measures for consideration to objectively track the ongoing public advantage of the Tennessee COPA and Virginia Cooperative Agreement. Agreement on these specific tracking measures should serve as the guide for long-term programmatic investment by the New Health System to improve community health.

Monitoring and evaluating the continued Public Advantage produced under the Tennessee COPA and the Virginia Cooperative Agreement are essential. We are committed to close coordination with the states to establish clear processes for both monitoring and evaluation. Because evaluation of commitments regarding population health are more complex and involve many factors, both shorter-term and longer-term, we propose to use the Kellogg Foundation’s Logic Model to inform the evaluation of these commitments.

Kellogg Foundation Logic Model for Evaluation



Under this model, effective measures by which we can evaluate progress towards long-term outcomes would reflect incremental investment in programs (inputs), measurements of activities and participation related to these programs (outputs), and outcomes, both short-term and medium-term. The short-term outcomes could include measurable changes in learning, such as awareness, knowledge, attitudes, skills, opinions, aspirations, and motivations. The medium-term outcomes could include measurable changes to actions such as behaviors, practices, decision making, policies, and social norms.

We believe close collaboration with the community, investment by the New Health System, and commitment to continuous and ongoing evaluation and improvement will result in positive short- and long-term outcomes that are only possible through the State Agreements.

Conclusion: Becoming Better Together

Our region has a once in a lifetime opportunity to create a long-lasting legacy of improved health by pursuing a merger between Wellmont and Mountain States. With the approvals of the states under the State Agreements, savings realized by reducing duplication and improving coordination will stay within the region and be reinvested in ways that benefit the community substantially through new services and capabilities, improved choice and access, managed costs and investment in both the region's economic development and its most challenging health problems.

Once the annually recurring merger related synergies have been fully realized, this merger will produce a level of annual spending to improve the health of the region equivalent to at least the spending capability of a new three-quarters of a billion dollar foundation. All of this investment will be in Northeast Tennessee and Southwest Virginia, and it will focus on improving the health, well-being, and economy of the communities we serve. Importantly, we can do all of this while maintaining local control of our healthcare system and improving the quality and cost of care.

Again, you may submit questions or make comments regarding this Pre-Submission Report using the link below:

www.BecomingBetterTogether.org



Appendix

ATTACHMENT I: COMMUNITY EVENTS, CORRESPONDENCE AND MEDIA INTERVIEWS

COMMUNITY EVENTS & PRESENTATIONS	
April 2, 2015	Proposed merger announcement public event
April 24, 2015	Kingsport Chamber breakfast
May 1, 2015	Bristol Tennessee/Virginia Chamber breakfast
May 6, 2015	Washington County Virginia Rotary
May 19, 2015	Johnson City Chamber Board
June 8, 2015	Kingsport Chamber Board
June 10, 2015	Southwest Virginia Health Authority
June 24, 2015	Bristol Tennessee/Virginia Chamber Board
July 7, 2015	Bristol Tennessee/Virginia Noon Rotary
July 23, 2015	Washington County Virginia Chamber Board
August 13, 2015	Elizabethton Community Round Table
August 20, 2015	Mental Health & Addiction Steering Committee
August 20, 2015	Abingdon Community Round Table
August 24, 2015	Population Health & Healthy Communities Steering Committee
August 28, 2015	Kingsport Chamber Breakfast
September 3, 2015	Virginia Department of Health Public Hearing
September 8, 2015	Healthy Children & Families Steering Committee
September 9, 2015	Mountain States Foundation Women's Luncheon
September 15, 2015	Marion Community Round Table
September 16, 2015	Johnson City Press Public Forum
September 17, 2015	Mental Health & Addiction Steering Committee
September 19, 2015	Sorensen Institute presentation
September 19, 2015	Lead Virginia
September 24, 2015	Research & Academics Steering Committee
September 24, 2015	Erwin Community Round Table
September 28, 2015	Population Health & Healthy Communities Steering Committee
September 29, 2015	Lebanon, Virginia, Community Round Table
September 30, 2015	Johnson City Rotary
October 1, 2015	Kingsport Community Round Table
October 6, 2015	Duffield Community Round Table
October 13, 2015	Healthy Children & Families Steering Committee
October 15, 2015	Bristol Community Round Table
October 16, 2015	Regional Health Care Symposium
October 20, 2015	Wise Community Round Table
October 21, 2015	Mental Health & Addiction Steering Committee

October 22, 2015	Johnson City Community Round Table
October 22, 2015	United Way of Southwest Virginia Summit
October 26, 2015	Population Health & Healthy Communities Steering Committee
October 28, 2015	Research & Academics Steering Committee
November 10, 2015	Healthy Children & Families Steering Committee
November 12, 2015	Johnson City Rotary
November 16, 2015	All Work Groups Meeting – Accountable Care Communities
November 16, 2015	Population Health Steering Committee
November 19, 2015	Mental Health & Addiction Steering Committee
December 2, 2015	Research & Academics Steering Committee
December 8, 2015	Healthy Children & Families Steering Committee
December 18, 2015	Mental Health & Addiction Steering Committee
December 18, 2015	All Work Groups Meeting – Impact of Opioids in Appalachia
See www.BecomingBetterTogether.org for additional upcoming events.	

COMMUNITY CORRESPONDENCE & ANNOUNCEMENTS

April 2, 2015	Proposed merger announcement news release
April 2, 2015	Launch of www.BecomingBetterTogether.org
April 7, 2015	Integration Council announcement news release
April 16, 2015	Better Together newsletter
May 6, 2015	Better Together newsletter
May 7, 2015	Joint Board Task Force announcement news release
June 2, 2015	Better Together newsletter
June 10, 2015	Better Together newsletter
June 10, 2015	Community Health Work Groups announcement news release
August 5, 2015	Better Together newsletter
August 5, 2015	Community Health Work Groups chairs & meeting dates announcement news release
August 24, 2015	Better Together newsletter
September 16, 2015	Letter of Intent announcement news release
September 16, 2015	Better Together newsletter

MEDIA INTERVIEWS

April 2, 2015	Proposed merger announcement interviews
April 22, 2015	Kingsport Times-News editorial board
April 22, 2015	WJHL editorial board
April 23, 2015	WCYB editorial board
April 23, 2015	Johnson City Press editorial board
May 7, 2015	WKPT editorial board
June 8, 2015	HealthLeaders Media
June 10, 2015	Community Health Work Groups announcement & interviews
June 11, 2015	Modern Healthcare interview
August 24, 2015	WJHL interview

September 16, 2015	Letter of Intent announcement interviews
September 16, 2015	Johnson City Press Forum and follow-up interviews
October 6, 2015	Interview with WCYB
October 12, 2015	Interview with the Johnson City Press
October 16, 2015	Interview with the Bristol Herald Courier
October 19, 2015	Interview with The Business Journal
November 11, 2015	Interviews with The Tennessean and WJHL
November 12, 2015	Interview with The Tennessean
November 13, 2015	Statement provided to the Johnson City Press, Roanoke Times and WKPT
November 16, 2015	Statement provided to WJHL
November 20, 2015	Statement provided to WJHL
December 1, 2015	Statement provided to WCYB
December 9, 2015	Statement provided to the Johnson City Press
December 15, 2015	Statement provided to The Business Journal and the Johnson City News & Neighbor
December 17, 2015	Statement provided to WJHL
December 23, 2015	Statement provided to The Post
December 28, 2015	Statement provided to the Johnson City Press
December 30, 2015	Statement provided to WXBQ and the Kingsport Times-News

Appendix

ATTACHMENT II: INCLUDED FACILITIES AND SERVICES

<p>Wellmont Hospitals Wellmont’s hospital operations consist of two tertiary referral medical centers: Holston Valley Medical Center in Kingsport, Tennessee, and Bristol Regional Medical Center in Bristol, Tennessee, and four wholly owned community hospitals: (1) Mountain View Regional Medical Center in Norton, Virginia, (2) Lonesome Pine Hospital in Big Stone Gap, Virginia, (3) Hawkins County Memorial Hospital in Rogersville, Tennessee, and (4) Hancock County Hospital, a critical access hospital, in Sneedville, Tennessee.</p>	
<p>Holston Valley Medical Center (Kingsport, TN)</p>	<p>Holston Valley Medical Center has been serving the Kingsport community for 80 years since opening in 1935. The 505-bed facility is staffed by more than 450 board-certified or board-eligible physicians and over 1,700 employees. Holston Valley Medical Center is a regional tertiary referral center offering a comprehensive array of inpatient and outpatient services, including advanced services and trauma services. The hospital serves as a teaching facility in partnership with schools such as East Tennessee State University and Lincoln Memorial University. It is an affiliate of Children’s Miracle Network Hospitals.</p>
<p>Bristol Regional Medical Center (Bristol, TN)</p>	<p>Bristol Regional Medical Center, founded in 1925, operates in a state-of-the-art facility that opened in 1994. The 348-bed facility is staffed by more than 336 board-certified or board-eligible physicians and over 1,600 employees. Bristol Regional Medical Center is a regional tertiary referral center offering a comprehensive array of inpatient and outpatient services, including advanced services and trauma services. The hospital serves as a teaching facility in partnership with schools such as East Tennessee State University and Lincoln Memorial University. It is an affiliate of Children’s Miracle Network Hospitals.</p>
<p>Wellmont Community Division Hospitals Wellmont community division hospitals include Lonesome Pine Hospital, Mountain View Regional Medical Center, Hawkins County Memorial Hospital, and Hancock County Hospital.</p>	
<p>Lonesome Pine Hospital (Big Stone Gap, VA)</p>	<p>A 60-licensed bed facility that has served the community since 1973. Lonesome Pine is a community hospital offering a full array of services, including emergency services and a variety of inpatient and outpatient services. The hospital serves as a teaching facility in partnership with schools such as Lincoln Memorial University. The Southwest Virginia Cancer Center, serving medical and radiation oncology patients, is part of Lonesome Pine Hospital operations. Lonesome Pine is staffed with 167 physicians, of whom 80% are board certified, and nearly 400 employees.</p>
<p>Mountain View Regional Medical Center (Norton, VA)</p>	<p>Mountain View is a 118-licensed bed full-service hospital and offers a full array of services, including emergency services and a variety of inpatient and outpatient services.. Mountain View joined Wellmont in 2007 and it is operated as a facility of Lonesome Pine Hospital under one Medicare provider number. Mountain View Regional Medical Center houses the system’s only hospital-based long-term care unit. For financial reporting purposes, Mountain View is consolidated with Lonesome Pine.</p>

<p>Mountain View Regional Medical Center (Norton, VA)</p>	<p>Mountain View is a 118-licensed bed full-service hospital and offers a full array of services, including emergency services and a variety of inpatient and outpatient services.. Mountain View joined Wellmont in 2007 and it is operated as a facility of Lonesome Pine Hospital under one Medicare provider number. Mountain View Regional Medical Center houses the system’s only hospital-based long-term care unit. The hospital serves as a teaching facility in partnership with schools such as Lincoln Memorial University. For financial reporting purposes, Mountain View is consolidated with Lonesome Pine. It is an affiliate of Children’s Miracle Network Hospitals.</p>
<p>Hawkins County Memorial Hospital (Rogersville, TN)</p>	<p>Established in 1961, the 50- bed hospital provides care in a rural setting. Hawkins County is staffed by more than 121 board-certified or board-eligible physicians and nearly 150 employees. Hawkins County Memorial is a community hospital offering a full array of services, including emergency services and a variety of inpatient and outpatient services. The hospital is a teaching facility in partnership with East Tennessee State University.</p>
<p>Hancock County Hospital (Sneedville, TN)</p>	<p>This 10-bed facility has been designated by the state as a critical-access hospital that provides care to a medically underserved region. Hancock County was built through a partnership between the system and the Hancock County Commission. Hancock County offers emergency services and a variety of inpatient and outpatient services. Additionally, air and ground medical transportation to a larger tertiary-care facility is available should a patient require further specialization. Hancock County is staffed with 40 physicians, of whom 68% are board certified. It is an affiliate of Children’s Miracle Network Hospitals.</p>

<p>Wellmont Corporate Entities: Ambulatory and Post-Acute Services Wellmont has been proactive in developing its capabilities across the care continuum through a variety of platforms, including medical groups, assisted living and skilled nursing care facilities, ambulatory surgery centers, urgent care facilities and other ancillary service offerings.</p>	
<p>Wellmont Medical Associates</p>	<p>A multispecialty practice group, Wellmont Medical Associates includes 135 physicians and 67 mid-levels and nurse practitioners, who deliver care in a number of fields.</p>
<p>Wellmont Cardiology Services</p>	<p>The Wellmont CVA Heart Institute offers an integrated approach with leading cardiovascular physicians and cutting-edge cardiovascular technologies and treatments. The institute includes 45 cardiovascular physicians, 23 physician assistants and nurse practitioners, and 575 cardiovascular service line employees.</p>
<p>Wellmont Madison House</p>	<p>The region’s only healthcare-affiliated assisted living residence, adult day care center and short-term overnight care program. The facility provides accommodations for 29 residents with staff supervision and access to 24-hour personal assistance. Services available to assisted living residents are also available to those in the short-term overnight care program.</p>
<p>Wexford House (Kingsport, TN)</p>	<p>A 174-bed skilled and long-term care facility, Wexford House provides comprehensive skilled and rehabilitative nursing care, including: physical therapy, speech therapy, and occupational therapy; residential custodial care; respite and hospice care.</p>

Wellmont/Health South IRF, LLC (Bristol, VA)	Joint venture between Wellmont and HealthSouth Corp., a national healthcare provider specializing in rehabilitation, to operate the Rehabilitation Hospital of Southwest Virginia in Bristol, Virginia. (25% Ownership)
Bristol Surgery Center (Bristol, TN)	Ambulatory surgery center located in Bristol, Tennessee.
Sapling Grove Ambulatory Surgery Center (Bristol, TN)	Ambulatory surgery center located in Bristol, Tennessee. The remaining ownership interest is held by various physicians. (65% Ownership)
Holston Valley Ambulatory Surgery Center (Kingsport, TN)	Ambulatory surgery center located in Kingsport, Tennessee. The remaining ownership interest is held by various physicians. (52% Ownership)
Marsh Regional Blood Center	Marsh Regional Blood Center is a wholly owned subsidiary of Wellmont that provides whole blood and other blood products to 16 hospitals and multiple cancer facilities in Northeast Tennessee and Southwest Virginia. Marsh Regional operates donor centers in Kingsport, Tennessee, and Bristol, Tennessee, and conducts mobile blood drives throughout the region.

Wellmont Corporate Entities: Integrated Support

In addition to Wellmont entities that involve direct patient care and service, Wellmont has also developed strong financial and operational support capabilities through the creation of a captive insurance company, a physician hospital organization, and a philanthropic foundation, which all support the system.

Wellmont Insurance Company SPC, LTD	Cayman captive insurance company which has been established for the purpose of insuring Wellmont's self-insured initial layer of professional liability coverage.
Highlands Wellmont Health Network	A physician hospital organization jointly owned by Wellmont Health System and Highlands Physicians, Inc. The organization includes around 1,000 physicians across the region along with Wellmont's inpatient and outpatient resources, providing a regional option for direct employer contracts and a platform for focused networks. (50% Ownership)
Wellmont Foundation, Inc.	A Tennessee nonprofit corporation and a 501(c)(3) organization, supports the mission, vision and values of Wellmont through the use of community involvement and philanthropic support. As the fundraising arm of Wellmont, Wellmont Foundation serves all of its hospitals and service lines throughout the region.

Mountain States Health Alliance Hospitals

All Mountain States wholly owned hospitals operate under the tax identification number of the Mountain States Health Alliance Corporation. The wholly-owned Mountain States acute care hospitals are described below.

Johnson City Medical Center (JCMC) (Johnson City, TN)	JCMC is a 445- bed regional tertiary referral center which also serves as a teaching hospital affiliated with East Tennessee State University. Founded in 1911, JCMC has transformed to provide a comprehensive array of inpatient and outpatient services, including advanced services and trauma services. Also located at JCMC are 34 skilled nursing beds, separately licensed as Franklin Transitional Care.
Niswonger Children’s Hospital (Johnson City, TN)	Niswonger Children’s Hospital is the region’s only children’s hospital. The 69-bed facility is staffed by pediatric experts to serve more than 200,000 children in a four-state, 29-county region. Niswonger provides a comprehensive array of inpatient and outpatient services for children. Niswonger houses one of only seven St. Jude Affiliate Clinics across the country.
Woodridge Psychiatric Hospital (Johnson City, TN)	Woodridge Psychiatric Hospital is an 84-bed inpatient provider of mental health and chemical dependency services for adults, adolescents, and children ages six and older. Woodridge is a psychiatrist-led facility that includes a team of mental health therapists, discharge planners, expressive therapists, and psychiatric nurses to assist the patient with finding the most beneficial level of treatment.
Indian Path Medical Center (Kingsport, TN)	Indian Path Medical Center (IPMC) is a 239-bed community hospital with roots dating back 40 years. Indian Path provides a full array of services, including emergency services and a variety of inpatient and outpatient services.
Sycamore Shoals Hospital (Elizabethton, TN)	Sycamore Shoals Hospital is a 121-bed acute care facility serving the residents of Carter and Johnson Counties. Sycamore Shoals offers a full array of services, including emergency services and a variety of inpatient and outpatient services. In addition, wellness services are provided through the Franklin Health and Fitness Center, located on the campus of Sycamore Shoals.
Franklin Woods Community Hospital (Johnson City, TN)	Franklin Woods Community Hospital is an 80-bed, LEED-certified* “green” facility. Opened in 2010, Franklin Woods provides a full array of services, including emergency medicine and a variety of inpatient and outpatient services. *Leadership in Energy and Environmental Design
Unicoi County Memorial Hospital (Erwin, TN)	Unicoi County Memorial Hospital, is a 48-bed acute care facility with an adjacent 46-bed skilled nursing facility. The hospital was founded in 1953 in Erwin, TN, and serves the residents of Unicoi County and the surrounding areas with a full array of services, including emergency services and a variety of inpatient and outpatient services.
Russell County Medical Center (Lebanon, VA)	Russell County Medical Center is a 78-bed, acute care and behavioral health hospital. The hospital serves the residents of Russell County, VA, and provides behavioral health services, emergency services, and a variety of inpatient and outpatient services.

Johnson County Community Hospital (Mountain City, TN)	Johnson County Community Hospital is a two-bed critical access hospital opened in 1998 by Mountain States Health Alliance, offering emergency services and a variety of inpatient and outpatient services to the residents of Johnson County.
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Mountain States' Joint Venture Facilities Mountain States' integrated healthcare delivery system also includes joint ventured facilities. The following summaries describe the joint venture entities.	
James H. and Cecile Quillen Rehabilitation Hospital (Johnson City, TN)	Quillen Rehabilitation Hospital houses 26 inpatient rehabilitation beds. The hospital is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and also provides a CARF-accredited stroke program. QRH offers pediatric and adolescent therapy for a wide range of diagnoses, such as stroke, brain injury, amputation, spinal cord injury, orthopedic injury, rheumatologic impairments, neurological and neuromuscular problems and major multiple trauma. The Mountain States partnership with HealthSouth consists of a stand-alone rehabilitation hospital joint venture of at least 36 rehab beds, with Mountain States maintaining a minority interest, and 50/50 board presence. The partnership with Signature HealthCARE will result in a skilled nursing facility with 47 beds and an assisted living facility with 60 beds.
Smyth County Community Hospital (Marion, VA)	Smyth County Community Hospital is a 44-bed, acute care facility located in Marion, VA. Smyth County's services also include a 109-bed skilled nursing care facility, branded as Francis Marion Manor Health & Rehabilitation. The hospital has served the residents of Smyth County, VA, for more than 45 years through a full array of services, including emergency services and a variety of inpatient and outpatient services. Smyth County Community Hospital also owns 100% of Southwest Community Health Services, Inc., described below.
Southwest Community Health Services, Inc.	Southwest Community Health Services is a for-profit entity, owned by Smyth County Community Hospital, which operates a pharmacy and provides other health services to the residents of Smyth County, VA.
Norton Community Hospital (Norton, VA)	Norton Community Hospital has served Southwest Virginia and Southeastern Kentucky since 1949. The 129-bed, acute care facility provides a full array of services, including emergency services and a variety of inpatient and outpatient services. Norton Community was the first American Osteopathic Association-accredited teaching facility in the commonwealth of Virginia and hosts residents in internal medicine.
Norton Community Physician Services, LLC	Norton Community Physician Services is a for-profit entity consisting of physician practices and pharmacy. NCPS employs 16 physicians and 4 mid-levels to serve the residents of Wise County and surrounding area.
Dickenson Community Hospital (Clintwood, VA)	Dickenson Community Hospital is one of two critical access hospitals operated by Mountain States Health Alliance. The hospital is licensed for 25 beds and provides emergency services and a variety of inpatient and outpatient services to the residents of Dickenson County.

Community Home Care, Inc.	Community Home Care is a home health agency located in Norton City, VA, that provides comprehensive quality care to patients within the comfort of their home.
Johnston Memorial Hospital (Abingdon, VA)	Johnston Memorial Hospital (JMH) is a 116-bed community hospital which was relocated to a new, state of the art facility in 2011. At that time, JMH was recognized as the first Gold Leadership in Energy and Environmental Design (LEED)-certified hospital in Southwest Virginia providing a full array of services, including emergency services and a variety of inpatient and outpatient services.
Abingdon Physician Partners	Abingdon Physician Partners is a physician practice owned and managed by Johnston Memorial Hospital consisting of 16 physicians and 5 mid-levels. JMH is 100% owner of Abingdon Physician Partners.
JMH Emergency Physicians, LLC	Johnston Memorial Hospital Emergency Physicians are fully employed ER physicians providing 24-hour emergency department coverage. JMH is 100% owner of JMH Emergency Physicians, LLC.

Other Mountain States' Entities	
Mountain States' integrated healthcare delivery system also includes other entities providing a variety of patient care and population health services. The following summaries describe other Mountain States corporate entities and their affiliates/subsidiaries.	
Integrated Solutions Health Network	Mountain States offers advanced population health management services through its subsidiary, Integrated Solutions Health Network (ISHN). ISHN is the corporate parent of AnewCare Collaborative and CrestPoint Health. AnewCare Collaborative is Mountain States' Accountable Care Organization, which operates a 14,000-member Medicare Shared Savings Program. CrestPoint Health operates TPA services for Mountain States team members and a Medicare Advantage Product with more than 5,000 covered lives at the end of 2015.
Mountain States Health Alliance Auxiliary, Inc.	The Mountain States Auxiliary was established in 1979 to provide financial support for various projects, particularly ones involving extra benefits for Mountain States team members, patients, and guests. The Auxiliary operates the Gift Shops and conducts sales of such items as uniforms, jewelry and books.
Blue Ridge Medical Management Corporation	Blue Ridge Medical Management Corporation (BRMMC) is a wholly owned, for-profit subsidiary of Mountain States Health Alliance. BRMMC owns and manages physician practices throughout the service area through its integrated physician organization, Mountain States Medical Group. Mountain States Medical Group includes more than 250 providers in over 90 locations representing 25 specialties, including eight urgent care sites. In addition to Mountain States Medical Group, other business units of BRMMC include Mountain States Properties, a real estate division which owns and manages almost one million square feet of medical office space; HealthPro Staffing, a staffing agency formed to provide staffing solutions to the Mountain States Health Alliance facilities and other healthcare organizations in the region; Medi-Serve Medical Equipment Company, a durable medical equipment and respiratory services company with three locations in Northeast Tennessee and Southwest Virginia; Mountain States Pharmacy, a retail pharmacy with five locations in Northeast Tennessee and Southwest Virginia; The Wellness Center, a health and fitness center; and ownership and investment in a number of joint ventures such as ambulatory surgery centers and urgent care facilities.

Mountain States Foundation

Mountain States Foundation is a not-for-profit entity providing philanthropic support to Mountain States Health Alliance through the coordination of fundraising and development activities. The Mountain States Foundation assisted with fundraising for the Niswonger Children’s Hospital, Johnson City Medical Center radiation oncology expansion, and various fundraising opportunities at local facilities throughout the system.

Exhibit 10.2

**Record of Community Stakeholder and Consumer Views
of the Proposed Cooperative Agreement**

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1. INTRODUCTION: SHARED COMMITMENT TO COMMUNITY & STAKEHOLDER ENGAGEMENT

Wellmont Health System and Mountain States Health Alliance (collectively, the “Parties”) made a significant announcement on April 2, 2015 – the two organizations agreed to explore the creation of a new, integrated and locally governed health system designed to be among the best in the nation and address the serious health issues facing Northeast Tennessee and Southwest Virginia.

In order to consummate the merger, the Parties must obtain approval from the State of Tennessee and the Commonwealth of Virginia. If approved, the Parties will enter into Cooperative Agreements with each State, which will outline the ongoing obligations of the Parties to the region and the terms of the ongoing supervision of the Cooperative Agreement by each State.

The Parties recognize the once-in-a-lifetime opportunity and know the success of the merger depends on the involvement of the stakeholders throughout the region, including residents, employees, patients, payers, and business and community members and leaders. In order to foster involvement, the Parties undertook extensive efforts to educate, update, and engage all stakeholders.

The public information and education efforts began with the launch of a new website, www.BecomingBetterTogether.org, designed to provide an overview of the Parties’ [vision for the future](#), [process to join together](#), [answers to frequently asked questions](#), [the latest news and updates](#), opportunities to submit questions and comments, and other helpful information. The Parties also provided updates to the community through press releases, Better Together newsletter updates to employees and more than 600 newsletter subscribers, internal updates and town hall meetings, presentations to community and civic group organizations, and other outreach initiatives.

Leaders from both systems have also talked with community members throughout the region, in auditoriums, coffee shops and restaurants, local businesses, higher education centers, and other venues, to seek input on the new health system the Parties envision for the region. Through the Community Health Work Group initiative in partnership with East Tennessee State University (ETSU), more than 150 community members to date have participated in work groups focused on discussing four key areas for health improvement in the region: Mental Health & Addiction, Healthy Children & Families, Research & Academics, and Population Health & Healthy Communities. Additionally, in cooperation with the College of Public Health at ETSU and in connection with the Parties’ goal to improve health care services through the new health system, the Parties have jointly sponsored and funded the region’s most substantial community health improvement assessment effort to date. The Parties also conducted 10 roundtable meetings where more than 175 community members gathered to discuss important local health issues.

All of the feedback collected since the merger was announced in Spring 2015 was used by the Parties to create the Pre-Submission Report, which invited the community to review and comment on its contents. This Exhibit provides a detailed outline of these many efforts to provide public information and education about the proposed Cooperative Agreement and the stakeholder feedback collected from across the region. The Parties are strongly committed to transparency in the Cooperative Agreement process and seek to fully engage all stakeholders, whose input will serve as the foundation for the new health system.

2. OFFICIAL BECOMING BETTER TOGETHER PRESS RELEASES

The Parties distributed seven press releases to local and national media to provide the latest information about the proposed merger and the process the Parties are following to obtain a Certificate of Public Advantage (COPA) in Tennessee and a Letter Authorizing Cooperative Agreement in Virginia. The press releases are included in this Exhibit and are archived on the [Stay Informed](#) page on the Better Together website.

Table 1. OFFICIAL BETTER TOGETHER ANNOUNCEMENTS	
4/2/2015	Wellmont Health System, Mountain States Health Alliance Announce Plans to Pursue an Integrated Health System
4/7/2015	Wellmont Health System, Mountain States Health Alliance Name Members of Integration Council
5/6/2015	Wellmont Health System, Mountain States Health Alliance Name Members of Joint Board Task Force
6/10/2015	Wellmont Health System, Mountain States Health Alliance to Seek Input on Key Health Issues, Call for Public Participation
8/5/2015	Wellmont, Mountain States Announce Chairs, Meeting Dates for Community Health Work Groups
9/16/2015	Wellmont, Mountain States File Letters of Intent to Begin Regulatory Approval Process in Tennessee and Virginia
1/7/2016	Wellmont, Mountain States Share Public Report Outlining Future Plans to Improve Health in Region

See **ATTACHMENT A:** Press Releases

3. BETTER TOGETHER NEWSLETTERS

As part of the Parties' commitment to keep community members and employees and physicians of both systems informed, the Parties developed an electronic Better Together Newsletter to highlight important information, including updates, key milestones of the process, and answers to frequently asked questions. Community members can sign up for the newsletter by visiting the Better Together website and were also invited to sign up at various community and internal events. Newsletters were also distributed to employees and physicians at both health systems. There are currently more than 600 people subscribed to receive Better Together Newsletters. **Attachment B** includes copies of all Better Together Newsletters.

Table 2. BETTER TOGETHER NEWSLETTERS	
Date	Headline
4/16/2015	Answering Your Questions, Our Vision, Questions of the Week
5/6/2015	Thank You, News and Updates, In the News, Questions of the Week
6/2/2016	News & Updates, Community Support, Questions of the Week
6/10/2016	Wellmont, Mountain States to Seek Input on Key Health Issues
8/5/2015	Wellmont, Mountain States Announce Community Health Work Groups Meeting Dates and Chairs
8/28/2015	Wellmont and Mountain States continue to make progress on exploring the creation of a new, integrated and locally governed health system, News & Updates
9/16/2015	Wellmont, Mountain States Take Important Next Steps in Proposed Merger Process, Community Support Continues
1/7/2016	Wellmont, Mountain States Share Exciting Commitments to Improve Region's Health

See **ATTACHMENT B**: Newsletters

4. EMPLOYEE AND PHYSICIAN INTERNAL ENGAGEMENT EFFORTS

In addition to the Better Together Newsletters, the Parties have provided ongoing updates to employees and physicians through various internal communications channels, such as employee and physician meetings, town hall updates and internal memos. **Attachment C** includes copies of the presentation materials distributed to employees and used at the internal town hall meetings and presentations.

A. INTERNAL TOWN HALL MEETINGS PRIOR TO RELEASE OF PRE-SUBMISSION REPORT

The following is a list of intentional outreach efforts by Wellmont Health System:

Table 3. WELLMONT HEALTH SYSTEM EMPLOYEE TOWN HALL MEETINGS PRIOR TO PRE-SUBMISSION REPORT	
Hawkins County Memorial Hospital April 1 at 8 a.m., 11 a.m. and 7 p.m. June 25 at 7 a.m. and noon June 26 at 7 a.m. August 27 at 3 p.m. August 28 at 7 a.m. and noon September 1 at 6 p.m. September 3 at 7 a.m. and 10 a.m. September 4 at 10 a.m.	Wellmont Corporate Offices April 1 at 9 a.m., 10 a.m. and 11 a.m. April 2 at 10 a.m., 2 p.m. and 4 p.m. June 23 at 10 a.m. and 11 a.m. June 24 at 9 a.m., 10 a.m. and 2 p.m. September 1 at 9 a.m., 10 a.m., 11 a.m. September 2 at 3 p.m. September 4 at 3 p.m.
Mountain View Regional Medical Center April 1 at 5 p.m. and 7 p.m. April 2 at 7 a.m. and 11 a.m. April 3 at 11 a.m. June 30 August 27	Lonesome Pine Hospital April 1 at 11 a.m. and 2 p.m. April 2 at 3 p.m. and 5 p.m. April 3 at 7 a.m. June 30 July 1 August 25
Holston Valley Medical Center April 1 at 2 p.m., 6 p.m. and 10 p.m. April 2 at 7 a.m. and 9 a.m. April 3 at 10 a.m. and 2 p.m. April 4 at 7 a.m. and noon June 27 at 7 a.m. and 10 a.m. June 29 at 10:30 a.m. June 30 at 7 a.m., 2:30 p.m., 7 p.m. July 1 at noon, 3 p.m. Aug. 26 at 7 a.m. and 10 a.m. Aug. 27 at 2 p.m. and 7 p.m. Aug. 29 at 10 a.m. Aug. 31 at noon	Bristol Regional Medical Center April 1 at 10:30 a.m. and 4 p.m. April 2 at noon and 4 p.m. April 3 at 10 a.m. and 2 p.m. June 29 at 7 a.m. and 9 a.m. June 30 at 3 p.m. July 1 at noon July 1 at 7 p.m. July 2 at 2 p.m. August 24 at 3 p.m. August 26 at 2 p.m. August 28 at 10 a.m. <i>The following quarterly nursing staff meetings also included Town Hall presentations:</i> August 25 at 7:45 a.m. and 8:30 p.m. August 27 at 9 a.m. and 7:45 p.m.
Hancock County Hospital April 1 at 2 p.m. June 24 at 1:30 p.m. August 26 at 1:30 p.m.	

September 1 at 1:30 p.m.	
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In addition to internal town hall meetings, Wellmont has provided ongoing updates to physicians at regularly scheduled meetings:

- **Holston Valley Medical Center & Bristol Regional Medical Center:** Updates occur at every monthly Medical Executive Committee meeting, monthly Physician Clinical Council meeting, quarterly medical staff meeting and monthly hospital board meeting.
- **Hawkins County Memorial Hospital:** Updates occur at medical/staff quality meetings, which occur every other month and the Medical Executive Committee, which occurs every other month.
- **Hancock County Hospital:** Updates occur at the Medical Executive Committee/Quality meeting, which occurs every other month.
- **Lonesome Pine Hospital & Mountain View Regional Medical Center:** Updates occur at the quarterly medical staff meeting and frequently at the monthly Medical Executive Committee meeting.

The following is a list of intentional outreach efforts by Mountain States Health Alliance:

Table 4. MOUNTAIN STATES HEALTH ALLIANCE EMPLOYEE TOWN HALL MEETINGS PRIOR TO PRE-SUBMISSION REPORT	
Johnston Memorial Hospital April 1 at 4:30 p.m., 6:30 p.m. and 7:30 p.m. April 2 at 7:30 a.m., 10:30 a.m. and 2:30 p.m.	Russell County Medical Center April 1 at 4:30 p.m., 6:30 p.m. and 7:30 p.m. April 2 at 10:30 a.m. and 2:30 p.m.
Woodridge Psychiatric Hospital April 2 at 7:15 p.m. April 3 at 7:15 a.m. May 20 at 7:15 p.m. May 22 at 11:30 a.m. May 29 at 7:15 a.m. May 29 at 11:30 a.m. June 3 at 7:15 p.m. July 8 at 7:15 a.m. July 9 at 11 a.m.	Johnson City Medical Center / Niswonger Children’s Hospital April 1 at 10:00 a.m. April 1 at 7:15 p.m. April 2 at 7:15 a.m. April 2 at 5:30 p.m. April 3 at 7:15 a.m. April 3 at 11:00 a.m. May 20 at 7:15 p.m. May 22 at 11:30 a.m. May 29 at 7:15 a.m. July 14 at 7:30 a.m. July 16 at 7:30 p.m. July 29 at 11:30 a.m. November 3 at 7:15 p.m. November 6 at 12:00 p.m. November 9 at 7:15 a.m.
Norton Community Hospital April 2 at 7:30 a.m., 10 a.m., 2 p.m. and 8 p.m. April 3 at 11 a.m., 1 p.m. and 3 p.m. July 21 at 7:30 a.m., 1:30 p.m. and 8 p.m. July 22 at 10:30 a.m. July 24 August 25 at 7:30 a.m. & 10 a.m. August 26 at 7:30 a.m., 9:30 a.m., 8 p.m. August 27 at 3:00 p.m.	Indian Path Medical Center April 1 at 4:30 p.m. and 8 p.m. April 2 at 6 a.m., 8 a.m., 10 a.m., noon, 2 p.m., 6 p.m. & 8 p.m. April 3 at 11:30 a.m. and 12:30 p.m. Sept. 15 at 4:30 p.m. Sept. 16 at 7:30 a.m. Dec. 15 at 4:30 p.m. Dec. 16 at 7:30 a.m.
Franklin Woods Community Hospital April 1 at 6:30 p.m. April 2 at 6 a.m., 6:15 a.m. and 11 a.m. July 7 at 11 a.m.	Smyth County Community Hospital / Francis Marion Manor April 1 at 7:30 p.m. April 2 at 8:00 a.m. April 2 at 9:30 a.m.

Table 4. MOUNTAIN STATES HEALTH ALLIANCE EMPLOYEE TOWN HALL MEETINGS PRIOR TO PRE-SUBMISSION REPORT	
July 10 at 7:15 a.m. July 15 at 7:15 p.m.	April 2 at 10:30 p.m. April 2 at 2:30 p.m.
Sycamore Shoals Hospital April 1 at 4:30 p.m. and 8 p.m. April 2 at 8 a.m. and 9 a.m. June 19 at noon Aug. 27 at noon Oct. 16 at noon Dec. 11 at noon	Unicoi County Memorial Hospital April 1 at 1:00 p.m. April 2 at 7:30 a.m. April 2 at 4:30 p.m.
Johnson County Community Hospital April 1 at 7 p.m. April 2 at noon	Mountain States Corporate Offices April 3 at 9 a.m. April 17 at 2 p.m.
Smyth County Community Hospital April 1 at 4:30 p.m. and 6:30 p.m.	Home Health April 2 at 8:30 a.m. (Johnson City) April 3 at 8:30 a.m. (Abingdon)
Dickenson Community Hospital April 2 at 3:00 p.m. August 6 at 10 a.m. August 28 at 7:15 p.m.	

In addition to internal town hall meetings, Mountain States has routinely offered merger updates at monthly and quarterly medical staff meetings at all facilities. Routine updates have also been provided as part of monthly department director and manager meetings.

See ATTACHMENT C:
Internal Town Hall Presentations

B. INTERNAL TOWN HALL MEETINGS AFTER RELEASE OF PRE-SUBMISSION REPORT

Following the release of the Pre-Submission Report on January 7, 2016, the Parties held more than 80 Town Hall meetings to provide employees and physicians an opportunity to learn more about the proposed commitments and ask questions related to the content of the Report or the merger. These meetings consisted of a prepared presentation that highlighted important information contained within the Pre-Submission Report and an open question and answer period. The following is a list of the meetings conducted by both Wellmont and Mountain States, including location and dates of meetings. A summary of questions and comments received at these meetings is included in Section C below. Copies of the materials used in the town hall meeting presentations are included in **Attachment C**.

Tables 5 & 6 include the schedule for all internal Town Hall meetings scheduled by the Parties through January 31, 2016.

Table 5. WELLMONT HEALTH SYSTEM EMPLOYEE TOWN HALL MEETINGS FOLLOWING RELEASE OF PRE-SUBMISSION REPORT	
Hawkins County Memorial Hospital January 12, 2016 – 2:00 pm January 12, 2016 – 3:00 pm January 13, 2016 – 7:00 pm January 15, 2016 – 3:00 pm	Wellmont Corporate Offices January 13, 2016 – 10:00 am January 14, 2016 – 1:00 pm January 14, 2016 – 2:00 pm January 15, 2016 – 2:00 pm
Mountain View Regional Medical Center January 12, 2016 – 7:00 am January 13, 2016 – 2:00 pm	Lonesome Pine Hospital January 12, 2016 – 2:00 pm January 13, 2016 – 7:00 am
Holston Valley Medical Center January 14, 2016 – 10:30 am January 15, 2016 – 2:00 pm January 16, 2016 – 10:00 am January 19, 2016 – 7:00 pm January 20, 2016 – 7:00 am January 26, 2016 – 12:00 pm	Bristol Regional Medical Center January 15, 2016 – 7:30 am January 18, 2016 – 9:00 am January 19, 2016 – 11:00 am January 19, 2016 – 4:00 pm January 21, 2016 – 7:30 am
Hancock County Hospital January 13, 2016 – 2:00 pm	

**Table 6. MOUNTAIN STATES HEALTH ALLIANCE EMPLOYEE TOWN HALL MEETINGS
FOLLOWING RELEASE OF PRE-SUBMISSION REPORT**

Johnston Memorial Hospital January 18, 2016 – 7:30 am January 18, 2016 – 9:00 am January 20, 2016 – ED Committee January 21, 2016 – 12:30 pm January 21, 2016 – 5:00 pm January 21, 2016 – 7:30 pm January 25, 2016 – 9:00 am January 28, 2016 – 6:00 pm January 28, 2016 – 7:30 pm	Mountain States Corporate Offices January 18, 2016 – 5:15 pm January 15, 2016 – 5:15 pm January 19, 2016 – 9:00 am January 7, 2016 – 10:00 am January 22, 2016 – 2:00 pm January 13, 2016 – 11 am January 22, 2016 – 3:30 pm January 22, 2016 – 2:00 pm
Blue Ridge Medical Management Corp. January 19, 2016 – 5:15 pm January 20, 2016 – 8:00 am January 20, 2016 – 5:15 pm January 22, 2016 – 7:30 am	Russell County Medical Center January 26, 2016 – 7:00 am January 26, 2016 – 6:00 pm January 28, 2016 – 11:00 am January 28, 2016 – 2:00 pm
Johnson City Medical Center / Niswonger Children’s Hospital January 19, 2016 – 7:00 pm January 20, 2016 – 11:00 am January 20, 2016 – 2:00 pm January 21, 2016 – 7:00 am	Indian Path Medical Center January 18, 2016 – 4:00 pm January 19, 2016 – 9:00 am January 20, 2016 – 7:00 am January 21, 2016 – 1:00 pm
Johnson County Community Hospital January 19, 2016 – 4:30 pm January 22, 2016 – 12:00 pm	Unicoi County Memorial Hospital January 19, 2016 – 1:00 pm January 19, 2016 – 6:30 pm
Home Health January 19, 2016 – 7:30 am January 20, 2016 – 8:30 am January 26, 2016 – 8:30 am	Norton Community Hospital January 19, 2016 – 1:30 pm January 19, 2016 – 8:30 pm January 20, 2016 – 7:30 am January 21, 2016 – 10:00 am January 21, 2016 – 1:30 pm
Franklin Woods Community Hospital January 14, 2016 – 7:15 am January 19, 2016 – 11:00 am January 21, 2016 – 9:00 pm	Smyth County Community Hospital January 19, 2016 – 6:30 pm January 20, 2016 – 3:30 pm January 21, 2016 – 3:00 pm January 21, 2016 – 3:30 pm
Sycamore Shoals Hospital January 18, 2016 – 10:00 am January 18, 2016 – 6:00 pm January 21, 2016 – 12:30 pm	Dickenson Community Hospital January 18, 2016 – 1:30 pm
Woodridge Psychiatric Hospital January 19, 2016 – 7:15 pm January 21, 2016 – 4:00 pm	

C. INTERNAL TOWN HALL MEETING SUMMARIES

The following are detailed summary reports of the comments and questions received at each internal town hall meeting conducted by Wellmont and Mountain States.

1. WELLMONT HEALTH SYSTEM TOWN HALL MEETING SUMMARIES

Hawkins County Memorial Hospital	Wellmont Health System
January 12, 2016 – 2:00 pm January 12, 2016 – 3:00 pm January 13, 2016 – 7:00 pm January 15, 2016 – 3:00 pm	LOCATION: Rogersville, TN
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • Will there be elimination of smaller facilities after the five-year period outlined in the pre-submission report? • Will employees keep their accumulated PTO and move it to the new system or will they be paid for it and have to start over? • What will our employee health insurance plan look like? • What are the telemedicine opportunities we might pursue? • If the merger is approved and jobs become open, will staff members have an opportunity to move around? • Will clinical educators have a role as we pursue the community health improvement initiatives • What will happen with our retirement plans? • Will the health insurance plan remain the same or change? • Will we continue to have a debit card with the plan? • What is the approximate date when the proposed merger will be final? • What will happen to the job of Quest lab employees? • A comment was made suggesting insurance benefits would be better or at least offset as far as cost increases. 	

Hancock County Hospital	Wellmont Health System
January 13, 2016 – 2:00 pm	LOCATION: Sneedville, TN
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • Will the CAPS program stay the same? Could the rate of pay go down? 	

Wellmont Corporate Offices	Wellmont Health System
January 13, 2016 – 10:00 am January 14, 2016 – 1:00 pm January 14, 2016 – 2:00 pm January 15, 2016 – 2:00 pm	LOCATION: Kingsport, TN
<p>QUESTIONS/COMMENTS:</p> <ul style="list-style-type: none"> • How can we square efficiencies with investments and job growth? • What about the non-tertiary hospitals? • Could the community hospital division hospitals close before the merger? • What is the time frame for the unwind plan? • How will the pediatrics plan affect the East Tennessee Children’s Hospital partnership? • Are we going to see more information unrolling? • Why aren’t there plans for a Virginia tertiary hospital? • What’s the timeline for post-merger decisions, such as IT systems? • Going between Star and Epic, some things are being deleted in transfer. What are we going to do about it? Physicians, billing, medical records all need the information and we want images to be matched with reports. • When can we talk with MSHA? • Insurance keeps going up – it is a monopoly. What happens with that? What about the patient? • Do you look for Anthem to come on board? • When do you (Todd) project closing? • The website was supposed to keep us better informed. It’s not updated. It hasn’t been in months. We have not been informed about anything. The newspaper tells us stuff weeks before we are told. Why couldn’t you have told us you were working on the pre submission report? • You said a community free of drug problems. Are you talking about the community itself or physician community? • We did 11 programs on opioid abuse for physicians what are we doing for the community? What programs will they have? • What if the state says no to the merger? • Anthem is in Virginia, will that make Virginia approval an issue? • Are there any other insurance companies causing problems? • To keep us informed of what is being met about, can we have the ELT meeting minutes? • You keep saying “if we go to EPIC.” We spent that much money; we shouldn’t get rid of it. • When Todd Dougan said “you may be asking yourself, where will the \$450 million be coming from,” the audience responded quickly with “no raises” • If an outside agency comes in, they let go of local people and then money goes back to the new company. I agree with our path because local will take care of local. • We need to recruit for psychiatry. • Doctors that are prescribing drugs need to check on their patients and see if they can come off those drugs. We should be looking for natural solutions. • Where is the money for the investments coming from? • Is the “black box” information a recommendation or a requirement? Will it be in the COPA? • When will we have details? 	

- What if Virginia requests an additional Southwest Virginia facility?
- Have there been discussions about a new brand/name?
- Will ETSU be eligible for new funding and grants?
- Can Holston Valley accommodate Indian Path’s case load?
- Where are the “black box” people and consultants located? Who chose them?
- Who manages the state oversight? Is there a board of licensure? How is this reported?
- Do we have a baseline of success for community health?
- When does the five-year period for facilities begin?
- How are we going to pay for the \$450 million?
- Will the initial investment put us in debt?
- What happens to the facilities after five years?
- What’s in this for the states?
- Will we be recruiting jobs/positions nationally? Will we be nationally competitive?
- Will there be an open dialogue throughout the COPA approval process?
- What if one state agrees but one doesn’t?
- What are the chances a federal agency will step in and block this?
- What happened to the \$5 billion amount earlier consultants said we needed before the MSHA announcement?
- Can the state extend the approval period?
- Are there similar mergers we can look to?
- What happens if we don’t meet the commitments?
- Can someone report us if we don’t meet a commitment?
- Will there be conflicts – like benefits – similar to the BRMC/HVMC merger?
- When can we expect to see opportunities and growth – specifically career development opportunities?

Bristol Regional Medical Center	Wellmont Health System
January 15, 2016 – 7:30 am January 18, 2016 – 9:00 am January 19, 2016 – 11:00 am January 19, 2016 – 4:00 pm January 21, 2016 – 7:30 am	LOCATION: Bristol, TN
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • Patients have confessed to me that they are scared about the potential merger. They make it sound like Mountain States isn't as good of a health care system and that their culture isn't as friendly. They simply have a bad perception of them, rather it be from actual experiences or word of mouth. Most of my patients feel Bristol Regional is known for treating patients more like family, especially compared to non-Wellmont facilities. • How do benefits work and what does that mean for me? • Are there vast differences in our benefit, PTO and insurance plans? I’ve heard MSHA pay more in premium cost and can’t hold as much PTO as we do. • Who is going to have more control going forward? Are we going to have to adapt to how MSHA does things? • What can we expect for our insurance, premiums and benefits - are we still going to be a high deductible plan? 	

- I am excited about spending money on research. However, is the research money we spend going to be assessed and valued? There are weird research campaigns going on in our area, like the study of cow flatulence on respiratory systems. How are we going to ensure these research projects we invest in are meaningful?
- What are we thinking along the lines of depleting substance abuse in our area? Do we have plans yet and will we get an opportunity to participate in these meetings and be a part of these think tanks?
- These commitments over the next 10 years sound expensive, how are we paying for it all - consolidations, loss of jobs, closing facilities?
- As far as community hospitals go, I am assuming they will fall under one umbrella and the new health care system, right? What about the existing contracts we have, like our skilled nursing facilities and contracted providers? What all are we keeping?
- Let's assume this merger actually happens and is approved, what's the timeframe until we'd be a new health care system finally?
- Will the community investments of \$450 million start on day one or later after we're a functioning health care system?
- Is there a chance this won't be approved?

Holston Valley Medical Center	Wellmont Health System
January 14, 2016 – 10:30 am January 15, 2016 – 2:00 pm January 16, 2016 – 10:00 am January 19, 2016 – 7:00 pm January 20, 2016 – 7:00 am January 26, 2016 – 12:00 pm	LOCATION: Kingsport, TN
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • What part does the Federal Government play in this process? • What if one state approves and the other does not? • If there is no competition then there really isn't a need for improvements, correct? • Can we afford to invest \$45 million a year after consolidating services and cutting health care costs without going into more debt? • Are we suspending capital purchases/improvements in preparation for the merger? • I've heard some state lawmakers oppose. Do we know who they are? • Will we still have two Level One Trauma Centers? If not, would it be centrally located? • When services are consolidated, have you projected the loss of jobs? • An employee's husband stated he felt there was no concern for Wellmont if the merger didn't take place. • What would the transition phase look like if it is determined one of our current facilities will be utilized for something different? • Do both states have the same time period of which they would be expected to oversee/supervise the operations of the new health system? • Will there be details in the COPA outlining how the states will provide oversight? • Are/will the two states be working together or independently? • Will the COPA satisfy the FTC? 	

Mountain View Regional Medical Center	Wellmont Health System
January 12, 2016 – 7:00 am January 13, 2016 – 2:00 pm	LOCATION: Norton, VA
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • Who, at a state level, will be receiving the report? • Do you see a “mass exodus” with regards to our physicians/clinical staff? • Will insurance plans be decided before or after everything is done? • If the states do not approve, then what? 	

Lonesome Pine Hospital	Wellmont Health System
January 12, 2016 – 2:00 pm January 13, 2016 – 7:00 am	LOCATION: Big Stone Gap, VA
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • If State of Tennessee and State of Virginia do not approve everything, do we still move forward? • If you read in the pre-submission report that the hospitals will run for 5 years does that mean we run as is or will there be change of some sort? • Do things change after 5 years? • What about jobs? • If a person is marked as a no hire at one facility and the other health system hires that person and then that person is, yet again let go, they wouldn’t have anywhere to go*- would they? • In respiratory, there is a pool of workers so will that pool be eligible to move to another facility? • Will the new company actually take info from the inside (clinical areas and areas as a whole)? • Is Lee County being considered at all? 	

2. MOUNTAIN STATES HEALTH ALLIANCE TOWN HALL MEETING SUMMARIES

Blue Ridge Medical Management Corp.	Mountain States Health Alliance
January 19, 2016 – 5:15 pm January 20, 2016 – 8:00 am January 20, 2016 – 5:15 pm January 22, 2016 – 7:30 am	LOCATIONS: Johnson City, TN Mountain City, TN Kingsport, TN Abingdon, VA
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • Will we adopt Wellmont’s EHR or will they adopt ours? • Are we going to change the dress code? <ul style="list-style-type: none"> ○ Will we still have to wear this blue? • Will family practice sites have to reapply to be certified as a patient centered medical home (PCMH)? • Has there been any discussion regarding GME positions that would be offered? <ul style="list-style-type: none"> ○ Added? ○ New residency programs? • What has been the response from ETSU? 	

Mountain States Corporate Offices	Mountain States Health Alliance
January 18, 2016 – 5:15 pm January 15, 2016 – 5:15 pm January 19, 2016 – 9:00 am January 7, 2016 – 10:00 am January 22, 2016 – 2:00 pm January 13, 2016 – 3:00 pm January 22, 2016 – 3:30 pm	LOCATION: Johnson City, TN
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • What is the cost of getting the State “COPA” agreements? • How do the residents of Kingsport feel about this merger? • How will for-profit be handled as is related to MSMG & Wellmont’s Physician groups? <ul style="list-style-type: none"> ○ Will they remain for-profit? • Will the new entity be not for profit? • What happens if one state only approves? • What EHR would we go with? • If the merger doesn’t happen, can Wellmont stand on its own? • Will the two IS Departments be merged and has there been any discussion about how the new department will be organized? • Will the newly formed company have a new name and new logo? • Has there been any discussion on how to handle behavioral health across our region with respect to the new company? Will we continue with psych services? • Has a budget been detailed out for how we will cover all expenses for IS systems? Will the “up to \$150 million for IT Systems cover everything?” • Has there been consideration regarding the new system partnering with the community and education systems to assist with college tuitions, increase job opportunities, etc. in order to 	

<p>improve the standard of living, raise education levels and therefore improve community health?</p> <ul style="list-style-type: none"> • Does the merger ultimately have to be approved by the FTC? • Are the TN and VA state offices communicating with each other about the merger?

Dickenson Community Hospital	Mountain States Health Alliance
January 18, 2016 – 1:30 pm	LOCATION: Clintwood, VA
QUESTIONS/COMMENTS:	
<ul style="list-style-type: none"> • No questions or comments received at Town Hall meeting. 	

Franklin Woods Community Hospital	Mountain States Health Alliance
January 14, 2016 – 7:15 am January 19, 2016 – 11:00 am January 21, 2016 – 9:00 pm	LOCATION: Johnson City, TN
QUESTIONS/COMMENTS:	
<ul style="list-style-type: none"> • Public sentiment - is it changing from fears of becoming a monopoly? • Are we merging or are we buying them out? • Premier contracts currently used today? • Will Unicoi still be built? • Services such as services outsourced at Wellmont but MSHA are in house - how will that be handled? • IT platform for FBU - CPM currently used - will we be moving to Soarian? 	

Home Health	Mountain States Health Alliance
January 19, 2016 – 7:30 am (Mediserve Gray) January 20, 2016 – 8:30 am (Johnson City) January 26, 2016 – 8:30 am (JMH Abingdon)	LOCATION: Johnson City, TN
QUESTIONS/COMMENTS:	
<ul style="list-style-type: none"> • No questions or comments received at Town Hall meetings. 	

Indian Path Medical Center	Mountain States Health Alliance
January 18, 2016 – 4:00 pm January 19, 2016 – 9:00 am January 20, 2016 – 7:00 am January 21, 2016 – 1:00 pm	LOCATION: Kingsport, TN
QUESTIONS/COMMENTS:	
<ul style="list-style-type: none"> • What did the slide mean that said “Provide credit for accrued vacation and sick leave”. • When will we hear back from the COPA filing? • If Tennessee or Virginia make changes to the COPA would both states have to approve the changes to proceed? • Do you foresee any opposition? • Dr. Morris Seligman was on the line and commented on IT. He stated no decision has been made yet as to what system would be used but that with all will be on a common platform. He stated even if the merger is successful it will be at least 2018 before changes would be 	

- made.
- What will be the displacement rate of employees after the merger takes place? Is there a certain percentage that will lose their jobs?

Johnson County Community Hospital	Mountain States Health Alliance
January 19, 2016 – 4:30 pm January 22, 2016 – 12:00 pm	LOCATION: Mountain City, TN
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • Will there be a new name? • Will our insurance change? • If they did not allow us to retain our current PL and sick time, what would have happened? • Would it be possible for an urgent care to be at JCCH and if not, can our ED bills be lowered for TM's and families since we don't have access to an urgent care? 	

Johnson City Medical Center / Niswonger Children's Hospital	Mountain States Health Alliance
January 19, 2016 – 7:00 pm January 20, 2016 – 11:00 am January 20, 2016 – 2:00 pm January 21, 2016 – 7:00 am	LOCATION: Johnson City, TN
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • When will the merger take place? • When the merger takes places, what about prices as there will be a monopoly? • What will happen with our benefits? As an additional question about benefits we are asked why our Wellness Center dues were more than other fitness centers, not making it affordable? • Has there been opposition to the merger? • I have elderly neighbors who are concerned about having a choice for healthcare, what can I share with them? • Are we looking at mental health programs for children? 	

Johnston Memorial Hospital	Mountain States Health Alliance
January 18, 2016 – 7:30 am January 18, 2016 – 9:00 am January 20, 2016 – 7:30 am (ED Committee) January 21, 2016 – 12:30 pm January 21, 2016 – 5:00 pm January 21, 2016 – 7:30 pm January 25, 2016 – 9:00 am January 28, 2016 – 6:00 pm January 28, 2016 – 7:30 pm	LOCATION: Abingdon, VA
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • What is the time frame for IT conversion to a common IT platform? 	

- There are two urgent cares in the area (Abingdon). What is the plan to deal with the duplication of services after the merger?
- How soon after the merger will we know the impact on our (ED physicians) jobs? Is there a plan to consolidate into one big ED group?
- Are certain organizations that know about the potential merger going to continue to fight it? Will it delay the process?
- How will we promote a drug free community?
- Will we standardize equipment like IV pumps?
- Will we be getting rid of MedHost?
- Will we all go to CrestPoint?
- What will we do about the 3rd grade education initiative?
- After states approve, does it go to the federal government?
- What is Anthem’s primary issue with the merger?
- Will benefits change?
- Will benefits be equivalent to what we have now?

Norton Community Hospital	Mountain States Health Alliance
January 19, 2016 – 1:30 pm January 19, 2016 – 8:30 pm January 20, 2016 – 7:30 am January 21, 2016 – 10:00 am January 21, 2016 – 1:30 pm	LOCATION: Norton, VA
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • No questions or comments received at Town Hall Meetings 	

Russell County Medical Center	Mountain States Health Alliance
January 26, 2016 –7:00 am January 26, 2016 – 6:00 pm January 28, 2016 – 11:00 am January 28, 2016 – 2:00 pm	LOCATION: Lebanon, VA
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • No questions or comments received at Town Hall meeting. 	

Smyth County Community Hospital	Mountain States Health Alliance
January 19, 2016 – 6:30 pm(Pharmacy Task Force) January 20, 2016 –3:30 pm January 21, 2016 – 3:00 pm January 21, 2016 – 3:30 pm (Francis Marion Manor)	LOCATION: Marion, VA
QUESTIONS/COMMENTS: <ul style="list-style-type: none"> • Current timeline for finalization of the merger? • Concerns about no competition. One system versus two. 	

- What you said about ‘what could be accomplished if the merger happened that couldn’t happen otherwise’ explain what you meant.
- Assuming the merger happens, what monitoring will be in place to assure the quality has actually improved and goals achieved?

Sycamore Shoals Hospital	Mountain States Health Alliance
January 18, 2016 – 10:00 am January 18, 2016 – 6:00 pm January 21, 2016 – 12:30 pm	LOCATION: Elizabethton, TN
QUESTIONS/COMMENTS:	
<ul style="list-style-type: none"> • What electronic health records system will we be using? • How do we get around the anti-trust issue? • What will be the new name and logo? • What will happen with employees that currently work for both Mountain States and Wellmont in regards to service years and PTO, etc.? • Which company has a more competitive pay scale? 	

Unicoi County Memorial Hospital	Mountain States Health Alliance
January 19, 2016 – 1:00 pm January 19, 2016 – 6:30 pm	LOCATION: Erwin, TN
QUESTIONS/COMMENTS:	
<ul style="list-style-type: none"> • Whose benefits package will we adopt? • How will this affect the construction of the new hospital in Unicoi Co? 	

Woodridge Psychiatric Hospital	Mountain States Health Alliance
January 19, 2016 – 7:15 pm January 21, 2016 – 4:00 pm	LOCATION: Johnson City, TN
QUESTIONS/COMMENTS:	
<ul style="list-style-type: none"> • Both have urgent clinics - can we keep them open longer to ensure costs are controlled but ensure access? • Do you have a model to follow from another company that has done this? • How do you know what to keep/what not to keep? • Excited about opportunities for mental health • Target not only the addiction piece on drug abuse but also the chronic piece (residential gaps) • Explore/pursue behavioral health center of excellence within next 6 months 	

5. COMMUNITY ENGAGEMENT EFFORTS

Since announcing the proposed merger in April 2015, the Parties have planned and/or participated in numerous community events and presentations, and a significant number of media interviews, with the goal of informing the community about the merger and soliciting and creating opportunities for the public to provide feedback. Below is a list of all external community engagement efforts of the Parties since the announcement of the proposed merger.

Presentation templates and handouts used at various community events and presentations are included as part of **Attachment D**.

A. COMMUNITY EVENTS AND PRESENTATIONS

Table 7. COMMUNITY EVENTS & PRESENTATIONS	
April 2, 2015	Proposed merger announcement public event
April 24, 2015	Kingsport Chamber breakfast
May 1, 2015	Bristol Tennessee/Virginia Chamber breakfast
May 6, 2015	Washington County Virginia Rotary
May 19, 2015	Johnson City Chamber Board
June 8, 2015	Kingsport Chamber Board
June 10, 2015	Southwest Virginia Health Authority
June 24, 2015	Bristol Tennessee/Virginia Chamber Board
July 7, 2015	Bristol Tennessee/Virginia Noon Rotary
July 23, 2015	Washington County Virginia Chamber Board
August 13, 2015	Elizabethton Community Round Table
August 20, 2015	Abingdon Community Round Table
August 20, 2015	Mental Health & Addiction Steering Meeting
August 24, 2015	Population Health Steering Committee
August 28, 2015	Kingsport Chamber Breakfast
September 3, 2015	Virginia Department of Health Public Hearing
September 8, 2015	Health Children Steering Committee
September 9, 2015	Mountain States Foundation Women's Luncheon
September 15, 2015	Marion Community Road Table
September 16, 2015	Johnson City Press Public Forum
September 17, 2015	Mental Health & Addiction Steering Committee
September 19, 2015	Sorensen Institute presentation
September 19, 2015	Lead Virginia
September 24, 2015	Research & Academics Steering Committee
September 24, 2015	Erwin Community Round Table
September 29, 2015	Lebanon, Virginia, Community Round Table
September 30, 2015	Johnson City Rotary
October 1, 2015	Kingsport Community Round Table
October 6, 2015	Duffield Community Round Table
October 13, 2015	Healthy Children & Families Steering Committee
October 15, 2015	Bristol Community Round Table
October 16, 2015	Regional Health Care Symposium
October 20, 2015	Wise Community Round Table

October 21, 2015	Mental Health & Addiction Steering Committee
October 22, 2015	Johnson City Community Round Table
October 22, 2015	United Way of Southwest Virginia Summit
October 26, 2015	Population Health & Healthy Communities Steering Committee
October 28, 2015	Research & Academics Steering Committee
November 10, 2015	Healthy Children & Families Steering Committee
November 12, 2015	Johnson City Rotary
November 16, 2015	All Work Groups Meeting – Accountable Care Communities
November 19, 2015	Mental Health & Addiction Steering Committee
December 2, 2015	Research & Academics Steering Committee
December 8, 2015	Healthy Children & Families Steering Committee
December 18, 2015	Mental Health & Addiction Steering Committee
December 18, 2015	All Work Groups Meeting – Impact of Opioids in Appalachia
January 5, 2016	Healthy Children & Families Steering Subcommittee
January 12, 2016	Healthy Children & Families Steering Committee
January 13, 2016	Research & Academics Steering Committee
January 18, 2016	Population Health Steering Committee
January 27, 2016	Research & Academics Steering Subcommittee
February 2, 2016	All Work Groups Meeting – Early Brain Development and Toxic Stress
February 4, 2016	Research & Academics Steering Committee

See **ATTACHMENT D**: Community Presentations and Materials

B. MEDIA INTERVIEWS

Table 8. MEDIA INTERVIEWS	
April 2, 2015	Proposed Merger announcement interviews
April 22, 2015	Kingsport Times News editorial board
April 22, 2015	WJHL editorial board
April 23, 2015	WCYB editorial board
April 23, 2015	Johnson City Press editorial board
May 7, 2015	WKPT editorial board
June 8, 2015	HealthLeaders Media
June 10, 2015	Community Workgroups announcement & interviews
June 11, 2015	Modern Healthcare
August 24, 2015	WJHL interview
September 16, 2015	Letter of Intent announcement interviews
September 16, 2015	Johnson City Press Forum and follow-up interviews
October 6, 2015	Interview with WCYB
October 12, 2015	Interview with Johnson City Press
October 16, 2015	Interview with the Bristol Herald Courier
October 19, 2015	Interview with The Business Journal
November 11, 2015	Interviews with The Tennessean and WJHL
November 12, 2015	Interview with The Tennessean
November 13, 2015	Statement provided to the Johnson City Press, Roanoke time and WKPT
November 16, 2015	Statement provided to WJHL
November 20, 2015	Statement provided to WJHL
December 1, 2015	Statement provided to WCYB
December 9, 2015	Statement provided to the Johnson City Pres
December 15, 2015	Statement provided to The Business Journal and the Johnson City News & Neighbor
December 17, 2015	Statement provided to WJH
December 23, 2015	Statement provided to The Post
December 28, 2015	Statement provided to the Johnson City Pres
December 30, 2015	Statement provided to WXBQ and the Kingsport Times-News
January 7, 2016	Media briefing for area media
January 7, 2016	Interview with Modern Healthcare
January 7, 2016	Interview with Kingsport Times-News
January 13, 2016	Statement to The Greeneville Sun
January 18, 2016	Interview with WCYB
January 27, 2016	Statement to WXBQ
February 3, 2016	Interview with Bristol Herald Courier
February 3, 2016	Interview with WCYB
February 9, 2016	Interview with WJHL
February 10, 2016	Kingsport Rotary Club (noon meeting)
February 12, 2016	Regional legislative breakfast

6. COMMUNITY GROUP MEETINGS

Leaders from both systems have also talked with community members throughout the region, in auditoriums, coffee shops and restaurants, local businesses, higher education centers, and other venues, to seek input on the new health system the Parties envision for the region. Through the Community Health Work Group initiative in partnership with East Tennessee State University (ETSU), more than 150 community members to date have participated in work groups focused on discussing four key areas for health improvement in the region: Mental Health & Addiction, Healthy Children & Families, Research & Academics, and Population Health & Healthy Communities. Additionally, in cooperation with the College of Public Health at ETSU and in connection with the Parties' goal to improve health care services through the new health system, the Parties have jointly sponsored and funded the region's most substantial community health improvement assessment effort to date. The Parties also conducted 10 roundtable meetings where more than 175 community members gathered to discuss important local health issues.

A. COMMUNITY HEALTH WORK GROUP MEETINGS

The Community Health Work Groups have served an important role in helping raise awareness of the proposed merger, solicit feedback from members of the community and discuss the factors in the region which lead to poor health outcomes. The schedule for these meetings is below and summaries of all of the meetings are included in this Exhibit: The Community Health Work Group Charters and Membership Lists are attached as other Exhibits to this Application.

Mental Health & Addiction Committee *(Meetings held from 9:30-Noon)*

- Thursday, August 20th, Millennium Centre, Johnson City
- Thursday, September 17th, Southwest Virginia Higher Education Center, Abingdon
- Wednesday, October 21st, Millennium Centre, Johnson City
- Thursday, November 19th, Southwest Virginia Higher Education Center, Abingdon
- Friday, December 18th, Millennium Centre, Johnson City

Healthy Children & Families Committee *(Meetings held from 9:30-Noon)*

- Tuesday, September 8th, Southwest Virginia Higher Education Center, Abingdon
- Tuesday, October 13th, Millennium Centre, Johnson City
- Tuesday, November 10th, Southwest Virginia Higher Education Center, Abingdon
- Tuesday, December 8th, Millennium Centre, Johnson City
- Tuesday, January 5th, Southwest Virginia United Way office (subcommittee meeting)_
- Tuesday, January 12th, Southwest Virginia Higher Education Center, Abingdon

Population Health & Healthy Communities Committee *(Meetings held from 9:30-Noon)*

- Monday, August 24th, Southwest Virginia Higher Education Center, Abingdon
- Monday, September 28th, Millennium Centre, Johnson City
- Monday, October 26th, Southwest Virginia Higher Education Center, Abingdon
- Monday, November 16th, Millennium Centre, Johnson City
- Monday, January 18th, Southwest Virginia Higher Education Center, Abingdon

Research & Academics Committee (*Meetings held from 9:30-Noon*)

- Thursday, September 24th, Millennium Centre, Johnson City
- Thursday, October 28th, Southwest Virginia Higher Education Center, Abingdon
- Wednesday, December 2nd, Millennium Centre, Johnson City
- Wednesday, January 13th, Southwest Virginia Higher Education Center, Abingdon
- Wednesday, January 27th, ETSU, (subcommittee meeting)
- Thursday, February 4, Millennium Centre, Johnson City

All Community Health Work Groups Meetings

- Monday, November 16 (9:00 – 10: 30), Millennium Centre, Johnson City, Topic: Accountable Care Communities
- Friday, December 18 (9:30 – 11:30), Millennium Centre, Johnson City, Topic: Impact of Opioids on Appalachia
- Tuesday, February 2 (9:00 – 10:30), Millennium Centre, Johnson City, Topic: Early Brain Development and Toxic Stress

B. COMMUNITY HEALTH ROUNDTABLE MEETINGS

More than 175 attendees participated in 10 roundtable meetings held from August to October in 2015. At these meetings, data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, “**What can you do to improve health in the community?**” At the end of the two rounds of small group discussion, notes were collected from the table moderators to be used for a final large group discussion to allow for further comment and clarification. Representatives from ETSU then compiled and analyzed this feedback and authored detailed summary reports included in **Attachment E**.

Included in **Attachment E** is a report summarizing the overall findings from the Community Health Roundtable meetings and a summary report for each individual Community Health Roundtable meeting.

The schedule of the Roundtable meetings is below.

Schedule of 2015 Roundtable Meetings

(Meetings for Community Members; meetings held from 5:30-7:30 p.m.)

- Thursday, August 13th, Tennessee College of Applied Technology, 425 TN-91, Elizabethton, Tenn.
- Thursday, August 20th, Southwest Virginia Higher Education Center, One Partnership Circle, Abingdon, Va.
- Tuesday, September 15th, Holston Hills Community Golf Course (Multi-Purpose Room), Marion, VA
- Thursday, September 24th, Tennessee National Guard Armory, 615 S. Main Street, Erwin, TN (Unicoi)
- Tuesday, September 29th, Russell County Conference Center, Lebanon, VA
- Thursday, October 1st, Food City Press Room, Kingsport, TN
- Tuesday, October 6th, Crooked Road Tech Center, Duffield, VA
- Thursday, October 15th, Bristol Motor Speedway, Bristol, TN
- Tuesday, October 20th, The Inn at Wise (Ballroom), Wise, VA
- Wednesday, October 21, United Way 2020 Summit with Robert Wood Johnson Foundation, Southwest Virginia Higher Education Center
- Thursday, October 22nd, Memorial Park Community Center, 510 Bert Street, Johnson City, TN

See **ATTACHMENT E**: Community Roundtable Meetings Summary Report (Includes Data from All Roundtable Meetings) & Community Roundtable Meeting Summary Reports by Community

C. SOUTHWEST VIRGINIA 2020 SUMMIT REPORT

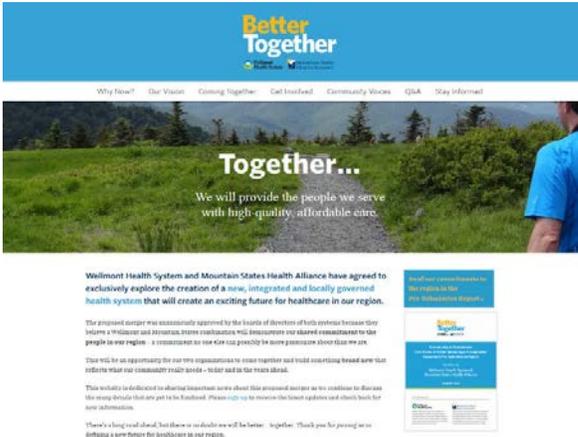
During the Southwest Virginia 2020 Summit, 65 attendees participated in a World Café style discussion around the question, “What can you do to improve health in the community?” At the end of group discussion, notes were collected from the table moderators, or “Table Hosts”, to be used for a final large group discussion to allow for further comment and clarification. Representatives from ETSU then compiled and analyzed this feedback and authored a summary report included in **Attachment F**.

Attachment F includes a summary report from the Southwest Virginia 2020 Summit.

See **ATTACHMENT F**: Southwest Virginia 2020 Summit Report

7. BETTER TOGETHER WEBSITE --- www.BecomingBetterTogether.org

In April 2015, Wellmont Health System and Mountain States Health Alliance launched the Better Together website to serve as a central point for information on the proposed merger and to provide anyone interested with an opportunity to learn more about the proposed merger and ask questions or provide feedback. The website contains information about the process the systems are following to obtain a Certificate of Public Advantage (COPA) in Tennessee and a Letter Authorizing Cooperative Agreement in Virginia, including announcements, frequently asked questions and opportunity for comment and community involvement.



The website also includes important documents related to the merger, including the Pre-Submission Report, the Letter of Intent filed with both States, status reports from Community Health Work Group meetings, and the shared vision of Wellmont and Mountain States.

Following the filing of the applications for a COPA in Tennessee and a Letter Authorizing Cooperative Agreement in Virginia, the Parties plan to make the public portion of these applications available on the website.

A. QUESTIONS & ANSWERS (Q&A)

Since April 2015, the Parties have received through the website hundreds of questions and comments from members of the community and employees from both systems. Many of the “most frequently asked questions” have been published and distributed on the website, in Better Together newsletters, discussed in internal town hall meetings, and other community input venues.

Table 9 below includes a complete list of the Q&A from the Better Together website. The Parties will continue to update this page with new questions and answers throughout the application review and approval process.

Table 9. Q&A FROM BECOMINGBETTERTOGETHER.ORG AS OF 2/9/16	
Questions	Answers
What does this mean for existing contracts or relationships for services (including labs, etc.)?	Today, nothing changes as both Wellmont and Mountain States continue as separate and independent organizations. It’s business as usual, and we’re committed to keeping our valued partners and the community informed along the way. We do know that any existing contracts that extend past the official closing will be honored by the proposed new organization, and anything that affects clinical services will be carefully considered with input from our physician leaders.
Will nurses be involved in the planning efforts for the proposed new organization?	<p>Yes, absolutely – there will be a number of ways nurses from both Wellmont and Mountain States will be heard through this process. In fact, we won’t be successful in accomplishing what we hope to do without the support and input of our nurses. As the Integration Council continues to progress, it will activate functional teams that will provide recommendations related to the operations of a merged system. We will want nursing to be well represented and active on these teams, which will focus specifically on areas like clinical operations, academics and research, and population health.</p> <p>Throughout this process, we encourage nursing leadership to stay closely in touch with hospital leadership to communicate questions and thoughts from nursing staff. Meanwhile, we will continue to seek the input of our team members in a variety of ways, including this website, our newsletter, internal and external town hall meetings, and more. We recognize the vital role our nurses play every day but especially in shaping the future of our proposed new system, and we’re committed to keeping our nurses updated on any opportunities to be involved.</p>
How does this decision impact ETSU?	<p>We believe our proposed new organization would positively impact East Tennessee State University and other academic institutions, as it would allow us to further advance clinical education in the region and to be more competitive in pursuing research dollars currently flowing elsewhere nationally. In fact, the president of ETSU will also serve as an ex-officio member of the new system’s Board.</p> <p>Both Mountain States and Wellmont have been forced to reduce residency positions in recent years. We believe this partnership can help reverse that</p>

Table 9. Q&A FROM BECOMINGBETTERTOGETHER.ORG AS OF 2/9/16	
Questions	Answers
	trend. We would partner with ETSU and others to strengthen the pipeline of physicians and allied health professionals and to attract research jobs and investments in our region. In addition, ETSU would help to conduct a substantial comprehensive regional health needs assessment to address health gaps and disparities, which will help shape the future direction of the potential new system and establish its priorities.
Which EHR system will be used by the combined entity?	<p>That is a major decision that has both strategic and clinical implications, and no decisions like this would be made until after the transaction closes (expected no earlier than the end of 2015). We will include significant input from our physicians before making any major decisions that will impact clinical care.</p> <p>What we do know today is that our combined organization would have a single EHR platform to ensure our facilities and providers work as seamlessly as possible with each other. We promise to share more information as soon as it's available.</p>
Will the community be able to provide input regarding the new name of the future organization?	Yes! As we explore creating a new, locally governed health system, we want to be sure the community – along with our own team members and physicians – has input in shaping it. We are not quite ready to begin the process of naming or branding, but stay tuned for how to chime in.
What is a COPA, and how does the state decide whether to grant a COPA?	<p>A COPA (Certificate of Public Advantage) in Tennessee is the effective approval of a cooperative agreement between two hospitals or health systems. It authorizes the parties to merge and directs the state to actively supervise aspects of the new health system to ensure it continues to benefit the community by providing healthcare that is affordable, accessible and high-quality.</p> <p>In Virginia, we will pursue a cooperative agreement process. The state evaluates the potential benefits of a cooperative agreement and considers whether one or more of the following benefits might result from the cooperative agreement, and whether those benefits outweigh any possible disadvantages:</p> <ul style="list-style-type: none"> • Enhancement of the quality of hospital and hospital-related care provided to citizens • Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities • Gains in the cost-efficiency of services provided by the hospitals involved • Improvements in the utilization of hospital resources and equipment • Avoidance of duplication of hospital resources
What has been announced?	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 be among the best in the

Table 9. Q&A FROM BECOMINGBETTERTOGETHER.ORG AS OF 2/9/16	
Questions	Answers
	nation and to address the serious health issues that affect our region. The new health system would bring together the capabilities of both organizations – under a new name – to serve the region and result in unprecedented quality and value.
Who made this decision?	The decision to explore a merger was made by the Wellmont and Mountain States boards of directors, and reflects a vision they developed following more than a year of merger discussions, internal analysis within each system and thoughtful conversations in the community. It reflects the desires of both organizations to ensure our region has access to the highest quality, affordable healthcare, and that we are able to meet the ever-changing needs of our communities.
Why was this decision made?	<p>In addition to the significant headwinds for hospitals nationally, our region suffers from serious health issues that need to be addressed. We have some of the highest rates of cardiovascular disease, diabetes and pulmonary disease in the country. We are experiencing an epidemic of addiction and untreated mental illness without access to the right level of inpatient and outpatient treatment. And, we admit more people to the hospital per thousand than most other areas of the nation.</p> <p>The cost of this poor health is not sustainable. Despite the high-quality care both systems provide today, there is more we can be doing to contribute to improving the health of our region. We believe that by working together in an integrated system, we could redirect spending away from wasteful duplication that has not added value, and invest in what evidence has shown will help make our region healthier while controlling costs and making healthcare more affordable.</p>
How will Wellmont and Mountain States bring distinct organizations and cultures together?	Culture and heritage are critically important to both organizations. That’s why we are creating a joint board task force, an integration council and a clinical council. Over the next many months, our board members and executive and physician leaders will be investing themselves in the work of exploring how to weave our operations and cultures together, so we benefit from the best of both.
Will projects planned be put on hold while this merger is explored?	Today, nothing changes as both Wellmont and Mountain States continue as separate and independent organizations. It’s “business as usual” for both of us.
What does this mean for our community?	<p>This would be a significant step forward for patient care, wellness, affordability and health education in our region. We would:</p> <ul style="list-style-type: none"> • Work to eliminate unnecessary duplication in our operations, enabling us to invest more in better coordinating patient care, improving quality and enhancing access throughout the communities we serve; • Invest in high-level specialty services, allowing more people to receive the care they need close to home; • Work with ETSU and our academic partners to conduct a comprehensive regional health needs assessment; then work hand-in-

Table 9. Q&A FROM BECOMINGBETTERTOGETHER.ORG AS OF 2/9/16	
Questions	Answers
	<p>hand to tackle some of the most important health issues our region faces, including high rates of smoking, obesity, physical inactivity and the adverse health effects that follow, such as high blood pressure, diabetes, heart disease and cancer;</p> <ul style="list-style-type: none"> • Work to improve access to substance abuse and mental health services in the region; and • Work with academic institutions, such as ETSU, to strengthen the pipeline of physicians and allied health professionals, and to attract research jobs and investments in our region.
What is the approval process for this merger?	<p>Upon completion of due diligence, should both systems vote to go forward, Wellmont and Mountain States will execute a definitive agreement, which will be followed by a process to obtain Tennessee and Virginia approvals of the merger. This will likely take us through the end of 2015.</p> <p>Together we will pursue a Certificate of Public Advantage (COPA) in Tennessee and a cooperative agreement in Virginia, which would permit the merger to go forward and establish a process for the states to supervise our proposed new organization. This agreement will ensure that the people we serve receive the highest level of care at an affordable cost.</p>
What happens next?	<p>Following a definitive agreement, we will enter a government approval phase that will likely take us through the end of 2015. During this time and until the moment of closing, both organizations will continue “business as usual” as two separate and independent organizations.</p>
Where can I learn more/stay updated?	<p>We will be communicating regularly over the coming days, weeks and months. Stay tuned. And, be sure to check back here for the latest updates.</p>
What are the plans for the future of pediatrics care?	<p>We see great opportunity to enhance and expand access to pediatric services through our proposed merger across the region. What that looks like specifically is part of the planning work ahead as we first identify gaps in what our communities need versus what either of our organizations offer today and can improve through the proposed merger. We look forward to sharing more information as our planning efforts unfold.</p>
Are there plans to close one of the two hospitals in Norton, Virginia?	<p>There are no plans to close any hospitals. The services and programs offered by both organizations through our hospitals and other locations are always evolving in ways that reflect the input of our physicians and the needs of our patients. Long-term, the new organization will conduct a comprehensive health needs assessment to identify opportunities for new community-based resources and possibilities that don’t exist today for our employees and communities.</p>
Won't we lose competition by combining Mountain States and Wellmont?	<p>Actually, with this merger, our patients and our region will have access to more choices and healthcare options than they do today. By combining our resources, we can draw more specialists and add new services for which people now have to drive hours to find. In addition, this potential</p>

Table 9. Q&A FROM BECOMINGBETTERTOGETHER.ORG AS OF 2/9/16	
Questions	Answers
	<p>new organization would involve the institution of a Certificate of Public Advantage or COPA in TN and a cooperative agreement in VA, which establishes enforceable commitments to guard against effects from any loss of competition.</p> <p>A COPA in TN / cooperative agreement in VA will mean that the health system must meet commitments in driving down unnecessary costs, keeping care affordable, improving quality of care, enhancing access and benefiting the communities we serve.</p>
How will patients benefit once our two organizations come together?	<p>Here are just a few of the ways our proposed future system will serve you, our patients:</p> <ul style="list-style-type: none"> • We'll invest in expanding access to care and services, while also maintaining access in our rural communities, so you can get the care you need close to home – at a cost that's affordable for you and your family. • Wherever you go in our integrated system to receive care – no matter which doctor you see – your care team will have your medical history at their fingertips through a systemwide technology platform, ensuring the care you receive takes your overall health into account. • Together, we'll be better able to coordinate your care between your doctor, the hospital and outpatient services like home health and pharmacy – improving the quality of care you receive and creating a superior experience every time you visit us. • We'll work on improving access to important services that so many people in our region need, like substance abuse treatment to stop the cycle of addiction and improved mental health services. • Working with East Tennessee State University, we'll identify and tackle head-on important health issues in our region, like heart disease, addiction and diabetes. • And much more.
Will there be any facility closures?	<p>Today, we are still very early in exploring the specifics of what our future organization will look like. What we do know today is our proposed new organization would be committed to providing people the care they need close to home. There will be changes throughout the new organization in order to offer new and different services, depending on what the community needs. We promise to share more information as soon as it's available.</p>
What color scrubs will the employees of the new system wear?	<p>At this point, there are no plans to make any changes. In the future, any changes like this would be determined with input from clinical leadership in the hospitals.</p>
Once the new system is formed, will employees receive tuition discounts or	<p>Our goal is to ensure we have a culture that attracts and retains outstanding team members, and provides opportunity for professional growth. These kinds of opportunities will be discussed at the appropriate time, but the objective will be to ensure a learning</p>

Table 9. Q&A FROM BECOMINGBETTERTOGETHER.ORG AS OF 2/9/16	
Questions	Answers
reimbursements because of the system's relationship to ETSU?	environment.
How will employee benefits be impacted (retirement, insurance, PTO, pension plan, etc.)?	We understand how important these types of questions are. Today, we are still very early in exploring the specifics of what our future organization will look like. What we can tell you today is that we would aspire to be one of the best healthcare employers in the country. Together, we would nurture a culture that promotes employee satisfaction and opportunity for professional growth. We promise to share more information when we are able.
Will employees be offered an early retirement option?	Today, we are still very early in exploring the specifics of what our future organization will look like. We promise to share more information when we are able.

B. PUBLIC FEEDBACK ON COMMUNITY ENGAGEMENT

Since April 2015, there have been nearly 15,000 visitors to the Better Together website, and more than 50,000 page views. Website visitors are invited to submit a question or comment through the site, and more than 200 comments and questions have been received to date. The previous Section A included the questions submitted through the website. This Section summarizes and categorizes the questions as well as the comments received on the website.

These questions and comments are included in their entirety and organized below into the following categories:

- Community Health Work Groups ◦ Community Health Roundtables
- Process ◦ Operations ◦ Organizational Structure
- Services ◦ Access ◦ Value ◦ Choice
- Workforce ◦ Staffing ◦ Benefits ◦ Training
- General ◦ Miscellaneous

1. PUBLIC FEEDBACK: COMMUNITY HEALTH WORK GROUPS/ COMMUNITY HEALTH ROUNDTABLES

In the Fall of 2015, the Parties launched their effort with ETSU to conduct a series of in-depth discussions about regional health issues through the Community Health Work Group meetings and the Community Health Roundtables with a broad array of stakeholders throughout Southwest Virginia and Northeast Tennessee. These discussions drove a significant number (59) of comments and questions to the BecomingBetterTogether.com website related to the themes, "Community Health Work Groups." Additionally, more than 100 community members expressed interest in participating in the initiative through the website. The comments relating to the Community Health Work Groups and Community Health Roundtables are below.

Table 10. WEBSITE COMMENTS & QUESTIONS		
Category: Community Health Work Groups, Community Health Roundtables		
Date	Name	Question/Comment
6/10/2015	Meg Foster	I am having trouble submitting the link to learn more about participating in a Work Group; it keeps stating validation errors occurred. Please advise, I am interested in any of the 3 groups; Healthy children and families, research and academics, and/or population health and healthy communities.
6/10/2015	Susanna Ashford	I would love to participate in these work groups!
6/11/2015	Doreen Heppert	I have attempted several times to submit the brief form indicating my interest in the Population Health & Healthy Communities work group. I keep receiving an error message "Validation errors occurred. Please confirm the fields and submit it again." I have checked all fields but receive the same validation error.
6/11/2015	Pat Pope	Hello, I am interested in participating in the work groups. When I submit the form, it continues to return a validation error. Please advise.
6/11/2015	Ann Hylton	I am interested in the Healthy Children and Families and Research and

Table 10. WEBSITE COMMENTS & QUESTIONS		
Category: Community Health Work Groups, Community Health Roundtables		
Date	Name	Question/Comment
		<p>Academics work groups. I am unable to submit via the electronic form. I continue to receive an error message.</p> <p>I live in Gray TN. Employer is Appalachian College of Pharmacy where I am assistant professors/ Clinical Pharmacist in the ED at Bristol Regional Medical center.</p> <p>Research and Academics: I am an assistant professor at Appalachian College of Pharmacy and a clinical pharmacist in the ED at Bristol Regional Medical Center. I am the residency program director for Appalachian College of Pharmacy and serve as a preceptor and residency committee member at Bristol Regional Medical Center. I used to work at the VA in Johnson City where I worked closely with members of the ETSU medical program. I feel that I am invested in the medical training in this region; physicians, nurses, pharmacists, and other sub-specialties.</p> <p>Healthy Children and Families: I am a mother to two children, 2.5 years and 8 months. I am also a strong breastfeeding advocate and a member of the local BABE coalition. I highly support the efforts of ETSU pediatrics with the Read N Play programs. I would like to see the work of ETSU/MSHA spread throughout the region to better serve all children. I have the input of a passionate mother and working professional.</p>
6/11/2015	Chris Ketron	I am a Masters prepared psych RN with 15 years in psych and long term care. I am very interested in seeing better treatment options for our mentally ill and substance abuse patients
6/11/2015	Meg Foster	<p>Hello, I still cannot submit on the work group page. I am interested in participating; I would like to be involved in community initiatives to improve health in all age groups. Currently I am a physical therapist and work in the hospital setting and see the effects of disease and unhealthy habits prolonging recovery of patients.</p> <p>I work with patients from all age groups, from tiny infants in the Neonatal intensive care to the elderly. One project that I recently worked on was coordinating the improvement of a healthier surgical candidate for total joint replacement surgeries. Dr. Carver, an anesthesiologist here at HVMC read a study that lowering BMI, smoking cessation, diabetic control and addressing undiagnosed sleep apnea can improve the recovery of patients undergoing surgery.</p> <p>We worked with the YMCA, physical therapists, Diabetes Treatment Center and HMG to emphasize prevention and a proactive approach to healthy living can improve outcomes and return people to independent community living. Improving community health has to reach across the continuum of care to maximize and improve the benefits of a healthy</p>

Table 10. WEBSITE COMMENTS & QUESTIONS		
Category: Community Health Work Groups, Community Health Roundtables		
Date	Name	Question/Comment
		lifestyle. We have to meet people where they currently are and pave the way to optimize their health and pass it on to the next generation.
6/11/2015	Sue Prill, MD MBA	I serve as principal investigator for many of our oncology clinical trials and have been active in research for many years. I would like to be included in the research forums if possible. Thanks.
6/13/2015	Jennifer Miller	I am interested in participating in the Mental Health work group.
6/17/2015	Jeretta Johnson	I am so excited to hear about this in our area. We have a great need for this program.
7/8/2015	Catherine Brillhart	I am interested in participating in a focus group setting. Thank you.
7/8/2015	Gary McGeough	I would like to be a part of the Population Health and Healthy Communities Group
7/8/2015	Kenneth Little	I would like to participate in the Population Health and Healthy Communities work group. Thank you! Ken
7/8/2015	Kristina K. Morris	Unit Coordinator with the Southwest Virginia Medical Reserve Corps. Would be happy to serve on any of the workgroups.
7/8/2015	Mark Overbay	As a retired physician, a former Wellmont employee and current dean of the School of Behavioral and Health Sciences at King University, I would be happy to assist with the Research and Academic committee if any additional help is needed. Mark Overbay, M.D.
7/9/2015	Angie Hagaman	I would like to receive the newsletter, and if possible serve on the mental health and addiction work group.
7/9/2015	Alice McCaffrey	As the Director of the Sullivan County Anti-Drug Coalition, I believe this work is very important and would like to participate in any way that would be appropriate. This is an opportunity to build substance abuse prevention into the new practices and procedures that will be developed.
7/9/2015	Angelee Murray	I am the Founder and Executive Director at Red Legacy Recovery. I would like to serve on the Mental Health & Addictions work group.
7/10/2015	Rhonda Helton	Is it to late to submit my name for the Healthy Children and Families work group?
7/10/2015	Mary Anne Gibson	I consider myself a strong advocate for children and families personally and through my work at the YWCA Bristol via the early childhood programing for 28 years. I look forward to being involved with the Healthy Children and Families Work Group. Will I receive information or do I need to continue to check this website for scheduled meetings?
7/11/2015	Sara Ellis	As a special education teacher for students with multiple disabilities and having worked at the community level in the regional Head Start program (People Inc.) prior to the Bristol Public Schools, I have a great interest in accessibility of health care for our special needs population.

Table 10. WEBSITE COMMENTS & QUESTIONS		
Category: Community Health Work Groups, Community Health Roundtables		
Date	Name	Question/Comment
		Though there are some services available through a few local agencies, we are lacking in the accessibility of some of the specialized health care professionals/needs as evidenced by this population and their families having to sometimes travel well out of the region for treatment and ongoing care. Too, the wonderful health care providers we do have are uncomfortable or simply have not received adequate training in caring for the special needs population. With the capability of saving more micro-premies, the increase in identifying individuals with autism, and drug/alcohol affected babies, the health care system must address the ongoing challenges posed by these individuals.
7/13/2015	Doris Stickley	I would be very interested in working in this area. Our Health Education Series we did at the BPL for two years was very popular, and it dealt with public health and community health concerns. The Library is always a great partner when you want to get out information, too.
7/13/2015	James H. Bangle	Would like to be involved in Mental Health and Addiction Group. I am a retired Lutheran Pastor Licensed Clinical Social Worker in private practice for 23 years. Have been a Law Enforcement Chaplain for 33 years. Lots of other stuff. Thanks for your consideration.
7/14/2015	Rhonda Chafin	Second Harvest would like to be involved in the Healthy Children and Families group. Please keep us posted on upcoming meetings. Rhonda Chafin Executive Director Second Harvest Food Bank of Northeast Tennessee
7/14/2015	Wendy Welch	Greetings - I am a member of the SW VA Health Authority and director of UVA Wise's Graduate Medical Education Consortium. After hearing the presentation at the Authority meeting and discussion with my board, I'd like to offer services to the Research and Academic work group, if feasible for your needs. Thanks. My phone is 276-328-0249.
7/15/2015	Han Chuan Ong	Hello! I am the Dean of the College of Arts & Sciences at King University and I would like to be participate in the working group on Research and Academics. I have a doctoral degree in molecular biology and have been an educator for 10 years.
7/16/2015	Debra Quarles Mills	I would like to be a part of the working group for Healthy Children and Families.
7/16/2015	Cathy Galyon Keramidas	Hello, Dr. Kim Hale told me about the group and asked if I would be interested in joining and I am very interested. I am an associate professor of early childhood special education and I have worked for 10+ years with families of children with disabilities. Please let me know if I would be a good addition to the group. I look forward to hearing from you. Cathy

Table 10. WEBSITE COMMENTS & QUESTIONS		
Category: Community Health Work Groups, Community Health Roundtables		
Date	Name	Question/Comment
7/20/2015	Lisa Tipton	Families Free is a licensed Alcohol and Drug and Mental Health treatment provider. As Executive Director I am very involved in our treatment division and also the provider work for DCS in the North East region. I would like to participate in the Healthy Children and Families workgroup.
7/24/2015	Katie Baker	I'd like to sign up to serve on the Health Children and Families committee.
7/24/2015	Terrie Walker	Hello, I am the Director of Clinical Research at Wellmont CVA Heart Institute. Is there a possibility of being a part of the group or board for Research and Academics? Thank you. Terrie
7/28/2015	Joy Fulkerson	Is it too late to join a work group. I am most interested in Healthy Children and Families and Population Health and Healthy Communities. Thank you.
7/31/2015	Liz Sluss	I am willing to volunteer on this task force as a clinical leader in Womens and childrens . This affects my patient population almost daily
7/31/2015	Liz Sluss	I am willing to volunteer in this arena as there is a huge gap in our region for our children
7/31/2015	Liz Sluss	<p>I see a huge disparity in the southwest VA and North east Tennessee region for services for children with disabilities, like a 4 month waiting list to have your child evaluated for developmental evaluation. Along with as a healthcare worker more and more substance abuse with MOMS and subutex even those in pain clinics the communication between providers is not there and in the end we are seeing fetal demises on the rise and feel it is directly contributed to the abuse and poor communication and guidelines to help the addicted.</p> <p>In example a mom on subutex is failing her drug screens by using multiple types of drugs. They have no consequences or guidelines such as incarceration to protect the infant until delivery. While I dont agree that incarceration is the answer something must be done. To see a beautiful infant who dies due to the mom going into withdrawal or see the ones who live in pain is heartbreaking. With our merger and our region we must come together and do you see this happening?</p>
8/5/2015	Sue Cantrell	are all four groups meeting at the same time?
8/5/2015	Terrie Walker	This is my RSVP to the August 13th meeting at TN college of Applied Technology in Elizabethton. Thank you. Terrie
8/5/2015	Carl Valenti	Would love to learn and participate in anyway to be a part of such a progressive idea.
8/5/2015	Linda Wright	We also need to direct our attention to mental health and drug and alcohol abuse issues in this region. I would advise bringing in leaders from Magnolia Ridge also. East Tennessee and Virginia population are seeing a lot more of alcohol and drug problems which is a problem in the region of Tennessee and

Table 10. WEBSITE COMMENTS & QUESTIONS		
Category: Community Health Work Groups, Community Health Roundtables		
Date	Name	Question/Comment
		Virginia. The crime rate is also skyrocketing, etc Some diagnoses cannot be treated with a medication. Thanks
8/6/2015	Kim Malone	How do I become involved in health care/concern group as a citizen? I think the information mentioned that you were looking for people to be in roundtable groups.
8/6/2015	President, Junior League of Johnson City	Our community impact area is women and children's health with a specific focus on prenatal care and substance abuse. Thank you for adding us to your newsletter!
8/8/2015	Adrienne Hess	My chief concern is with mental health care, but also I'm very concernwed about palliative care, esp. for the elderly who have an operation, go to a rehab, then have relapses, back to the hospital. What does Medicare cover, in Assisted Living facilities, both in Va. and in Tn?
8/9/2015	Mary Wiley	I am currently scheduled to work on 8/13/15 however I will try to get someone to cover part of my shift to attend the Elizabethton meeting. Traveling to Abingdon is just too far at this time from my location.
8/14/2015	Andrew S. Rhinehart	I'm sorry, but I will not be able to attend either of the round table discussions.
8/16/2015	Cathy Puhr	As a newly retired ARNP, and with experience in working with at risk populations, would very much like to be included in the public meetings scheduled by the hospitals
8/18/2015	Alice McDowell	I am signed up for the Thursday, august 20 meeting, but would like to change to the sept 15th, since I live in marion. let me know if this is possible.
8/18/2015	Kim Quiring	I am interested in helping with the Research work group. I have a background in spine research and a member of the Society of Clinical Research Associates. Thank you! Kim 423-277-7075
8/21/2015	Beverly Meadows	I signed up for the Research and Academics work group but have not been informed of a meeting date. Could you please provide? Thank you. Beverly Meadows, PhD, RN
8/24/2015	Sandy Franklin	I would like to know which company will provide our dietary services (Aramark, Cisco??)
8/28/2015	Beverly Meadows	A colleague has been attending the Mental Health meetings where participants are very engaged. When are the future meetings for population health as well as research/academics?
8/31/2015	Rosalee Sites	I signed up for the meetings for Community health as well as the Psych/drug addiction groups. I have not heard of any meetings times/dates. have they strted yet?
9/20/2015	Elbert Dean Ray	I know that maybe this merger is and or will work on these problems in our society with the drug and substance abuse patients but as an employee of Wellmont something needs to be done now and would ask

Table 10. WEBSITE COMMENTS & QUESTIONS		
Category: Community Health Work Groups, Community Health Roundtables		
Date	Name	Question/Comment
		<p>that someone would address these problems as they are now. Putting off what you may do is not solving what is happening at this present time.</p> <p>We need someone to do something now because it is causing a big problem within the hospital setting of helping very sick patients and then throwing in the druggies that disrupt the whole hospital environment and staff, who are not trained and know how to handle these people. Nurses are hired to take care of sick patients period, not drug addicts. We have a very big problem that needs to be addressed in the present time not down the road. Please work on this problem. Thank You</p>
9/24/2015	Trudy Hughes	<p>So excited about the work to address health issues in a wholistic and seamless fashion...</p> <p>Please keep me updated!</p> <p>Thanks!</p>
9/25/2015	Bee Stuart	<p>Kim Short will be coming with me. Her email address is ksshort03@gmail.com.</p> <p>Thank you</p>
9/30/2015	Dennis Golob	<p>Would you please cancel my reservation for the Oct 1 Kingsport meeting. Sorry.</p>
10/1/2015	Rosalee Sites	<p>i cannot attend the roundtable meeting this evening as i ended up with a conflict.</p>
10/18/2015	Bill Francisco	<p>The City of Johnson City has committed 28 acres to develop an environmental education park on King Springs Rd. n/k/a "Jacob's Nature Park at Sinking Creek." The State of Tennessee has committed funding to wetlands expansion and educational signage to address the E. coli in Sinking Creek. This community has donated nearly \$30,000 through four years of annual fundraising with the "Jacob Francisco Memorial Century & Awareness Walk." Those funds are being spent to build a handicap-accessible bridge over Sinking Creek at the park. The development still requires \$30,000 to build a pavilion with a living roof that will function as an outdoor classroom; \$50,000 for wetlands boardwalk; and \$30,000 for an additional bridge to link hiking trails with intended wetlands boardwalk.</p> <p>The non-profit organization, Boone Watershed Partnership, and the City of Johnson City have been working together to develop this little city park in a neighborhood surrounded by young families and seniors in low-income housing initiatives and next door to a group home for adults with intellectual disabilities. This venture merits investment consideration by MSHA/Wellmont as it addresses public health concerns of water quality, childhood obesity, and recreational access for seniors and intellectually disabled neighbors.</p>

Table 10. WEBSITE COMMENTS & QUESTIONS		
Category: Community Health Work Groups, Community Health Roundtables		
Date	Name	Question/Comment
		I will be out of town during the public forum at the Memorial Park Community Center on October 22, 2015; otherwise, I would attend to present this opportunity for tangible investment in the public health of Johnson City. More information about the development may be found at www.jacobfrancisco.com and contacting me at my email address provided above. Thank you for any sincere consideration in this venture.
10/19/2015	Ida Mullins	I am very interested in the initiatives being planned for our community. Please provide me with any information that may describe the progress of the community health initiative. Thank you in advance for your attention.
12/7/2015	Mina McVeigh	I am interested in attending the Mental Health and Addiction Working Group. Do I need to RSVP or register?

2. PUBLIC FEEDBACK: PROCESS, OPERATIONS, ORGANIZATIONAL STRUCTURE

Parties received 32 comments through the Better Together website related to the Tennessee COPA/Virginia Cooperative Agreement process, current or future operations and/or the organizational structure of the proposed new health system. The Parties understand that the proposed merger and cooperative agreement process is unique, and they have worked to address these themes on the Better Together website, in the Pre-Submission Report and in the extensive information provided by the Parties in the Tennessee COPA and the Virginia Cooperative Agreement applications. The comments relating to Process, Operations and Organizational Structure are below.

Table 11. WEBSITE COMMENTS & QUESTIONS		
Category: Process, Operations, Organizational Structure		
Date	Name	Comment
4/2/2015	Zilipah Patton	What are the future plans for involving nursing leadership such as a CNO at the highest level of the leadership team. I know there is a President, CEO, COO, and CFO. However, with this being healthcare it is vital to include clinicians such as a CMO and CNO. Not only for decision making, but advocacy and more. Thank you!
4/2/2015	Zilipah Patton	What are the future plans for involving nursing leadership such as a CNO at the highest level of the leadership team. I know there is a President, CEO, COO, and CFO. However, with this being healthcare it is vital to include clinicians such as a CMO and CNO. Not only for decision making, but advocacy and more. Thank you!
4/2/2015	Michael	How about Highland's Wellness Health System or (Alliance) for a name?
4/3/2015	John Kerber	Do you have any thoughts on what the new system will have to do to meet the COPA conditions in TN and VA?

Table 11. WEBSITE COMMENTS & QUESTIONS		
Category: Process, Operations, Organizational Structure		
Date	Name	Comment
4/3/2015	Tom Conkle	Just curious as to what the combined health care system will be called. I understand it will not be Mountain States or Welmont. When will the new name be announced?
4/3/2015	Adam Honeycutt	Can we name the new group the Appalachian Regional Health Partnership?
4/3/2015	Julia Blair	Where do we submit new name suggestions/ideas? Novus: latin for novel, extraordinary, a new thing. Precedo: latin to surpass, excell. Coactum: latin to bring together, to drive.
4/7/2015	Shane Morgan	I think allowing the employees from both systems the opportunity to submit suggestions for the new organization name would 'jumpstart' the excitement of the merger with the employees. Is this a possibility?
4/16/2015	April Hodges	Our pharmaceutical reps have voiced concerned about being able to come into the different offices as Mountain States doesnt allow them in. Will reps still be allowed to come in to meet with the providers?
4/16/2015	Sharon Sogioka	Will any of the computer systems or software commonly used by either company end up changing?
5/6/2015	Pamela Hartgrove	Why are there no nurses on the merger board? Nursing is the biggest profession in the hospital and it appears that input from nursing has not been sought. There is no discipline better prepared to speak regarding patient needs than the bedside nurse.
5/6/2015	Tina Strong	Will there be any type of Employee Committee to review what's being decided upon that affects our processes / or to review and question what's going on in the merger process from employee's standpoint?
5/7/2015	Linda Coffman, RN	At what point will employee representatives be involved in the merger process?
5/24/2015	Teresa Stephens	Thank you for creating this website to share news of the merger. I am unable to find how nursing will be represented in this process. As leaders in healthcare and coordinators of patient care, the nursing staff at both organizations represent a large percentage of employees and contribute extensively to all areas of services. I encourage you to consider the addition of these important team members to your leadership team. Sincerely, Teresa M. Stephens, PHD, MSN, RN, CNE University of Tennessee College of Nursing and The University of Tennessee Medical Center (Blountville, TN Resident)
6/2/2015	Beth Fraley	where do the billing offices fit into all the planning? Are we going to be shifted around to merge into the MSHA office in Johnson City or will they come to Kingsport/Bristol or will we meet in the middle somewhere and form a new office?
6/2/2015	Patti	How are the nurses being chosen to be a part of the Integration Council?

Table 11. WEBSITE COMMENTS & QUESTIONS		
Category: Process, Operations, Organizational Structure		
Date	Name	Comment
	Martin	
6/3/2015	Leslie Gilliam	One of our Johnson City facilities has heard several rumors; that we have already merged, Wellmont was purchased by MSHA, that it didn't matter if a patient went to a MSHA facility over a Wellmont facility that we were all one...just to name a few. On a recent marketing trip, several offices confirmed they had told patients this because they thought that was the truth...they also said that is what they heard on the news (which we know that is not true, but that was the perception taken). Is there any way that our Council can clarify this with all parties? Thank you.
6/10/2015	Ken Fleenor	Will the new entity continue to use the Virginia state police helicopter to take away revenue generating business from present vendors of helicopter services to MSHA and Wellmont?
6/26/2015	Rose Luster	What role, if any, does the federal government play in this decision?
7/8/2015	Connie Garrett	Will potential merger of insurance carriers influence merger of Wellmont Health System and Mountain States Health Alliance?
7/14/2015	Spencer	How large (number of providers) will the combined system be, and how will that compare to other regional systems?
8/21/2015	Beverly Meadows	I was curious as to how nursing would be represented in key elements of your new organization. I had not seen mention of their participation on major committees.
8/28/2015	Beth Fraley	What will this mean for the billing department? Rumors fly around and the one that is worrying some of us is that you'll outsource the billing. Also will we continue using our new expensive computer system or will there be another one that we will be using
9/23/2015	Elbert Dean Ray	I have sent a few of my concerns to you but this time I have a question that I would like to have and answer to. If better together is what the main point is Together then why is it that between Holston Valley and Bristol Regional, two of the largest Hospitals in the area, that the same policies are not the same. If something at Holston Valley is doing then why is it not being done or tried at Bristol Regional. I have heard of things that are being done at Holston Valley that could help at BRMC but are not being done at BRMC. Why is that I want to know?
9/24/2015	Eric Vaughn	My understanding is that someone submitted these questions and have not seen or gotten a response. I heard Anthem was the biggest holdout and weren't in favor of a monopoly. Is this still the issue? And now for the rumor of the week. We have heard that they have hired someone to replace Chris Spencer and he is the same person that is over the new company Intellihartx here in Kingsport. The rumor we're hearing is that our jobs are going to be outsourced to this company, is this true?
10/28/2015	Loren McDougall	Hello, Will investors have access to the term sheet or any other documents that specifically relate to the proposed financial landscape of the newly integrated entity? Financial consideration and change in capital structure are two areas I would like to have more insight into.

Table 11. WEBSITE COMMENTS & QUESTIONS		
Category: Process, Operations, Organizational Structure		
Date	Name	Comment
		Thank you, LM
12/2/2015	Rover	<p>Look I did not want to give my name or email, but there are a couple of things that need to be addressed.</p> <p>First of all, this website needs to be updated. Please include the public meetings that were held and inform us of the questions that were asked and how you responded to them. some of us want to know.</p> <p>What is ETSU doing? Aren't they supposed to be doing some great study of the area to help with this merger? How is that study going? What efforts is ETSU making currently to assess the needs of our community.</p> <p>There is currently a group interested in actively stopping this merger, talk about it. Address it. Who is behind it. how are you going to address it. Why do you think they are doing it. Does this organization have any merit? What can we do as employees if we do not agree with this group to combat the errors in their message?</p> <p>We all should know by now that the FTC is involved with both Hospitals about this merger. This is because of the media. Don't you think you should give an update to this update or to the employees?</p>
12/10/2015	John Thomas	<p>Can we have some news about becoming better together? We have not heard anything about becoming better together.</p> <p>Thank you.</p>
12/29/2015	John Thomas	<p>I recently emailed a question about the latest news. I have yet to receive a response. I as a member of the community that uses Holston Valley and Wellmont Medical Associates exclusively I think you owe the public and myself some updates. It is piss poor management of a website if you can not respond to an email. I hope that it is not an indication of how the new company will be run. I expect to hear from you soon.</p> <p>Thanks,</p> <p>John Thomas</p>
12/29/2015	John Thomas	<p>I recently emailed a question about the latest news. I have yet to receive a response. I as a member of the community that uses Holston Valley and Wellmont Medical Associates exclusively I think you owe the public and myself some updates. It is piss poor management of a website if you can not respond to an email. I hope that it is not an indication of how the new company will be run. I expect to hear from you soon.</p> <p>Thanks,</p> <p>John Thomas</p>
12/31/2015	Beth Fraley	<p>We haven't heard anything about the merge in several months (sometime around early summer if I remember right). Now all of a sudden there's an article about the merge and things didn't progress like they were suppose to by fall of 2015. This was in the newspaper</p>

Table 11. WEBSITE COMMENTS & QUESTIONS		
Category: Process, Operations, Organizational Structure		
Date	Name	Comment
		yesterday. It was our understanding that before anything went public we as Wellmont employees were suppose to be told first. Why are we not hearing ANYTHING and why all the secrets still? This affects us all, don't you think we need to know as well? Put yourself in our shoes, you'd want to know.
1/6/2016	Debbie Stidham	When is the target date for the merger?

3. PUBLIC FEEDBACK: SERVICES, ACCESS, VALUE & CHOICE

The Parties received 26 comments and questions related to Services, including availability, access, value and choice that will be offered after the merger. From the beginning, leaders at Wellmont and Mountain States have been committed to finding a solution to the region’s unique and significant health issues that will expand access and choice, improve the quality of care and stem the growth of health care costs. The Parties have addressed these issues in the Pre-Submission Report and in the extensive information provided by the Parties in the Tennessee COPA and Virginia Cooperative Agreement applications. The website comments relating to the Services are below.

Table 12. WEBSITE COMMENTS & QUESTIONS		
Category: Services		
Date	Name	Question/Comment
4/2/2015	Heather Helvey	What does this mean for Cardiology, and Urgent Care, especially in Abingdon? Since MSHA is notorious for cutting employee positions, how many are going to be cut due to this merger? This merger gives no choice to patients now. Patients will leave the area to seek doctors and treatments.
4/2/2015	Bruce Jones	Will Norton Community and Mountain View Medical Center both remain open (Norton, VA)? The rumor is that NCH is expanding their ER so MVMC can close.
4/2/2015	Donna Davis	What will happen to the two different sets of physicians who are in the Abingdon area competing against one another (i.e., heart specialists, family practitioners, orthopedists, etc.?)
4/4/2015	Kim Roop	Excited about potentials, yet anxious about unknowns. Concerned about duplication of services..specifically level 1 trauma designation. Any thoughts?
4/5/2015	Brandon	I am concerned that the merger will bring a lack of competition and "choice" for patients in their health care. What reassurance do we have that a monopoly in regional healthcare is beneficial to us? Also, what are some reference sources for the declining inpatient volumes in this region, given that "we have some of the highest rates of cardiovascular disease, diabetes, and pulmonary disease in the country"?

Table 12. WEBSITE COMMENTS & QUESTIONS		
Category: Services		
Date	Name	Question/Comment
		I feel our volumes have increased rather than decreased based on my caseload at the hospital (I am in the therapy department).
4/6/2015	S. Gail Hess	Will the merger affect the VA facility? Right now anyone who needs to be transferred somewhere else goes to Johnson City. Will the patient now have a choice of Johnson City or Holston Valley?
4/7/2015	TJ Kelly	Wellmont already closed Lee Regional in Lee County and left us without a hospital. There are 2 hospitals in Norton. Do you plan on shutting one of them down when this takes place? I assume that if you do it will be Mountain View as you've been pouring money into Norton Community...
4/8/2015	Kellie Winters	I know there is still a lot to be determined yet regarding jobs, but we are all curious about the status of the labs. MSHA owns their labs but Wellmont does not. Is it the plan to have all of the labs fall under the ownership of the new system, will MSHA labs go to Quest, or will they remain separate? There is always concern when a merger happens, and the wellmont labs have been through several mergers and acquisitions recently. It would be nice to know which direction we may be headed. Thank you
4/8/2015	Stephanie Scissom, RN	Being a part of the mental health team at Woodridge, a lot of focus is on this type of care, is it possible that a new facility will open possibly in Kingsport?
4/9/2015	Debra Hanshew	With this new health system being formed, what will happen to the laboratory portion of Wellmont? Currently, they contract to Quest whereas MSHA owns Synergy. Someone said that they were told that this would be a good opportunity for Quest - but has Quest been notified so they can begin their own decision making to decide if they would even want to pursue? Is there a possibility that the new system could buyout all current Quest lab employees and convert the labs into Synergy (or a newly named laboratory services)?
5/14/2015	Macon Hogan	What are the plans for pediatrics care at Bristol Regional and Holston Valley?
6/2/2015	Jessica Beeler	Will lab still be Quest?
6/2/2015	Tim Nuckols	What is the expected impact of the merger for Marsh Regional Blood Center?
6/3/2015	Donna Sexton	I am from Southwest Virginia. I have had many people outside of the hospital express a deep concern about this merger. Many of these people bypass Johnston Memorial Hospital & Smyth County Community Hospital because they do not wish to go to a MSHA hospital. What will happen to their options when BRMC becomes a part of MSHA? Also, when Wellmont first mentioned finding someone to merge with we were told it would be someone who is financially sound? Is MSHA financially sound or "in deep debt" as most people feel they are? If they are in financial trouble why did Wellmont choose a merger with them?

Table 12. WEBSITE COMMENTS & QUESTIONS		
Category: Services		
Date	Name	Question/Comment
		This is a real concern for the people of Southwest Virginia. One that needs to be addressed by the leadership of Wellmont & Mountain States.
6/3/2015	Ty	Kingsport, Bristol, and Johnson City each have their own daVinci Robotic Surgery programs. How will each of these programs be affected once the merger takes place? When the news first discussed the merger, they interviewed the Mayor of Kingsport, and he said that each hospital had a million machine that would need to be centralized to be more cost-effective. Is this the current plan to centralize into one daVinci program, or will the current programs remain intact?
6/4/2015	Mary Wiley	Are there any plans to set up additional Psych facilities or departments to alleviate the load and assist the community members in need of these treatment facilities? We see so many patients who are in need of assistance that unfortunately spend upwards to 72 hours in the ER waiting for placement because there is no where for them to go. It is a real problem that I hope would be considered in the future. Thank you for your time.
6/23/2015	Edie Lane	Has there been discussion of possible Behavioral Health services being brought back to Kingsport?
8/2/2015	Jennifer Divers	Are you aware of the Roanoke Times article about Lee County, VA and its attempt to reopen their facility? It casts a negative light on Wellmont and portrays an antagonist relationship between the two systems? Would you comment on that? And also would you assist in reopening the Lee County facility?
8/6/2015	Lynn Shurtleff	<p>Truthfully, I am not a fan of MSHA. I have had horrible experiences at JCMC and Sycamore Shoals ER. I have told my surgeon if the only place he can do replacement surgery is JCMC, I will find another surgeon because I will not go back there. Disorganization, under staffing, poor equipment maintenance and poor care.</p> <p>I do not believe that lack of competition is a good thing and know that where my parents live in FL that has only 1 system, you have no choices and no options except to leave the area, which the elderly and lower income cannot do. I haven't heard anyone say they think this is a good thing except those that stand to benefit from it. As an insurance agent that specializes in Medicare coverage with almost 500 clients, I know those in the Bristol area do not want a MSHA hospital and the recommended hospital is Holston Valley. Fear is that if MSHA takes over, we will lose doctors that want nothing to do with MSHA and the level of care will drop and the patients will suffer.</p>
8/15/2015	Marty Landis	What you are doing is called a MONOPOLY and, by definition, reduces the choices for the consumer. It SUCKS!
8/27/2015	Tabetha	What are the plans for the outpatient cancer centers of both

Table 12. WEBSITE COMMENTS & QUESTIONS		
Category: Services		
Date	Name	Question/Comment
	Davis	companies?
8/28/2015	Beverly Meadows	Are there plans to recruit geriatricians to the area?
9/1/2015	Martin Ruppel	To receive Better Together newsletter. One question how will this merger effect two hospitals in Norton , VA and any effect on LPH Big Stone Gap , VA.
9/17/2015	Beth Fraley	in our last town hall meeting we when ask about insurances and their roll in our merge we were told that most were ok and in agreement with the merge but some including Anthem were not on board yet. Have all the insurance companies come "on board" with the merge yet? With the letter of intent being filed I would hope so. Anthem is a big provider around here and that would cause a lot of issues with a lot of people who would be patients at the new formed company.
10/12/2015	Danny	I would guess people are going to be upset if they have to travel to another location for specialty services. How can money be saved without consolidating some specialties?
10/22/2015	Carole	How will this merger not represent a " MONOPOLY" for southwest va. and east tennessee ?

4. PUBLIC FEEDBACK: WORKFORCE

The Parties received 39 comments and questions related to workforce issues, including recruitment, retention, staffing, benefits and training. The Parties understand that the ability to attract and retain a robust workforce is vital to the proposed new health system’s success. Reflecting the Parties’ vision to become one of the best health system employers in the country and one of the most attractive health systems for physicians and employee team members, they have addressed these concerns in both the Pre-Submission Report and in the extensive information provided by the Parties in the Tennessee and Virginia applications. The comments relating to the Workforce are below.

Table 13. WEBSITE COMMENTS & QUESTIONS		
Category: Workforce		
Date	Name	Question/Comment
4/2/2015	Margie Fitzgerald	I know from the Town Hall meetings that seniority will be kept, my two questions are: will FMLA that does not expire till 2016 be kept as is, & will PTO hours accrued as of time of merger be kept ? Thank you
4/2/2015	S. Gail Hess	If employees, with either system, must be terminated, will there be an incentive offered for early retirement?
4/2/2015	Shanoah	There are so many rumors about jobs being eliminated. I left Indian Path Medical Center to come to Holston Valley in order to pursue my dream in the department I have always wanted to be in. At IPMC, the chance of career advancement was not an option due to management on the floor I was working on. I have been at HVMC for 2 years now and over a year

Table 13. WEBSITE COMMENTS & QUESTIONS		
Category: Workforce		
Date	Name	Question/Comment
		ago was able to finally transfer to my dream job and I love it. In our department, so many nurses are talking about job elimination. I can't imagine losing my job, because I am where I always wanted to be and am so happy and thriving and learning daily. It is so hard to find a job in the department I work for and if I lost my position with this merger would not have an option to go anywhere else, because it is owned by the same company. My husband and I are foster parents in the process of adoption and cannot move until the adoption is final this summer hopefully, if jobs will be lost with this merger, we will both have to move which would cause us to lose the children we have now. Then if we tried to become foster parents somewhere else, it would take a long time. I know at this moment job loss is a rumor, but we need to know the answer. I am a big fan of change and doing whatever it takes to make a better community and health care system and have tried to ignore all the rumors the past 6 months. At the same time I am secretly playing scenarios over and over in my head, because Wellmont employees both my husband and I, and we have to think what is best for our family. I know the Q&A page says this isn't decided yet, but please take into consideration that this is an answer people are depending on. Thank you.
4/3/2015	April Draper	I know a few people who work in the laboratories with Wellmont and I know that the lab staff is out sourced to Quest/Solstace. My question is how is this going to work going forward with the lab staff, will staffing become outsourced or once the contract with Quest/Solstace expires will the employees there be offered positions within the new organization? Also, I know that they do not have a dress code as far as scrub colors within their labs, are we going to continue with the colors we have or are we going to explore new options and perhaps a vote for new colors moving forward as a new organization? Thank you in advance for your response and taking our concerns into consideration.
4/3/2015	Patricia Rebmann	What will become of the Wellmont Pension Plan after the merger?
4/3/2015	Patricia Rebmann	Is there a possibility of an early retirement incentive being offered to employees nearing retirement age with 25-30 years of service?
4/3/2015	Tom Conkle	What about our insurance coverage? Will we continue to have Crestpoint or would we hopefully be offered something better?
4/4/2015	Chris Ratliff	I recently started working at MSHA Norton Community Hospital. My start date was 11-1-14. I was wondering if I should be concerned about losing my job. Should I be concerned?
4/4/2015	Chris Ratliff	I started working at Norton Community on 11-1-14. I am currently an RN on night shift and I am concerned that with this new merger that I may lose my job. Thank you.
4/5/2015	Randy	Will the employees who work at both Bristol Regional Med Center and

Table 13. WEBSITE COMMENTS & QUESTIONS		
Category: Workforce		
Date	Name	Question/Comment
		Johnson Memorial Hospital in order to make ends meet have to quit one of their jobs?
4/6/2015	Gilda W. McKinney	How will this merger affect our benefits as MSHA employees? What will we loose or how will benefit with this merger? Please state what will happen to our MSHA retirement.
4/6/2015	S. Gail Hess	Will the possible merger have any impact on employees who have retired and receive the HVMC defined benefit and insurance benefits?
4/6/2015	S. Gail Hess	If the merger should include termination for some employees, will there be consideration made for an early retirement incentive?
4/7/2015	Amanda Finley	<p>Merger concerns</p> <p>I've been through mergers before (Pensacola, FL), and I know how rumors spread. Many from the outside, not from the employees. I know that's crazy, but true. I have 2 concerns at this point. I may have more as time passes.</p> <ol style="list-style-type: none"> 1. There are rumors that a nurses union will be initiated to protect our jobs, salary, etc. Please be prepared for this rumor. I've heard it several times in the last week. 2. The "No tobacco policy" will be eliminated. I hope this does not happen. Many patients have commented to me on how nice it is to not smell tobacco on the staff. It also keeps the staff on task, no more 30-45 minute smoke breaks. And our campus is so much cleaner. 3 years ago, I had to wade through cigarette butts to get to my car. I hope we do not return to the parking lot looking like an ashtray. We do NOT need to regress by eliminating that policy. Plus, it pays and saves in various ways to have healthier employees. <p>Thank you from a concerned MSHA employee. Amanda Finley RN.</p>
4/7/2015	Clara Dye	Will the merger affect our PTO that we have already earned and if so, how will it be affected. Thanks ! Clara
4/9/2015	Stacey Blevins	With the "new organization" teaming up with ETSU, will this benefit employees regarding tuition discounts/reimbursement? If so, will this apply to our children or other family members?
4/16/2015	April Lunsford	Will Wellmont employees see a change in their pay to equal that of Mountain States employees?
4/16/2015	Beth	With a huge increase in the number of team members, I hope there will be a better insurance plan out there that is not such a high deductible, and covers more percentage. Is this a possibility?
4/16/2015	Betty Watkins	With a huge increase in the number of team members, I hope there will be a better insurance plan out there that is not such a high deductible, and covers more percentage. Is this a possibility?
4/17/2015	Karen	What does this merger mean for those of us who work for both hospital systems?
4/17/2015	Kassie Denney	How will nursing students who have the MSHA or Wellmont scholarship be affected? Will we still be accountable for three years with the new

Table 13. WEBSITE COMMENTS & QUESTIONS		
Category: Workforce		
Date	Name	Question/Comment
		company even if we signed a contract for Mountain States?
4/17/2015	Kim Barnett	Will our PPO's be able to serve us in the hospital again?
4/17/2015	Sylvia Garrett	Will we still have certain color scrubs to wear? It would be nice to have some autonomy in what we as nurses wear.
4/20/2015	Tiffany	When will employees of MSHA and WHS be able to transfer to each others facilities without losing seniority?
4/21/2015	Marlene Allison	I understand you are in the early stages and do not have the answers to a lot of our questions. If jobs will be cut, offices be closed, ect. How much time will we be given in advance before this happens?
4/21/2015	Shara Bledsoe	My boyfriend is a PAC with MSHA, he chose to work with MSHA in his current position due to the pay being much greater than what was offered by Wellmont. His contract will end in May 2016, how will his income be effected by this merger? Kindly,
5/7/2015	Joy Allison	There are hundreds of people that work their regular job for one health system then work PRN for the other health system. For example an employee that works in the ER at Abingdon full time then in surgery at Bristol PRN. How will these employees be affected by the merger?
6/2/2015	Connie Puckett	What will happen when the merger occurs to employees who might be doing the same jobs at Wellmont & at Mountain States-in other words would seniority play a part in keeping their job if a duplicate of services happens?
6/4/2015	Linda Richardson	What about layoffs and cutting staff. This will be the only hospital from Smyth County to Johnson City. What will happen to to community as a whole when this occurs? Some will have to leave this area to find work.
6/5/2015	Terry Hedrick	Will current employees have to reapply for their positions?
6/10/2015	Barbara Wood	Will we have lower deductibles on our health insurance?
6/22/2015	Shirley Jupino	I think it will be a good step, if we at MSHA will have many more Doctors to go to from the Wellmont group. Will Crestpoint be the insurance offered?
7/29/2015	April	What will occur with pay scale? Wellmont and their contract holders pay scale is higher than that at MSHA. How will that affect pay rates across this new system and with current employees at both companies?
8/3/2015	Connie Garrett	Mountain States has had numerous "job fairs" recently. Will this mean less job opportunities for Wellmont employees if staff readjustments are indicated after the merger takes place?
8/28/2015	elizabeth wagner	Since we are now "better together." How about giving employees in-network privileges at Wellmont to MSHA employees.Any plans to do so?
8/28/2015	Margie	Both CEO's say there is a great need for healthcare employees, but,

Table 13. WEBSITE COMMENTS & QUESTIONS		
Category: Workforce		
Date	Name	Question/Comment
	Fitzgerald	cutting out duplication of services sounds like cutting jobs. Is that so?
8/28/2015	Mary Adams	If someone loses their job because of policy error and not for rehire. How would this effect future employment at another hospital if they are all owed by one cooperation? If not for rehire in the area you have lived most of your life, would be forced to move to another location, thus leaving family, friends behind and loss of revenue to the community.
9/29/2015	Brandon	Will there be any changes in jobs for the Wellmont Volunteers? As in less or the same?
10/13/2015	Leslie Gilley	I know this is an early thought at this time. This question is in regards to our 401K and 340B that we have accumulated over time. Can we have an option to roll this account over to a private finance company that has better options for mutual funds? We could make a higher % on retirement than we do now. If we chose to leave the company this would be an option. I have been with Wellmont 18 years and I have almost 5 different funds from changes we have made. I really don't need sixth one to keep up with.

5. PUBLIC FEEDBACK: GENERAL, MISCELLANEOUS

In addition to questions and comments received related to specific thematic topics outlined above, there were 28 questions and comments that are best described as "general/miscellaneous." To the extent possible, the Parties have addressed these concerns in the Pre-submission Report and in the Tennessee and Virginia applications. The general and miscellaneous comments are below.

Table 14. WEBSITE COMMENTS & QUESTIONS		
Theme: General, Miscellaneous		
Date	Name	Question/Comment
4/2/2015	Amy Callahan	please send news letter
4/2/2015	Jeanette D. Blazier	Congratulations! Let's make the articulated vision happen!
4/2/2015	Nathan A. Rowe, RN	Hope to come grow with you
4/3/2015	Mike Horton	I am an MSHA employee but please send updates to my yahoo account also.
4/3/2015	John Thomas	I just wanted to say that I am excited that these two great systems are planning on merging. I look forward to hearing all the updates.
4/3/2015	Myria Weems	Dear Team, I will have everyone in my prayers as you set out on this endeavor. I believe it will be done right and with integrity. It will make our region a better place to live and receive top quality care. Thank you for allowing team members to be in the loop!

Table 14. WEBSITE COMMENTS & QUESTIONS		
Theme: General, Miscellaneous		
Date	Name	Question/Comment
		Sincerely, Myria Weems
4/6/2015	David	Looking forward to seeing this amazing transformation unfold. Thanks for including me in the conversation. Respectfully,
4/6/2015	Wanda Salyer	Thanks!
4/6/2015	Wendy Wakefield	Prayers for everyone. This will be a great merger for our region.
4/7/2015	Trish Riggan	I'd like to follow the updates.
4/10/2015	Wayne McKee	I believe this is a wonderful for the communities served by Wellmont and Mountain States Health Alliance. I worked for one of the sytems for over 3 years and felt and said then that the 2 sytems working together had the potential to do much more for the region working collaboratively than either could ever do operating independently. It'sgood news for the systems and the people of this region.
4/16/2015	Gary Mabrey	so proud of the courageous leadership shown by the Mountain States Health Alliance and Wellmont Health system...we will be the Cleveland Clinic or Mayo of the South.
4/17/2015	Kim Hall	Thanks for this info!
5/6/2015	Jason Stidham	Interested in receiving newsletter
5/8/2015	Jonathan Sanders	I'm looking forward to seeing what we can do with both health systems aligned.
6/1/2015	Tom Cooper	I'd like to receive the Better Together Newsletters. Thank you.
6/12/2015	Rebecca Henderson	I would like to be added to the newsletter list, please. Thank you!
7/17/2015	Beth Barnette	I own and publish the Kingsport Town Planner Community Calendar. I am working with Eastman and Healthy Kingsport to represent them in our publication. I'm interested in meeting with a marketing representative to make an introduction to our publication. Our full color print calendar is mailed free of charge to 30,000 Kingsport residents. I realize there are a lot of moving parts as you transition your organizations, but my purpose at this point is to introduce you to the community service we provide and allow you to consider what we can do to help in your branding/messaging going forward. I can send more information including an electronic version of our calendar with your permission. Please advise the best way to do so. Thank you. Beth Barnette, Owner Kingsport Town Planner Calendar 423.306.1237
7/20/2015	Ruth Armstrong	Hurry!
7/27/2015	Leah Smith	Please add me to your newsletter mailing list. I would like to attend your public meetings. Leah Smith
7/28/2015	James Daniel	Please add me to the list for your newsletter?
8/8/2015	Vicky Atwoodretired team member 12218....peace, good health, happiness to us all.....:-)

Table 14. WEBSITE COMMENTS & QUESTIONS		
Theme: General, Miscellaneous		
Date	Name	Question/Comment
	Hash	
8/9/2015	Tim Flannagan	<p>Hello.</p> <p>I have a LIVE Streaming business located in the Tri-Cities and was inquiring to see if you would like to open up your round table meetings to a larger audience by LIVE streaming them. My fee is just \$150 and the event will stay up online for 30 days.</p> <p>Please contact me for more information.</p> <p>Thank you, Tim Flannagan NuVision Marketing 423.366.0159</p>
9/11/2015	Linda Burchette	I am a reporter for the Smyth County News & Messenger in Marion, VA. and am interested in receiving press releases from the organization.
9/23/2015	Dorothy A. Balhis	I would like to share this
10/5/2015	Joe Fuller	<p>I would like to get on mailing list for the newsletter</p> <p>Thanks, Joe Fuller 628 Whitetail Cir Nickelsville, VA 24271</p> <p>276-479-2148</p>
11/23/2015	Kathy Horan	<p>Good morning.</p> <p>I work in a marketing office for a hospital in New Jersey and am conducting research into branding agencies used by health care companies as part of merger integration communication. Can you share with me if Welcomont and Mountain States have hired a branding agency? And if so, did they develop the Better Together logo used throughout the merger Web site?</p> <p>Thank you. Kathy Horan Marketing Manager Monmouth Medical Center Long Branch, N.J.</p>
1/5/2016	Brent Howell	Please add me to the newsletter and email list. Thank you.

C. WEBSITE COMMENTS ON PRE-SUBMISSION REPORT

The public was invited to review and provide feedback on the Pre-Submission Report, which was released and posted on the Better Together website on January 7, 2016. During the public comment period, which ran through February 12, 2016, the Parties received 28 comments and questions through the Better Together website.

Table 15. WEBSITE COMMENTS & QUESTIONS SUBMITTED BETWEEN JANUARY 7, 2016 AND FEBRUARY 12, 2016.			
Date	Name	City	Comment
1/7/2016	David Winship	Abingdon, VA	I think it is important to specifically note the needs of elders in the community, and not expect that their needs are the same as others in an "adult" category.
1/7/2016	Jennifer Cordle		How would the merging of two hospitals affect our team members that work at both facilities? This will have a large impact on Radiology department and ER nurses more so than most. Would they(employees) be able to work at both facilities with a different job code or would it fall under Virginia law stating they could only work 40 hrs until overtime affects them and overtime is not usually a preferred thing to use. I ask because this will affect many family and workers at both facilities. If we follow Virginia law on this several people will lose one of their jobs and this could hurt our employees and local family. I appreciate the time and information. This is just a concern. Thank You Jennifer Cordle
1/7/2016	John Spear	Bristol, TN	I am an independent physician and see nothing in your pre-submission report stating that the proposed merged system (which would likely be the biggest or second biggest employer in our area) will not discriminate against independent physician practices when health system employees seek medical care from those independent physicians. In the past Wellmont has chosen to require their employees to pay more out of pocket for care from independent physicians than Wellmont-employed physicians. I see nothing stating the new system won't do it again. I cannot support any merged entity that will not provide a legally binding guarantee against this predatory practice, which Wellmont has been ever so willing to engage in before.
1/8/2016	Mack Mathews	Kingsport, TN	Merger seems to be right on task. Biggest deficiency of Mental Health Care is being addressed.
1/8/2016	Mack Mathews	Kingsport, TN	Appears the merger is right on task. Most glaring deficiency of Mental Health Care in the community is being addressed.
1/8/2016	Randy Hodge		I've heard that CrestPoint Health is being bought by a large insurance company.

Table 15. WEBSITE COMMENTS & QUESTIONS SUBMITTED BETWEEN JANUARY 7, 2016 AND FEBRUARY 12, 2016.			
Date	Name	City	Comment
			Is this true?
1/8/2016	Debra		Will it really help with heart patients or will it cause new problems, in getting a dr that you can work with because alot of us live below poverty level as we are told by the dhs people so we don't have alot of extra money to spend on medicines, because it is either meds or eating or rent for our apt, we would like to hear about the costs for the procedures that we have to have.
1/8/2016	Thorne Olinger	St. Charles, VA	Wellmont flat out destroyed healthcare in Lee county by closing our hospital. Then fighting out county tooth and nail to give the hospital back to us. Now it wants to merge with MSHA to not have to file for bankruptcy? This is a very bad move on MSHA part. As of right now we lee county folks have lost so many of our citizens to death because of the long trip to critical care. Yes their is Lonesome Pine Hospital but all they do is ship them to Holston Valley Medical Center without regard of how bad those people were. And while we are talking about Holston Valley Medical Center and Lonesome Pine Hospital you put up a big talk about how good these hospitals are but the fact is they are on the borderline of flat out crappy. I think that if MSHA wants all these hospitals her in this area they should do a but out of wellmont and be done with them altogether. It would be really nice if this site would have a G+ page so everyone in this county "LEE" could let you know how of a bad idea this really is.
1/9/2016	Leton Harding	Wise, VA	Please add me to your email information list. Thank you Leton Harding
1/11/2016	Brant Kelch		Thank you for your consideration of these comments and questions.
1/11/2016	Rhonda Hall		Please include Clinical Nurse Specialists in your plans for post graduate training. This group of nurses could really rock if recognized as just as valuable to the team as a Nurse Practitioner or a Physician's Assistant.
1/12/2016	James Wallin	Kingsport, TN	I am very pleased to read the section "Enhanced Healthcare Services" which speaks to mental health issues, crisis management etc. I know that Woodridge is the only location for people who need both medical treatment and counseling but Kingsport is in need of a satellite facility as well. Reading the newspapers is confirmation of the need for this. Thanks for all your efforts. Regards. Jim Wallin
1/15/2016	Ashley Shaffer		Is there a plan to include investigator sponsored research studies of all disciplines as well as clinical trials? A research

Table 15. WEBSITE COMMENTS & QUESTIONS SUBMITTED BETWEEN JANUARY 7, 2016 AND FEBRUARY 12, 2016.			
Date	Name	City	Comment
			partnership with ETSU should include all disciplines that are involved in patient care, and both qualitative as well as quantitative research. This would address the entire patient to help us understand how we could care for them more holistically. This is an awesome opportunity for interprofessional research and to raise the level of the science of patient care.
1/18/2016	Marty Sutton		I see the involvement of physicians at a very high level, at the table, as plans are discussed and decisions are being made. Is nursing there at the table at the same level? Nursing is a large percentage of the workforce that is present in all areas across the continuum, most times 24/7/365 being the eyes and ears for other disciplines as well as being advocates for patients. Will there be any nurses on the board of the new entity helping to shape policy and make decisions regarding care as well as workforce issues? It's understood that the physician brings patients to the system, but they need hands on care while there; care after the procedure, surgery, medication, etc.
1/19/2016	Georgita Washington		I have just a few questions/comments after hearing the overview of the pre-submission report and reading the document.
1/22/2016	Janita Adams		It is well-documented that mental health as a specialty service (i.e., community mental health) has poor reach to the population as a whole. About 50% of the population will struggle with mental health concerns in a given year. A vast majority will seek help in primary care, not mental health. These findings are supported by my own research in NE TN and SW VA. When primary care physicians refer to specialty mental health, only 17-30% of referred patients follow-through. Placing a mental health provider in primary care provides an opportunity for the concern to be addressed immediately in a coordinated fashion that is consistent with the medical home. Moreover, integrated behavioral health allows for patient consultation on any number of lifestyle changes that have significant impact on health (and some of the key needs in this region: smoking cessation, weight loss, increased physical activity, adherence to medical regiment, etc.). Finally, well integrated behavioral/mental health in primary care allows for prevention programming.
1/25/2016	Beth Fraley		Starting to hear A LOT of commercials on the radio about Carillion clinics needing nurses. At one time Carillion was one of the rumors for the merge, are they still a factor? Maybe merging with both MSHA and Wellmont if

Table 15. WEBSITE COMMENTS & QUESTIONS SUBMITTED BETWEEN JANUARY 7, 2016 AND FEBRUARY 12, 2016.			
Date	Name	City	Comment
			something happens with the COPA/Cooperative Agreement issue?
1/26/2016	Jodi Polaha Jones		I urge the Joint Board Task Force and Integration Council to re-consider the existing plan for bolstering mental health services in the region. Models for integrating behavioral health into primary care have substantial evidence of effectiveness across the Triple Aim as well as growing policy support.
1/30/2016	Mae		How many ppl are going to be out of a job once the merger becomes a reality?
2/4/2016	Susan Laguardia	Kingsport, TN	I am very impressed with the comprehensive nature of the report and the specific commitments outlined in the six key areas that are to be implemented over the next ten years. I am especially interested in the commitment to improve community health. My work with nonprofit agencies in our community focuses on the physical and economic health and well-being of our citizens. I especially like what I read in the first key area about investment in children's health, wellness programs and the promotion of drug-free communities. I believe that the joining of our two medical systems will lead to cost efficiencies, increased access to higher quality medical professionals and potential better outcomes. My hope is that costs will be contained as competition between the systems is eliminated. I am in favor of the merger being approved.
2/4/2016	Gary Poe	Kingsport, TN	I am particularly pleased that the new healthcare entity will be a merger of two non-profits who have outstanding records of providing both excellent healthcare and service to the community. It is of huge benefit to the community that the management will continue to be local and operating surpluses will continue to accrue to the benefit of the local community. I like that the pre-sub. report defines the commitments being made.
2/4/2016	Lisa Buchanan	Kingsport, TN	The merger of Wellmont and Mountain States health systems will be positive for individuals and families in our region. I look forward to greater continuity of care and better access to specialists. As a former social worker, I am particularly encouraged by the awareness of and plans to address the unique health needs of our area – substance abuse and mental health, neonatal abstinence syndrome, childhood obesity, and other poverty-related health problems.
2/5/2016	Mike Beery	Johnson City, TN	I am supportive of this merger for several specific reasons addressed below.

Table 15. WEBSITE COMMENTS & QUESTIONS SUBMITTED BETWEEN JANUARY 7, 2016 AND FEBRUARY 12, 2016.			
Date	Name	City	Comment
			<p>There is a significant need in our region to eliminate the duplication of services that has led to an inefficient business model.</p> <p>There is a significant need in the region to improve the overall comprehensive health of the citizens with a focus on prevention.</p> <p>There is a significant need to have a patient record system that is available for any review by any medical staff....not just the primary physician in one location.</p> <p>This pre-submission includes a strong set of metrics (checks and balances) that will track the improved performance of cost, quality and services.</p>
2/9/16	Fielding Rolston		<p>Congratulations on the development of a plan that effectively addresses the health issues of our region. This plan will reduce costs, improve quality, and enhance the value of ETSU Medical School.</p>
2/11/16	Gary Mabrey	Johnson City, TN	<p>This report illustrates the basis for the merger and the benefits to the region. Our citizens will accrue the benefits with improved healthcare.</p> <p>We will address prevention and wellness in ways that will enhance our quality of life. Recruitment of needed specialties will occur as well as vital research that will enhance the assets of ETSU Academic Health Science Center, Milligan College and other higher ed institutions.</p> <p>This will be great for business retention and recruitment. We applaud the leadership of these two fine institutions and look forward to the merger.</p>
2/11/16	Miles Burdine	Kingsport, TN	<p>So many positive reasons that the merging of Wellmont and Mountain States needs to happen. Among them: Significant cost savings, less duplication, more research opportunities, access to services that have typically not been available here, significant branding opportunities, potential for capital investment and job creation, etc. Our communities appreciate and respect the transparency that has been evident throughout the process.</p>
2/11/16	Nicole Austin	Kingsport, TN	<p>It is truly encouraging to see both systems coming together to make healthcare even better in our region. As a representative of the business community and as a patient I am looking forward to seeing all the positive outcomes this merger will create. Thank you to both systems for leading and for all the hard work that has gone in to making this happen.</p> <p>Nicole</p>
2/12/16	Charlie	Kingsport,	<p>Thanks for all the work you're doing. This report is</p>

Table 15. WEBSITE COMMENTS & QUESTIONS SUBMITTED BETWEEN JANUARY 7, 2016 AND FEBRUARY 12, 2016.

Date	Name	City	Comment
	Glass	TN	impressive and I am encouraged by the progress and commitment to improving community health. I particularly am looking forward to your commitment of \$75million toward working with community agencies and existing resources to impact population health in our region. There is a tremendous opportunity for the new health system to "shepherd" existing community resources toward some key common goals. We don't need to reinvent the wheel, and this report indicates you are in agreement with that. Thank you!

8. COMMUNITY LETTERS OF SUPPORT

Officials in both Virginia and Tennessee received 60 letters from employers, community organizations, and other leaders from across the region served by the Parties who fully support the merger and the Parties' vision for improving the health of the region. Copies of these letters were provided to Wellmont and Mountain States, and a list of them is below.

Copies of all of the letters listed below are included as part of **Attachment G**.

Table 16. Letters of Support submitted between July 7, 2015 and Tuesday, February 9, 2016.

Table 16. LETTERS OF SUPPORT SUBMITTED BETWEEN JULY 7, 2015 AND FEBRUARY 8, 2016			
Organization	Addressed To	Date	Notes
Dr. Weberling & Associates	Secretary William Hazel	N/A	Attached
Lottie Fields Ryan	Commissioner John Dreyzehner	N/A	Attached
UBS	Commissioner John Dreyzehner	7/7/15	Attached
Ideal Rental Properties	Commissioner John Dreyzehner	7/8/15	Attached
Judy Seaton	Commissioner John Dreyzehner	7/8/15	Attached
S. H. Anderson, Jr.	Commissioner John Dreyzehner	7/13/15	Attached
Southwest Virginia Higher Education Center	Secretary William Hazel	7/15/15	Attached
Leonard Companies, Ltd.	Secretary William Hazel	7/20/15	Attached
South-West Insurance Agency	Secretary William Hazel	7/20/15	Attached
Ball Construction Co., Inc.	Secretary William Hazel	7/21/15	Attached
Calvin & Leslie Clifton	Commissioner John Dreyzehner	7/21/15	Attached
Cary Street Partners, LLC	Attorney General Mark Herring	7/21/15	Attached
Cary Street Partners, LLC	Secretary William Hazel	7/21/15	Attached
Miners Exchange Bank	Secretary William Hazel	7/21/15	Attached
Colgard Outdoor Sports	Secretary William Hazel	7/23/15	Attached
Damascus	Secretary William Hazel	7/23/15	Attached
Friendship Enterprises	Elliott Moore	7/24/15	Attached
Friendship Enterprises	Commissioner John Dreyzehner	7/24/15	Attached
Norton Redevelopment & Housing Authority	Secretary William Hazel	7/24/15	Attached
Bank of Tennessee	Commissioner John Dreyzehner	7/27/15	Attached
Bank of Tennessee	Secretary William Hazel	7/27/15	Attached
Bank of Tennessee	Secretary William Hazel	7/27/15	Attached
Charles E. Good	Commissioner John Dreyzehner	7/27/15	Attached
Farm Credit Country Mortgages	Secretary William Hazel	7/27/15	Attached
C. Thomas Davenport, Jr.	Commissioner John Dreyzehner	7/28/15	Attached
Strongwell	Commissioner John Dreyzehner	7/28/15	Attached
VHCC	Secretary William Hazel	7/28/15	Attached
JAS General Contractor	Commissioner John Dreyzehner	7/29/15	Attached

Table 16. LETTERS OF SUPPORT SUBMITTED BETWEEN JULY 7, 2015 AND FEBRUARY 8, 2016			
Organization	Addressed To	Date	Notes
Strongwell	Secretary William Hazel	7/29/15	Attached
Citizens Bank	Commissioner John Dreyzehner	7/31/15	Attached
Town of Clintwood	Secretary William Hazel	8/3/15	Attached
First Bank & Trust Company	Secretary William Hazel	8/7/15	Attached
Dillon Company	Secretary William Hazel	8/11/15	Attached
GRC Construction	Commissioner John Dreyzehner	8/11/15	Attached
HealthSouth	Commissioner John Dreyzehner	8/11/15	Attached
Washington County Chamber of Commerce	Secretary William Hazel	8/23/15	Attached
Appalachian Power	Commissioner John Dreyzehner	8/24/15	Attached
YMCA	Commissioner John Dreyzehner	8/28/15	Attached
First Baptist Church	Commissioner John Dreyzehner	9/2/15	Attached
Healing Hands Health Center	Commissioner John Dreyzehner	9/28/15	Attached
Healing Hands Health Center	Secretary William Hazel	9/28/15	Attached
Dickenson County Chamber of Commerce	Secretary William Hazel	10/13/15	Attached
Chris Mullins Co, LLC	Commissioner John Dreyzehner	10/15/15	Attached
Mike McIntire	Commissioner John Dreyzehner	11/2/15	Attached
Mike McIntire	Attorney General Herbert Slatery	11/2/15	Attached
Eastman Credit Union	Commissioner John Dreyzehner	11/3/15	Attached
Rebecca C. Coleman	Secretary William Hazel	11/11/15	Attached
The United Company	Commissioner John Dreyzehner	11/11/15	Attached
The United Company	Secretary William Hazel	11/11/15	Attached
Jeanette D. Blazier, Former Mayor	Commissioner John Dreyzehner	11/12/15	Attached
Bank of Tennessee	Commissioner John Dreyzehner	11/18/15	Attached
Bill Gatton Chevrolet	Commissioner John Dreyzehner	11/18/15	Attached
Bill Gatton Chevrolet	Secretary William Hazel	11/18/15	Attached
Northeast State	Commissioner John Dreyzehner	11/24/15	Attached
John M. Vann	Commissioner John Dreyzehner	11/30/15	Attached

See ATTACHMENT G: Community Letters of Support

**Record of Community Stakeholder and Consumer Views
of the Proposed Cooperative Agreement**

ATTACHMENT A

Better Together Press Releases



FOR IMMEDIATE RELEASE:

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Media Advisory: Wellmont and Mountain States leaders invite members of the media to join us for a media briefing today at 2 p.m. in the Warriors Path Amphitheater in the Executive Conference Center at MeadowView Conference Resort & Convention Center. We invite set-up at 1:45 p.m.

**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.

About Wellmont Health System

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WELLMONT HEALTH SYSTEM, MOUNTAIN STATES HEALTH ALLIANCE NAME MEMBERS OF INTEGRATION COUNCIL

As Wellmont Health System and Mountain States Health Alliance proceed with plans for integrating the two organizations, they have selected members of a committee that will help direct this multi-tiered process.

The two not-for-profit companies announced on Thursday, April 2, that they have agreed to explore the creation of a new, integrated and locally governed health system. The systems have now entered a due diligence period and are working to develop a definitive agreement.

This 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.

One of the first elements of the process is the selection of an integration council. This group of executive and physician leaders is the working group charged with overseeing pre-merger planning. The integration council will have an equal number of representatives from Wellmont and Mountain States and make its recommendations to the joint board task force, which is the governing group that will consist of leaders from each health system.

The Wellmont council members are:

- Eric Deaton, executive vice president and chief operating officer
- Alice Pope, executive vice president and chief financial officer
- Todd Norris, senior vice president for system advancement
- Gary Miller, senior vice president of legal affairs and general counsel
- Dr. Dale Sargent, system medical director for hospitalist services and former chief medical officer

Wellmont still has one physician slot to fill.

The Mountain States council members are:

- Marvin Eichorn, executive vice president and chief operating officer
- Dr. Morris Seligman, executive vice president and chief medical officer
- Lynn Krutak, senior vice president and chief financial officer

- Tony Keck, senior vice president and chief development officer
- Tim Belisle, senior vice president and general counsel
- Dr. Sandra Brooks, a system board member and vice president of Watauga Pathology Associates

“We are excited to be taking the first steps in the integration planning process with our counterparts at Wellmont,” said Alan Levine, Mountain States’ president and CEO. “Both organizations have assembled a team of talented and knowledgeable leaders, and their focus is now on putting the pieces in place for a definitive agreement.”

“These are outstanding members of our organizations, and they will play an important role in developing a plan for integration of the new health system that will further advance the quality of care in our region,” said Bart Hove, Wellmont’s president and CEO. “These are exciting times for Wellmont, but we still have much work to complete in the process of planning how the organizations will integrate, once we obtain all legal clearances. But we are pleased to be making tremendous progress as we move forward on this beneficial initiative.”

Among other tasks, the council will conduct a cultural assessment and ensure a proper due diligence is conducted. The council will also coordinate the process for the attainment of the certificate of public advantage in Tennessee and similar administrative approval from Virginia.

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WELLMONT HEALTH SYSTEM, MOUNTAIN STATES HEALTH ALLIANCE NAME MEMBERS OF JOINT BOARD TASK FORCE

Task force to represent existing governing bodies as proposed merger process moves forward

KINGSPORT and JOHNSON CITY, Tenn. – (May 4, 2015) – Wellmont Health System and Mountain States Health Alliance leaders have appointed a joint board task force as work continues to explore the creation of a new, integrated and locally governed health system.

The joint board task force is a committee of the two boards acting as a liaison and providing information and guidance about developments in the transaction exploration process. Totalling 14 members, the task force is composed of an equal number of representatives appointed by the Mountain States and Wellmont boards. The members represent a cross section of regional and physician leadership from the community, incorporating those with experience in governance, administration, business and strategy – both in health care and in the business community.

The group is primarily responsible for providing a conduit to the existing boards of directors about the progress being made as the two systems undertake due diligence and transaction analysis and pursue a potential definitive agreement.

Wellmont's joint board task force members are:

- **Dr. Nelson Gwaltney**, of Bristol, Tennessee, a member of the Wellmont board of directors, president of Highlands Physicians Inc. and a general surgeon on the medical staff of Bristol Regional Medical Center;
- **Bart Hove**, of Kingsport, Tennessee president and CEO of Wellmont Health System;
- **Roger Leonard**, of Bristol, Tennessee, chair of the Wellmont board of directors and a senior adviser to England & Company;
- **Roger K. Mowen Jr.**, of Kingsport, Tennessee, a member of the Wellmont board of directors and retired senior vice president of global developing businesses and corporate strategy for Eastman Chemical Company;
- **Dr. Doug Springer**, of Kingsport, Tennessee, a gastroenterologist on the medical staff of Holston Valley Medical Center, a member of the Wellmont board of directors and immediate past president of the Tennessee Medical Association;

- **Dr. David Thompson**, of Bristol, Tennessee, an internal medicine physician with Wellmont Medical Associates in Bristol, who also practices in Abingdon, Virginia, and is a Wellmont board member and chairman of the Wellmont Medical Associates board of directors; and
- **Keith Wilson**, of Kingsport, Tennessee, who owns a secondary residence and a farm in Scott County, Virginia, a member of the Wellmont board of directors, publisher of the Kingsport Times-News and president of Northeast Tennessee Media Group.

Mountain States' joint board task force members are:

- **Barbara Allen**, of Johnson City, Tennessee, chair of the Mountain States board of directors and general manager of Stowaway Storage, a family-owned business in Johnson City;
- **Bob Feathers**, of Kingsport, Tennessee, a member of the Mountain States board of directors and president and CEO of Workspace Interiors, Inc.;
- **Alan Levine**, of Johnson City, Tennessee, president and CEO of Mountain States Health Alliance;
- **Dr. David May**, of Elizabethton, Tennessee, a member of the Mountain States board of directors and immediate past president of the medical staff at Sycamore Shoals Hospital;
- **Dr. Rick Moulton**, of Johnson City, Tennessee, medical director of clinical integration for State of Franklin Healthcare Associates and chairman of the SoFHA patient centered medical home committee;
- **Gary Peacock**, of Marion, Virginia, a member of the Mountain States board of directors, former chair of the Smyth County Community Hospital board of directors, and retired senior vice president of Royal Mouldings; and
- **Clem Wilkes, Jr.** of Johnson City, Tennessee, a member of the Mountain States board of directors and co-manager of Citizens Investment Services, a subsidiary of Citizens Bank Tri-Cities.

From now until the potential transaction closes, Wellmont and Mountain States will remain separate and independent organizations, conducting “business as usual.” Their respective boards of directors continue to govern the operations of each health system separately and independently, until all regulatory approvals have been granted and the merger is complete.

A board for the new proposed system will be appointed prior to the completion of the merger.

“During this current phase, our primary focus is on due diligence, confirming the transaction’s potential for substantial cost-savings, quality-of-care enhancements and other community benefits, pursuing a definitive agreement and laying the groundwork for creating the new system,” said Bart Hove, president and CEO of Wellmont. “The joint board task force and integration council will focus on preparing for what we expect will be a highly successful integration. Once the new health system is formed post-closing, a new board will take over the responsibility for governance and overseeing the implementation of an exciting vision for the future of health care in this region, which will be crafted with significant input from our physicians, team members and the community.”

“Some of the tasks before us include due diligence, a more detailed analysis and quantification of the transaction’s substantial benefits for the community, culture and governance audits and preparations for crafting our application for a certificate of public advantage in Tennessee and a similar approval in Virginia,” said Alan Levine, president and CEO of Mountain States. “We view the certificate of public advantage and the regulatory process as an important memorialization of our commitment to the people of this region, and

we're excited to begin working toward that goal. We are definitely committed to seeking public input, and this is the next order of business.”

For more information, please visit www.becomingbettertogether.org.

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WELLMONT HEALTH SYSTEM, MOUNTAIN STATES HEALTH ALLIANCE TO SEEK INPUT ON KEY HEALTH ISSUES, CALL FOR PUBLIC PARTICIPATION

Work groups to hold public meetings, provide input to assist health systems in development of long-term plan for improving the health of the region

KINGSPORT and JOHNSON CITY, Tenn. – (June 10, 2015) – Mountain States Health Alliance and Wellmont Health System officials are creating four community work groups designed to provide public input as the two organizations continue to explore the creation of a new, integrated and locally governed entity.

Through the website, BecomingBetterTogether.org, the health systems are requesting participation in the work groups from the community as well as subject matter experts such as nurses and other health professionals, doctors, public health officials and community advocates.

“Our organizations have committed to an open process as we consider the creation of a truly new health improvement organization for our region,” said Bart Hove, president and CEO of Wellmont. “These work groups provide a great opportunity for interested organizations and individuals to participate with us as we develop our strategies for improving the health of our area.”

The work groups will provide input in solving some of the region’s most challenging health issues: Mental Health and Addiction, Healthy Children and Families, Research and Academics, and Population Health and Healthy Communities. The work groups’ findings will be used by East Tennessee State University as part of a deep-dive health needs assessment that will be conducted after the proposed merger between Mountain States and Wellmont is complete.

That assessment will provide a road map for the proposed new health system as it lays out a 10-year plan to improve community health. The work group meetings are designed to focus specifically on health improvement and are separate from public meetings that will be held in Tennessee and Virginia as part of the state approval process for the proposed merger.

The work groups are divided into four key areas of opportunity:

Mental Health and Addiction – This group will evaluate the inventory of mental health and addiction services for adults and children in the area. Among other tasks, this group will assess gaps in access points, review strategies to prevent drug and alcohol use among youth and explore structures to better integrate primary care in coordinating mental health and addiction treatment. The proposed new system will be dedicated to partnering with the medical and social service community to combat addiction and help the next generation achieve its potential.

Healthy Children and Families – This group will identify the most prominent physical, behavioral and social health problems among children in the region and explore their causes. The group will examine access points for children and evaluate strategies that have worked well in other communities. In addition, this group will identify gaps in educational achievement, particularly literacy and basic skills, and take inventory of community services available for children with special needs and developmental or physical disabilities.

Research and Academics – This group will identify specific ways the proposed new organization can work with ETSU and other academic institutions to substantially enhance the health and economic development of the region by expanding research, training, and the application of public health policy to improve health.

Population Health and Healthy Communities – Incorporating input from the other work groups, this group will identify the top health problems in the region and their clinical and social causes and will inventory current and past efforts to address these problems. The group will also identify successful community governance structures used locally or nationally (such as accountable care communities) that leverage schools, businesses, civic and faith groups, health care providers and government to improve health and wellness.

“Reducing untimely deaths and suffering from heart disease, diabetes, addiction and other chronic diseases through better screening, prevention and treatment is critical to improving the overall health of our region,” said Alan Levine, president and CEO of Mountain States. “But a healthy community is much more than the absence of disease – it means educated, safe and confident young people and adults able to pursue their ambitions and contribute to our community’s well-being.”

The work groups will begin meeting in July and will continue through the end of the year. Each group will hold public meetings, which will rotate throughout Northeast Tennessee and Southwest Virginia, to seek input from members of the community as well as organizations and experts interested in these areas. Each work group will be led by a subject matter expert and will include members from throughout the region who represent a broad variety of experience and perspectives. Work groups will be staffed by members of Mountain States and Wellmont along with master’s and doctoral level students from ETSU.

Work groups will provide regular updates as well as final findings to the Integration Council, a group of executive and physician leaders from both systems who are overseeing the analysis and making preparations for the integration of the proposed combined system.

As these groups form, due diligence research, led by the Integration Council and the Joint Board Task Force, continues between Wellmont and Mountain States to establish the proposed new system. The next step is approval of a definitive agreement by both organizations’ boards of directors, after which the systems will enter a government approval phase that will likely take through the end of 2015.

During the due diligence and government approval phases and until the closing, Mountain States and Wellmont will continue “business as usual” as two separate and independent organizations.

To learn more about the work groups and how to participate, visit BecomingBetterTogether.org.

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WELLMONT, MOUNTAIN STATES ANNOUNCE CHAIRS, MEETING DATES FOR COMMUNITY HEALTH WORK GROUPS

Community round table meetings to solicit public input on important health issues in the region

KINGSPORT and JOHNSON CITY, Tenn. – (August 5, 2015) – Mountain States Health Alliance and Wellmont Health System have scheduled a series of community meetings to solicit input as the organizations work together to solve some of the region’s most challenging health issues, as part of the proposed merger.

The meetings are part of the health systems’ previously announced work groups initiative that will focus on four key areas: Mental Health & Addiction; Healthy Children & Families; Population Health & Healthy Communities; and Research & Academics. More than 100 community members responded to the call for participation through the BecomingBetterTogether.org website, and dozens more were recommended by key stakeholders as valuable participants in the process.

“We are pleased with the sincere interest throughout the region, and we are grateful for these distinguished members of the community who have agreed to lead these work groups,” said Alan Levine, president and CEO of Mountain States.

Eight community leaders have agreed to serve as chairpersons leading the four work groups:

- Mental Health & Addiction: Dr. Teresa Kidd, president and CEO of Frontier Health, and Eric Greene, senior vice president of Virginia services for Frontier Health;
- Healthy Children & Families: Dr. David Wood, chair of the department of pediatrics at East Tennessee State University and chief medical officer of Niswonger Children’s Hospital, and Travis Staton, CEO of United Way of Southwest Virginia;
- Population Health & Healthy Communities: Dr. Randy Wykoff, dean of ETSU’s College of Public Health, and Lori Hamilton, RN, director of healthy initiatives for K-VA-T Food City;
- Research & Academics: Dr. Wilsie Bishop, vice president for health affairs and chief operating officer of East Tennessee State University, and Jake Schrum, president of Emory & Henry.

“This is a tremendously talented group of individuals with expertise that spans multiple disciplines and geographic regions,” said Bart Hove, president and CEO of Wellmont. “We are honored to

have them on board in this process and will benefit from their broad knowledge and community involvement.”

The public has a critical role to play in this process. The College of Public Health at East Tennessee State University (ETSU) will coordinate a series of community round table meetings designed to give residents an opportunity to provide input on the most pressing health concerns they see in their communities. The round table meetings will be held in various locations throughout the region, with a goal of soliciting input from a broad audience, including rural areas.

In addition, Wellmont and Mountain States leaders are partnering with ETSU and the work group chairs to assemble steering committees for each focus area. The steering committees will hold separate meetings to examine top health issues and also review presentations from health experts and community members. Wellmont and Mountain States officials are working with the eight chairpersons to finalize membership for the steering committees. Once complete, the members’ names will be posted on BecomingBetterTogether.org. Both the community round table meetings and the work group steering committee meetings are open to the public.

The first two community round table meetings will take place Aug. 13 and Aug. 20.

- Thursday, August 13, 5:30 – 7:30 p.m.

Tennessee College of Applied Technology, 425 TN-91, Elizabethton, Tenn.

- Thursday, August 20, 5:30 – 7:30 p.m.

Southwest Virginia Higher Education Center, One Partnership Circle, Abingdon, Va.

Community members who wish to attend a meeting are asked to RSVP online at BecomingBetterTogether.org. Additional meetings will be scheduled in the coming weeks; for the most up-to-date schedule, visit BecomingBetterTogether.org.

The public meetings will be facilitated by ETSU’s College of Public Health and will feature a “world café” style discussion with participants circulating through a series of small group tables to exchange thoughts and ideas. ETSU staff will record the information presented during the meetings and compile findings from the meetings into a comprehensive report that will be used by the proposed new health system.

“Here in our region, there is a cycle of poor health that we see being passed from one generation to the next,” said Dr. Randy Wykoff, dean of the ETSU College of Public Health. “Our goal is to gather information that will allow the proposed new health improvement organization to use its resources to help break that intergenerational cycle of poor health. The proposed merger between Mountain States and Wellmont affords our region the opportunity to impact health in ways that weren’t possible in the past, so this is a very exciting opportunity from a public health perspective.”

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WELLMONT, MOUNTAIN STATES FILE LETTERS OF INTENT TO BEGIN REGULATORY APPROVAL PROCESS IN TENNESSEE AND VIRGINIA

Actions mark next steps in the process to pursue state approval for the proposed merger

KINGSPORT and JOHNSON CITY, Tenn. (September 16, 2015) – Wellmont Health System and Mountain States Health 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) this fall. 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.

These actions mark the next steps in the regulatory processes the organizations are following as they explore the creation of a new, integrated and locally governed health system designed to be among the best in the nation and address the serious health issues that affect our region.

“The underlying purpose for the proposed merger is to reduce the growth in health care costs, improve the health of our region and invest in the growth of our economy,” said Alan Levine, president and CEO of Mountain States. “The job creators and employers in our region support this model because they know, as we do, that a locally governed system, under the enforceable agreement of a COPA, will be the best alternative to the widespread consolidation wave happening to hospitals and insurance companies.”

Next, the two organizations will finalize a definitive agreement, which is another formal step in the process to solidify the proposed partnership. The date for expected completion of the merger has not been set but will not occur before state approval has been granted.

A COPA in Tennessee and the cooperative agreement approval process in Virginia will allow Wellmont and Mountain States 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.

“COPA regulation with active supervision by the states is a proven and effective tool to protect consumers, as opposed to traditional hospital mergers occurring all across the country that do not include state involvement and ongoing oversight,” said Bart Hove, president and CEO of Wellmont. “With this proposed merger, our patients and our region will have access to more choices and health care options than they do today – and more than with any other solution.”

“In fact, other paths we explored could have led to loss of local control and jobs to new owners outside the region, as well as increased costs. We believe the proposed merger is the best approach for our community, and we greatly appreciate the hard work of officials in both states to provide a path for our vision to become a reality.”

Tennessee’s Department of Health recently released interim regulations governing COPAs in Tennessee, and Virginia’s Department of Health is finalizing rules to oversee similar cooperative agreements in that state. The rules provide a process and framework for state officials to follow in receiving and reviewing applications for a COPA/cooperative agreement and then actively supervising these agreements if approved.

In Virginia, a group of 25 physicians, community members and business leaders recently attended a meeting hosted by the Virginia Department of Health to express their opinions on the proposed regulations as well as their support for the proposed merger.

“We’ve been truly humbled by the outpouring of support we’ve received from business leaders, physicians and the community over the past few months,” Hove said. “It’s great to see that so many people in our region share our excitement about what we’re creating.”

“As we’ve said from the beginning, we are committed to being transparent about the efforts underway to pursue approval for our proposed merger,” Levine said. “While filing the letters of intent with Tennessee and Virginia are important next steps, they are simply two of many that will occur in the next few months. There is still a lot of work ahead. But, we grow more confident every day in our ability to work together to create a bright future for health care in our region.”

View copies of the [Tennessee](#) and [Virginia](#) letters of intent.

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.

FOR IMMEDIATE RELEASE



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Teresa Hicks, Mountain States
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Media Advisory: We invite members of the media to join us for a media briefing today at 2 p.m. at the Bristol Chamber of Commerce. Set up is available at 1:45 p.m. A conference call line is also available at 2 p.m. by calling 855-749-4750, with the access code of 28068129.

**WELLMONT, MOUNTAIN STATES SHARE PUBLIC REPORT OUTLINING
FUTURE PLANS TO IMPROVE HEALTH IN REGION**

Report reflects extensive community input, describes commitments in six key areas

KINGSPORT and JOHNSON CITY, Tenn. (January 7, 2016) – Mountain States Health Alliance and Wellmont Health System today released a public report outlining a series of binding commitments the proposed new organization will make about how it will operate and uniquely serve the community together. The report describes commitments in six key areas to improve health in the region.

The commitments include: improving community health, enhancing health care services, expanding health care choices and access to care, enhancing health care value, investing in health research and education, and attracting and retaining a strong workforce.

Unlike traditional mergers and consolidation, the proposed organization also commits to reduce the pace of growth in health care costs to below the national average by placing limits on negotiated rates with insurers.

“Our management teams working together continue to make very careful and deliberate progress with the proposed merger and are excited to take this next step by sharing our transformational vision, which has drawn widespread support from community, business and governmental leaders throughout our region and respective states,” said Roger Leonard, chair of Wellmont’s board of directors. “We look forward to working with officials in Tennessee and Virginia as they evaluate the report and upcoming filings so this process can reach a successful conclusion. We appreciate their engagement and willingness to provide the framework that will produce an innovative, nationally recognized model that will promote improved health and quality of life for our families, friends and neighbors.”

The pre-submission report, required by the regulatory approval processes in Tennessee and Virginia, precedes the filing of applications for approval of the proposed merger in both states.

“The path we are pursuing is an innovative model unlike the traditional mergers that are common among hospitals and providers today,” said Barbara Allen, chair of the Mountain States board of directors. “We believe our proposed alternative is better. It is the only model that maintains local

governance, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in our region and invests those dollars in the improved health of our region while preserving local jobs.”

Specifically, Wellmont and Mountain States are committing to a series of transformational investments, made possible through financial efficiencies that will be achieved with the proposed merger, in the following ways over the next 10 years:

- **At least \$75 million** to invest in population health improvements to meet the unique health needs of our region through a 10-year plan to be developed with the community and the public health resources at ETSU;
- **At least \$140 million** to expand community-based mental health services, residential and outpatient addiction recovery programs, and tobacco and substance abuse prevention programs as well as to further support children’s and rural health services;
- **At least \$85 million** to develop and grow academic and research opportunities, support post-graduate health care training, and strengthen the pipeline and preparation of health professionals in the region; and
- **Up to \$150 million** to implement a common information technology platform to support the regional exchange of health information, connect our hospitals, physicians and other caregivers, and allow the combined system to offer higher quality, more convenient and more cost-effective care for patients.

The commitments outlined in the report were developed after careful review of a variety of research and data, including the state health plans from Tennessee and Virginia, the Southwest Virginia Health Authority’s Blueprint for Health Improvement and Health-Enabled Prosperity, the two organizations’ initial due diligence, input from community meetings, local health data and statistics, projected health needs, existing services, financial data, and more.

“These commitments reflect months of extensive conversations with stakeholders across our region,” said Alan Levine, president and CEO of Mountain States. “The transformational investments outlined in this report would not be possible without the savings realized by combining our two organizations.”

Wellmont and Mountain States anticipate filing the applications for a Certificate of Public Advantage (COPA) with the Tennessee Department of Health and a cooperative agreement with the Southwest Virginia Health Authority in late January after a period of public comment on the pre-submission report. The applications will initiate the state review process, which is expected to extend into the late summer of 2016.

Should Tennessee and Virginia approve the applications and the merger becomes final, the state and commonwealth will supervise the new organization and enforce the commitments to ensure the public benefits.

“Our health systems are fortunate to have highly regarded physicians and other dedicated professionals who have enabled us to serve the region with distinction for decades,” said Bart Hove, Wellmont’s president and CEO. “Because of the investments we are committing to make, new opportunities will be created that will provide a brighter future with more opportunities for all because we will be a stronger organization together than would otherwise be the case.”

The community is encouraged to review the report and comment on its contents at www.BecomingBetterTogether.org. The website also provides further information about the proposed merger process, including frequently asked questions, news and updates and more. A summary of the commitments outlined in the pre-submission report is attached to this release.

About Wellmont Health System

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###

**Record of Community Stakeholder and Consumer Views
of the Proposed Cooperative Agreement**

ATTACHMENT B

Better Together Newsletters

Better Together



Answering Your Questions

Recently, Wellmont Health System and Mountain States Health Alliance [announced historic plans](#) to explore the creation of a new, integrated and locally governed health system. Since that time, we have been overwhelmed by the terrific support and interest in what we are pursuing together.

We have also received a number of important questions asking why this is happening and what it means for our hospitals, physicians, team members and communities.

We are committed to answering as many of those questions as we can and to being as transparent as possible as our organizations pursue the work ahead. That's why we have created a couple of sources to accomplish that:

1. **The Better Together newsletter** – This newsletter will be sent out periodically to physicians and team members at both organizations, along with others in our community who sign up. It will have the latest information, address questions, and feature voices from the region. If you have ideas to make it better, [let us know](#). People who are interested in receiving the newsletter can sign up at [BecomingBetterTogether.org](#).
2. **[BecomingBetterTogether.org](#)** – We recently launched a website solely dedicated to providing the public with information about our shared vision to address the health issues that affect our region. There, we will provide updates about our efforts to unite our organizations. We encourage you to visit this site to learn more, submit questions, and stay

up-to-date with the latest information – for example, we recently announced the [members of our Integration Council](#), which is charged with overseeing planning for the proposed merger.

Wellmont and Mountain States are committed to this process of exploration into creating a new, integrated system that will help make our region healthier while controlling costs and making healthcare more affordable.

Thank you for your interest and support. Many of you have taken the time to share your thoughts and ask important questions – it's clear that you care about the future of healthcare in our region just as much as we do.

Our Vision

To learn more about our shared vision for the future, view this new video below featuring Bart Hove, president and CEO of Wellmont, and Alan Levine, president and CEO of Mountain States.



Questions of the Week

In each newsletter, we will answer a couple of the hottest questions. For more answers, [please go to our website](#), which will be updated frequently.

“Will the community be able to provide input regarding the new name of the future organization?”

Yes! As we explore creating a new, locally governed health system, we want to be sure the community – along with our own team members and physicians – has input in shaping it. We are not quite ready to begin the process of naming or branding, but stay tuned for how to chime in.

“How will employee benefits be impacted (retirement, health insurance, PTO, pension plan, etc.)?”

We understand how important these types of questions are. Today, we are still very early in exploring the specifics of what our future organization will look like.

What we can tell you today is that we would aspire to be one of the best healthcare employers in the country. Together, we would nurture a culture that promotes employee satisfaction and opportunity for professional growth. We promise to share more information when we are able.

“Won’t we lose competition by combining Mountain States and Wellmont?”

Actually, with this merger, our patients and our region will have access to more choices and healthcare options than they do today. By combining our resources, we can draw more specialists and add new services for which people now have to drive hours to find. In addition, this potential new organization would involve the institution of a Certificate of Public Advantage or COPA, which establishes enforceable commitments to guard against effects from any loss of competition. A COPA will mean that the health system must meet commitments in driving down unnecessary costs, keeping care affordable, improving quality of care, enhancing access and benefiting the communities we serve. [Learn more about the COPA process here.](#)

Have a question? [Submit it by clicking here](#), or to this email address:

info@becomingbettertogether.com.

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Better Together



Thank You

Welcome to the second edition of the Better Together newsletter. We received great feedback on our first edition, [which can be read here](#). We'll continue to provide regular updates on our process through this newsletter, our website – BecomingBetterTogether.org – and in other ways. Many of you have also visited our [Q&A page](#) to read the latest questions and answers or to ask your own question. We hope you'll continue to do so moving forward.

News and Updates

Our process to explore a potential merger is on track, and we want you to be the first to know an important update. When we made our announcement last month, we shared that a Joint Board Task Force would be created to act as a governing body of the process as we conduct due diligence, move toward a definitive agreement, and then move toward seeking regulatory approvals for the potential integration of our two organizations. This task force will be composed of members appointed by the current boards of Wellmont and Mountain States, as well as the CEOs of the two systems. Today, we're excited to announce the following members of the task force.

From Wellmont:

- **Dr. Nelson Gwaltney**, of Bristol, Tennessee, a member of the Wellmont board of directors, president of Highlands Physicians Inc. and a general surgeon on the medical staff of Bristol Regional Medical Center

- **Bart Hove**, of Kingsport, Tennessee president and CEO of Wellmont Health System
- **Roger Leonard**, of Bristol, Tennessee, chair of the Wellmont board of directors and a senior adviser to England & Company
- **Roger K. Mowen Jr.**, of Kingsport, Tennessee, a member of the Wellmont board of directors and retired senior vice president of global developing businesses and corporate strategy for Eastman Chemical Company
- **Dr. Doug Springer**, of Kingsport, Tennessee, a gastroenterologist on the medical staff of Holston Valley Medical Center, a member of the Wellmont board of directors and immediate past president of the Tennessee Medical Association
- **Dr. David Thompson**, of Bristol, Tennessee, an internal medicine physician with Wellmont Medical Associates in Bristol, who also practices in Abingdon, Virginia, and is a Wellmont board member and chairman of the Wellmont Medical Associates board of directors
- **Keith Wilson**, of Kingsport, Tennessee, who owns a secondary residence and a farm in Scott County, Virginia, a member of the Wellmont board of directors, publisher of the Kingsport Times-News and president of Northeast Tennessee Media Group

From Mountain States:

- **Barbara Allen**, of Johnson City, Tennessee, chair of the Mountain States board of directors and general manager of Stowaway Storage, a family-owned business in Johnson City
- **Bob Feathers**, of Kingsport, Tennessee, a member of the Mountain States board of directors and president and CEO of Workspace Interiors, Inc.
- **Alan Levine**, of Johnson City, Tennessee, president and CEO of

Mountain States Health Alliance

- **Dr. David May**, of Elizabethton, Tennessee, a member of the Mountain States board of directors and immediate past president of the medical staff at Sycamore Shoals Hospital
- **Dr. Rick Moulton**, of Johnson City, Tennessee, medical director of clinical integration for State of Franklin Healthcare Associates and chairman of the SoFHA patient centered medical home committee
- **Gary Peacock**, of Marion, Virginia, a member of the Mountain States board of directors, former chair of the Smyth County Community Hospital board of directors, and retired senior vice president of Royal Mouldings
- **Clem Wilkes, Jr.** of Johnson City, Tennessee, a member of the Mountain States board of directors and co-manager of Citizens Investment Services, a subsidiary of Citizens Bank Tri-Cities

[Learn more about the Joint Board Task Force »](#)

The Integration Council, which was [named last month](#), has begun its work and will make recommendations for consideration by leadership and the Joint Board Task Force. For reference again, below are the members of the Integration Council.

From Wellmont:

- **Eric Deaton**, executive vice president and chief operating officer
- **Alice Pope**, executive vice president and chief financial officer
- **Todd Norris**, senior vice president for system advancement
- **Gary Miller**, senior vice president of legal affairs and general counsel
- **Dr. Dale Sargent**, system medical director for hospitalist services and

former chief medical officer

- **Dr. Bob Funke**, a member of Holston Valley Medical Center's Physician Clinical Council and former hospital board of directors member

From Mountain States:

- **Marvin Eichorn**, executive vice president and chief operating officer
- **Dr. Morris Seligman**, executive vice president and chief medical officer
- **Lynn Krutak**, senior vice president and chief financial officer
- **Tony Keck**, senior vice president and chief development officer
- **Tim Belisle**, senior vice president and general counsel
- **Dr. Sandra Brooks**, a system board member and vice president of Watauga Pathology Associates

In The News

In case you missed it, here are several recent news articles that may be of interest to you:

- [MSHA, Wellmont officials answer viewer questions about merger](#)
- [Graduating nurses see opportunity in Tri-Cities health care future](#)
- [MSHA/Wellmont merger has support of TN's largest physicians organization](#)
- [Merger will impact ETSU](#)

Thanks to [Eastman Chemical Company](#) and the president of District 5 of the [Tennessee Nurses Association](#) (which represents our region) for their positive comments and support of our process and vision.

“Eastman supports the decision to unify the systems in an effort to improve the quality and affordability of and access to health care in the region.”

CeeGee McCord, Eastman Chemical Company; Source: [Kingsport Times-News](#)

“The Tennessee Nurses Association embraces the decision as one that will improve the quality of health care in our region, control spiraling costs, and better address the chronic health care issues facing this state.”

Teresa A. Martin, MSN, FNP-BC, District President, on behalf of District 5, Tennessee Nurses Association; Source: [WCYB](#)

Questions of the Week

In each newsletter, we will answer a couple of the hottest questions. For more answers, please go to [our website](#), which will be updated frequently.

“Are there plans to close one of the two hospitals in Norton, Virginia?”

A: There are no plans to close any hospitals. The services and programs offered by both organizations through our hospitals and other locations are always evolving in ways that reflect the input of our physicians and the needs of our patients. Long-term, the new organization will conduct a comprehensive health needs assessment to identify opportunities for new community-based resources and possibilities that don't exist today for our employees and communities.

“How does this decision impact ETSU?”

A: We believe our proposed new organization would positively impact East Tennessee State University and other academic institutions, as it would allow us to further advance clinical education in the region and to be more

competitive in pursuing research dollars currently flowing elsewhere nationally. In fact, the president of ETSU will also serve as an ex-officio member of the new system's Board.

Both Mountain States and Wellmont have been forced to reduce residency positions in recent years. We believe this partnership can help reverse that trend. We would partner with ETSU and others to strengthen the pipeline of physicians and allied health professionals and to attract research jobs and investments in our region. In addition, ETSU would help to conduct a substantial comprehensive regional health needs assessment to address health gaps and disparities, which will help shape the future direction of the potential new system and establish its priorities.

“What EHR system will be used by the combined entity?”

A: That is a major decision that has both strategic and clinical implications, and no decisions like this would be made until after the transaction closes (expected no earlier than the end of 2015). We will include significant input from our physicians before making any major decisions that will impact clinical care. What we do know today is that our combined organization would have a single EHR platform to ensure our facilities and providers work as seamlessly as possible with each other. We promise to share more information as soon as it's available.

Have a question? [Submit it by clicking here](#) or to this email address: info@becomingbettertogether.org.



Better Together



News & Updates

Welcome to the third edition of the Better Together newsletter.

Wellmont Health System and Mountain States Health Alliance continue the work of exploring our proposed future organization. Here are several updates:

- **COPA legislation:** On May 18, Gov. Bill Haslam, R-Tenn., signed a bill amending the state of Tennessee's Certificate of Public Advantage (COPA) statute. We supported this legislation, and applaud the governor for signing it. This statute provides guidelines to ensure that mergers, like the one we are exploring, provide for high quality, cost effective health care. The COPA will represent an agreement between our new system and the state of Tennessee, and compliance with the content of the agreement will be actively supervised by the state.
- **Nurse involvement in our planning efforts:** We've received several thoughtful questions through the [Better Together](#) website regarding the involvement of nurses in the planning efforts for the proposed new organization. See this week's "Questions of the Week" below. Our nurses are a vital part of both organizations and will be critically important in our proposed future organization as well. There will be a number of ways nurses and team members from both organizations will be heard through this process, and we'll keep you updated of these opportunities along the way.

- **iPad mini giveaways:** Congratulations to Beverly Stephens and Mike Housewright! Beverly won an iPad mini after entering the drawing at our Better Together booth during the Leadercast event in Kingsport, and Mike won an iPad mini after entering the drawing at the Tennessee Valley Corridor Summit at East Tennessee State University. Enjoy!

Community Support

We thank the Chambers of Commerce of Kingsport, Bristol and Johnson City / Jonesborough / Washington County for their recent letter of support for our proposed merger. The Chambers have invested a lot of time, on behalf of their hundreds of member businesses, learning about the possibilities for our region with the proposed merger. The support of the business community, which pays much of the cost of health care in our region, is critical to the success of the proposed new organization. The [letter can be read here](#). Here is a brief excerpt:

“The Chambers of Commerce ... endorse the proposed merger of Wellmont Health System and Mountain States Health Alliance to an integrated single system. We believe this offers the best opportunity for the betterment of our region's healthcare.”

The Chambers of Commerce of Kingsport, Bristol and Johnson City / Jonesborough / Washington County

Additionally, we want to thank Dr. Doug Springer of the Tennessee Medical Association for his statement of support:

“Combining strengths, assets and liabilities would enable these systems to focus more on quality, population health management, mental health programs and other services benefiting the entire region.”

Douglas J. Springer, MD, immediate past president of the Tennessee Medical Association

Questions of the Week

In each newsletter, we will answer a couple of the hottest questions. For more answers, please go to [our website](#), which will be updated frequently.

“Will nurses be involved in the planning efforts for the proposed new organization?”

A: Yes, absolutely – there will be a number of ways nurses from both Wellmont and Mountain States will be heard through this process. In fact, we won't be successful in accomplishing what we hope to do without the support and input of our nurses. As the Integration Council continues to progress, it will activate functional teams that will provide recommendations related to the operations of a merged system. We will want nursing to be well represented and active on these teams, which will focus specifically on areas like clinical operations, academics and research, and population health.

Throughout this process, we encourage nursing leadership to stay closely in touch with hospital leadership to communicate questions and thoughts from nursing staff. Meanwhile, we will continue to seek the input of our team members in a variety of ways, including our [Better Together website](#), our newsletter, internal and external town hall meetings, and more. We recognize the vital role our nurses play every day but especially in shaping the future of our proposed new system, and we're committed to keeping our nurses updated on any opportunities to be involved.

“What are the plans for the future of pediatrics care?”

A: We see great opportunity to enhance and expand access to pediatric services through our proposed merger across the region. What that looks like specifically is part of the planning work ahead as we first identify gaps in what our communities need versus what either of our organizations offer today and can improve through the proposed merger. We look forward to sharing more information as our planning efforts unfold.

Have a question? Submit it by clicking [here](#) or to this email address:

info@becomingbettertogether.org.

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Better Together



Wellmont, Mountain States to Seek Public Input on Key Health Issues

Welcome to a special edition of the Better Together newsletter. We have an exciting update to share and wanted you to be among the first to know.

Mountain States Health Alliance and Wellmont Health System officials **are creating four community work groups designed to provide public input** as the two organizations continue to explore the creation of a new, integrated and locally governed entity. [Learn more »](#)

The work groups will provide input in solving some of the region's most challenging health issues:

- [Mental Health and Addiction](#)
- [Healthy Children and Families](#)
- [Research and Academics](#)
- [Population Health and Healthy Communities](#)

Through [BecomingBetterTogether.org](#), we invite the community as well as subject matter experts such as nurses and other health professionals, doctors, public health officials and community advocates to

get involved in these four work groups.

The work groups will:

- Begin meeting in July and continue through the end of the year.
- Hold public meetings throughout Northeast Tennessee and Southwest Virginia to seek community input.
- Be led by a subject matter expert and include members from throughout the region who represent a broad variety of experience and perspectives. The group members will be determined soon.
- Be staffed by members of Mountain States and Wellmont along with master's and doctoral level students from East Tennessee State University.
- Provide regular updates as well as final findings to the Integration Council, a group of executive and physician leaders from both systems who are overseeing the analysis and making preparations for the integration of the proposed combined system.

The work groups' findings will be used by East Tennessee State University as part of a deep-dive health needs assessment that will be conducted after the proposed merger between Mountain States and Wellmont is complete.

That assessment will provide a road map for the proposed new health system as it lays out a 10-year plan to improve community health.

Our organizations have committed to an open process as we consider the creation of a truly new health improvement organization for our region. These work groups **provide a great opportunity for interested organizations and individuals to participate with us** as we develop our strategies for improving the health of our area.

Visit BecomingBetterTogether.org to learn more about how to get involved.

In the coming weeks and months, the website will be updated to include the latest work group news, meeting schedules and more.

As always, if you have questions or thoughts to share, [let us know](#).

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Better Together



Wellmont, Mountain States Announce Community Health Work Groups Meeting Dates and Chairs

Earlier this summer, Wellmont Health System and Mountain States Health Alliance announced an exciting new initiative to seek the public's input as the organizations work together to try to solve some of our region's most important health issues: **Mental Health & Addiction; Healthy Children & Families; Research & Academics; and Population Health & Healthy Communities.**

We are overwhelmed and excited by how many people in our community expressed interest in getting involved in this important discussion – over 100 people signed up to participate through our website.

Today, we're excited to share the next steps in this initiative.

Several local community leaders have been [selected as chairpersons to lead the work groups](#), and the first of a series of community meetings have been scheduled.

Eight community leaders have agreed to serve as chairpersons of the four work groups:

- [Mental Health & Addiction](#): Dr. Teresa Kidd, president and CEO of

Frontier Health, and Eric Greene, senior vice president of Virginia services for Frontier Health;

- Healthy Children & Families: Dr. David Wood, chair of the department of pediatrics at East Tennessee State University and chief medical officer of Niswonger Children's Hospital, and Travis Staton, CEO of United Way of Southwest Virginia;
- Population Health & Healthy Communities: Dr. Randy Wykoff, dean of ETSU's College of Public Health, and Lori Hamilton, RN, director of healthy initiatives for K-VA-T Food City;
- Research & Academics: Dr. Wilsie Bishop, vice president for health affairs and chief operating officer of East Tennessee State University, and Jake Schrum, president of Emory & Henry.

Additionally, the first two community round table meetings will take place on August 13th and 20th:

- **August 13, 5:30 – 7:30 p.m.**
Tennessee College of Applied Technology
425 TN-91, Elizabethton, Tenn.
- **August 20, 5:30 – 7:30 p.m.**
Southwest Virginia Higher Education Center
One Partnership Circle, Abingdon, Va.

We hope you will join us for one of these meetings, as well as future meetings as they are scheduled throughout Northeast Tennessee and Southwest Virginia. If you plan to attend, [we ask that you submit a quick RSVP online](#). Your RSVP is encouraged but not required.

Wellmont and Mountain States continue to explore the creation of a new, integrated and locally governed health system designed to be among the best in the nation. The discussions to occur and the findings of the community health work groups will be incredibly valuable as we plan for a

bright future for health care in our region.

Visit BecomingBetterTogether.org to stay up to date on the latest news regarding the work groups, the proposed merger and more.

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Better Together



Wellmont and Mountain States continue to make progress on exploring the creation of a new, integrated and locally governed health system.

Over the past few months, we've been humbled by the outpouring of support we've received from the community.

It's exciting to see that so many people in our region believe in the vision of our proposed future health system and the benefits of a local solution to tackling our regional health care needs. In fact, we've had more than 10,000 unique visitors to BecomingBetterTogether.org. We want to thank you for your thoughtful questions and support for this potential new health system.

Additionally, we've received numerous public statements of support from community and business leaders, academic leaders, elected officials and more, such as East Tennessee State University, the [local Chambers of Commerce](#), Eastman Chemical Company and the Tennessee Medical Association. You can view the [latest media clips, including supportive op-eds and letters to the editor, here](#).

News & Updates

Community Health Work Groups Initiative

This month, we launched the community work groups initiative in partnership with ETSU as a way to gain public input in developing a 10-year health improvement plan for the region. These groups, led by subject matter experts, will continue to meet throughout Northeast Tennessee and Southwest Virginia through the end of the year. We are very encouraged by the almost 100 community members who joined us in both Elizabethton and Abingdon to kick off this important work.

Visit BecomingBetterTogether.org to learn more about how to get involved and to RSVP for an upcoming meeting near you.

Proposed Merger Progress

We continue to pursue due diligence and other important steps toward a potential agreement to combine the health systems, including measuring the likely cost and quality benefits, **determining the structure of the proposed system** and **engaging with key stakeholders** such as employees, physicians and the community to understand what's important to them regarding the proposed system and our vision for the future.

There are several upcoming milestones in the process to finalize our proposed partnership.

- This fall, we expect to execute a **Definitive Agreement (DA)** between our two organizations, which is the next step in the process toward seeking government approval to merge.
- With that in mind, we will also file a **Letter of Intent (LOI)** to the Department of Health in Tennessee, which is a required first step before we submit a COPA (Certificate of Public Advantage) application in Tennessee.
- There is still a lot of work ahead, and we're committed to keeping you informed of the progress we're making. We'll continue sharing news as we have it in a variety of ways, including through updates to BecomingBetterTogether.org.

Finally, in case you missed it, Bart Hove, president and CEO of Wellmont,

and Alan Levine, president and CEO of Mountain States, answered viewer questions about the proposed merger on WJHL Monday. [See what they had to say here.](#)

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Better Together



Wellmont, Mountain States Take Important Next Steps in Proposed Merger Process

We have an update to share and wanted you to be among the first to know. **Wellmont and Mountain States have filed a letter of intent (LOI) with the Tennessee Department of Health**, indicating we will submit an application for a Certificate of Public Advantage (COPA) this fall. **In Virginia, we have submitted a similar letter of intent with the Southwest Virginia Health Authority**, signaling our intent to request approval by the commonwealth of the anticipated cooperative agreement between the two systems.

These important filings show **we are moving forward** with the state regulatory approval processes, but we still have many more steps to complete in the coming months.

A COPA in Tennessee and the cooperative agreement approval process in Virginia will allow Wellmont and Mountain States 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.

We appreciate the great work of the officials in both states as they create the guideposts that will oversee our proposed

merger. Tennessee's Department of Health recently released interim regulations governing COPAs in Tennessee, and Virginia's Department of Health is finalizing rules to oversee similar cooperative agreements in that state.

Next, the two organizations will finalize a definitive agreement, which is another formal step in the process to solidify the proposed partnership. The date for expected completion of the merger has not been set but will not occur before state approval has been granted.

We're encouraged by our great progress. **In fact, the more we work together, the more excited we become about building a new approach to health care in our region.** We promise to keep everyone informed as we reach coming milestones.

Read the [news release here](#) and [view the LOIs here](#).

Community Support Continues

We want to thank everyone for the support we've received in recent months. Earlier this month, a group of 25 physicians, community members and business leaders attended a meeting hosted by the Virginia Department of Health to express their opinions on the proposed regulations as well as their support for the proposed merger.

Here is what a few attendees had to say:

- “Leonard Companies has been doing business in Southwest Virginia for 61 years. As business people and citizens of the area that will be affected we support the merger of these two health care systems. We believe that this consolidation will assist the five-state region by enhancing quality physician recruitment, provide a broader array of medical specialists available to the rural communities of our area, and assist in much needed economic development for the region.” - **Dave Leonard, II, vice president, Leonard Land and Livestock**

- “A properly regulated environment will allow the entities to bring high quality healthcare to the people in our region at an affordable cost. This is a unique situation that will help ensure the future of healthcare in Southwest Virginia.” - **Martin Kent, president and chief operating officer, The United Company**
- “My Chamber of Commerce represents hundreds of businesses. One important factor in having a healthy and thriving economy is having a healthy community. Mountain States Health Alliance and Wellmont Health System are working on a proposed merger. Providing affordable, high-quality healthcare with broad access is the vision. Healthcare is complicated and the regulations...will give these two organizations the ability to become a single entity with one goal: making the people in our region healthy.” - **Beth Rhinehart, president and CEO, Bristol, Tennessee and Virginia Chamber of Commerce**
- “I see every day how healthcare is changing. I support the proposed merger...because in today’s complicated and rapidly changing healthcare landscape it’s important to look for ways to improve care and keep costs down.”- **Skip Skinner, executive director, LENOWISCO**
- “As a physician, I have seen many changes in healthcare both locally and across the country, many of them driven by regulatory reform. The ... legislation passed in Virginia last year was an important step towards ensuring healthcare remains available to people in our area and that costs remain competitive. The proposed merger between Wellmont Health System and Mountain States Health Alliance is just one example of what can be achieved under the enabling legislation and a sound regulatory environment.” - **Dr. Maurice Nida, Norton, Virginia physician with Wellmont Medical Associates**

These are just a few of the voices of the many local people and organizations that have expressed support for what Mountain States and Wellmont are working to accomplish through the proposed merger.

These expressions of support are the latest in a series of positive statements

from our community, which has included East Tennessee State University, the local [Chambers of Commerce](#), Eastman Chemical Company and the Tennessee Medical Association. Additionally, you can [view the latest media clips, including supportive op-eds and letters to the editor, here](#).

Visit [BecomingBetterTogether.org](#) for the latest news and updates.

 FORWARD

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Better Together



Wellmont, Mountain States Share Exciting Commitments to Improve Region's Health

Today, we're excited to share a **public report** proposing **important commitments** about how we will operate and uniquely serve our community as a new health system. **This report is the result of more than nine months of extensive work by physician leaders, board members and executives from Wellmont and Mountain States, and hundreds of conversations with people all across our region** about the area's critical health needs and how best to address them.



The report describes our commitment to make a series of transformational investments to improve health in the region. These investments will be achieved through financial efficiencies gained through the proposed merger and the proposed new health system's commitment to reinvest those savings for community benefit and health improvement.

The report outlines important commitments to positively impact health

care and economic development in the region as a combined system in six key areas:

- **Improving Community Health**
- **Enhancing Health Care Services**
- **Expanding Access and Choice**
- **Improving Health Care Value: Managing Quality, Cost and Services**
- **Investing in Health Research and Graduate Medical Education**
- **Attracting and Retain a Strong Workforce**

[The pre-submission report](#) is the latest step in the process for the proposed merger of the two health systems. Next, we expect to file applications for a COPA in Tennessee and a cooperative agreement in Virginia in late January after a period of public comment on the report. The applications will initiate the state review process, which is expected to extend into the late summer of 2016.

Since we announced our proposed merger in April, we have been grateful for the outpouring of support we have received throughout the region. As we move forward, we'll continue to provide updates in a variety of ways.

Know that we remain committed to the creation of a brand new health system designed to meet the unique needs of our region, both today in the future. In fact, the further we move down this path, and as additional details of what we'll be able to achieve together are clarified, the more excited we are about this innovative vision.

Our region has a once in a lifetime opportunity to create a lasting legacy of improved health by pursuing a merger between Wellmont and Mountain States. With the approval of the states under a COPA in Tennessee and a cooperative agreement in Virginia, the savings realized by reducing unnecessary duplication and improving coordination will stay within the region and be reinvested in ways that benefit the community substantially.

To learn more, please visit BecomingBetterTogether.org to review the commitments, [download the full report](#), and provide your thoughts and feedback.

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**Record of Community Stakeholder and Consumer Views
of the Proposed Cooperative Agreement**

ATTACHMENT C

Internal Town Hall Presentations

Better Together



Leadership Team Discussion

Moving Forward with Vision

Leadership Team Presentation – April 2015

What We Are Announcing

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 be among the best in the nation and address the serious health issues that affect our region.

Timeline

- Tuesday (3/31)
 - WHS Board Meeting
- Wednesday (4/1)
 - Senior Leadership Call
 - MSHA Board Meeting
 - Physician Leadership Meeting
 - Select VIP Calls
 - Anticipated Signing of Letter of Intent
- Thursday (4/2)
 - VIP Calls
 - Community Board Call
 - Internal Memo
 - Press Release; Invite to Press Briefing
 - Press Briefing
 - Town Halls throughout the System
 - Medical Staff Meetings

Your Role

- Credible source of information
- Leader of town halls and other key meetings
- Sounding board for employees and physicians
- Liaison back to leadership about the pulse

Key Messages

**Better
Together**



We have a great vision.

- As a combined system, we would work to unite the resources of both systems with one common purpose – to make the next generation of this **region healthier than today's, and to make sure** those who need healthcare services today can access the best care available in the nation.

We are creating something new.

- Neither organization is acquiring the other one.
- We will have a new name.
- We will have a new board, equal parts Wellmont and Mountain States, plus two independent members and the President of ETSU.



Apart, we face a number of challenges.

- Significant national industry challenges.
 - Increasing reimbursement cuts, the decline of inpatient volumes, constrained revenue, the move of services to the outpatient setting, and the increasing difficulty in recruiting and retaining physicians.
- Plus, our region suffers from serious health issues that need to be addressed.
 - Some of the highest rates of cardiovascular disease, diabetes and pulmonary disease in the country; an epidemic of addiction and untreated mental illness without access to the right level of inpatient and outpatient treatment; and we admit more people to the hospital per thousand than most other areas of the nation.



Together, we will make our region healthier.

- By working together in an integrated system, we can redirect spending away from wasteful duplication that has not added value, and instead invest in what evidence has shown will help make our region healthier while controlling costs.



We will be one of the most attractive systems for physicians and team members nationally.

- Physicians will have a strong voice during the integration process and will help guide the formation of the new system.
- A counsel of physician leaders from both organizations will be formed to address matters related to the provision of clinical services and other medical staff matters.
- All existing contracts and medical privileges will be honored for employed and independent physicians in good standing.
- Our pay and benefits will be competitive in order to attract the best and brightest team members.
- No major layoffs are anticipated.



There is much planning work to do.

- Now, we enter a planning period for several months.
- This work will be led by a Joint Board Task Force and an Integration Council, including executive and physician leaders from both systems.
- If we decide to proceed with a definitive agreement, we will then enter a government approval phase likely through the end of 2015.



What is a COPA?

- We will pursue government approval under the COPA (Certificate of Public Advantage) statute in TN.
- A COPA authorizes us to merge and directs the state to actively supervise our new health system to ensure that we continue to benefit the community by providing healthcare that is affordable, accessible, cost-efficient and high-quality.
- In VA, we will pursue a process similar to a COPA defined by a proposed statute that has been passed by **the legislature and awaits the governor's signature.**



Until then...

- During the due diligence and government approval phases, both Mountain States and Wellmont **will continue “business as usual” as two separate and independent organizations.**

Better Together



Joint Announcement Presentation – April 2015

What We Are Announcing

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 be among the best in the nation and address the serious health issues that affect our region.

We are creating something new.

- This is a **merger** – not an acquisition by either organization – and we will have a **new name**.
- A **new board** will have equal representation from Wellmont and Mountain States, and two new independent members, plus the President of ETSU (non-voting).
- The new organization will be managed by an **executive team** with representatives from each organization: Executive Chairman & President Alan Levine, CEO Bart Hove, COO Marvin Eichorn and CFO Alice Pope.



Apart, we face a number of challenges.

- Significant industry and local business challenges
 - Increasing reimbursement cuts, the decline of inpatient volumes, the move of services to the outpatient setting, the increasing difficulty in recruiting and retaining physicians
- **Our region's serious health issues**
 - Some of the highest rates of cardiovascular disease, diabetes and pulmonary disease in the country
 - Epidemic of addiction and untreated mental illness without access to the right level of inpatient and outpatient treatment
 - More people admitted to the hospital per thousand than most other areas of the nation



Together, we will make our region healthier.

- The cost of this poor health is not sustainable, and **we must take transformational steps to resolve these issues.**
- By working together in an integrated system, we can redirect spending away from wasteful duplication that has not added value, and instead invest in what evidence has shown will help **make our region healthier while controlling costs.**



Together, we have a great vision.

As a combined system, we would work to unite the resources of both systems with one common purpose – to **make the next generation of this region healthier than today's, and to make sure** those who need healthcare services today can access the **best care available** in the nation.



We will be one of the best healthcare employers in the country.

- We will nurture a **culture that promotes employee satisfaction** and opportunity for professional growth.
- **Physicians will have a strong voice** during the integration process and will help guide the formation of the new system.
- A **council of physician leaders** from both organizations will be formed to address matters related to the provision of clinical services and other medical staff matters.



A COPA affirms our commitment to the community.

- We will pursue approval under the **Certificate of Public Advantage** statute in TN and a similar process in VA.
- A COPA authorizes us to merge and directs the state to actively supervise our new health system to ensure that it continues to benefit the community by providing healthcare that is affordable, accessible, cost-efficient and high-quality.



There is much planning work to do.

- A **joint board task force** will oversee the effort, and an **integration council**, with executive and physician leaders from both systems, will oversee the integration analysis and further develop integration plans.
- Following a definitive agreement, we will then enter a government approval phase likely **through the end of 2015**.



Until then...

- Nothing changes today.
- During the due diligence and government approval phases, both Mountain States and Wellmont will continue “business as usual” as **two separate and independent organizations**.



Keeping You Informed

- We promise to keep everyone informed.
 - We'll share ongoing updates in our regular internal communications, on the Intranet, in town hall meetings, etc.
 - We are launching a new website as a resource for news, FAQs and more: www.BecomingBetterTogether.org.
 - We welcome your questions and comments along the way. Send them to info@becomingbettertogether.org.



Some Key Questions

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How will we bring our two distinct organizations and cultures together?

Culture and heritage are critically important to both **organizations. That's why we are creating a joint board task force, an integration council and a clinical council.** Over the next many months, our board members and executive and physician leaders will be investing themselves in the work of exploring how to weave our operations and cultures together, so we benefit from the best of both.



When would the merger be finalized?

We believe a merger can be finalized by the end of 2015, once all steps are completed.



What does this mean for jobs?

There are a number of details yet to be determined, and this is the work before leadership and the integration council over the coming months. What we do know today is that our combined organization would be committed to being one of the best healthcare employers in the country and to nurture a culture that promotes employee satisfaction and opportunity for professional growth. We promise to share **more information as soon as it's available.**



Will physicians need to reapply for privileges?

No. If we merge, all medical staff members in good standing would maintain their medical staff privileges.



Will projects planned be put on hold while this merger is explored?

Today, nothing changes as both Wellmont and Mountain States continue as separate and independent organizations. It's "business as usual" for both of us.



How long before we start to see changes resulting from a merger?

Nothing changes until this transaction is complete, which is likely to take us through the end of 2015. After that time, there will still be significant work before us. Our commitment is to manage any change carefully and methodically, but also expeditiously to capture the cost, quality and access benefits as quickly as possible starting from day one of the new health system. It is for this reason that we will begin appropriate integration planning – but not implementation – prior to closing.



What does this mean for our community?

This would be a significant step forward for patient care, wellness, affordability and health education in our region. We would:

- Invest in **high-level specialty services**, allowing more people to receive the care they need close to home;
- Work with ETSU and our academic partners to conduct a comprehensive regional health needs assessment; then work hand-in-hand to **tackle some of the most important health issues our region faces**, including high rates of smoking, obesity, physical inactivity and the adverse health effects that follow, such as high blood pressure, diabetes, heart disease and cancer;
- Work to **improve access to substance abuse and mental health services** in the region;
- Work to eliminate unnecessary duplication in our operations, enabling us **to invest more in better coordinating patient care, improving quality and enhancing access** throughout the communities we serve; and
- Work with academic institutions, such as ETSU, to **strengthen the pipeline of physicians and allied health professionals, and to attract research jobs and investments** in our region.



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Other questions?

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[INSERT MEETING TITLE]

[INSERT DATE]

Town Hall Presentation Template – June 2015

Today's Agenda

- Quick Recap: Our Proposed Partnership
- Where We Are Today
- **What's Next**
- Q&A

First – Thank You.

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**Quick Recap: Our Proposed
Partnership**

4

The Proposed Transaction

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 be among the best in the nation and address the serious health issues that affect our region.

It's an **opportunity** for our two organizations to come together and build something **brand new** that reflects what our community really needs – today and in the years ahead.

The Proposed Transaction



- This is a **merger** – not an acquisition by either organization – and we will have a **new name**.
- The new **organization's executive team** will include representatives from each organization:
 - Executive Chairman & President Alan Levine
 - CEO Bart Hove
 - COO Marvin Eichorn
 - CFO Alice Pope
- A **new board** will have equal representation from Wellmont and Mountain States, two new independent members and the president of ETSU (nonvoting).

Challenges We Face: Industry and Local



Increasing reimbursement cuts



The decline of inpatient volumes



The move of services to the outpatient setting



Increasing difficulty in recruiting and retaining physicians



And more

Challenges We Face: Regional Health Issues



Some of the highest rates of cardiovascular disease, diabetes and pulmonary disease in the country.



Epidemic of addiction and untreated mental illness without access to the right level of inpatient and outpatient treatment.



More people admitted to the hospital per thousand than most other areas of the nation.

Our Vision

As a combined system, we will unite the resources of both systems with one common purpose – to **make the next generation of this region healthier** than today’s and to make sure those who need health care services today can access the **best care available** in the nation.

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Our Vision

Together...



As a single integrated health system and significant employer, our new system will be uniquely able to provide the people we serve with even **higher quality, more affordable care.**



We will **aim to be among the best health systems in the nation**, known for outstanding clinical outcomes, superior patient experience and affordability.



We will be one of the **most attractive health systems for physicians and team members.**



We will **partner with physicians and clinically integrate** to derive new quality and value for the patients, businesses and payors who rely on us.



We will achieve **long-term financial stability and sustainability** through the capture of major merger-specific cost-efficiencies, wise stewardship of resources and sound fiscal management.

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Where We Are Today

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The Process for Coming Together

- Pursue approval under the **Certificate of Public Advantage** statute in TN and a similar process in VA.
 - A COPA authorizes us to merge and directs the state to actively supervise our new health system to ensure that it continues to benefit the community by providing care that is affordable, accessible, cost-efficient and high-quality.
- **COPA legislation update:**
 - TN: Gov. Haslam signed amendments to existing COPA statute.
 - VA: New law goes into effect July 1, 2015.



The Process for Coming Together

Recently announced the members of two planning groups:

Joint Board Task Force:

Representatives from both system boards; will serve as liaison to boards and provide guidance during exploration process.

Integration Council:

Executive and physician leaders from both systems; will oversee the integration analysis and further develop integration plans.

IC and JBTF Focus Areas

- **Working to solidify the proposed partnership**
 - Developing Definitive Agreement
 - Preparing COPA application
 - Working with regulatory agencies and TN/VA
- **Determining the structure of the proposed system**
 - Developing bylaws/structure for potential system; governance audit
 - Conducting study to explore cost savings to refocus resources for community benefit
 - Integration planning: brand assessment; cultural audit; employee focus groups
- **Engaging with key stakeholders**
 - Includes employees, physicians, community
 - To understand what's important to you regarding proposed system and its vision
 - One way we'll seek input is through community work groups initiative

Community Input Work Groups



Mental Health
& Addiction



Healthy Children
& Families



Research &
Academics



Population Health
& Healthy Communities

www.becomingbettertogether.org/get-involved

About the Work Groups

The **work groups will provide input in solving some of the region's most** challenging health issues. The work groups will:

- Begin meeting in July and continue through the end of the year.
- Hold public meetings throughout Northeast Tennessee and Southwest Virginia to seek community input.
- Led by a subject matter expert; will include members from throughout the region who represent a broad variety of experience and perspectives.
- Staffed **by members of Mountain States and Wellmont along with master's and doctoral level students from ETSU.**
- Provide regular updates as well as final findings to the Integration Council.

Community Support

**MORE THAN 8,000
UNIQUE VISITORS
TO THE WEBSITE**

**500+ EXTERNAL
SUBSCRIBERS TO
THE NEWSLETTER**

**NUMEROUS PUBLIC
STATEMENTS
OF SUPPORT FROM
COMMUNITY AND
BUSINESS LEADERS,
ACADEMIC LEADERS,
ELECTED OFFICIALS
AND MORE**

**ACTIVELY
ENGAGING
IN THE COMMUNITIES
WE SERVE**

“The Chambers of Commerce ... endorse the proposed merger of Wellmont Health System and Mountain States Health Alliance to an integrated single system. We believe this offers the best opportunity for the betterment of our region's healthcare.”

The Chambers of Commerce of Kingsport, Bristol and Johnson City/Jonesborough/Washington County

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“Eastman supports the decision to unify the systems in an effort to improve the quality and affordability of and access to health care in the region.”

CeeGee McCord, Eastman Chemical Company

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“The Tennessee Nurses Association embraces the decision as one that will improve the quality of health care in our region, control spiraling costs, and better address the chronic health care issues facing this state.”

Teresa A. Martin, MSN, FNP-BC, District President, on behalf of District 5, Tennessee Nurses Association

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“Combining strengths, assets and liabilities would enable these systems to focus more on quality, population health management, mental health programs and other services benefiting the entire region.”

Douglas J. Springer, MD, immediate past president on behalf of the Tennessee Medical Association

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What's Next

What's Ahead

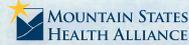
- Following a definitive agreement, we will enter a government approval phase that will likely take us **through the end of 2015**.
- During the due diligence and government approval phases and until the moment of closing, both Mountain States and Wellmont will continue “business as usual” as **two separate and independent organizations**.

Keeping You Informed

- Committed to sharing ongoing updates
- Website: BecomingBetterTogether.org
 - Latest news, FAQs, resources, and more
- The Better Together newsletter
 - Distributed internally and externally
- Send questions and comments to: info@BecomingBetterTogether.org



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Questions?

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Proposed Merger Update

Town Hall Presentation Template – August 2015

1

The Proposed Transaction



- This is a **merger** – not an acquisition by either organization – and we will have a **new name**.
- The new **organization's executive team** will include representatives from each organization:
 - Executive Chairman & President Alan Levine
 - CEO Bart Hove
 - COO Marvin Eichorn
 - CFO Alice Pope
- A **new board** will have equal representation from Wellmont and Mountain States, two new independent members and the president of ETSU (nonvoting).



2

Our Vision

Together...



As a single integrated health system and significant employer, our new system will be uniquely able to provide the people we serve with even **higher quality, more affordable care.**



We will **aim to be among the best health systems in the nation**, known for outstanding clinical outcomes, superior patient experience and affordability.



We will be one of the **most attractive health systems for physicians and team members.**



We will **partner with physicians and clinically integrate** to derive new quality and value for the patients, businesses and payors who rely on us.



We will achieve **long-term financial stability and sustainability** through the capture of major merger-specific cost-efficiencies, wise stewardship of resources and sound fiscal management.

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Where We Are Today

We are making great progress.

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Working Closely with State Officials

- **Working with officials in both states** as we continue to gain clarity around the regulatory approval process required to finalize our proposed partnership.
- Pursue approval under the **Certificate of Public Advantage** statute in TN and a similar process in VA.
 - A COPA authorizes us to merge and directs the state to actively supervise our new health system to ensure that it continues to benefit the community by providing care that is affordable, accessible, cost-efficient and high-quality.
- Both states recently issued **interim rules** governing COPAs in TN and similar cooperative agreements in VA.



What's Ahead

- There are **several upcoming milestones** in the process to finalize our proposed partnership.
 - This fall, we expect to execute a **Definitive Agreement (DA)** between our two organizations, which is the next step in the journey to solidify our proposed partnership.
 - With that in mind, we will also file a **Letter of Intent (LOI)** to the Department of Health in Tennessee in the coming month, which is a required first step before we submit a COPA application in Tennessee at a minimum 45 days later.

Working with the Community



Mental Health
& Addiction



Healthy Children
& Families



Research &
Academics



Population Health
& Healthy Communities

www.becomingbettertogether.org/get-involved

Keeping You Informed

- Committed to sharing ongoing updates
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info@BecomingBetterTogether.org



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Questions?

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Town Hall Update
January 2016

Town Hall Presentation: Pre-Submission Report

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Where We Are Today

Key Milestones Timeline



Pre-Submission Report Overview

- Released January 7, 2016
- Public report designed for the community; comments are welcome**
- To be followed by filing COPA/cooperative agreement applications

Full Report Available:
BecomingBetterTogether.org/report



Report Highlights

- Result of **more than nine months** of extensive work
- Outlines important commitments in **six key areas**
- The report also describes a **series of transformational investments** we will make as a combined system over the next 10 years to improve health in the region
 - Made possible through financial efficiencies to be achieved



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Commitments & Investments

Commitments

- **Improve Community Health**
- **Enhance Health Care Services**
- **Expand Access and Choice**
- **Improve Health Care Value: Managing Quality, Cost and Services**
- **Invest in Health Research and Graduate Medical Education**
- **Attract and Retain a Strong Workforce**



Improve Community Health

Invest \$75 million over 10 years in programs to address common health issues in children and adults

- Creating strong starts for children
- Living well in the community
- Promoting a drug-free community
- Decrease avoidable hospital admission and ER use



Improve Community Health



Strong starts for children

- Childhood obesity
- Birth outcomes
- Type 1 and 2 diabetes
- Neonatal abstinence syndrome
- Third-grade reading proficiency

Living well in the community

- Diabetes
- Cardiovascular disease
- Breast, cervical, colorectal and lung cancer

Drug-free communities

- Prevent substance abuse in youth
- Prevent tobacco use in youth
- Reduce overprescription of painkillers
- Combat drug addiction through:
 - Crisis management
 - Residential treatment
 - Community-based support

Connect high-need, high-cost uninsured individuals to care

- Intensive case management
- Primary care
- Behavioral health crisis management
- Residential addiction treatment
- Intensive outpatient treatment services

Enhance Health Care Services

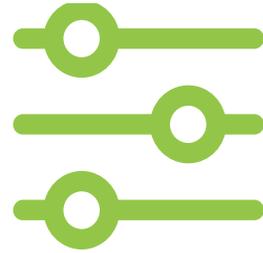
Invest \$140 million over 10 years in needed specialty services

- Expand residential and outpatient addiction recovery programs and community-based mental health services
 - Mobile crisis management
 - Intensive outpatient services
 - Addiction resources for adults and children
- Recruit and retain pediatric subspecialists in accordance with **Niswonger Children's Hospital physician needs assessment**
- Develop dedicated emergency facilities for children in Kingsport and Bristol and deploy pediatric telemedicine to rural communities
- Develop a plan to meet physician staffing needs in underserved and rural areas



Expand Access and Choice

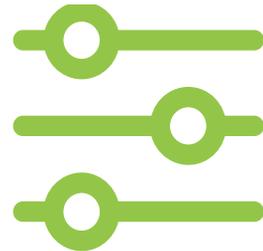
- Maintain three full-service tertiary hospitals in Johnson City, Kingsport and Bristol
- Repurpose some current facilities to develop and enhance access to needed services
- Ensure physicians are able to practice where they choose and patients are able to seek care where they choose



Expand Access and Choice

The new health system will value a robust and successful independent physician community.

- Work with the independent physician community to build an array of service offerings
- Maintain open medical staffs at all facilities, with possible exception of hospital-based physicians
- Not require independent physicians to practice **exclusively at the new health system's hospitals**
- Not take steps to prohibit independent physicians from participating in health plans of their choice



Improve Health Care Value

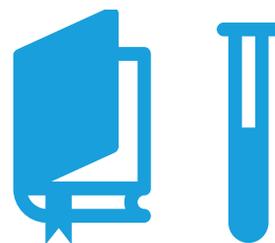
- Reduce the pace of health care cost growth by placing **limits on negotiated rates with insurers**
- **Invest approximately \$150 million** over 10 years to facilitate electronic health information exchange and develop a common electronic health record platform
- Develop a regionwide clinical services network, collaborating to improve health outcomes
- Work in good faith with insurers to protect **consumers' network access**



Expand Health Research & Graduate Medical Education

The new health system will invest \$85 million over 10 years to support academics and research

- Work with partners in TN and VA to develop and grow academic and research opportunities
- Support post-graduate health care training
- Increase residency slots
- Create new specialty fellowship opportunities
- Strengthen the pipeline and preparation of health professionals



Attract and Retain a Strong Workforce

- Continue to provide competitive pay and benefits
- Provide credit for accrued vacation and sick leave
- Honor prior service credit for eligibility and vesting under employee benefit plans maintained by each organization
- **Combine the best of each organization's career development opportunities**



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The Path We're Pursuing

The Path We're Pursuing

Our Path

State oversight.

Through a COPA/cooperative agreement, the proposed organization must be approved by both states, and then be actively supervised to ensure it benefits the community by providing affordable, accessible, cost-efficient and high-quality care for years to come.

The Alternative

No enforceable protections for the community.

Standard "out-of-market" acquisitions of hospitals do not generally include strict enforcement mechanisms to protect consumers or ensure the community benefits.

The Path We're Pursuing

Our Path

A health system designed for our region.

Together, we will create efficiencies, expand services, increase choices, improve access to care, and address the serious health issues that affect our region and matter most to the people we serve.

The Alternative

No accountability.

An outside health system could be free to take merger-related savings and jobs out of our communities. That organization would face no requirement or local accountability to make the investments in community health that our region so desperately needs.

We believe our proposed alternative is better.

It is the only model that maintains local governance, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in our region and invests those dollars in the improved health of the people we serve while also preserving local jobs.

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Next Steps

- Expect to announce reaching a **Definitive Agreement** and **filing COPA/cooperative agreement applications** in late January.
- **Working with officials in both states** to ensure applications are deemed complete; review period will likely extend into the late summer of 2016.



Keeping You Informed

- Committed to sharing updates
 - Visit **BecomingBetterTogether.org** for the latest news, FAQs, resources and more
 - Ongoing newsletters/internal updates
- Send general questions and comments to:
info@BecomingBetterTogether.org
- Visit **BecomingBetterTogether.org/report** to review and provide feedback on the pre-submission report



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Questions?

**Record of Community Stakeholder and Consumer Views
of the Proposed Cooperative Agreement**

ATTACHMENT D

Community Presentations and Materials

Better Together



Johnson City Chamber of Commerce Board Meeting
May 19, 2015

Thank you.

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Today's Discussion

- The Proposed Transaction
- The Challenges We Face
- Our Vision
- The Process for Coming Together
- **What's Ahead**
- Community Support
- Keeping You Informed

The Proposed Transaction

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 be among the best in the nation and address the serious health issues that affect our region.

It's an **opportunity** for our two organizations to come together and build something **brand new** that reflects what our community really needs – today and in the years ahead.

The Proposed Transaction



- This is a **merger** – not an acquisition by either organization – and we will have a **new name**.
- The new **organization's executive team** will include representatives from each organization:
 - Executive Chairman & President Alan Levine
 - CEO Bart Hove
 - COO Marvin Eichorn
 - CFO Alice Pope
- A **new board** will have equal representation from Wellmont and Mountain States, two new independent members and the president of ETSU (nonvoting).

Challenges We Face: Industry and Local



Increasing reimbursement cuts



The decline of inpatient volumes



The move of services to the outpatient setting



Increasing difficulty in recruiting and retaining physicians



And more

Challenges We Face: Regional Health Issues



Some of the highest rates of cardiovascular disease, diabetes and pulmonary disease in the country.



Epidemic of addiction and untreated mental illness without access to the right level of inpatient and outpatient treatment.



More people admitted to the hospital per thousand than most other areas of the nation.

Our Vision

As a combined system, we will unite the resources of both systems with one common purpose – to **make the next generation of this region healthier** than today's and to make sure those who need health care services today can access the **best care available** in the nation.

Better Together

Our Vision

Together...



As a single integrated health system and significant employer, our new system will be uniquely able to provide the people we serve with even **higher quality, more affordable care.**



We will **aim to be among the best health systems in the nation**, known for outstanding clinical outcomes, superior patient experience and affordability.



We will be one of the **most attractive health systems for physicians and team members.**



We will **partner with physicians and clinically integrate** to derive new quality and value for the patients, businesses and payors who rely on us.



We will achieve **long-term financial stability and sustainability** through the capture of major merger-specific cost-efficiencies, wise stewardship of resources and sound fiscal management.

The Process for Coming Together

- Pursue approval under the **Certificate of Public Advantage** statute in TN and a similar process in VA.
 - A COPA authorizes us to merge and directs the state to actively supervise our new health system to ensure that it continues to benefit the community by providing care that is affordable, accessible, cost-efficient and high-quality.
- **COPA legislation update:**
 - TN: Awaiting the signature of Gov. Haslam by May 21st to amendments to existing COPA statute.
 - VA: New law goes into effect July 1, 2015.



The Process for Coming Together

Recently announced the members of two planning groups:

Joint Board Task Force:

Representatives from both system boards; will serve as liaison to boards and provide guidance during exploration process.

Integration Council:

Executive and physician leaders from both systems; will oversee the integration analysis and further develop integration plans.

What's Ahead

- We are preparing to **launch a new initiative in partnership with ETSU** to solicit the input of nurses, clinical leaders and community members.
- This input will be crucial as we develop a **10-year plan for a healthier region.**

What's Ahead

- Following a definitive agreement, we will enter a government approval phase that will likely take us **through the end of 2015.**
- During the due diligence and government approval phases and until the moment of closing, both Mountain States and Wellmont will continue “business as usual” as **two separate and independent organizations.**

Community Support

**NEARLY 7,000
UNIQUE VISITORS
TO THE WEBSITE**

**500+ EXTERNAL
SUBSCRIBERS TO
THE NEWSLETTER**

**NUMEROUS PUBLIC
STATEMENTS
OF SUPPORT FROM
COMMUNITY AND
BUSINESS LEADERS,
ACADEMIC LEADERS,
ELECTED OFFICIALS
AND MORE**

**ACTIVELY
ENGAGING
IN THE COMMUNITIES
WE SERVE**

“The Chambers of Commerce ... endorse the proposed merger of Wellmont Health System and Mountain States Health Alliance to an integrated single system. We believe this offers the best opportunity for the betterment of our region's healthcare.”

The Chambers of Commerce of Kingsport, Bristol and Johnson City/Jonesborough/Washington County

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“Eastman supports the decision to unify the systems in an effort to improve the quality and affordability of and access to health care in the region.”

CeeGee McCord, Eastman Chemical Company

**Better
Together**



“The Tennessee Nurses Association embraces the decision as one that will improve the quality of health care in our region, control spiraling costs, and better address the chronic health care issues facing this state.”

*Teresa A. Martin, MSN, FNP-BC, District President,
on behalf of District 5, Tennessee Nurses Association*

**Better
Together**



“Combining strengths, assets and liabilities would enable these systems to focus more on quality, population health management, mental health programs and other services benefiting the entire region.”

*Douglas J. Springer, MD, immediate past president
on behalf of the Tennessee Medical Association*

**Better
Together**



Keeping the Community Informed

- Committed to sharing ongoing updates
- Website: BecomingBetterTogether.org
 - Latest news, FAQs, resources, and more
- The Better Together newsletter
 - Distributed internally and externally
 - Sign up to receive it through the website
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Questions?

Better Together



Kingsport Chamber of Commerce Board Meeting
June 8, 2015

Thank you.

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Better Together



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Statements of Support

- The Chambers of Commerce
*Kingsport, Bristol and Johnson City/
Jonesborough/Washington County*
- CeeGee McCord
Eastman Chemical Company
- Teresa A. Martin,
*MSN, FNP-BC, District President, on behalf
of District 5, Tennessee Nurses Association*
- Douglas J. Springer,
*MD, immediate past president on behalf
of the Tennessee Medical Association*
- Craig Becker
*President, Tennessee Hospital Association
(Personal endorsement, not official
THA endorsement)*
- Phil Roe
U.S. Rep., R-Tenn
- Ron Ramsey
Tennessee Lt. Gov., R-Blountville
- Dr. Brian Noland
President, East Tennessee State University



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Questions?

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Community Health Roundtable Meeting
Southwest Virginia Higher Education Center
Aug. 20, 2015

Today's Meeting

- Proposed Merger Update
- Community Health Roundtables
- Your Role
- **ETSU's Role**
- Getting Started

Thank you for participating in this critical effort.

Better Together



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Proposed Merger Update

Challenges We Face: Regional Health Issues



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Our Vision

- Create a true health improvement organization.
- Work with the community to improve the health of the region.
- Solicit community input to tackle our toughest health issues.



The Process for Coming Together

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Community Health Work Groups

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Community Input Focus Areas



Mental Health & Addiction



Healthy Children & Families



Research & Academics



Population Health & Healthy Communities

Review the charters for each focus area at BecomingBetterTogether.org

About the Work Groups

The work groups will provide input in trying to solve some of the region's most challenging health issues. Eight community leaders have agreed to serve as chairpersons:

Mental Health & Addiction:

- Dr. Teresa Kidd, president and CEO of Frontier Health
- Eric Greene, SVP of Virginia services for Frontier Health

Healthy Children & Families:

- Dr. David Wood, chair of the department of pediatrics at ETSU and CMO of Niswonger Children's Hospital
- Travis Staton, CEO of United Way of Southwest Virginia

Population Health & Healthy Communities:

- Dr. Randy Wykoff, dean of ETSU's College of Public Health
- Lori Hamilton, RN, director of healthy initiatives for K-VA-T Food City

Research & Academics:

- Dr. Wilsie Bishop, VP for health affairs and COO of ETSU
- Jake Schrum, president of Emory & Henry



Wellmont Health System



MOUNTAIN STATES HEALTH ALLIANCE

Your Role

- Roundtables are designed to **give the community an opportunity to provide input** on the most important health issues facing our region.
- Information shared in this meeting will be presented to the work group steering committees for **inclusion in their discussions and reports.**



Wellmont Health System



MOUNTAIN STATES HEALTH ALLIANCE

Role of ETSU

- We have partnered with ETSU's College of Public Health to facilitate and manage this process.
- ETSU will capture the information presented at roundtable meetings and steering committee meetings and compile a comprehensive report.
- Regular updates and final findings will be provided to the Integration Council.
- The proposed new health system will work with community partners to tackle these important health issues and develop a long-term health improvement plan for the region.



**Better
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Getting Started

Better Together



WELLMONT HEALTH SYSTEM and MOUNTAIN STATES HEALTH ALLIANCE

have each been privileged for decades to serve you – our families, friends and neighbors. To ensure that tradition continues well into the future, we are exploring **combining our two systems to create a new, integrated and locally governed health system to better meet your healthcare needs.**

BecomingBetterTogether.org

Better Together



You are our most important priority. Here are just a few of the ways our proposed future system will serve you:

- » We'll invest in expanding access to care and services, while also maintaining access in our rural communities, so you can get the care you need close to home – at a cost that's **affordable for you and your family.**
- » Wherever you go in our integrated system to receive care – no matter which doctor you see – your care team will have **your medical history at their fingertips** through a systemwide technology platform, ensuring the care you receive takes your overall health into account.
- » Together, we'll be better able to coordinate your care between your doctor, the hospital and outpatient services like home health and pharmacy – improving the quality of care you receive and creating a **superior experience** every time you visit us.
- » We'll work on improving access to **important services that so many people in our region need**, like substance abuse treatment to stop the cycle of addiction and improved mental health services.
- » Working with East Tennessee State University, **we'll identify and tackle head-on important health issues in our region**, like heart disease, addiction and diabetes.
- » And much more.

BecomingBetterTogether.org

BecomingBetterTogether.org

- Here are just a few of the ways our proposed future system will serve our patients:
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BecomingBetterTogether.org

Better Together



After months of research and community engagement, Wellmont Health System and Mountain States Health Alliance are prepared to make a series of important commitments and transformational investments in six key areas over the next 10 years to improve health in the region.



Improve Community Health – We will invest at least **\$75 million** in population health improvements to meet the unique health needs of our region through a 10-year plan to be developed with the community and the public health resources at ETSU.



Enhance Health Care Services – We will invest at least **\$140 million** to expand community-based mental health services, residential and outpatient addiction recovery programs, and tobacco and substance abuse prevention programs as well as to further support children's and rural health services.



Expand Access and Choice – We will maintain three full-service tertiary hospitals in Johnson City, Kingsport and Bristol; repurpose some current facilities to develop and enhance access to needed services; and ensure physicians are able to practice where they choose and patients are able to seek care where they choose.



Improve Health Care Value – We will invest up to \$150 million to implement a common information technology platform to support the regional exchange of health information, connect our hospitals, physicians and other caregivers and allow the combined system to offer higher quality, more convenient and more cost-effective care for patients.



Expand Health Research and Graduate Medical Education – We will invest at least \$85 million to develop and grow academic and research opportunities, support post-graduate health care training, and strengthen the pipeline and preparation of health professionals in the region.



Attract and Retain a Strong Workforce – We will offer competitive pay and benefits to attract and retain the best and brightest team members, and combine the best of each organization's career development opportunities – enabling us to become one of the top health system employers in the country.

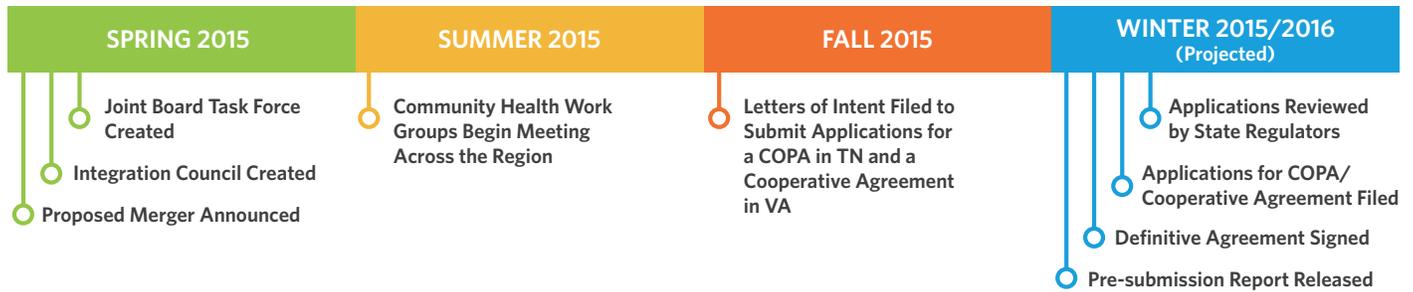
Learn more about our community commitments in a report we've developed as part of the regulatory approval process. View the report and provide feedback at: [BecomingBetterTogether.org](https://www.becomingbettertogether.org)

The Path We're Pursuing

In April 2015, Wellmont Health System and Mountain States Health Alliance began to explore how health care in our region could look if we joined together. We had a promising vision, but we wanted to learn more from our friends, neighbors and the community to understand how we could best serve you.

We've met with thousands of people - in communities we serve both large and small - to answer questions, talk about how to best tackle our region's critical health care issues and discuss our commitment to keeping care affordable and accessible.

That work continues today, and we're making excellent progress toward bringing our organizations together. Here is a brief snapshot of our efforts:



The path we are pursuing is an innovative model unlike traditional mergers so common among hospitals and providers today. Here is how our path is different:

Our Path

- **State oversight.** Through a COPA/cooperative agreement, the proposed organization must be approved by both states, and then be actively supervised to ensure it benefits the community by providing affordable, accessible, cost-efficient and high-quality care for years to come.
- **A health system designed for our region.** Together we will create efficiencies, expand services, increase choices, improve access to care, and address the serious health issues that affect our region and matter most to the people we serve.

The Alternative

- **No enforceable protections for the community.** Standard "out-of-market" acquisitions of hospitals do not generally include strict enforcement mechanisms to protect consumers or ensure the community benefits.
- **No accountability.** An outside health system could be free to take merger-related savings and jobs out of our communities. That organization would face no requirement or local accountability to make the investments in community health that our region desperately needs.

We believe our proposed alternative is better. It is the only model that maintains local governance, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in our region and invests those dollars in the improved health of our region while also preserving local jobs.

Learn more at: BecomingBetterTogether.org





Our Vision

After more than a year of evaluating how best to navigate a challenging future for hospitals, Mountain States Health Alliance and Wellmont Health System agreed, in April of last year, to exclusively explore the creation of a new, integrated and locally governed health system to address the serious health issues facing the region.

Some issues are unique to our area, such as having the third lowest hospital wage index in the nation and the disproportionately poor health status of our regional population. Other challenges are faced by health systems throughout the region, such as increasing reimbursement cuts, the decline of inpatient volumes and more.

As a single integrated health system and major employer in our region, our new system will be able to provide the people we serve with even higher quality, more affordable care.

What We Are Creating

As a combined system, we will work to unite the resources of both systems with one common purpose — to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access the best care available in the nation.

- » We will **aim to be among the best health systems in the nation**, known for outstanding clinical outcomes, superior patient experience and affordability.
- » We will aspire to become one of the **most attractive health systems for physicians and team members**.

- » We will **partner with physicians and clinically integrate** to derive new quality and value for the patients, businesses and payors who rely on us.
- » We will achieve **long-term financial stability and sustainability** through the capture of major merger-specific cost-efficiencies, wise stewardship of resources and sound fiscal management.
- » We will be actively supervised under a Certificate of Public Advantage in Tennessee and a cooperative agreement in Virginia that will include **enforceable targets for cost, quality and access and population health**.

Statements of Support

» "Eastman supports the decision to unify the systems in an effort to improve the quality and affordability of and access to health care in the region."

— CeeGee McCord, Eastman Chemical Company

» "A properly regulated environment will allow the entities to bring high quality health care to the people in our region at an affordable cost. This is a unique situation that will help ensure the future of health care in Southwest Virginia."

— Martin Kent, President and Chief Operating Officer, The United Company

» "My Chamber of Commerce represents hundreds of businesses. One important factor in having a healthy and thriving economy is having a healthy community. Mountain States Health Alliance and Wellmont Health System are working on a proposed merger. Providing affordable, high-quality health care with broad access is the vision. Health care is complicated and the regulations...will give these two organizations the ability to become a single entity with one goal; making the people in our region healthy."

— Beth Rhinehart, President and CEO, Bristol, Tennessee and Virginia Chamber of Commerce

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 a 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.

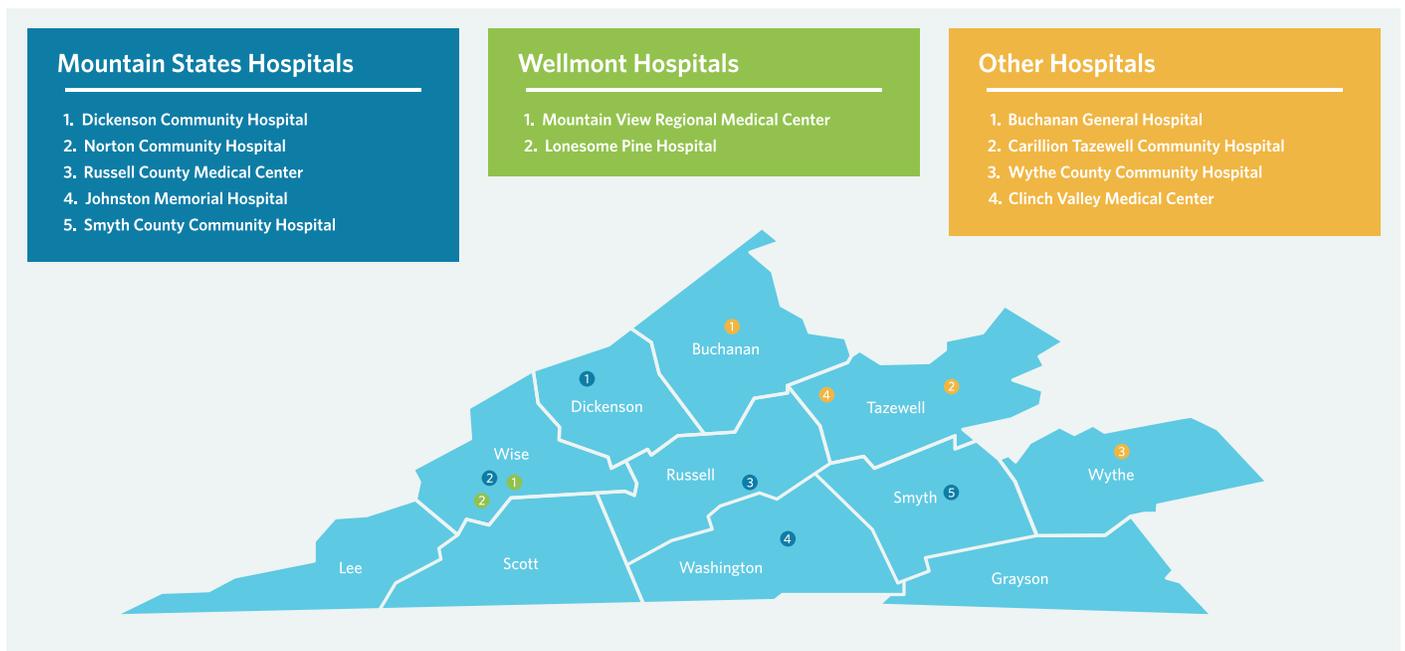
- » \$1 billion annual revenue
- » 8,300+ full-time equivalent employees
- » 400+ employed physicians and mid-level providers
- » 1,717 staffed beds
- » 239,606 emergency department visits
- » \$92,443,348 provided in community benefit
- » \$508 million annually in direct income for employees

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.

- » \$773 million annual revenue
- » 5,800 full-time equivalent employees
- » 271 employed physicians & mid-level providers
- » 781 staffed beds
- » 170,331 emergency department visits
- » \$85,512,017 provided in community benefit
- » \$322 million annually in direct income for employees

Overview of Southwest Virginia Hospitals



Better Together



Kingsport Rotary Club presentation
Wednesday, Feb. 10, 2016

Better Together



Where We Are Today

Key Milestones Timeline



Pre-Submission Report Overview

- Released January 7, 2016
- Public report designed for the community; comments are welcome**
- To be followed by filing COPA/cooperative agreement applications

Full Report Available:
BecomingBetterTogether.org/report



Report Highlights

- Result of **more than nine months** of extensive work
- Outlines important commitments in **six key areas**
- The report also describes a **series of transformational investments** we will make as a combined system over the next 10 years to improve health in the region
 - Made possible through financial efficiencies to be achieved



Better Together



Commitments & Investments

Commitments

- **Improve Community Health**
- **Enhance Health Care Services**
- **Expand Access and Choice**
- **Improve Health Care Value: Managing Quality, Cost and Services**
- **Invest in Health Research and Graduate Medical Education**
- **Attract and Retain a Strong Workforce**



Improve Community Health

Invest \$75 million over 10 years in programs to address common health issues in children and adults

- Creating strong starts for children
- Living well in the community
- Promoting a drug-free community
- Decreasing avoidable hospital admission and ER use



Improve Community Health



Strong starts for children

- Childhood obesity
- Birth outcomes
- Type 1 and 2 diabetes
- Neonatal abstinence syndrome
- Third-grade reading proficiency

Living well in the community

- Diabetes
- Cardiovascular disease
- Breast, cervical, colorectal and lung cancer

Drug-free communities

- Prevent substance abuse in youth
- Prevent tobacco use in youth
- Reduce overprescription of painkillers
- Combat drug addiction through:
 - Crisis management
 - Residential treatment
 - Community-based support

Connect high-need, high-cost uninsured individuals to care

- Intensive case management
- Primary care
- Behavioral health crisis management
- Residential addiction treatment
- Intensive outpatient treatment services

Enhance Health Care Services

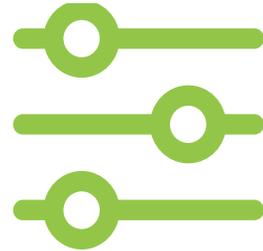
Invest \$140 million over 10 years in needed specialty services

- Expand residential and outpatient addiction recovery programs and community-based mental health services
 - Mobile crisis management
 - Intensive outpatient services
 - Addiction resources for adults and children
- Recruit and retain pediatric subspecialists in accordance with **Niswonger Children's Hospital physician needs assessment**
- Develop dedicated emergency facilities for children in Kingsport and Bristol and deploy pediatric telemedicine to rural communities
- Develop a plan to meet physician staffing needs in underserved and rural areas



Expand Access and Choice

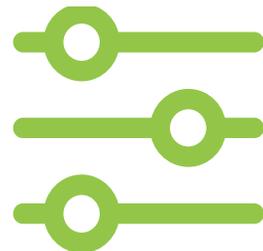
- All hospitals to remain operational as clinical and healthcare institutions for at least five years
- Maintain three full-service tertiary hospitals in Johnson City, Kingsport and Bristol
- Repurpose some current facilities to develop and enhance access to needed services
- Ensure physicians are able to practice where they choose and patients are able to seek care where they choose



Expand Access and Choice

The new health system will value a robust and successful independent physician community.

- Work with the independent physician community to build an array of service offerings
- Maintain open medical staffs at all facilities, with possible exception of hospital-based physicians
- Not require independent physicians to practice **exclusively at the new health system's hospitals**
- Not take steps to prohibit independent physicians from participating in health plans of their choice



Improve Health Care Value

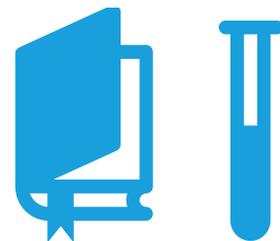
- Reduce the pace of health care cost growth by placing **limits on negotiated rates with insurers**
- **Invest approximately \$150 million** over 10 years to facilitate electronic health information exchange and develop a common electronic health record platform
- Develop a regionwide clinical services network, collaborating to improve health outcomes
- Work in good faith with insurers to protect **consumers' network access**



Expand Health Research & Graduate Medical Education

The new health system will invest \$85 million over 10 years to support academics and research

- Work with partners in TN and VA to develop and grow academic and research opportunities
- Support post-graduate health care training
- Increase residency slots
- Create new specialty fellowship opportunities
- Strengthen the pipeline and preparation of health professionals



Attract and Retain a Strong Workforce

- Continue to provide competitive pay and benefits
- Provide credit for accrued vacation and sick leave
- Honor prior service credit for eligibility and vesting under employee benefit plans maintained by each organization
- **Combine the best of each organization's career development opportunities**



Better Together

The Path We're Pursuing

The Path We're Pursuing

Our Path

State oversight.

Through a COPA/cooperative agreement, the proposed organization must be approved by both states, and then be actively supervised to ensure it benefits the community by providing affordable, accessible, cost-efficient and high-quality care for years to come.

The Alternative

No enforceable protections for the community.

Standard "out-of-market" acquisitions of hospitals do not generally include strict enforcement mechanisms to protect consumers or ensure the community benefits.

The Path We're Pursuing

Our Path

A health system designed for our region.

Together, we will create efficiencies, expand services, increase choices, improve access to care, and address the serious health issues that affect our region and matter most to the people we serve.

The Alternative

No accountability.

An outside health system could be free to take merger-related savings and jobs out of our communities. That organization would face no requirement or local accountability to make the investments in community health that our region so desperately needs.

We believe our proposed alternative is better.

It is the only model that maintains local governance, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in our region and invests those dollars in the improved health of the people we serve while also preserving local jobs.

**Better
Together**



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Next Steps

- Expect to announce signing a **Definitive Agreement** and **filing COPA/cooperative agreement applications** in the coming weeks.
- **Working with officials in both states** to ensure applications are deemed complete; review period will likely extend throughout 2016.



Keeping You Informed

- Committed to sharing updates
 - Visit **BecomingBetterTogether.org** for the latest news, FAQs, resources and more
 - Ongoing newsletters/internal updates
- Send general questions and comments to:
info@BecomingBetterTogether.org
- Visit **BecomingBetterTogether.org/report** to review and provide feedback on the pre-submission report



Better Together

Questions?

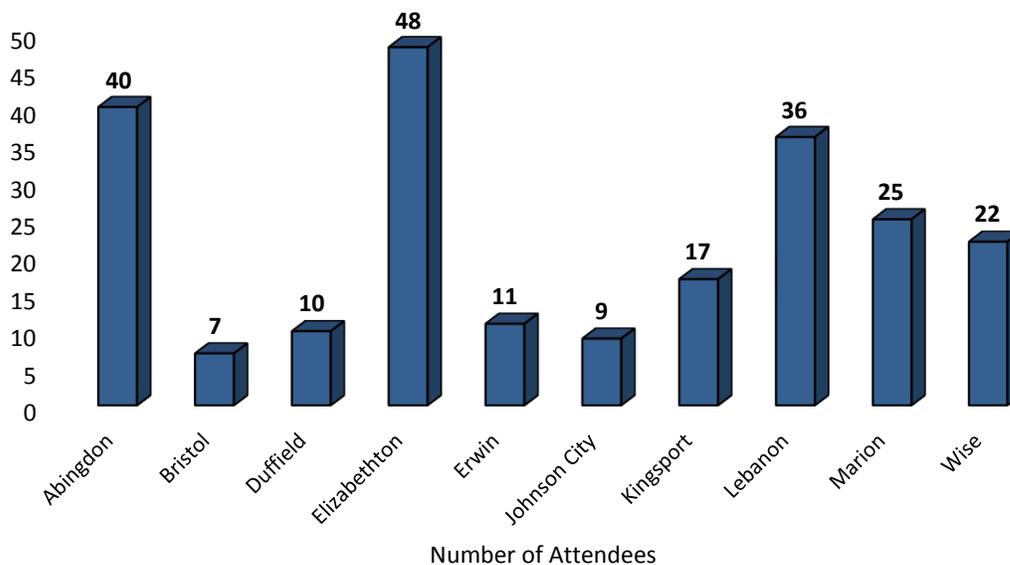
**Record of Community Stakeholder and Consumer Views
of the Proposed Cooperative Agreement**

ATTACHMENT E

Roundtable Summary Reports

At the Community Health Roundtable meetings, there were a total of 225 attendees at ten separate events. These meetings were held from August to October, 2015. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during multiple rounds of small group discussions. For the purpose of the Community Health Roundtable meetings, participants were asked to address the question, “**What can you do to improve health in the community?**” At the end of two rounds of small group discussion, notes were collected from the table moderators, or “Table Hosts,” to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

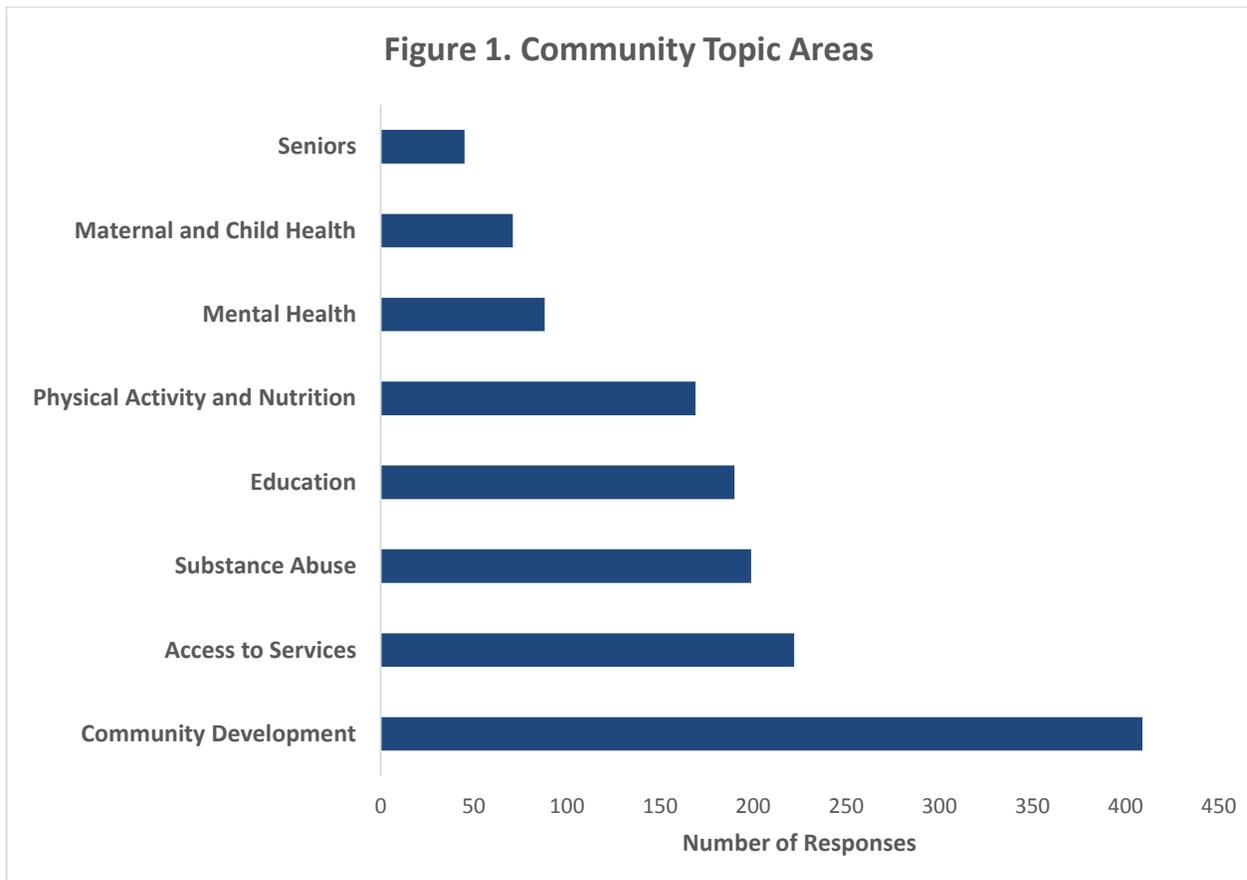
Attendance at Community Health Roundtable Meetings, by Location



Main Topics of Discussion

Eight major categories of discussion emerged among the participants, within which several sub-categories were identified. The eight major categories were:

- Community Development
- Access to Services
- Substance Abuse
- Education
- Physical Activity and Nutrition
- Mental Health
- Maternal and Child Health
- Seniors



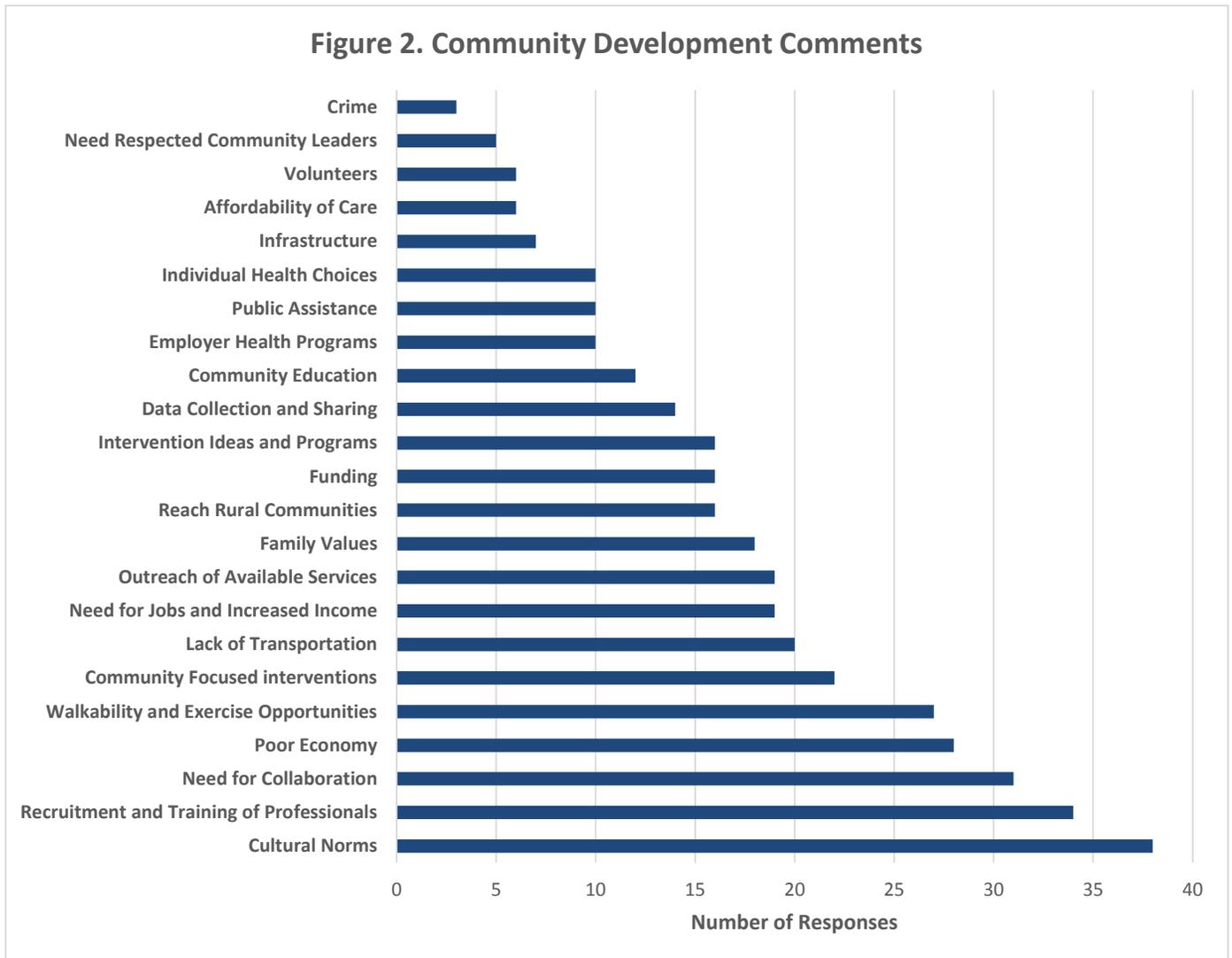
Community Development was the most talked-about topic during the discussion. Comments included such topics as:

- cultural norms
- recruitment and training of professionals
- need for collaboration among organizations
- poor economy
- need for walkability and exercise opportunities
- community-focused interventions
- lack of transportation

Other topics included the need for jobs and increased income, outreach of available services, changing family values, reaching rural communities, funding, intervention ideas and programs. Topics with a notable amount of discussion were data collection and sharing, community education, employer health programs, reliance on public assistance and individual health choices.

Consideration of these issues is important as we recruit new businesses and industry to the region while focusing on the need for economic development. Capacity issues exist with building more schools. Improved regional cooperation/collaboration is also required; we must change this mindset by changing behaviors. We need better communication to improve health literacy and the perceived personal relevance of health issues to individuals within

our community. We must prevent the abuse of public assistance, while also making sure those living in hopelessness and poverty are aware of available services and access resources appropriately. Organizations should make healthy choices more convenient and incentivize positive health behaviors. There is a driving need to have a strategic focus on what is tearing down our community and work towards a community wellness model. Figure 2 illustrates the comment distribution within the category of Community Development.



Substance Abuse was the second largest topic of concern among the attendees. Focus areas within this topic included:

- tobacco use and smoking
- access to resources
- community education
- the need for treatment facilities
- physician responsibility and over prescribing

Other important topics were drug court, drug abuse, prevention education for youth, providers and alternative pain management resources. Policy initiatives, family issues and prescription tracking were also widely mentioned. From

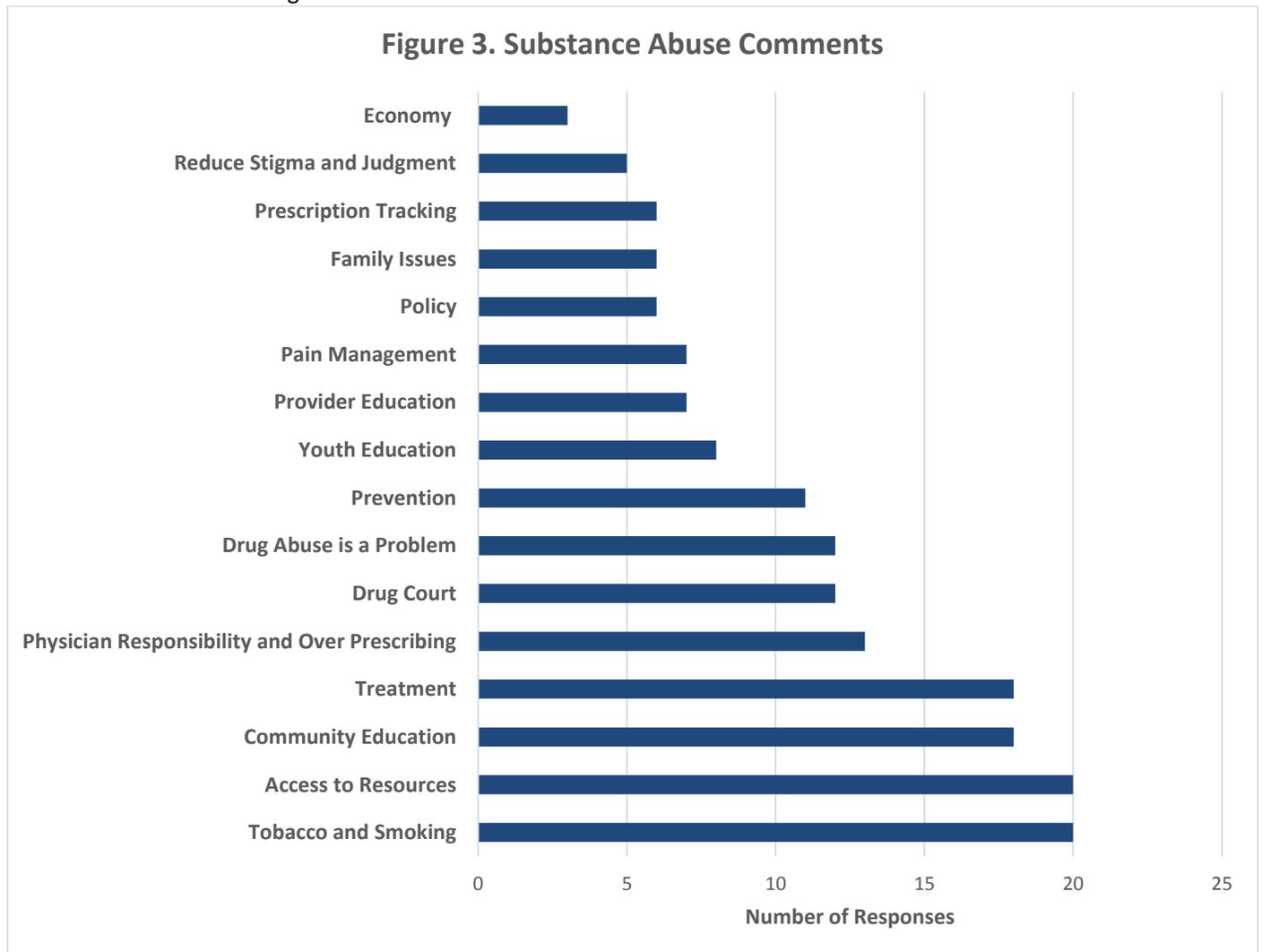
specific comments there is a need to increase education about abuse, halt the illegal production of drugs and implement stricter policies for employees who smoke.

Addiction recovery centers should be accessible and affordable, and serve people of all ages. People also must be able to locate social services that help with basic needs, such as food and housing. We must educate all young people about the risks of drug abuse; those who do abuse substances need treatment, not just jail.

Doctors write too many painkiller prescriptions because it is easier, and substance abuse has not been a priority in the past. However, both physicians and patients should try to find other approaches to managing pain in addition to (or instead of) pain medications.

To address the issue of smoking and youth tobacco use, we should focus on smoking cessation and enforce higher taxes.

Because drug abuse is intergenerational there is an urgent need for education, and to reduce the stigma around drug abuse. People must receive treatment to stop the intergenerational problem. Figure 3 shows the distribution of comments around the categories related to substance abuse.



Access to Services was a broad topic that was prevalent within every major discussion topic. Subgroups within the topic included:

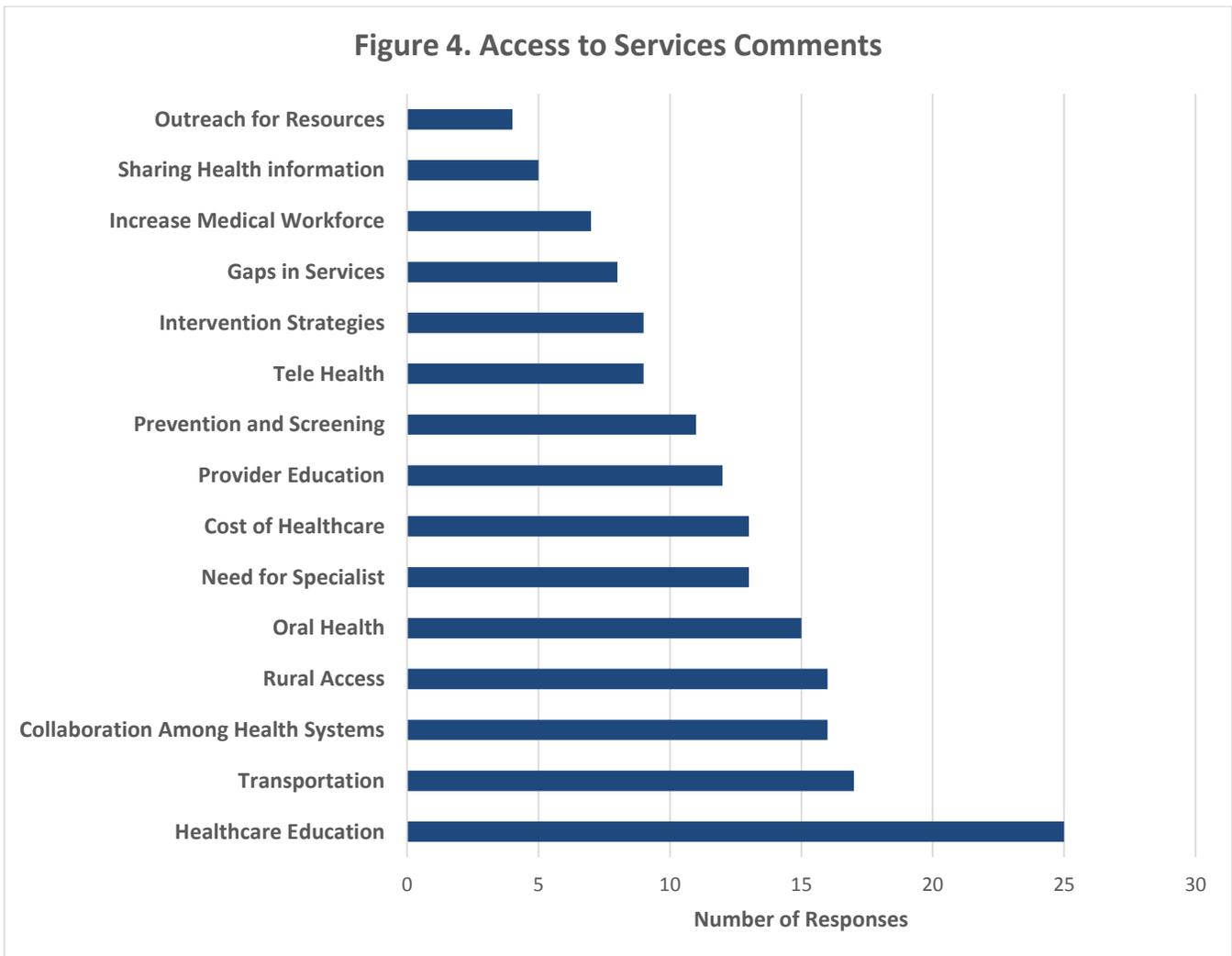
- health care education
- the need for transportation
- collaboration among health systems
- increasing rural access
- oral health services

Other topics included were the need for specialists, cost of health care, provider education, prevention and screening, telehealth use, intervention strategies, gaps in services and an increase in the medical workforce.

Particular comments focused on integrating technology, such as telehealth, and the need to collaborate with health systems, pharmacies, doctors and schools.

There is a significant need for transportation services, and to help people navigate the health care system in order to understand insurance and increase awareness of available resources. Health coaches are needed, as well as a strategy to engage people to care for their own health. It was also mentioned there is a lack of dental and specialized care in the region (although it is shown to be difficult to recruit physicians to poorer areas). Concerns were expressed about some providers being less comfortable or capable to handle some of these special conditions. Our underprivileged people flood emergency rooms but there is still trouble getting services to rural people and avoiding over-centralization.

It's important not to view short-term costs vs. long-term outcomes. Our community needs a health information exchange and to know what services are available. Figure 4 displays comment frequencies within the category of Access to Services.



Education was a broad topic that was included in a majority of topics. Participants indicated a need for education in the areas of:

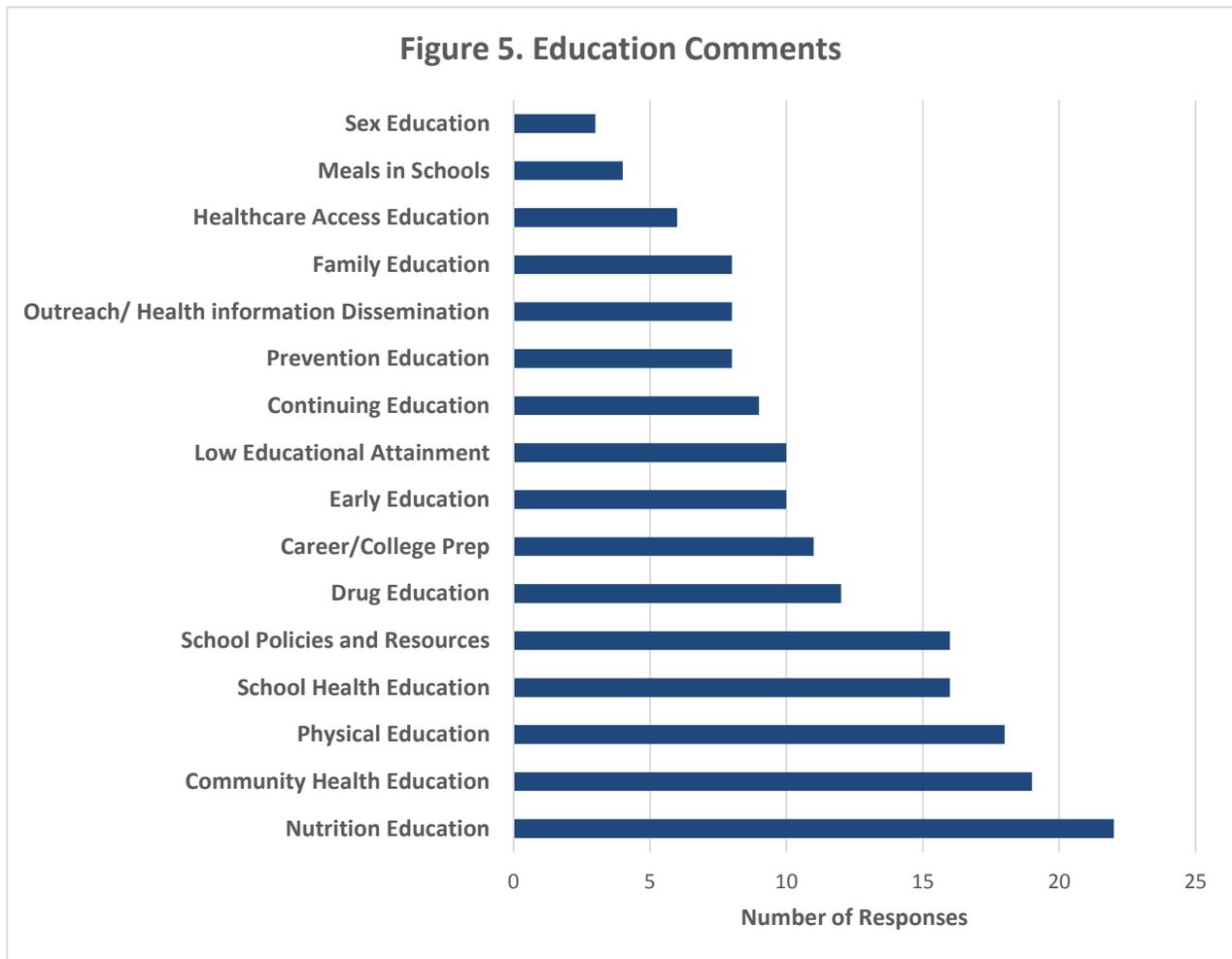
- nutrition
- drug abuse
- school health
- prevention
- family
- sex
- continuing and community health
- physical activity
- early education

Additional topics include school policies and resources, career and college prep, health care access education, outreach and information dissemination and a low educational attainment among the community. The need was identified to provide prevention education that can cut across constituencies, educate kids and break poor health habits in adults.

Other comments indicate there is a lack of health education, both formal and informal, and a need for better education about what individuals can do to help themselves.

School systems must to work together to provide a well-rounded education, and increase physical activities in the school (some have taken it out of the curriculum). Continuing education should move beyond the barriers of state/county lines and there should be an increase in career counselors in high schools to prepare students for both college and career tracks. It also was expressed that the high school drop-out rate is increasing.

Health education in public schools should be present in each grade and include parents because people do not know where to access health care. Education is the best tool for prevention. Figure 5 displays comment frequencies for the subgroups under Education.



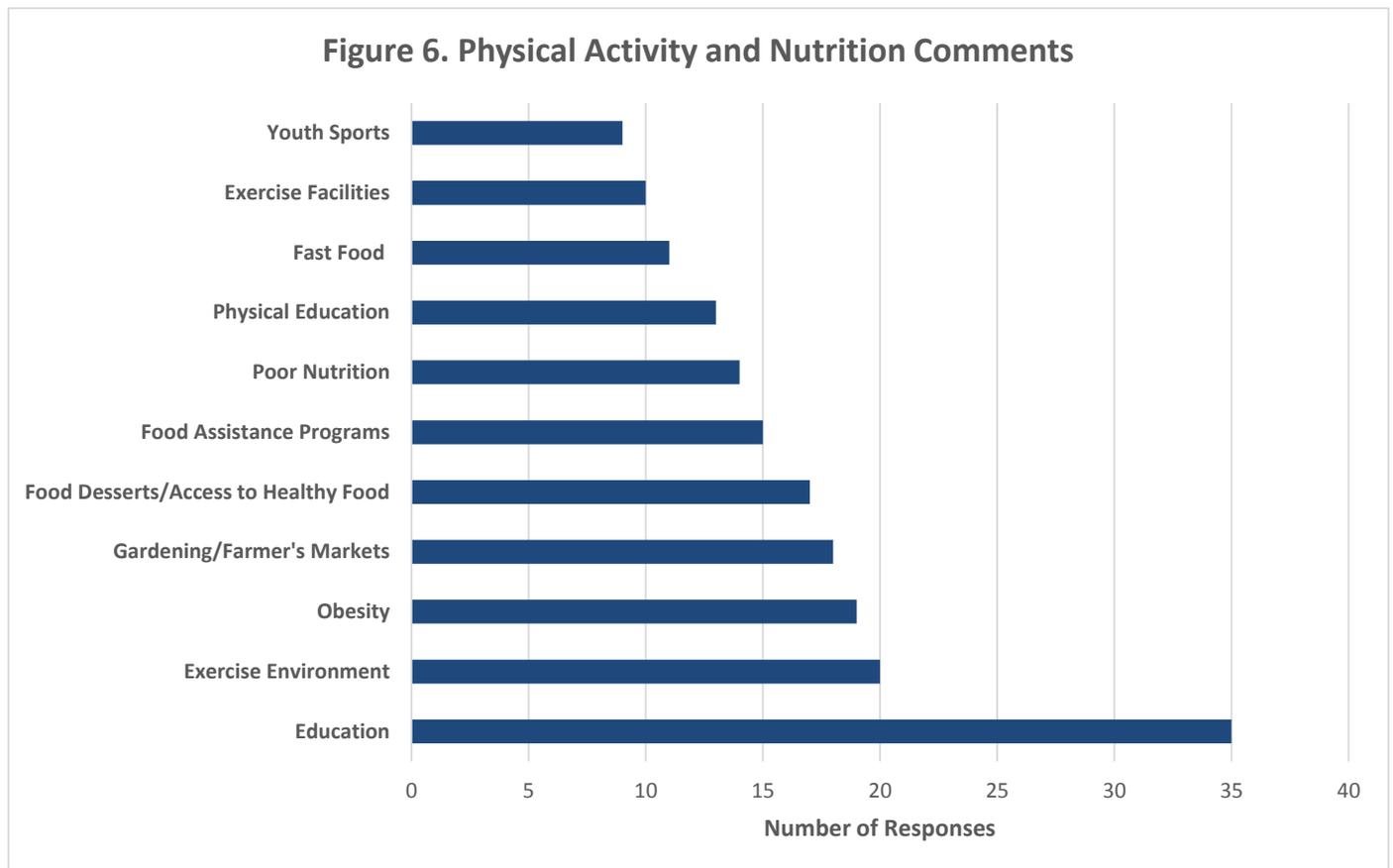
Nutrition and Physical Activity was a prominent concern among the meeting participants. Topics included:

- education
- obesity
- the need for an exercise environment
- increase gardening/farmer's markets
- food desserts/lack of access to healthy food

Other topics were food assistance programs, poor nutrition, lack of physical education, fast food availability and the need for exercise facilities and youth sports. Comments about nutrition and physical activity were focused on changing the community to build an environment to promote walking more, and addressing the lack of access to healthy foods in communities without grocery stores.

Obesity rates are increasing year by year; fast food is convenient and cheap for everyone, but is not high quality food and the serving size has increased. Physical education has been cut, or it is minimal.

The community needs nutrition and wellness classes. Food pantries help families, but there should be community support for farm-to-table restaurants and additional community gardens. There is also a lack of area fitness facilities where sports teams and clubs can give children a feeling of family. Figure 6 displays comment frequencies for Physical Activity and Nutrition subgroups.



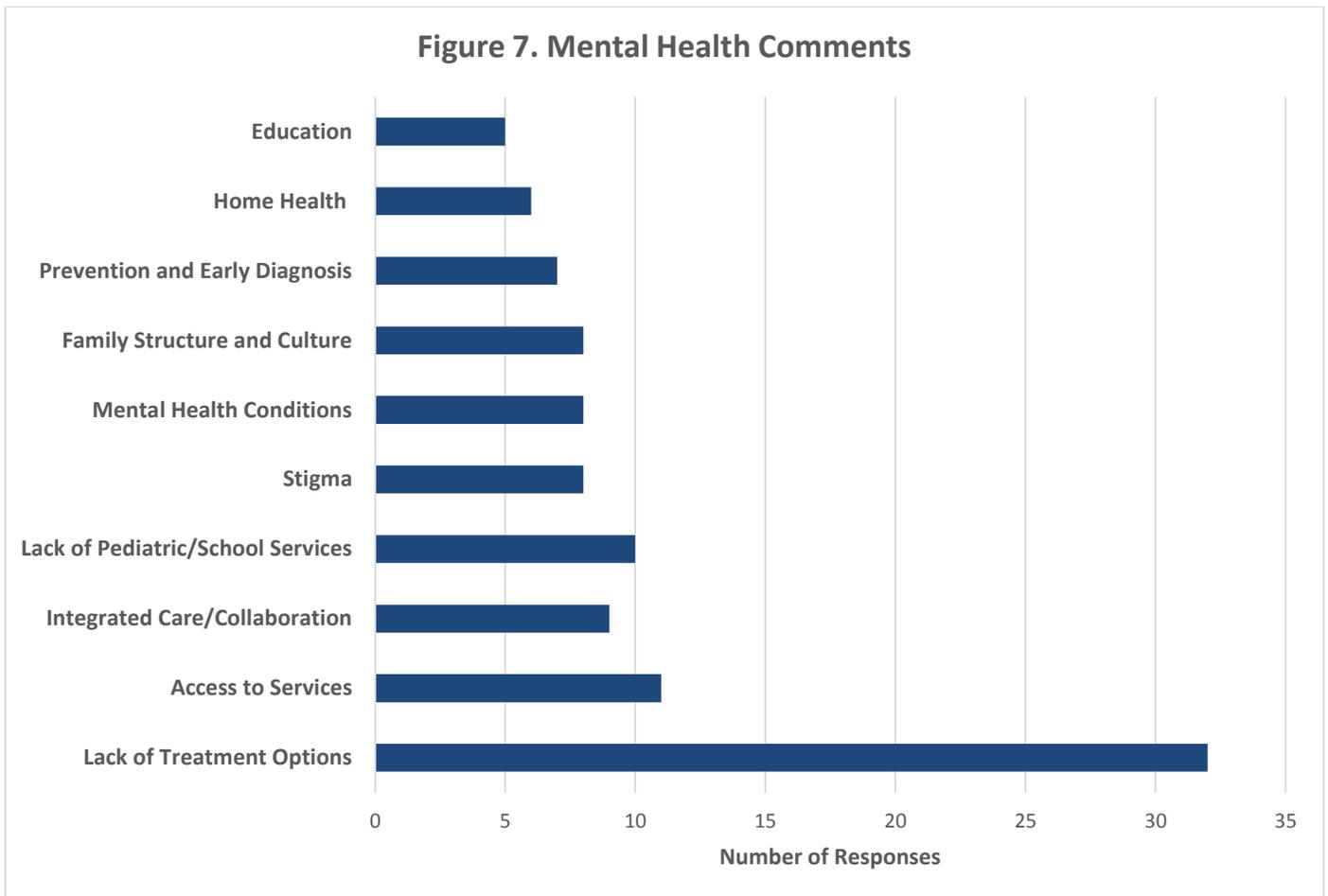
Mental Health was a concern among the meeting participants. Discussion topics include:

- lack of treatment options and facilities (the most significant topic)
- access to services
- need for integrated care/collaboration
- lack of pediatric/school services
- the stigma associated with mental health conditions

Other topics were family structure and culture, prevention and early diagnosis, home health and education. Comments about mental health noted a lack of places and resources to care for the overflow of mental health patients in hospitals. The need for mental health facilities and resources to manage self-help groups or peer supports were also mentioned.

Individuals said there are even fewer services for those most in need, and basic screenings and outreach should be in primary care offices so they can provide education and prevention services. Families who want to care for mentally ill loved ones sometimes do not have an adequate understanding of the person's needs, or support to handle or prevent incidents at home.

People are afraid to admit they struggle with mental health. We should improve education, increase access to services and enhance early-detection measures for people. Public schools should screen all children and increase mental health/behavioral services to address mental health issues for the entire family. Figure 7 shows the distribution of comments around the category of Mental Health.



Maternal and Child Health discussions were centered around:

- need for services
- community education about risky behaviors and pregnancy

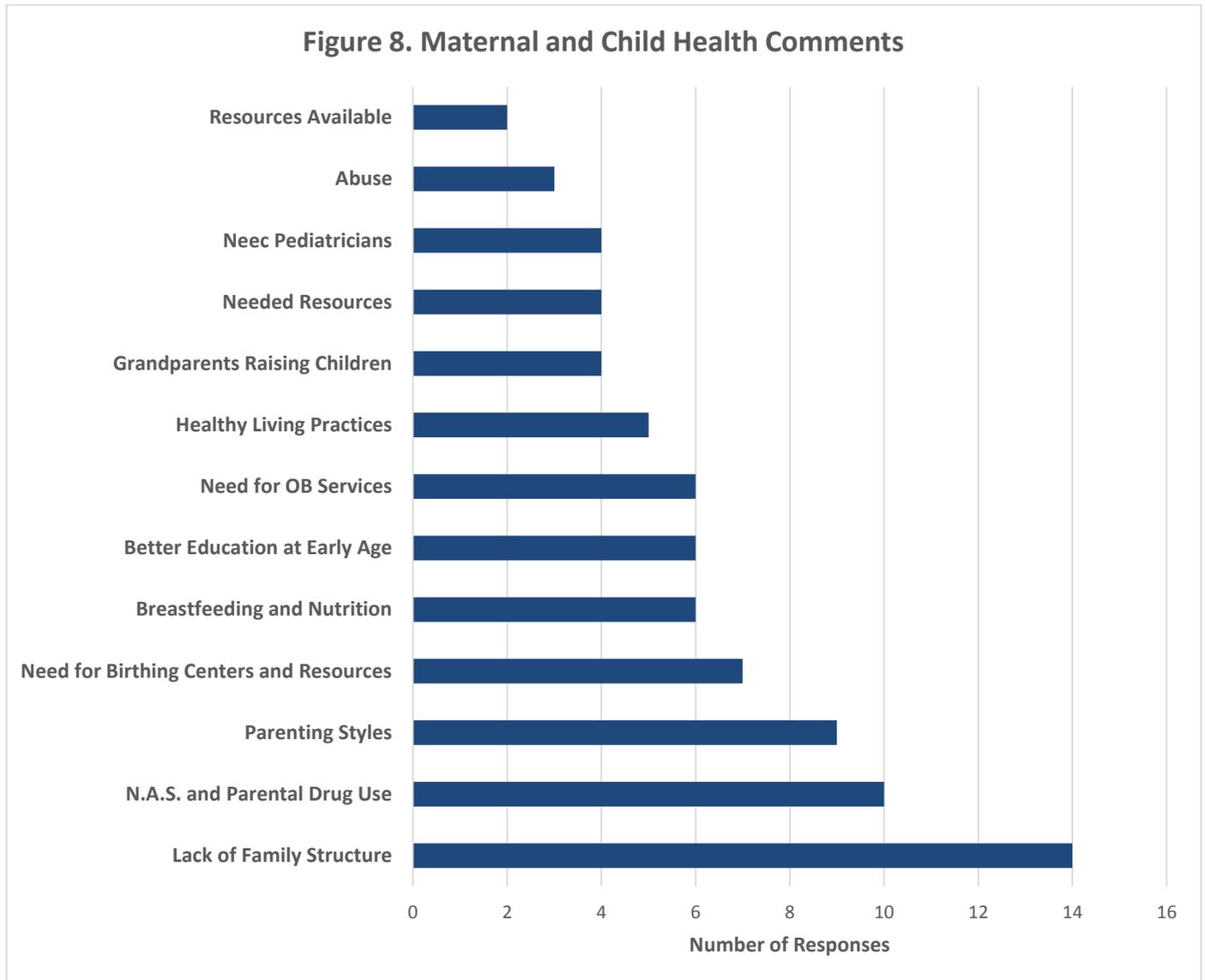
Other topics included: lack of family structure, neonatal abstinence syndrome and parental drug use, parenting styles, the need for birthing centers and resources, breastfeeding, nutrition and better education at an early age.

Additional topics were the need for OB/GYN services, healthy living practices, grandparents raising children, pediatricians, abuse and resources available.

Comments made specifically about maternal and child health expressed concern for the breakdown of families. They recommended that parents need to set more limits on kids, and noted there is a lack of guidance and support in family. There should be more community education at an early age about tobacco, physical activity, nutrition, STDs and birth control.

Mother-friendly childbirth and breastfeeding support groups with incentives were expressed as needs, as well as prenatal interventions for substance abuse and resources for special needs. Child care also should be available at

wellness centers. It was mentioned several times that there is a need for pediatricians and mobile services to schools. Figure 8 displays comment frequencies for Maternal and Child Health subtopics.



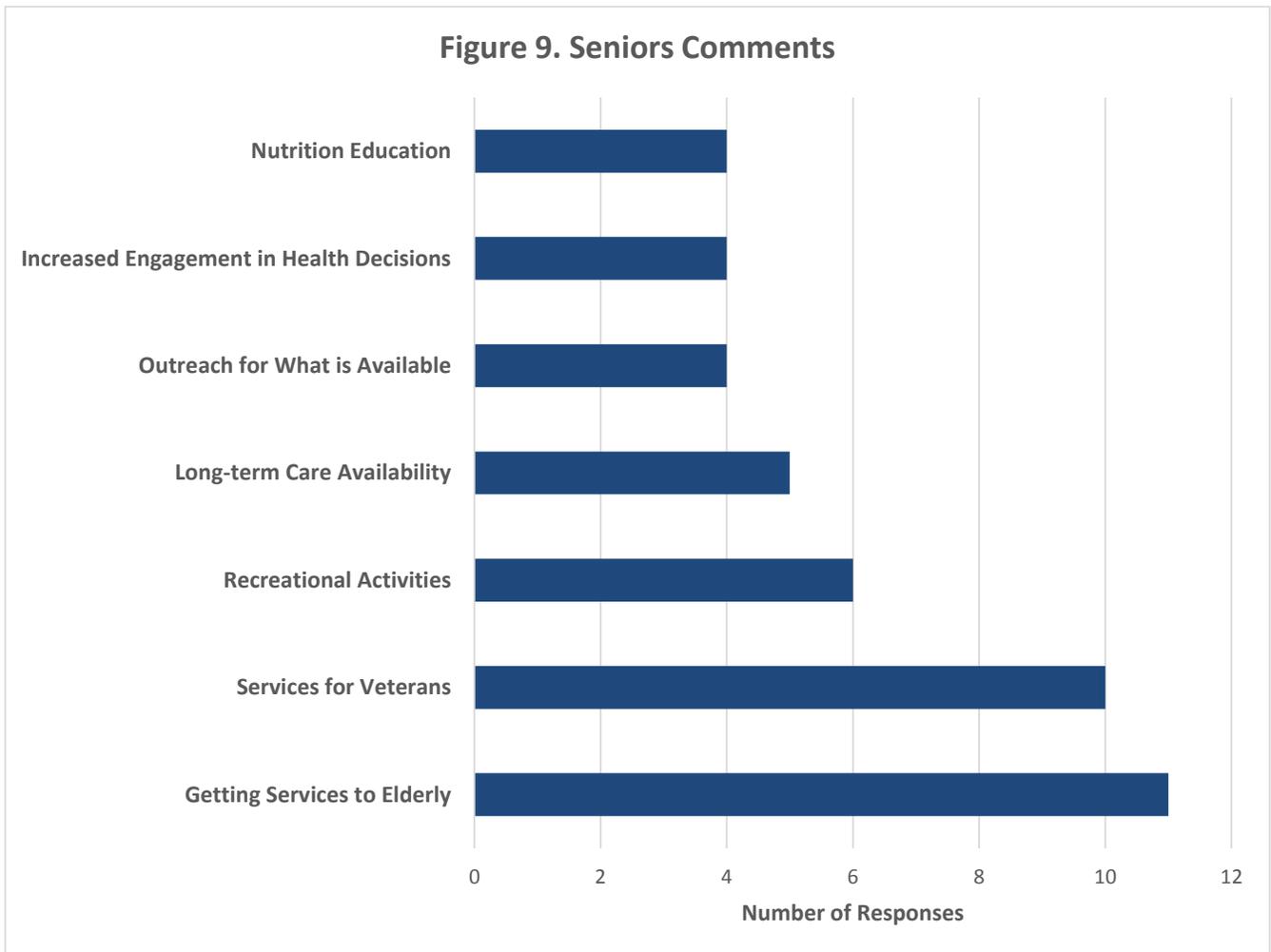
Senior issues focused on areas such as:

- availability of services for the elderly
- services for veterans
- recreational activities
- availability of long-term care

Other topics were outreach to create awareness of what is available, increased engagement in health decisions and nutrition education. Comments were made indicating a need to recognize the aging population and their needs.

Prevention care is also important for the elderly, especially shingles shots, flu vaccines and mobile immunizations. We need to go to seniors' homes to provide services and create more opportunities for physical exercise.

Our elderly population is increasing, but no new beds are opening up. Distances to facilities like the VA center are too far and there is an overall lack of availability for veterans. Figure 9 shows the distribution of comments around category of Seniors.



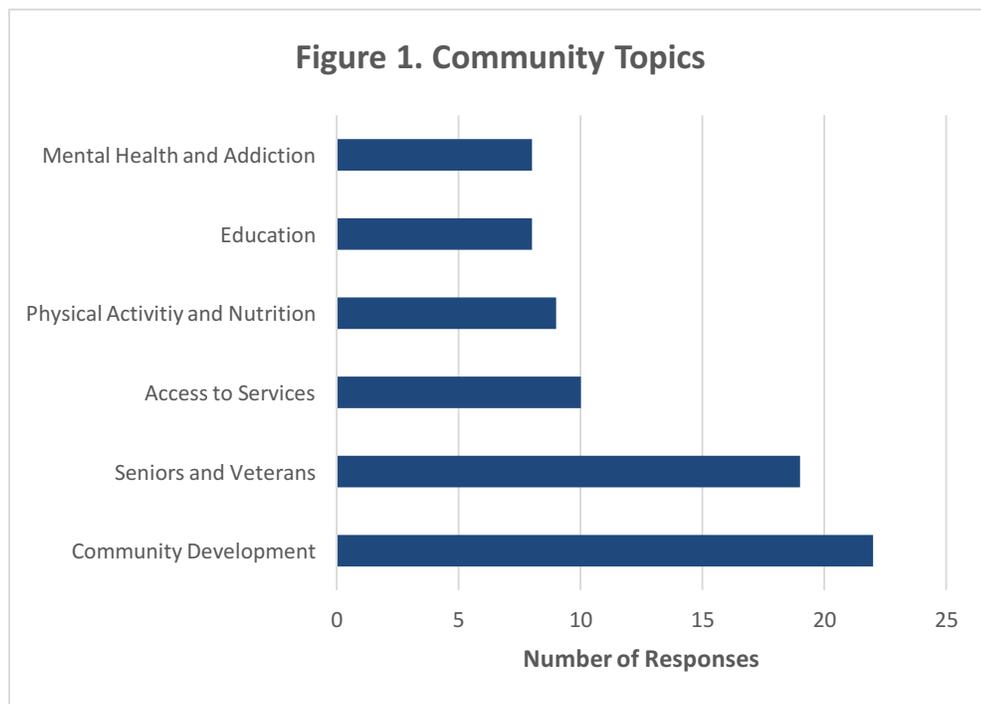


At the Wise meeting there were 22 attendees sitting around 4 tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, “**What can you do to improve health in the community?**” At the end of two rounds of small group discussion, notes were collected from the table moderators, or “Table Hosts”, to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

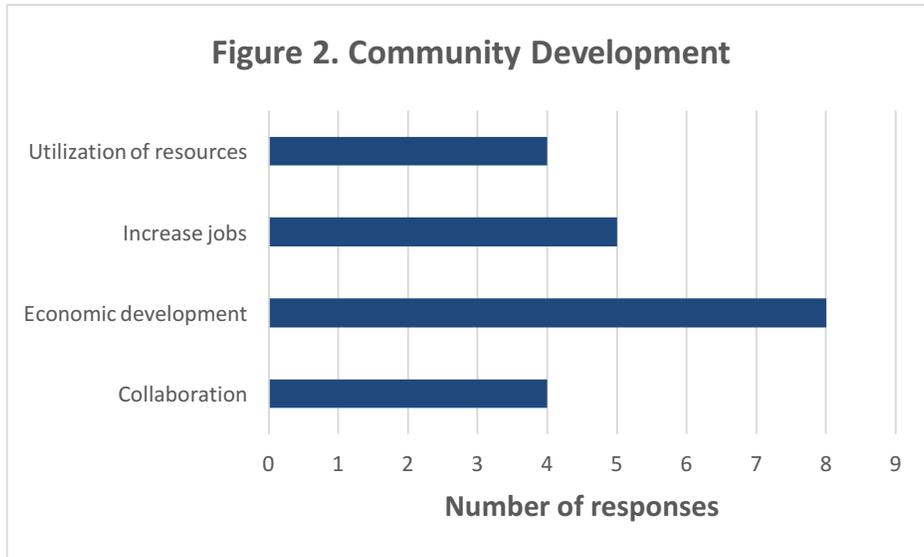
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

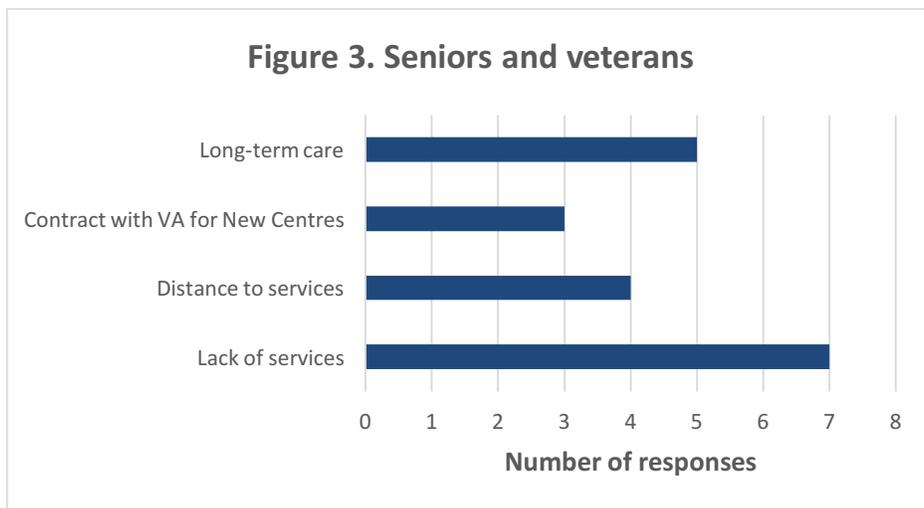
- Community Development
- Seniors and Veterans
- Access to Services
- Physical Activity and Nutrition
- Education
- Mental Health and Addiction



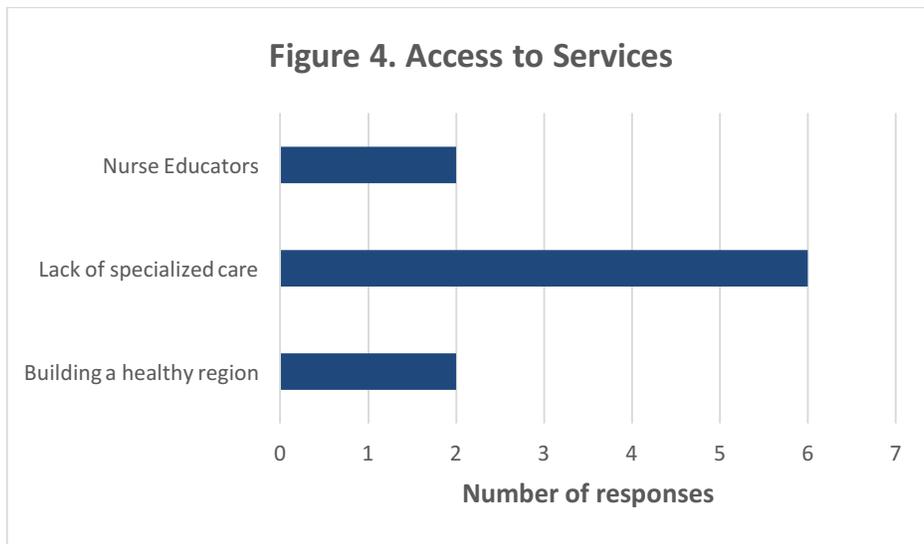
Community Development was the most talked about topic during the discussion. In order to identify specific categories within the discussion around community development, comments were broken out and considered individually. Topics under community development included utilization of resources, increase jobs, economic development and collaboration. Figure 2 illustrates the Comment distribution within this topic.



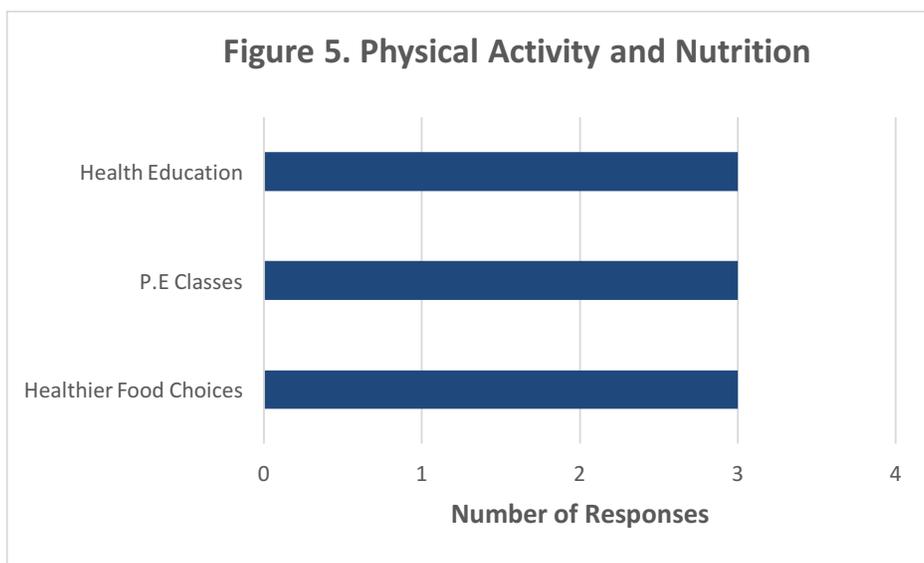
Seniors and Veterans was the second largest topic of concern among the attendees. Focus areas within this topic included distance to services, lack of services, need for long-term care and additional contracts with VA for new centers. Figure 3 shows the distribution of Comments around these categories.



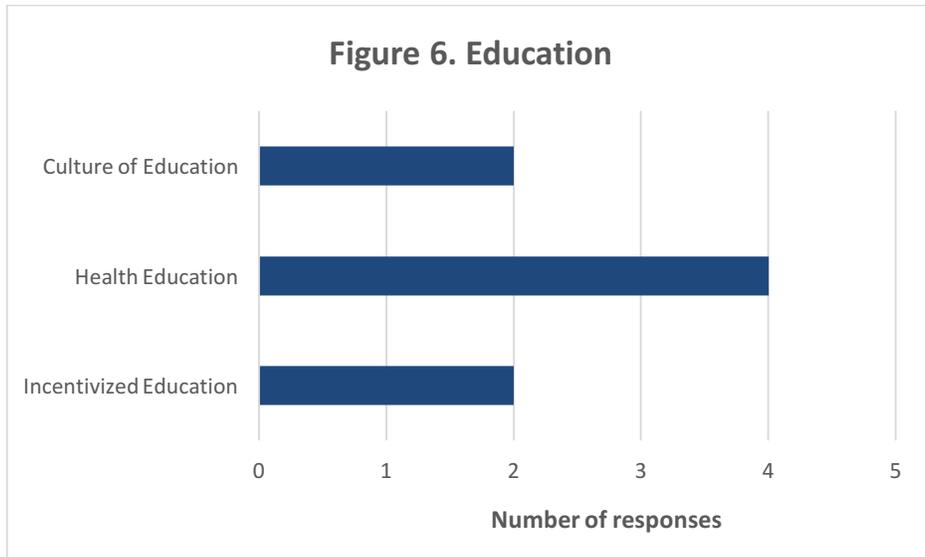
Access to Services was a broad topic that was prevalent within every major discussion topic. Subgroups within the topic were the need for building a healthy region, lack of specialized care and more nurse educators. Participants indicated the need for subspecialists and more physicians in the region. Figure 4 displays Comment frequencies within the subgroups.



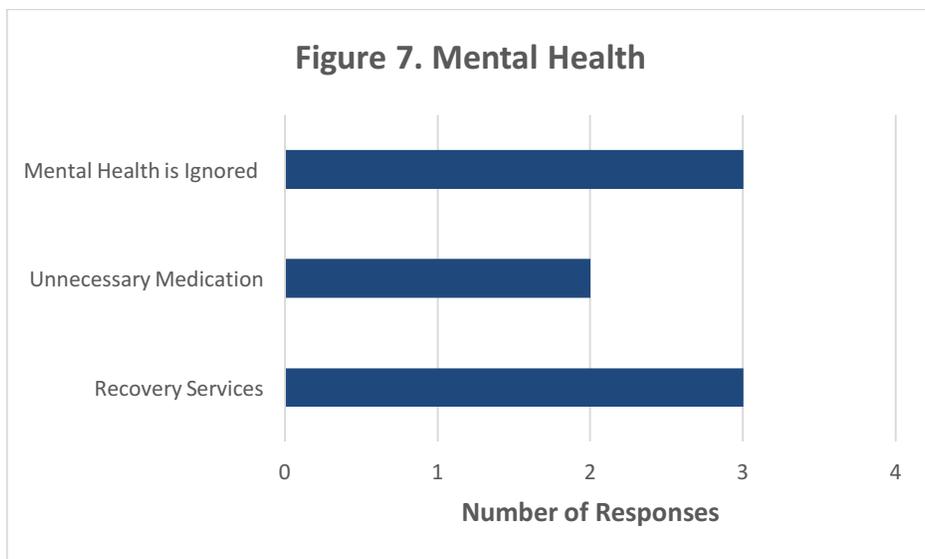
Nutrition and Physical Activity was a prominent concern among the meeting participants. Folks indicated a need for healthier food choices, P.E classes and health education. Healthier food choices, P.E classes and health education each were discussed equally. Figure 5 displays Comment frequencies for these subgroups.



Education was a broad topic that was prevalent within every major discussion topic. Folks indicated a need for incentivized education, culture of education and increased health education. Figure 6 displays Comment frequencies for these subgroups.



Mental Health was a prominent concern among the meeting participants. Subgroups within the topic included Concerns about mental health being ignored, unnecessary education and recovery services. The need for recovery and treatment services being available and affordable to all people was mentioned. Figure 7 shows the distribution of Comments around these categories.

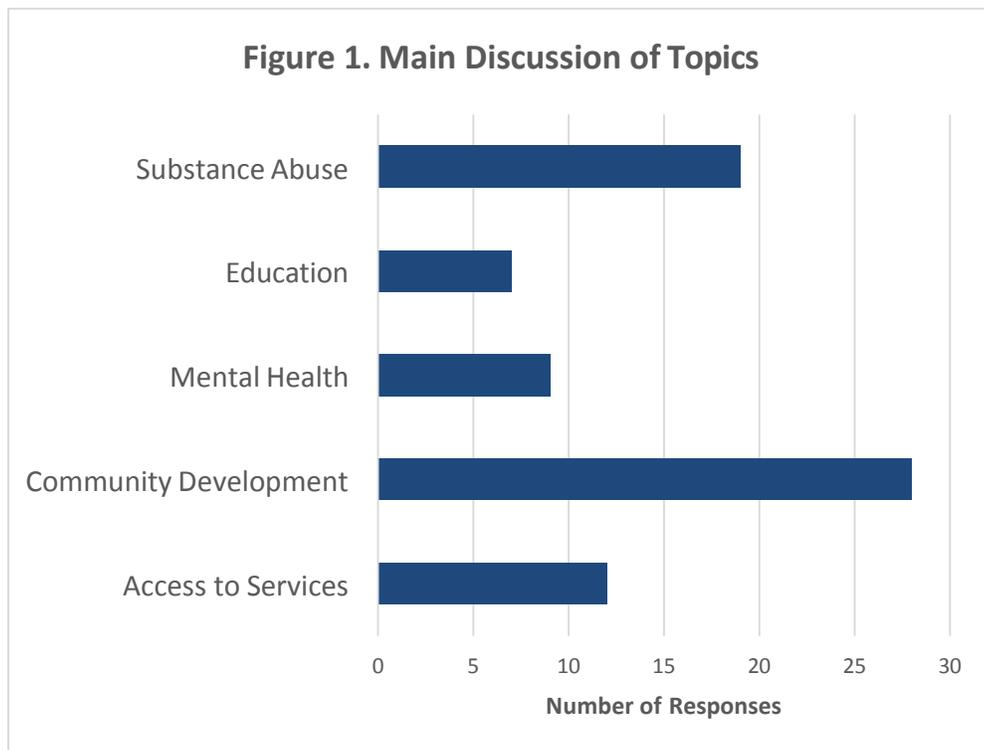


At the Johnson City meeting there were nine attendees sitting around two tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, “**What can you do to improve health in the community?**” At the end of two rounds of small group discussion, notes were collected from the table moderators, or “Table Hosts,” to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

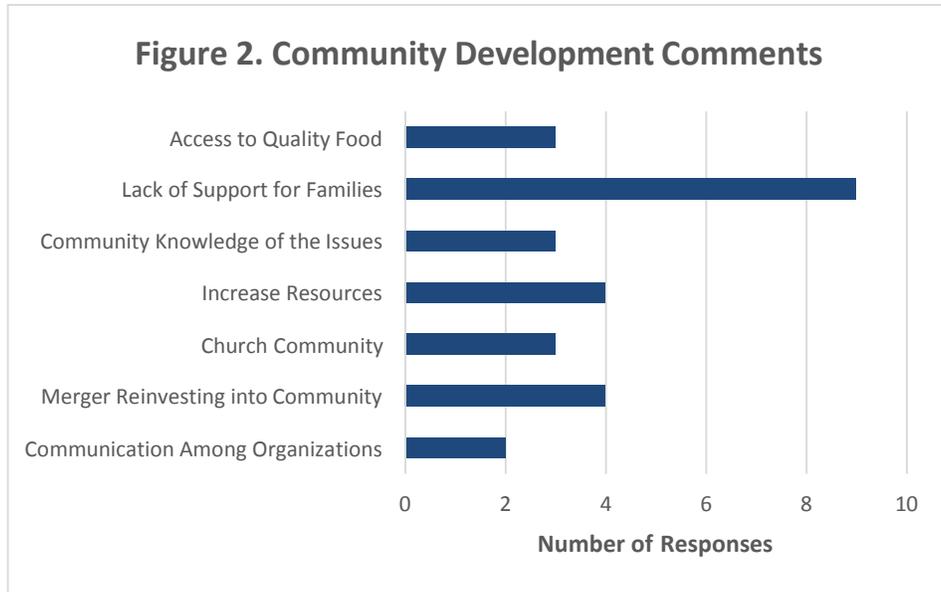
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified:

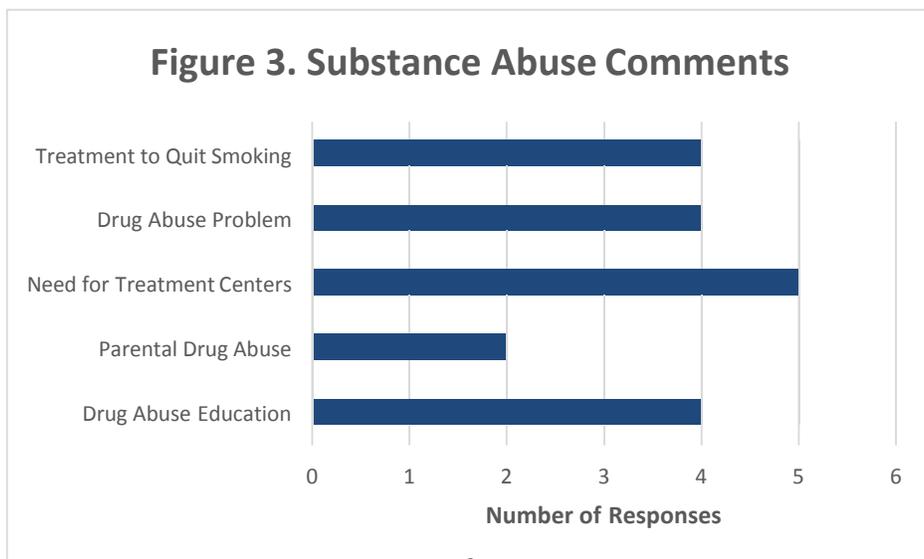
- Substance Abuse
- Education
- Mental Health
- Community Development
- Access to Services



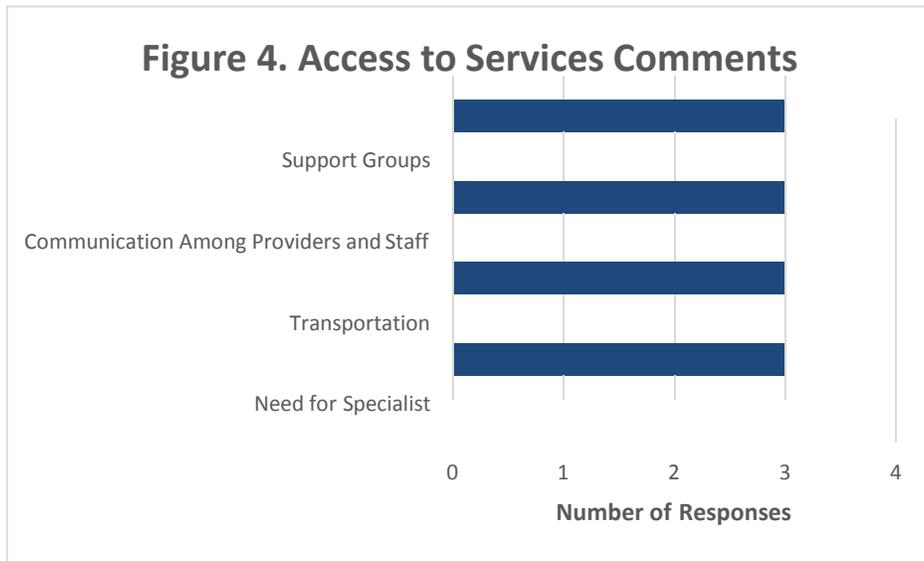
Community Development was the most talked about topic during the discussion. In order to identify specific categories within the discussion around community development, comments were broken out and considered individually. Topics under community development included access to quality food, lack of support for families, community knowledge of the issues, increasing resources, the need for church communities, concerns about the merger investing in to the community and communication among organizations. Figure 2 illustrates the comment distribution within this topic.



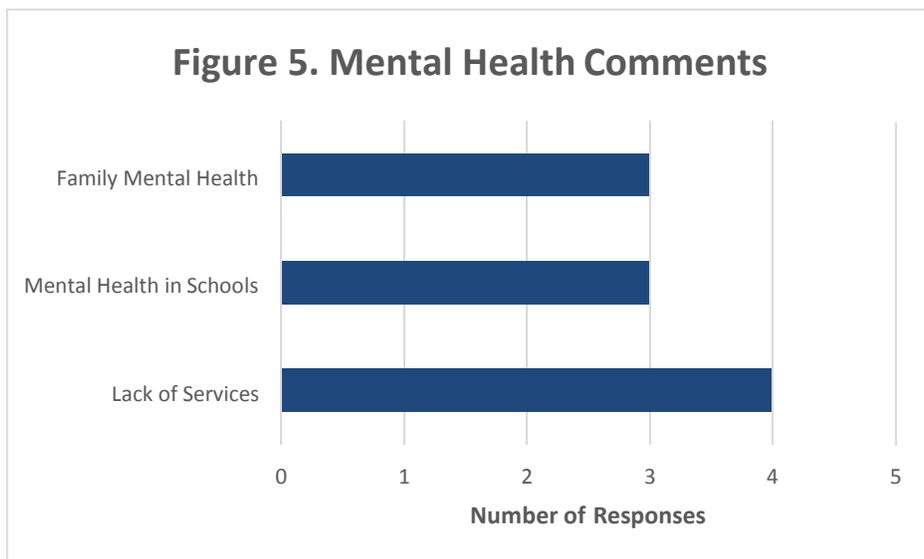
Substance Abuse was the second largest topic of concern among the attendees. Focus areas within this topic included: the need for treatments to help quit smoking, the recognition of the drug abuse problem, need for treatment centers, parental drug abuse and the need for drug abuse education. Figure 3 shows the distribution of comments around these categories.



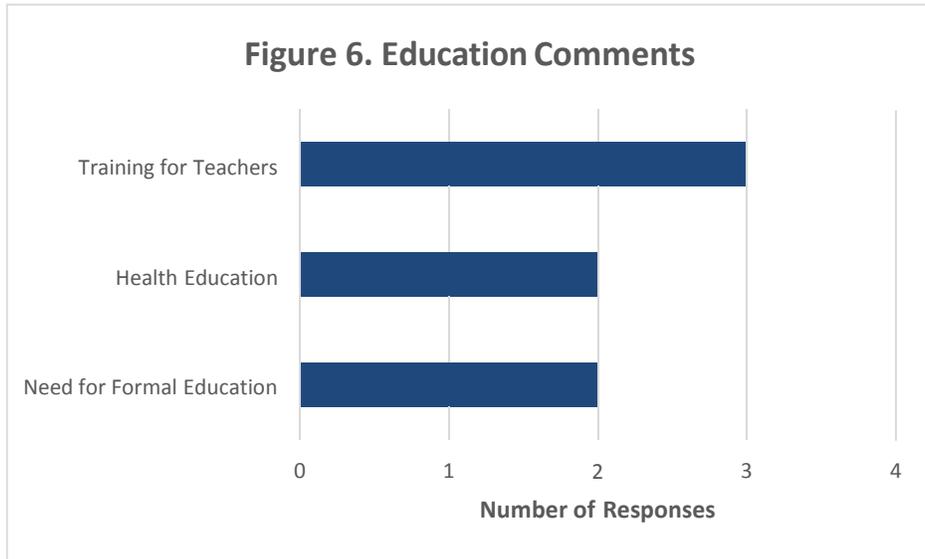
Access to Services was a broad topic that was prevalent within every major discussion topic. Subgroups within the topic were the need for support groups for chronic conditions, transportation, the need for specialists and communication among hospital providers and staff. Participants indicated the need for Mountain States Health Alliance to accept Blue Cross Blue Shield, and improved communication between nurses and doctors when new patients are admitted. Figure 4 displays comment frequencies within the subgroups.



Mental Health comments were considered separately from substance abuse in order to identify specific mental health needs within the community. The discussion around mental health dealt with lack of access to resources, the need for mental health services in schools and family mental health services. Many felt there was a need for education and services to be provided in schools regarding mental health. Figure 5 displays comment frequencies for this discussion topic.



Education is a broad topic that was prevalent within every major discussion topic. Subgroups within the topic were the need for teacher training, health education and the need for formal education. Participants indicated the need for teachers to be trained on health issues and medications children may be taking. Figure 6 displays comment frequencies within the subgroups.

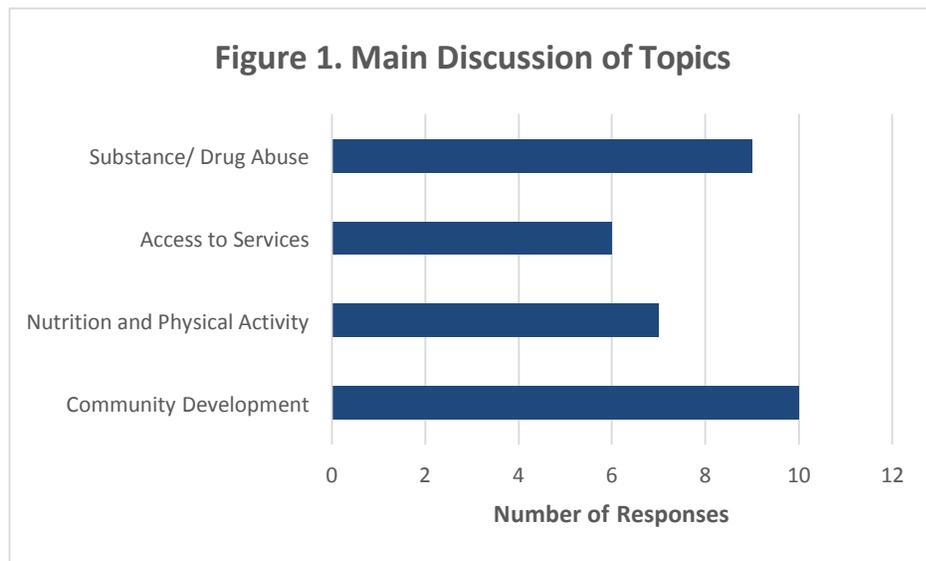


At the Bristol meeting there were seven attendees sitting around two tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, “**What can you do to improve health in the community?**” At the end of two rounds of small group discussion, notes were collected from the table moderators, or “Table Hosts,” to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

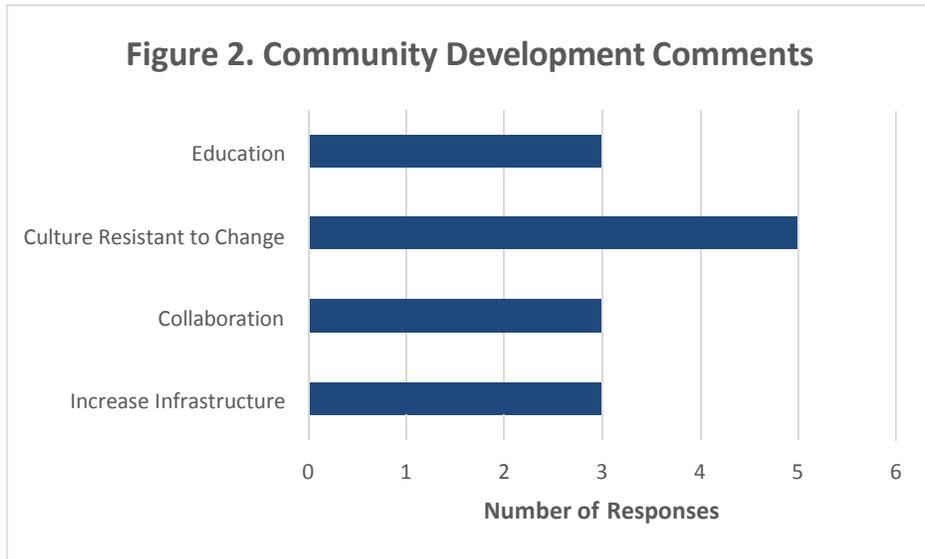
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

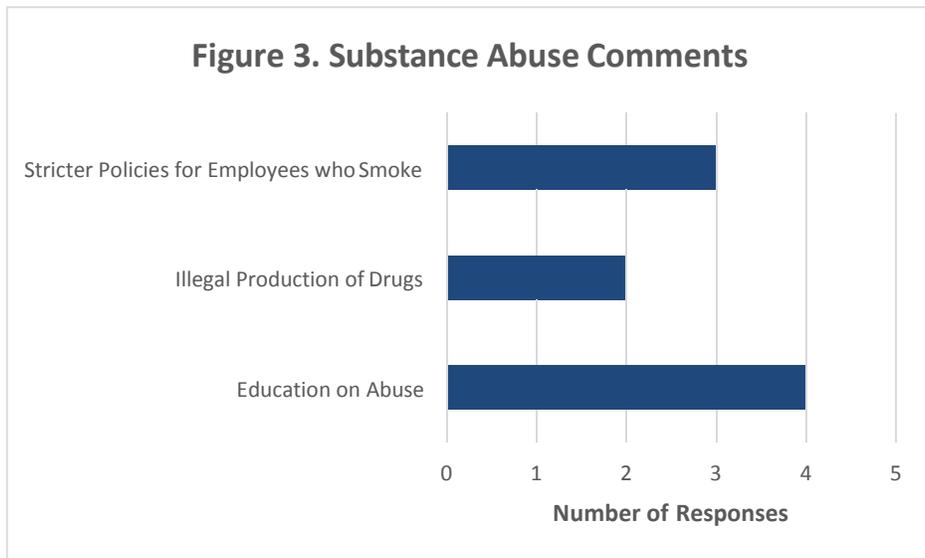
- Substance Abuse
- Nutrition and Physical Activity
- Access to Services
- Community Development



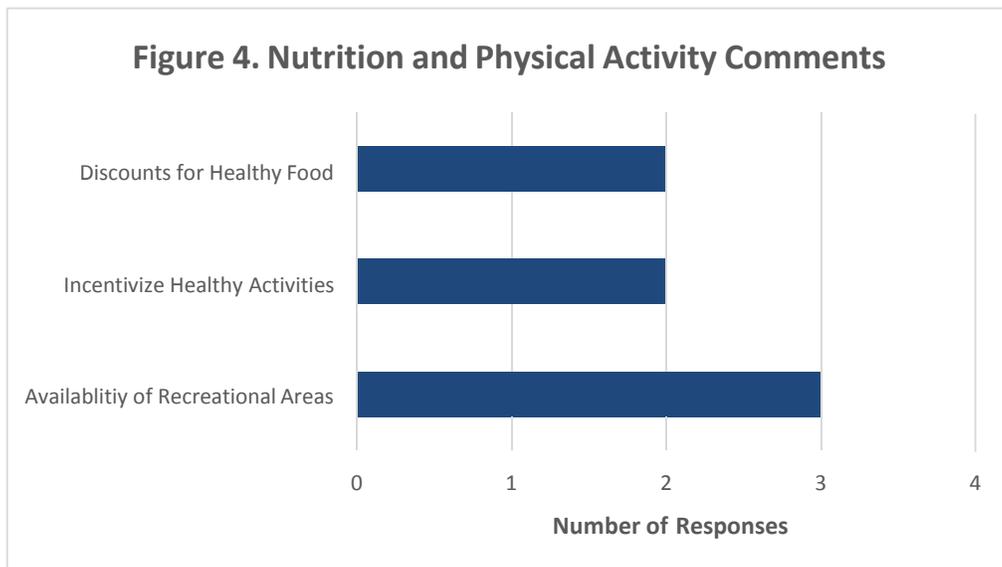
Community Development was the most talked about topic during the discussion. In order to identify specific categories within the discussion around community development, comments were broken out and considered individually. Topics under community development included the problem of culture being resistant to change, collaboration, education and increasing infrastructure. Figure 2 illustrates the comment distribution within this topic.



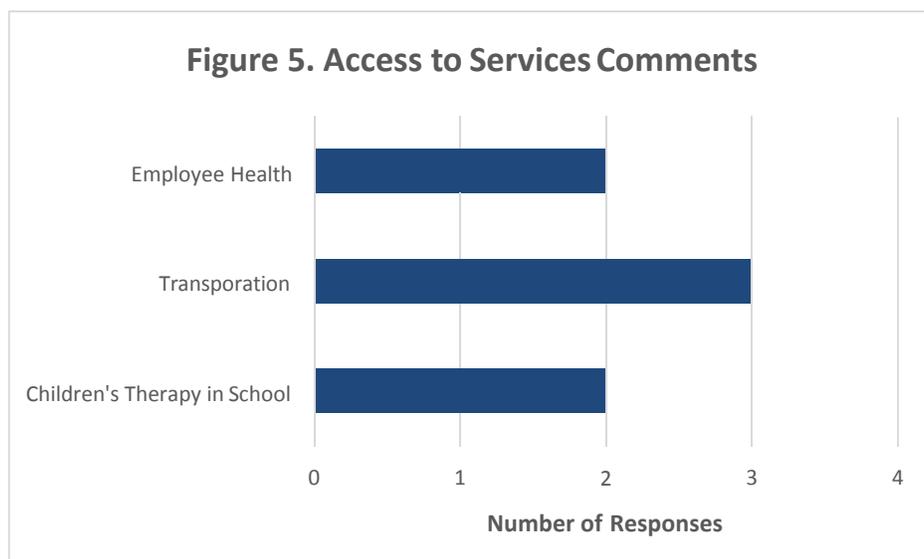
Substance Abuse was the second largest topic of concern among the attendees. Focus areas within this topic included: increasing education about abuse, halting the illegal production of drugs and creating stricter policies for employees who smoke. Figure 3 shows the distribution of comments around these categories.



Nutrition and Physical Activity was a prominent concern among the meeting participants. Participants indicated a need for incentivizing healthy activities, increasing availability of recreational areas and providing discounts for healthy food. When discussing lack of availability of recreational areas, people mentioned the need for connecting people to the outdoors and increasing facilities for recreational activity. Figure 4 displays comment frequencies for these subgroups.



Access to Services was a broad topic that was prevalent within every major discussion topic. Subgroups within the topic were the need for transportation, children’s therapy in schools and employee health programs. Participants indicated the need for transportation for children and for community members to receive health services. Figure 5 displays comment frequencies within the subgroups.

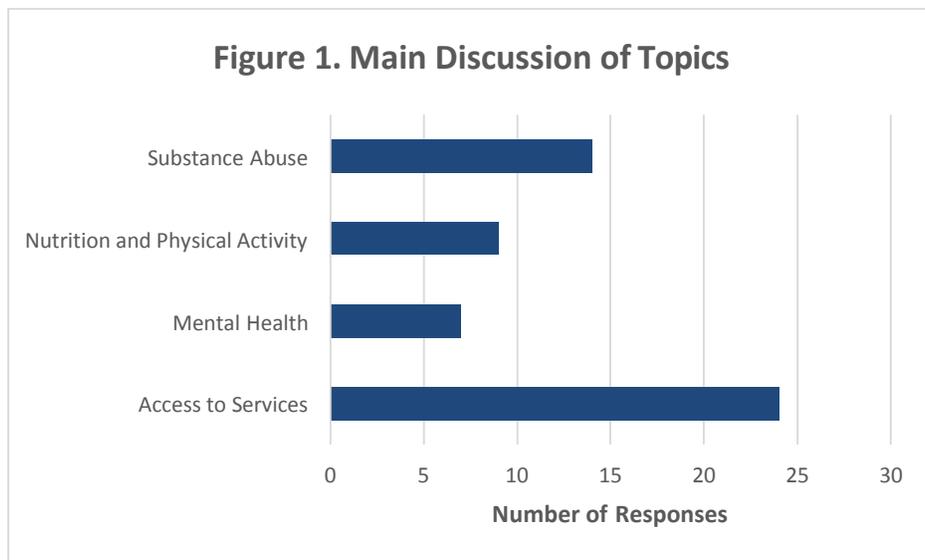


At the Duffield meeting there were ten attendees sitting around two tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, “**What can you do to improve health in the community?**” At the end of two rounds of small group discussion, notes were collected from the table moderators, or “Table Hosts,” to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

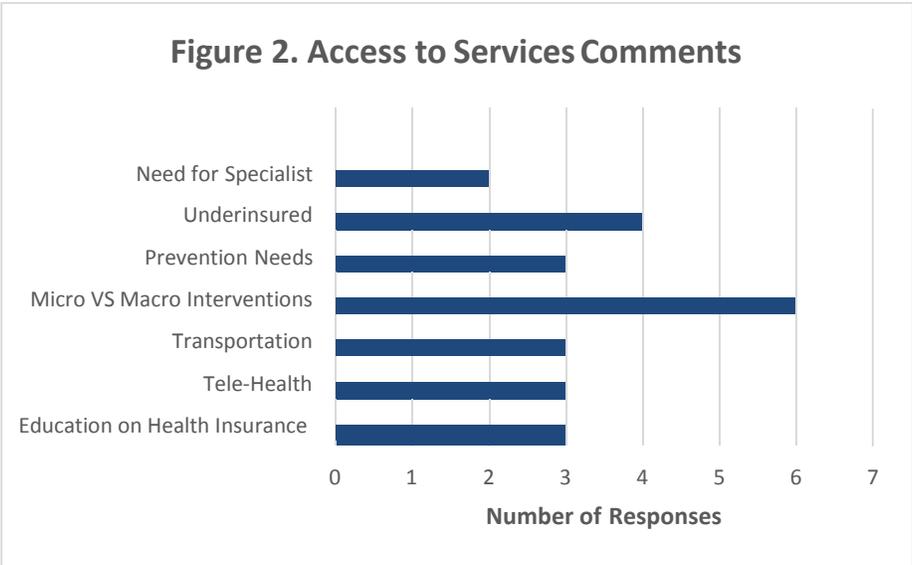
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

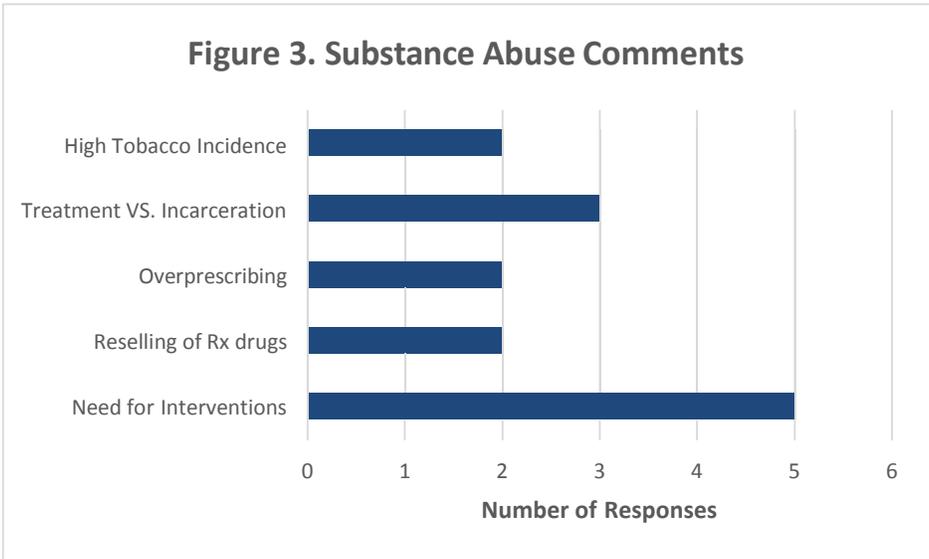
- Mental Health
- Substance Abuse
- Nutrition and Physical Activity
- Access to Services



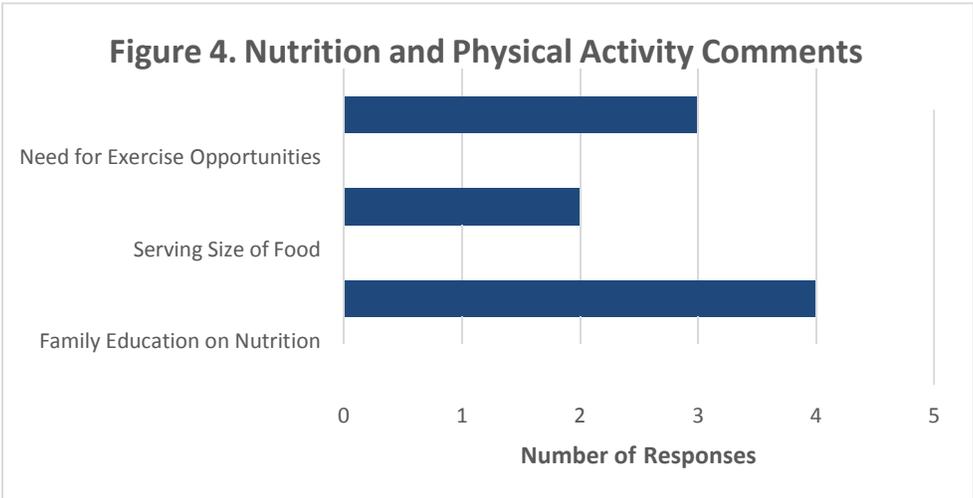
Access to Services was the most talked about topic during the discussion. In order to identify specific categories within the discussion around access, comments were broken out and considered individually. Topics under access to services included uninsured/underinsured individuals, prevention needs, a need for more specialists, micro and macro intervention options, transportation, telehealth and education. Comments about micro and macro interventions mentioned interventions for underserved populations and a community focus on intervention strategies. Figure 2 illustrates the comment distribution within this topic.



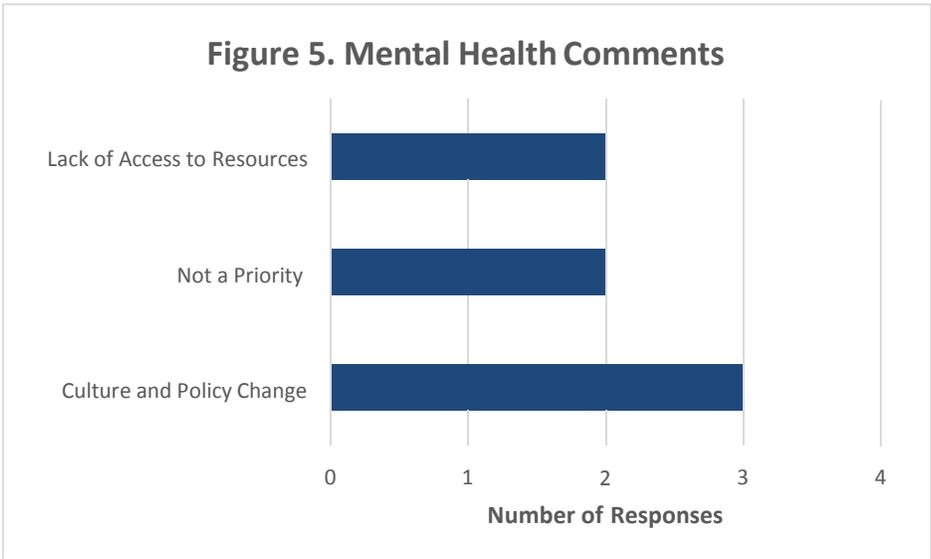
Substance Abuse was the second largest topic of concern among the attendees. Focus areas within this topic included: high tobacco incidence, reselling of prescription drugs, overprescribing, treatment options before incarceration and the need for interventions. Figure 3 shows the distribution of comments around these categories.



Nutrition and Physical Activity was a prominent concern among the meeting participants. Participants indicated a need for nutrition education (in schools and for families) and increased convenience and availability of exercise opportunities. Sub-categories developed for this summary analysis include exercise opportunities, serving size of food and family education on nutrition. Figure 4 displays comment frequencies for these subgroups.



Mental Health comments were considered separately from substance abuse in order to identify specific mental health needs within the community. The discussion around mental health dealt with lack of access to resources, mental health not being a priority, and culture/policy change. Many felt there was a lack of adolescent mental health care and inpatient facilities. Figure 5 displays comment frequencies for this discussion topic.

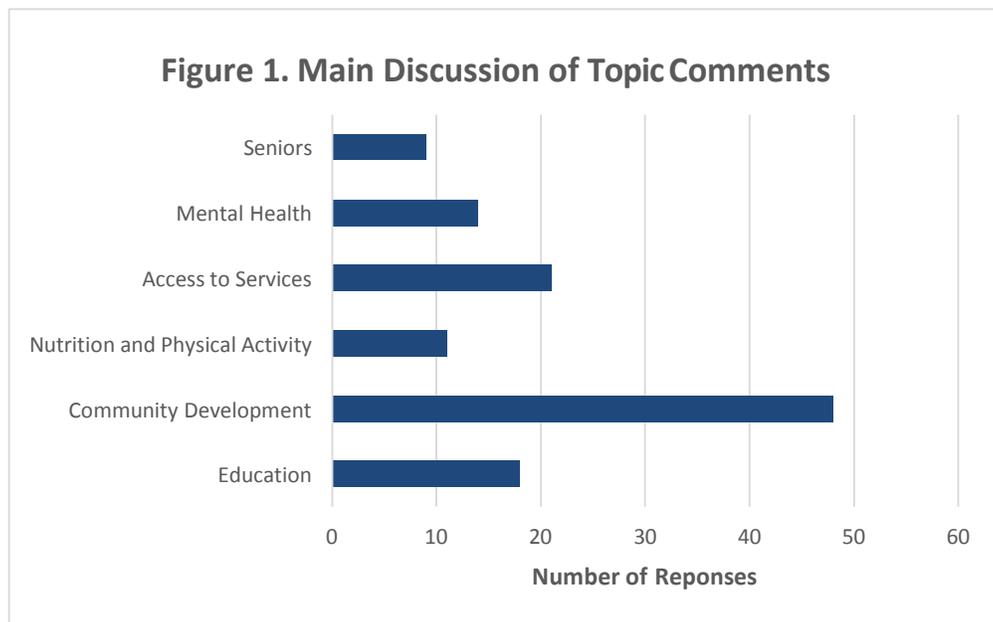


At the Kingsport meeting there were 17 attendees sitting around 4 tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, “**What can you do to improve health in the community?**” At the end of two rounds of small group discussion, notes were collected from the table moderators, or “Table Hosts”, to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

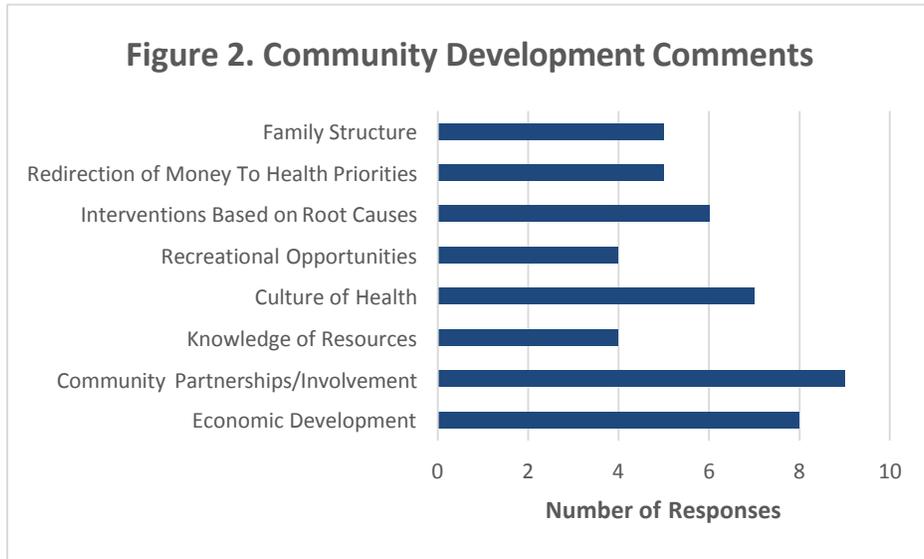
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

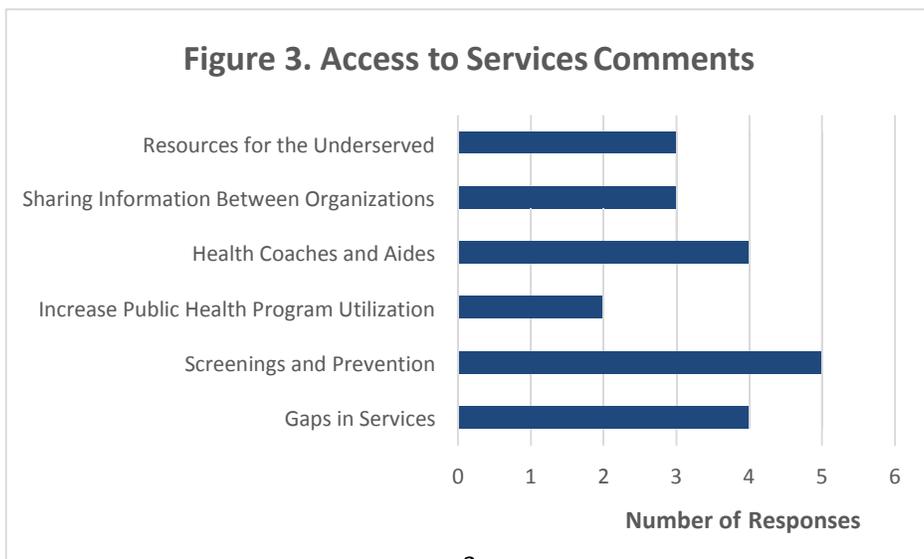
- Education
- Community Development
- Nutrition and Physical Activity
- Access to Services
- Mental Health
- Seniors



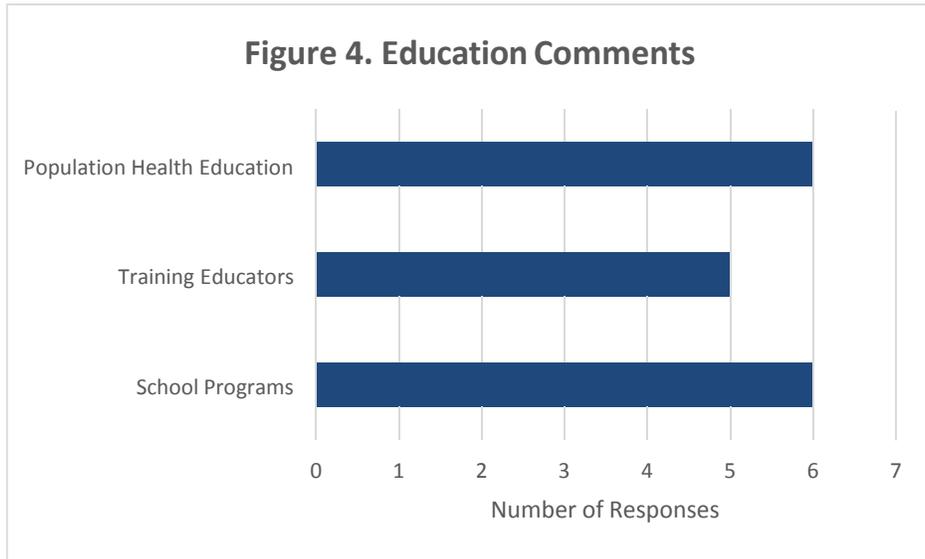
Community Development was characterized by concerns about the family structure, redirection of money to health priorities, interventions based on root causes, increased recreational opportunities, creating a culture of health, knowledge of resources, community partnerships/involvement and economic development. Participant comments included the need for creating jobs, providing opportunities for physical activity and focusing on root based problems. Economic Development was one of the main concerns with decreasing income status, need for reduction of competitive cost and creating a culture where people want to work. Figure 2 displays the rate of comments in each of these categories.



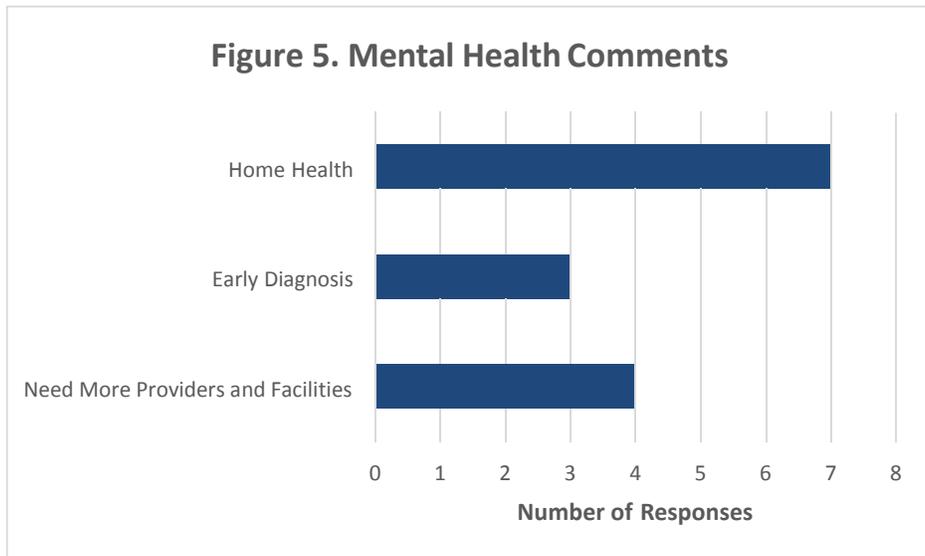
Access to Services was the second largest topic of concern among the attendees. In order to identify specific categories within the discussion around access, comments were broken out and considered individually. Topics under access to services included resources for the underserved, sharing information between organizations, health coaches and aids, increasing public health program utilization and gaps in services. Programs needed ranged from prevention, educational needs in home health and better sharing of information between organizations. Figure 3 illustrates the comment distribution within this topic.



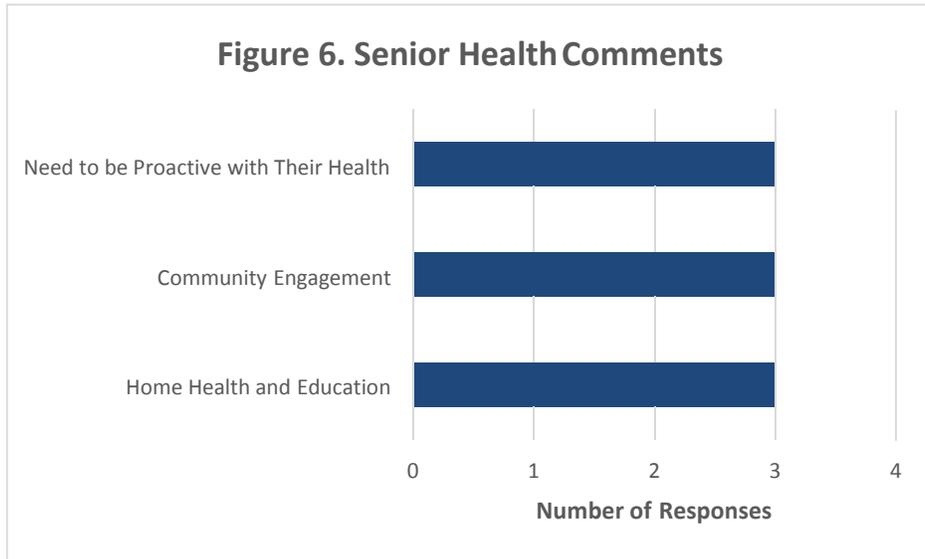
Education is a broad topic that was prevalent within every major discussion topic. Subgroups within the topic were school programs, training educators and population health education. Participants indicated the need for training focus to be based on local issues, literacy and children new healthy habits. Figure 4 displays comment frequencies within the subgroups.



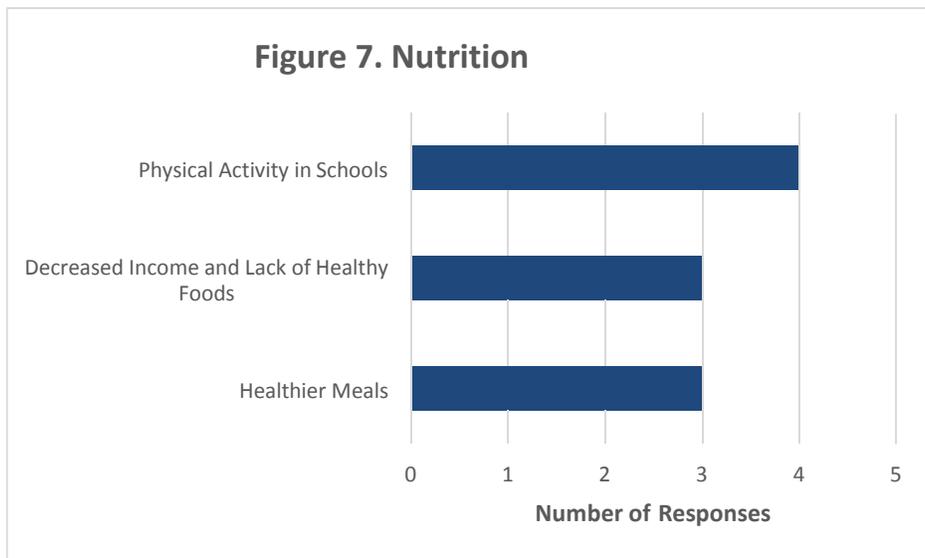
Mental Health comments were focused around needed services. The discussion around mental health dealt with home health services, early diagnosis and the need for more practitioners. Many felt there was a lack of adolescent and pediatric mental health services and mental health treatment facilities. Figure 5 displays comment frequencies for this discussion topic.



Senior Health was concentrated on the need for engagement and access to services. Folks indicated that home health and education, community engagement and the need to be proactive with their health were main concerns. Access to preventive care, need for better way to get services to seniors and education on existing resources were some of the topics mentioned. Figure 8 displays comment frequencies for these subgroups.



Physical Activity and Nutrition was a prominent concern among the meeting participants. Folks indicated that lack of physical activity and the need for more tailoring of dietetic information. Decreasing income and the lack of healthy foods, physical activity in schools and healthier meals were the subcategories expressed in the meeting. Figure 7 displays Comment frequencies for these subgroups.

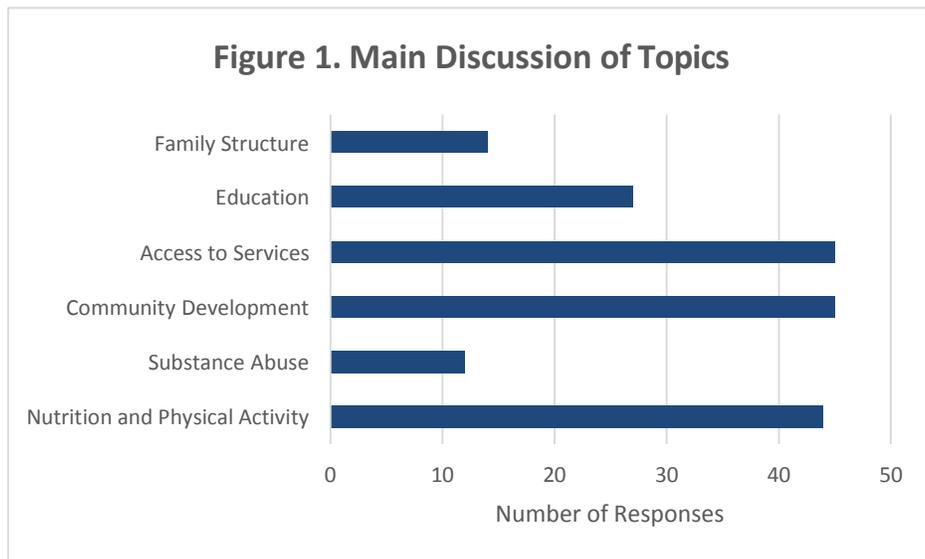


At the Lebanon meeting there were 36 attendees sitting around six tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable meetings, participants were asked to address in their conversations the question, “**What can you do to improve health in the community?**” At the end of two rounds of small group discussion, notes were collected from the table moderators, or “Table Hosts,” to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

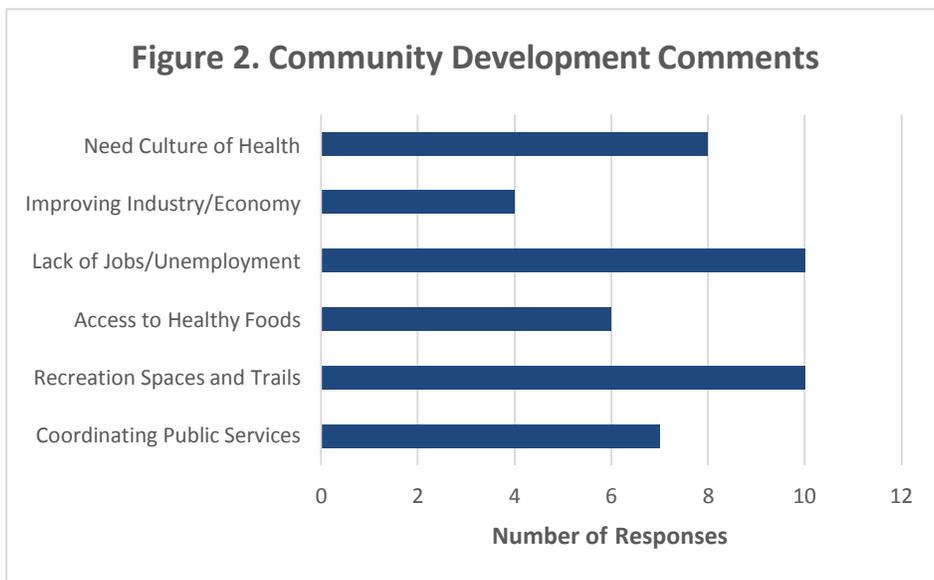
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

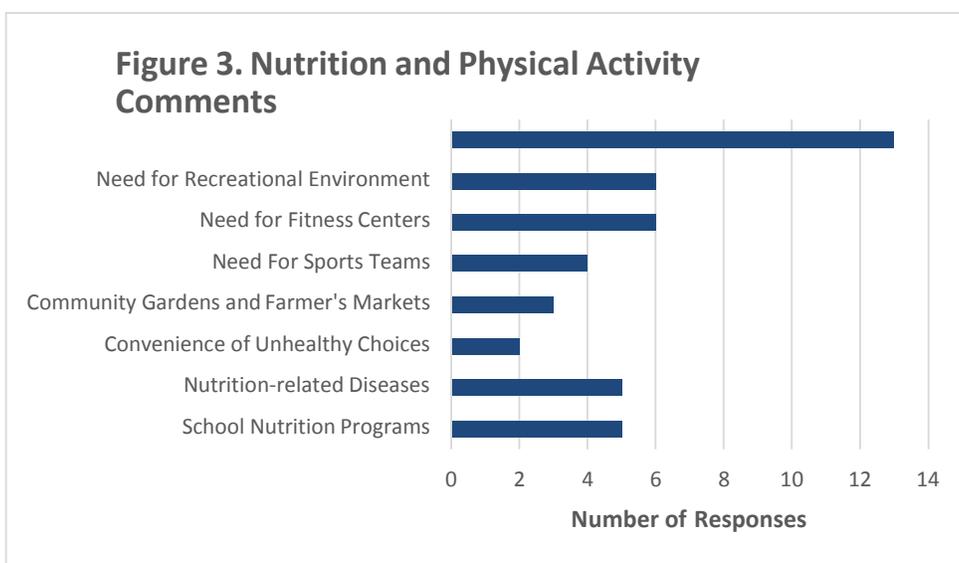
- Nutrition and Physical Activity
- Substance Abuse
- Community Development
- Access to Services
- Education
- Family Structure



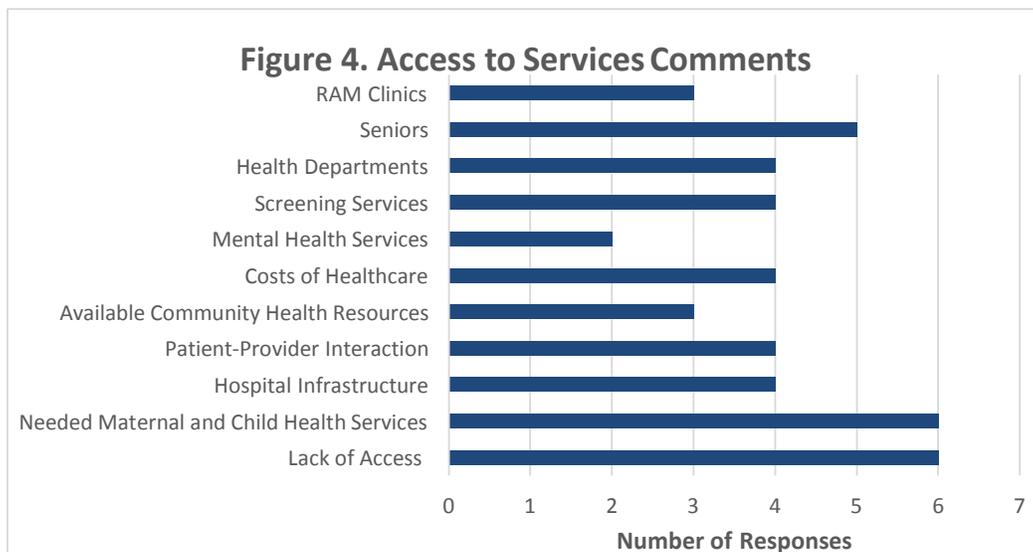
Community Development was characterized by concerns about establishing a culture of health, improving industry and the economy, lack of jobs/unemployment, access to healthy foods, recreation spaces and trails and coordination of public services. Figure 2 displays the rate of comments in each of these categories.



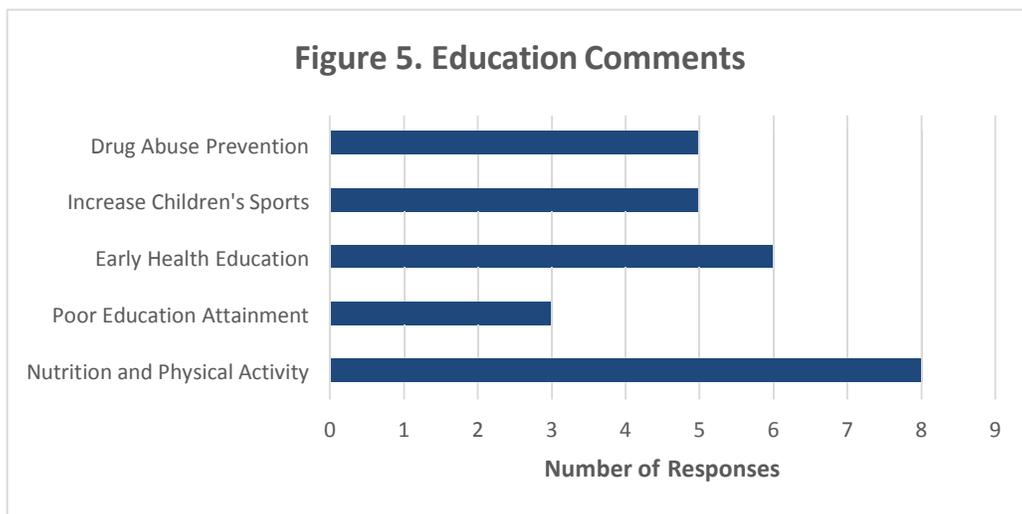
Nutrition and Physical Activity was a prominent concern among the meeting participants. People attending indicated a need for a recreational environment, need for more fitness centers and sports teams, community gardens and farmer’s markets, the convenience of unhealthy choices, nutrition-related diseases, school nutrition programs and education. Folks mentioned specific needs for exercise trails, children’s sports teams and fitness centers in the community. Figure 3 displays comment frequencies for these subgroups.



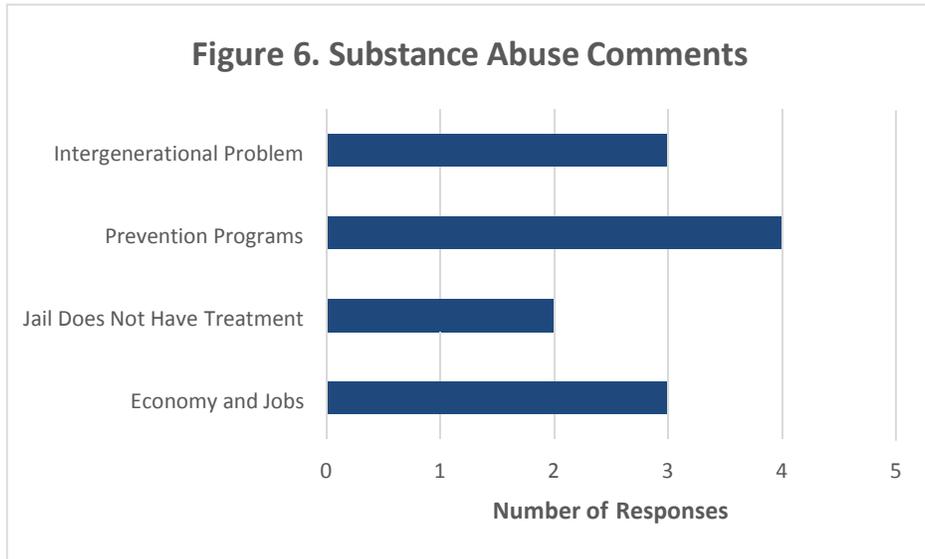
Access to Services was a major topic of concern among the attendees. In order to identify specific categories within the discussion around access, comments were broken out and considered individually. Topics under access to services included lack of access to services, maternal and child health services, hospital infrastructure, patient-provider Interaction, available community health resources, cost of health care, and the need for mental health services, screening services, health departments, seniors and RAM clinics. Programs needed ranged from pediatricians, transportation, senior exercise classes and reduction of health care costs. Figure 4 illustrates the comment distribution within this topic.



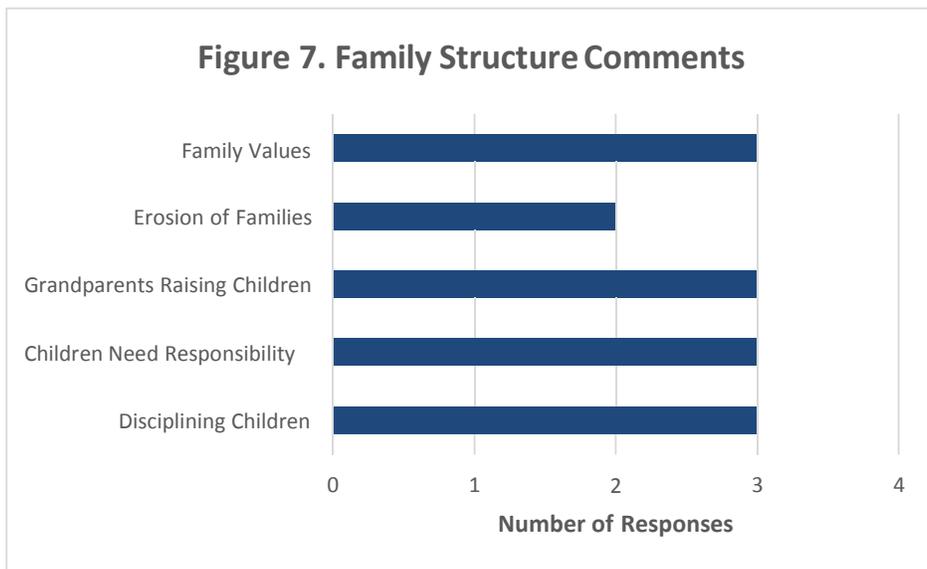
Education is a broad topic that was prevalent within the majority of discussion topics. Participants indicated the need for drug abuse prevention, increasing children’s sports, early health education, nutritional and physical activity as well as the problem of poor educational attainment. Ideas specific to the types of education, the targeted age group, as well as setting were included in this major topic. Subgroups within the topic were early education for children, self-esteem and more physical activity in schools. Figure 5 illustrates the comment distribution within this topic.



Substance Abuse was another concern among the attendees. Focus areas within this topic included: jails lacking treatment for addicts, economy and jobs, the need for prevention programs and drug abuse as an intergenerational problem. There were not any specific substances identified from the notes. Figure 6 shows the distribution of comments around these categories.



Family Structure comments were considered separately from Community Development in order to identify specific culture and family structural concerns within the community. Focus areas within this topic included: family values, erosion of family structure, grandparents raising children, children needing responsibility and the need to discipline children. Figure 7 shows the distribution of comments around these categories.



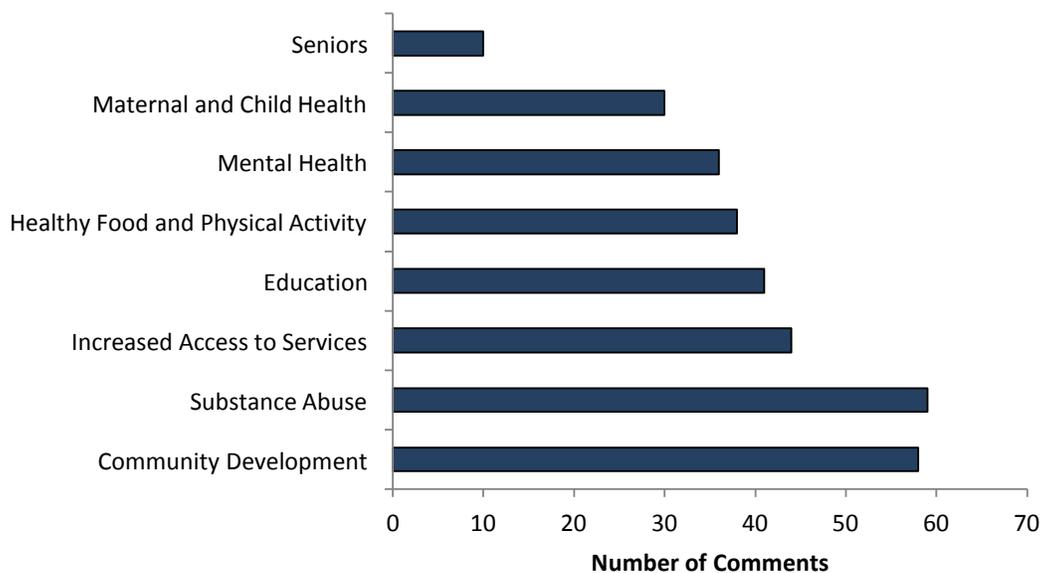
At the Elizabethton meeting there were 48 attendees sitting around eight tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable meetings, participants were asked to address in their conversations the question, “**What can you do to improve health in the community?**” At the end of two rounds of small group discussion, notes were collected from the table moderators, or “Table Hosts,” to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

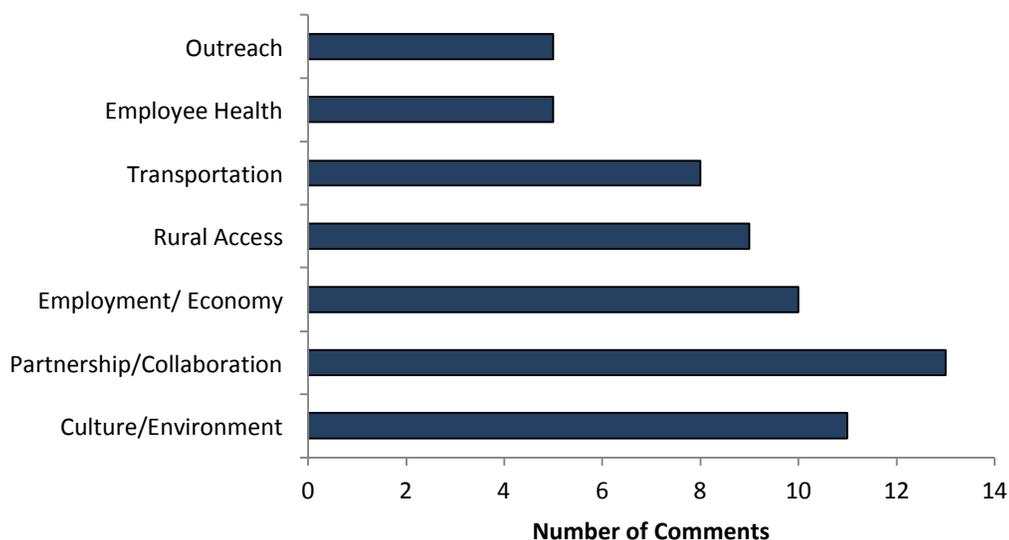
- Community Development
- Substance Abuse
- Increased Access to Services
- Education
- Healthy Food and Physical Activity
- Mental Health
- Maternal and Child Health
- Seniors

Figure 1. Main Discussion Topic Comments



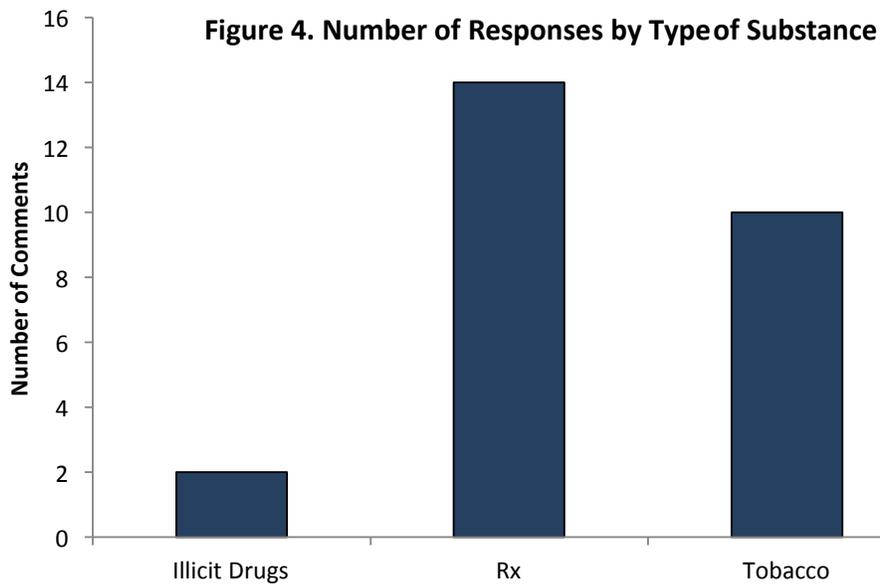
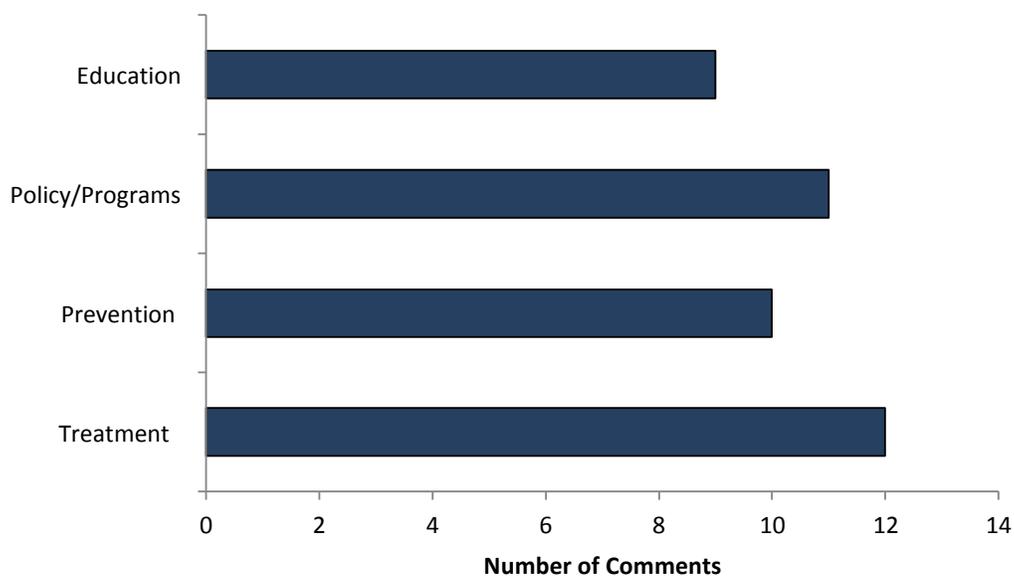
Community Development was characterized by concerns about the local environment, employment, collaborative infrastructure (government and private sector partnerships), rural access to services, transportation, employee health and outreach. Figure 2 displays the rate of comments in each of these categories.

Figure 2. Community Development Comments



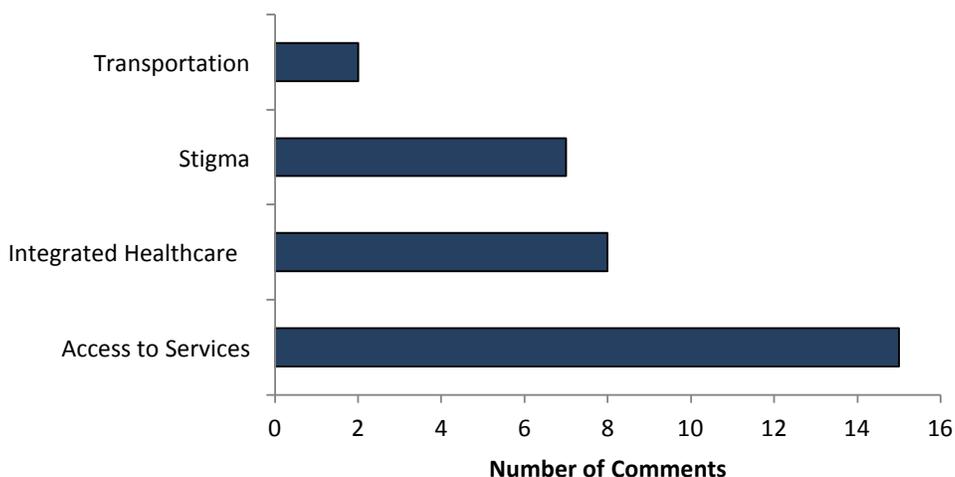
Substance Abuse was the second largest topic of concern among the attendees. Focus areas within this topic included: treatment services access and development, prevention services, policy and programs and education. There were three categories of substances identified from the notes (illicit drugs, prescription drugs and tobacco) Figure 3 shows the distribution of comments around these categories. Figure 4 displays the frequency of comments for each of the three identified substances (illicit drugs, prescription drugs and tobacco).

Figure 3 Substance Abuse Comments



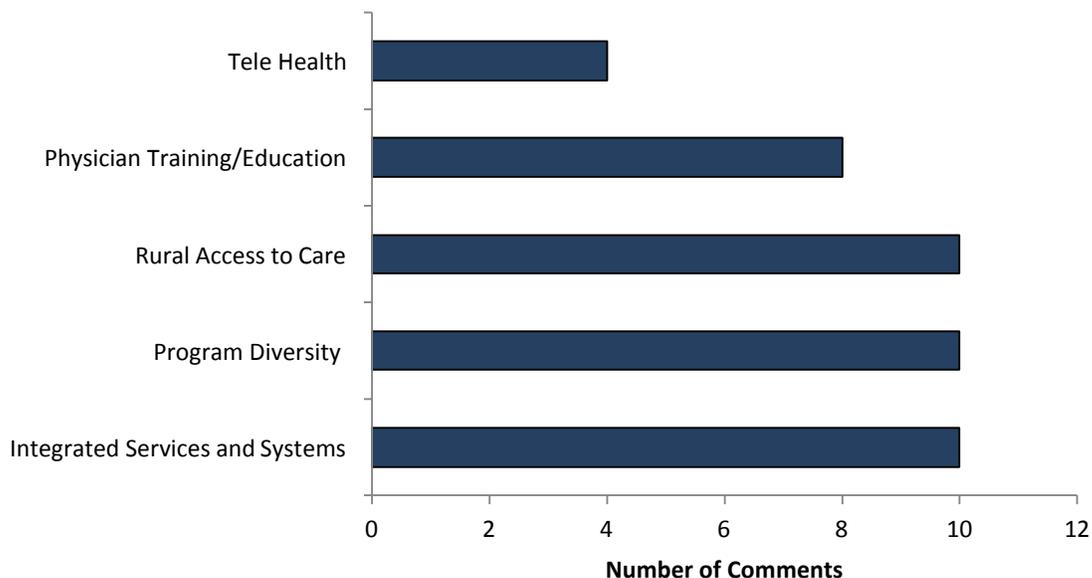
Mental Health comments were considered separately from substance abuse in order to identify specific mental health needs within the community. The discussion around mental health dealt with access to services, integrated health care, stigma and transportation concerns. Many felt there was a lack of inpatient and outpatient services in the region and that stigma was a substantial barrier to treatment. Figure 5 displays comment frequencies for this discussion topic.

Figure 5. Mental Health Comments



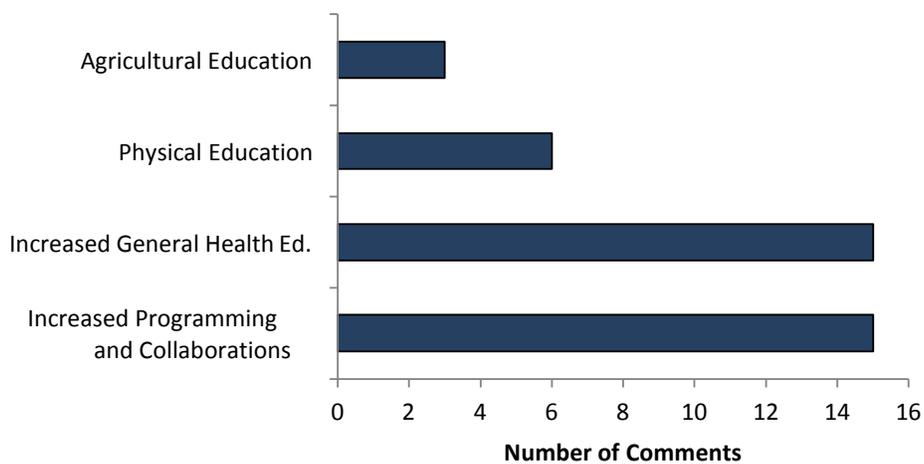
Increased Access to Services was a concern across all the main topics of discussion. In order to identify specific categories within the discussion around access, comments were broken out and considered individually. Topics under access to services included integrated services and systems, program diversity, rural access to care, physician training/education and telemedicine. Integrated services and systems comments dealt with the need for collaborations between physicians, insurance companies and the community as well as a strong need for integrated data solutions. Program diversity included comments around the need for oral care and behavioral health in the primary care setting. Figure 6 illustrates the comment distribution within this topic.

Figure 6. Increased Access to Services Reponses



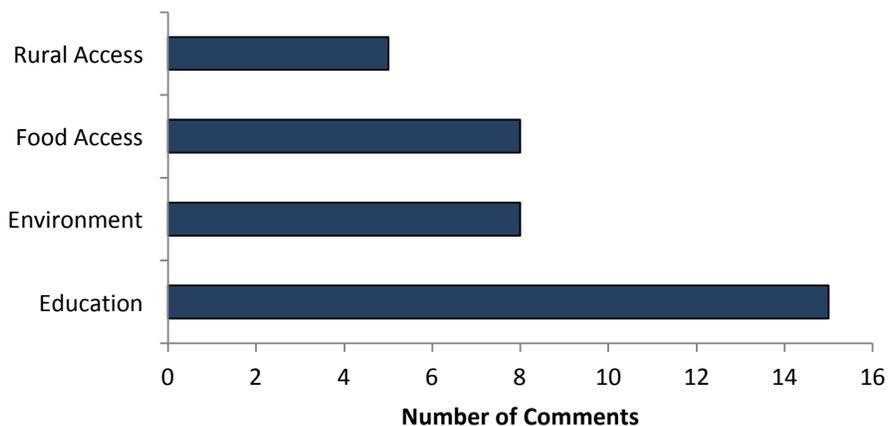
Education is a broad topic that was prevalent within every major discussion topic. Ideas specific to the types of education, the targeted age group and setting were included in this major topic. Subgroups within the topic were increased programming and collaborations, increased general health education, physical education and agricultural education. Participants indicated the need for increased resources, education outside of the schools and collaborative school system infrastructures. The agricultural education component dealt with the development of community and school gardens, a concept seen across the discussion topics. Figure 7 displays comment frequencies within the subgroups.

Figure 7. Education Comments



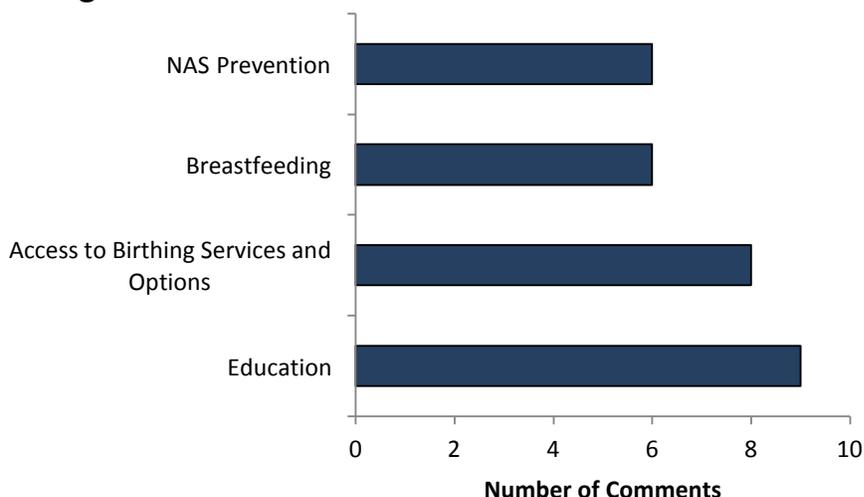
Healthy Food and Physical Activity was a prominent concern among the meeting participants. Participants indicated a need for nutrition education and physical activity in schools, as well as the need for environmental changes and improvements to increase physical activity. Access to fresh food and the concept of food deserts was a concern expressed in the meeting. Sub-categories developed for this summary analysis include education, environment, food access and rural access. Figure 8 displays comment frequencies for these subgroups.

Figure 8. Healthy Food and Physical Activity Comments



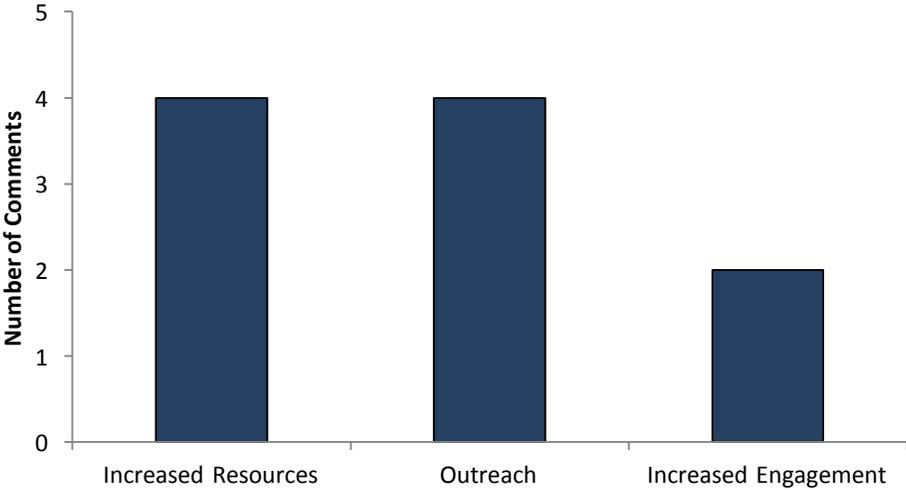
Maternal and Child Health discussions were centered in large part around educating the community about risky behaviors and pregnancy. A large percentage of the comments on this topic also dealt with increasing access to birthing services and options such as midwives and mother-friendly childbirth. Participants also indicated a need to encourage breastfeeding within the community and a non-specific set of comments called for the prevention of neonatal abstinence syndrome (NAS). Figure 9 displays comment frequencies for this discussion topic.

Figure 9. Maternal and Child Health Comments



Senior health was the discussion topic with the least comments of all the categories. Participants citing this population as one in need of attention discussed the potential benefits of increased resources (family, housing, etc.), outreach efforts such as educating the public and increased engagement with the senior community through activities and collaborative centers. Figure 10 displays the comment frequencies within this discussion topic.

Figure 10. Senior Comments



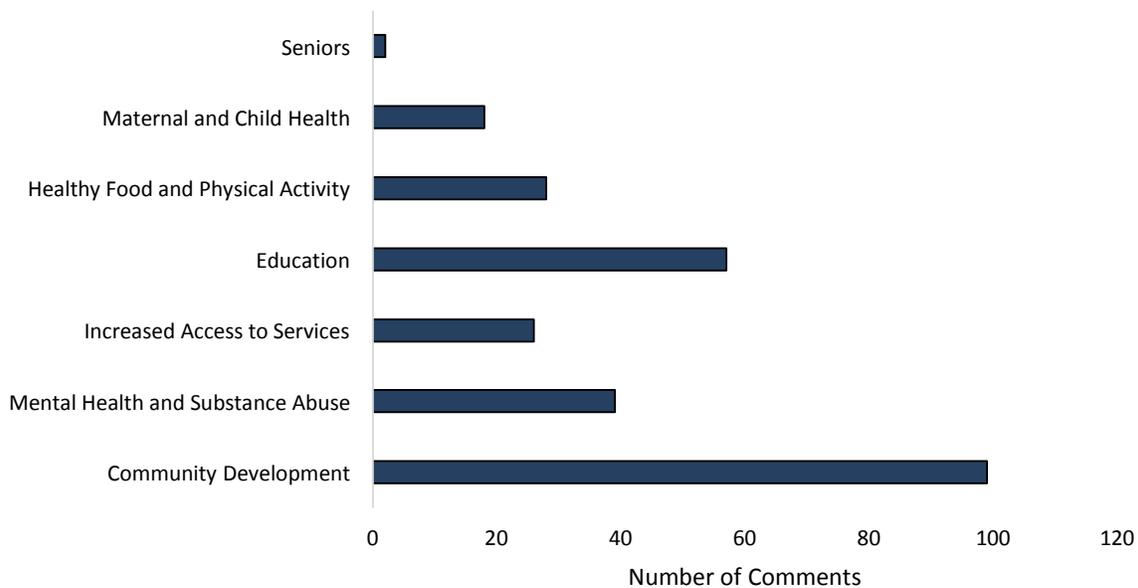
At the Abingdon meeting there were 40 attendees sitting around eight tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, “**What can you do to improve health in the community?**” At the end of two rounds of small group discussion, notes were collected from the table moderators, or “Table Hosts,” to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

Main Topics of Discussion

Below are the major categories of discussion among the participants, within which several sub-categories have been identified.

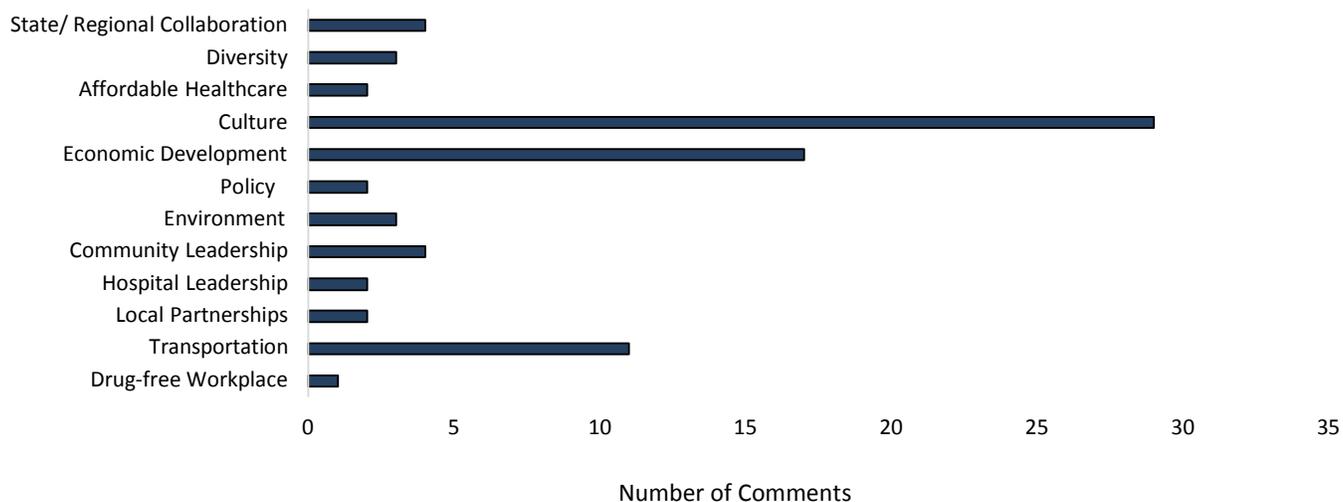
- Community Development
- Mental Health Substance Abuse
- Increased Access to Health Services
- Education
- Healthy Food and Physical Activity
- Maternal and Child Health
- Seniors

Figure 1. Community Comment by Discussion Topic Area



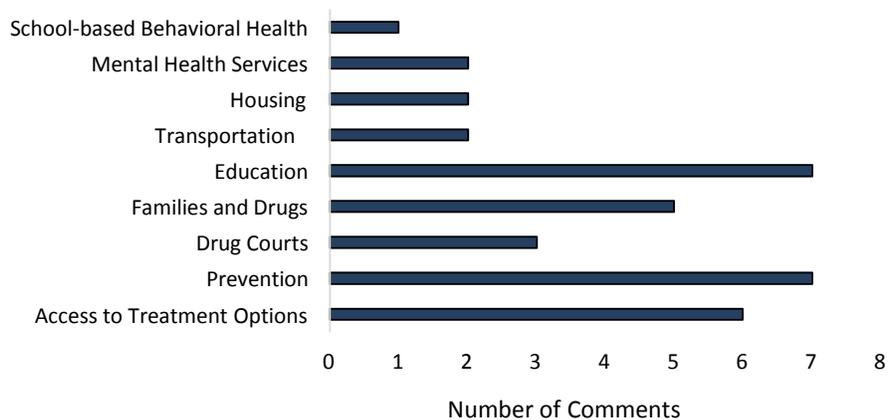
Community Development was a topic of discussion that dealt with the need for increased support and cohesion across the region to ensure a healthier community. Concerns within this topic included the local environment, economic development, the need for partnerships to increase resources for health care, transportation, employee health and outreach. Figure 2 displays the rate of comments in each of these categories.

Figure 2. Community Comments on Improving Health through Community Development



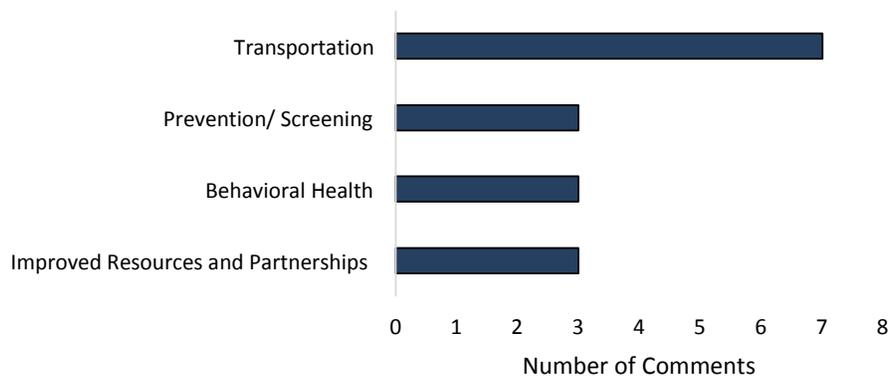
Mental Health and Substance Abuse was the third largest topic of concern among the attendees. Focus areas within this topic included: treatment services access and development, prevention services, policy and programs, family support and school-based programming.

Figure 3. Community Comments on Mental Health and Substance Abuse



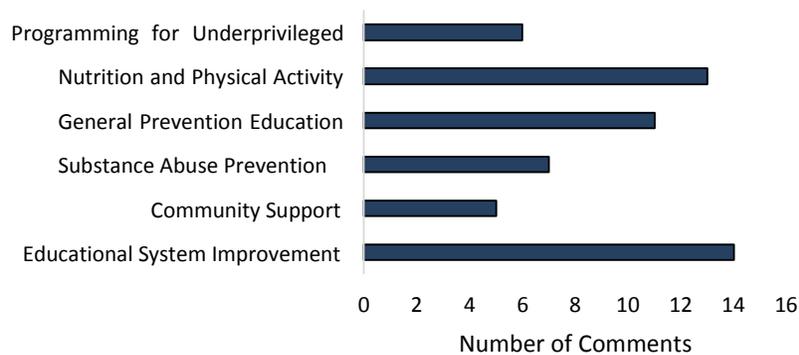
Increased Access to Services was a concern across all of the main topics of discussion. In order to identify specific categories within the discussion around access, comments were broken out and considered individually. Topics under access to services included transportation, prevention/ screening, behavioral health and improved collaboration to better leverage resources. The comments in the last category, improved resources and partnerships, dealt with the need for collaborations between physicians, insurance companies and the community as well as a strong need for integrated data solutions.

Figure 4. Community Comments on Ensuring Access to Health Care



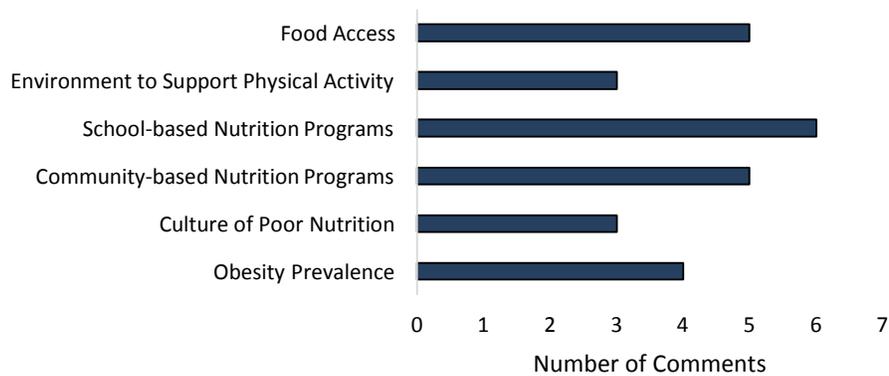
Education was the second most identified category of problem and potential solutions. Comments around this topic focused on the need to improve the current education system through community support and programs for underprivileged families. Attendees also cited a need for substance abuse education to reduce stigma and decrease rates of substance abuse in children and families. An increase in prevention education including nutrition education was also noted by the group.

Community Comments on Education



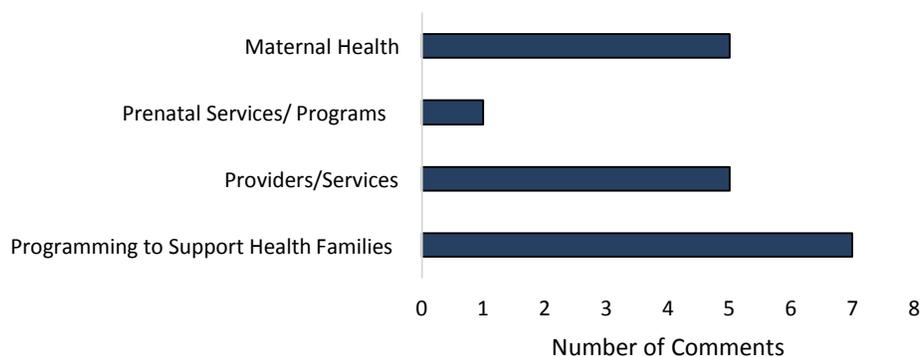
Healthy Food and Physical Activity was a prominent concern among the meeting participants. Participants indicated a need for nutrition education and physical activity in schools, as well as the need for environmental changes and improvements to increase physical activity. Comment frequencies for these subgroups.

Frequency of Comments on Healthy Food and Physical Activity



Maternal and Child Health discussions were centered around educating the community about risky behaviors and pregnancy. A large percentage of the comments on this topic also dealt with increasing access to services, maternal education regarding health and programming to support the family before and after birth.

Frequency of Comments for Maternal and Child Health



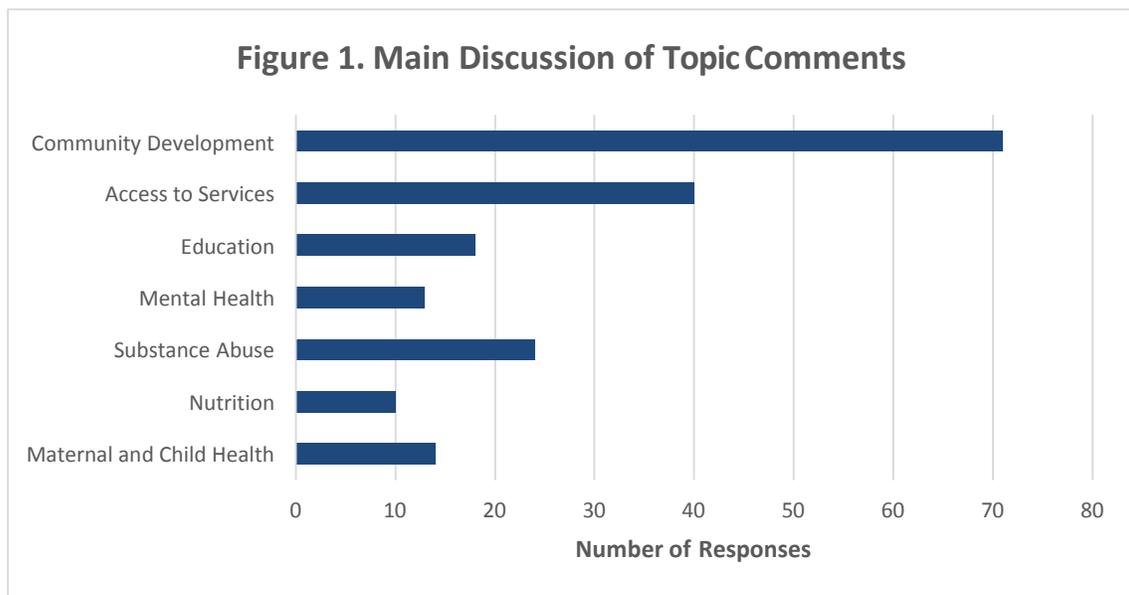
Senior health was the discussion topic with the least comments of all the categories. Participants concerned about the senior population called for more overall engagement by the community and increased resources to keep this population supported and healthy.

At the Marion meeting there were 25 attendees sitting around five tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable meetings, participants were asked to address in their conversations the question, “**What can you do to improve health in the community?**” At the end of two rounds of small group discussion, notes were collected from the table moderators, or “Table Hosts,” to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

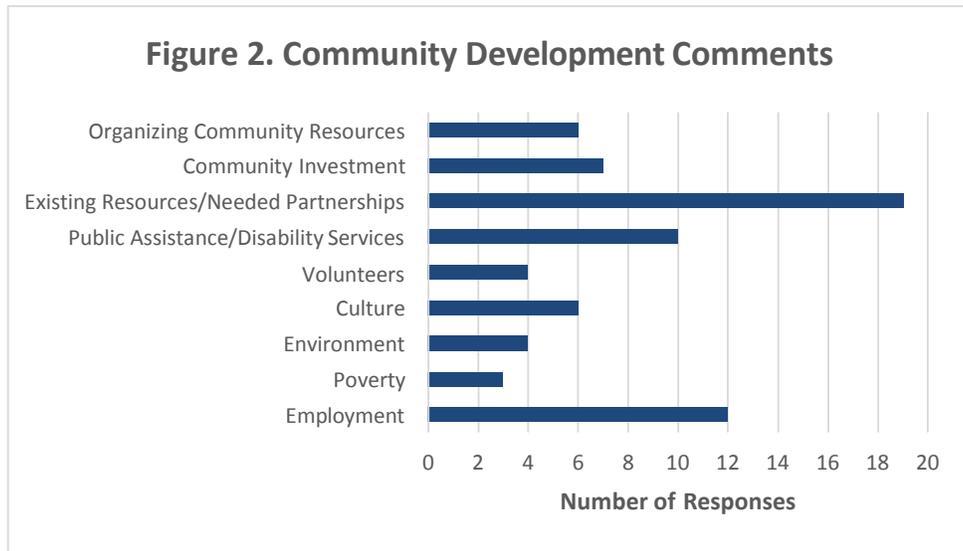
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

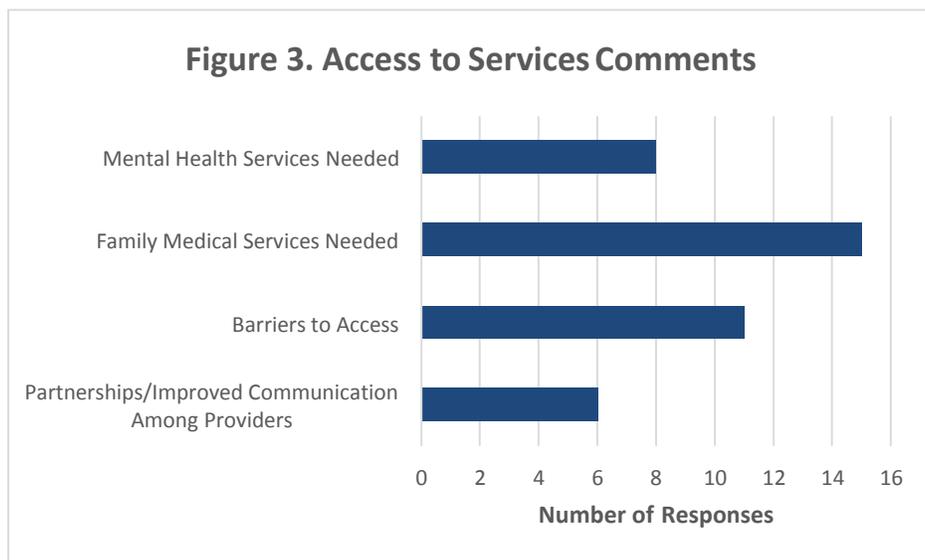
- Community Development
- Substance Abuse
- Access to Services
- Education
- Nutrition
- Mental Health
- Maternal and Child Health



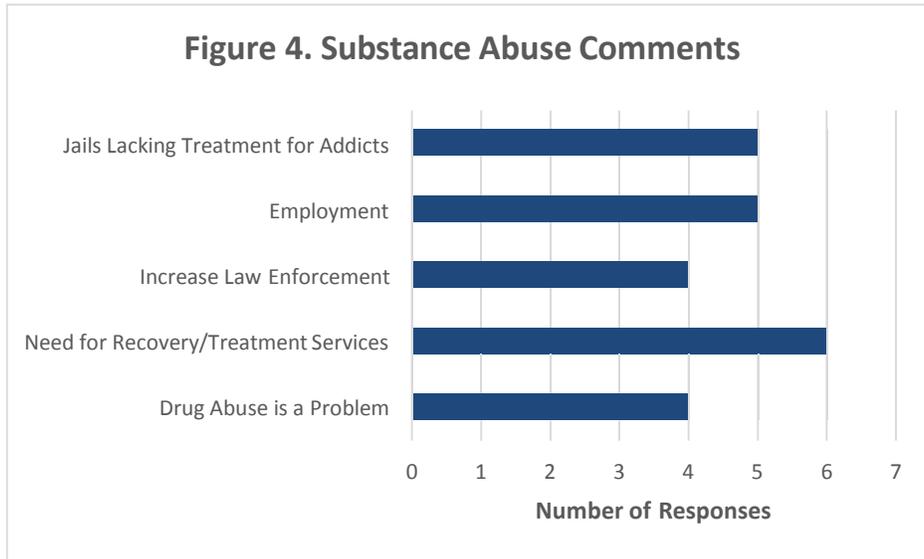
Community Development was characterized by concerns about the existing resources/needed partnerships, organizing community resources, community investment, employment, public assistance/disability services, culture, local environment, volunteer opportunities and poverty. Participants included the need for a mailing of services and locations, increasing the number of job fairs and jobs, and the idea that public assistance should not be generational. Employment was one of the main concerns with career training needs, increasing minimum wage and recruiting professionals to the area. Figure 2 displays the rate of comments in each of these categories.



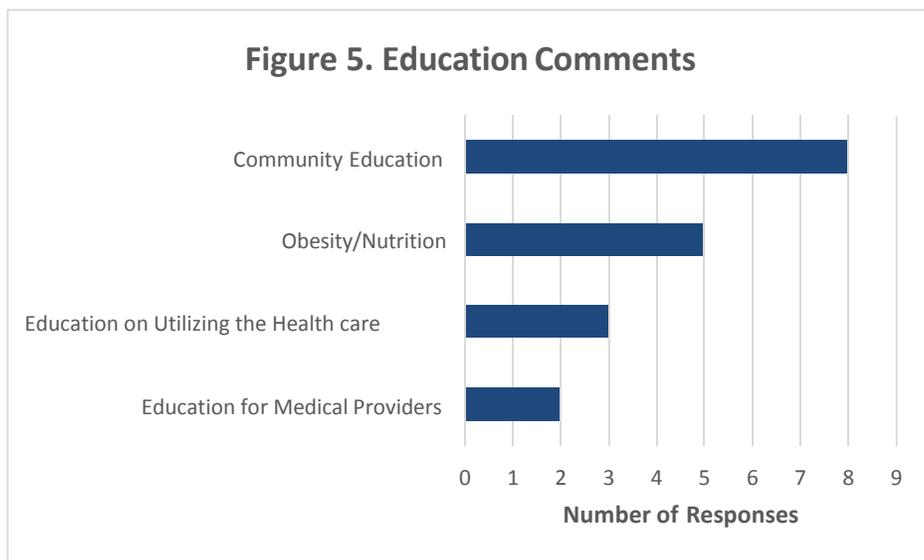
Access to Services was the second largest topic of concern among the attendees. In order to identify specific categories within the discussion around access, comments were broken out and considered individually. Topics under access to services included barriers to access, mental health and family medical services needed and partnerships/improved communication among providers. Programs needed ranged from dental care services, preventive care to adolescent mental health services and OB/GYN. Figure 3 illustrates the comment distribution within this topic.



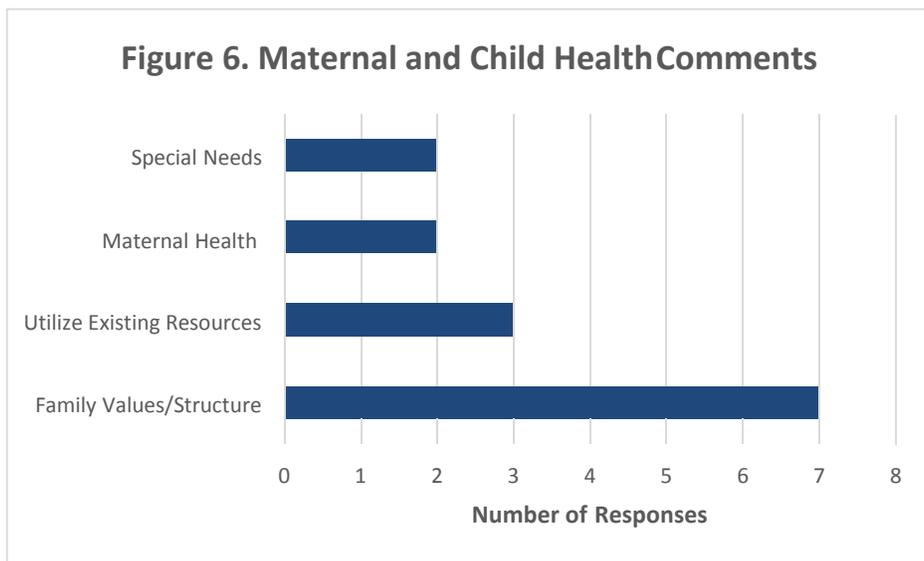
Substance Abuse was the third largest topic of concern among the attendees. Focus areas within this topic included: jails lacking treatment for addicts, employment, increasing law enforcement, need for recovery/treatment services and overall agreement that drug abuse is a problem. There were not any specific substances identified from the notes. Figure 4 shows the distribution of comments around these categories.



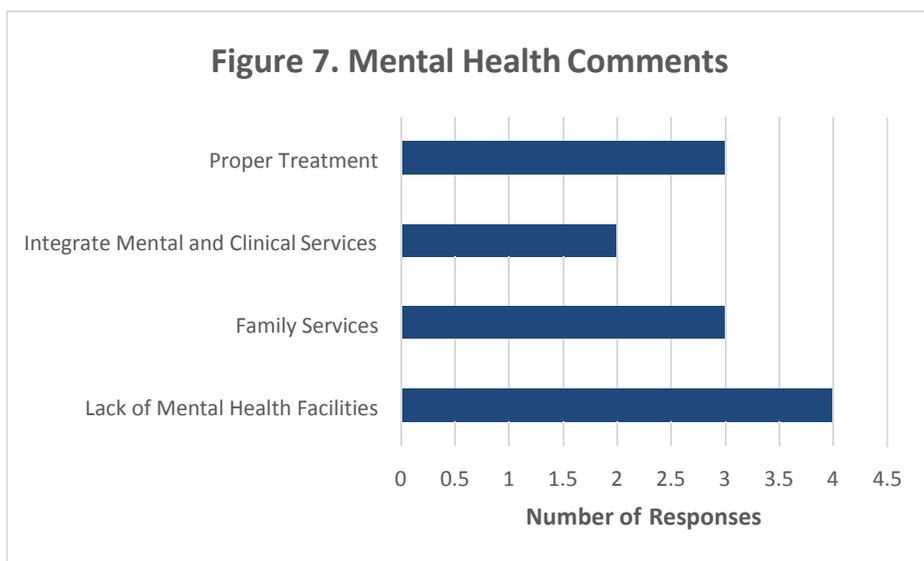
Education is a broad topic that was prevalent within every major discussion topic. Ideas specific to the types of education, the targeted age group and setting were included in this major topic. Subgroups within the topic were community health, obesity/nutrition and education for medical providers and accessing/using the health care system. Participants indicated the need for medical education and education on navigating the health care system and where to go. Figure 5 displays comment frequencies within the subgroups.



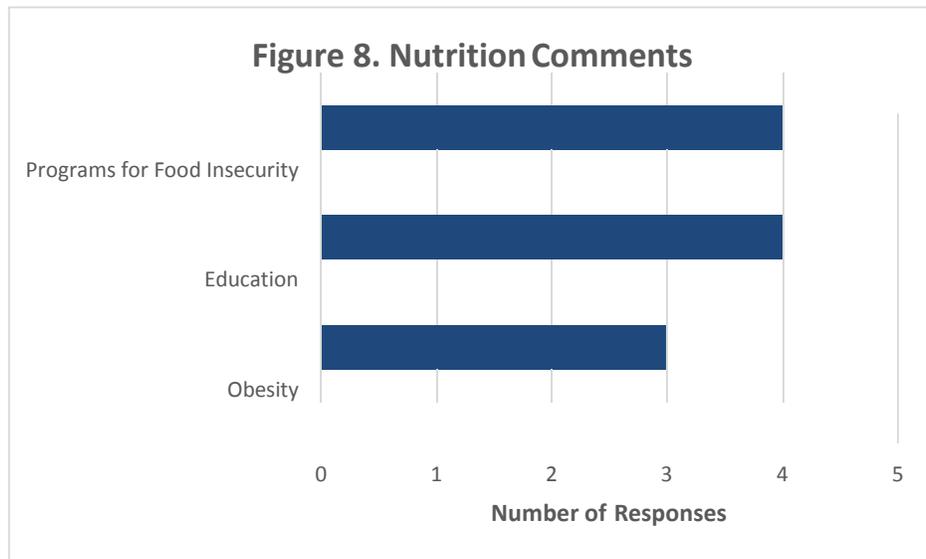
Maternal and Child Health discussions were centered in large part family values and family structure. A large percentage of the comments on this topic also dealt with grandparents raising grandchildren, the need for OB services and care for special needs. Participants also mentioned existing resources and the increase of single parents. Figure 6 displays comment frequencies for this discussion topic.



Mental Health comments were considered separately from substance abuse in order to identify specific mental health needs within the community. The discussion around mental health dealt with integrated mental and clinical services, family services and lack of mental health facilities and proper treatment. Many felt there was a lack of adolescent and pediatric mental health services and mental health treatment facilities. Figure 7 displays comment frequencies for this discussion topic.



Nutrition was a prominent concern among the meeting participants. Participants indicated that obesity is a problem in the community and nutrition education is needed in the schools. Access to food pantries and community gardens were listed as some of the ideas expressed in the meeting. Sub-categories developed for this summary analysis include education, obesity and programs for food insecurity. Figure 8 displays comment frequencies for these subgroups.

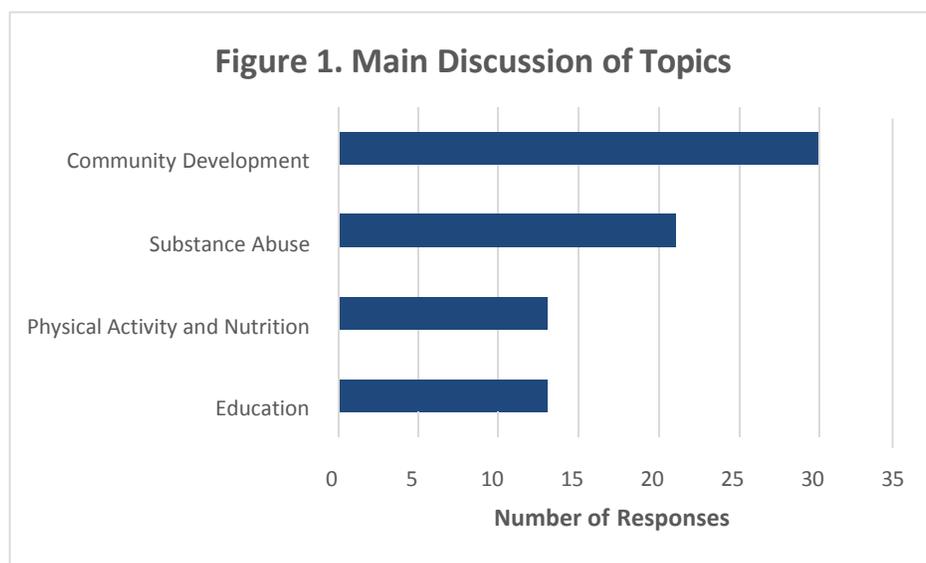


At the Erwin meeting there were 11 attendees sitting around three tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable meetings, participants were asked to address in their conversations the question, “**What can you do to improve health in the community?**” At the end of two rounds of small group discussion, notes were collected from the table moderators, or “Table Hosts,” to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

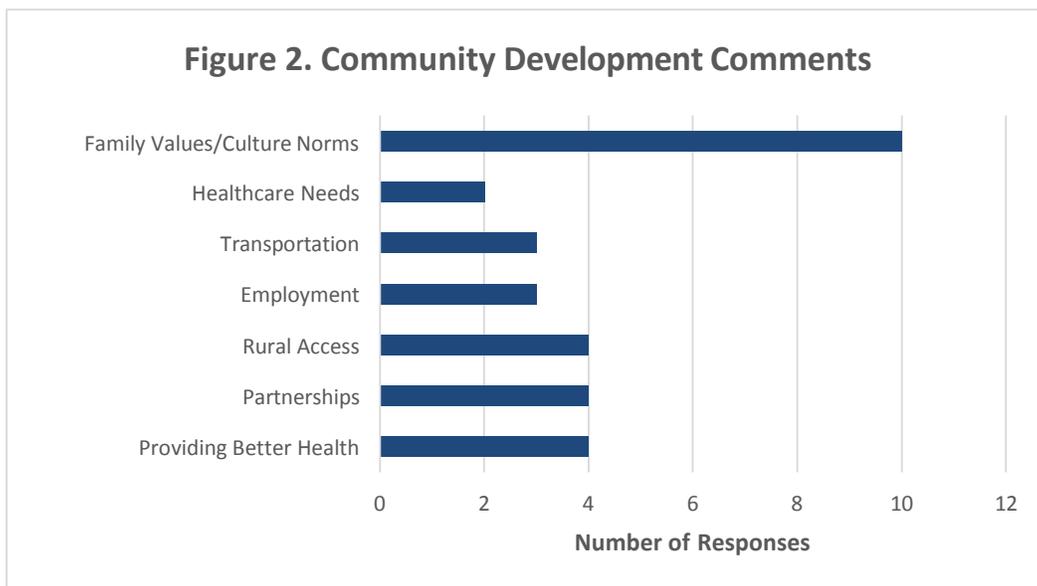
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

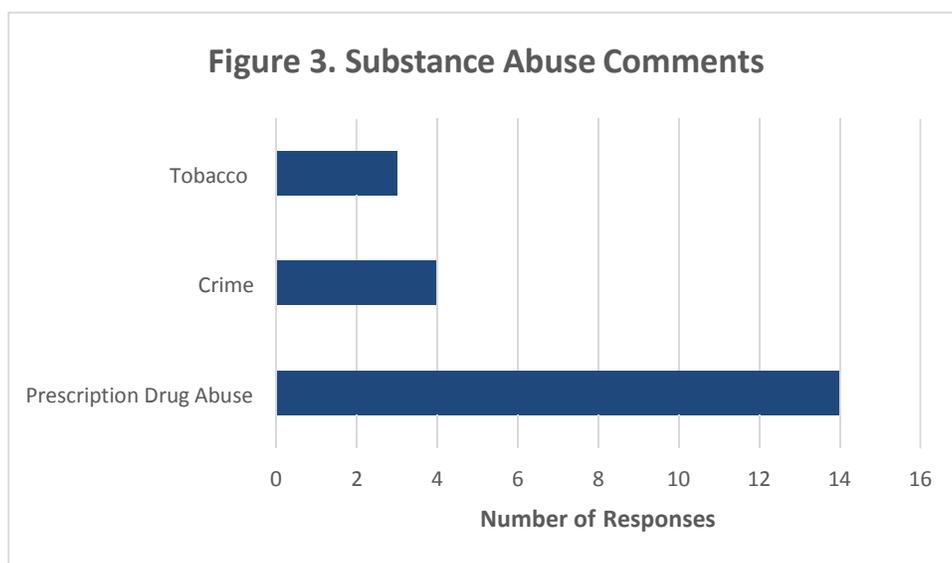
- Community Development
- Substance Abuse
- Nutrition and Physical Activity
- Education

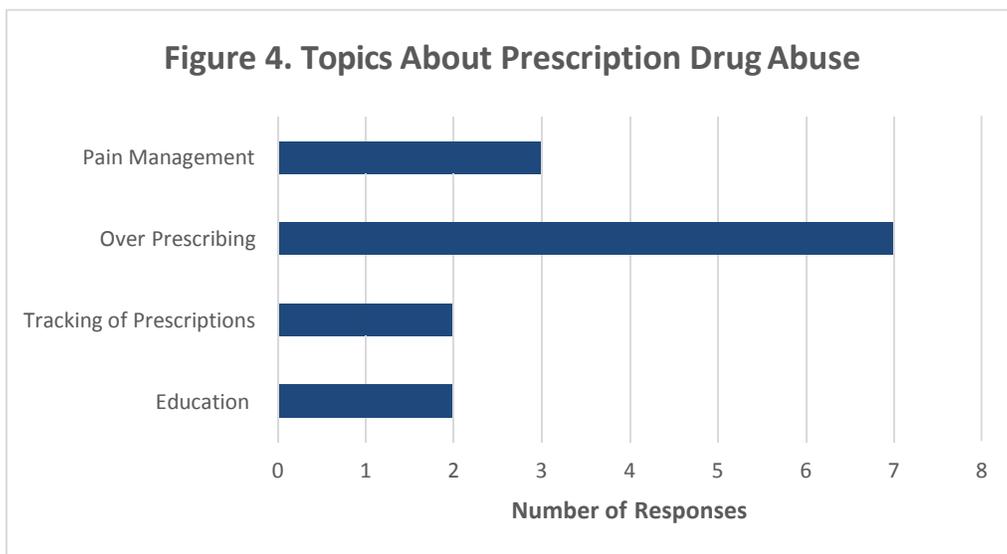


Community Development was characterized by concerns about family values and cultural norms, providing better health information, partnerships, rural access, employment, transportation and health care needs. Figure 2 displays the rate of comments in each of these categories.

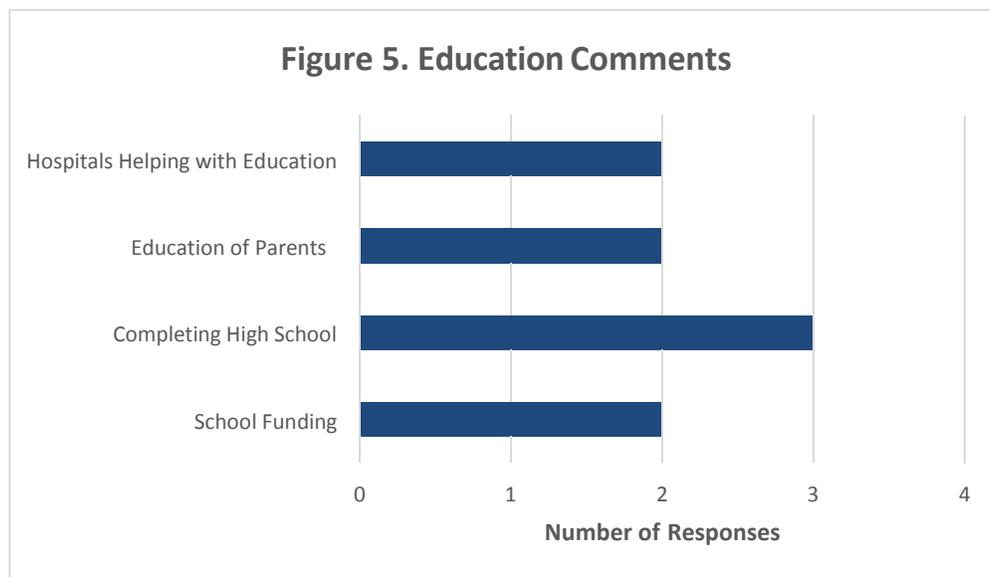


Substance Abuse was the second largest topic of concern among the attendees. Focus areas within this topic included: prescription drug abuse, crime and tobacco. There were several categories related to prescription drug abuse identified from the notes including over prescribing, education, pain management and tracking of prescriptions. Figure 3 shows the distribution of comments around these categories. Figure 4 displays the frequency of comment for each of the topics surrounding prescription drug abuse.

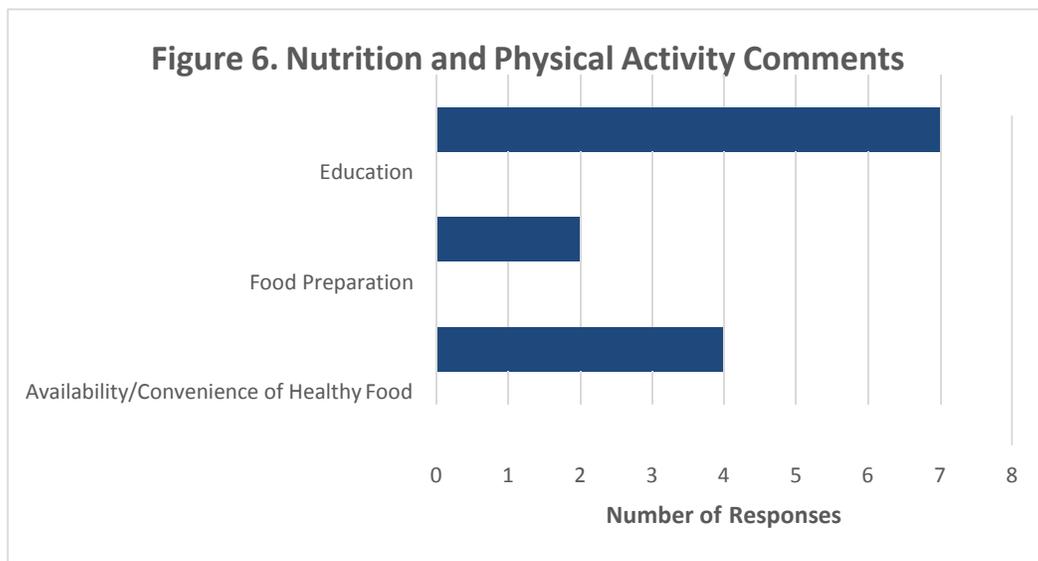




Education is a broad topic that was prevalent within the majority of discussion topics. Ideas specific to the types of education, the targeted age group and setting were included in this major topic. Subgroups within the topic were partnerships, communication, high school completion and education of parents. Participants indicated the need for increased resources, education outside of the schools and collaborative school system infrastructures. Figure 5 displays comment frequencies within the subgroups.



Nutrition and Physical Activity was a prominent concern among the meeting participants. Participants indicated a need for nutrition education and physical activity in the schools, as well as the need for convenience and increased availability of healthy food. Sub-categories developed for this summary analysis include education, availability/convenience of healthy foods and food preparation. Figure 6 displays comment frequencies for these subgroups.



**Record of Community Stakeholder and Consumer Views
of the Proposed Cooperative Agreement**

ATTACHMENT F

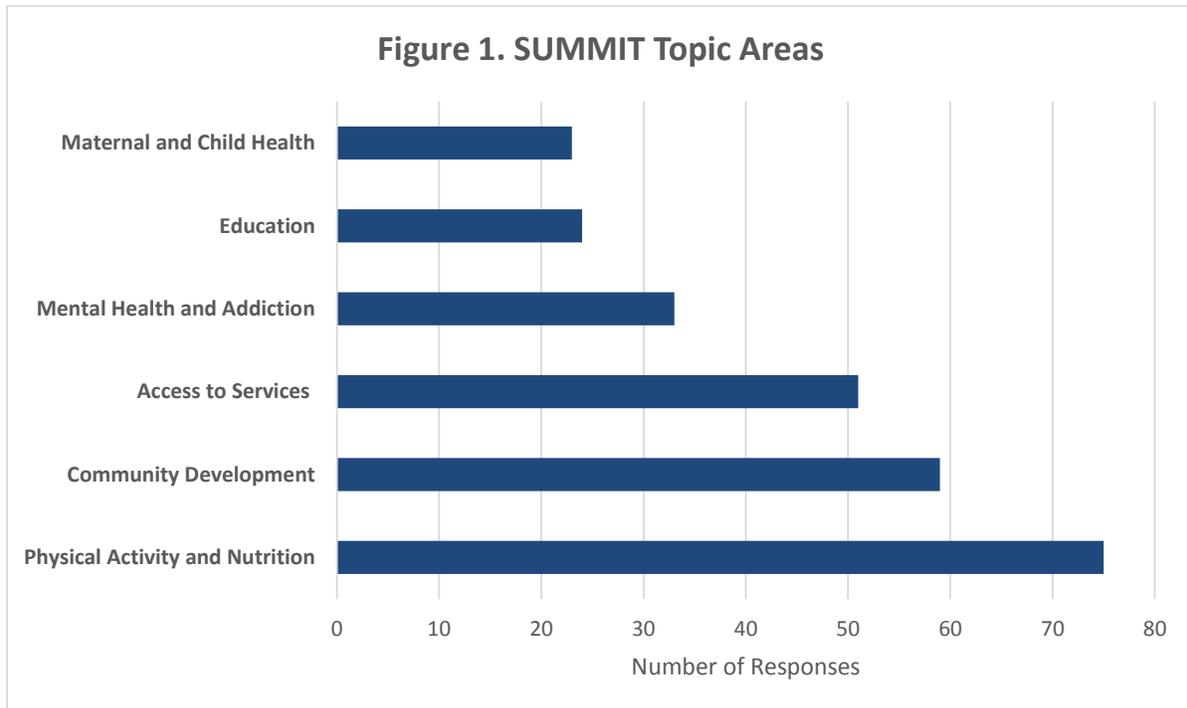
Southwest Virginia 2020 Summit Report

During the Southwest 2020 SUMMIT, 65 attendees participated in a World Café style discussion around the question, **“What can you do to improve health in the community?”** At the end of group discussion, notes were collected from the table moderators, or “Table Hosts,” to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

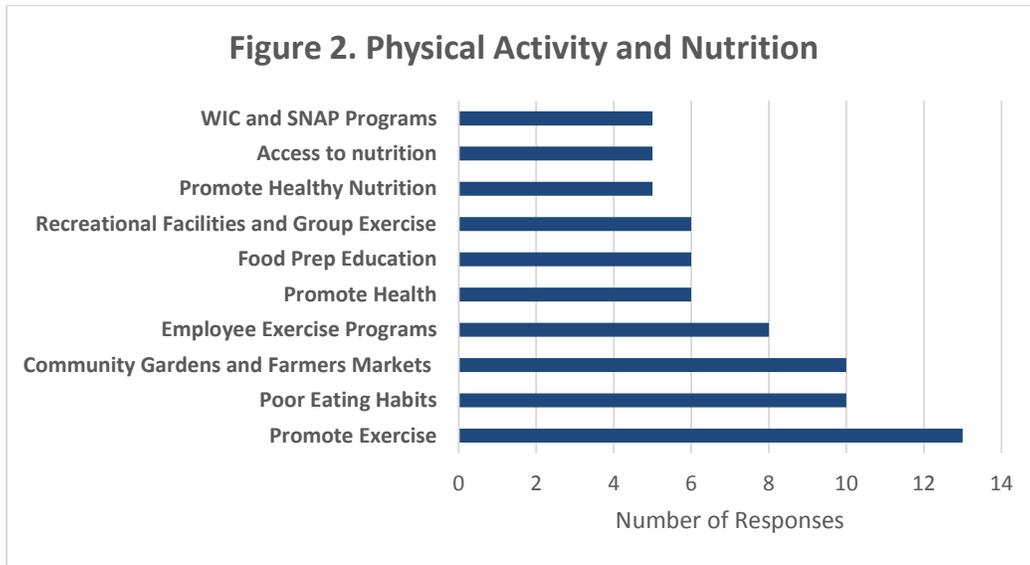
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

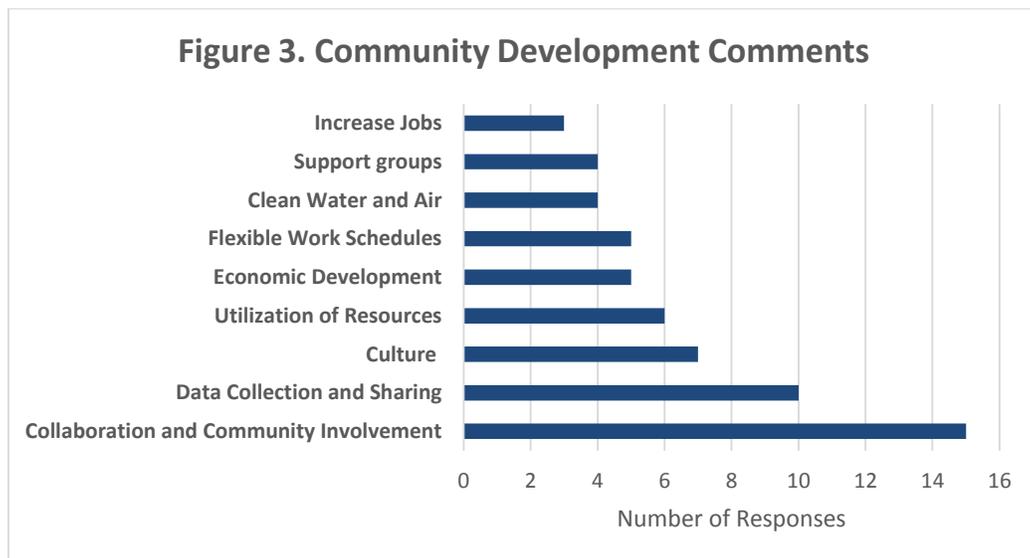
- Physical Activity and Nutrition
- Community Development
- Access to Services
- Mental Health and Addiction
- Education
- Maternal and Child Health



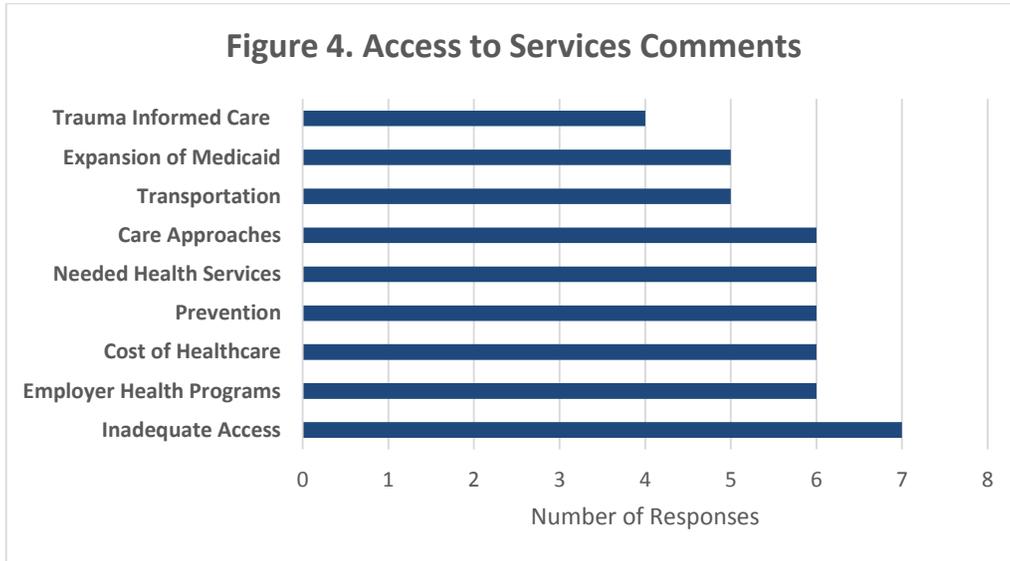
Nutrition and Physical Activity was the most talked about topic during the discussion. Folks indicated a concern about promoting exercise, poor eating habits, increasing community gardens and farmer’s markets, employee exercise programs, promoting health and food prep education. There was also mentioned a need for recreational facilities and group exercise, promoting healthy nutrition, access to nutrition and WIC and SNAP Programs. Figure 2 displays comment frequencies for these subgroups.



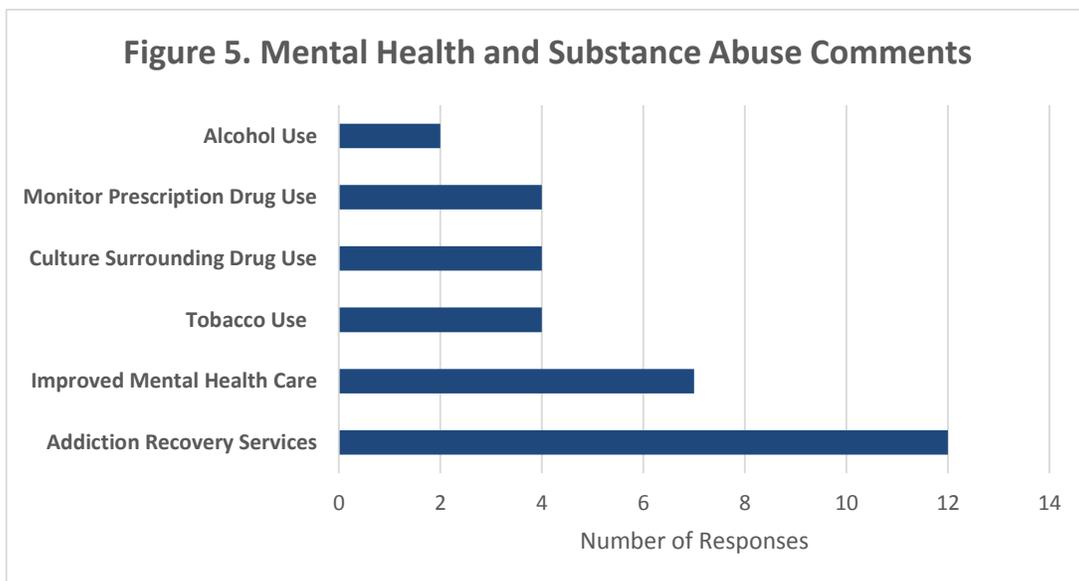
Community Development was the second largest topic of concern among the attendees. In order to identify specific categories within the discussion around community development, comments were broken out and considered individually. Topics under community development included collaboration and community involvement, data collection and sharing, culture, use of resources and economic development. Other topics included flexible work schedules, clean water and air, support groups and increasing jobs. Figure 3 illustrates the comment distribution within this topic.



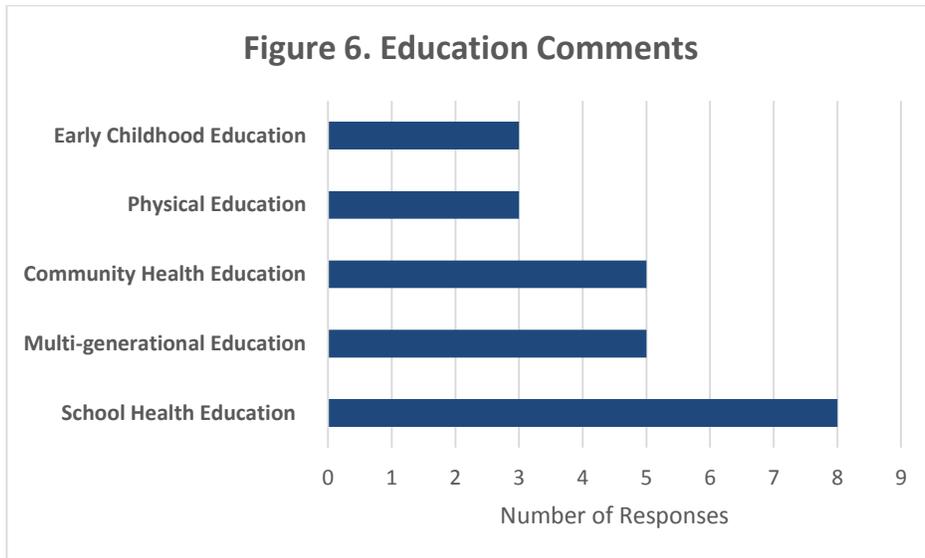
Access to Services was a broad topic that was prevalent within every major discussion topic. Subgroups within the topic were the issues of inadequate access, employer health programs, cost of health care, prevention, needed health services, care approaches, transportation, expansion of Medicaid and trauma informed care. Participants indicated the lack of transportation to health services. Figure 4 displays comment frequencies within the subgroups.



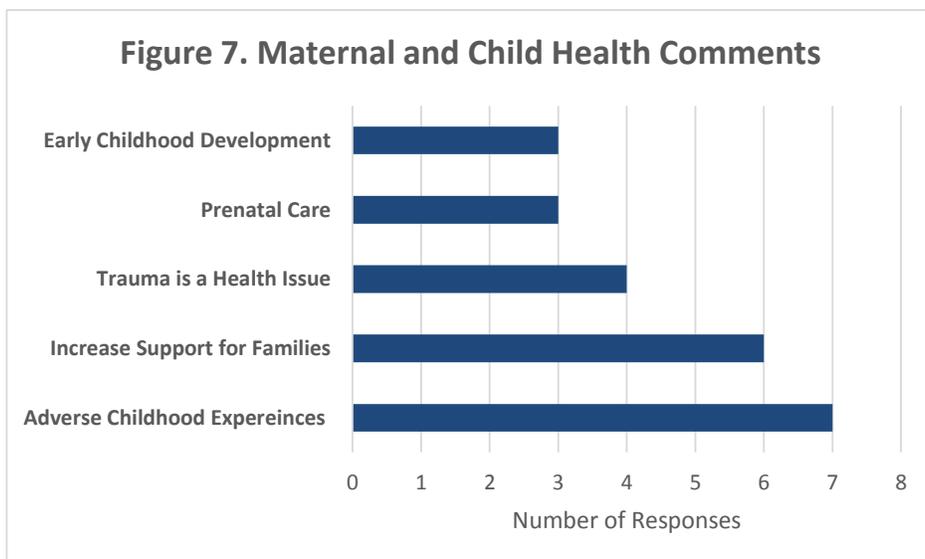
Mental Health and Substance Abuse was a widespread topic. Subgroups within the topic included: addiction recovery services, improved mental health care, tobacco use, culture surrounding drug use, monitoring prescription drug use and alcohol use. Figure 5 shows the distribution of comments around these categories.



Education was a prominent concern among the meeting participants. Participants indicated a need for school health education, multi-generational education, community health education, physical education and early childhood education. During discussion school health education had more comments. Figure 6 displays comment frequencies for these subgroups.



Maternal and Child Health discussions were centered in large part around Adverse Childhood Experiences (ACEs). Topics included: adverse childhood experiences, increase support for families, trauma being a health issue, prenatal care and early childhood development. Figure 7 shows the distribution of comments around these categories.



**Record of Community Stakeholder and Consumer Views
of the Proposed Cooperative Agreement**

ATTACHMENT G

Community Letters of Support



July 27, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

Dear Commissioner Dreyzehner:

As we move into the Regulatory approval of the merger of the Wellmont Health Organization and the Mountain States Health Alliance, I am delighted to have the opportunity to write a letter recommending the COPA approval of this amazing opportunity. Our bank, Bank of Tennessee, is the largest commercial bank between Roanoke and Knoxville so we're right in the heart of the footprint of where the two hospital organizations are located. This gives us an incredibly sensitive feel for what goes on in this area, as you can imagine.

As an outsider looking in at the functioning hospital organization in Northeast Tennessee and Southwest Virginia, it is a paradox to examine the combination of Wellmont back in 1996 when Kingsport and Bristol united to form the Wellmont Health Organization. Obviously, there were doubters that did not think this was a good idea; history proved them wrong. The Wellmont Health Organization became a very strong, high-quality, efficient hospital group that we are all proud of. Through the years, competition between Johnson City's Mountain States Health Alliance and Wellmont sadly created unnecessary competition and a strain between the major three cities in this region, Kingsport, Bristol and Johnson City. With the two boards of each health organization having signed a term sheet, the region of Southwest Virginia and Northeast Tennessee now has the opportunity and vision to become one of the outstanding hospital groups in the nation.

Just across the mountain an hour from us in Asheville, North Carolina, in 1995 a COPA was issued by the State of North Carolina for the combination of Mission Hospital and St. Joseph Hospital (now called Mission Hospital) to move forward. Since that time, the quality of medicine has continued to improve. Today Mission Hospital is honored to be one of the top 100 health organizations in America for the fifth consecutive year. The cost to the patient

Commissioner John Dreyzehner
July 27, 2015
Page 2

at Mission Hospital has risen at a slower rate than competitive costs across the State of North Carolina. If every hospital in the United States performed at the level of Mission Hospital (and we expect the new combination in Northeast Tennessee and Southwest Virginia to perform at this level) then:

- More than 164,000 additional patients would survive each year in this country
- Nearly 82,000 additional patients could be complication free
- The average patient stay would decrease one-half day across the country
- Six billion dollars would be saved in this country

THE ABOVE COMMENTS ARE BASED ON THE ANALYSIS OF MEDICARE INPATIENTS OVER ONE YEAR.

Probably one of the two most important issues that would be addressed (other than quality of healthcare) would be the containment of reasonable cost of healthcare. With the combination of the two hospitals:

- We would have nearly two billion in revenues; if our hospitals were located anywhere else in the country, we'd be closer to a three billion dollar system. Our revenues are strained by the Medicare Wage Index being so low here in our area.
- The system would have one billion dollars in cash
- The operating margins already at AA bond level ratings
- The system would have \$1.5 billion in debt with a system that has one billion dollars in cash
- The system would have \$225 million dollars per year in re-occurring cash flow

The reason I set this out, obviously as a banker, is cost containment is so important and necessary for the COPA to fulfill its mission.

The best reason to start this organization as a combination is to make meaning; to create a product or service to make our world in Northeast Tennessee and Southwest Virginia a better place to live. That's what this is all about.

Sincerely yours,

W. B. Greene, Jr.
Chairman
BancTenn Corporation

WBGJr/dba

cc: General Herbert Slatery III
Elliott Moore
✓ Andy Hall

First Baptist Church

200 West Church Circle • Kingsport, Tennessee 37660
Telephone (423) 247-4122 • Fax (423) 247-4130 • web-site: fbckpt.net

Dr. Marvin G. Cameron
Pastor
mcameron@fbckpt.net

September 2, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

Dear Mr. Dreyzehner:

I am writing to offer my support of the proposed merger between Wellmont Health System and Mountain States Health Alliance. I write as one who visits numerous hospitals in our region at least weekly in my role as a minister. I am honored to serve as Pastor of the First Baptist Church of Kingsport, Tennessee, where I began work in 2001. Our church is as old as our city! Both were constituted in 1917, but we are actually three months older than our government.

I believe the proposed merger is beneficial to our region because it gives the greatest opportunity for local control of the health care of our region. Our region suffers from some of the most challenging health issues in the state. I fear that outside control could lead to diminished response to the acute needs of this region.

My interest in this merger arises from the challenges we face in recruiting and retaining the best caregivers our region demands. I am also aware of the unique financial challenges facing health care in our region due to our Medicare index, the demographics of our region and the financial hardship of many of our citizens.

The proposed merger allows the two systems to occupy a unique place in the life of our region. The synergy provided by their mutual connection to the Quillen School of Medicine will give our region a needed boost in economic development and the ability to make a difference in the lives of our people.

I am fortunate to know personally many of the leaders of both health care systems. I know them as people of integrity who care deeply for our region and our people. I also know the investment of time, energy and

resources they have given to their mutual endeavors to remain independent. They have arrived at the best decision for the people of our region through the proposed merger and I am happy to support it.

Thank you for your work on behalf of the people of Tennessee. If I may be of assistance to you through the COPA process, please feel free to contact me at this address.

Sincerely,

A handwritten signature in black ink, appearing to read "Marvin Cameron", with a long horizontal flourish extending to the right.

Marvin Cameron, Pastor

**CC: General Herbert Slatery III
Office of the Attorney General and Reporter
P.O. Box 20207
Nashville TN 37202-0207**



**FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY**

August 28, 2015

2015 YMCA Officers

David Woodmansee,
Chair

Dory Creech,
Vice Chair

Lynn Tully,
Secretary

Troy Clark,
Treasurer

Roger Mowen,
Past Chair

Charlie Glass,
CEO

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Dear Dr. Dreyzehner,

I am writing this letter in support of the integration of the Wellmont and Mountain States Health Systems into a single health system.

The Greater Kingsport Family YMCA is a 501(c)3 not-for-profit organization serving the greater Kingsport area of northeast Tennessee. We started out serving youth and families, meeting child care and youth development needs. Recently, as you know, we have taken on a new role in being a community resource for healthy living—we support over 18,000 members in their efforts to make healthy choices. We are doing that through our youth programs (child care and day camp supporting families), in our facility, and through community efforts like Healthy Kingsport. The YMCA's Diabetes Prevention Program has allowed us to begin targeting a specific population that has a likelihood of becoming Type II Diabetic, and greatly reducing their risk. Credible, evidence-based programs like this are indicators of successes taking place in our region, but we need a collective effort of all the pieces working together towards the same measurable goals, to really tackle the chronic disease prevention opportunities.

Reaching that healthy state in our region has many challenges and barriers. Resolving those is not a simple task and will require a process that can address complex issues. I have seen success with the Collective Impact model in various communities around the country, as well as here, through Healthy Kingsport. We are seeing small pockets and evidence of progress, but we need to scale those to a regional effort. I believe that model, on a large scale, is what we need to successfully impact the health of our entire region. Wellmont and Mountain States are both committed to improving the health of our region. However, as competitors, they are not able to function as the neutral "Backbone Organization," a necessary component for a successful Collective Impact model. As they join forces, they will have the opportunity to function as the neutral system supporting all the efforts towards a common goal. As a combined organization, Wellmont and Mountain States believe they can work to unite the resources of both systems with one common purpose – to make the next generation of this region healthier than today's. They will also have an opportunity to unite all the organizations in all our communities to do the same.

Board Members

Keith Barger

Troy Clark

Dory Creech

Mike Culligan

Joy Eastridge

Camille Evans

Scott Fowler, M.D.

Flint Gray

Doug Haile

Steve Hiscutt

Greg Jeansonne, M.D.

Maggie Lengyel

Michael Lockard

Cara McConnell

Diana Meredith

Brian Miller

Josh Morgan

Roger Mowen

Chris Mullins

Deb Reynolds

Clay Rolston

Kingsley Rutters

Forooz Smalley

Mike Stice

Perry Stuckey

Lynn Tully

Debbie Davis Waltermire

Amy Wenk

David Woodmansee

Jubal Yennie

YMCA Wellmont Center

Greater Kingsport Family YMCA

1840 Meadowview Pkwy, Kingsport, TN 37660

P 423 247 9622 F 423 578 2199

www.ymcakpt.org

YMCA Mission:

To put Christian principles
into practice through
programs that build healthy
spirit, mind, and body for all.

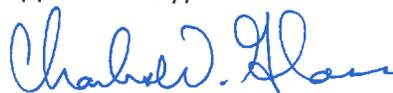
The combined system with expanded resources and a larger footprint will create a new opportunity and potential for real and measurable success. Combined with East Tennessee State University and the vast array of resources available through the university and the medical school, we will have access to one of, if not, the best network and system in the country to really move the needle towards creating a healthy region.

In addition to population health challenges, the health care environment is a challenge itself, particularly for small hospitals and systems. In order for one to survive in today's reimbursement environment, it is necessary to maximize resources, financial as well as human. From purchasing, to electronic health records, to regulations, to recruiting, to specialty areas, to basic care, duplicating efforts to deal with them is not productive. The proposed merger between Mountain States Health Alliance and Wellmont Health System is a response to these challenges, and an opportunity to change the way our local health care providers are able to work together to tackle the health care challenges affecting our region. This will be an opportunity for the two organizations to come together and build something brand new, in a cost-effective manner that reflects what this community really needs – today and in the years ahead.

I support this proposed merger because I believe that together, Wellmont and Mountain States will have the opportunity to truly impact the way health care is delivered in our region. They will have the opportunity—and I believe they will pursue it—to lead the communities they serve, and the organizations in them, in addressing health and health care issues with a multitude of solutions towards a common goal. This local solution to our region's health care challenges is a far better scenario than other partnerships Mountain States and Wellmont have considered outside our community.

I care deeply about this region and our future, as do you, and I know you will thoughtfully consider all of the benefits this proposed merger will bring to our region, both today and in the generations to come. Thank you for your consideration and for all of your work towards improving the health of all Tennesseans.

Appreciatively,



Charles W. Glass, CEO
Greater Kingsport Family YMCA

cc: General Herbert Slatery III



AEP - Appalachian Power
420 Riverport Road
Kingsport, TN 37660

August 24, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

RE: Proposed Merger of the Wellmont and Mountain States Health Alliance Systems

Dear Commissioner Dreyzehner:

I am the District Manager for Appalachian Power Company's Kingsport District which provides electric distribution services to 47,000 customers in Northeast Tennessee and over 100,000 customers in Southwest Virginia. Appalachian Power is a subsidiary of American Electric Power; we are an investor owned electric utility and are regulated in Tennessee by the Tennessee Regulatory Authority. I have worked in the utility industry for 38 years and have worked for regulated investor owned utilities for most of those years.

The cost of health care and health insurance is becoming one of the biggest concerns to our employees and their families. Appalachian Power employs over 200 employees directly in the area served by my district and another 70 contract workers. Wellmont and Mountain States Health Alliance are the regional health services providers for most of that area.

As the manager of a regulated utility, I have come to understand very well the relationship between investment in facilities to serve the customers we serve and the rates they pay for our product. For my portion of the utility, any investment we make must be paid for by the customers in my part of the world so I have looked on with concern as the two health systems have, over a number of years, matched and have attempted to one up each other with investments in new facilities and new technologies. I become concerned when I think about the cost of those investments and consider the impact investments of that magnitude might have on the rates of the customers I serve as the footprint of the two health systems matches the footprint of my service territory.

There is no doubt that investments in new technologies and new facilities are necessary to provide the healthcare the region needs, but investment in duplicated facilities and technologies just for the sake of competition makes very little sense. My years of working in a regulated environment have disciplined my thinking so I make necessary investments but reject quickly investments that over-reach and are just not prudent. In our world, our regulators can and do deny recovery for imprudent investments so we continuously scrutinize our plans and avoid over-building and over-staffing; this effort keeps our costs and our customers' rates low.

I see nothing but good in the merger of the two systems and the oversight of their operations by the states of Tennessee and Virginia. I believe the combination of the systems will continue to provide the citizens of this region with the best healthcare while improving the cost profile of the combined system saving its citizens millions of dollars. I urge you to approve the Certificate of Public Advantage so this most needed merger can move forward.

Isaac J. Webb
District Manager
AEP – Appalachian Power

C: General Herbert Slatery III

HEALTHSOUTH

Rehabilitation Hospital

August 11, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Dear Commissioner Dreyzehner,

I am CEO at HealthSouth Rehabilitation Hospital in Kingsport, TN. In my 22 years of experience in healthcare administration, there has never been a time of greater change in health care – both locally in our region and across the U.S. Sweeping changes have been and will continue to occur for our nation’s hospitals, physicians and patients, in many cases making it harder for patients, families and businesses to get the care they need, when and where they need it. When my 150 employees or their dependents need acute healthcare services, they receive that care at either Wellmont Health System or Mountain States Health Alliance.

I am concerned about the industry challenges that hospitals are facing and in particular the two health systems, Wellmont Health System or Mountain States Health Alliance, that care for myself, my family, and my employees. These challenges include increasing reimbursement cuts in a market that already has one of if not the lowest Medicare reimbursements in the Nation, declining inpatient volumes, constrained revenue, and increasing difficulty in recruiting and retaining physicians.

The proposed merger between Mountain States Health Alliance and Wellmont Health System is a response to these challenges, and an opportunity to change the way our local health care providers are able to work together to tackle the health care challenges affecting our region. By joining together, they could redirect spending away from wasteful duplication that has not added value, and invest in efforts to make our region healthier while controlling costs and making health care more affordable for all. While no solution can perfectly address the mounting headwinds facing our national healthcare providers, I believe this proposed merger is right for our region.

The significant advantages I see include better coordinated care through a unified electronic health record. The proposed merger’s ability to recruit and retain the best and brightest physicians through cooperation and coordination with East Tennessee State University and the

Quillen College of Medicine is paramount to addressing the serious health issues in our region. Finally, enhance needed services, like substance abuse and mental health which is going largely untreated and relegated to only reactionary treatment from our crowded emergency rooms.

I support this proposed merger because I believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region. This local solution to our region's health care challenges is a far better scenario than other partnerships Mountain States and Wellmont have considered outside our community. Please give your thoughtful consideration to the benefits this proposed merger will bring to our region.

Sincerely,

A handwritten signature in black ink that reads "Troy Clark". The signature is written in a cursive, flowing style.

Troy Clark, MSHA, MBA, FACHE
Chief Executive Officer
HealthSouth Rehabilitation Hospital

Cc: General Herbert Slatery III
Office of the Attorney General and Reporter
P.O. Box 20207 Nashville, TN 37202-0207



August 11, 2015

Department of Health
ATTN: Commissioner John Dreyzehner
425 5th Avenue North
Nashville, TN 37243

Dear Commissioner John Dreyzehner,

Goins Rash Cain Construction, Inc. proudly supports the proposed merger between Mountain States Health Alliance and Wellmont Health System. Since 1988, Goins Rash Cain Construction, Inc. has been responsible for over one billion dollars of building construction. As a successful construction company for over 27 years, we provide personalized, responsive service to each client. We employ the latest technology and implement consistent construction procedures at the best cost. As a company who thrives on helping our community grow, we are hoping to see our health care opportunities expand in this region.

We, as a company, would not be successful if it were not for our valued employees and clients. Goins Rash Cain Construction wants our community to be provided with the best healthcare possible. With our local healthcare providers teaming up, we believe our region will be able to tackle any health care challenges we face. There are many serious health issues that need to be addressed in our region. Cardiovascular disease, diabetes, pulmonary disease, addiction, and untreated mental illness burden our region. With Mountain States Health Alliance and Wellmont Health System merging, this will allow us to have better access to health care.

Goins Rash Cain deeply cares about this region and its future. We believe the Mountain States Health Alliance and Wellmont Health System merger is the right step in the direction towards a brighter future for East Tennessee. This health system merger will give a positive impact to our community today and the next generations to come. As a company who thrives on expanding this region, we would like to see this community build a stronger health system.

Sincerely,

A handwritten signature in black ink, appearing to read "Luther Cain", is written over a horizontal line. The signature is stylized and cursive.

Luther Cain, President

July 21, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

RE: Statement of Support for the proposed merger of
Wellmont Health System / Mountain States Health Alliance

Commissioner Dreyzehner,

Please accept this letter of support for the proposed merger of our local healthcare providers:
Wellmont Health System and Mountain States Health Alliance.

My wife, Leslie, and I are lifelong residents of Northeast Tennessee. We have had the opportunity to live and work in other regions, but we have found that Northeast TN offers the very best of everything that we need to live happy and healthy lives. Our adult children were both born and raised here and share our love for the region.

Quality, local healthcare is one of the things that we, as a region, have simply taken for granted. Both Wellmont and Mountain States have provided the very highest quality healthcare to our family and friends through the years. During the recent decade or so, we have witnessed many changes, growth, and improvements to both organizations. However, in our opinion, the competitive nature of having two major, regional providers has resulted in the repetition of facilities and services.

Our support for this merger is based on *affordability* and *accessibility* of quality healthcare for our family and future generations in the region. We see this merger as the very best option for the future of our region. As someone who cares deeply about this region and our residents, I trust that you will thoughtfully consider all of the benefits that this proposed merger will bring to our region, both today and for future generations.

Thank you for the opportunity to comment and to provide this letter of support for the merger.

Sincerely,



Calvin D. Clifton

cc: General Herbert Slatery III
Office of the Attorney General and Reporter
P.O. Box 20207
Nashville, TN 37202-0207



MEMBER FDIC

www.citizensbank24.com

July 31, 2015

Commissioner John Dreyzehner
Tennessee Department of Health
425 Fifth Avenue South
Nashville, Tennessee 37243

Dear Commissioner Dreyzehner:

Since its founding in 1934, an optimistic vision of the future for the Tri-Cities region is virtually synonymous with the Citizens Bank name. Today, Citizens Bank operates as a locally-owned, tax-paying small business helping other local individuals, businesses and organizations succeed by providing lending, deposit and investment services. Citizens Bank literally invests in the future of the Tri-Cities region.

In addition, our bank's executives and staff have devoted countless hours to improving the community through participating in boards and decision-making bodies, guiding civic projects, volunteering in the community and donating thousands of dollars to local and regional causes.

Our commitment to the region runs deep, which is why I am writing in support of the merger between Wellmont Health System and Mountain States Health Alliance.

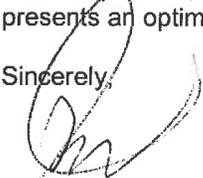
Despite the progress in treating diseases, East Tennessee continues to face significant challenges when it comes to the health of the local population. Cardiovascular disease, diabetes, pulmonary disease, addiction and untreated mental illness are just some of the major afflictions impacting healthcare in our region. In addition, local hospitals face significant challenges in delivering high quality service with the threat of declining revenues.

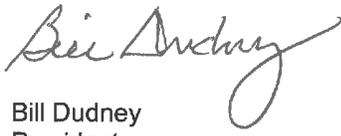
The proposed merger between Wellmont and Mountain States is a local solution to a complex problem. By combining resources directed towards a common purpose, reducing overhead costs and expanding access to services, the combined organization stands to truly impact the way healthcare is delivered in our region.

This merger stands to benefit the region in innumerable ways, but we are most excited about how it will contribute to attracting and retaining medical talent, enhancing medical services and improving quality access to healthcare at the lowest possible cost.

Like our passion, we believe the proposed merger between Wellmont and Mountain States presents an optimistic vision for the future and we encourage you to approve this request.

Sincerely,


Joe LaPorte, III
Chairman & CEO


Bill Dudney
President

cc: General Herbert Slatery III
Office of the Attorney General and Reporter
P. O. Box 20207
Nashville, Tennessee 37202-0207

BRISTOL
P.O. Box 1218
Bristol, TN 37621-1218
423-989-4400
Fax 423-989-4445

ELIZABETHTON
P.O. Box 1900
Elizabethton, TN 37644-1900
423-543-2265
Fax 423-543-7400

JOHNSON CITY
P.O. Box 1265
Johnson City, TN 37605-1265
423-952-2265
Fax 423-854-9085

KINGSPORT
P.O. Box 687
Kingsport, TN 37662-0687
423-245-2265
Fax 423-378-0415

CHRIS MULLINS CO., L.L.C.

ACOUSTICAL CEILINGS • INSULATION

October 15, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

RE: Proposed Merger of Wellmont Health System and
Mountain States Health Alliance

Dear Commissioner Dreyzehner:

I am writing this letter as the Chief Manager of an Acoustical Ceiling and Insulation subcontracting firm that has been in business in Kingsport, Tennessee since 1949. My father started this business and I now have two sons in the business with me. We currently have 30 employees.

As a family that has lived in Kingsport all of our lives, we are committed to this region and want our health care system to be the very best that it can be not only for our own family but for our employees and all citizens of this area. We do offer health insurance to our full-time employees but premiums are very high and difficult for many to afford. Affordability seems to be the biggest challenge for all of us.

We want our employees to be able to receive the best care that is available and feel that merging Wellmont and Mountain States under the COPA statute will benefit all of us greatly. We need a health system in place to work for all of us.

Sincerely,



Chris L. Mullins
Chief Manager

cc: General Herbert Slatery III
Office of the Attorney General & Reporter
P. O., Box 20207
Nashville, TN 37202-0207

Mike McIntire
■ Pendleton Place
Kingsport, TN 27664
November 2, 2015

Commissioner Dreyzehner
Department of Health
425 Fifth Avenue North
Nashville, Tennessee 37243

Dear Commissioner Dreyzehner:

Re: Support for Merger of Wellmont and Mountain State Health Systems

I am a long-term resident of Kingsport and current serve our city as Vice Mayor. My wife and I have had the need to utilize the services provided by both health systems and have always been pleased with the service and the outcome. I want to express my strong support for the merger of these two systems and to briefly state why I think this merger is in the best interests of the citizens in our region.

My support is based on the following:

- I recognize that the complex financial strains on the health care system are placing extreme pressure on all health care systems and controlling costs are essential to survival. Consolidations and mergers are the most obvious ways to achieve cost savings. Merger of our two local systems provides these cost savings while maintaining control of our hospitals in the region and their focus on the unique health needs. This has the highest probability of assuring high quality medical services that our communities need.
- While consolidation will likely result in some job reductions in some areas, the two systems together should be able to offer better medical services overall and should also be able to have sufficient patient load to add some subspecialty care which now requires patients to travel to larger systems.
- The combined system should be able to bring better focus on major health issues in our region including substance abuse, mental health, heart disease, diabetes, and obesity and help assure that our next generation is healthier than the current one.
- Concerns about monopolistic issues are largely unfounded because prices are controlled by the Federal government (Medicare and Medicaid) and insurance companies. I can see no reason that a merged health system could charge higher prices for medical services.
- Because of a significantly larger health care system, the opportunity to expand medical related work with East Tennessee State University to tackle public health issues in our region is an added bonus to the merger and one that has not only improved health implications but also economic development opportunities in the medical field in the region.

I believe these factors strongly favor your approval of the merger of Mountain State Health Alliance and Wellmont Health System and I strongly recommend your approval.

Sincerely,

Mike McIntire



PO Box 1989
Kingsport, TN 37662
Phone: 423.229.8200
or 800.999.2328

November 3, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

Dear Commissioner Dreyzehner:

My name is Olan Jones and I am the CEO/President of Eastman Credit Union (ECU). Founded in 1934 and headquartered in Kingsport, Tennessee, ECU is the largest credit union in TN and one of the 50th largest credit unions in the U.S. employing over 600 individuals. As a not-for-profit organization, ECU is a strong supporter of the communities we serve.

The purpose of this letter is to let you know that I support the proposed merger of Wellmont Health System and Mountain States Health Alliance.

We all know there has never been a time of greater change in health care - both locally in our region, as well as across the U.S. Significant changes have been and will continue to occur for our nation's hospitals, physicians and patients, in many cases making it harder for patients, families and businesses to get the care they need, when and where they need it.

Additionally, there are significant challenges facing our region:

- **Industry Challenges for Hospitals:** These include increasing reimbursement cuts, declining inpatient volumes, constrained revenue, and increasing difficulty in recruiting and retaining physicians.
- **Regional Health Issues:** Serious health issues in our region that need to be addressed include cardiovascular disease, diabetes, pulmonary disease, addiction and untreated mental illness – and the cost of this poor health is not sustainable. Additional factors unique to our region include the rural nature of many hospitals and the need to expand investment in research and physician training programs.

The proposed merger between Wellmont and Mountain States is a response to these challenges, and an opportunity to change the way our local health care providers work together to tackle the health care challenges affecting our region. This will be an opportunity for the two organizations to come together and build a new organization, one that reflects what this community needs – today and in the years to come.

As a combined organization, Wellmont and Mountain States believe they can work to unite the resources of both systems with one common purpose – to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access the best care available in the nation. By joining together, they could redirect spending away from wasteful duplication that has not added value, and invest in efforts to make our region healthier while controlling costs and making health care more affordable for all.



PO Box 1989
Kingsport, TN 37662
Phone: 423.229.8200
or 800.999.2328

In Tennessee, the two organizations are pursuing approval under the COPA (Certificate of Public Advantage) statute. Under a COPA agreement, our region's employers, patients and payors will be protected. State supervision will ensure the future combined organization will continue to benefit the community by providing health care that is affordable, accessible, cost-efficient and most importantly, high-quality.

This local solution to our region's health care challenges is far better scenario than other partnerships Wellmont and Mountain States have considered outside our community – partnerships that have been shown elsewhere to lead to increased pricing without necessarily improving quality.

Growing up in Kingsport, I learned the value of community; the value of people working together for the greater good. It was because of these community values that I chose to raise my family in this community, base my entire professional career in this community, and serve on a number of committees, boards and project teams in this community. I believe, together, Wellmont and Mountain States can collaborate to truly impact the way health care is delivered in our region. I hope you will thoughtfully consider all of the benefits this proposed merger will bring to our region, both today and in the generations to come.

With kind regard,

A handwritten signature in blue ink, appearing to read "Olan Jones", is written over the typed name and title.

Olan Jones
CEO/President

cc: General Herbert Slatery III



Healing Hands Health Center

245 Midway Medical Park
Bristol, Tennessee 37620
www.healinghandshealthcenter.org

September 28, 2015

Commissioner John Dreyzhner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Dear Dr. Dreyzhner,

Healing Hands Health Center would like to offer its support for the proposed merger between Wellmont Health System and Mountain States Health Alliance. The work of these two hospital systems and their dedicated staff provides health care services to many residents who, without them, would have limited access to care. Like both groups, Healing Hands works to serve the residents of Southwest Virginia and Northeast Tennessee. Since 1997, we've been able to provide more than 65,000 charitable medical, dental, vision, chiropractic and counseling services to the hard-working, uninsured individuals on Northeast Tennessee and Southwest Virginia. We work hard to keep people out of the Emergency Department and helping them live happier and healthier lives.

We understand the role and impact the merger would have on our community in expanding access to services to those in our area. We recognize that as a combined organization, Wellmont and Mountain States can work to unite the resources of both systems with one common purpose – to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access the best care available in the nation. By joining together, they could redirect spending away from wasteful duplication that has not added value, and invest in efforts to make our region healthier while controlling costs and making health care more affordable for all.

Each community organization has its role, and that shared responsibility and willingness to work together has served to improve the overall well-being of the population. Expanded access to health care has long been a need in the area and a goal of community leaders and safety net partners. With this project, Wellmont and Mountain States will be able to provide patients with much needed access to high-quality care. Again, we believe this model of service integration will also maximize efficiency and contain costs, while improving health outcomes via a coordinated, inter-disciplinary treatment plan.

Healing Hands Health Center is proud to support this proposed merger because we believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region; of which we will all benefit. This local solution to our region's health care challenges is a far better scenario than other partnerships Mountain States and Wellmont have considered outside our community – partnerships that have been shown elsewhere to lead to increased pricing without necessarily improving quality.

If you need more information, please feel free to contact me at (423) 652-2516.

Sincerely,

Helen Scott
Executive Director

1005 Glenway Avenue
Bristol, Virginia 24201-3473
(276) 466-3322

The United Company



November 11, 2015

Commissioner John Dreyzehner
Tennessee Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

RE: Proposed Merger of Wellmont Health System and Mountain States Health Alliance

Dear Commissioner Dreyzehner:

The United Company, a diversified private investment company, is a long standing corporate citizen of the region with many of our employees working and living here. In addition to my duties at the Company, I serve as a member of the Board of Directors for Bristol Regional Medical Center and a member of the Population Health and Healthy Communities Steering Committee, a committee established jointly by Wellmont Health System and Mountain States Health Alliance to discuss the area's largest healthcare challenges and how best they can be addressed on a regional basis. We have several challenges and it will take outside-of-the-box solutions to help the region advance the quality of care needed.

A certificate of public advantage is deliberate in its attempt to provide the ability for uniquely positioned health care systems to come together under regulation and supervision from the state. It is my view that a certificate of public advantage provides an opportunity for this region to take an important step forward in ensuring quality, comprehensive and affordable health care. As you are aware, in accordance with the law, appropriate state officials will continue to act in an oversight capacity ensuring action taken is consistent with sound health care policy. Once approved and implemented, I would encourage you to help ensure steady cost monitoring and enforcement, but retain the ability for the proposed new health system to be nimble in meeting our population health needs.

November 11, 2015

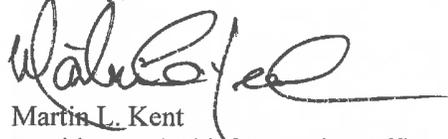
Page Two

I have heard, and understand in theory, concerns that have been raised by a few regarding reduced competition. As an employer who provides a self-funded insurance plan for our full-time employees, we appreciate efforts to keep quality healthcare affordable. However, as you know the proper evaluation to be made is not will there be less competition, but whether the benefits likely to result from a proposed cooperative agreement outweigh the disadvantages likely to result from that reduced competition. It is here, looking at the benefits to be considered, including affordability, where I believe the scales tip clearly in favor of a carefully structured, and appropriately regulated, cooperative agreement.

One example cited, Mission Health System in Asheville, North Carolina, a community within a two hour drive of much of this region and with many similarities to it, appears to have operated for years under a certificate of public advantage. It is my understanding that costs have risen at a lower rate than most of the nation and the system has been ranked by some near the very top of all healthcare providers across the country on clinical quality and efficiency. As healthcare policy continues to evolve in the years ahead, a strong system with the resources and experience needed to understand and tackle our unique needs will be critical.

Bottom line, given our unique needs the status quo is not getting us where we all collectively believe we need to go. However, through this proposed merger and within the proper regulatory environment we believe we can get there. Thank you for your important work on this initiative.

Sincerely,



Martin L. Kent
President and Chief Operating Officer

cc: The Honorable Herbert H. Slatery III, Tennessee Attorney General and Reporter

November 12, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

CC: General Herbert Slating III
Office of the Attorney General and Reporter
P.O. Box 20207
Nashville, TN

Dear Commissioner Dreyzehner,

I am writing in support of the proposed merger between Wellmont Health System and Mountain States Health System in North East Tennessee. For most of my adult life I have been directly or indirectly involved in health care issues. My husband has practiced pediatrics in the Kingsport area for the past 48 years. I have served on the Holston Valley Medical Center Board of Directors for 12 plus years and served as Chair of the Board that also placed me on the Wellmont System Board of Directors. For six years I served as Mayor of the City of Kingsport where the well-being of our employees was a major concern. I've been an advocate for health and wellness issues in a professional and volunteer capacity and currently serve on the Advisory Council for Healthy Kingsport, a partner with the Healthy Tennessee initiative.

It has been well documented that the health status of our region needs to be improved. We have serious health care problems in the area of diabetes, cardiovascular disease, substance abuse and obesity. It is my strong believe that we can address these and other health care issues more effectively with a combined health care system. With the elimination of competing efforts, serious overlap of services and with our combined scarce resources directed at these regional problems we can expect better outcomes and begin to see improvements in the health status of our citizens.

Also, in this ever changing health care climate in which we find ourselves, a combined system will be able to improve access to much needed services for our citizens. We believe working together will create a stronger force than working separately. Our region is simply too small to support two competing health care systems. I am excited about the possibilities that a merger holds for our region. Together we will be working to make our next generation healthier than today's and to make sure those who need health care services can access the best care available in the nation.

Sincerely,

A handwritten signature in cursive script that reads "Jeanette D. Blazier". The signature is written in black ink and is positioned above the printed name.

Jeanette D. Blazier
Former Mayor, City of Kingsport, Tennessee

CUSTOMER 1 ONE, INC.
Bill Gatton



Cadillac

ISUZU

1000 West State Street • Bristol, Tennessee 37620 • (423) 764 5121 • www.billgatton.com

November 18, 2015

Commissioner John Dreyzehner
Dept. of Health
425 5th Ave. North
Nashville, TN 37243

Commissioner Dreyzehner,

I am writing to you in regards to the proposed merger of Mountain States Health Alliance and Wellmont Health System

Our organization, Bill Gatton Automotive Group, employs 150 individuals in the Tri-Cities area of Tennessee and Southwest Virginia. Additionally we have physical operations in both states and have provided automotive services to this region for over 47 years.

We, as with most businesses, are very concerned with the cost and quality of available health care for our employees and customers. We live in a region where cardiovascular disease, obesity and drug abuse are major health challenges. Through this proposed merger and collaboration with East Tennessee State University along with Quillen College of Medicine and the Bill Gatton College of Pharmacy, we believe an informed and educated populace can change this tide.

Lower costs can be obtained by eliminating the duplication of services and technology these two health systems are employing today. We believe cost, through the COPA process, can be controlled by the supervision of the State of Tennessee and the Commonwealth of Virginia.

We fully support this proposed merger as a way to positively impact the way health care is delivered in our area and hope you will thoughtfully consider all of the benefits this merger will bring to our region.

Respectfully yours,

Chris Lee

COO Bill Gatton Automotive Group

cc: General Herbert Slatery III, Office of the Attorney General and Reporter, P.O. 20207,
Nashville, TN 37202-0207

John M. Vann

Fairway Drive • Bristol, TN 37620
Phone: 423. [REDACTED] • E-Mail: [REDACTED]

November 30, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Dear Commissioner Dreyzehner:

It is with tremendous enthusiasm that I write in support of the proposed merger between Wellmont Health System and Mountain States Health System.

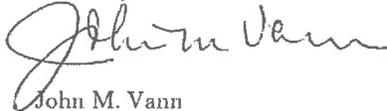
I am proud of our region and prouder still of the two very fine health systems in our area. With the changes we have experienced in health care overall, it is incumbent upon systems to seek ways to circumvent the barriers to continued high quality patient care. I believe that Wellmont performed a very thorough search for a qualified merger partner to gain efficiencies while maintaining highest standards of care. The fact that Mountain States was determined to be the partner of choice through this process is a testimony to both systems' strong desire to serve the region for the betterment of all.

Our region is blessed with a wonderful environment in which to work and live. Yet, our region is plagued with chronic health issues that impact the quality of life. The economic condition of the region has also been compromised in recent years. Having faced the challenge of employing nearly 200 professionals and trying to attract talented colleagues to our region, I believe the strength of the merged health system will be a draw not only for physicians who will see the benefits of a unified health system, but for new employees of all businesses and new industries seeking a high quality location – a very important by-product of this process. The combined organization will also capitalize and expand its scope for research and innovative care with the collaboration with ETSU School of Medicine, producing yet another boost to our local and regional economic development efforts.

Uniting the resources of the two systems creates so many opportunities for better access to healthcare and improved service to the public through educational programs on issues that affect the health and wellbeing of families in our area.

These and many more reasons are why I stand in support of the proposed merger. I trust that you and your office have and will continue to affirm this decision as the best for the future of healthcare in our region.

Sincerely,



John M. Vann

CC: General Herbert Slatery III
Office of the Attorney General and Reporter
P.O. Box 20207
Nashville, TN 37202-0207



November 18, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

Dear Commissioner Dreyzehner,

Bank of Tennessee and I have been very involved in the proposed merger of our two health systems headquartered in Johnson City and Kingsport, Tn. Our board recognizes the impact of local ownership and control, of our health care delivery system. Once it became known that Wellmont had essentially put themselves up for sale to an out of town hospital system, we sprang into action to ignite and unite the communities that they serve. Our position was quite clear from the outset. Merge the two hospitals and form a stronger alliance with ETSU. The benefits are numerous in spite of some overlapping jobs that will be eliminated.

We helped facilitate meetings to explain to the public what we stood to gain and what we stood to lose. We also helped with communications between the state governments and other regulatory agencies that will need to deal with the COPA.

In short, Bank of Tennessee is all in for the merger of these two hospital systems and we will help in any way to make it happen.

Thank you for your diligence and consideration in this matter. We believe that our employees, families, extended community and future generations will be much better served this way.

Sincerely,

A handwritten signature in black ink that reads "Roy L. Harmon, Jr." with a large, stylized flourish at the end.

Roy L. Harmon, Jr.
Chairman and CEO





July 27, 2015

Dr. William Hazel, Jr.
Secretary of Health and
Human Resources
P. O. Box 1475
Richmond, VA 23218

Dear Dr. Hazel:

As we move into the Regulatory approval of the merger of the Wellmont Health Organization and the Mountain States Health Alliance, I am delighted to have the opportunity to write a letter recommending the COPA approval of this amazing opportunity. Our bank, Bank of Tennessee, is the largest commercial bank between Roanoke and Knoxville so we're right in the heart of the footprint of where the two hospital organizations are located. This gives us an incredibly sensitive feel for what goes on in this area, as you can imagine.

As an outsider looking in at the functioning hospital organization in Northeast Tennessee and Southwest Virginia, it is a paradox to examine the combination of Wellmont back in 1996 when Kingsport and Bristol united to form the Wellmont Health Organization. Obviously, there were doubters that did not think this was a good idea; history proved them wrong. The Wellmont Health Organization became a very strong, high-quality, efficient hospital group that we are all proud of. Through the years, competition between Johnson City's Mountain States Health Alliance and Wellmont sadly created unnecessary competition and a strain between the major three cities in this region, Kingsport, Bristol and Johnson City. With the two boards of each health organization having signed a term sheet, the region of Southwest Virginia and Northeast Tennessee now has the opportunity and vision to become one of the outstanding hospital groups in the nation.

Just across the mountain an hour from us in Asheville, North Carolina, in 1995 a COPA was issued by the State of North Carolina for the combination of Mission Hospital and St. Joseph Hospital (now called Mission Hospital) to move forward. Since that time, the quality of medicine has continued to improve. Today Mission Hospital is honored to be one of the top 100 health organizations in America for the fifth consecutive year. The cost to the patient

Dr. William Hazel, Jr.
July 27, 2015
Page 2

at Mission Hospital has risen at a slower rate than competitive costs across the State of North Carolina. If every hospital in the United States performed at the level of Mission Hospital (and we expect the new combination in Northeast Tennessee and Southwest Virginia to perform at this level) then:

- More than 164,000 additional patients would survive each year in this country
- Nearly 82,000 additional patients could be complication free
- The average patient stay would decrease one-half day across the country
- Six billion dollars would be saved in this country

THE ABOVE COMMENTS ARE BASED ON THE ANALYSIS OF MEDICARE INPATIENTS OVER ONE YEAR.

Probably one of the two most important issues that would be addressed (other than quality of healthcare) would be the containment of reasonable cost of healthcare. With the combination of the two hospitals:

- We would have nearly two billion in revenues; if our hospitals were located anywhere else in the country, we'd be closer to a three billion dollar system. Our revenues are strained by the Medicare Wage Index being so low here in our area.
- The system would have one billion dollars in cash
- The operating margins already at AA bond level ratings
- The system would have \$1.5 billion in debt with a system that has one billion dollars in cash
- The system would have \$225 million dollars per year in re-occurring cash flow

The reason I set this out, obviously as a banker, is cost containment is so important and necessary for the COPA to fulfill its mission.

The best reason to start this organization as a combination is to make meaning; to create a product or service to make our world in Northeast Tennessee and Southwest Virginia a better place to live. That's what this is all about.

Sincerely yours,

W. B. Greene, Jr.
Chairman
BancTenn Corporation

WBGJr/dba

cc: Attorney General Mark Herring
Elliott Moore
✓ Andy Hall



Ball Construction Co., Inc.

1675 Park Ave.
Norton, Va. 24273
Phone (276) 679-1016
Fax (276) 679-2962

July 21, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
P. O. Box 1475
Richmond, Va. 23218

CC: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, Va. 23219

I am writing this letter to address the merger between Wellmont Health System and Mountain States Health Alliance. I am the owner of Ball Construction Co., Inc., located in Norton, Va. We have been in business since 1960 and currently have approximately 25 employees. We are a general contractor doing mostly commercial work.

One of the benefits of our company is that we have made health insurance available to our employees and with the current rising cost of health care, it has been quite a challenge for them and me. As a combined organization, Wellmont and Mountain States believe they can work to unite the resources of both systems with one common purpose -- to make the next generation of this region healthier than today's, and to make sure those who need health care services can access the best care available. By joining together, they could redirect spending away from wasteful duplication that has not added value and invest in efforts to make our region healthier while controlling costs and making health care more affordable for everyone.

As someone who cares about this region and our future, I hope you will consider all of the benefits this proposed merger will bring to our region, both today and in the generations to come.

Sincerely,

Mike Ball

07/21/2015

Attorney General Mark Herring
900 East Main Street
Richmond, VA 23219

Mr. Herring:

My name is Michael McCool and I am a Vice President and Partner at Cary Street Partners in Abingdon, VA. Cary Street Partners is a Wealth Management and Investment Banking firm based in Richmond, VA. Our practice is based in Abingdon, VA. I am writing this letter in support of the merger between Wellmont Health System and Mountain States Health Alliance.

As you know, there has never been a time of greater change in health care, both locally in our region and across the United States. Sweeping changes have been and will continue to occur for our nation's hospitals, physicians, and patients, in many cases making it harder for patients, families and businesses to get the care they need, when and where they need it. In our region specifically, it is of great importance that we have a thriving, economically viable hospital system. Not only do our citizens need and deserve the best care, but also with the downturn in the energy markets, we need the jobs. In our rural area we need to expand investments into the quality and availability of care in all areas. I feel this merger will help achieve that aim. I feel the proposed merger is a response to the challenges that face our area.

As a combined organization, Wellmont and Mountain States believe they can work to unite the resources of both systems with one common purpose, to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access health care that can compete with any other area in the nation. I feel that by coming together these two units can reduce wasteful expense and invest in efforts to make sure our region has access to the best doctors and care, all while making it more affordable to the patient. In closing I support this proposed merger because I believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region. As a citizen who cares deeply about the present and future of our region, I hope you will consider all of the benefits this proposed merger will bring to our region not only immediately, but for generations to come. Thank you.

Sincerely,

Michael F. McCool
VP/Partner
Cary Street Partners, LLC





Healing Hands Health Center

245 Midway Medical Park
Bristol, Tennessee 37620
www.healinghandshealthcenter.org

September 28, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
Post Office Box 1475
Richmond, Virginia 23218

Dear Dr. Hazel,

Healing Hands Health Center would like to offer its support for the proposed merger between Wellmont Health System and Mountain States Health Alliance. The work of these two hospital systems and their dedicated staff provides health care services to many residents who, without them, would have limited access to care. Like both groups, Healing Hands works to serve the residents of Southwest Virginia and Northeast Tennessee. Since 1997, we've been able to provide more than 65,000 charitable medical, dental, vision, chiropractic and counseling services to the hard-working, uninsured individuals on Northeast Tennessee and Southwest Virginia. We work hard to keep people out of the Emergency Department and helping them live happier and healthier lives.

We understand the role and impact the merger would have on our community in expanding access to services to those in our area. We recognize that as a combined organization, Wellmont and Mountain States can work to unite the resources of both systems with one common purpose – to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access the best care available in the nation. By joining together, they could redirect spending away from wasteful duplication that has not added value, and invest in efforts to make our region healthier while controlling costs and making health care more affordable for all.

Each community organization has its role, and that shared responsibility and willingness to work together has served to improve the overall well-being of the population. Expanded access to health care has long been a need in the area and a goal of community leaders and safety net partners. With this project, Wellmont and Mountain States will be able to provide patients with much needed access to high-quality care. Again, we believe this model of service integration will also maximize efficiency and contain costs, while improving health outcomes via a coordinated, inter-disciplinary treatment plan.

Healing Hands Health Center is proud to support this proposed merger because we believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region; of which we will all benefit. This local solution to our region's health care challenges is a far better scenario than other partnerships Mountain States and Wellmont have considered outside our community – partnerships that have been shown elsewhere to lead to increased pricing without necessarily improving quality.

If you need more information, please feel free to contact me at (423) 652-2516.

Sincerely,

Helen Scott
Executive Director

Rebecca C. Coleman

P.O. Box [REDACTED]

Gate City, VA 24251

Dr. William Hazel Jr.

Secretary of Health and Human Resources

P.O. Box 1475 Richmond, VA 23218

Dear Secretary Hazel:

I am writing to express my support for the proposed merger between Wellmont Health System and Mountain States Health Alliance (MSHA).

As longtime District Director and later Chief of Staff and Senior Advisor to Representative Rick Boucher of Virginia's Ninth Congressional District, I have been all too aware of the increasing difficulty of recruiting and retaining physicians in Southwest Virginia. Further, I have observed over the years with dismay the trend of cutting reimbursements to doctors and hospitals in rural regions such as ours. In Virginia, where the General Assembly has declined to participate in federal Medicaid Expansion, the situation has become dire for our hospitals, as evidenced by the closure of several smaller ones throughout the region.

These factors are among many significant challenges faced by both Systems, and they require development of an approach to containing costs and recruiting qualified medical personnel that is unlikely, if not impossible to achieve in a highly competitive environment. The proposed merger will allow the two systems to avoid wasteful duplication and better coordinate care, while making health care more affordable and enhancing needed services for residents.

In light of the many challenges they are facing, it seems unlikely that either MSHA or Wellmont as a stand-alone institution can continue to provide the high quality, regionwide medical services to which we are accustomed. However, the potential for either to seek a formal partnership with an entity that

November 11, 2015

Page 2

lacks actual ties to or a stake in Southwest Virginia or East Tennessee is widely considered to be fraught with risk in terms of the provision of health care to residents throughout this region. This proposed local partnership between MSHA and Wellmont is much more likely to offer our citizens expanded yet affordable access to healthcare provided by high quality medical personnel.

I urge favorable consideration of the proposed merger, and I appreciate the opportunity to share these thoughts with you.

With best regards, I am

Sincerely,

A handwritten signature in black ink that reads "Rebecca C. Coleman". The signature is written in a cursive style with a large initial 'R'.

Rebecca C. Coleman

CC: Attorney General Mark Herring

Office of the Attorney General

900 East Main Street

Richmond, VA 23219

1005 Glenway Avenue
Bristol, Virginia 24201-3473
(276) 466-3322

The United Company



November 11, 2015

The Honorable William Hazel, Jr., M.D.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, Virginia 23218

RE: Proposed Merger of Wellmont Health System and Mountain States Health Alliance

Dear Secretary Hazel:

The United Company, a diversified private investment company, is a long standing corporate citizen of the region with many of our employees working and living here. In addition to my duties at the Company, I serve as a member of the Board of Directors for Bristol Regional Medical Center and a member of the Population Health and Healthy Communities Steering Committee, a committee established jointly by Wellmont Health System and Mountain States Health Alliance to discuss the area's largest healthcare challenges and how best they can be addressed on a regional basis. We have several challenges and it will take outside-of-the-box solutions to help the region advance the quality of care needed.

A certificate of public advantage is deliberate in its attempt to provide the ability for uniquely positioned health care systems to come together under regulation and supervision from the state. It is my view that a certificate of public advantage provides an opportunity for this region to take an important step forward in ensuring quality, comprehensive and affordable health care. As you are aware, in accordance with the law, appropriate state officials will continue to act in an oversight capacity ensuring action taken is consistent with sound health care policy. Once approved and implemented, I would encourage you to help ensure steady cost monitoring and enforcement, but retain the ability for the proposed new health system to be nimble in meeting our population health needs.

November 11, 2015

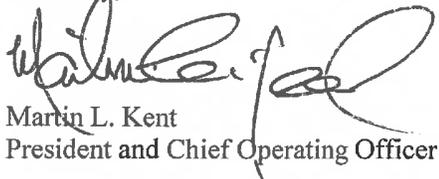
Page Two

I have heard, and understand in theory, concerns that have been raised by a few regarding reduced competition. As an employer who provides a self-funded insurance plan for our full-time employees, we appreciate efforts to keep quality healthcare affordable. However, as you know the proper evaluation to be made is not will there be less competition, but whether the benefits likely to result from a cooperative agreement outweigh the disadvantages likely to result from that reduced competition. It is here, looking at the benefits to be considered, including affordability, where I believe the scales tip clearly in favor of a carefully structured, and appropriately regulated, cooperative agreement.

One example cited, Mission Health System in Asheville, North Carolina, a community within a two hour drive of much of this region and with many similarities to it, appears to have operated effectively for years under a certificate of public advantage. It is my understanding that costs have risen at a lower rate than most of the nation and the system has been ranked by some near the very top of all health care providers across the country on clinical quality and efficiency. As health care policy continues to evolve in the years ahead, a strong system with the resources and experience needed to understand and tackle our unique needs will be critical.

Bottom line, given our unique needs the status quo is not getting us where we all collectively believe we need to go. However, through this proposed merger and within the proper regulatory environment we believe we can get there. Thank you for your important work on this initiative.

Sincerely,



Martin L. Kent
President and Chief Operating Officer

cc: The Honorable Mark Herring, Attorney General of Virginia

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Bill Gatton



Cadillac

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November 18, 2015

Dr. William Hazel Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

Dr. Hazel,

I am writing to you in regards to the proposed merger of Mountain States Health Alliance and Wellmont Health System

Our organization, Bill Gatton Automotive Group, employs 150 individuals in the Tri-Cities area of Tennessee and Southwest Virginia. Additionally we have physical operations in both states and have provided automotive services to this region for over 47 years.

We, as with most businesses, are very concerned with the cost and quality of available health care for our employees and customers. We live in a region where cardiovascular disease, obesity and drug abuse are major health challenges. Through this proposed merger and collaboration with East Tennessee State University along with Quillen College of Medicine and the Bill Gatton College of Pharmacy, we believe an informed and educated populace can change this tide.

Lower costs can be obtained by eliminating the duplication of services and technology these two health systems are employing today. We believe cost, through the COPA process, can be controlled by the supervision of the State of Tennessee and the Commonwealth of Virginia.

We fully support this proposed merger as a way to positively impact the way health care is delivered in our area and hope you will thoughtfully consider all of the benefits this merger will bring to our region.

Respectfully yours,

Chris Lee
COO Bill Gatton Automotive Group

cc: Attorney General Mark Herring, Office of the Attorney General, 900 East Main Street,
Richmond, VA 23219

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**FRIENDSHIP
ENTERPRISES**
AUTOMOTIVE • INVESTMENTS • REAL ESTATE

July 24, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Dear Commissioner John Dreyzehner,

Friendship has been in business since 1993. We are in the automotive / motorsports business with 16 locations throughout Bristol, Kingsport, Johnson City, TN as well as Boone and Forest City, North Carolina. We currently employ over 300 Team Members.

As you know, there has never been a time of greater change in health care – both locally in our region and across the U.S. Sweeping changes have been and will continue to occur for our nation's hospitals, physicians and patients, in many cases making it harder for patients, families and businesses to get the care they need, when and where they need it.

Additionally, there are significant challenges facing our region:

o **Industry Challenges (for hospitals):** These include increasing reimbursement cuts, declining inpatient volumes, constrained revenue, and increasing difficulty in recruiting and retaining physicians.

o **Regional Health Issues:** Serious health issues in our region that need to be addressed include cardiovascular disease, diabetes, pulmonary disease, addiction and untreated mental illness – and the cost of this poor health is not sustainable. Additional factors unique to our region include the rural nature of many hospitals and the need to expand investment in research and physician training programs.

The proposed merger between Mountain States Health Alliance and Wellmont Health System is a response to these challenges, and an opportunity to change the way our local health care providers are able to work together to tackle the health care challenges affecting our region. This will be an opportunity for the two organizations to come together and build something brand new that reflects what this community really needs – today and in the years ahead.

As a combined organization, Wellmont and Mountain States believe they can work to unite the resources of both systems with one common purpose – to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access the best care available in the nation. By joining together, they could redirect spending away from wasteful duplication that has not added value, and invest in efforts to make our region healthier while controlling costs and making health care more affordable for all.

Together, Wellmont and Mountain States will:

- o Work with East Tennessee State University to tackle important public health issues
- o Enhance needed services, like substance abuse and mental health
- o Expand access to care, while keeping healthcare affordable
- o Better coordinate care through electronic health records
- o Attract and retain the best and brightest physicians
- o Strive to be one of the best healthcare employers in the nation



FRIENDSHIP ENTERPRISES

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In Tennessee, the two organizations are pursuing approval under the COPA (Certificate of Public Advantage) statute. Under a COPA agreement, our region's employers, patients and payors will be protected. State supervision will ensure the future combined organization will continue to benefit the community by providing health care that is affordable, accessible, cost-efficient and most importantly, high-quality.

I support this proposed merger because I believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region. This local solution to our region's health care challenges is a far better scenario than other partnerships Mountain States and Wellmont have considered outside our community – partnerships that have been shown elsewhere to lead to increased pricing without necessarily improving quality.

As someone who cares deeply about this region and our future, I hope you will thoughtfully consider all of the benefits this proposed merger will bring to our region, both today and in the generations to come.

Sincerely,

Mitch Walters
President / CEO
Friendship Enterprises



**NORTHEAST
STATE**

Office of the President

November 24, 2015

Commission John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Dear Mr. Dreyzehner:

I am writing to provide how Northeast State Community College strongly supports the merger of Wellmont Health Care System and Mountain States Health Alliance. With six health related programs of study, it is critical that we have viable health care systems where our students can participate in clinical settings to enhance their skills as potential employees of these systems. It is also important to the citizens that we have a very strong, competitive system to meet the health care needs of our region. We believe that the two systems will be "Better Together."

Northeast State is celebrating 50 years in 2016 of service to the Northeast Tennessee Region. We added health programs over the last 10 years to meet the need of the health care providers and graduate around 150 students annually who live in this region and apply for health positions in the health care industry in this region. We enroll close to 400 students annually in AD Nursing, Dental Assisting, EMT, Cardio-Vascular, Medical Technology, and Surgical Technologies. We continually assess program needs to see if we need to add additional programs of study and also frequently ask our health system employers to identify skills sets that our graduates need to be the most successful if employed by our regional health care systems.

Northeast State has ranked first in TBR and UT Public 2 year and 4 year institutions in performance outcomes for the last two years in a row. We enroll around 7500 students annually and employ around 400 full time employees and approximately 250 part-time employees.

We have had close affiliation with both systems over the last several years and each has been a great partner, but the merger would provide event greater leverage and competitive edge for our region and as a college in providing a voice and impact for Northeast Tennessee in health care services. I have served on the workforce development board of directors for Mountain States Health Alliance and on the board for Indian Path Medical Center. Quality and integrity are two ways I would describe my experience with these great institutions.

Again, Northeast State Community College strongly supports the merger of Wellmont Health System and Mountains States Health Alliance to create one of the best systems in the nation.

Sincerely,

Janice H. Gilliam, Ed. D.
President

Cc: General Herbert Slatery III

Northeast State
Community College
A Tennessee Board of Regents Institution

2425 Highway 75, P.O. Box 246
Blountville, TN 37617
423.323.3191 Fax 423.323.0209
www.NortheastState.edu

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Donald Baker

COUNCIL MEMBERS
Danny Lambert
Talbert Bolling
Jeremy Fleming
Doris Rife
Ron Kendrick

August 3, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Services
P.O. Box 1475
Richmond, Virginia 23218

Re: Proposed Merger between Wellmont Health System and Mountain States Health Alliance

Dear Dr. Hazel:

I am pleased to write to you in support of the proposed merger between Wellmont Health System and Mountain States Health Alliance. I believe the proposed partnership is an important step in improving and assuring excellent health care for the people of Southwest Virginia.

As you are well aware, there has never been a time of greater change and challenges locally in our region, across Virginia and in the United States for hospitals, physicians and patients. The ability for patients to get the healthcare they need and healthcare providers to deliver that care is critical but challenging.

With industry changes for hospitals in particular and the need for regional solutions regarding significant health care issues for the community, it is my opinion that all of our constituents can best be served by the proposed solutions proposed by the successful merger of these two well recognized healthcare leaders.

I am fully confident that the ongoing supervision provided by the Commonwealth of Virginia is more than sufficient to protect the region's employers, patients and payers. Additionally, it will ensure the future combined organization will continue to benefit the community by providing health care that is affordable, accessible, cost-efficient, and most importantly, high quality.

Page 2

Thank you in advance for your careful consideration of this matter and if you have any questions at all, please feel free to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald Baker". The signature is fluid and cursive, with a long horizontal stroke at the end.

Donald Baker
Mayor

cc: The Honorable Mark Herring
Attorney General of Virginia

Dickenson County Chamber of Commerce

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October 13, 2015

Dr. William Hazel Jr.
Secretary of Health & Human Services
P.O. Box 1475
Richmond, VA 23218

Dear Dr. Hazel,

The Dickenson County Chamber of Commerce supports the merger of Wellmont Health System and Mountain States Health Alliance to an integrated single system.

We feel due to the overall challenges facing healthcare, this merger would be the best solution for our region in overall healthcare. We hope to see positive results from this merger in an overall better quality of life for our citizens in healthcare and for an enhanced economic growth in our counties.

Both Wellmont Health System and Mountain States Health Alliance have great assets and strengths. The merger between Mountain States Health Alliance and Wellmont Health System is an opportunity to change the way our local health care providers work together to tackle the healthcare challenges affecting our citizens in the region, thus making us a stronger community.

We see a positive future for our region and feel this comprehensive Health Care System will be an asset to retain and recruit businesses.

Our chamber cares deeply about our citizens and businesses in this region. We look forward to reaping the benefits this merger will bring to our region in the near future.

Sincerely,

A handwritten signature in cursive script that reads "Rita Surratt".

Rita Surratt, President/CEO
Dickenson County Chamber of Commerce

Mike McIntire
█ Pendleton Place
Kingsport, TN 27664
November 2, 2015

General Herbert Slatery III
Office of the Attorney General and Reporter
P.O. Box 20207
Nashville, Tennessee 37202=0207

Dear General Herbert Slatery III:

Re: Support for Merger of Wellmont and Mountain State Health Systems

I am a long-term resident of Kingsport and current serve our city as Vice Mayor. My wife and I have had the need to utilize the services provided by both health systems and have always been pleased with the service and the outcome. I want to express my strong support for the merger of these two systems and to briefly state why I think this merger is in the best interests of the citizens in our region.

My support is based on the following:

- I recognize that the complex financial strains on the health care system are placing extreme pressure on all health care systems and controlling costs are essential to survival. Consolidations and mergers are the most obvious ways to achieve cost savings. Merger of our two local systems provides these cost savings while maintaining control of our hospitals in the region and their focus on the unique health needs. This has the highest probability of assuring high quality medical services that our communities need.
- While consolidation will likely result in some job reductions in some areas, the two systems together should be able to offer better medical services overall and should also be able to have sufficient patient load to add some subspecialty care which now requires patients to travel to larger systems.
- The combined system should be able to bring better focus on major health issues in our region including substance abuse, mental health, heart disease, diabetes, and obesity and help assure that our next generation is healthier than the current one.
- Concerns about monopolistic issues are largely unfounded because prices are controlled by the Federal government (Medicare and Medicaid) and insurance companies. I can see no reason that a merged health system could charge higher prices for medical services.
- Because of a significantly larger health care system, the opportunity to expand medical related work with East Tennessee State University to tackle public health issues in our region is an added bonus to the merger and one that has not only improved health implications but also economic development opportunities in the medical field in the region.

I believe these factors strongly favor your approval of the merger of Mountain State Health Alliance and Wellmont Health System and I strongly recommend your approval.

Sincerely,

Mike McIntire

S. H. Anderson, Jr.
■ 161 Cherokee Street
KINGSPORT, TN 37660

HOME ADDRESS:
■ Leedy Road
Kingsport, TN 37664

TELEPHONES
Office — 423-247-6861
Fax — 423-247-6728
Lake — 423-538-6749
S.C. — 843-886-2929
Home — 423-
Cell — 423-

July 13, 2015

EMAIL
■

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Kingsport, Tenn.

Dear Mr. Dreyzehner:

I am very much for the merger of the Wellmont Health Care System with Mountain States Health Care System. This merger would give our two systems local control. With the East Tennessee State Medical School, we could greatly advance health care for the entire region. The merger would stop the duplication of so many services.

Ford

We operate three automobile dealerships here in Kingsport with over 100 employees. I have, along with my family, been involved with Wellmont since Holston Valley Hospital was built in Kingsport in 1932. My Father was a past President of the hospital and I was President of the Foundation and served on the hospital board for many years.

Chevrolet

Yours very truly,

S. H. Anderson, Jr.

S.H. Anderson, Jr.

Cadillac

CC: General Herbert Slatery III
Elliott Moore

Subaru

Volkswagen

LAW OFFICES
C. THOMAS DAVENPORT, JR.

P. O. Box 966
BRISTOL, TENNESSEE 37621-0966

July 28, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

General Herbert Slatery, II
Office of the Attorney General and Reporter
P.O. Box 20207
Nashville, TN 37202-0207

Re: Proposed Merger between Wellmont Health System and Mountain States Health Alliance

Commissioner Dreyzehner, and General Slatery,

In my practice I serve as General Counsel to a number of locally headquartered businesses with employee counts ranging from 50 or 60 to 500. While my clients are in disparate fields, one major common denominator is that they are all struggling with the costs and complexity of providing health insurance for their employees in the current healthcare climate.

When the first statement of the intended merger was published I was initially dubious as to any benefit that would accrue to my clients from this action. However, at this point having read and listened critically to the case made for the merger by the respective representatives of these hospital groups, I am convinced that their intent is good, that their hearts are in the right place, and that this merger may be the last, best hope for maintaining the high quality of healthcare in our region.

They are serious about:

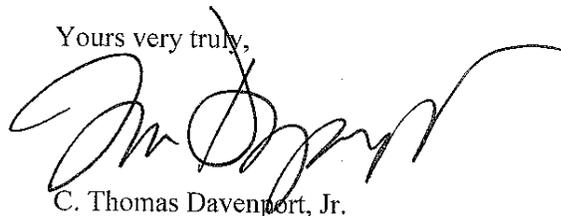
- marshalling resources and eliminating duplication;
- enhancing needed services like substance abuse, mental health and preventative care;
- expanding access; and
- maintaining high quality healthcare while keeping it affordable.

I support this proposed merger because I truly believe that together these organizations can impact in a major way the quality and affordability of healthcare delivered in our region.

As the process for approval of the Certificate of Public Advantage proceeds, I would urge you to consider the benefits this proposed merger would bring to our region and the bleak alternative for future generations if it can't go forward.

Thank you.

Yours very truly,



C. Thomas Davenport, Jr.

CTD/mjs

Charles E. Good
[REDACTED] Town & Country Dr.
Jonesborough, TN 37659

July 27, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

RE: Proposed merger
MSHA and Wellmont

Dear Commissioner Dreyzehner,

I have recently retired as President and CEO of Frontier Health. Frontier Health, as you know, is a regional community behavioral health service. Services by 1000 staff are provided in the eight northeast counties of Tennessee and the three western most counties of Virginia.

I am writing to support the proposed merger between Mountain States Health Alliance and Wellmont Health System. I believe Frontier Health is an excellent example of "regional services" under the direction of a local board of directors. I believe MSHA and Wellmont can and will deliver and effective, efficient, and locally led health service throughout our region.

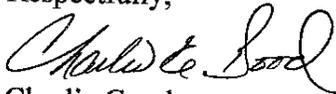
Both systems currently have excellent relationships with ETSU, our physician groups, Frontier Health, Mountain Home, and others throughout our communities. The systems proposed "local" solution is much preferable to other partnerships the systems have explored.

As I recall the COPA process was used by the local mental health agencies when Frontier Health was created in the late 1990s. Again, I believe the resulting benefit to our communities would mirror Frontier's success.

Affordable health care which is accessible and cost efficient is the predictable outcome if this merger is approved. The resulting benefit of regional high-quality health care is our goal.

Thank you for your consideration of this matter.

Respectfully,



Charlie Good

cc: General Herbert Slatery III
Office of the Attorney General and Reporter
PO Box 20207; Nashville, TN 37202-0207

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July 8, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Commissioner Dreyzehner,

I am a small business owner who has worked in this region all my life.

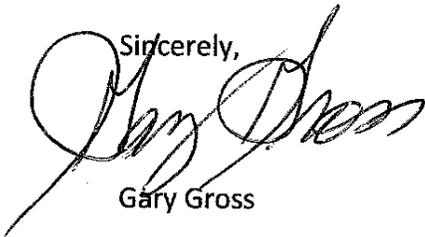
I have received care from both Mountain States Health Alliance and Wellmont Health, and I have the highest regard for their people and the services they provide. I endorse this merger because I believe healthcare is different than any other kind of business.

Competition has not resulted in lower prices and more services. Rather, it has caused an unnecessary duplication of services. I have a heart machine, you have a heart machine. I have a scanner, you have a scanner. Even though we're almost across the street from each other!

This merger gives us the opportunity to eliminate duplicate services and spend those precious resources on services we do not currently have in this region. I also believe that eliminating duplicate services will actually, in the long run, lower prices.

For these reasons, I urge you to approve the merger between the two organizations.

Sincerely,

A handwritten signature in black ink, appearing to read "Gary Gross", written over the word "Sincerely,".

Gary Gross

cc: General Herbert Slatery III



UBS Financial Services Inc.
214 E Mountcastle Drive
Suite 1-A
Johnson City, TN 37601
Tel. 423-928-7144
Fax 423-928-8738
Toll Free 800-729-4848

www.ubs.com

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

July 7th, 2015

Dear Commissioner Dreyzehner,

I am writing to you to voice my support for the impending merger of Mountain States Health Alliance and Wellmont Healthcare. I work in Johnson City for UBS Financial Services Inc. as a Vice President in their Wealth Management Division where between Johnson City and Kingsport we employ 10 advisors and 5 support staff and provide healthcare through Aetna to their families. Not only do we have a thriving business here in the Tri Cities but we also have made a huge investment in the state of Tennessee by moving a large part of our infrastructure system from New Jersey and New York to Nashville where our goal is to employ close to 1,000 people in the near future.

As an East Tennessee native having grown up in Johnson City in the 60's,70's and early 80's I was pleasantly surprised when I moved back in the late 90's from the likes of Cincinnati and Sacramento, California. Not only had Johnson City transformed from a retail perspective but we had also built a first class healthcare system to include a medical school, a top notch hospital system and first rate physicians.

With the rapid changes in healthcare and the costs and implications of ACA, I feel that it is imperative that the impending merger of MSHA and Wellmont be allowed to move forward. A strong healthcare system and educated employees are two of the main reasons people and businesses relocate and stay in areas. We are lucky to have both in the Tri Cities. We meet with clients all day long who are in support of the decision to merge both systems and keep those high paying jobs in our area free from outside pressures. A combined system will create synergies in patient care and research and thereby allow it to deliver even higher patient care at a reasonable cost.

So as a Financial Professional that is proud to live in East Tennessee, I would hope that you see the merits in the impending merger and the economic benefits to our community as well as the economic benefits to two of our largest employers. Thank you for your time and consideration of such an important decision for East Tennessee for many years to come.

Sincerely,

A handwritten signature in black ink, appearing to read "Brandon Linton".

Brandon Linton
Vice President – Wealth Management

July 8, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Commissioner Dreyzehner,

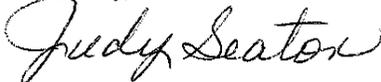
As a cancer survivor, I know how important it is to have access to quality healthcare and medical specialists close to home. I believe the merger of MSHA and Wellmont will provide us with new opportunities to recruit more specialists to Northeast Tennessee and Southwest Virginia.

Having lived here all my life, I have seen firsthand what happens to healthcare when two different systems try to compete. Particularly when it comes to specialists, I believe competition has actually made it harder to recruit and retain them in our region.

These specialists and subspecialists spend a lot of time and money to get trained. I understand they need a certain amount of patient volume for it to make economic sense for them to come to an area. Unfortunately, having two competing systems has meant we have been unable to get to the kind of volume these specialists need.

This merger will allow our physicians to work together to meet the needs of the people of our region. Please, I urge you, to approve this merger.

Sincerely,



Judy Seaton

cc: General Herbert Slatery III



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JOHN D. TICKLE
CHAIRMAN

July 28, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

Dear Commissioner Dreyzehner:

I am writing you today to offer my support in inaugurating the Mountain States Health Alliance with the Wellmont Health System, both of which operate in Northeast Tennessee and Southwest Virginia.

Our company, Strongwell, provides health benefits to several hundred families which live in Northeast Tennessee and Southwest Virginia. Our health cost, besides raw material and labor cost, is our largest expense. Strongwell's health cost continues to be uncontrollable and rising each year in the double digit range.

Strongwell competes in a world economy and we ship our products all over the world. Strongwell is recognized as the world leader and the largest in our industry.

Over the years I have been very much involved with our health system, serving on the Bristol Regional Medical Board for 5 ½ years with 4 ½ of that as the Chairman. During that time, we built a brand new hospital at a new location which opened in 1994.

Obviously, for our region to continue to grow, prosper and provide opportunities for all its citizens, we must provide outstanding health care at an affordable cost. Change in the healthcare industry has been going on forever, but even more so at the present time and it appears that it will continue into the future. For the two health systems to survive and provide our communities with outstanding healthcare at the lowest cost possible, it is imperative that approval for the merger of the Mountain State Health Alliance and the Wellmont Health System be granted.

I appreciate your support. If you have any questions, please do not hesitate to give me a call at any time.

Sincerely,

John D. Tickle

cc: Attorney General Herbert Slatery III



FRIENDSHIP ENTERPRISES

AUTOMOTIVE • INVESTMENTS • REAL ESTATE

July 24, 2015

Elliott Moore
Vice President, Community and Government Relations
Mountain States Health Alliance
32 6th Street
Bristol, TN 37620

Dear Elliott Moore,

Friendship Enterprises was formed in 1993 and is primarily a group of retail automobile dealerships, motorsports franchises and an automotive service center. We have 16 locations throughout Bristol, Kingsport, Johnson City, TN as well as Boone and Forest City NC. We have over 300 team members employed at all of our locations.

It is no secret that the biggest concern in business is the cost and availability of health care. The sweeping changes that have occurred for our nation's hospitals, physicians and patients makes it almost impossible for patients, families and businesses to get the care they need, when and where they need it and at a cost that they can afford.

The vast majority of our team members cannot even afford health care premiums and it is a terrible burden for our companies as well. There must be a stop to the rising costs. It is possible for health care costs to actually drive companies out of business, and this is purely a devastating reality for our national economy.

I do not need to continue to review the facts that you already know, but I do believe that merging Wellmont and Mountain States into a single health care system would greatly benefit our entire region and its employers and citizens. As a matter of fact, this model should be utilized with every health care system in every market in America. We simply cannot afford the redundancies that we have now in our market.

We have competing facilities in nearly every market in our region and it is confusing for the patients and certainly not efficient in operating costs. Nearly every other business or entity has been forced to merge to survive and to provide the level of service required. This is necessary in both the private and public sectors.

The governing body of the State of Tennessee can and will insure that we have competitive pricing and a high level of service upon a merger between the two hospitals. This is the best opportunity we will ever have in our market to grow and create a super regional medical complex that could not only serve our area, but offer specialties that could benefit a global audience. This would be absolutely great for economic development in our region.

As someone who sincerely cares about our region, not only based on quality of life, growth and economic development, I hope you will consider all of the benefits of this proposed merger between



FRIENDSHIP ENTERPRISES

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Wellmont and Mountain States. It is the right thing to do not only today, but to benefit the next generation.

Please call me if you need further opinions or an explanation of this letter. There are so many reasons to support this merger.

Good Luck and God Bless.

With Best Regards,

Mitch Walters
President/CEO
Friendship Enterprises



Norton Redevelopment & Housing Authority

200 SIXTH STREET, N.W.

NORTON, VIRGINIA 24273-1989

TEL. 276/679-0020 • FAX 276/679-0026 • TDD 276/679-0020

July 24, 2015

Dr. William Hazel Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

Dear Sir:

The Norton Redevelopment and Housing Authority (NRHA) was Chartered by the City of Norton in 1958 to demolish blighted property and housing in the City and to help provide low income families with affordable, sanitary, and safe housing. The Authority employs 10+ employees and is subsidized by the U. S. Department of Housing and Urban Development.

Serving as the Executive Director of NRHA for the past 26 years I have seen health care cost in this area sky rocket. The Authority does offer all full time employees health insurance coverage but in some cases our employees and the 390+ residents we serve, have to drive 50+ miles to receive specialized medical care and procedures that is not offered locally.

As a business that helps those in need, I believe that integrating Wellmont and Mountain States into a single health system would greatly benefit my residents and employees. As a combined organization, Wellmont and Mountain States can combine their resources to make our region healthier while controlling costs and making health care more affordable. The union would also give them an advantage at drawing specialized talent and in obtaining specialized trauma services to the area.

On behalf of the NRHA I support this merger, because it will definitely impact the way health care is delivered in our region. Our region is a region to be proud of and I care deeply for it. I hope you will consider all the benefits this proposed merger will bring to our region in the years to come.

Sincerely,

John E. Black
Executive Director

Cc: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, VA 23219

WASHINGTON COUNTY CHAMBER OF COMMERCE
1 GOVERNMENT CENTER PLACE, SUITE D
ABINGDON, VIRGINIA 24210

(276) 628-8141 FAX (276) 628-3984

WWW.WASHINGTONVACHAMBER.ORG

CHAMBER@BVU.NET

August 23, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Services
P.O. Box 1475
Richmond, VA 23218

The Washington County, Virginia Chamber of Commerce endorses the proposed merger between Mountain States Health Alliance and Wellmont Health System. We stand with our colleagues from the Chambers of Commerce of Kingsport, Bristol and Johnson City/Jonesborough/Washington County Tennessee, who have also expressed their support for the proposed merger.

Our Chamber of Commerce represents well over 550 businesses and individuals. Our members represent industries as varied as banking, education, manufacturing, medical, professional services, and retail. Our members' experience ranges from multi-generation families to start-up businesses.

Our community's health needs span the spectrum of routine maintenance, advanced diagnostic and surgical procedures, cancer treatment and prevention, mental illness, and substance abuse. Our health needs also require accessible and affordable options.

We believe integrating Mountain States Health Alliance and Wellmont Health System into one locally governed health system would provide our community and region great benefits. Our residents already face the challenge of limited health insurance options and this proposed new, integrated system will allow our residents the opportunities to use the physicians and facilities closest to them. Further, we believe the proposed new health system will allow increased resources to be spent on patient care as opposed to non-patient centered resources demanded by competition.

We believe the active supervision of Virginia's Health Commissioner, individually or in collaboration with Tennessee, will ensure that excellent, accessible healthcare will be provided by the proposed new health system to our community at a reasonable cost. We are hopeful the elimination of duplicative advertising, recruiting, and regulation compliance efforts will provide enhanced patient offerings in order to make our communities healthier.

The proposed merger between Mountain States Health Alliance and Wellmont Health System will allow our communities to offer and provide qualified local leadership. Our current relationships with both systems give us comfort knowing local people will be making decisions locally.

Again, the Washington County, Virginia Chamber of Commerce endorses the proposed merger between Mountain States Health Alliance and Wellmont Health System. We believe this proposed merger provides the best opportunity to advance healthcare in our community and region.



Jamea Blevins
2015 President

CC: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, VA 23219

July 15, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 24218

Dear Dr. Hazel:

I am Associate Director for the Southwest Virginia Higher Education Center, located in Abingdon, Virginia. The Center is 18 years old and serves as a campus for nine top-ranked colleges and universities within the Commonwealth. We provide opportunities for adults to obtain bachelor's, master's and doctoral degrees in over 96 fields of study. In addition, we offer a variety of professional development and non-degree programs for those who desire to improve their education while living at home and maintaining a full-time job. We have a staff of 45 individuals, both full- and part-time.

I support the proposed merger between Mountain States Health Alliance and Wellmont Health System because I believe that combining the two systems into a single system will truly impact the way healthcare is delivered in our region. We are geographically isolated from top-level healthcare systems, and economics and transportation often prevent local residents from traveling great distances to obtain state-of-the-art healthcare. The merger of these entities will eliminate a duplication of services that has neither added value nor improved healthcare for our region. The cost savings could be invested in efforts to make our region healthier while controlling costs and making healthcare more accessible to our residents.

A combined organization, coupled with the nation's top leadership in healthcare administration, could benefit our community by providing healthcare that is affordable, accessible, cost-efficient and most importantly, high-quality.

I hope you will thoughtfully consider all of the benefits this proposed merger will bring to our region, both today and in the generations to come.

Sincerely,



William D. Carmack
Associate Director

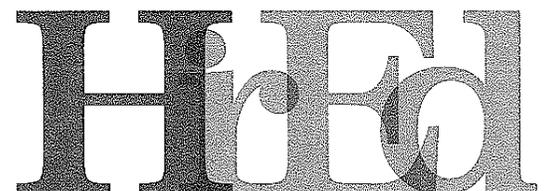
One Partnership Circle

PO Box 1987

Abingdon, VA 24212

(276) 619-4300

www.swcenter.edu



SOUTHWEST VIRGINIA
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A Partnership of Top-Ranked Universities with a Space for YOU.



Colgard Outdoor Sports

July 23, 2014

Dr. William Hazel, Jr.
Secretary of Health and Human Services
P. O. Box 1475
Richmond, VA 23218

Dear Secretary Hazel:

As an owner of a small business operating in Wise County, Virginia, I am pleased to offer a letter of support for the proposed merger between Wellmont Health System and Mountain States Health Alliance. The availability of comprehensive, affordable and accessible health care is a crucial factor in the economic health of our community and subsequently directly impacts the success of my business.

My brother and I are owners of Colgard Outdoor Sports located in Norton, Virginia. It is a small family-owned business, which we have transitioned from a mining supply sales operation established in 1978 to a sporting goods retail business as the mining business receded in our area. We employ a total of 9 individuals.

As a small employer, it has always been a struggle to provide health insurance benefits to our employees. The implementation of the Affordable Care Act did not ease that struggle; it merely changed the dynamics we have to deal with to provide health benefits. Both our employees that have health insurance benefits and those that do not need access to health services and sometimes those are simply not readily available.

I would describe the Wise County health care environment as consisting of "too much but too little" from a services perspective. With three hospitals in our county, there is emergency room access and acute care access, and should be described as excessive access. What we desperately have too little of would be mental health and substance abuse care, and preventive and specialty care. In the customers I serve on a daily basis, I see too often the effects of lack of education about health issues. We have significant heart disease and pulmonary issues that are often the result of the high incidence of smoking in our region. We are living in a reactive health care environment rather than one that is proactively working towards improving the health of the residents of the area.

600 Park Avenue NE, P. O. Box 757, Norton, VA 24273
276-679-1728

Secretary William Hazel, Jr.

July 23, 2015

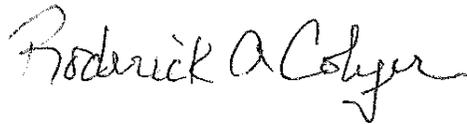
Page Two

I believe the joining of the two health systems would combine resources and make available levels of care that do not exist today. With the supervision of the state governments in Virginia and Tennessee, the fear that many have about lack of competition increasing cost can be overcome. Perhaps the focus that needs to be shifted to the needs for specific areas of care could occur if the systems become one system working to improve health overall.

I do believe a new health system would be a positive for the region. My business is a small business but I believe where healthcare is concerned "Bigger Is Better". The combined resources of these two quality systems could change the way health care is provided in our region and improve the health of our residents.

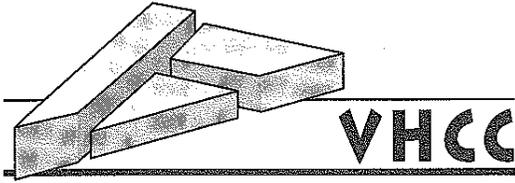
Thank you for the opportunity to share my thoughts on the proposed merger.

Sincerely,

A handwritten signature in cursive script that reads "Roderick A. Colyer".

Roderick A. Colyer
Colgard Outdoor Sports

cc: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, VA 23219



Virginia Highlands Community College
P.O. Box 828 • Abingdon, Virginia • 24212-0828
www.vhcc.edu • 276-739-2400

July 28, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Services
P.O. Box 1475
Richmond, VA 23218

Dear Dr. Hazel,

It is my pleasure to submit this letter in support of the proposed merger between Wellmont Health System and Mountain States Health Alliance.

As you know, Virginia's community colleges were created nearly a half century ago to address the unmet needs in the communities they serve. Virginia Highlands Community College takes that mission seriously and has established itself as a leading provider of quality, affordable higher education in Southwest Virginia. Working closely with business leaders and community organizations throughout the City of Bristol, Washington County and Smyth County, VHCC has made significant contributions to the economy and overall quality of life that we enjoy in our region.

A key to VHCC's success has always been its strong working relationship with the area's healthcare providers. In fact, the Virginia Appalachian Tricollege Nursing Program - a joint venture of VHCC, Mountain Empire Community College and Southwest Virginia Community College - is a leading provider of registered nurses in our region. Graduates of VHCC's Radiology, Paramedic, and Nurse Aide programs are also working throughout our region, providing quality care that makes Southwest Virginia a great place to live. VHCC remains committed to each of these programs and to maintaining cooperative partnerships with both Wellmont and Mountain States.

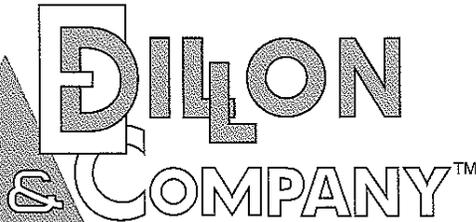
Just as VHCC has evaluated and adjusted its programs throughout the years to meet the changing needs of our community, the time may have come for our region's healthcare providers to evaluate the way our healthcare is delivered to our area. The idea behind the merger is to create a stronger healthcare system that is better equipped to meet the medical needs of our community.

Thank you for allowing me to share my thoughts on this important issue.

Sincerely,

Dr. Gene C. Couch, Jr.
President

cc: Attorney General Mark Herring



AN AMERICAN OWNED COMPANY SINCE 1868

P.O. BOX 160

Swords Creek, Virginia 24649

(276) 873-6816

Fax (276) 873-4208

August 11, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
P O Box 1475
Richmond, VA 23218

Dear Dr. Hazel:

E. Dillon & Company has been an employer in Russell County Virginia since 1962. We presently have 87 employees most of whom live in Russell and surrounding counties. The rural areas are very difficult to attract doctors and other health care providers.

I believe that underutilization of facilities and duplication of services has increased costs significantly. I support this proposed merger between Mountain States and Wellmont, and I think it would help contain health care cost for our employees and our company and provide more services than presently offered.

I believe that the state's active supervision will ensure the health and economic well-being of the region.

Quality health care and cost containment are vital for all employers in the region as a benefit to their employees. Rising health care costs for our company have exceeded annually the CPI which has made it more difficult each year to provide quality health coverage for our employees. I believe the merger will help control this cost in the future.

I support and endorse the merger of Mountain States Health Alliance and Wellmont Health System.

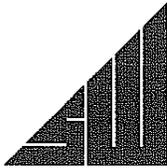
Sincerely,

A handwritten signature in black ink, appearing to read "Otey C. Dudley". The signature is fluid and cursive, written over a white background.

Otey C. Dudley
President Emeritus

CC: Attorney General Mark Herring

Since 1868



South-West Insurance Agency, Inc.

BIG STONE GAP OFFICE

220 Wood Avenue East | P.O. Drawer S
Big Stone Gap, Virginia 24219
(276) 523-4111
(276) 523-5208 Fax

NORTON OFFICE

132 11th Street, SW | P.O. Box 700
Norton, Virginia 24273
(276) 679-3511 | (800) 679-2551 | (276) 679-3537 Fax
Financial Services: (800) 523-3770

JONESVILLE OFFICE

241 Hill Street | P.O. Box 346
Jonesville, Virginia 24263
(276) 346-1932
(276) 346-1813 Fax

July 20 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
PO Box 1475
Richmond VA 23218

Dear Dr. Hazel,

South-West Insurance Agency, Inc., has offices in Norton, Big Stone Gap, Jonesville VA, and Johnson City TN and employs thirty individuals in Virginia and Tennessee. We sell property, casualty, life and health insurance to customers in both states. Our business was established in 1908.

We believe that the merger of Mountain States Health Alliance and Wellmont would improve the delivery of health insurance in both states. The combining of these two entities would help attract the best and brightest physicians. The merger would better coordinate care through electronic health records. It would also enhance needed services such as mental health care and substance abuse treatment.

In closing, the proposed merger is an opportunity to change the way health care is delivered in both Virginia and Tennessee.

Sincerely,

James K. Gilley
Senior Vice President
South-West Insurance Agency, Inc.



“Real People Answer Our Phones”
www.s-west.com



First Bank
& Trust Company

Member FDIC

P.O. Box 1000 • Abingdon, VA 24212 • 276-623-2323 • Fax: 276-628-5860

August 7, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

Dear Dr. Hazel,

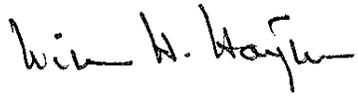
The purpose of my letter is to express my support for the proposed merger between Wellmont Health System and Mountain States Health Alliance. As the CEO of the 12th largest Virginia banking institution, headquartered in southwest Virginia, I am keenly aware of how both health organizations have impacted our employees and our business operation. Under the current scenario, both health organizations are in strong competition with each other to utilize their health service, often to the detriment of the patient. For example;

- 1) Both Wellmont and Mountain States have specialized health services unique to their own organization. Yet under the current scenario, a very limited amount of patient information is shared, thereby necessitating duplication of testing when most specialized services are time sensitive.
- 2) Statistical data clearly indicates that serious health issues unique to the rural nature of our region clearly exist and need to be addressed. By combining both health organizations and eliminating the duplication of administrative costs, attention and resources can be redirected to addressing cardiovascular disease, diabetes, addiction and untreated mental illness, so prevalent in southwest Virginia and east Tennessee.
- 3) Increased difficulty in recruiting and retaining qualified physicians to our region has negatively impacted the quality of health care for our employees. By combining both organizations, I believe we have a much stronger and broader health provider capable of recruiting and retaining the best and brightest physicians for the benefit of our community.

I further support this proposed merger because I believe that both organizations working together as one, can positively impact the quality and delivery of health care to southwest Virginia and east Tennessee. A local solution to our region's health care challenges is a much better scenario than partnering with a health entity located outside of our area, that are more concerned about pricing and increasing inpatient volume than about the ultimate health care of the people in our region.

As someone who cares deeply about our region and our future, I hope you will favorably consider the benefits that this merger will bring to the region.

With kindest regards,

A handwritten signature in black ink that reads "William H. Hayter". The signature is written in a cursive style with a large, prominent initial "W".

William H. Hayter
President & CEO

WHH/al

CC: Attorney General, Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, VA 23219



7/27/2015

Dr. William Hazel Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

Dear. Dr. Hazel,

I am writing on behalf of Farm Credit of the Virginias to express our support of a strong local medical care system that is affordable, accessible and cost efficient.

Farm Credit of the Virginias is a part of the Farm Credit System which was established in 1916 and is the largest single provider of agricultural credit in the United States. With more than 20 branches across our footprint, our employees are hometown people who are involved in their communities. Because of this, we know it is increasingly important for those in rural areas to have access to top quality, affordable health care and a local medical system that can tailor health care to address specific regional health issues.

The proposed merger between Wellmont Health System and Mountain States Health Alliance has the potential to have a positive impact on health care in this region by providing this important local medical care system.

Sincerely,

A handwritten signature in cursive script, appearing to read "David E. Lawrence".

David E. Lawrence
Chief Executive Officer
Farm Credit of the Virginias

Cc: Attorney General Mark Herring



LEONARD COMPANIES, Ltd.

DAVID A. LEONARD

President

1780 East Main Street, Box 10
276-889-4252
276-889-5655 Fax
leonardcompanies@bvunet.net
www.leonardcompanies.net

July 20, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Services
P. O. Box 1475
Richmond, VA 23218

Dr. Hazel:

We are writing this letter in support of the proposed Mountain States Health Alliance/Wellmont Health System corporate coalescence.

Leonard Companies has been doing business in Southwest Virginia for 61 years and we are primarily involved in commercial development and leasing of land, in agriculture, and investment activities. We have seen many changes to our community of southwestern Virginia and northeast Tennessee through these years, and believe today's biggest challenges facing the Russell County community are medical mental health, addiction to both illegal and prescription drugs, and obesity.

We believe that the merger of these two health systems will assist the five-state region by enhancing quality physician recruitment, provide a broader array of medical specialists available to the rural communities of our area, assist in the economic development of our area, and focus more of the two health systems' funds on medical care, alleviating competition and duplicated costs related to two separate entities.

As business people and citizens of the area that will be affected, we are in support of the merger because we believe that a united Mountain States and Wellmont will promote creativity, accelerate insight and technology, resulting in a positive impact on the way health care is delivered in our region.

Sincerely,

Three handwritten signatures in black ink. The first signature is for David A. Leonard, the second for David A. Leonard II, and the third for Sarah Leonard Wilson.

David A. Leonard
President

David A. Leonard II
Vice-President

Sarah Leonard Wilson
Vice-President

cc: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, VA 23219

Offices: The Shopping Center of Russell County, Lebanon, Virginia 24266

07/21/2015

Dr. William Hazel Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

Mr. Hazel:

My name is Michael McCool and I am a Vice President and Partner at Cary Street Partners in Abingdon, VA. Cary Street Partners is a Wealth Management and Investment Banking firm based in Richmond, VA. Our practice is based in Abingdon, VA. I am writing this letter in support of the merger between Wellmont Health System and Mountain States Health Alliance.

As you know, there has never been a time of greater change in health care, both locally in our region and across the United States. Sweeping changes have been and will continue to occur for our nation's hospitals, physicians, and patients, in many cases making it harder for patients, families and businesses to get the care they need, when and where they need it. In our region specifically, it is of great importance that we have a thriving, economically viable hospital system. Not only do our citizens need and deserve the best care, but also with the downturn in the energy markets, we need the jobs. In our rural area we need to expand investments into the quality and availability of care in all areas. I feel this merger will help achieve that aim. I feel the proposed merger is a response to the challenges that face our area.

As a combined organization, Wellmont and Mountain States believe they can work to unite the resources of both systems with one common purpose, to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access health care that can compete with any other area in the nation. I feel that by coming together these two units can reduce wasteful expense and invest in efforts to make sure our region has access to the best doctors and care, all while making it more affordable to the patient. In closing I support this proposed merger because I believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region. As a citizen who cares deeply about the present and future of our region, I hope you will consider all of the benefits this proposed merger will bring to our region not only immediately, but for generations to come. Thank you.

Sincerely,



Michael F. McCool
VP/Partner
Cary Street Partners, LLC

DAMASCUS

Corporation

**P.O. Box 610
Abingdon, VA 24212
(276) 676-2376**

7/23/15

Dr. William Hazel Jr.
Secretary of Health and Human Services
P.O. Box 1475
Richmond, VA 23218

Dear Secretary Hazel:

I am writing this letter as a small business owner living and working in Southwest, Virginia. My partners and I own 2 manufacturing operations in Abingdon, VA and a 3rd operation in Bluefield, VA. Our 60+ employee base comes primarily from Southwest, VA but as far away as Southern, WV and East, Tn. I am also writing this letter as a community board member of Johnston Memorial Hospital located in Abingdon, VA.

In the last decade we have seen tremendous change in the health care benefits we offer our employees. Much, but not all of the change has been positive. In our rural part of Virginia establishing top-notch, cost effective healthcare is often challenging on a personal level. On a corporate level we have had only provided one health network for employees for many years. My business partners and I are encouraged by the potential integration of Wellmont and Mountain States. For many years we have been concerned about the future ability of our rural health providers to remain financially relevant in today's rapidly changing healthcare environment. We believe the combined entity will allow for better recruitment of doctors and professionals to the region, stronger financial position that will allow utilization of the latest healthcare technology and equipment, and better access for our employee base.

As our Secretary of Health I am sure you are aware of the poor health statistics our region maintains. We believe a combined health system that maintains local headquarters in our region is the only way to keep a high level of care and address the challenges of our rural population. In the past years we have seen many industries leave our area draining the base of talented, well-educated individuals. We urge you and your agency to support the merger of Wellmont and Mountain States to keep our health system focused on the needs of our region and financially capable of continuing to meet the ever changing healthcare environment.

Sincerely



Eric Miller, CPA
President
Damascus Corporation
Platnick Crane and Steel
Wolf Hill Fabricators

Cc: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, VA 23219



STRONGWELL®

JOHN D. TICKLE
CHAIRMAN

July 29, 2015

Dr. William Hazel Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

Dear Dr. Hazel:

I am writing you today to offer my support in inaugurating the Mountain States Health Alliance with the Wellmont Health System, both of which operate in Northeast Tennessee and Southwest Virginia.

Our company, Strongwell, provides health benefits to several hundred families which live in Northeast Tennessee and Southwest Virginia. Our health cost, besides raw material and labor cost, is our largest expense. Strongwell's health cost continues to be uncontrollable and rising each year in the double digit range.

Strongwell competes in a world economy and we ship our products all over the world. Strongwell is recognized as the world leader and the largest in our industry.

Over the years I have been very much involved with our health system, serving on the Bristol Regional Medical Board for 5 ½ years with 4 ½ of that as the Chairman. During that time, we built a brand new hospital at a new location which opened in 1994.

Obviously, for our region to continue to grow, prosper and provide opportunities for all its citizens, we must provide outstanding health care at an affordable cost. Change in the healthcare industry has been going on forever, but even more so at the present time and it appears that it will continue into the future. For the two health systems to survive and provide our communities with outstanding healthcare at the lowest cost possible, it is imperative that approval for the merger of the Mountain State Health Alliance and the Wellmont Health System be granted.

I appreciate your support. If you have any questions, please do not hesitate to give me a call at any time.

Sincerely,

John D. Tickle

cc: Attorney General Mark Herring

Miners Exchange Bank

P.O. Box 1197

Coeburn, Va. 24230

276-395-2230

July 21, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, Va. 23218

CC: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, Va. 23219

Dear Gentlemen;

I am the President and Chief Executive Officer of Miners Exchange Bank. Our bank was chartered in 1982 and has been blessed to serve the citizens of Southwest Virginia and Northeast Tennessee for the past 33 years. Our corporate office is located in Coeburn, Va. and we have four other branches located in Wise County. We also have been operating in Northeast Tennessee for the past decade with a branch located in Gray, Tennessee. We are a full-service commercial bank that offers a full array of financial services to our clientele'. We currently employ approximately 70 individuals at our main office and branch locations.

I have closely watched the development of the healthcare industry in our region over the past thirty years. Wise County is considered to be a rural area, and our access to many of the specialty services offered by the larger hospitals has been somewhat limited. Competition between the larger hospitals to provide primary care to the people of this area has, in my opinion, somewhat thwarted the ability to attract the level of specialty services that are needed in this area. I am very excited about the potential merger between Wellmont and Mountain States into a single health system. We presently have three hospitals in Wise County which, in my opinion, is two too many. A single strong hospital in Wise County with access to expanded services would be a great asset to our people. I sincerely believe that a united effort would bring an increase of service lines and a greater focus on the healthcare needs of the people of our region.

Miners exchange Bank is one of the larger employees in Wise County, Virginia. Many of our employees must travel to the larger tertiary care hospitals in the Tri-Cities area whenever a more complex procedure is necessary. This creates hardships for families that have to make the travel to these hospitals. I realize that sometimes it is necessary to be transferred to a larger facility that possesses the level of expertise that is necessary to treat certain illnesses. However, with a unified focus on the health needs of our communities, I believe that the proper level of services could be provided that would ensure that the quality and accessibility of proper healthcare to the citizens of Northeast Tennessee and Southwest Virginia. I feel confident that, with the supervision and guidance

that would be provided by the state, the merger of these two hospitals would be a great blessing to our region.

In this time of sweeping change in the healthcare industry, a merger of these two hospitals would be beneficial in many ways. I believe that we would have:

- Expanded services
- The ability to attract an even greater pool of top physicians
- A greater pool of resources
- Less competition and more cooperation
- Greater focus on the particular healthcare needs of each locality in the service area
- More affordable healthcare

I whole-heartedly support this merger and feel that it is the best opportunity that we have ever had, or likely ever will have, to positively affect the way that healthcare is delivered in our region. I encourage you to be supportive of this effort as well.

If you have any questions, or would like to contact me directly, please feel free to do so. I may be reached at the number above, at my direct dial number (276-395-2711) or at my cell number (276-219-2101).

Sincerely,

A handwritten signature in cursive script that reads "Charles R. Ward".

Charles R. Ward
President



Dr. Weberling & Associates

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

1701 Euclid Avenue
Bristol, VA 24201
Phone: 276-466-4227
Fax: 276-466-3937

Dear Dr. Hazel,

Wise County Shopping Plaza
Wise, VA 24293
Phone 276-679-5612
Fax 276-679-0978

I have been a practicing Virginia optometrist, with offices in Bristol and Wise, Virginia, for the past thirty years. What I have witnessed over those years, especially in Wise, is a dire need for assessable health care. The union of Wellmont and Mountain State Hospitals would enable a synergy that the two hospitals by themselves do not provide.

Since arriving in Bristol in 1974, I have been involved, and served, on numerous non-profit boards, as well as many city committees. As Mayor of Bristol, Virginia, I became even more aware of the needs of our community and our citizens. The benefits of this merger to Bristol are clear; the reduction of expenses in health care is very necessary in this high unemployment and low salary area. These two institutions will be able to provide unified care, and funds used for duplication of services will be eliminated. Using the best of both systems, our citizens will get the best care at a reduced cost. The active supervision of both states will ensure our citizens the finest health care at an affordable price.

Northeast Tennessee and southwest Virginia are the most overlooked areas in both states. This union is needed to help attract jobs to our region.

Douglas R. Weberling, O.D.
Randy A. Birt, O.D.

Thank you for your time, and I hope you concur that this will be a benefit for our citizens.

Douglas R. Weberling, O.D.



CC General Herbert Slatery III

245 Birch Street
P.O. Box 725
Blountville, TN 37617
Phone (423) 323-8017
Fax (423) 323-1065

July 29, 2015

Commissioner John Dreyzehner

Department of Health

425 5th Avenue

Nashville, Tennessee 37243

Dear Commissioner Dreyzehner,

As a resident of the Bristol, Tennessee community I support and encourage in the investigation for the merger of the Wellmont and Mountain States Hospital. I believe we can find a better, more cost effect, and better health care by combining the best of both organizations.

As a business owner of JA Street and Associates for 30 years in the Bristol Community, I've also experienced the continuing health cost increase with less coverage to my employees and me. I'm hoping by combining services with the proposed merger, local health insurance cost will lower while care increases.

In Tennessee, the two organizations are pursuing approval under the COPA (Certificate of Public Advantage) statute. Under a COPA agreement, our region's employers, patients and payers will be protected. State supervision will ensure the future combined organization will continue to benefit the community by providing health care that is affordable, accessible, and cost-efficient and most importantly, high-quality.

I support this proposed merger because I believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region. This local solution to our region's health care challenges is a far better scenario than other partnerships Mountain States and Wellmont have considered outside our community – partnerships that have been shown elsewhere to lead to increased pricing without necessarily improving quality.

As someone who cares deeply about this region and our future, I hope you will thoughtfully consider all of the benefits this proposed merger will bring to our region, both today and in the generations to come.

Thank you,

Jim Street
Founder and CEO
JA Street and Associates

CC General Herbert Slatery III

Commissioner John Dreyzehner

Department of Health

425 5th Avenue North

Nashville, Tennessee 37243

Dear Commissioner Dreyzehner,

I am writing in support of the proposed merger between Mountain States Health Alliance (MSHA) and Wellmont Health System (Wellmont).

I recently retired as Vice President and General Manager for CenturyLink in Tennessee and Western North Carolina having worked in the industry for more than 32 years. As a major regional employer in the highly competitive communications industry, CenturyLink was challenged to provide a competitive health benefit plan for employees while keeping costs down as much as possible. With a significant number of our employees in a bargained for environment, the cost of health care was always a difficult discussion at the negotiating table. Clearly no one likes benefits to be reduced or costs to be increased. And in the bargained for environment, companies are locked in for several years to whatever they negotiate. I firmly believe merging MSHA and Wellmont will aid CenturyLink and others with common challenges. Having spent many years seeing how services might be duplicated between the systems or requests for donations to purchase much needed equipment were sought from both, I can tell you there has been great interest in how to control costs for years.

I am an elected member of the Johnson City Board of Education and I see directly the impact of our region's health issues on our students, employees and families. With the COPA expectations, I am confident with the focus of a combined organization we can begin to see a reduction in the incidence and severity of issues such as diabetes, addiction and cardiovascular disease. By having a laser focus on these health issues and collaborating with ETSU, true improvements can be realized.

I also serve on the board of Frontier Health and realize how much better we can serve our region's mental health needs with the combined system and partnership with Frontier. The ability to have access to services more readily available with the combined footprint of MSHA and Wellmont will be a wonderful outcome of the merger.

I also have been chair of our local chamber and our economic development organization. Having quality health care and controlling costs are huge goals for economic development and retaining and growing our existing businesses. And I am very excited by the opportunity to see money that has previously

been used for duplicated services be used in a more strategic way. Those monies can be used to either invest in research and solutions to our region's health issues or to purchase state of the art equipment one time versus for two systems.

Thank you in advance for your strong consideration and yes vote to approve the proposed merger. I truly feel our region will benefit by the combined organization.

Regards,

A handwritten signature in black ink, appearing to read "Lottie Fields Ryans". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Lottie Fields Ryans

Exhibit 11.1

Signed Copy of the Cooperative Agreement

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**Master Affiliation Agreement
and
Plan of Integration**

By and Between

**Wellmont Health System
and
Mountain States Health Alliance**

Dated as of February 15, 2016

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THIS MASTER AFFILIATION AGREEMENT AND PLAN OF INTEGRATION (this "Agreement") is dated as of February 15, 2016, by and between Wellmont Health System, a Tennessee nonprofit public benefit corporation with a principal place of business in Kingsport, Tennessee ("Wellmont") and Mountain States Health Alliance, a Tennessee nonprofit public benefit corporation with a principal place of business in Johnson City, Tennessee ("MSHA"). Wellmont and MSHA are each a "Party" and collectively the "Parties."

WHEREAS, Wellmont is a Tennessee public benefit corporation that serves as the parent entity of a health care delivery system which operates hospitals and health care facilities in Tennessee and Virginia; and

WHEREAS, MSHA is a Tennessee public benefit corporation that serves as the parent entity of a health care delivery system which operates hospitals and health care facilities in Tennessee and Virginia; and

WHEREAS, the Parties share a common and unifying charitable mission to provide high quality affordable health care and health care-related services; to expand access to health care services; and to promote and improve the health care status of the communities they serve; and

WHEREAS, Wellmont and MSHA have concluded that it is in the best interests of the residents of the respective communities that they merge their organizations by establishing a single parent company with a self-perpetuating board of directors that oversees all of the assets and operations of the previously separate Parties and all of their respective Affiliates (identified on Exhibit A hereto) on the terms and conditions set forth herein (the "Affiliation") for the purpose of enhancing the provision of high quality and cost effective health care that such a unified structure will facilitate, and for the purpose of positioning the combined systems to adapt effectively to the changes taking place locally and nationally in the health care delivery and financing systems; and

WHEREAS, Wellmont and MSHA reflected these understandings in a nonbinding Term Sheet executed on April 2, 2015; and

WHEREAS, the United States Supreme Court has determined that immunity (known as State action immunity) from federal anti-trust law is available to non-State actors when: (1) such non-State actors carry on their activity pursuant to a clearly articulated policy of the involved State(s) to displace competition with State regulation of the activity to be carried on by non-State actors; and (2) such regulation displacing competition is actively supervised by the involved State(s); and

WHEREAS, both the State of Tennessee and the Commonwealth of Virginia have set out by statute a clear policy permitting, in certain circumstances, the displacement of competition with regulation by the State in the merger of hospital and other healthcare organizations, and both the State of Tennessee and the Commonwealth of Virginia have articulated by statute its intent to actively oversee and supervise any such merger it approves; and

WHEREAS, it is the intent of Wellmont and MSHA to seek approval of their merger, as detailed in this Agreement, pursuant to the statutory schemes of the State of Tennessee and the

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Commonwealth of Virginia, which would permit the displacement of competition that otherwise exists between Wellmont and MSHA with regulation by both the State of Tennessee and the Commonwealth of Virginia, and it is further the parties' intent to submit the regulation of their merger to the active and continuing oversight of both the State of Tennessee and the Commonwealth of Virginia, all in order to secure State action immunity from federal anti-trust laws to the fullest extent permitted and required; and

WHEREAS, this Agreement is intended to memorialize the actions that each of Wellmont and MSHA must take in order to effect the Affiliation.

NOW, THEREFORE, in consideration of the representations, warranties, premises and the mutual covenants and agreements hereinafter contained, each of the parties hereto, intending to be legally bound, hereby agree as follows:

Article I Shared Vision and Guiding Principles.

Section 1.01 Shared Vision and Guiding Principles. Wellmont and MSHA hereby adopt the statements of Shared Vision and Guiding Principles attached as Exhibit B to this Agreement.

Section 1.02 Community Benefit.

(a) To carry out the Shared Vision and Guiding Principles, prior to the Effective Date Wellmont and MSHA shall have caused Newco, Inc. ("Parent Company") to be formed as a Tennessee nonprofit public benefit corporation to serve as the parent entity of the integrated health system created by the Wellmont and MSHA Affiliation.

(b) Parent Company will operate in accordance with the "community benefit standards" as they apply to Code Section 501(c)(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 (subject to certain exclusive physician service arrangements in connection with the provision of hospital-based specialty medical services approved by the governing body of Parent Company from time to time), (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.

(c) Parent Company will maintain the Parties' existing or equivalent community benefit and education programs and services in effect as of the Effective Time, subject to (i) changes approved by the Parent Company Board of Directors from time-to-time to reflect changing circumstances of the communities served by the Parent Company health system, and (ii) changes in law, policy or regulation as applicable.

(d) Parent Company will abide by policies and provisions of charity care that are no less generous than the policies of the Parties in effect as of the Effective Time, subject to changes in law, policy or regulation as applicable. Notwithstanding Parent

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Company's commitment to maintain and abide by charity care policies as generous as past policies, nothing herein guaranties any particular level of furnished charity care.

Article II System Structure.

Section 2.01 Actions and Amendments to Organize Parent Company.

(a) Parent Company Formation and Interim Governance. The articles of incorporation (the "Interim Parent Company Articles") and bylaws (the "Interim Parent Company Bylaws") of Parent Company are set forth in Exhibit C-1. The individuals whose names are listed as directors on Exhibit C-2 have been appointed by the Parties pursuant to the Parent Company Bylaws to serve as the directors of Parent Company until the Effective Time (the "Interim Directors"). The individuals whose names are listed as officers on Exhibit C-2 have been appointed by the Interim Directors pursuant to the Parent Company Bylaws to serve as the officers of Parent Company until the Effective Time (the "Interim Officers"). The Interim Directors and Interim Officers shall only take such actions as the Parties direct to complete the organization of Parent Company or to effect the transactions contemplated by this Agreement.

(b) Form 1023 Application. The Interim Directors and Interim Officers shall cause Parent Company to file an Application for Recognition of Exemption Under Code Section 501(c)(3) on Form 1023, and to take such actions and to execute, deliver and file such additional documents and information as may be reasonably necessary to obtain recognition of Parent Company as an organization exempt from taxation under the Code.

(c) Amended Parent Company Articles and Bylaws. On the Effective Date, the Interim Directors shall cause the Parent Company Articles to be amended and restated in the form set forth in Exhibit C-3 (the "Amended Parent Company Articles"), and the Parent Company Bylaws to be amended and restated in the form set forth in Exhibit C-4 (the "Amended Parent Company Bylaws").

(d) Board of Directors of Parent Company.

(i) On the Effective Date the Parties shall cause the individuals who are selected pursuant to the principles described in subsection (ii) below to be elected the directors of Parent Company as of the Effective Time in accordance with the Amended Parent Company Bylaws (the "Initial Directors"). The Initial Directors shall serve until the earlier of their resignation or removal or until their successors are duly elected and qualified in accordance with the Amended Parent Company Bylaws. Simultaneously with such election, the Interim Directors shall submit their resignations, which shall take effect at the Effective Time.

(ii) The directors of Parent Company shall be selected on the following principles. Wellmont and MSHA will each appoint six (6) members to serve on the Board of Directors of Parent Company. Wellmont and MSHA will jointly select two (2) members of the Board of Directors of Parent Company, who shall not be incumbent members of the board of directors of either Wellmont or

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MSHA. At least two of the persons appointed by each of Wellmont and MSHA shall be licensed physicians who are members of the medical staff of one or more hospitals affiliated with Parent Company; provided, however, that at no time will the number of Interested Persons on the Board of Directors who have voting rights be more than a minority of the total number of directors who have voting rights, and provided further that the total number of voting Directors shall not exceed seventeen (17). The Executive Chairman/President of Parent Company will serve on the Board of Directors of Parent Company as an ex-officio voting member. The initial Chief Executive Officer of Parent Company will serve on the Board of Directors of Parent Company as an ex-officio voting member for a term of two years after the Effective Time. At the conclusion of the initial Chief Executive Officer's two-year term, the Chief Executive Officer will rotate off the Board of Directors of the Parent Company and a replacement director shall be elected in accordance with the terms of the Amended Parent Company Bylaws. The President of East Tennessee State University will serve on the Amended Parent Company Board of Directors as an ex officio nonvoting member.

(e) Parent Company Board Committees. Subject to the rights of the Board pursuant to the Amended Parent Company Bylaws, the Parent Company Board of Directors will have the following standing committees: Executive; Finance; Audit and Compliance; Quality, Service and Safety; Executive Compensation; Community Benefit; Workforce; and Governance / Nominating. By the Effective Date, the Parties shall mutually determine the individuals who shall serve as the initial members of such committees and the Parent Company Board shall appoint such individuals to such committee memberships.

(f) Board Officers. Effective as of the Effective Time, the Board Officers of Parent Company shall consist of an Executive Chairman/President, a Vice Chairman/Lead Independent Director, a Chief Executive Officer, a Secretary and a Treasurer and shall be the individuals whose names are listed on Exhibit D-1, who shall serve in such office until the earlier of their resignation or removal or until their successors are duly elected or appointed and qualified in accordance with the Amended Parent Company Bylaws.

(g) Initial Management Team of Parent Company. The initial corporate officers of Parent Company (the "Initial Management Team") shall include the Executive Chairman/President, Chief Executive Officer, Chief Operating Officer and Chief Financial Officer. On the Effective Date, the Initial Directors shall cause the individuals whose names and corporate offices are listed on Exhibit D-1 to be elected to such offices. Simultaneously with such election, the Interim Officers shall submit their resignations, which shall take effect at the Effective Time.

(i) The position description for the Executive Chairman/President shall be substantially similar to the position description attached hereto as Exhibit D-2 and ensure the position is the most senior officer of Parent Company. The employment contract for the Executive Chairman/President in the form and containing the terms approved by the Joint Board Task Force, the MSHA Board

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and the Wellmont Board prior to the date of this Agreement will be executed by the Vice Chair/Lead Independent director on behalf of the Parent Company and by the Executive Chairman/President on the Effective Date. The Executive Chairman/President shall report to the Board of Parent Company which shall be responsible for conducting the evaluation of the Executive Chairman/President. In the event of separation between the Parent Company and the Executive Chairman/President prior to the second anniversary of the Effective Time, the position shall be filled as described in the Amended Parent Company Bylaws.

(ii) The position description for the Chief Executive Officer shall be substantially similar to the position description attached hereto as Exhibit D-3. The employment contract for the Chief Executive Officer in the form and containing the terms negotiated by the Executive Chairman/President and ratified by the Joint Board Task Force, the MSHA Board and the Wellmont Board prior to the date of this Agreement will be executed by the Executive Chairman/President on behalf of Parent Company and by the Chief Executive Officer on the Effective Date. The Chief Executive Officer shall report to the Executive Chairman/President, who shall be responsible for conducting the evaluation of the Chief Executive Officer.

(iii) The position descriptions for Chief Operating Officer and the Chief Financial Officer of the Parent Company, as developed by the Chief Executive Officer and approved by the Executive Chairman/President are attached hereto as Exhibit D-4.

(iv) On or soon after the Effective Date, the Executive Chairman/President will submit to the Parent Company Board for its approval, a proposed policy for delegating Board authority to corporate officers for managing and conducting the business of the Parent Company.

(h) Governance. The Parent Company shall be governed in accordance with the terms and practices set forth in the Amended Parent Company Bylaws as they are modified from time to time in accordance with the vote and process set forth therein.

Section 2.02 Membership Changes and Amendments to Governing Documents of MSHA and Wellmont.

(a) MSHA Membership Changes and Amendments. On the Effective Date, MSHA shall cause Parent Company to become its sole member by amending and restating its Articles of Incorporation effective as of the Effective Time in a form mutually agreed upon by the Parties (the "Amended MSHA Articles") and filing the Amended MSHA Articles with the Tennessee Secretary of State. On the Effective Date, MSHA shall cause its Bylaws to be amended and restated in a form mutually agreed upon by the Parties (the "Amended MSHA Bylaws") effective as of the Effective Time.

(b) Wellmont Membership Changes and Amendments. On the Effective Date, Wellmont shall cause Parent Company to become its sole member by amending and

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restating its Articles of Incorporation effective as of the Effective Time in a form mutually agreed upon by the Parties (the "Amended Wellmont Articles") and filing the Amended Wellmont Articles with the Tennessee Secretary of State. On the Effective Date, Wellmont shall cause its Bylaws to be amended and restated in a form mutually agreed upon by the Parties effective as of the Effective Time (the "Amended Wellmont Bylaws").

(c) MSHA and Wellmont Boards of Directors. On the Effective Date, the individuals selected by the Parties to be the initial directors of the Parent Company shall also be elected the directors of MSHA and Wellmont as of the Effective Time.

(d) Affiliate Membership Changes and Amendments. Prior to the Effective Date, the Parties will agree upon the modifications and amendments necessary to conform the Articles of Organization, Charters, Bylaws and Operating Agreements of all the Wellmont Subsidiaries and all the MSHA Subsidiaries to establish an initial equal role for Wellmont and MSHA in governance of each of them during the Integration Period and to make such other changes as the Parties agree are necessary or appropriate to establish and maintain the direct or indirect authority of the Newco Board of Directors over all such Subsidiaries.

Section 2.03 Effective Time. The Affiliation shall be effective as of the day and hour specified in Section 5.01 of this Agreement (the "Effective Time").

Section 2.04 Debts and Liabilities. At the Effective Time subject to the approval of the Parent Company Board of Directors, Parent Company shall guarantee such tax exempt and taxable bond indebtedness of Wellmont and MSHA as is necessary to result in an increase in the credit rating assigned by the three principal credit rating agencies to the aggregate outstanding bond indebtedness of all entities within the integrated healthcare system overseen by the Parent Company.

Section 2.05 Name of the Integrated Health System. Prior to the Effective Date, the Parties shall agree upon the name of the integrated health system created by the Wellmont and MSHA Affiliation, which name shall be reflected in the Charter and Bylaws of Parent Company that will become effective at the Effective Time.

Section 2.06 Indemnification, Exculpation and Insurance.

(a) The Amended Parent Company Bylaws, Amended MSHA Bylaws and Amended Wellmont Bylaws shall include the fullest indemnification and exculpation of the current and former directors, officers, and board committee members of each organization or who served at the request of any of them as a director or officer of another Person (the "Indemnified Parties") that is allowable under Tennessee law both with respect to service prior to the Effective Time and with respect to service following the Effective Time. Such Bylaws shall also provide for advancement of the costs of defense upon a finding by the Parent Company Board of Directors that the individual seeking advancement of such costs met the standard of conduct for indemnification and upon the individual providing a written undertaking to repay the advanced amounts in the

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event that the Parent Company Board of Directors ultimately determines that the individual was not entitled to indemnification under applicable Tennessee law.

(b) For a period of six years from and after the Effective Time, Parent Company shall either cause to be maintained in effect the current policies of directors' and officers' liability insurance and fiduciary liability insurance maintained by MSHA and Wellmont or provide substitute policies for the Company and its current and former directors and officers who are currently covered by the directors' and officers' and fiduciary liability insurance coverage currently maintained by the Company in either case, of not less than the existing coverage and having other terms not less favorable to the insured persons than the directors' and officers' liability insurance and fiduciary liability insurance coverage currently maintained by MSHA and Wellmont with respect to claims arising from facts or events that occurred on or before the Effective Time (with insurance carriers having at least an "A" rating by A.M. Best with respect to directors' and officers' liability insurance and fiduciary liability insurance), except that in no event shall Parent Company be required to pay with respect to such insurance policies in respect of any one policy year more than 250% of the aggregate annual premium most recently collectively paid by MSHA and Wellmont prior to the date of this Agreement (the "Maximum Amount"), and if Parent Company is unable to obtain the insurance required by this Section 2.06(b) it shall obtain as much comparable insurance as possible for the years within such six-year period for an annual premium equal to the Maximum Amount, in respect of each policy year within such period. In lieu of such insurance, prior to the Effective Date Parent Company may, at its option, purchase a "tail" directors' and officers' liability insurance policy and fiduciary liability insurance policy for the MSHA, Wellmont and their current and former directors and officers who are currently covered by the directors' and officers' and fiduciary liability insurance coverage currently maintained by MSHA and Wellmont, such tail to provide coverage in an amount not less than the existing coverage and to have other terms not less favorable to the insured persons than the directors' and officers' liability insurance and fiduciary liability insurance coverage currently maintained by MSHA and Wellmont with respect to claims arising from facts or events that occurred on or before the Effective Time; provided that in no event shall the cost of any such tail policy in respect of any one policy year exceed the Maximum Amount. In the event Parent Company purchases such tail coverage, Parent Company shall cease to have any obligations under the first sentence of this Section 2.06(b). Parent Company shall maintain such policies in full force and effect, and continue to honor the obligations thereunder.

(c) In the event that Parent Company, MSHA or Wellmont or any of their successors or assigns (i) consolidates with or merges into any other Person and is not the continuing or surviving corporation or entity of such consolidation or merger or (ii) transfers or conveys all or substantially all of its properties and assets to any Person, then, and in each such case, Parent Company, MSHA or Wellmont, as applicable, shall cause proper provision to be made so that the successors and assigns of Parent Company, MSHA or Wellmont, as applicable, assume the obligations set forth in this Section 2.06.

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(d) For a period of six years from and after the Effective Time, each of Parent Company, MSHA and Wellmont shall maintain in effect the provisions in its articles of incorporation and bylaws to the extent they provide for indemnification, advancement and reimbursement of expenses and exculpation of each Indemnified Party as applicable, with respect to facts or circumstances occurring at or prior to the Effective Time, on the same basis as set forth in its articles of incorporation and bylaws in effect as of the Effective Time, which provisions shall not be amended during such time except as required by applicable law or except to make changes permitted by applicable law that would enlarge the scope of the Indemnified Parties' indemnification rights thereunder.

(e) The provisions of this Section 2.06 shall survive the consummation of the transactions contemplated by this Agreement, (ii) are intended to be for the benefit of, and will be enforceable by, each of the Indemnified Parties, his or her heirs and his or her representatives, and (iii) are in addition to, and not in substitution for, any other rights to indemnification or contribution that any such Person may have by contract or otherwise.

Article III Representations and Warranties of Wellmont.

Subject to the limitations and qualifications set forth in this Agreement, Wellmont represents and warrants to MSHA the matters set forth below. Statements by Wellmont with respect to the Wellmont Subsidiaries (as defined in Section 3.03) refer to all of its subsidiaries.

Section 3.01 Effect of Agreement. Assuming the due execution and delivery of this Agreement by MSHA, this Agreement is a legal, valid, and binding obligation of Wellmont and is enforceable against it in accordance with its terms, except as enforceability may be restricted, limited or delayed by applicable bankruptcy or other laws affecting creditors' rights generally and except as enforceability may be subject to general principles of equity. Except as set forth in a confidential memorandum delivered by Wellmont legal counsel to MSHA legal counsel prior to the date of this Agreement (the "Wellmont Counsel Memorandum"), the execution, delivery and performance of this Agreement by Wellmont are within its corporate powers. Except as set forth in the Wellmont Counsel Memorandum, or otherwise expressly provided in this Agreement, the execution, delivery, and performance of this Agreement by Wellmont and the consummation of the transactions contemplated hereby by Wellmont will not: (i) require the consent, approval, or authorization of any person, corporation, partnership, joint venture, or other business association or public authority; (ii) violate any provisions of law applicable to Wellmont or to any of the Wellmont Subsidiaries now or immediately prior to the Effective Date; (iii) with or without the giving of notice or the passage of time, or both, conflict with or result in a breach or termination of any provision of, or constitute a material default under, or result in the creation of any lien, charge, or encumbrance upon any of the properties or assets of Wellmont or any of the Wellmont Subsidiaries pursuant to, any corporate charter, bylaw, indenture, note, bond, pledge, mortgage, deed of trust, lease, license, contract, agreement, commitment, or other instrument or obligation, or any order, judgment, award, decree, statute, ordinance, or regulation, to which Wellmont or any of the Wellmont Subsidiaries is a party or by which Wellmont or any of the Wellmont Subsidiaries or any of their respective material assets or properties may be bound; or (iv) result in the acceleration of any indebtedness of Wellmont or any of the Wellmont Subsidiaries or increase the rate of interest payable by Wellmont or by any of the Wellmont Subsidiaries with respect to any indebtedness.

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Section 3.02 Organization; Power; Good Standing. Wellmont is a nonprofit corporation duly organized and validly existing under the laws of the State of Tennessee and has all requisite corporate power and authority to own, lease, and operate its properties, to carry on its business as now being conducted, and to enter into this Agreement and perform its obligations hereunder. True and correct copies of the Articles of Incorporation and Bylaws or Articles of Organization and Operating Agreements, as applicable, of each of Wellmont and the Wellmont Subsidiaries have been provided to MSHA. Neither the character of the properties owned or leased by Wellmont nor the nature of the business conducted by Wellmont requires the licensing or qualification of Wellmont as a corporation in any jurisdiction other than the State of Tennessee and the Commonwealth of Virginia.

Section 3.03 Wellmont Subsidiaries. Other than as disclosed in the Wellmont Counsel Memorandum, Wellmont does not directly or indirectly own any interest in any other corporation, partnership, joint venture, or other business association or entity, foreign or domestic. Such corporations, partnerships, joint ventures, or other business entities set forth in the Wellmont Counsel Memorandum of which it owns, directly or indirectly, more than fifty percent (50%) of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests) are referred to herein each as a "Wellmont Subsidiary" or collectively as the "Wellmont Subsidiaries." Set forth in the Wellmont Counsel Memorandum is an indication of the interest owned by Wellmont in each corporation, partnership, joint venture, or other business association or entity in which Wellmont owns any of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests). With respect to the Wellmont Subsidiaries, Wellmont represents and warrants the following:

(a) Each Wellmont Subsidiary that is a corporation is a corporation duly organized, validly existing, and in good standing under the laws of the jurisdiction of its incorporation. Each Wellmont Subsidiary that is a limited liability company is duly formed and validly existing under the laws of its jurisdiction of formation.

(b) Each Wellmont Subsidiary has the corporate power, or power under the Tennessee Limited Liability Company Act, the Virginia Limited Liability Company Act, or the Companies Law of the Cayman Islands, as the case may be, and its internal governing documents, as applicable, and authority to own, lease, and operate its properties and to carry on its business as presently conducted or presently proposed to be conducted.

(c) Each Wellmont Subsidiary is duly qualified to do business as a foreign corporation or limited liability company, as the case may be, and is in good standing, in each jurisdiction where the character of its properties owned or held under lease or the nature of its activities makes such qualification necessary.

(d) All of the outstanding shares of capital stock or other equity interests of the Wellmont Subsidiaries that are for-profit entities and all membership interests in non-profit entities are, in each case, validly issued, fully paid, and non-assessable.

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(e) All of the outstanding shares of capital stock of, or other ownership or membership interests in, each of the Wellmont Subsidiaries owned by Wellmont or by any of the Wellmont Subsidiaries are so owned free and clear of any liens, claims, charges, or encumbrances. There are no outstanding options, warrants, subscriptions, calls, rights, convertible securities, or other agreements or commitments obligating Wellmont or any of the Wellmont Subsidiaries to issue, transfer, or sell any securities of any Wellmont Subsidiary.

(f) There are no voting trusts, standstill, shareholder, partnership, operating, or other agreements or understandings to which Wellmont or a Wellmont Subsidiary is a party or is bound with respect to the voting of the capital stock or other ownership interest in any Wellmont Subsidiary.

Section 3.04 Financial Statements. Wellmont has delivered to MSHA, or will deliver to MSHA within five (5) days of becoming available, copies of (i) its audited consolidated financial statements for the years ended June 30, 2013 and June 30, 2014 and for each year thereafter through the Effective Date, as presented by the auditors regularly retained by Wellmont, together with any management letters issued by the auditors in connection with the foregoing and a written copy of all material presented to the Audit Committee of the Wellmont Board, and (ii) its unaudited interim consolidated financial reports for the year ended June 30, 2015 and for the for the two months ended August 31, 2015 and each month thereafter through the Effective Date. Such financial statements, together with the notes thereto, and such interim unaudited consolidated financial reports (collectively, the "Financial Statements"), are in accordance with the books and records of Wellmont; and except as otherwise set forth in the Wellmont Counsel Memorandum, fairly present in all material respects the financial position of Wellmont and the results of operations and cash flows for the years then ended or other periods indicated in conformity with generally accepted accounting principles ("GAAP") applied on a consistent basis throughout such periods, except to the extent that the interim unaudited consolidated financial reports contain no notes and are subject to year-end audit adjustments that are not, individually or in the aggregate, material and, except as noted in such statements, consistent with prior periods. The most recent balance sheet of Wellmont included in its Financial Statements is referred to herein as its "Balance Sheet." The "Balance Sheet Date" shall mean June 30, 2015.

Section 3.05 Absence of Undisclosed Liabilities. Other than with respect to matters addressed in Section 3.17, representations concerning which are contained only in Section 3.17, except as expressly disclosed or reserved against on the Balance Sheet or as specifically set forth in the Wellmont Counsel Memorandum, neither Wellmont nor any of the Wellmont Subsidiaries had, as of the Balance Sheet Date, any debts, liabilities, or obligations of any nature, whether accrued, absolute, contingent, or otherwise, and whether due or to become due, including, but not limited to, guarantees, liabilities, or obligations on account of Taxes (as defined in Section 3.08 below), other governmental charges, duties, penalties, interest, fines, or obligations to refund, required in accordance with GAAP to be disclosed on the Balance Sheet.

Section 3.06 Absence of Certain Changes. Except as set forth in the Wellmont Counsel Memorandum, as disclosed to MSHA prior to the date hereof through the process established in Section 5.04 for sharing Competitive Sensitive Information (the "Black Box Process"), or as

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permitted by this Agreement, since the Balance Sheet Date, Wellmont has suffered no Material Adverse Effect.

Section 3.07 Contracts. The Wellmont Counsel Memorandum contains a list of all contracts, agreements, commitments, and arrangements to which Wellmont or any of the Wellmont Subsidiaries are a party or by which any of their assets are bound or affected that: (i) involve the expenditure by Wellmont or any of the Wellmont Subsidiaries thereto of more than \$250,000 on an annual basis; or (ii) to the Knowledge of Wellmont, are with, or relate to, any physician; or (iii) to the Knowledge of Wellmont, are with, or relate to, any Disqualified Person within the meaning of Section 4958(f) of the Internal Revenue Code of 1986, as amended (the "Code")(each a "Wellmont Material Contract"). "Knowledge of Wellmont" when used in this Agreement means the actual knowledge of the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, or the General Counsel of Wellmont. For avoidance of doubt, the term Disqualified Person shall include persons (including any physicians or their family members) who are or were, at any time during the five-year period ending on the Effective Date: (a) voting members of the subject organization's governing body; (b) presidents, chief executive officers, chief operating officers, and other persons with ultimate responsibility for implementing the decisions of the governing body or for supervising the management, administration, or operation of the organization, regardless of title; (c) treasurers and chief financial officers and other persons with ultimate responsibility for managing the finances of the organization, regardless of title; (d) in a position to exercise substantial influence over the subject organization's affairs, including (i) persons who have or share authority to control or determine a substantial portion of the organization's capital expenditures, operating budget, or compensation for employees, (ii) persons who manage a discrete segment or activity of the organization that represents a substantial portion of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole, (iii) persons who are substantial contributors to the organization (within the meaning of Code Section 507(d)(2)(A)), taking into account only contributions received by the organization during its current taxable year and the four preceding taxable years; and (iv) persons whose compensation is primarily based on revenues derived from activities of the organization, or of a particular department or function of the organization, that the person controls; (e) family members of persons meeting a definition in (a)-(d) above (for this purpose, "family members" are limited to the following: spouse, brothers or sisters (by whole or half-blood), spouses of brothers or sisters (by whole or half-blood), ancestors, children, grandchildren, great grandchildren, and spouses of children, grandchildren, and great grandchildren); and (f)(i) a corporation in which persons described in (a)-(e) own more than 35 percent of the combined voting power; (ii) a partnership in which persons described in (a)-(e) own more than 35 percent of the profits interests; or (iii) a trust or estate in which persons described in (a)-(e) own more than 35 percent of the beneficial interests. Other than as set forth in the Wellmont Counsel Memorandum, neither Wellmont nor any of the Wellmont Subsidiaries has entered into any Wellmont Material Contract. All Wellmont Material Contracts are valid and enforceable in accordance with their terms, except as such enforceability may be limited by bankruptcy, insolvency, receivership, and other laws affecting creditors' rights generally and general principles of equity. Wellmont and the Wellmont Subsidiaries and, to the Knowledge of Wellmont, all other parties to each of the foregoing arrangements, have performed in all material respects their respective obligations to date required to be performed under each Wellmont Material Contract. Except as disclosed in the Wellmont Counsel Memorandum, neither

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Wellmont nor any of the Wellmont Subsidiaries nor, to the Knowledge of Wellmont, any other party, is in default or in arrears in any material respect under the terms of any of the foregoing arrangements, and no condition exists or event has occurred that, with the giving of notice or the lapse of time or both, would constitute a material default under any of them. Except as noted to the contrary in the Wellmont Counsel Memorandum, none of the rights of Wellmont or any of the Wellmont Subsidiaries under any of such agreements is subject to termination or modification as the result of the transactions contemplated by this Agreement. Correct and complete copies of all written contracts referenced in the Wellmont Counsel Memorandum and true and complete summaries of any oral contracts or other arrangements therein referenced have been made available to MSHA.

Section 3.08 Tax Matters. For purposes of this Section:

(a) "Tax" or "Taxes" means any federal, state, or local income (including unrelated business income), gross receipts, license, payroll, employment, excise, severance, stamp, occupation, premium, environmental (including taxes under Code Section 59A), capital stock, franchise, profits, withholding, social security (or similar), unemployment, disability, real property, personal property, sales, use, transfer, registration, estimated, or other tax of any kind whatsoever, including any interest, penalty, or addition thereto, whether disputed or not.

(b) "Tax Return" means any return, declaration, report, claim for refund, or information return or statement relating to Taxes, including any schedule or attachment thereto, and including any amendment thereof.

(c) Wellmont and the Wellmont Subsidiaries will have timely filed all federal income tax returns and all other material Tax Returns that they are required to file on or before the Effective Date. All such Tax Returns are correct and complete in all material respects. All material Taxes due and owing by Wellmont and the Wellmont Subsidiaries have been paid or reserved against in such party's Financial Statements. Neither Wellmont nor the Wellmont Subsidiaries currently are the beneficiary of any extension of time within which to file any Tax Return except as set forth in the Wellmont Counsel Memorandum. No written claim has been made within the last 3 years by an authority in a jurisdiction where Wellmont or the Wellmont Subsidiaries do not file Tax Returns that they are or may be subject to taxation by that jurisdiction.

(d) Wellmont and the Wellmont Subsidiaries have withheld and paid all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, stockholder, or other third party.

(e) There is no material dispute or claim concerning any Tax liability of Wellmont or any entity listed in Schedule 3.03 of the Wellmont Counsel Memorandum either: (i) claimed or raised by any governmental authority in writing and brought to the attention of any of the directors, officers, or employees responsible for Tax matters of Wellmont and the Wellmont Subsidiaries; or (ii) as to which any of the directors, officers, or employees responsible for Tax matters of Wellmont and the Wellmont Subsidiaries has knowledge based upon personal contact with any agent of such governmental

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authority. Except as disclosed in the Wellmont Counsel Memorandum, neither Wellmont nor any of the Wellmont Subsidiaries is the subject of an audit or examination by any governmental authority with respect to its potential liability for Taxes.

(f) Neither Wellmont nor the Wellmont Subsidiaries has waived any statute of limitations in respect of Taxes or agreed to any extension of time with respect to a Tax assessment or deficiency.

(g) Other than as disclosed in the Wellmont Counsel Memorandum, Wellmont and each of the Wellmont Subsidiaries is not a party to and have no continuing obligations under any Tax allocation or sharing agreement. Wellmont and each of the Wellmont Subsidiaries: (i) have not been members of an affiliated group (within the meaning of Code § 1504(a)) filing a consolidated federal income Tax Return, and (ii) have no liability for the Taxes of any entity or unincorporated organization (other than Wellmont and the Wellmont Subsidiaries) under Treasury Regulation § 1.1502-6 (or any similar provision of state, local, or foreign law), as a transferee or successor, by contract or otherwise.

(h) The unpaid Taxes of Wellmont and the Wellmont Subsidiaries: (i) did not, as of the Balance Sheet Date, exceed by any material amount the reserve for Tax liability (excluding any reserve for deferred Taxes established to reflect timing differences between book and Tax income) set forth on the face of the Balance Sheet as of the Balance Sheet Date (rather than in any notes thereto), and (ii) will not exceed by any material amount that reserve as adjusted for the passage of time through the Effective Date in accordance with the past custom and practice of Wellmont and the Wellmont Subsidiaries in filing its Tax Returns.

(i) Wellmont and the Wellmont Subsidiaries that claim to be tax-exempt under Code Section 501(c)(3) (for purposes of this Section 3.08.(i) only, the "Tax-Exempt Wellmont Subsidiaries") have, by reason of letters from the Internal Revenue Service, been determined by the Internal Revenue Service to be exempt from federal income taxation under Code Section 501(c)(3) and not to be private foundations under Code Section 509(a). Wellmont has no Knowledge of any facts or circumstances which would cause the Internal Revenue Service to revoke such determinations or to conclude that Wellmont or the Tax Exempt Wellmont Subsidiaries are "private foundations" as defined in Code Section 509(a). Wellmont has no Knowledge of any facts or circumstances indicating that any part of the net earnings of Wellmont or the Tax Exempt Wellmont Subsidiaries inures to the benefit of any private member or individual, within the meaning of Code Section 501(c)(3). Neither Wellmont nor the Tax-Exempt Wellmont Subsidiaries has taken or permitted any action that would subject Wellmont or any Tax-Exempt Wellmont Subsidiary to penalty excise taxes (also known as "Intermediate Sanctions") under the Taxpayer Bill of Rights 2 (Pub. L. No. 104-168, 110 Stat. 1452).

Section 3.09 Title to Properties. Except as set forth in the Wellmont Counsel Memorandum, Wellmont and the Wellmont Subsidiaries have good and marketable title to, or a valid leasehold interest in, all their real and personal property and other assets, tangible and intangible, subject to no security interest, pledge, lien, encumbrance, claim, charge, or other

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restrictions other than; (a) those incurred in the ordinary course of Wellmont's business, including those related to debt obligations of Wellmont reflected in the Financial Statements, and (b) "Permitted Liens." For the purposes of this Agreement, "Permitted Liens" shall mean: (i) easements that do not materially adversely affect the full use and enjoyment of the Owned Real Property (as defined in Section 3.13 below) or Leased Real Property (as defined in Section 3.13 below) for the purposes for which it is currently used or materially detract from its value; (ii) imperfections of title and encumbrances, if any, individually or in the aggregate, which are not material, do not materially detract from the marketability or value of the properties subject thereto, and do not materially impair the operations of the owner thereto; (iii) liens for taxes not yet due and payable; and (iv) liens incurred in the ordinary course of business in connection with governmental insurance or benefits or to secure performance of leases and contracts (other than for borrowed money) which liens do not, individually or in the aggregate, materially and adversely affect the full use and enjoyment of the properties to which they are attached.

Section 3.10 Litigation. The Wellmont Counsel Memorandum contains a true and correct listing of all material litigation, administrative, arbitration, and other proceedings in which Wellmont or any of the Wellmont Subsidiaries is currently involved, and all court decrees or administrative orders to which Wellmont or any of the Wellmont Subsidiaries is subject. Other than as shown in the Wellmont Counsel Memorandum or disclosed to MSHA prior to the date hereof through the Black Box Process, there is no claim, action, suit, proceeding (legal, administrative, or otherwise), investigation, or inquiry (by an administrative agency, governmental body, or otherwise) pending as to which Wellmont has been served process or otherwise notified or, to the Knowledge of Wellmont, threatened in writing by or against, Wellmont or any of the Wellmont Subsidiaries, their properties or assets, or the transactions contemplated hereby, at law or in equity, or before or by any federal, state, municipal, or other governmental department, commission, board, agency, instrumentality, or authority, domestic or foreign, the result of which could reasonably be expected to have a Material Adverse Effect.

Section 3.11 Compliance with Law. Other than with respect to matters addressed in Section 3.17, representations concerning which are contained only in Section 3.17, and except as set forth in the Wellmont Counsel Memorandum or disclosed to MSHA prior to the date hereof through the Black Box Process, Wellmont and the Wellmont Subsidiaries are in compliance in all material respects with all applicable laws, rules, regulations, and licensing requirements of all federal, state, local, and foreign authorities.

Section 3.12 Permits and Licenses. Wellmont and the Wellmont Subsidiaries maintain in full force and effect all permits, licenses, orders, and approvals necessary for them to carry on their respective businesses as presently conducted other than such permits, licenses, orders, and approvals the absence of which, individually or in the aggregate, has not had and would not reasonably be expected to have a Material Adverse Effect. All fees and charges incident to such permits, licenses, orders, and approvals have been fully paid and are current, and no suspension or cancellation of any such permit, license, order, or approval has been threatened or could result by reason of the transactions contemplated by this Agreement. Neither Wellmont nor any of the Wellmont Subsidiaries have received any notice from any Governmental Entity that any Wellmont Facilities are not in substantial compliance with all of the terms, conditions, and provisions of such permits, consents, approvals, or licenses. Wellmont heretofore has made

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available to MSHA correct and complete copies of all such permits, consents, orders, approvals, and licenses. A list of all permits, licenses, orders, and approvals held by Wellmont and the Wellmont Subsidiaries is set forth in the Wellmont Counsel Memorandum.

Section 3.13 Real Property.

(a) Owned. With respect to all real property reflected on the respective balance sheets of Wellmont and the Wellmont Subsidiaries (collectively, the "Owned Real Property"), except as set forth in the Wellmont Counsel Memorandum, (i) neither Wellmont nor any Wellmont Subsidiary has agreed, orally or in writing, or is otherwise obligated, to sell, lease, encumber, or otherwise dispose of any of the Owned Real Property; and (ii) other than tenant leases entered into in the ordinary course of operations, no person or entity has any leasehold interest in, and no person or entity (other than Wellmont or a Wellmont Subsidiary) has any right to use, operate, or occupy any of the Owned Real Property.

(b) Leased. With respect to all real property leased by Wellmont or the Wellmont Subsidiaries which (i) involve the expenditure by Wellmont or any of the Wellmont Subsidiaries of more than \$250,000 on an annual basis or (ii) to the Knowledge of Wellmont, are with, or relate to, any physician (collectively, the "Leased Real Property") and all leases relating thereto (collectively, the "Real Property Leases"), Wellmont represents and warrants that except as set forth in Wellmont Counsel Memorandum, (i) each Real Property Lease is valid, binding, and enforceable in accordance with its terms and is in full force and effect, and there are no offsets or defenses by either landlord or tenant thereunder; (ii) there are no existing breaches of or defaults under, and no events or circumstances have occurred which, with or without notice or lapse of time, or both, would constitute a breach of or a default under, any of the Real Property Leases; and (iii) consummation of the Affiliation will not constitute or result in a breach or default under any Real Property Lease. A list of all Real Property Leases of Wellmont and the Wellmont Subsidiaries is set forth in the Wellmont Counsel Memorandum.

(c) Improvements. The Owned Real Property and the Leased Real Property are zoned for the various purposes for which the buildings and other improvements located thereon (the "Improvements") are presently being used, except in the case of permitted nonconforming uses. All of the Improvements and all uses thereof are in material compliance with all applicable zoning and land use laws, ordinances, and regulations. No part of any of the Improvements encroach on any real property not included in the Owned Real Property or the Leased Real Property in such a way that the remediation of the encroachment would prevent Wellmont's continued use of the Improvements to such an extent as to materially affect such Party's operations.

Section 3.14 Environmental Protection. Except as set forth in the Wellmont Counsel Memorandum, and to the Knowledge of Wellmont:

(a) Wellmont and the Wellmont Subsidiaries are in compliance in all material respects with federal, state, and local environmental laws and regulations that are

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applicable to Wellmont and the Wellmont Subsidiaries and to their respective business operations.

(b) No substances that are defined and regulated by applicable environmental laws and regulations as toxic substances, hazardous wastes, hazardous materials, or hazardous substances (including, without limitation, asbestos, and petroleum and its constituents) (collectively, "Hazardous Substances") have been stored, disposed of, or released in or on the Owned Real Property, the Leased Real Property, the Improvements, or other assets of Wellmont or the Wellmont Subsidiaries in any manner, locations, or amounts that are outside of the ordinary course of business for Wellmont and the Wellmont Subsidiaries, or that violate applicable environmental laws and regulations, or that create material response duties or material cleanup liability for Wellmont or any of the Wellmont Subsidiaries.

(c) Wellmont and the Wellmont Subsidiaries have received no written notices regarding any potential claims, costs, or liabilities being asserted or to be asserted against Wellmont or the Wellmont Subsidiaries arising from or related to the off-site transport or disposal of Hazardous Substances from the owned Real Property or the Lease Real Property.

Section 3.15 Insurance. Other than as set forth in the Wellmont Counsel Memorandum, Wellmont and the Wellmont Subsidiaries maintain in force valid, binding, and enforceable insurance policies providing adequate coverage for all risks normally insured against by others in the businesses of Wellmont and the Wellmont Subsidiaries. All premiums due thereon have been paid and will be paid through the Effective Date. Neither Wellmont nor any of the Wellmont Subsidiaries has been refused any insurance by any insurance carrier during the past two years. All insurance policies maintained by Wellmont and by the Wellmont Subsidiaries are described in the Wellmont Counsel Memorandum.

Section 3.16 Employees; Benefit Plans.

(a) Except as set forth in the Wellmont Counsel Memorandum, there are no Plans, as defined below, contributed to, maintained, or sponsored by Wellmont or any of the Wellmont Subsidiaries, to which Wellmont or any Wellmont Subsidiary is obligated to contribute or with respect to which it has any current or future obligation or liability, including all Plans contributed to, maintained, or sponsored in the past six years by any current or former member of the controlled group of companies, within the meaning of Sections 414(b), 414(c), 414(m), and 414(o) of the Code, of which Wellmont or any of the Wellmont Subsidiaries is a member. For the purposes of this Agreement, the term "Plans" shall mean: (i) employee benefit plans as defined in Section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), whether or not funded and whether or not terminated; (ii) employment agreements (exclusive of physician contracts); and (iii) personnel policies or fringe benefit plans, policies, programs, and arrangements, whether or not subject to ERISA, whether or not funded, whether written or unwritten, and whether or not terminated, including without limitation, stock bonus, deferred compensation, pension, severance, bonus, vacation, sabbatical, travel, incentive, and health, disability, and welfare plans.

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(b) Except as set forth in the Wellmont Counsel Memorandum, none of the Plans obligates Wellmont or any of the Wellmont Subsidiaries to pay separation, severance, termination, or similar-type benefits solely as a result of any transaction contemplated by this Agreement or solely as a result of a "change in control," as such term is used in Section 280G of the Code and the regulations promulgated thereunder.

(c) Except as set forth in the Wellmont Counsel Memorandum, each Plan and all related trusts, insurance contracts, and funds have been maintained, funded, and administered in compliance with all applicable laws and regulations, including but not limited to ERISA and the Code. Each Plan that is intended to be a qualified retirement plan and its related trust, if any, are qualified under Code Section 401(a) and Code Section 501(a) and have been determined by the Internal Revenue Service to qualify, and nothing has occurred since the latest determination of their qualified status by the Internal Revenue Service to cause the loss of such qualification. In addition to the foregoing, each Plan that is intended to be a tax-deferred annuity plan within the meaning of Code Section 403(b), has been administered in accordance with the provisions of that Section. Except as set forth the Wellmont Counsel Memorandum, no Plan that is qualified under Code Section 401(a) has ever been merged with or accepted transfers from another Plan under Code Section 414(1).

(d) Wellmont has provided to MSHA the latest actuarial valuation report for each Plan that is a defined benefit pension plan and the most recent information on contributions and the fair market value of the assets for each Plan. All financial and employee census data, and all other information provided by Wellmont to the actuaries for each such Plan in order to prepare the latest actuarial report for each such Plan was true, correct and complete in all material respects. With respect to each Plan that is subject to the funding requirements of Section 412 of the Code and Section 302 of ERISA, all contributions required to have been made for all periods ending prior to or as of the Effective Date (including periods from the first day of the then-current plan year to the Effective Date) have been made, and no accumulated funding deficiency (as defined in Code Section 412(a)) has been incurred, without regard to any waiver granted under Code Section 412. With respect to each other Plan, all required payments, premiums, contributions, reimbursements, or adequate accruals for all periods ending prior to or as of the Effective Date have been made within the time due. Except as set forth in the Wellmont Counsel Memorandum, no Plan which is a qualified retirement plan within the meaning of Section 401(a) of the Code ("Qualified Plan") has any material unfunded liabilities.

(e) There have been no prohibited transactions with respect to any Plan which could result in liability to the Representing Party, any of the Wellmont Subsidiaries, or any of their respective employees that, individually or in the aggregate, could have a Material Adverse Effect. There has been no breach of fiduciary duty (including violations under Part 4 of Title I of ERISA) with respect to any Plan which could result in liability to the Representing Party, any of the Wellmont Subsidiaries, or any of their respective employees that, individually or in the aggregate, could have a Material Adverse Effect. No action, suit, proceeding, hearing, or investigation relating to any Plan

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(other than routine claims for benefits) is pending or has been threatened, and neither Wellmont nor any of the Wellmont Subsidiaries, nor any of their respective employees, has knowledge of any fact that would reasonably be expected to form the basis for such action, suit, proceeding, hearing, or investigation. Except as set forth in the Wellmont Counsel Memorandum, no matters are currently pending with respect to any Plan under the Employee Plans Compliance Resolution System maintained by the Internal Revenue Service or any similar program maintained by any other government authority.

(f) Except as disclosed in the Wellmont Counsel Memorandum, neither Wellmont nor any of the Wellmont Subsidiaries has ever sponsored, maintained, contributed to, had any obligation to contribute to, or had any other liability under or with respect to any employee pension benefit plan covered by Title IV of ERISA, Section 302 of ERISA, or Section 412 of the Code. Neither Wellmont nor any of the Wellmont Subsidiaries has ever had any obligation to contribute to, participated in, or been subject to any liability under or with respect to any "multiemployer plan" as defined in Section 3(37) of ERISA or any "multiple employer welfare arrangement" as defined in Section 3(40)(A) of ERISA.

(g) Except as disclosed in the Wellmont Counsel Memorandum, neither Wellmont nor any of the Wellmont Subsidiaries has ever sponsored, maintained, administered, contributed to, had any obligation to contribute to, or had any other liability under or with respect to any policy, practice, agreement, or Plan which provides health, life, or other coverage for former directors, officers, or employees (or any spouse or former spouse or other dependent thereof), other than benefits required by COBRA or comparable state-mandated health plan continuation coverage.

(h) Neither Wellmont nor any of the Wellmont Subsidiaries has ever maintained a "voluntary employees' beneficiary association" within the meaning of Section 501(c)(9) of the Code or any other "welfare benefit fund" as defined in Section 419(e) of the Code.

(i) With respect to each Plan that is subject to COBRA and that benefits any current or former employee of Wellmont or any of the Wellmont Subsidiaries, Wellmont or the Wellmont Subsidiaries has complied in all material respects with the continuation coverage requirements of COBRA to the extent such requirements are applicable.

(j) All reports and information relating to each Plan required to be filed with a government authority have been timely filed and are accurate in all material respects, all reports and information relating to each such Plan required to be disclosed or provided to participants or their beneficiaries have been timely disclosed or provided, and there are no restrictions on the right of Wellmont or any of the Wellmont Subsidiaries to terminate or decrease (prospectively) the level of benefits under any Plan after the Effective Date without liability to any participant or beneficiary thereunder.

(k) Except as reflected in the Wellmont Counsel Memorandum, each Plan sponsored by Wellmont or any of the Wellmont Subsidiaries is terminable at the discretion of such entity with no more than 30 days' advance notice and without material cost to such entity. Wellmont and any of the Wellmont Subsidiaries may, without

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material cost, withdraw their employees, directors, officers, and consultants from any Plan which is not sponsored by such entity. Except as reflected in the Wellmont Counsel Memorandum, no Plan has any provision which could increase or accelerate benefits or any provision which could increase liability to MSHA as a result of the transactions contemplated hereby, alone or together with any other event. Except as reflected in the Wellmont Counsel Memorandum, no Plan imposes withdrawal charges, redemption fees, contingent deferred sales charges, or similar expenses triggered by termination of the plan or cessation of participation or withdrawal of employees thereunder. No officer, trustee, agent, or employee of Wellmont or any of the Wellmont Subsidiaries has made any oral or written representation which is inconsistent with the terms of any Plan which may be binding on such Plan, the Representing Party, or any of the Wellmont Subsidiaries.

(l) Each nonqualified deferred compensation plan within the meaning of Code Section 409A has been administered in compliance in all material respects with the plan terms, to the extent consistent with Code Section 409A and the applicable guidance, as described in IRS Notice 2007-86.

(m) Neither Wellmont nor any of the Wellmont Subsidiaries has any leased employees within the meaning of Code Section 414(n).

Section 3.17 Medicare Participation/Accreditation.

(a) For purposes of this Section:

(i) "Governmental Entity" shall mean any government or any agency, bureau, board, directorate, commission, court, department, official, political subdivision, tribunal, or other instrumentality of any government, whether federal, state, or local, domestic or foreign.

(ii) "Person" shall mean an association, a corporation, a limited liability company, an individual, a partnership, a limited liability partnership, a trust, or any other entity or organization, including a Governmental Entity.

(b) All hospitals and other health care providers owned or operated as continuing operations by Wellmont or any Wellmont Subsidiary (each, a "Wellmont Facility," and together, the "Wellmont Facilities") that make claims for payment under Title XVIII of the Social Security Act ("Medicare") and Title XIX of the Social Security Act ("Medicaid") are eligible to receive payment without restriction under Medicare and Medicaid, and each of them is a "provider" or "supplier" with valid and current provider agreements and with one or more provider numbers with the federal Medicare program and the Medicaid program of Tennessee or Virginia (the "Government Programs") through a contractor, a fiscal intermediary, or a carrier, as applicable. Each of the Wellmont Facilities that makes claim for payment under TRICARE programs is a "provider" with valid and current provider agreements and with one or more provider numbers with TRICARE. Each Wellmont Facility is in compliance with the conditions of participation for the Government Programs and TRICARE in all material respects and

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has received all approvals or qualifications necessary for capital reimbursement of the assets of Wellmont or a Wellmont Subsidiary, except where the failure to be in such compliance or to have such approvals or qualifications would not individually or in the aggregate have a Material Adverse Effect on Wellmont or on any of the Wellmont Subsidiaries. There is not pending, nor to the Knowledge of Wellmont, threatened, any proceeding or investigation under the Government Programs or TRICARE involving Wellmont or the Wellmont Facilities. The cost reports of Wellmont and the Wellmont Facilities for the Government Programs for the fiscal years through June 30, 2014 and for subsequent periods that are required to be filed on or before the Effective Date have been or will be properly filed and, to the Knowledge of Wellmont, are or will be complete and correct in all material respects. Wellmont and the Wellmont Subsidiaries are in material compliance with filing requirements with respect to cost reports of the Wellmont Facilities and, to the Knowledge of Wellmont, such reports do not claim, and none of the Wellmont Facilities have received payment or reimbursement in excess of the amount provided by federal or state law or any applicable agreement, except where excess reimbursement was noted on the cost report. Except for claims, actions, and appeals in the ordinary course of business, there are no material claims, actions, or appeals pending before any commission, board, or agency, including any contractor, fiscal intermediary, or carrier, or Governmental Entity, with respect to any Government Program cost reports or claims filed with respect to the Wellmont Facilities, on or before the date of this Agreement, or any disallowances by any commission, board, or agency in connection with any audit of such cost reports.

(c) Except as disclosed in the Wellmont Counsel Memorandum or disclosed to MSHA prior to the date hereof through the Black Box Process, to the Knowledge of Wellmont, all billing practices of Wellmont and the Wellmont Subsidiaries with respect to the Wellmont Facilities to all third party payors, including the Government Programs, TRICARE, and private insurance companies, have been in compliance with all applicable federal and state laws, regulations, and policies of such third party payors and Government Programs in all material respects, and (to the Knowledge of Wellmont) neither Wellmont nor the Wellmont Facilities have billed or received any payment or reimbursement in excess of amounts allowed by state or federal law.

(d) Except as set forth in the Wellmont Counsel Memorandum, each Wellmont Facility eligible for such accreditation is accredited by The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or other appropriate accreditation agency.

(e) Neither Wellmont nor any of the Wellmont Subsidiaries nor (to the Knowledge of Wellmont) any member, trustee, officer, or employee of Wellmont or any of the Wellmont Subsidiaries, nor any agent acting on behalf of or for the benefit of any of the foregoing, has directly or indirectly in connection with any of the Wellmont Facilities; (i) offered or paid, solicited or received, any remuneration, in cash or in kind, to or from, or made any financial arrangements with, any past, present, or potential customers, past or present suppliers, patients, physicians, contractors, or third party payors of Wellmont or any of the Wellmont Facilities in order to induce referrals or

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otherwise generate business or obtain payments from such Persons to the extent any of the foregoing is prohibited by federal or state law; (ii) given or agreed to give, or is aware that there has been made or that there is any agreement to make, any gift or gratuitous payment of any kind, nature, or description (whether in money, property, or services) to any customer or potential customer, supplier, or potential supplier, contractor, third party payor, or any other Person to the extent any of the foregoing is prohibited by federal or state law; (iii) made or agreed to make, or is aware that there has been made, or that there is any agreement to make, any contribution, payment, or gift of funds or property to, or for the private use of, any governmental official, employee, or agent where either the contribution, payment, or gift or the purpose of such contribution, payment, or gift is or was illegal under the laws of the United States or under the law of any state or any other Governmental Entity having jurisdiction over such payment, contribution, or gift; (iv) established or maintained any unrecorded fund or asset for any purpose or made any misleading, false, or artificial entries on any of its books or records for any reason; or (v) made, or agreed to make, or is aware that there has been made, or that there is any agreement to make, any payment to any Person with the intention or understanding that any part of such payment would be used for any purpose other than that described in the documents supporting such payment.

(f) Neither Wellmont nor any of the Wellmont Subsidiaries, nor (to the Knowledge of Wellmont) any member, trustee, officer, or employee of Wellmont nor any of the Wellmont Subsidiaries, is a party to any contract, lease agreement, or other arrangement (including any joint venture or consulting agreement) related to Wellmont or any of the Wellmont Facilities with any physician, health care facility, hospital, nursing facility, home health agency, or other Person who is in a position to make or influence referrals to or otherwise generate business for Wellmont with respect to any of the Wellmont Facilities, to provide services, lease space, lease equipment, or engage in any other venture or activity, to the extent that any of the foregoing is prohibited by any federal or state law.

(g) Wellmont represents and warrants to MSHA that neither it nor any of the Wellmont Subsidiaries: (i) is currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the "Federal health care programs"); (ii) is or has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; or (iii) is, to the Knowledge of Wellmont, under investigation with respect to matters which may result in such party being excluded from participation in the Federal health care programs.

Section 3.18 Minute and Stock Transfer Books. The minute books of Wellmont and the Wellmont Subsidiaries are true, correct, complete, and current in all material respects, and contain accurate and complete records of all material actions taken by their respective Boards of Directors, Members or Managers and, in the case of for-profit Wellmont Subsidiaries, their respective shareholders. All signatures contained in such minute books are the true signatures of

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the persons whose signatures they purport to be. The stock (or other equity) transfer books of each for-profit Wellmont Subsidiary are true, correct, complete, and current in all respects.

Section 3.19 Records. All records, technical data, asset ledgers, books of account, inventory records, budgets, supplier records, payroll and personnel records, computer programs, correspondence, and other files of Wellmont and the Wellmont Subsidiaries are true, accurate, and complete in all material respects and those items that are subject to generally accepted accounting principles have been maintained in all material respects in accordance therewith.

Section 3.20 No Other Representations or Warranties. None of Wellmont nor any affiliate thereof, nor any of their agents (financial, legal or otherwise), makes or has made any representations or warranties, express or implied, of any nature whatsoever relating to Wellmont or the Wellmont Subsidiaries or the business of Wellmont and the Wellmont Subsidiaries or otherwise in connection with the transactions contemplated by this Agreement, other than those representations and warranties of Wellmont expressly set forth in this ARTICLE III. Wellmont hereby expressly disclaims, and MSHA acknowledges that it is not relying on, any other express or implied representations or warranties with respect to any matter whatsoever, including any express or implied representation or warranty as to the completeness of the information contained in this Agreement. Without limiting the generality of the foregoing, MSHA acknowledges that none of Wellmont nor any affiliate or agents thereof has made, and shall not be deemed to have made, any representations or warranties, express or implied, in, or concerning the accuracy or completeness of, the materials relating to the business of Wellmont and the Wellmont Subsidiaries made available to MSHA and its affiliates and agents, including due diligence materials, or in any presentation about the business of Wellmont and the Wellmont Subsidiaries by Wellmont, management of Wellmont or others in connection with the transactions contemplated by this Agreement, and no statement contained in any of such materials or made in any such presentation shall be a representation or warranty hereunder or otherwise or be relied upon by MSHA in executing, delivering and performing this Agreement. MSHA acknowledges that any cost estimates, projections or other predictions, any data, any future financial information or any memoranda or offering materials or presentations, including but not limited to, any confidential information memorandum or similar materials made available by Wellmont, its affiliates or agents are not and shall not be deemed to be or to include representations or warranties of Wellmont, and are not and shall not be relied upon by MSHA or its affiliates in executing, delivering and performing this Agreement. Furthermore, Wellmont and MSHA each hereby acknowledge that this Agreement embodies the justifiable expectations of sophisticated parties derived from arm's-length negotiations; all parties to this Agreement specifically acknowledge that no party has any special relationship with another party that would justify any expectation beyond that of an ordinary buyer and an ordinary seller in an arm's-length transaction.

Article IV Representations and Warranties of MSHA.

Subject to the limitations and qualifications set forth in this Agreement, MSHA represents and warrants to Wellmont the matters set forth below. Statements by MSHA with respect to the MSHA Subsidiaries (as defined in Section 4.03) refer to all of its subsidiaries.

Section 4.01 Effect of Agreement. Assuming the due execution and delivery of this Agreement by Wellmont, this Agreement is a legal, valid, and binding obligation of MSHA and is enforceable against it in accordance with its terms, except as enforceability may be restricted, limited or delayed by applicable bankruptcy or other laws affecting creditors' rights generally and except as enforceability may be subject to general principles of equity. Except as set forth in a confidential communication delivered by MSHA legal counsel to Wellmont legal counsel prior to the date of this Agreement (the "MSHA Counsel Memorandum"), the execution, delivery and performance of this Agreement by MSHA are within its corporate powers. Except as set forth in the MSHA Counsel Memorandum, or otherwise expressly provided in this Agreement, the execution, delivery, and performance of this Agreement by MSHA and the consummation of the transactions contemplated hereby by MSHA will not: (i) require the consent, approval, or authorization of any person, corporation, partnership, joint venture, or other business association or public authority; (ii) violate any provisions of law applicable to MSHA or to any of the MSHA Subsidiaries now or immediately prior to the Effective Date; (iii) with or without the giving of notice or the passage of time, or both, conflict with or result in a breach or termination of any provision of, or constitute a material default under, or result in the creation of any lien, charge, or encumbrance upon any of the properties or assets of MSHA or any of the MSHA Subsidiaries pursuant to, any corporate charter, bylaw, indenture, note, bond, pledge, mortgage, deed of trust, lease, license, contract, agreement, commitment, or other instrument or obligation, or any order, judgment, award, decree, statute, ordinance, or regulation, to which MSHA or any of the MSHA Subsidiaries is a party or by which MSHA or any of the MSHA Subsidiaries or any of their respective material assets or properties may be bound; or (iv) result in the acceleration of any indebtedness of MSHA or any of the MSHA Subsidiaries or increase the rate of interest payable by MSHA or by any of the MSHA Subsidiaries with respect to any indebtedness.

Section 4.02 Organization; Power; Good Standing. MSHA is a nonprofit corporation duly organized and validly existing under the laws of the State of Tennessee and has all requisite corporate power and authority to own, lease, and operate its properties, to carry on its business as now being conducted, and to enter into this Agreement and perform its obligations hereunder. True and correct copies of the Articles of Incorporation and Bylaws or Articles of Organization and Operating Agreements, as applicable, of each of MSHA and the MSHA Subsidiaries have been provided to Wellmont. Neither the character of the properties owned or leased by MSHA nor the nature of the business conducted by MSHA requires the licensing or qualification of MSHA as a corporation in any jurisdiction other than the State of Tennessee and the Commonwealth of Virginia.

Section 4.03 MSHA Subsidiaries. Other than as disclosed in Schedule 4.03 of the MSHA Counsel Memorandum, MSHA does not directly or indirectly own any interest in any other corporation, partnership, joint venture, or other business association or entity, foreign or domestic. Such corporations, partnerships, joint ventures, or other business entities set forth in

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the MSHA Counsel Memorandum of which it owns, directly or indirectly, more than fifty percent (50%) of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests) are referred to herein each as a "MSHA Subsidiary" or collectively as "MSHA Subsidiaries." Set forth in the MSHA Counsel Memorandum is an indication of the interest owned by MSHA in each corporation, partnership, joint venture, or other business association or entity in which MSHA owns any of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests). With respect to the MSHA Subsidiaries, MSHA on behalf of itself and the MSHA Subsidiaries, represents and warrants the following:

(a) Each MSHA Subsidiary that is a corporation is a corporation duly organized, validly existing, and in good standing under the laws of the jurisdiction of its incorporation. Each MSHA Subsidiary that is a limited liability company is duly formed and validly existing under the laws of its jurisdiction of formation.

(b) Each MSHA Subsidiary has the corporate power, or power under the Tennessee Limited Liability Company Act or the Virginia Limited Liability Company Act, as the case may be, and its internal governing documents, as applicable, and authority to own, lease, and operate its properties and to carry on its business as presently conducted or presently proposed to be conducted.

(c) Each MSHA Subsidiary is duly qualified to do business as a foreign corporation or limited liability company, as the case may be, and is in good standing, in each jurisdiction where the character of its properties owned or held under lease or the nature of its activities makes such qualification necessary.

(d) All of the outstanding shares of capital stock or other equity interests of the MSHA Subsidiaries that are for-profit entities and all membership interests in non-profit entities are, in each case, validly issued, fully paid, and non-assessable.

(e) All of the outstanding shares of capital stock of, or other ownership or membership interests in, each of the MSHA Subsidiaries owned by MSHA or by any of its MSHA Subsidiaries are so owned free and clear of any liens, claims, charges, or encumbrances. There are no outstanding options, warrants, subscriptions, calls, rights, convertible securities, or other agreements or commitments obligating MSHA or any of the MSHA Subsidiaries to issue, transfer, or sell any securities of any MSHA Subsidiary.

(f) There are no voting trusts, standstill, shareholder, partnership, operating, or other agreements or understandings to which MSHA or an MSHA Subsidiary is a party or is bound with respect to the voting of the capital stock or other ownership interest in any MSHA Subsidiary.

Section 4.04 Financial Statements. MSHA has delivered to Wellmont, or will deliver to Wellmont within five (5) days of becoming available, copies of (i) its audited consolidated financial statements for the years ended June 30, 2013 and June 30, 2014 and for each year thereafter through the Effective Date, as presented by the auditors regularly retained by MSHA, together with any management letters issued by the auditors in connection with the foregoing and

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a written copy of all material presented to the Audit Committee of the MSHA Board, and (ii) its unaudited interim consolidated financial reports for the year ended June 30, 2015, and the two months ended August 31, 2015 and each month thereafter through the Effective Date. Such financial statements, together with the notes thereto, and such interim unaudited consolidated financial reports (collectively, the "Financial Statements"), are in accordance with the books and records of MSHA; and except as otherwise set forth in the MSHA Counsel Memorandum, fairly present in all material respects the financial position of MSHA and the results of operations and cash flows for the years then ended or other periods indicated in conformity with GAAP applied on a consistent basis throughout such periods, except to the extent that the interim unaudited consolidated financial reports contain no notes and are subject to year-end audit adjustments that are not, individually or in the aggregate, material and, except as noted in such statements, consistent with prior periods. The most recent balance sheet of MSHA included in its Financial Statements is referred to herein as its "Balance Sheet." The "Balance Sheet Date" shall mean June 30, 2015.

Section 4.05 Absence of Undisclosed Liabilities. Other than with respect to matters addressed in Section 4.17, representations concerning which are contained only in Section 4.17, except as expressly disclosed or reserved against on the Balance Sheet or as specifically set forth in the MSHA Counsel Memorandum, neither MSHA nor any of the MSHA Subsidiaries had, as of the Balance Sheet Date, any debts, liabilities, or obligations of any nature, whether accrued, absolute, contingent, or otherwise, and whether due or to become due, including, but not limited to, guarantees, liabilities, or obligations on account of Taxes (as defined in Section 4.08 below), other governmental charges, duties, penalties, interest, fines, or obligations to refund, required in accordance with GAAP to be disclosed on the Balance Sheet.

Section 4.06 Absence of Certain Changes. Except as set forth in the MSHA Counsel Memorandum, as disclosed to Wellmont prior to the date hereof through the Black Box Process, or as permitted by this Agreement, since the Balance Sheet Date, MSHA has suffered no Material Adverse Effect (as defined in Section 3.06).

Section 4.07 Contracts. The MSHA Counsel Memorandum contains a list of all contracts, agreements, commitments, and arrangements to which MSHA or any of the MSHA Subsidiaries are a party or by which any of their assets are bound or affected that: (i) involve the expenditure by MSHA or any of the MSHA Subsidiaries thereto of more than \$250,000 on an annual basis; (ii) to the Knowledge of MSHA, are with, or relate to, any physician; or (iii) to the Knowledge of MSHA, are with, or relate to, any Disqualified Person within the meaning of Section 4958(f) of the Code (each a "MSHA Material Contract"). "Knowledge of MSHA" when used in this Agreement means the actual knowledge of the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, or the General Counsel of MSHA. For avoidance of doubt, the term Disqualified Person shall include persons (including any physicians or their family members) who are or were, at any time during the five-year period ending on the Effective Date: (a) voting members of the subject organization's governing body; (b) presidents, chief executive officers, chief operating officers, and other persons with ultimate responsibility for implementing the decisions of the governing body or for supervising the management, administration, or operation of the organization, regardless of title; (c) treasurers and chief financial officers and other persons with ultimate responsibility for managing the finances of the

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organization, regardless of title; (d) in a position to exercise substantial influence over the subject organization's affairs, including (i) persons who have or share authority to control or determine a substantial portion of the organization's capital expenditures, operating budget, or compensation for employees, (ii) persons who manage a discrete segment or activity of the organization that represents a substantial portion of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole, (iii) persons who are substantial contributors to the organization (within the meaning of Code Section 507(d)(2)(A)), taking into account only contributions received by the organization during its current taxable year and the four preceding taxable years; and (iv) persons whose compensation is primarily based on revenues derived from activities of the organization, or of a particular department or function of the organization, that the person controls; (e) family members of persons meeting a definition in (a)-(d) above (for this purpose, "family members" are limited to the following: spouse, brothers or sisters (by whole or half-blood), spouses of brothers or sisters (by whole or half-blood), ancestors, children, grandchildren, great grandchildren, and spouses of children, grandchildren, and great grandchildren); and (f)(i) a corporation in which persons described in (a)-(e) own more than 35 percent of the combined voting power; (ii) a partnership in which persons described in (a)-(e) own more than 35 percent of the profits interests; or (iii) a trust or estate in which persons described in (a)-(e) own more than 35 percent of the beneficial interests. Other than as set forth in the MSHA Counsel Memorandum, neither MSHA nor any of the MSHA Subsidiaries has entered into any MSHA Material Contract. All MSHA Material Contracts are valid and enforceable in accordance with their terms, except as such enforceability may be limited by bankruptcy, insolvency, receivership, and other laws affecting creditors' rights generally and general principles of equity. MSHA and the MSHA Subsidiaries and, to the Knowledge of MSHA, all other parties to each of the foregoing arrangements, have performed in all material respects their respective obligations to date required to be performed under each MSHA Material Contract. Except as disclosed in the MSHA Counsel Memorandum, neither MSHA or any of the MSHA Subsidiaries nor, to the Knowledge of MSHA, any other party, is in default or in arrears in any material respect under the terms of any of the foregoing arrangements, and no condition exists or event has occurred that, with the giving of notice or the lapse of time or both, would constitute a material default under any of them. Except as noted to the contrary in the MSHA Counsel Memorandum, none of the rights of MSHA or any of the MSHA Subsidiaries under any of such agreements is subject to termination or modification as the result of the transactions contemplated by this Agreement. Correct and complete copies of all written contracts referenced in the MSHA Counsel Memorandum and true and complete summaries of any oral contracts or other arrangements therein referenced have been made available to Wellmont.

Section 4.08 Tax Matters. For purposes of this Section:

(a) "Tax" or "Taxes" means any federal, state, or local income (including unrelated business income), gross receipts, license, payroll, employment, excise, severance, stamp, occupation, premium, environmental (including taxes under Code Section 59A), capital stock, franchise, profits, withholding, social security (or similar), unemployment, disability, real property, personal property, sales, use, transfer, registration, estimated, or other tax of any kind whatsoever, including any interest, penalty, or addition thereto, whether disputed or not.

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(b) "Tax Return" means any return, declaration, report, claim for refund, or information return or statement relating to Taxes, including any schedule or attachment thereto, and including any amendment thereof.

(c) MSHA and the MSHA Subsidiaries will have timely filed all federal income tax returns and all other material Tax Returns that they are required to file before the Effective Date. All such Tax Returns are correct and complete in all material respects. All material Taxes due and owing by MSHA and the MSHA Subsidiaries have been paid or reserved against in such party's Financial Statements. Neither MSHA nor the MSHA Subsidiaries currently are the beneficiary of any extension of time within which to file any Tax Return except as set forth the MSHA Counsel Memorandum. No written claim has been made within the last 3 years by an authority in a jurisdiction where MSHA or the MSHA Subsidiaries do not file Tax Returns that they are or may be subject to taxation by that jurisdiction.

(d) MSHA and the MSHA Subsidiaries have withheld and paid all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, stockholder, or other third party.

(e) There is no material dispute or claim concerning any Tax liability of MSHA or any entity listed in the MSHA Counsel Memorandum either: (i) claimed or raised by any governmental authority in writing and brought to the attention of any of the directors, officers, or employees responsible for Tax matters of MSHA and the MSHA Subsidiaries; or (ii) as to which any of the directors, officers, or employees responsible for Tax matters of MSHA and the MSHA Subsidiaries has knowledge based upon personal contact with any agent of such governmental authority. Except as disclosed in the MSHA Counsel Memorandum, neither MSHA nor any of the MSHA Subsidiaries is the subject of an audit or examination by any governmental authority with respect to its potential liability for Taxes.

(f) Neither MSHA nor the MSHA Subsidiaries has waived any statute of limitations in respect of Taxes or agreed to any extension of time with respect to a Tax assessment or deficiency.

(g) Other than as set forth in the MSHA Counsel Memorandum, MSHA and each of the MSHA Subsidiaries is not a party to and have no continuing obligations under any Tax allocation or sharing agreement. MSHA and each of the MSHA Subsidiaries: (i) have not been members of an affiliated group (within the meaning of Code § 1504(a)) filing a consolidated federal income Tax Return, and (ii) have no liability for the Taxes of any entity or unincorporated organization (other than MSHA and the MSHA Subsidiaries) under Treasury Regulation § 1.1502-6 (or any similar provision of state, local, or foreign law), as a transferee or successor, by contract or otherwise.

(h) The unpaid Taxes of MSHA and the MSHA Subsidiaries: (i) did not, as of the Balance Sheet Date, exceed by any material amount the reserve for Tax liability (excluding any reserve for deferred Taxes established to reflect timing differences between book and Tax income) set forth on the face of the Balance Sheet as of the

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Balance Sheet Date (rather than in any notes thereto), and (ii) will not exceed by any material amount that reserve as adjusted for the passage of time through the Effective Date in accordance with the past custom and practice of MSHA and the MSHA Subsidiaries in filing its Tax Returns.

(i) MSHA and the MSHA Subsidiaries that claim to be tax-exempt under Code Section 501(c)(3) (for purposes of this Section 4.08.(i) only, the "Tax-Exempt MSHA Subsidiaries") have, by reason of letters from the Internal Revenue Service, been determined by the Internal Revenue Service to be exempt from federal income taxation under Code Section 501(c)(3) and not to be private foundations under Code Section 509(a). MSHA has no Knowledge of any facts or circumstances which would cause the Internal Revenue Service to revoke such determinations or to conclude that MSHA or the Tax Exempt MSHA Subsidiaries are "private foundations" as defined in Code Section 509(a). MSHA has no Knowledge of any facts or circumstances indicating that any part of the net earnings of MSHA or the Tax Exempt MSHA Subsidiaries inures to the benefit of any private member or individual, within the meaning of Code Section 501(c)(3). Neither MSHA nor the Tax-Exempt MSHA Subsidiaries has taken or permitted any action that would subject MSHA or any Tax-Exempt MSHA Subsidiary to penalty excise taxes (also known as "Intermediate Sanctions") under the Taxpayer Bill of Rights 2 (Pub. L. No. 104-168, 110 Stat. 1452).

Section 4.09 Title to Properties. Except as set forth in the MSHA Counsel Memorandum, MSHA and the MSHA Subsidiaries have good and marketable title to, or a valid leasehold interest in, all their real and personal property and other assets, tangible and intangible, subject to no security interest, pledge, lien, encumbrance, claim, charge, or other restrictions other than; (a) those incurred in the ordinary course of MSHA's business, including those related to debt obligations of MSHA reflected in the Financial Statements, and (b) "Permitted Liens." For the purposes of this Agreement, "Permitted Liens" shall mean; (i) easements that do not materially adversely affect the full use and enjoyment of the Owned Real Property (as defined in Section 4.13 below) or Leased Real Property (as defined in Section 4.13 below) for the purposes for which it is currently used or materially detract from its value; (ii) imperfections of title and encumbrances, if any, individually or in the aggregate, which are not material, do not materially detract from the marketability or value of the properties subject thereto, and do not materially impair the operations of the owner thereto; (iii) liens for taxes not yet due and payable; and (iv) liens incurred in the ordinary course of business in connection with governmental insurance or benefits or to secure performance of leases and contracts (other than for borrowed money) which liens do not, individually or in the aggregate, materially and adversely affect the full use and enjoyment of the properties to which they are attached.

Section 4.10 Litigation. The MSHA Counsel Memorandum contains a true and correct listing of all material litigation, administrative, arbitration, and other proceedings in which MSHA or any of the MSHA Subsidiaries is currently involved, and all court decrees or administrative orders to which MSHA or any of the MSHA Subsidiaries is subject. Other than as shown in the MSHA Counsel Memorandum or as disclosed to Wellmont prior to the date hereof through the Black Box Process, there is no claim, action, suit, proceeding (legal, administrative, or otherwise), investigation, or inquiry (by an administrative agency,

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governmental body, or otherwise) pending as to which MSHA has been served process or otherwise notified or, to the Knowledge of MSHA, threatened in writing by or against, MSHA or any of the MSHA Subsidiaries, their properties or assets, or the transactions contemplated hereby, at law or in equity, or before or by any federal, state, municipal, or other governmental department, commission, board, agency, instrumentality, or authority, domestic or foreign, the result of which could reasonably be expected to have a Material Adverse Effect.

Section 4.11 Compliance with Law. Other than with respect to matters addressed in Section 4.17, representations concerning which are contained only in Section 4.17, and except as set forth in the MSHA Counsel Memorandum or disclosed to Wellmont prior to the date hereof through the Black Box Process, MSHA and the MSHA Subsidiaries are in compliance in all material respects with all applicable laws, rules, regulations, and licensing requirements of all federal, state, local, and foreign authorities.

Section 4.12 Permits and Licenses. MSHA and the MSHA Subsidiaries maintain in full force and effect all permits, licenses, orders, and approvals necessary for them to carry on their respective businesses as presently conducted other than such permits, licenses, orders, and approvals the absence of which, individually or in the aggregate, has not had and would not reasonably be expected to have a Material Adverse Effect. All fees and charges incident to such permits, licenses, orders, and approvals have been fully paid and are current, and no suspension or cancellation of any such permit, license, order, or approval has been threatened or could result by reason of the transactions contemplated by this Agreement. Neither MSHA nor any of the MSHA Subsidiaries have received any notice from any Governmental Entity that any MSHA Facilities are not in substantial compliance with all of the terms, conditions, and provisions of such permits, consents, approvals, or licenses. MSHA heretofore has made available to Wellmont correct and complete copies of all such permits, consents, orders, approvals, and licenses. A list of all permits, licenses, orders, and approvals held by MSHA and the MSHA Subsidiaries is set forth in the MSHA Counsel Memorandum.

Section 4.13 Real Property.

(a) Owned. With respect to all real property reflected on the respective balance sheets of MSHA and the MSHA Subsidiaries (collectively, the "Owned Real Property"), except as set forth in the MSHA Counsel Memorandum, (i) neither MSHA nor any MSHA Subsidiary has agreed, orally or in writing, or is otherwise obligated, to sell, lease, encumber, or otherwise dispose of any of the Owned Real Property; and (ii) other than tenant leases in the ordinary course of operations, no person or entity has any leasehold interest in, and no person or entity (other than MSHA or a MSHA Subsidiary) has any right to use, operate, or occupy any of the Owned Real Property.

(b) Leased. With respect to all real property leased by MSHA or the MSHA Subsidiaries and which (i) involve the expenditure by MSHA or any of the MSHA Subsidiaries thereto of more than \$250,000 on an annual basis or (ii) to the Knowledge of MSHA, are with, or relate to, any physician (collectively, the "Leased Real Property") and all leases relating thereto (collectively, the "Real Property Leases"), MSHA represents and warrants that except as set forth in the MSHA Counsel Memorandum, (i) each Real Property Lease is valid, binding, and enforceable in accordance with its terms

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and is in full force and effect, and there are no offsets or defenses by either landlord or tenant thereunder; (ii) there are no existing breaches of or defaults under, and no events or circumstances have occurred which, with or without notice or lapse of time, or both, would constitute a breach of or a default under, any of the Real Property Leases; and (iii) consummation of the Affiliation will not constitute or result in a breach or default under any Real Property Lease. A list of all Real Property Leases of MSHA and the MSHA Subsidiaries is set forth in the MSHA Counsel Memorandum.

(c) Improvements. The Owned Real Property and the Leased Real Property are zoned for the various purposes for which the buildings and other improvements located thereon (the "Improvements") are presently being used, except in the case of permitted nonconforming uses. All of the Improvements and all uses thereof are in material compliance with all applicable zoning and land use laws, ordinances, and regulations. No part of any of the Improvements encroach on any real property not included in the Owned Real Property or the Leased Real Property in such a way that the remediation of the encroachment would prevent MSHA's continued use of the Improvements to such an extent as to materially affect such Party's operations.

Section 4.14 Environmental Protection. Except as set forth in the MSHA Counsel Memorandum, and to the Knowledge of MSHA:

(a) MSHA and the MSHA Subsidiaries are in compliance in all material respects with federal, state, and local environmental laws and regulations that are applicable to MSHA and the MSHA Subsidiaries and to their respective business operations.

(b) No substances that are defined and regulated by applicable environmental laws and regulations as toxic substances, hazardous wastes, hazardous materials, or hazardous substances (including, without limitation, asbestos, and petroleum and its constituents) (collectively, "Hazardous Substances") have been stored, disposed of, or released in or on the Owned Real Property, the Leased Real Property, the Improvements, or other assets of MSHA or the MSHA Subsidiaries in any manner, locations, or amounts that are outside of the ordinary course of business for MSHA and the MSHA Subsidiaries, or that violate applicable environmental laws and regulations, or that create material response duties or material cleanup liability for MSHA or any of the MSHA Subsidiaries.

(c) MSHA and the MSHA Subsidiaries have received no written notices regarding any potential claims, costs, or liabilities being asserted or to be asserted against MSHA or the MSHA Subsidiaries arising from or related to the off-site transport or disposal of Hazardous Substances from the owned Real Property or the Lease Real Property.

Section 4.15 Insurance. Other than as set forth in the MSHA Counsel Memorandum, MSHA and the MSHA Subsidiaries maintain in force valid, binding, and enforceable insurance policies providing adequate coverage for all risks normally insured against by others in the businesses of MSHA and the MSHA Subsidiaries. All premiums due thereon have been paid

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and will be paid through the Effective Date. Neither MSHA nor any of the MSHA Subsidiaries has been refused any insurance by any insurance carrier during the past two years. All insurance policies maintained by MSHA and by the MSHA Subsidiaries are described in the MSHA Counsel Memorandum.

Section 4.16 Employees; Benefit Plans.

(a) Except as set forth in the MSHA Counsel Memorandum, there are no Plans, as defined below, contributed to, maintained, or sponsored by MSHA or any of the MSHA Subsidiaries, to which MSHA or any MSHA Subsidiary is obligated to contribute or with respect to which it has any current or future obligation or liability, including all Plans contributed to, maintained, or sponsored in the past six years by any current or former member of the controlled group of companies, within the meaning of Sections 414(b), 414(c), 414(m), and 414(o) of the Code, of which MSHA or any of the MSHA Subsidiaries is a member. For the purposes of this Agreement, the term "Plans" shall mean: (i) employee benefit plans as defined in Section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), whether or not funded and whether or not terminated; (ii) employment agreements (exclusive of physician contracts); and (iii) personnel policies or fringe benefit plans, policies, programs, and arrangements, whether or not subject to ERISA, whether or not funded, whether written or unwritten, and whether or not terminated, including without limitation, stock bonus, deferred compensation, pension, severance, bonus, vacation, sabbatical, travel, incentive, and health, disability, and welfare plans.

(b) Except as set forth in the MSHA Counsel Memorandum, none of the Plans obligates MSHA or any of the MSHA Subsidiaries to pay separation, severance, termination, or similar-type benefits solely as a result of any transaction contemplated by this Agreement or solely as a result of a "change in control," as such term is used in Section 380G of the Code and the regulations promulgated thereunder.

(c) Except as set forth in the MSHA Counsel Memorandum, each Plan and all related trusts, insurance contracts, and funds have been maintained, funded, and administered in compliance with all applicable laws and regulations, including but not limited to ERISA and the Code. Each Plan that is intended to be a qualified retirement plan and its related trust, if any, are qualified under Code Section 401(a) and Code Section 501(a) and have been determined by the Internal Revenue Service to qualify, and nothing has occurred since the latest determination of their qualified status by the Internal Revenue Service to cause the loss of such qualification. In addition to the foregoing, each Plan that is intended to be a tax-deferred annuity plan within the meaning of Code Section 403(b), has been administered in accordance with the provisions of that Section. Except as set forth in the MSHA Counsel Memorandum, no Plan that is qualified under Code Section 401(a) has ever been merged with or accepted transfers from another Plan under Code Section 414(1).

(d) MSHA has provided to Wellmont the latest actuarial valuation report for each Plan that is a defined benefit pension plan and the most recent information on contributions and the fair market value of the assets for each Plan. All financial and

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employee census data, and all other information provided by MSHA to the actuaries for each such Plan in order to prepare the latest actuarial report for each such Plan was true, correct and complete in all material respects. With respect to each Plan that is subject to the funding requirements of Section 412 of the Code and Section 302 of ERISA, all contributions required to have been made for all periods ending prior to or as of the Effective Date (including periods from the first day of the then-current plan year to the Effective Date) have been made, and no accumulated funding deficiency (as defined in Code Section 412(a)) has been incurred, without regard to any waiver granted under Code Section 412. With respect to each other Plan, all required payments, premiums, contributions, reimbursements, or adequate accruals for all periods ending prior to or as of the Effective Date have been made within the time due. Except as set forth in the MSHA Counsel Memorandum, no Plan which is a qualified retirement plan within the meaning of Section 401(a) of the Code ("Qualified Plan") has any material unfunded liabilities.

(e) There have been no prohibited transactions with respect to any Plan which could result in liability to the Representing Party, any of the MSHA Subsidiaries, or any of their respective employees that, individually or in the aggregate, could have a Material Adverse Effect. There has been no breach of fiduciary duty (including violations under Part 4 of Title I of ERISA) with respect to any Plan which could result in liability to the Representing Party, any of the MSHA Subsidiaries, or any of their respective employees that, individually or in the aggregate, could have a Material Adverse Effect. No action, suit, proceeding, hearing, or investigation relating to any Plan (other than routine claims for benefits) is pending or has been threatened, and neither MSHA nor any of the MSHA Subsidiaries, nor any of their respective employees, has knowledge of any fact that would reasonably be expected to form the basis for such action, suit, proceeding, hearing, or investigation. Except as set forth in the MSHA Counsel Memorandum, no matters are currently pending with respect to any Plan under the Employee Plans Compliance Resolution System maintained by the Internal Revenue Service or any similar program maintained by any other government authority.

(f) Except as disclosed in the MSHA Counsel Memorandum, neither MSHA nor any of the MSHA Subsidiaries has ever sponsored, maintained, contributed to, had any obligation to contribute to, or had any other liability under or with respect to any employee pension benefit plan covered by Title IV of ERISA, Section 302 of ERISA, or Section 412 of the Code. Neither MSHA nor any of the MSHA Subsidiaries has ever had any obligation to contribute to, participated in, or been subject to any liability under or with respect to any "multiemployer plan" as defined in Section 3(37) of ERISA or any "multiple employer welfare arrangement" as defined in Section 3(40)(A) of ERISA.

(g) Except as disclosed in the MSHA Counsel Memorandum, neither MSHA nor any of the MSHA Subsidiaries has ever sponsored, maintained, administered, contributed to, had any obligation to contribute to, or had any other liability under or with respect to any policy, agreement, practice, or Plan which provides health, life, or other coverage for former directors, officers, or employees (or any spouse or former spouse or

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other dependent thereof), other than benefits required by COBRA or comparable state-mandated health plan continuation coverage.

(h) Neither MSHA nor any of the MSHA Subsidiaries has ever maintained a "voluntary employees' beneficiary association" within the meaning of Section 501(c)(9) of the Code or any other "welfare benefit fund" as defined in Section 419(e) of the Code.

(i) With respect to each Plan that is subject to COBRA and that benefits any current or former employee of MSHA or any of the MSHA Subsidiaries, MSHA or the MSHA Subsidiaries has complied in all material respects with the continuation coverage requirements of COBRA to the extent such requirements are applicable.

(j) All reports and information relating to each Plan required to be filed with a government authority have been timely filed and are accurate in all material respects, all reports and information relating to each such Plan required to be disclosed or provided to participants or their beneficiaries have been timely disclosed or provided, and there are no restrictions on the right of MSHA or any of the MSHA Subsidiaries to terminate or decrease (prospectively) the level of benefits under any Plan after the Effective Date without liability to any participant or beneficiary thereunder.

(k) Except as reflected in the MSHA Counsel Memorandum, each Plan sponsored by MSHA or any of the MSHA Subsidiaries is terminable at the discretion of such entity with no more than 30 days' advance notice and without material cost to such entity. MSHA and any of the MSHA Subsidiaries may, without material cost, withdraw their employees, directors, officers, and consultants from any Plan which is not sponsored by such entity. Except as reflected in the MSHA Counsel Memorandum, no Plan has any provision which could increase or accelerate benefits or any provision which could increase liability to Wellmont as a result of the transactions contemplated hereby, alone or together on with any other event. Except as reflected in the MSHA Counsel Memorandum, no Plan imposes withdrawal charges, redemption fees, contingent deferred sales charges, or similar expenses triggered by termination of the plan or cessation of participation or withdrawal of employees thereunder. No officer, trustee, agent, or employee of MSHA or any of the MSHA Subsidiaries has made any oral or written representation which is inconsistent with the terms of any Plan which may be binding on such Plan, the Representing Party, or any of the MSHA Subsidiaries.

(l) Each nonqualified deferred compensation plan within the meaning of Code Section 409A has been administered in compliance in all material respects with the plan terms, to the extent consistent with Code Section 409A and the applicable guidance, as described in IRS Notice 2007-86.

(m) Neither MSHA nor any of the MSHA Subsidiaries has any leased employees within the meaning of Code Section 414(n).

Section 4.17 Medicare Participation/Accreditation.

(a) For purposes of this Section:

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(i) "Governmental Entity" shall mean any government or any agency, bureau, board, directorate, commission, court, department, official, political subdivision, tribunal, or other instrumentality of any government, whether federal, state, or local, domestic or foreign.

(ii) "Person" shall mean an association, a corporation, a limited liability company, an individual, a partnership, a limited liability partnership, a trust, or any other entity or organization, including a Governmental Entity.

(b) All hospitals and other health care providers owned or operated as continuing operations by MSHA or any MSHA Subsidiary (each, a "MSHA Facility," and together, the "MSHA Facilities") that make claims for payment under Title XVIII of the Social Security Act ("Medicare") and Title XIX of the Social Security Act ("Medicaid") are eligible to receive payment without restriction under Medicare and Medicaid, and is a "provider" or "supplier" with valid and current provider agreements and with one or more provider numbers with the federal Medicare program and the Medicaid program of Tennessee or Virginia (the "Government Programs") through a contractor, a fiscal intermediary, or a carrier, as applicable. Each of the MSHA Facilities that make claims for payment under TRICARE programs is a "provider" with valid and current provider agreements and with one or more provider numbers with TRICARE. Each MSHA Facility is in compliance with the conditions of participation for the Government Programs and TRICARE in all material respects and has received all approvals or qualifications necessary for capital reimbursement of the assets of MSHA or a MSHA Subsidiary, except where the failure to be in such compliance or to have such approvals or qualifications would not individually or in the aggregate have a Material Adverse Effect on MSHA or on any of the MSHA Subsidiaries. There is not pending, nor to the Knowledge of MSHA, threatened, any proceeding or investigation under the Government Programs or TRICARE involving MSHA or the MSHA Facilities. The cost reports of MSHA and the MSHA Facilities for the Government Programs for the fiscal years through June 30, 2014 and for each subsequent period required to be filed on or before the Effective Date have been or will be properly filed and, to the Knowledge of MSHA, are or will be complete and correct in all material respects. MSHA and the MSHA Subsidiaries are in material compliance with filing requirements with respect to cost reports of the MSHA Facilities and, to the Knowledge of MSHA, such reports do not claim, and none of the MSHA Facilities have received payment or reimbursement in excess of the amount provided by federal or state law or any applicable agreement, except where excess reimbursement was noted on the cost report. Except for claims, actions, and appeals in the ordinary course of business, there are no material claims, actions, or appeals pending before any commission, board, or agency, including any contractor, fiscal intermediary, or carrier, or Governmental Entity, with respect to any Government Program cost reports or claims filed with respect to the MSHA Facilities, on or before the date of this Agreement, or any disallowances by any commission, board, or agency in connection with any audit of such cost reports.

(c) Except as set forth in the MSHA Counsel Memorandum or disclosed to Wellmont prior to the date hereof through the Black Box Process, to the Knowledge of

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MSHA, all billing practices of MSHA and the MSHA Subsidiaries with respect to the MSHA Facilities to all third party payors, including the Government Programs, TRICARE, and private insurance companies, have been in compliance with all applicable federal and state laws, regulations, and polices of such third party payors and Government Programs in all material respects, and (to the Knowledge of MSHA) neither MSHA nor the MSHA Facilities have billed or received any payment or reimbursement in excess of amounts allowed by state or federal law.

(d) Except as set forth in the MSHA Counsel Memorandum, each MSHA Facility eligible for such accreditation is accredited by The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or other appropriate accreditation agency.

(e) Neither MSHA nor any of the MSHA Subsidiaries nor (to the Knowledge of MSHA) any member, trustee, officer, or employee of MSHA or any of the MSHA Subsidiaries, nor any agent acting on behalf of or for the benefit of any of the foregoing, has directly or indirectly in connection with any of the MSHA Facilities; (i) offered or paid, solicited or received, any remuneration, in cash or in kind, to or from, or made any financial arrangements with, any past, present, or potential customers, past or present suppliers, patients, physicians, contractors, or third party payors of MSHA or any of the MSHA Facilities in order to induce referrals or otherwise generate business or obtain payments from such Persons to the extent any of the foregoing is prohibited by federal or state law; (ii) given or agreed to give, or is aware that there has been made or that there is any agreement to make, any gift or gratuitous payment of any kind, nature, or description (whether in money, property, or services) to any customer or potential customer, supplier, or potential supplier, contractor, third party payor, or any other Person to the extent any of the foregoing is prohibited by federal or state law; (iii) made or agreed to make, or is aware that there has been made, or that there is any agreement to make, any contribution, payment, or gift of funds or property to, or for the private use of, any governmental official, employee, or agent where either the contribution, payment, or gift or the purpose of such contribution, payment, or gift is or was illegal under the laws of the United States or under the law of any state or any other Governmental Entity having jurisdiction over such payment, contribution, or gift; (iv) established or maintained any unrecorded fund or asset for any purpose or made any misleading, false, or artificial entries on any of its books or records for any reason; or (v) made, or agreed to make, or is aware that there has been made, or that there is any agreement to make, any payment to any Person with the intention or understanding that any part of such payment would be used for any purpose other than that described in the documents supporting such payment.

(f) Neither MSHA nor any of the MSHA Subsidiaries, nor (to the Knowledge of MSHA) any member, trustee, officer, or employee of MSHA nor any of the MSHA Subsidiaries, is a party to any contract, lease agreement, or other arrangement (including any joint venture or consulting agreement) related to MSHA or any of the MSHA Facilities with any physician, health care facility, hospital, nursing facility, home health agency, or other Person who is in a position to make or influence referrals to or otherwise generate business for MSHA with respect to any of the MSHA Facilities, to provide

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services, lease space, lease equipment, or engage in any other venture or activity, to the extent that any of the foregoing is prohibited by any federal or state law.

(g) MSHA represents and warrants to Wellmont that neither it nor any of the MSHA Subsidiaries: (i) is currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the "Federal health care programs"); (ii) is or has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; or (iii) is, to the Knowledge of MSHA, under investigation with respect to matters which may result in such party being excluded from participation in the Federal health care programs.

Section 4.18 Minute and Stock Transfer Books. The minute books of MSHA and the MSHA Subsidiaries are true, correct, complete, and current in all material respects, and contain accurate and complete records of all material actions taken by their respective Boards of Directors, Members or Managers and, in the case of for-profit MSHA Subsidiaries, their respective shareholders. All signatures contained in such minute books are the true signatures of the persons whose signatures they purport to be. The stock (or other equity) transfer books of each for-profit MSHA Subsidiary are true, correct, complete, and current in all respects.

Section 4.19 Records. All records, technical data, asset ledgers, books of account, inventory records, budgets, supplier records, payroll and personnel records, computer programs, correspondence, and other files of MSHA and the MSHA Subsidiaries are true, accurate, and complete in all material respects and those items that are subject to generally accepted accounting principles have been maintained in all material respects in accordance therewith.

Section 4.20 No Other Representations or Warranties. None of MSHA nor any affiliate thereof, nor any of their agents (financial, legal or otherwise), makes or has made any representations or warranties, express or implied, of any nature whatsoever relating to MSHA or the MSHA Subsidiaries or the business of MSHA and the MSHA Subsidiaries or otherwise in connection with the transactions contemplated by this Agreement, other than those representations and warranties of MSHA expressly set forth in this ARTICLE II. MSHA hereby expressly disclaims, and Wellmont acknowledges that it is not relying on, any other express or implied representations or warranties with respect to any matter whatsoever, including any express or implied representation or warranty as to the completeness of the information contained in this Agreement. Without limiting the generality of the foregoing, Wellmont acknowledges that none of MSHA nor any affiliate or agents thereof has made, and shall not be deemed to have made, any representations or warranties, express or implied, in, or concerning the accuracy or completeness of, the materials relating to the business of MSHA and the MSHA Subsidiaries made available to Wellmont and its affiliates and agents, including due diligence materials, or in any presentation about the business of MSHA and the MSHA Subsidiaries by MSHA, management of MSHA or others in connection with the transactions contemplated by this Agreement, and no statement contained in any of such materials or made in any such presentation shall be a representation or warranty hereunder or otherwise or be relied upon by Wellmont in executing, delivering and performing this Agreement. Wellmont acknowledges that any cost estimates, projections or other predictions, any data, any future financial information or

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any memoranda or offering materials or presentations, including but not limited to, any confidential information memorandum or similar materials made available by Wellmont, its affiliates or agents are not and shall not be deemed to be or to include representations or warranties of Wellmont, and are not and shall not be relied upon by MSHA or its affiliates in executing, delivering and performing this Agreement. Furthermore, Wellmont and MSHA each hereby acknowledge that this Agreement embodies the justifiable expectations of sophisticated parties derived from arm's-length negotiations; all parties to this Agreement specifically acknowledge that no party has any special relationship with another party that would justify any expectation beyond that of an ordinary buyer and an ordinary seller in an arm's-length transaction.

Article V Pre-Effective Date Covenants and Regulatory Approvals.

Section 5.01 Effective Date. Subject to the satisfaction or waiver by the appropriate Party of all the conditions precedent to Closing specified in Article VI and Article VII, the consummation of the Affiliation and the other transactions contemplated by this Agreement (the "Closing") shall take place at a mutually agreed neutral location at 10:00 A.M. local time on or before September 1, 2016 or at a mutually agreed time within five business days after all conditions have been satisfied or waived (the "Effective Date"), unless the parties hereto agree in writing upon a different time, date, or place. The parties agree that no actions to be taken on the Effective Date shall be deemed consummated until all actions required to be taken at or before Closing under this Agreement are consummated. The "Effective Time" of the Affiliation shall be the later of 12:00:01 A.M. local time on September 1, 2016 or on the date on which all actions required to be taken at Closing are consummated.

Section 5.02 Conduct of Business. Between the date hereof and the Effective Time, each of Wellmont and MSHA covenants and agrees that its business and those of its Subsidiaries will be conducted in a manner not materially different from past practice and, except as otherwise approved by MSHA or Wellmont, as the case may be, in writing, only in the ordinary course. Wellmont and MSHA shall provide, not less than five business days prior to the Effective Date, any updates to its Counsel Memorandum necessary to make its Counsel Memorandum true, correct and complete as of the Effective Time.

Section 5.03 Negative Covenants.

(a) Between the date hereof and the Effective Time, Wellmont agrees that, except as otherwise agreed herein as set forth in Schedule 5.03(a) of this Agreement, or pursuant to MSHA's prior written consent, Wellmont will not and will cause each Wellmont Subsidiary not to:

(i) Except as expressly permitted herein, amend its present Articles of Incorporation or Bylaws (or other governing documents in the case of Wellmont Subsidiaries that are not corporations), sell any material portion of its assets or properties except in the ordinary course of business or change in any material manner the character of its business;

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(ii) Encumber, mortgage, pledge, or suffer any lien to be placed against any of its properties or assets, except in the ordinary course of business;

(iii) Incur any indebtedness for borrowed money other than draws in the ordinary course of business against credit lines existing on the date hereof; assume, guarantee, endorse, or otherwise become responsible for the obligations of any other individual, firm, or corporation, or make any loans or advances to any individual, firm, or corporation; or make any material change in any investment allocation; or

(iv) 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 MSHA 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 its hospitals or any material portion of its assets, or provide information to any person who may be interested in any of the foregoing, or permit any trustee, officer, employee, agent, or other affiliate to do any of the foregoing.

(b) Between the date hereof and the Effective Time, MSHA agrees that, except as otherwise agreed herein as set forth in Schedule 5.03(b) of this Agreement, or pursuant to Wellmont's prior written consent, MSHA will not and will cause each MSHA Subsidiary not to:

(i) Except as expressly permitted herein, amend its present Articles of Incorporation or Bylaws (or other governing documents in the case of MSHA Subsidiaries that are not corporations), sell any material portion of its assets or properties except in the ordinary course of business or change in any material manner the character of its business;

(ii) Encumber, mortgage, pledge, or suffer any lien to be placed against any of its properties or assets, except in the ordinary course of business;

(iii) Incur any indebtedness for borrowed money other than draws in the ordinary course of business against credit lines existing on the date hereof; assume, guarantee, endorse, or otherwise become responsible for the obligations of any other individual, firm, or corporation, or make any loans or advances to any individual, firm, or corporation; or make any material change in any investment allocation; or

(iv) 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

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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 Wellmont 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 its hospitals or any material portion of its assets, or provide information to any person who may be interested in any of the foregoing, or permit any trustee, officer, employee, agent, or other affiliate to do any of the foregoing.

Section 5.04 Confidentiality; Access to Books, Records, and Properties.

(a) The Parties acknowledge that they are bound by and hereby ratify and affirm the terms of the Confidentiality Agreement entered into by the parties as of April 2, 2014 (the "Confidentiality Agreement").

(b) 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.

(c) Subject to subsection (b) above, each of Wellmont and MSHA shall afford to the other Party and such Party's representatives full access to its properties, books, and records and those of its Subsidiaries during normal business hours in order that each Party may have full opportunity to make such reasonable investigation as it desires of the affairs of the other Party and its Subsidiaries, provided that such Party's right of access and inspection shall not interfere unreasonably with the business or operations of the other Party. 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 MSHA, Tim Belisle, Esq. or his designees.

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(d) Except as and to the extent required by law, without the prior written consent of the other Party, neither MSHA 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 the Affiliation or any of the terms, conditions or aspects of the Affiliation 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 Affiliation prior to the communication of the same.

Section 5.05 Regulatory Filings; Efforts to Close. Unless and until this Agreement is terminated pursuant to Article VIII, each of MSHA and Wellmont shall exercise reasonable diligence to: (a) make or obtain all consents, approvals, authorizations, registrations, and filings with all Governmental Entities or administrative agencies as are required in connection with the consummation of the transactions contemplated by this Agreement; (b) provide such other information and communications to any Governmental Entity as MSHA, Wellmont, or such Governmental Entities may reasonably request; and (c) otherwise take such actions necessary to satisfy all conditions to Closing and to Close. Without limiting the generality of the foregoing, MSHA and Wellmont shall, as promptly as practicable and in cooperation with each other, to the extent required by law, complete and file with the appropriate authorities the notification forms and any other documents, and provide such information, as required under the Hart-Scott-Rodino Antitrust Improvements Act of 1976 ("HSR"), the Tennessee Public Benefit Hospital Sales and Conveyance Act of 2006, §§55-531 et seq. of the Code of Virginia, and the Government Programs. MSHA and Wellmont will, and will cause their respective counsel to, supply to each other copies of all material correspondence, filings or written communications by such party or its Affiliates with any Governmental Entity or staff members thereof, with respect to the Affiliation. Neither Party shall be required to affirmatively sue any applicable governmental agency in order to obtain the regulatory approvals required by Sections 6.05 and 7.05, nor shall either party be required to defend any action or proceeding by or before any court or other governmental body or agency which seeks to restrain, prohibit, or invalidate the transactions contemplated by this Agreement.

Section 5.06 Cooperative Agreement.

(a) The Parties deem this Agreement to be their "cooperative agreement" as defined in the Tennessee Hospital Cooperation Act of 1993, as amended (the "Tennessee COPA Act") and § 15.2-5369 of the Code of Virginia (the "Virginia COPA Act" and together with Tennessee COPA Act, the "COPA Acts").

(b) As promptly as practicable after the execution date hereof, Wellmont and MSHA will apply to the Tennessee Department of Health for a certificate of public advantage pursuant to the Tennessee COPA Act, and to the Southwest Virginia Health Authority and to the Virginia Department of Health for approval, pursuant to § 15.2-5384.1 of the Code of Virginia, of this Agreement as the cooperative agreement

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(collectively, the “Approvals”). Each of Wellmont and MSHA shall exercise reasonable diligence to obtain the Approvals.

(c) Reasonable diligence shall include each party participating diligently and continuously participating in the processes established by each of Tennessee and Virginia for the granting of the Approvals until the earlier of: (i) the date on which it is clear that the final terms and conditions of both Approvals have been established by the Tennessee and Virginia Departments of Health; or (ii) The Outside Date established by Section 8.01(b) of this Agreement. Neither Party shall be required to affirmatively sue any applicable governmental agency in order to obtain the Approvals, nor shall either party be required to defend any action or proceeding by or before any court or other governmental body or agency which seeks to restrain, prohibit, or invalidate the transactions contemplated by this Agreement.

Section 5.07 Resolution of Open Diligence Items. Each Party has identified for the other Party specific items (the “Open Diligence Items”) which arose from the identifying Party’s diligence of the other Party, about which the identifying Party has requested the other Party to provide additional information. Each Party shall provide to the identifying Party, as soon as practicable, but in any event within sixty (60) days after the signing of this Agreement, such additional information concerning the Open Diligence Items as the identifying Party may reasonably request. Thereafter, each Party will use good faith efforts to resolve the questions, comments and concerns raised by the identifying Party with respect to the Open Diligence Items, including without limitation, providing additional information concerning the Open Diligence Items as the identifying Party may reasonably request.

Article VI Conditions Precedent to the Obligations of MSHA.

The obligations of MSHA to consummate the Affiliation contemplated by this Agreement are, except to the extent expressly waived in writing by a party, subject to the satisfaction at or prior to the Effective Date of each of the following conditions:

Section 6.01 Accuracy of Representations and Warranties. The representations and warranties of Wellmont set forth in this Agreement shall have been true and correct on the date of this Agreement and shall be true and correct in all material respects on and as of the Effective Date, with the same force and effect as though made on and as of the Effective Date, except as affected by the transactions contemplated hereby, and there shall be delivered to MSHA on the Effective Date a certificate to such effect signed by an executive officer of Wellmont; provided that a material inaccuracy or combination of material inaccuracies of the representations and warranties of Wellmont shall not be sufficient grounds for MSHA to not consummate the Affiliation unless the disclosed inaccuracy or inaccuracies are of a character or nature that could reasonably be expected to have a Material Adverse Effect with respect to Wellmont or that constitute grounds for not Closing under another Section of this Article VI.

Section 6.02 Performance of Agreements. Wellmont shall have performed in all material respects all obligations and agreements and complied in all material respects with all covenants and conditions contained in this Agreement to be performed or complied with by such party at or prior to the Effective Date, and there shall be delivered to each party on the Effective Date a

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certificate to such effect signed by an executive officer of Wellmont; provided that a material failure to perform or combination of material failures to perform shall not be sufficient grounds for MSHA to not consummate the Affiliation unless the material failure or failures to perform could reasonably be expected to have a Material Adverse Effect with respect to Wellmont or that constitute grounds for not Closing under another Section of this Article VI.

Section 6.03 Actual Actions. There shall not be any actual action or proceeding by or before any court or other governmental body or agency which (a) seeks to restrain, prohibit, or invalidate the transactions contemplated by this Agreement or (b) could reasonably be expected to materially affect the right of Parent Company, MSHA or Wellmont to own, operate, or control a material portion of their respective assets after the Effective Date.

Section 6.04 Necessary Consents; Notices. All authorizations, consents, and approvals by any third parties, including all federal, state, and local regulatory bodies and officials, that are necessary for the consummation of the transactions contemplated by this Agreement shall have been received and shall be in full force and effect; provided that, except for the condition set forth in Section 6.08, absence of one or more non-governmental third-party consents shall not be sufficient grounds for MSHA to not consummate the Affiliation unless the absence of such non-governmental third-party consent or consents could reasonably be expected to have a Material Adverse Effect or constitute grounds for not Closing under another Section of this Article VI. Without limiting the generality of the foregoing, MSHA shall not be obligated to consummate the transactions contemplated hereby unless it receives reasonably satisfactory evidence that (a) the Wellmont Board has ratified, adopted, confirmed and approved this Agreement and the transactions herein contemplated which evidence means receipt from Wellmont of a certified copy of resolutions of its Board of Directors to such effect adopted in the manner required by the law of Tennessee, and (b) all of the conditions in Section 6.05 have been satisfied.

Section 6.05 Regulatory Matters.

(a) If applicable, the waiting period imposed by the Hart-Scott-Rodino Antitrust Improvements Act of 1976 shall have expired or been terminated.

(b) The Attorney General and Reporter of Tennessee shall have issued written notice of his decision to take no action with respect to the Affiliation pursuant to the Tennessee Public Benefit Hospital Sales and Conveyance Act of 2006, Tennessee Code §§ 48-68-201, et seq.

(c) The Attorney General of Virginia shall not have issued any correspondence or communication to the parties indicating that the Attorney General will take action with respect to any notice filing made pursuant to §§55-531 et seq. of the Code of Virginia.

(d) The Approvals shall have been received from the Tennessee Department of Health, the Southwest Virginia Health Authority and the Virginia Department of Health.

(e) The terms and conditions of the foregoing regulatory approvals shall be satisfactory in form and substance to the Board of Directors of MSHA.

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Section 6.06 Absence of Material Adverse Change.

(a) From the date hereof through the Effective Date, there shall have not occurred any event or circumstance or combination of events or circumstances that would reasonably be expected to have a Material Adverse Effect with respect to Wellmont.

(b) Neither (i) the Open Diligence Items identified by MSHA which have not been resolved to the reasonable satisfaction of MSHA, nor (ii) any litigation pending against Wellmont, would reasonably be expected to have a Material Adverse Effect with respect to Wellmont.

Section 6.07 Other Matters. The actions required by Sections 2.01(b),(c), (d), (e), (f), (g)(i), and (g)(ii), 2.02, and 2.05, including without limitation, preparation and attachment to this Agreement of relevant Exhibits, shall have occurred.

Section 6.08 Note Holders Waivers. The holders of the Notes shall have unconditionally waived any Event of Default resulting from or arising out of the transactions contemplated by this Agreement.

Article VII Conditions Precedent to the Obligations of Wellmont.

The obligations of Wellmont to consummate the Affiliation contemplated by this Agreement are, except to the extent expressly waived in writing by a party, subject to the satisfaction at or prior to the Effective Date of each of the following conditions:

Section 7.01 Accuracy of Representations and Warranties. The representations and warranties of MSHA set forth in this Agreement shall have been true and correct on the date of this Agreement and shall be true and correct in all material respects on and as of the Effective Date, with the same force and effect as though made on and as of the Effective Date, except as affected by the transactions contemplated hereby, and there shall be delivered to Wellmont on the Effective Date a certificate to such effect signed by an executive officer of MSHA; provided that a material inaccuracy or combination of material inaccuracies of the representations and warranties of MSHA shall not be sufficient grounds for Wellmont to not consummate the Affiliation unless the disclosed inaccuracy or inaccuracies are of a character or nature that could reasonably be expected to have a Material Adverse Effect with respect to Mountain States or that constitute grounds for not Closing under another Section of this Article VII.

Section 7.02 Performance of Agreements. MSHA shall have performed in all material respects all obligations and agreements and complied in all material respects with all covenants and conditions contained in this Agreement to be performed or complied with by such party at or prior to the Effective Date, and there shall be delivered to each party on the Effective Date a certificate to such effect signed by an executive officer of MSHA; provided that a material failure to perform or combination of material failures to perform shall not be sufficient grounds for Wellmont to not consummate the Affiliation unless the material failure or failures to perform could reasonably be expected to have a Material Adverse Effect with respect to Mountain States or that constitute grounds for not Closing under another Section of this Article VI.

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Section 7.03 Actual Actions. There shall not be any actual actions or proceedings by or before any court or other governmental body or agency which (a) seek to restrain, prohibit, or invalidate the transactions contemplated by this Agreement or (b) could reasonably be expected to materially affect the right of Parent Company, MSHA or Wellmont to own, operate, or control a material portion of their respective assets after the Effective Date.

Section 7.04 Necessary Consents; Notices. All authorizations, consents, and approvals by any third parties, including all federal, state, and local regulatory bodies and officials, that are necessary for the consummation of the transactions contemplated by this Agreement shall have been received and shall be in full force and effect; provided that, except for the condition set forth in Section 7.08, absence of one or more non-governmental third-party consents shall not be sufficient grounds for Wellmont to not consummate the Affiliation unless the absence of such non-governmental third-party consent(s) could reasonably be expected to have a Material Adverse Effect or constitute grounds for not Closing under another Section of this Article VII. Without limiting the generality of the foregoing, Wellmont shall not be obligated to consummate the transactions contemplated hereby unless it receives reasonably satisfactory evidence that (a) the MSHA Board has ratified, adopted, confirmed and approved this Agreement and the transactions herein contemplated which evidence means receipt from MSHA of a certified copy of resolutions of its Board of Directors to such effect adopted in a manner required by the law of Tennessee, and (b) all of the conditions in Section 7.05 have been satisfied.

Section 7.05 Regulatory Approvals.

(a) If applicable, the waiting period imposed by the Hart-Scott-Rodino Antitrust Improvements Act of 1976 shall have expired or been terminated.

(b) The Attorney General and Reporter of Tennessee shall have issued written notice of his decision to take no action with respect to the Affiliation pursuant to the Tennessee Public Benefit Hospital Sales and Conveyance Act of 2006, Tennessee Code §§ 48-68-201, et seq.

(c) The Attorney General of Virginia shall not have issued any correspondence or communication to the parties indicating that the Attorney General will take action with respect to any notice filing made pursuant to §§55-531 et seq. of the Code of Virginia.

(d) The Approvals shall have been received from the Tennessee Department of Health, the Southwest Virginia Health Authority and the Virginia Department of Health.

(e) The terms and conditions of the foregoing regulatory approvals shall be satisfactory in form and substance to the Board of Directors of Wellmont.

Section 7.06 Absence of Material Adverse Change.

(a) From the date hereof through the Effective Time, there shall not have occurred any event or circumstance or combination of events or circumstances that would reasonably be expected to have a Material Adverse Effect with respect to Mountain States.

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(b) Neither (i) the Open Diligence Items identified by Wellmont which have not been resolved to the reasonable satisfaction of Wellmont, nor (ii) any litigation pending against MSHA, would reasonably be expected to have a Material Adverse Effect with respect to MSHA.

Section 7.07 Other Matters. The actions required by 2.01(b),(c), (d), (e), (f), (g)(i), and (g)(ii), 2.02, and 2.05, including without limitation, preparation and attachment to this Agreement of relevant Exhibits, shall have occurred.

Section 7.08 Note Holders Waivers. The holders of the Notes shall have unconditionally waived any Event of Default resulting from or arising out of the transactions contemplated by this Agreement.

Article VIII Termination.

Section 8.01 Termination. This Agreement may be terminated and the transactions contemplated hereby abandoned prior to the Closing upon the following terms:

- (a) By both Parties upon their mutual written consent
- (b) By either Wellmont or MSHA if Closing shall not have occurred on or before the Outside Date and, within the fourteen (14) day period immediately preceding such Outside Date, such Party gives written notice of its intent to terminate effective as of the Outside Date should Closing not have previously occurred. For purposes of this Agreement, the term “Outside Date” means the date that is one (1) year after the date of this Agreement and, unless earlier terminated as provided in this Article VIII, the expiration date of each subsequent automatic three-month extension, provided that the party electing to terminate this Agreement shall not then be in breach of this Agreement;
- (c) By MSHA, if (without any breach by MSHA of any of its obligations hereunder) satisfaction of any condition to Closing set forth in Article VI becomes impossible and such failure of such satisfaction is not waived by MSHA; or
- (d) by Wellmont, if (without any breach by Wellmont of any of its obligations hereunder) satisfaction of any condition to Closing set forth in Article VII becomes impossible and such failure of compliance is not waived by Wellmont.

Section 8.02 Effect of Termination. In the event of any termination of this Agreement, as provided by Section 8.01, no Party will have any further rights or obligations hereunder, except that the obligations of the parties contained in this Section 8.02 (Effect of Termination), and in Sections 5.04(a) (Confidentiality), 10.02 (Survival), 10.03 (Brokerage), 10.04 (Expenses), 10.05 (Governing Law and Venue), 10.06 (Entire Agreement), 10.07 (Amendments and Modifications), 10.08 (Assignment), 10.09 (Captions), 10.11 (Notices), 10.12 (Successors and Assigns), 10.13 (Public Announcement), 10.14 (Construction and Certain Definitions), and any related definitional provisions set forth in this Agreement shall survive and (b) termination shall not relieve any party of any liability for a breach of, or for any misrepresentation under, this

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Agreement, or be deemed to constitute a waiver of any available remedy (including specific performance) for any such breach or misrepresentation.

Article IX Additional Covenants.

Section 9.01 Joint Board Task Force. The Parties have formed a Joint Board Task Force, comprised of an equal number of their respective existing board members and the CEOs of each and listed on Exhibit E to oversee the pre-Closing activities of the Integration Council identified in Section 9.02 below. As promptly as practicable after the date hereof, MSHA and Wellmont will jointly select two (2) additional members of the Joint Board Task Force, neither of whom may be incumbent members of either Party's board of directors. Further, upon signing of this Agreement, the Parties will jointly invite the incumbent President of East Tennessee State University to join the Joint Board Task Force. If at any time prior to the Effective Date, the identity of the individuals who will serve as the Initial Directors changes, then the individuals on the Joint Board Task Force will be modified to conform to the expected identity of the Initial Directors.

Section 9.02 Integration Council. The Parties have established an Integration Council, comprised of twelve (12) members listed on Exhibit E, as a nonexclusive means to prepare the parties for integration, and, among other things, to retain independent consultant (the "Consultant(s)") to undertake a comprehensive analysis of the clinical, operational and financial functions of Wellmont and MSHA to (a) identify, substantiate and quantify the cost-savings and quality-enhancement opportunities achievable specifically from the Affiliation and (b) help establish a timeline and integration plan for achieving these opportunities. Prior to Closing, the Integration Council shall:

(a) engage on a regular basis, with the Consultant(s) for periodic reports on the Consultant(s)' analysis and supply information as needed to further the analysis, and prepare the Parties for integration to ensure a system approach that best serves the needs of the community and region based on objective information; and

(b) Develop a draft Parent Company 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. Upon the Effective Time, the draft policy shall be submitted to the Board of Directors of the Parent Company for approval.

Wellmont and MSHA may jointly engage additional third-party consultants to advise the Integration Council. The Integration Council shall report to the Joint Board Task Force. All of the activities of the Integration Council prior to the Effective Time shall be reviewed by and advised in advance by legal counsel to ensure compliance with all applicable legal and regulatory restrictions. Establishment of the Integration Council is not intended to be the sole means to prepare for post-Closing integration of the Parties to establish the Parent Company health system. The directors, officers and management teams of each party may take such other planning steps as they determine to be necessary or appropriate to prepare for the post-Closing integration. The Chief Executive Officer, in consultation with the Executive Chairman/President, shall determine whether it is in the interest of the Parent Company for the

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Integration Council to disband upon the Effective Date or for it to perform any specified functions post-Closing serving in the capacity of an advisory council to the Initial Management Team.

Section 9.03 Public Health Needs Assessment. After the Effective Time, Parent Company 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:

- (a) 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;
- (b) Improvement of behavioral health services, mental health, addiction recovery, and services for people with developmental disabilities;
- (c) Enhancement of programs to reduce drug abuse in the region, specifically among women in child-bearing years;
- (d) Establishment of programs to improve health literacy;
- (e) Development of programs to improve child wellness – physical and emotional;
- (f) Growth of medical research programs; and
- (g) 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 served by Parent Company and its Affiliates.

Section 9.04 Hospital and Affiliate Governance. Subject to the provisions of any existing joint venture and other contractual agreements, the governing board of all hospitals and other Affiliates will be appointed by, and serve at the pleasure of, the Parent Company Board of Directors. The Parent Company Board shall have final authority as sole member of Parent Company's ownership interest in any hospital, joint venture or partnership. Except as provided below, the existing governing boards of hospitals and Affiliates as of the Effective Time will continue to serve unless and until replaced by the Parent Company Board. To the degree any of the Boards of any subsidiary or wholly-owned organizations of Wellmont or MSHA have membership constituted to include Board Members of Wellmont or MSHA, such composition shall be modified such that initially there is an equal representation from Wellmont and MSHA. The composition of the boards of the respective physician organizations of Wellmont and MSHA will be approved by the Parent Company Board. The charters of the Wellmont and MSHA foundations will require that their respective funds as of the Effective Time be used consistent with the intent of the original donors thereof.

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Section 9.05 Clinical Council.

(a) Promptly after the Closing, Parent Company will develop a physician-led clinical council (the “Clinical Council”) (composed of appropriate balances of private physicians, group practice physicians and employed physicians whose initial composition is determined by the Parent Company Board of Directors) to guide, advise and assist in implementation of a 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. The initial Clinical Council will equally represent physicians whose primary practice venue is Wellmont or MSHA.

(b) The Clinical Council will include Parent Company management representatives but will be composed primarily of physician representatives. The Clinical Council will report to the Chief Medical Officer of Parent Company. The Chair of the Clinical Council will be a physician member of the active medical staff(s) of one or more Parent Company-affiliated hospitals, will serve on the Quality Committee of the Parent Company Board, and will provide ongoing reports on the activities of the Clinical Council to the Parent Company Board through the Quality and Safety Committee function of the Parent Company 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.

Section 9.06 Corporate Headquarters. Within two (2) years of closing, the Parent Company Board of Directors will direct that Parent Company senior management evaluate the most suitable, cost-effective and appropriate location of the corporate headquarters of Parent Company and make a recommendation to the Board for consideration and approval. The Parent Company corporate headquarters shall not be located on the campus of any Parent Company affiliated hospital.

Section 9.07 Employees.

(a) After the Effective Time, all active employees of Wellmont, MSHA and their Affiliates will continue their employment at-will upon substantially similar terms and conditions with respect to base salaries and wages, job duties, titles and responsibilities that are provided to such employees immediately prior to Closing, except that certain positions that are identified as synergies may be eliminated. Normal employment practices, including terminations and reductions in force, will be unaffected.

(b) Parent Company 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 MSHA, and will waive any eligibility requirement or pre-existing condition limitation for persons covered under each Parties’ employee benefit

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plans. Parent Company will provide all employees credit for accrued vacation and accumulated sick leave.

(c) Parent Company 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.

Section 9.08 Medical Staffs; Physician Contracts.

(a) Parent Company is committed to a pluralistic, physician-led medical staff model that embraces the strengths of private practice, group practice and employed physicians.

(b) All existing medical staff members in good standing at any hospital affiliated with Wellmont or MSHA immediately prior to the Effective Time shall maintain such privileges immediately after the Effective Time, subject to the medical staff bylaws then in effect. All medical staff bylaws of any such hospital will remain in effect following the Effective Time. Notwithstanding any provision herein to the contrary, no term of this Agreement shall be deemed to (i) create any contract with any member of the medical staff, (ii) give any member of the medical staff the right to retain his or her medical staff privileges after the Effective Time, (iii) interfere with the right of Wellmont, MSHA or any affiliated hospital to terminate any member of the medical staff's privileges in accordance with such hospital's then current medical staff bylaws or (iv) interfere with the right of Parent Company, Wellmont, and MSHA or any affiliated hospital to modify such hospital's medical staff bylaws.

(c) All contracts of Wellmont, MSHA, and their respective Affiliates with physicians deemed compliant with applicable law in accordance with the due diligence process followed by the Parties, including employment agreements, in effect as of the Effective Time will be performed in accordance with their terms after the Effective Time.

Section 9.09 Existing Affiliations. Parent Company will initially maintain the Wellmont and MSHA joint ventures, affiliations and other outsourced contracts/relationships existing at the Effective Time. Opportunities to optimize such structures will continue to be evaluated by the Parent Company Board and management team post-Closing.

Section 9.10 Information Technology. As soon as practicable after the Effective Time, all Parent Company hospitals will fully integrate into a common information system platform.

Section 9.11 Insurance Platforms. As soon as practicable after the Effective Time, Parent Company will review the structure of the existing insurance platforms of Wellmont and MSHA and work to spread risk, reduce costs and realize efficiencies that result from the Affiliation.

Section 9.12 Philanthropic Gifts. Parent Company will honor the intent of all gifts, bequests, grants and donations provided to either MSHA or Wellmont by a donor to be used for charitable purposes by a tax-exempt organization.

Article X Miscellaneous Provisions.

Section 10.01 Nonsurvival of Representations and Warranties. None of the representations and warranties in Articles III or IV of this Agreement shall survive the Effective Time.

Section 10.02 Survival of Covenants. All covenants contained in this Agreement that contemplate performance thereof following the Effective Time will survive for the period so contemplated by such covenant whether for a specified number of years or by reference to a specified external event or circumstance, and may be enforced during, or timely following, their duration.

Section 10.03 Brokerage. Except for Wellmont's engagement of Kaufman Hall, each of Wellmont and MSHA represents and warrants to the other that it has not dealt with any business broker, real estate agent, finder, or other third party broker or intermediary in connection with the subject of this Agreement or the transactions contemplated hereby.

Section 10.04 Expenses; Termination Payment.

(a) Except to the extent provided in Section 10.04(b), whether or not the transactions contemplated by this Agreement are consummated, MSHA shall bear seventy percent (70%) of all of the expenses incurred by MSHA or Wellmont for the accounting, legal, investment banking, and other professional services provided to either Party which arise out of the term sheet executed by the Parties effective April 2, 2015, the negotiation and preparation of this Agreement, and the transactions contemplated by, the performance of or compliance with any condition or covenant set forth in, and the consummation of the transactions provided for in, this Agreement, including Due Diligence Expenses (the "Expenses"). Wellmont shall bear thirty percent (30%) of the Expenses.

(b) Notwithstanding Section 10.04(a), Wellmont shall pay all of the amount, if any, by which Wellmont Due Diligence Expenses exceeds MSHA Due Diligence Expenses and MSHA shall pay all of the amount, if any, by which MSHA Due Diligence Expenses exceeds Wellmont Due Diligence Expenses, and the amount of Expenses subject to subsection (a) shall be reduced by the amount of such excess. "Wellmont Due Diligence Expenses" shall mean fees and expenses charged by Baker, Donelson, Bearman, Caldwell and Berkowitz, P.C. and Hunter, Smith and Davis LLP to Wellmont arising from their respective legal diligence reviews of MSHA and its Subsidiaries, and fees and expenses charged by Navigant Consulting, Inc. and others to Wellmont arising from their respective financial, business, and operational reviews of MSHA. "MSHA Due Diligence Expenses" shall mean fees and expenses charged by Seigfreid Bingham P.C. to MSHA arising from its legal diligence review of Wellmont and its Subsidiaries, and fees and expenses charged by BKD, LLP and by Pershing Yoakley and Associates, P.C. to MSHA arising from their respective financial, business, and operational reviews of Wellmont. In order for any other expenses incurred directly by a Party to be considered its Due Diligence Expenses, such expenses shall be reviewed and determined by the Parties to be for due diligence review.

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(c) Without limiting subsections (a) and (b) above, the expenses subject to this Section 10.04 shall include those the Joint Board Task Force or the Board of Directors of MSHA or Wellmont, as applicable, determine are necessary or appropriate to perform the Parties obligations specified in this Agreement. MSHA has retained an information technology consultant to conduct a comprehensive review of both party's information technology systems. The Parties agree that this review is outside the scope of the agreed cost sharing, so that MSHA will pay 100% of this expense. The Parties may also make other exceptions to the agreed upon cost sharing on a case-by-case basis.

(d) On February 29, 2016, and again within ninety (90) days after the date this Agreement is terminated, MSHA and Wellmont shall provide each other with a report setting forth all Expenses, including a separate report showing Due Diligence Expenses, incurred by them through December 15, 2015 or the date of termination, as applicable, together with such reasonable supporting detail as either Party may request, subject to such redactions as may be required to preserve attorney-client privilege, comply with HIPAA and other applicable privacy laws, or to prevent the disclosure of Competitive Sensitive Information. Not less than thirty (30) days after such reports are provided, MSHA shall pay Wellmont, or Wellmont shall pay to MSHA cash in the amount that will result in Expenses, including Due Diligence Expenses, incurred through December 15, 2015 or the termination date, as applicable, being shared in the proportions set forth in subsection (a) above, as adjusted or limited as required by subsections (b) and (c) above, and taking into account the net effect of prior interim monthly payments made by each Party to the other. Beginning March 15, 2016, within fifteen (15) days after the end of each calendar quarter thereafter prior to the Effective Date, MSHA and Wellmont shall provide to each other a written report of Expenses, including a separate report showing Due Diligence Expenses, incurred through the end of the preceding quarter, together with such reasonable supporting detail as either Party may request, subject to such redactions as may be required to preserve attorney-client privilege, comply with HIPAA and other applicable privacy laws, or to prevent the disclosure of Competitive Sensitive Information. Not less than fifteen (15) days after such reports are provided, MSHA shall pay to Wellmont, or Wellmont shall pay to MSHA, as applicable, cash in the amount that will result in Expenses incurred through the end of the preceding month (not including the Due Diligence Expenses) being shared in the proportions set forth in subsection (a) above.

(e) In addition to any other payments required pursuant to this Section 10.04, in the event MSHA elects to terminate this Agreement pursuant to Section 8.01(c) in circumstances in which the conditions to Closing set forth in Article VI, other than the condition set forth in Section 6.05(e), have been satisfied, or Wellmont elects to terminate this Agreement pursuant to Section 8.01(d) in circumstances in which the conditions to Closing set forth in Article VII, other than the condition set forth in Section 7.05(e), have been satisfied, the Party exercising the right to terminate shall pay to the other Party cash in an amount equal to One Million, Five Hundred Thousand Dollars (\$1,500,000).

Section 10.05 Governing Law; Venue.

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(a) This Agreement and the transactions contemplated herein shall be governed by, interpreted, construed, and enforced in accordance with the laws of the State of Tennessee applicable to contracts made and to be performed entirely within the State of Tennessee without giving effect to choice or conflict law provisions that would cause the application of the domestic substantive laws of any other jurisdiction.

(b) Any suit, action or other proceeding arising out of this Agreement or any transaction contemplated hereby shall be brought exclusively in the state or federal court located in the jurisdiction in which the corporate headquarters of the defending party is located (the "Proper Court"). Each party irrevocably and unconditionally waives any objection to the laying of venue of any such action, suit or proceeding in the Proper Court and further irrevocably and unconditionally waives and agrees not to plead or claim that any such action, suit or proceeding brought in the Proper Court has been brought in an inconvenient forum.

Section 10.06 Entire Agreement. This Agreement (together with the Schedules and any subsidiary documents incorporated herein) contains the entire agreement of the parties with respect to the subject matter hereof. Notwithstanding the foregoing, the parties acknowledge that they are bound by the terms of the Confidentiality Agreement, other than in cases in which it conflicts with the terms of this Agreement in which instances the terms of this Agreement shall prevail.

Section 10.07 Amendments and Modifications. This Agreement shall not be modified, amended, or changed in any respect except in writing duly signed by the parties hereto and each party hereby waives any right to amend this Agreement in any other way.

Section 10.08 Assignment. Neither party may assign any of its rights or delegate any of its duties under this Agreement without the prior written consent of the other party.

Section 10.09 Captions. Captions in this Agreement are solely for the purposes of identification and shall not in any manner alter or vary the interpretation or construction of this Agreement.

Section 10.10 Execution in Counterparts. This Agreement may be executed in more than one counterpart, each of which shall be deemed to be an original, but all of which shall be deemed to constitute one instrument. It shall not be necessary for all parties to have signed the same counterpart provided that all parties have signed at least one counterpart.

Section 10.11 Notices. All notices or other communications that are required or permitted hereunder shall be given in writing and shall be given either by personal delivery, by FedEx or other overnight courier, or by facsimile, shall be deemed to have been given when personally delivered, when deposited with charges prepaid with FedEx or other nationally recognized overnight courier service, or when transmitted to a facsimile machine, addressed to the respective parties as follows:

Wellmont: Wellmont Health System
1905 American Way

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Kingsport, Tennessee 37660
Attn: Bart Hove, President & CEO

With a copy (which shall not constitute notice) to:

Wellmont Health System
1905 American Way
Kingsport, Tennessee 37660
Attn: Gary D. Miller, General Counsel

and to: Baker Donelson Bearman Caldwell & Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201
Attn: Richard G. Cowart, Esq.

MSHA: Mountain States Health Alliance
303 Med Tech Parkway, Suite 303
Johnson City, TN 37604
Attn: Alan Levine, President

With a copy (which shall not constitute notice) to:

Mountain States Health Alliance
303 Med Tech Parkway, Suite 370
Johnson City, TN 37604
Attn: Tim Belisle, General Counsel

Any party may by notice change the address to which notice or other communications to such party are to be delivered or mailed.

Section 10.12 Successors and Assigns. All of the terms and provisions of this Agreement shall be binding upon and shall inure to the benefit of the parties hereto, their successors, and, to the extent permitted herein, their assigns. No third parties are intended to benefit, however, from the terms and provisions hereof or from any representation, warranty, covenant, or obligation set forth herein or in any schedule, exhibit, or other writing delivered pursuant hereto.

Section 10.13 Public Announcement. Except as and to the extent required by law, without the prior written consent of the other party, neither MSHA 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 this Agreement or any of the terms, conditions or aspects of this Agreement 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 transactions contemplated by this Agreement prior to the communication of the same.

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Section 10.14 Construction and Certain Definitions.

(a) Each party to this Agreement and its counsel have reviewed and revised this Agreement. The normal rule of construction to the effect that any ambiguities are to be resolved against the drafting party shall not be employed in the interpretation of this Agreement or of any amendments or Schedules to this Agreement.

(b) References to this Agreement are references to this Agreement and to the Exhibits and Schedules to this Agreement

(c) References to any document (including this Agreement) are references to that document as amended, consolidated, supplemented, novated or replaced by the parties thereto from time to time.

(d) References to Sections and Articles are references to sections and articles of this Agreement.

(e) References to a party to this Agreement shall include its respective successors and permitted assigns.

(f) The gender of all words in this Agreement includes the masculine, feminine and neuter, and the number of all words in this Agreement include the singular and plural.

(g) The word "including" shall mean including without limitation, unless followed by the word "only."

[Signature page follows]

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IN WITNESS WHEREOF, the parties hereto have executed or caused to be executed this Agreement on the day and year first above written.

WELLMONT HEALTH SYSTEM

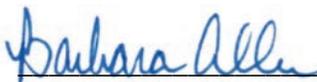
By: 

Roger Leonard
Chairman of the Board of Directors

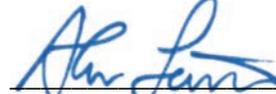


Bart Hove
President and CEO

MOUNTAIN STATES HEALTH ALLIANCE

By: 

Barbara Allen
Chairman of the Board of Directors



Alan Levine
Chief Executive Officer

EXHIBITS

- Exhibit A. Affiliates.**
- Exhibit B. Shared Vision and Guiding Principles.**
- Exhibit C-1. Interim Parent Company Articles and Interim Parent Company Bylaws.**
- Exhibit C-2. Interim Directors and Interim Officers.**
- Exhibit C-3 Amended Parent Company Articles.**
- Exhibit C-4 Amended Parent Company Bylaws.**
- Exhibit D-1. Parent Company Board Officers and Initial Management Team**
- Exhibit D-2. Position Description of Executive Chairman/President**
- Exhibit D-3. Position Description of CEO**
- Exhibit D-4. Position Descriptions of COO and CFO**
- Exhibit E. Joint Board Task Force**
- Exhibit F. Integration Council**
- Exhibit G. Definitions.**

EXHIBIT A

Affiliates

MSHA AFFILIATES

Set forth below is an indication of the interest owned by MSHA in each corporation, partnership, joint venture, or other business association or entity in which MSHA owns any of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests):

- Smyth County Community Hospital (80.0%)
- Mountain States Health Alliance Auxiliary, Inc. (100%)
- Mountain States Foundation (100%)
- Integrated Solutions Health Network (99.83%)
- Anew Care Collaborative, LLC (owned 100% by Integrated Solutions Health Network)
- CrestPoint Health Insurance Company, Inc. (owned 100% by Integrated Solutions Health Network)
- Norton Community Hospital (50.1%)
- Norton Community Physician Services, LLC (owned 100% by Norton Community Hospital)
- Dickenson Community Hospital, Inc. (owned 100% by Norton Community Hospital)
- Community Home Care, Inc. (owned 100% by Norton Community Hospital)
- Johnston Memorial Hospital, Inc. (50.1%)
- Abingdon Physician Partners (owned 100% by Johnston Memorial Hospital, Inc.)
- JMH Emergency Physicians, LLC (owned 100% by Johnston Memorial Hospital, Inc.)
- Blue Ridge Medical Management Corporation (100%)
- Mountain States Physician Group, Inc. (owned 100% by Blue Ridge Medical Management Corporation)
- Mountain States Properties, Inc. (owned 100% by Blue Ridge Medical Management Corporation)
- Kingsport Ambulatory Surgery Center, L.L.C. (owned 43% by Blue Ridge Medical Management Corporation)
- MediServe Medical Equipment of (owned 100% by Blue Ridge Medical Management Corporation)
- Kingsport, Inc. (owned 100% by Blue Ridge Medical Management Corporation)
- Emmaus Community Healthcare, LLC (owned 75% by Blue Ridge Medical Management Corporation)
- Wilson Pharmacy, Inc. (owned 100% by Blue Ridge Medical Management Corporation)
- The Castle Project, LLC (owned 5% by Blue Ridge Medical Management Corporation)
- Quillen Rehabilitation Hospital of Johnson City, LLC (owned 49.9% by Blue Ridge Medical Management Corporation)
- Mountain Empire Surgery Center, L.P (owned 33.86% by Blue Ridge Medical Management Corporation)

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- TLC Tri-Cities Laser Center, Inc. (owned 20% by Blue Ridge Medical Management Corporation)

WELLMONT AFFILIATES

Set forth below is an indication of the interest owned by Wellmont in each corporation, partnership, joint venture, or other business association or entity in which Wellmont owns any of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests).

- Wellmont Health System (100%)
- Wellmont Cardiology Services (100%)
- Wellmont Foundation, Inc. (100%)
- Wellmont/HealthSouth IRF, LLC (25%)
- Wellmont Madison House (100%)
- Wellmont Hawkins County Memorial Hospital, Inc. (100%)
- Wellmont Medical Associates (100%)
- Wellmont Health Management Services, Inc. (100%)
- Advanced Home Care (5.76%)
- Highlands Wellmont Health Network, Inc. (50%)
- Renaissance Surgery (33%)
- Holston Valley Ambulatory Surgery Facility, LLC (52%)
- Sapling Grove Ambulatory Surgery Facility, LLC (65%)
- Wellmont Integrated Network, LLC (100%)
- Wellmont Health Management Services, LLC (100%)
- Wellmont Imaging Services (100%)
- Holston Valley Imaging Center (100%)
- Wellmont Sleep Services (100%)
- Wellmont Wexford House (100%)
- Wellmont Insurance Company SPC, LTD (100%)
- Wellmont Inc. (100%)
- Wellmont Health Services Inc. (100%)
- Professional Park Assoc., LLC (12.72%)
- Bristol Surgery Center, LLC (100%)
- Medical Mall Pharmacy (100%)
- Medical Laundry (100%)
- MCOT, Inc. (100%)
- Wellmont Physician Services (100%)

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- WPS Providers, Inc. (100%)

EXHIBIT B

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.

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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

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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

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- 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

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EXHIBIT C-1

Interim Parent Company Articles and Interim Parent Company Bylaws

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EXHIBIT C-2

Interim Directors and Interim Officers

Directors: Barbara Allen, Roger Leonard, Roger Mowen, and Gary Peacock

Officers:

President: Alan Levine

Secretary/Treasurer: Alice Pope

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EXHIBIT C-3

Amended Parent Company Articles

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EXHIBIT C-4

Amended Parent Company Bylaws

EXHIBIT D-1

Parent Company Board Officers and Initial Management Team

Board Officers shall be:

- (i) Executive Chairman/President: Alan Levine
- (ii) Vice Chairman/Lead Independent Director: To be nominated by Wellmont and affirmed by the non-management members of the Joint Board Task Force
- (iii) Treasurer: To be determined by the Joint Board Task Force
- (iv) Secretary: To be determined by the Joint Board Task Force
- (v) Chief Executive Officer: Bart Hove

The Initial Management Team shall be:

- (i) Executive Chairman/President: Alan Levine
- (ii) Chief Executive Officer: Bart Hove
- (iii) Chief Operating Officer: Marvin Eichorn
- (iv) Chief Financial Officer: Alice Pope

Individuals appointed to the Board Officer positions identified in (ii), (iii), and (iv) above as of the Effective Time shall be set forth in an updated Exhibit E-1 to be attached hereto and initialed by the Parties on the Effective Date.

EXHIBIT D-2

Position Description of 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 the Corporation'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 Nominating Committee, initiating change and planning succession in board appointments subject to the bylaws and board approval.

Induction, Development and Performance Evaluation

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- 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 the Corporation.
- 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 Corporation with appropriate delegation of authority to the CEO on operational matters.
- Representing the Corporation 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 the Corporation and on healthcare issues in general.
- Maintaining and promoting the Corporation'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 the Corporation Board and Management Team.

The Executive Chairman/President is accountable to, and reports to the Corporation's Board.

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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 Corporation Board for ensuring the provision of the highest quality of patient care and customer service in all the Corporation facilities and business units.
- Responsible for management of the organization's debt.

Aligning the organization: continuing to drive the integration of the Corporation to create a cohesive, responsive organization by eliminating redundancies, capitalizing on economies of scale, and fostering a system mentality

EXHIBIT D-3

Position Description of CEO

Leadership

- The Chief Executive Officer of the Corporation reports to the Executive Chairman/President and is the senior executive in charge of all business operations of the Corporation 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 the Corporation'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 the Corporation'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 Corporation 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.

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- 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 D-4

Position Descriptions of COO and CFO

Chief Operating Officer

Leadership

- The Chief Operating Officer (COO) for NEWCO reports directly to the NEWCO CEO and is responsible for the effective and efficient operations of the System and any subsidiary components as directed by the Chief Executive Officer. The COO shall ensure proper operational focus consistent with the organization's strategic plan.
- The COO provides direction to key executives and other members of the management team to ensure the objectives of the organization are met, including optimal patient experience, quality and financial outcomes.
- The COO shall communicate with clarity, and develop talent within the organization to enhance the growth of future company leaders.

Major Responsibilities

- Interface with key NEWCO operational executives, subsidiaries and corporate support functions to ensure operational effectiveness throughout the organization.
- Develop and foster effective collaboration between corporate support functions, clinical leadership, physician leadership and other functions to ensure an integrated approach to providing services and fulfilling the hospitals clinical, research and educational goals and objectives.
- Oversee major workforce and resource decisions.
- Develop new business strategies.
- Attention is to be given to systems, program development, quality, fiscal management, compliance and clinical management measures, physician relationships, outreach strategies, work culture enhancement and internal communication and consensus building.

Direct Reports

- Key corporate and operating entities shall report to the COO, as determined from time to time by the CEO in consultation with the Executive Chairman/President.

Chief Financial Officer

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Leadership

- The Chief Financial Officer of NEWCO reports directly to the NEWCO CEO and is responsible for overseeing and implementing the financial strategy and operations for NEWCO. This position is responsible for financial reporting, financial compliance, budgeting, treasury management including investment and debt management, asset management including capital planning and budgeting, and payer relations.
- The position must effectively communicate and collaborate with departmental leadership, medical staff leadership, system leadership and the boards and committees of NEWCO to ensure an integrated approach to financial services.

Major Responsibilities

- Financial and strategic planning for assigned areas including but not limited to budget development, capital planning, cash forecasting, investment management/planning and payer relations.
- Foster relations between corporate entities
- Present to external audiences

Direct Reports

- Key corporate and operations finance personnel as determined from time to time by the CEO in consultation with the Executive Chairman/President

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EXHIBIT E

Joint Board Task Force

MSHA

Barbara Allen
Bob Feathers
Clem Wilkes, Jr.
Gary Peacock
Dr. David May
Dr. David Moulton
Alan Levine

WHS

Roger Leonard
Roger Mowen
Keith Wilson
Dr. Nelson Gwaltney
Dr. Doug Springer
Dr. David Thompson
Bart Hove

EXHIBIT F

Integration Council

MSHA

Marvin Eichorn (Co-Chair)

Dr. Morris Seligman

Lynn Krutak

Tony Keck

Dr. Sandra Brooks

Tim Belisle

WHS

Eric Deaton (Co-Chair)

Alice Pope

Dr. Robert Funke

Dr. Dale Sargent

Todd Norris

Gary Miller

EXHIBIT G

Definitions

- 1.01 "Affiliation" has the meaning set forth in the Recitals.
- 1.02 "Agreement" has the meaning set forth in the Recitals.
- 1.03 "Amended Wellmont Articles" has the meaning set forth in Section 2.01(a)(ii).
- 1.04 "Amended Wellmont Bylaws" has the meaning set forth in Section 2.01(a)(ii).
- 1.05 "Approvals" has the meaning set forth in Section 5.06(b).
- 1.06 "Balance Sheet" has the meaning set forth in Sections 3.04. and 4.04.
- 1.07 "Black Box Process" has the meaning set forth in Section 3.06.
- 1.08 "Clinical Council" has the meaning set forth in Section 9.05(a).
- 1.10 "Competitive Sensitive Information" has the meaning set forth in Section 5.04.
- 1.11 "Consultant(s)" has the meaning set forth in Section 9.02.
- 1.12 "Code" has the meaning set forth in Sections 3.07.
- 1.13 "Confidentiality Agreement" has the meaning set forth in Section 5.04.
- 1.14 "COPA Acts" has the meaning set forth in Section 5.06(a).
- 1.15 "Effective Date" has the meaning set forth in Section 5.01.
- 1.16 "Effective Time" has the meaning set forth in Section 5.01.
- 1.17 "ERISA" has the meaning set forth in Sections 3.16(b) and 4.16(b).
- 1.17 "Expenses" has the meaning set forth in Section 10.04.
- 1.18 "Event of Default" has the meaning given it in the Master Indenture.
- 1.19 "Federal health care programs" has the meaning set forth in Sections 3.17(g) and 4.17(g).
- 1.20 "Financial Statements" has the meaning set forth in Sections 3.04 and 4.04.
- 1.21 "GAAP" has the meaning set forth in Sections 3.04.
- 1.22 "Government Programs" has the meaning set forth in Sections 3.17(b) and 4.17(b).

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- 1.23 "Governmental Entity" has the meaning set forth in Section 3.17(a)(i) and 4.17(b)(i).
- 1.24 "Hazardous Substances" has the meaning set forth in Sections 3.14(b) and 4.14(b).
- 1.25 "HSR" has the meaning set forth in Section 5.05.
- 1.26 "Improvements" has the meaning set forth in Section 3.13(c) and 4.13(c).
- 1.27 "Initial Management Team" has the meaning set forth in Section 2.01(f).
- 1.28 "Interested Person" means with respect to any individual serving on or otherwise eligible to serve on the Parent Company Board of Directors, any committee of the Parent Company Board of Directors, the Board of Directors or any Board committee of MSHA, Wellmont, and any of their subsidiaries, that such individual fits within the published guidance issued by the Exempt Organizations Division of the Internal Revenue Service of the United States of America (the IRS EO Division) regarding which individuals are considered interested persons with respect to 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.
- 1.29 "Intermediate Sanctions" has the meaning set forth in Sections 3.08(i) and 4.08(i).
- 1.30 "Knowledge of MSHA" has the meaning set forth in Section 4.07.
- 1.31 "Knowledge of Wellmont" has the meaning set forth in Section 3.07.
- 1.32 "Leased Real Property" has the meaning set forth in Sections 3.13(b) and 4.13(b).
- 1.33 "Master Indenture" means the Amended and Restated Master Trust Indenture, dated as of February 1, 2000, as supplemented by the Thirty-Ninth Supplemental Master Indenture dated as of July 1, 2013 between MSHA and The Bank of New York Mellon Trust Company, as Master Trustee.
- 1.34 "Material Adverse Effect" means, with respect to any Party, any event, circumstance, development, condition, occurrence, state of facts, change or effect that is or is reasonably likely to have (i) a material adverse effect on the business, assets, results of operations or financial condition of such Party and its Subsidiaries, taken as a whole or (ii) a material adverse effect on the ability of such Party to consummate the transactions contemplated by this Agreement in either case, other than any event, circumstance, development, condition, occurrence, state of facts, change or effect resulting from any one or more of the following: (A) any change in the United States or foreign economies or securities or financial markets in general; (B) any change that affects any industry in which such Party operates; (C) any change arising in connection with natural disasters or acts of nature, hostilities, acts of war, sabotage or terrorism or military actions or any escalation or material worsening of any such hostilities, acts of war, sabotage or terrorism or military actions existing or underway as of the date hereof; (D) any action taken by the other Party to this Agreement with respect to the transactions contemplated by this Agreement; (E) any changes in applicable Laws, accounting rules or the interpretation thereof; (F) the failure of such Party to meet any projections; (G) compliance by such Party with the

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terms of, or taking any action required by, this Agreement; (H) actions required to be taken by such Party under applicable law or contracts; or (I) the public announcement of this Agreement or the consummation of the transactions contemplated by this Agreement.

- 1.35 "Medicaid" has the meaning set forth in Sections 3.17(b) and 4.17(b).
- 1.36 "Medicare" has the meaning set forth in Sections 3.17(b) and 4.17(b).
- 1.37 "MSHA" has the meaning set forth in the Recitals.
- 1.38 "MSHA Financial Statements" has the meaning set forth in Section 4.08.
- 1.39 "MSHA Facility" and "MSHA Facilities" have the meaning set forth in Section 4.17(b).
- 1.40 "MSHA Material Contract" has the meaning set forth in Section 4.07.
- 1.41 "MSHA Subsidiary" and "MSHA Subsidiaries" have the meaning set forth in Section 4.03.
- 1.42 "Notes" means the Mountain States Health Alliance Notes Series 2013A, Series 2013B, Series 2013C, Series 2013D, Series 2013E, Series 2013F, Series 2013G, Series 2013H issued pursuant to the Master Indenture.
- 1.43 "Outside Date" has the meaning set forth in Section 8.01(b).
- 1.44 "Owned Real Property" has the meaning set forth in Sections 3.13(a) and 4.13(a).
- 1.45 "Parent Company" has the meaning set forth in Section 1.02(a).
- 1.46 "Parent Company Articles" has the meaning set forth in Section 2.01(a).
- 1.47 "Parent Company Bylaws" has the meaning set forth in Section 2.01(a).
- 1.48 "Party" and "Parties" have the meaning set forth in the Recitals.
- 1.49 "Permitted Liens" has the meaning set forth in Sections 3.09 and 4.09.
- 1.50 "Person" has the meaning set forth in Sections 3.17(a)(ii) and 4.17(a)(ii).
- 1.51 "Plans" has the meaning set forth in Sections 3.16(b) and 4.16(b).
- 1.52 "Prior Representation" has the meaning set forth in Section 5.07.
- 1.53 "Proper Court" has the meaning set forth in Section 10.05(b).
- 1.54 "Qualified Plan" has the meaning set forth in Sections 3.16(e) and 4.16(e).
- 1.55 "Real Property Leases" has the meaning set forth in Sections 3.13(b) and 4.13(b).

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- 1.56 "Tax" and "Taxes" have the meaning set forth in Sections 3.08(a) and 4.08(a).
- 1.57 "Tax-Exempt Wellmont Subsidiaries" has the meaning set forth in Section 3.08(i).
- 1.58 "Tax Exempt MSHA Subsidiaries" has the meaning set forth in Section 4.08(i).
- 1.59 "Tax Return" has the meaning set forth in Sections 3.08(b) and 4.08(b).
- 1.60 "Tennessee COPA Act" has the meaning set forth in Section 5.06(a).
- 1.61 "Virginia COPA Act" has the meaning set forth in Section 5.06(a).
- 1.62 "Wellmont" has the meaning set forth in the Recitals.
- 1.63 "Wellmont Facility" and "Wellmont Facilities" have the meaning set forth in Section 3.17(b).
- 1.64 "Wellmont Material Contract" has the meaning set forth in Section 3.07.
- 1.65 "Wellmont Subsidiary" and "Wellmont Subsidiaries" have the meaning set forth in Section 3.03.

Exhibit 11.2

Organizational Chart of Mountain States

Mountain States Health Alliance

Legal Structure

Mountain States Health Alliance
 (Franklin Woods Community Hospital, Indian Path Medical Center, Johnson City Medical Center, Johnson County Community Hospital, Niswonger Children's Hospital, Russell County Medical Center, Sycamore Shoals Hospital, Unicoi County Memorial Hospital, Woodridge Psychiatric Hospital)

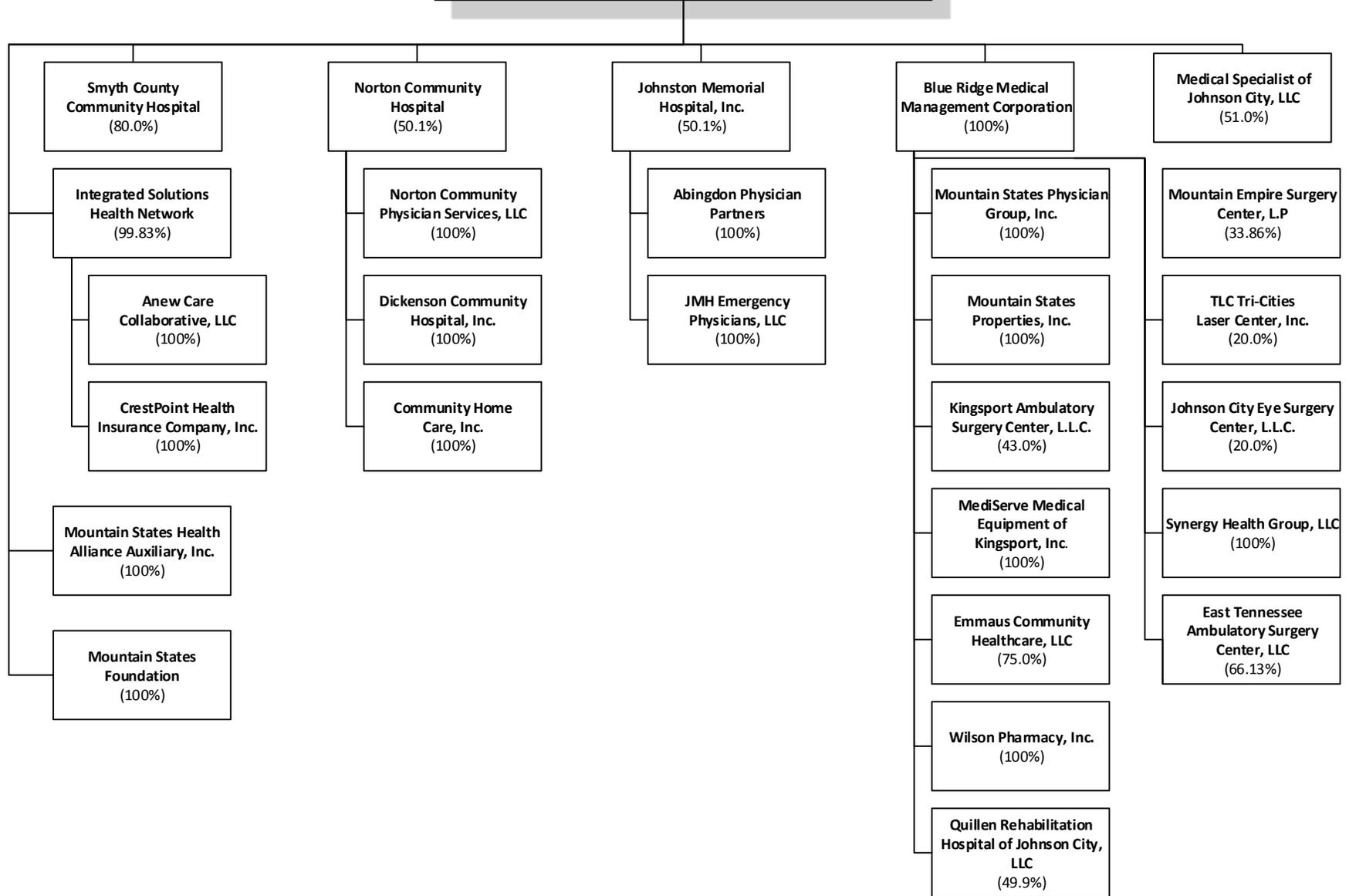


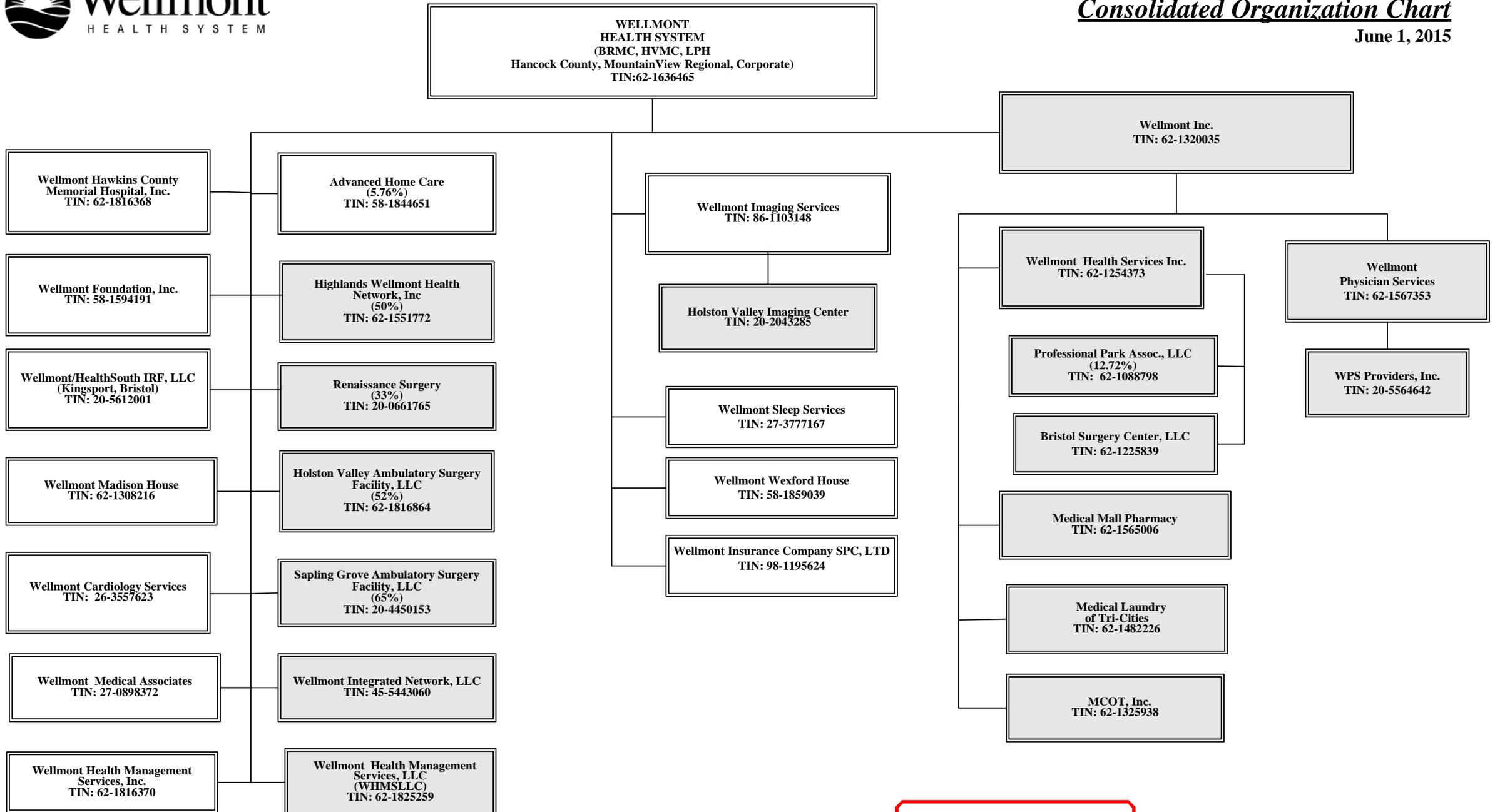
Exhibit 11.3

Organizational Chart of Wellmont



Wellmont Health System
Consolidated Organization Chart

June 1, 2015



Not-For-Profit Corporation (White)
For-Profit Corporation (Gray)

Approval Signature

Date

Exhibit 11.4

Financial Summary for Mountain States

Mountain States Health Alliance Summary for the Fiscal Years
Ended June 30, 2011 through June 30, 2015

Volumes:

Fiscal Year ended June 30, 2011:

As compared to fiscal 2010, inpatient admissions of 61,035 increased by 1.6%. Observation patients increased 13.8%, from 18,358 to 20,894. Total “patients in a bed” increased 4.4%, from 78,460 to 81,929. Deliveries increased 1.1%, from 4,461 to 4,511. Outpatient visits (inclusive of physician and urgent care clinics) declined slightly by 0.8% to 1,546,325. Emergency room visits decreased 3.3%, from 250,942 to 242,677; urgent care visits increased slightly by 0.7%.

Fiscal Year ended June 30, 2012:

As compared to fiscal 2011, inpatient admissions remained relatively flat with a slight increase of 119 or 0.2% to 61,154. Observation patients increased 6.2%, from 20,894 to 22,179. Total “patients in a bed” increased 1.7%, from 81,929 to 83,333. Deliveries declined 4.9%, from 4,511 to 4,288. Consistent with industry trends more volumes shifted from an inpatient to outpatient settings, outpatient visits (inclusive of physician and urgent care clinics) increased by 2.8% to 1,590,307. Emergency room visits increased by 1.7%, from 242,677 to 246,821; urgent care visits increased 11.5%.

Fiscal Year ended June 30, 2013:

As compared to fiscal 2012, inpatient admissions decreased by 3,051 or 5.0% to 58,103. Observation patients increased 6.2%, from 22,179 to 23,554. Total “patients in a bed” decreased 2.0%, from 83,333 to 81,657 primarily due to the implementation of accountable care organizations and high deductible health plans in our area. Deliveries increased by 0.4%, from 4,288 to 4,306. Outpatient visits (inclusive of physician and urgent care clinics) increased by 4.7% to 1,664,755. Emergency room visits increased by 1.1%, from 246,821 to 249,415; urgent care visits increased 23.2% due to a combined effect of an increase in utilization and the opening of a new location.

Fiscal Year ended June 30, 2014:

As compared to fiscal 2013, inpatient admissions continued to decline by 1,063 or 1.8% to 57,040. Observation patients increased 2.8%, from 23,554 to 24,218. Total “patients in a bed” decreased 0.5%, from 81,657 to 81,258. Surgeries increased by 2.6%. Deliveries decreased by 2.2%, from 4,306 to 4,213. Outpatient visits (inclusive of physician and urgent care clinics) increased by 1.7% to 1,693,521. Emergency room visits decreased by 3.9%, from 249,415 to 239,606; urgent care visits increased slightly by 0.1%

Fiscal Year ended June 30, 2015:

As compared to fiscal 2014, inpatient admissions increased by 5,009 or 8.8% to 62,049. Observation patients decreased 3.3%, from 24,218 to 23,407. Total “patients in a bed” increased 5.2%, from 81,258 to 85,456. Recent volume growth is attributed to a realization in pent-up demand as a result of several years of high deductible health plans as well as a strong flu season. Surgeries increased by 3.9%. Deliveries increased by 2.3%, from 4,213 to 4,312. Outpatient visits (inclusive of physician and urgent care clinics) increased by 2.9% to 1,742,769. Emergency room visits increased by 6.8%, from 239,606 to 255,857; urgent care visits increased by 10.8%.

Statement of Operations:

Fiscal Year ended June 30, 2011:

Due to increased volumes over fiscal 2010, net patient revenue increased \$37.0 million or 4.0%. Total Revenue increased by \$36.8 million or 3.9%.

Total Expenses increased \$26.6 million or 2.8%. Salaries, contract labor, and benefits increased by \$16.4 million or 3.5% driven by an increase in FTEs in patient care areas to support higher volume as well as an increase in employed providers. Supply costs decreased by \$6.0 million or 3.4% driven by focused initiatives in supply chain. Fees increased by \$3.4 million or 4.1% mainly as a result of higher physician fees. Depreciation increased by \$19.1 million or 27.9% due to completion of a new hospital and several construction projects. Amortization expense decreased by \$10.6 million due to the ASC 958-805 requirement for not-for-profit entities to cease amortization of goodwill and perform impairment testing in the future.

Income from operations of \$25.8 million for fiscal 2011 increased \$10.2 million over income from operations in fiscal 2010 of \$15.6 million.

Fiscal Year ended June 30, 2012:

Net patient revenue increased \$6.3 million or 0.7% over fiscal 2011. Other revenue increased \$14.7 million mainly due to revenue earned for Electronic Health Record Meaningful Use and vendor contract concessions. Significant costs were incurred to purchase and implement the systems necessary to achieve Meaningful Use. Total Revenue increased by \$21.0 million or 2.1%.

Total Expenses increased \$36.7 million or 3.8%. Salaries, contract labor, and benefits increased by \$29.3 million or 6.0% driven by an increase in FTEs in patient care areas to support higher volume as well as an increase in employed providers. Fees increased by \$12.0 million mainly as a result of higher purchased services and physician fees. Other expense increased by \$6.6 million mainly due to an increase in maintenance contracts for the Electronic Health Record. The above increases were offset by a decrease in depreciation of \$14.4 million resulting from a facility being fully depreciated in 2011.

Income from operations of \$9.9 million for fiscal 2012 declined by \$15.6 million over income from operations in fiscal 2011 of \$25.8 million.

Fiscal Year ended June 30, 2013:

Due to volume declines from fiscal 2012, net patient revenue decreased \$20.6 million or 2.1%. Other revenue increased \$25.1 million mainly due to revenue earned for Electronic Health Record Meaningful Use as compared to approximately \$5 million in fiscal 2012. Total Revenue increased by \$4.5 million or 0.4%.

Total Expenses increased \$13.0 million or 1.3%. Salaries, contract labor, and benefits increased by \$3.9 million or 0.8% driven by an decrease in FTEs in patient care areas due to lower volume and a focus on labor management offset by an increase in employed providers. Supply costs decreased by \$7.2 million or 4.2% driven by a decrease in volume. Fees increased by \$8.0 million mainly as a result of higher purchased services and physician fees. Other expense increased by \$4.6 million mainly due to an increase in maintenance contracts for the Electronic Health Record. Depreciation expense increased by \$5.9 million due to completion of a new hospital. Interest expense decreased by \$2.7 million due to lower interest rates on variable rate debt.

Due to the decline in volume and continued pressure on reimbursement from both governmental and commercial sources, income from operations of \$1.6 million for fiscal 2013 declined by \$8.3 million over income from operations in fiscal 2012 of \$9.9 million.

Fiscal Year ended June 30, 2014:

Net patient revenue decreased \$3.8 million or 0.4% under fiscal 2013. Other revenue increased \$7.1 million mainly due to premium revenue in the provider sponsored Medicare Advantage health plan. Total Revenue increased by \$3.2 million or 0.3%.

Total Expenses decreased \$5.5 million or 0.5%. Salaries, contract labor, and benefits increased by \$16.4 million or 3.1% driven by an decrease in FTEs in patient care areas due to lower volume and a focus on labor management offset by an increase in employed providers. Fees increased by \$9.7 million mainly as a result of higher physician fees. Other expense increased by \$9.0 million mainly due to medical costs related to the provider sponsored Medicare Advantage plan. Depreciation expense decreased by \$9.5 million due to a change in the estimated useful lives of plant and equipment.

As a result of a focus on cost reduction and operating efficiencies, income from operations of \$10.4 million for fiscal 2014 increased by \$8.3 million over income from operations in fiscal 2013 of \$1.6 million.

Fiscal Year ended June 30, 2015:

Due to an increase in volume, net patient revenue increased \$71.5 million or 7.5% over fiscal 2014. Other revenue decreased \$0.7 million mainly due to an increase in premium revenue in

the provider sponsored Medicare Advantage health plan offset by a decrease in revenue earned for Electronic Health Record Meaningful Use. Total Revenue increased by \$70.8 million or 6.9%.

Total Expenses increased \$47.9 million or 4.7%. Salaries, contract labor, and benefits increased by \$10.7 million or 2.1% driven by an increase in FTEs in patient care areas due to higher volume. Fees increased by \$4.7 million mainly as a result of higher physician fees. Supply costs increased by \$12.3 million or 7.5% driven by the increase in volume and increase in cost of pharmaceuticals. Other expense increased by \$23.5 million mainly due to medical costs related to the provider sponsored Medicare Advantage plan. Depreciation expense decreased by \$2.2 million due a reduction in capital expenditures compared to previous years.

Income from operations of \$33.3 million for fiscal 2015 (unaudited) increased by \$22.9 million over income from operations in fiscal 2014 of \$10.4 million.

Balance Sheet and Ratios:

Fiscal Year ended June 30, 2011:

Total assets increased by approximately \$68 million mainly due to an increase in property, plant, and equipment and patient accounts receivable offset by a decline in cash and investments. Total liabilities decreased by almost \$18 million mainly due to a decline in long-term debt.

Operating cash flow margins continue to be strong reaching 15.7%. Operating margin for fiscal 2011 was 2.6% with days cash on hand at 253.2. During the period from 2006 to 2009, the Alliance pursued an acquisition growth strategy in its core service area. The Alliance acquired an interest in five hospital facilities and these investments leveraged the balance sheet. Long term debt to capitalization was 64.5% and debt service coverage was 2.6. However, the above average operating cash flow of the Alliance adequately supports the debt load. FTEs per AOB were 4.94 with labor expense as a percentage of net patient revenue at 48.8%.

Fiscal Year ended June 30, 2012:

Total assets decreased by approximately \$57 million mainly due to a decline in the market value of investments and capital spending. Total liabilities decreased by approximately \$84 million mainly due to the elimination of the call option liability.

Operating margin for fiscal 2012 declined to 1.0%. As a result of the decline in market value of investments, increases in patient receivables, and capital spending, days cash on hand decreased to 214.9. The majority of the decrease in days cash on hand was planned and was a result of funding major construction projects from operating cash flow. Long term debt to capitalization declined to 63.6% and debt service coverage was 2.5. FTEs per AOB were 4.90 with labor expense as a percentage of net patient revenue at 52.3%.

Fiscal Year ended June 30, 2013:

Total assets increased by approximately \$98 million mainly due to an increase in market value of investments, an increase in patient receivables and an increase in land and assets held for expansion. Total liabilities increased by approximately \$36 million mainly due to an increase in long-term debt offset by a decrease in the fair value of interest rate swaps. The increase in long-term debt was due to borrowings to finance capital expenditures including a new surgery tower project at Johnson City Medical Center.

Operating cash flow margin remained steady however operating margin for fiscal 2013 declined to 0.2%. Days cash on hand increased to 235.4. Long term debt to capitalization declined to 62.3% and debt service coverage declined to 2.3. FTEs per AOB were 4.85 with labor expense as a percentage of net patient revenue at 53.9%.

Fiscal Year ended June 30, 2014:

Total assets increased by approximately \$44 million mainly due to an increase in investments and an increase in patient receivables. Capital spending moderated in fiscal 2014 after a period of intense capital spending during the prior six years in which major projects completed during this time included the construction of three replacement hospitals and a new surgery tower. Total liabilities decreased by approximately \$16 million mainly due to a decrease in long-term debt.

Operating cash flow margin of approximately 12% remained on par with fiscal 2013. Operating margin for fiscal 2014 increased to 1.0%. Days cash on hand increased to 257.7. Long term debt to capitalization improved to 59.9% and debt service coverage declined to 2.2. FTEs per AOB were 4.49 with labor expense as a percentage of net patient revenue at 52.3%.

Fiscal Year ended June 30, 2015:

Total assets increased by approximately \$22 million mainly due to an increase in investments. Total liabilities decreased by approximately \$32 million mainly due to a decrease in long-term debt.

Operating margin for fiscal 2014 increased to 3.1%. Days cash on hand increased to 265.3. Long term debt to capitalization improved to 57.1% and debt service coverage improved to 2.3. FTEs per AOB were 4.36 with labor expense as a percentage of net patient revenue at 50.9%.

Attachments:

- Attachment A - Bonds Official Statement for 2011 bonds
- Attachment B - Bonds Official Statement for 2012 bonds
- Attachment C - Bonds Official Statement for 2013 bonds
- Attachment D - Covenant Compliance Certificates for the Last Five Years

- Attachment E - Officer's Certificate accompanying the Independent Auditor's Report for FY10 to FY14
- Attachment F - Audited Financial Statements for 2009 to 2014
- Attachment G - EMMA – Annual Disclosures for 2010 to 2015 and Material Event Disclosures
- Attachment H - Rating Agency Reports

Exhibit 11.4

Attachment A

Mountain States Bonds Official Statement for 2011 Bonds

SUPPLEMENT TO OFFICIAL STATEMENT DATED OCTOBER 14, 2011

\$211,800,000

MOUNTAIN STATES HEALTH ALLIANCE

**The Health and Educational Facilities Board of
the City of Johnson City, Tennessee
Hospital Revenue Bonds
(Mountain States Health Alliance)**

**Industrial Development Authority of
Smyth County (Virginia)
Hospital Revenue Bonds
(Mountain States Health Alliance)**

**Series 2011A
\$65,260,000**

**Series 2011B
\$20,000,000**

**Series 2011C
\$49,875,000**

**Series 2011D
\$60,705,000**

**Mountain States Health Alliance
Taxable Bonds**

**Series 2011E
\$15,960,000**

This Supplement to the Official Statement dated October 14, 2011, has been prepared by Mountain States Health Alliance (the "Alliance") in connection with the issuance and sale by (1) The Health and Educational Facilities Board of the City of Johnson City, Tennessee of its \$65,260,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011A (the "Series 2011A Bonds"), and its \$20,000,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011B (the "Series 2011B Bonds"), (2) the Industrial Development Authority of Smyth County of its \$49,875,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011C (the "Series 2011C Bonds"), and its \$60,705,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011D (the "Series 2011D Bonds"), and (3) the Alliance of its \$15,960,000 Taxable Bonds, Series 2011E (the "Series 2011E Bonds"). The Series 2011A Bonds, the Series 2011B Bonds, the Series 2011C Bonds and the Series 2011E Bonds are referred to collectively as the "Series 2011 Bonds".

This Supplement should be read together with the entire Official Statement. Reference is made to the entire Official Statement for information relevant to the information set forth below as well as other information regarding the Series 2011 Bonds and the Alliance. As with the summaries and explanations in the Official Statement hereby supplemented, summaries and explanations of various documents, or provisions thereof, do not purport to be complete and are qualified by reference to the complete documents. All capitalized terms not defined herein shall have the same meaning as in the Official Statement.

Replacement Information. The following paragraph replaces in its entirety the paragraph with the identical heading in the section "THE SERIES 2011 BONDS" on page 15 of the Official Statement. The sole distinction between the two paragraphs is the addition of the final sentence in the paragraph set forth below.

No Purchase After Event of Default

Anything in the Indentures to the contrary notwithstanding, there shall be no purchases of Series 2011 Bonds pursuant to such Indenture if there shall have occurred and be continuing an Event of Default of which the Trustee has knowledge that immediately requires the acceleration of the Series 2011 Bonds under such Indenture. However, the occurrence of such an Event of Default does not alter the obligation of the Bank under the Letter of Credit, including any obligation of the Bank that occurs in connection with any such acceleration of the Series 2011 Bonds.

Date of Supplement: October 28, 2011

In the opinion of Bass, Berry & Sims PLC, Bond Counsel, under existing law and subject to conditions described in "TAX MATTERS," interest on the Series 2011 Tax-Exempt Bonds (as defined below) (a) will not be included in gross income for federal income tax purposes, (b) will not be an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations and (c) will not be included in the calculation of adjusted current earnings for purposes of computing the alternative minimum income tax on corporations. Interest on the Series 2011 Tennessee Bonds (as defined below) will be exempt from all state, county and municipal taxation in Tennessee except inheritance, transfer, estate taxes and except that interest may not be exempt from Tennessee franchise and excise taxes. The income on the Series 2011 Virginia Bonds (as defined below), including any profit made on the sale thereof, is exempt from all taxation by the Commonwealth of Virginia or any political subdivision thereof. A holder may be subject to other federal tax consequences as described in "TAX MATTERS."

\$211,800,000**MOUNTAIN STATES HEALTH ALLIANCE**

**The Health and Educational Facilities Board of the City
of Johnson City, Tennessee
Hospital Revenue Bonds
(Mountain States Health Alliance)**

**Series 2011A
\$65,260,000**

**Series 2011B
\$20,000,000**

**Industrial Development Authority of
Smyth County (Virginia)
Hospital Revenue Bonds
(Mountain States Health Alliance)**

**Series 2011C
\$49,875,000**

**Series 2011D
\$60,705,000**

**Mountain States Health Alliance
Taxable Bonds**

**Series 2011E
\$15,960,000**

Dated: Date of Delivery**Maturity: As shown on inside cover page**

This Official Statement contains information relating to the offering of multiple series of bonds (each, a "Series") by or for the benefit of Mountain States Health Alliance (the "Alliance"), a Tennessee non-profit corporation, and related hospital entities, with all such bonds, both tax exempt and taxable, secured on a parity basis with each other and certain previously issued bonds and bonds that may be issued in the future.

At the request of the Alliance, (1) The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the "Tennessee Issuer") is issuing its \$65,260,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011A (the "Series 2011A Bonds"), and its \$20,000,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011B (the "Series 2011B Bonds") and, together with the Series 2011A Bonds, the "Series 2011 Tennessee Bonds"), and (2) the Industrial Development Authority of Smyth County (the "Virginia Issuer") is issuing its \$49,875,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011C (the "Series 2011C Bonds"), and its \$60,705,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011D (the "Series 2011D Bonds") and, together with the Series 2011C Bonds, the "Series 2011 Virginia Bonds"). The Series 2011 Tennessee Bonds and the Series 2011 Virginia Bonds are referred to collectively as the "Series 2011 Tax-Exempt Bonds" and the Tennessee Issuer and the Virginia Issuer are referred to together as the "Issuers." The Series 2011 Tax-Exempt Bonds are limited obligations of the respective Issuer, payable from payments to be made by the Alliance to the Bond Trustee pursuant to separate Loan Agreements between each Issuer and the Alliance and related entities, and pursuant to the Series 2011 Tax-Exempt Obligations, hereinafter defined, which are issued under and secured by the Amended and Restated Master Trust Indenture dated as of February 1, 2000, as amended (the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee, which provides the security for the Series 2011 Tax-Exempt Obligations.

Simultaneously with the issuance of the Series 2011 Tax-Exempt Bonds, the Alliance will issue its own \$15,960,000 Taxable Bonds, Series 2011E (the "Series 2011 Taxable Bonds"), which will constitute Obligations issued under and secured by the Master Indenture. The Series 2011 Taxable Bonds and the Series 2011 Tax-Exempt Bonds are referred to collectively as the Series 2011 Bonds. **The Series 2011 Taxable Bonds are being issued directly by the Alliance and not through any governmental authority or other conduit issuer.**

The Series 2011 Bonds will be issued in denominations of \$100,000 or any integral multiples of \$5,000 in excess thereof and will bear interest at variable rates as described herein from their date of issuance until maturity or any earlier Conversion Date for the Fixed Rate. Each Series of Series 2011 Bonds will be subject to redemption prior to maturity, including optional redemption, mandatory sinking fund redemption and extraordinary optional redemption as described herein. The Series 2011 Bonds will be subject to mandatory tender for purchase prior to maturity under the circumstances described herein.

The timely payment of the principal of and interest on the Series 2011 Bonds and the purchase price of tendered Series 2011 Bonds of each Series will be secured by separate irrevocable, transferable direct-pay letters of credit (each, a "Letter of Credit") issued by the following providers:

Series 2011A	Series 2011B	Series 2011C	Series 2011D	Series 2011E
U.S. Bank National Association	PNC Bank, National Association	U.S. Bank National Association	Mizuho Corporate Bank, Ltd. New York Branch	Mizuho Corporate Bank, Ltd. New York Branch

(each, individually a "Bank" and, collectively, the "Banks"). Each Letter of Credit will entitle the Bond Trustee to draw thereunder amounts equal to the principal amounts of the Series 2011 Bonds outstanding and up to 37 days' interest thereon calculated at a rate of 12% per annum. Each Letter of Credit will expire on October 19, 2014, unless renewed, and each may be replaced by a Substitute Letter of Credit as described herein.

Payment of each Series of Series 2011 Bonds will be secured by a separate Letter of Credit. The Letter of Credit related to one Series of Series 2011 Bonds does not secure payments of principal or purchase price of or interest on any other Series of Series 2011 Bonds.

The Series 2011 Bonds, when issued, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York ("DTC"). DTC will act as securities depository for the Series 2011 Bonds. Purchasers will not receive certificates representing their ownership interest in the Series 2011 Bonds purchased. Interest on the Series 2011 Bonds will accrue from the date of issuance and be payable by the Bond Trustee to DTC for the account of DTC Participants, who are responsible for crediting the accounts of the beneficial owners.

The Series 2011 Tax-Exempt Bonds will be limited obligations of the respective Issuer, payable solely from the sources described in this Official Statement and will not constitute or create any debt, liability or obligation of the State of Tennessee, the Commonwealth of Virginia or any political subdivision or agency thereof or a pledge of the faith and credit of the State of Tennessee, the Commonwealth of Virginia or any political subdivision or agency thereof. Neither the faith and credit nor taxing power of any state or any political subdivision or agency thereof will be pledged to the payment of the Series 2011 Tax-Exempt Bonds.

This cover page contains certain information for quick reference only. It is not a summary of this issue. Investors must read the entire Official Statement to obtain information necessary to make an informed investment decision. For a description of certain risk factors relating to the Series 2011 Bonds, see "CERTAIN RISK FACTORS."

The Series 2011 Tax-Exempt Bonds are offered when, as and if issued, subject to the approving opinion of Bass, Berry & Sims PLC, Nashville and Knoxville, Tennessee, as Bond Counsel, and certain other conditions. As to certain matters of Virginia law, Bond Counsel is relying on the opinion of Hunton & Williams LLP, Richmond, Virginia. In connection with the issuance of the Series 2011 Bonds, certain legal matters will be passed upon by Anderson, Fugate & Givens, Johnson City, Tennessee, as counsel to the Alliance, Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Tennessee Issuer, Gwyn & Tate, Marion, Virginia, as counsel to the Virginia Issuer, Thompson Coburn LLP, St. Louis, Missouri, as counsel to the Banks, and Hunton & Williams LLP, as Underwriters' Counsel. The Public Advisory Corporation serves as financial advisor to the Alliance. It is expected that the Series 2011 Bonds will be issued and available for delivery to DTC in New York, New York, on or about October 19, 2011.

**BofA Merrill Lynch
as Underwriter for the Series 2011 Bonds**

**US Bancorp
as Co-Manager for the Series 2011A and 2011C Bonds**

**INFORMATION REGARDING MATURITIES, INITIAL RATE PERIODS
AND REMARKETING AGENTS**

**The Health and Educational Facilities Board of the City of Johnson City, Tennessee
Hospital Revenue Bonds
(Mountain States Health Alliance),**

\$65,260,000	\$20,000,000
Series 2011A	Series 2011B
Initial Rate Period: Weekly	Initial Rate Period: Weekly
Due: July 1, 2033	Due: July 1, 2033
Cusip: 478271 JS9	Cusip: 478271 JT7
Remarketing Agent:	Remarketing Agent:
BofA Merrill Lynch	BofA Merrill Lynch

**Industrial Development Authority of Smyth County
Hospital Revenue Bonds
(Mountain States Health Alliance),**

\$49,875,000	\$60,705,000
Series 2011C	Series 2011D
Initial Rate Period: Weekly	Initial Rate Period: Weekly
Due: July 1, 2031	Due: July 1, 2031
Cusip: 832870 AT6	Cusip: 832870 AU3
Remarketing Agent:	Remarketing Agent:
U.S. Bancorp Investments, Inc.	BofA Merrill Lynch
and	
U.S. Bank Municipal Securities Group,	
a division of	
U.S. Bank National Association	

\$15,960,000
Mountain States Health Alliance
Taxable Bonds
Series 2011E
Interest Rate Period: Weekly
Due: July 1, 2026
Cusip: 62427T AA9
Remarketing Agent:
BofA Merrill Lynch

No dealer, salesperson, or other person has been authorized to give any information or to make any representation, other than the information contained in this Official Statement, in connection with the offering of the Series 2011 Bonds, and, if given or made, such information or representation must not be relied upon as having been authorized by the Issuers, the Alliance or the Underwriters. The information in this Official Statement is subject to change without notice, and neither the delivery of this Official Statement nor any sale hereunder shall, under any circumstances, create any implication that there has been no change in the affairs of the Issuers, the Alliance or others since the date hereof. This Official Statement does not constitute an offer or solicitation in any jurisdiction in which such offer or solicitation is not authorized, or in which any person making such offer or solicitation is not qualified to do so, or to any person to whom it is unlawful to make such offer or solicitation. The information set forth herein has been obtained from the Issuers, the Alliance and other sources that are believed to be reliable, but it is not guaranteed as to accuracy or completeness by the Underwriters.

THE PRICES AT WHICH THE SERIES 2011 BONDS ARE OFFERED TO THE PUBLIC BY THE UNDERWRITERS MAY VARY FROM THE INITIAL PUBLIC OFFERING PRICES APPEARING ON THE FOREGOING PAGE. IN ADDITION, THE UNDERWRITERS MAY ALLOW CONCESSIONS OR DISCOUNTS TO DEALERS AND OTHER FROM THE PRICES AT WHICH THE SERIES 2011 BONDS ARE OFFERED TO THE PUBLIC. IN CONNECTION WITH THE OFFERING OF THE SERIES 2011 BONDS, THE UNDERWRITERS MAY EFFECT TRANSACTIONS THAT STABILIZE OR MAINTAIN THE MARKET PRICE OF THE SERIES 2011 BONDS AT A LEVEL ABOVE THAT WHICH MIGHT OTHERWISE PREVAIL IN THE OPEN MARKET. SUCH STABILIZING, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME.

THE SERIES 2011 BONDS WILL NOT BE REGISTERED BY THE ISSUERS OR THE ALLIANCE UNDER THE SECURITIES ACT OF 1933, AS AMENDED, OR ANY STATE SECURITIES LAW AND WILL NOT BE LISTED ON ANY STOCK OR OTHER SECURITIES EXCHANGE. NEITHER THE SECURITIES AND EXCHANGE COMMISSION NOR ANY OTHER FEDERAL, STATE, MUNICIPAL, OR OTHER GOVERNMENTAL ENTITY OR AGENCY SHALL HAVE PASSED UPON THE ACCURACY OR ADEQUACY OF THIS OFFICIAL STATEMENT.

IN MAKING ANY INVESTMENT DECISION, INVESTORS MUST RELY ON THEIR OWN EXAMINATION OF THE TERMS OF THE OFFERING, INCLUDING THE MERITS AND RISKS INVOLVED. THESE SECURITIES HAVE NOT BEEN RECOMMENDED BY ANY FEDERAL OR STATE SECURITIES COMMISSION OR REGULATORY AUTHORITY. FURTHERMORE, THE FOREGOING AUTHORITIES HAVE NOT CONFIRMED THE ACCURACY OR DETERMINED THE ADEQUACY OF THIS OFFICIAL STATEMENT. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

THIS OFFICIAL STATEMENT CONTAINS FORWARD-LOOKING STATEMENTS THAT ARE SUBJECT TO A NUMBER OF RISKS AND UNCERTAINTIES, INCLUDING THOSE DESCRIBED IN "CERTAIN RISK FACTORS," HEREIN, MANY OF WHICH ARE BEYOND THE ISSUERS AND THE ALLIANCE'S CONTROL. FORWARD-LOOKING STATEMENTS ARE TYPICALLY IDENTIFIED BY WORDS SUCH AS "BELIEVE," "EXPECT," "ANTICIPATE," "INTEND," "ESTIMATE" AND SIMILAR EXPRESSIONS. ACTUAL RESULTS COULD DIFFER MATERIALLY FROM THOSE CONTEMPLATED BY THESE FORWARD-LOOKING STATEMENTS AS A RESULT OF FACTORS ("CAUTIONARY STATEMENTS") SUCH AS THOSE DESCRIBED IN "CERTAIN RISK FACTORS" HEREIN. IN LIGHT OF THESE RISKS AND UNCERTAINTIES, THERE CAN BE NO ASSURANCE THAT THE RESULTS AND EVENTS CONTEMPLATED BY THE FORWARD-LOOKING INFORMATION CONTAINED IN THIS OFFICIAL STATEMENT WILL IN FACT TRANSPIRE. YOU ARE CAUTIONED NOT TO PLACE UNDUE RELIANCE ON THESE FORWARD-LOOKING STATEMENTS. NEITHER THE ISSUERS NOR THE ALLIANCE UNDERTAKE ANY OBLIGATION TO UPDATE OR REVISE ANY FORWARD-LOOKING STATEMENTS. ALL SUBSEQUENT WRITTEN OR ORAL FORWARD-LOOKING STATEMENTS ATTRIBUTABLE TO THE ISSUERS AND THE ALLIANCE OR PERSONS ACTING ON THEIR BEHALF ARE EXPRESSLY QUALIFIED IN THEIR ENTIRETY BY THE CAUTIONARY STATEMENTS.

Other than with respect to information concerning each Bank and its respective Letter of Credit contained under the headings "THE LETTERS OF CREDIT - Terms of the Letters of Credit" and "THE BANKS" and in Appendix G, none of the information in this Official Statement has been supplied or verified by the Banks, and the Banks do not make any warranty, express or implied, as to (i) the accuracy or completeness of such information, (ii) the validity of the Bonds, or (iii) the tax status of interest on the Bonds.

The Remarketing Agent is Paid by the Alliance. The Remarketing Agent's responsibilities include determining the interest rate from time to time and remarketing Series 2011 Bonds that are optionally or mandatorily tendered by the owners thereof, all as further described in this Official Statement. The Remarketing Agent is appointed by the Alliance and is paid by the Alliance for its services. As a result, the interests of the Remarketing Agent may differ from those of existing holders and potential purchasers of Series 2011 Bonds.

The Remarketing Agent Routinely Purchases Series 2011 Bonds for its Own Account. The Remarketing Agent is permitted, but not obligated, to purchase tendered Series 2011 Bonds for its own account. The Remarketing Agent, in its sole discretion, routinely acquires tendered Series 2011 Bonds for its own inventory in order to achieve a successful remarketing of the Series 2011 Bonds (i.e., because there otherwise are not enough buyers to purchase the Series 2011 Bonds) or for other reasons. However, the Remarketing Agent is not obligated to purchase Series 2011 Bonds, and may cease doing so at any time without notice. The Remarketing Agent may also make a market in the Series 2011 Bonds by routinely purchasing and selling Series 2011 Bonds other than in connection with an optional or mandatory tender and remarketing. Such purchases and sales may be at or below par. However, the Remarketing Agent is not required to make a market in the Series 2011 Bonds. The Remarketing Agent may also sell any Series 2011 Bonds it has purchased to one or more affiliated investment vehicles for collective ownership or enter into derivative arrangements with affiliates or others in order to reduce its exposure to the Series 2011 Bonds. The purchase of Series 2011 Bonds by the Remarketing Agent may create the appearance that there is greater third party demand for the Series 2011 Bonds in the market than is actually the case. The practices described above also may reduce the supply of Series 2011 Bonds that may be tendered in a remarketing.

Series 2011 Bonds May Be Offered at Different Prices on any Date. The Remarketing Agent is required to determine on the Adjustment Date the applicable rate of interest that, in its judgment, is the lowest rate that would permit the sale of the Series 2011 Bonds at par plus accrued interest, if any, on the Adjustment Date. The interest rate will reflect, among other factors, the level of market demand for the Series 2011 Bonds (including whether the Remarketing Agent is willing to purchase Series 2011 Bonds for its own account). There may or may not be Series 2011 Bonds tendered and remarketed on an Adjustment Date, the Remarketing Agent may or may not be able to remarket any Series 2011 Bonds tendered for purchase on such date at par and the Remarketing Agent may sell Series 2011 Bonds at varying prices to different investors on such date or any other date. The Remarketing Agent is not obligated to advise purchasers in a remarketing if it does not have third party buyers for all of the Series 2011 Bonds at the remarketing price. In the event the Remarketing Agent owns any Series 2011 Bonds for its own account, the Remarketing Agent may, in its sole discretion in a secondary market transaction outside the tender process, offer the Series 2011 Bonds on any date, including the Adjustment Date, at a discount to par to some investors.

The Ability To Sell the Series 2011 Bonds other than through Tender Process May Be Limited. While the Remarketing Agent may buy and sell Series 2011 Bonds, it is not obligated to do so and may cease doing so at any time without notice. Thus, investors who purchase the Series 2011 Bonds, whether in a remarketing or otherwise, should not assume that they will be able to sell their Series 2011 Bonds other than by tendering the Series 2011 Bonds in accordance with the tender process. The Letter of Credit is not available to purchase Series 2011 Bonds other than those tendered in accordance with a sale of Series 2011 Bonds by the bondholder to the Remarketing Agent. The Letter of Credit will only be drawn when such Series 2011 Bonds have been properly tendered in accordance with the terms of the transaction.

Remarketing Agent May Be Removed, Resign or Cease Remarketing the Series 2011 Bonds Without a Successor Being Named. Under certain circumstances the Remarketing Agent may be removed or have the ability to resign or cease its remarketing efforts, without a successor having been named, subject to the terms of the Remarketing Agreement.

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OFFICIAL STATEMENT

INTRODUCTION

This Official Statement, including its cover page and appendices, provides information in connection with the issuance and sale of multiple series of bonds by or for the benefit of Mountain States Health Alliance (the “Alliance”), a Tennessee non-profit corporation, and related entities, with all such bonds, both tax exempt and taxable, secured on a parity basis with each other and certain previously issued bonds and bonds that may be issued in the future. See below “Sources of Payment and Security for the Series 2011 Bonds.”

The Series 2011 Tax Exempt Bonds

At the request of the Alliance, bonds will be issued for the benefit of the Alliance by (1) The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the “Tennessee Issuer”), and (2) the Industrial Development Authority of Smyth County (the “Virginia Issuer”).

The Tennessee Issuer is issuing the following series of bonds (collectively, the “Series 2011 Tennessee Bonds”):

\$65,260,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011A (the “Series 2011A Bonds”), and

\$20,000,000 the Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011B (the “Series 2011B Bonds”).

The Virginia Issuer is issuing the following series of bonds (collectively, the “Series 2011 Virginia Bonds”):

\$49,875,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011C (the “Series 2011C Bonds”), and

\$60,705,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011D (the “Series 2011D Bonds”).

The Series 2011 Tennessee Bonds and the Series 2011 Virginia Bonds are referred to collectively as the “Series 2011 Tax-Exempt Bonds,” and the Tennessee Issuer and the Virginia Issuer are referred to collectively as the “Issuers.” Capitalized terms used herein and not otherwise defined have the meanings given thereto (1) in the Amended and Restated Master Trust Indenture dated as of February 1, 2000, as amended (the “Master Indenture”), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee (the “Master Trustee”), (2) in the case of the Series 2011 Tax-Exempt Bonds, in separate Bond Trust Indentures, each dated as of October 1, 2011 (the “Tennessee Indenture” and the “Virginia Indenture” and together, the “Issuer Bond Indentures”), between the respective Issuers and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the “Bond Trustee”), and (3) in the case of the Series 2011 Taxable Bonds, in the Thirtieth Supplemental Master Trust Indenture dated as of October 1, 2011 (the “Thirtieth Supplement”), between the Alliance and the Master Trustee.

The terms “Indenture” and “Indentures” are used herein (a) to refer to the Issuer Bond Indentures when applicable to the Series 2011 Tax-Exempt Bonds and (b) to refer to the Thirtieth Supplement when applicable to the Series 2011 Taxable Bonds. Likewise, the term “Trustee” is used herein (a) to refer to the Bond Trustee when applicable to the Series 2011 Tax-Exempt Bonds and (b) to refer to the Master Trustee when applicable to the Series 2011 Taxable Bonds.

The Series 2011 Taxable Bonds

The Series 2011 Taxable Bonds will be issued in the amount of \$15,960,000 by the Alliance pursuant to the Thirtieth Supplement. The Series 2011 Taxable Bonds are being issued directly by the Alliance and not through any governmental authority or other conduit issuer.

The Alliance

The Mountain States Health Alliance (the “Alliance”) is a Tennessee nonprofit corporation that is an “exempt organization” under Section 501(c)(3) of the Internal Revenue Code of 1986 (the “Code”). The Alliance provides an integrated, comprehensive continuum of care to people in 29 counties in Tennessee, Virginia, Kentucky, and North Carolina. The Alliance currently operates 13 hospital facilities containing a total of 1,749 licensed beds, and serves a population of over 1,000,000 in 29 counties and two independent cities in the States of Tennessee, Virginia, Kentucky and North Carolina. Its integrated health care delivery system also includes 23 primary/preventive care centers and 12 outpatient care sites. **For additional information regarding the Alliance, see Appendix A.**

The Obligated Issuers

The Alliance, Blue Ridge Medical Management Corporation (“Blue Ridge”), Norton Community Hospital (“Norton”) and Smyth County Community Hospital (“Smyth”) are each an Obligated Issuer as such term is used in the Master Indenture (hereinafter defined). Only the Obligated Issuers are obligated to make payments on the Series 2011 Bonds. See Appendix A - “HISTORY AND OVERVIEW - Operations of Subsidiary and Other Affiliates,” and “CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS.”

The Banks

The timely payment of the principal of and interest on the Series 2011 Bonds and the purchase price thereof will be secured by irrevocable transferable direct-pay letters of credit issued by (1) in the case of the Series 2011A Bonds and the Series 2011C Bonds, U.S. Bank National Association, (2) in the case of the Series 2011B Bonds, PNC Bank, National Association, and (3) in the case of the Series 2011D Bonds and the Series 2011 Taxable Bonds, Mizuho Corporate Bank, Ltd. See Appendix G.

The Remarketing Agents

Merrill Lynch, Pierce, Fenner and Smith Incorporated will serve as the Remarketing Agent for the Series 2011 Tennessee Bonds, the Series 2011D Bonds and the Series 2011 Taxable Bonds. U.S. Bancorp Investments, Inc. and U.S. Bank Municipal Securities Group, a division of U.S. Bank National Association, will serve as the Remarketing Agent for the Series 2011C Bonds.

Plan of Finance

The proceeds of the Series 2011 Tax-Exempt Bonds are being loaned to the Alliance pursuant to separate Loan Agreements, each dated as of October 1, 2011 (respectively, the “Tennessee Loan Agreement” and the “Virginia Loan Agreement” and, together, the “Loan Agreements”), between each Issuer and the Alliance and related entities. The proceeds of the Series 2011 Tax-Exempt Bonds will be used by the Alliance and related entities (1) to refinance outstanding indebtedness (2) to finance capital improvements and equipment acquisitions at facilities owned by the Alliance and its affiliates and (3) to pay certain expenses incurred in connection with the issuance of the Series 2011 Tax-Exempt Bonds. The proceeds from the sale of the Series 2011 Taxable Bonds will be used to finance capital improvements and equipment acquisitions at facilities owned by Smyth and Blue Ridge Medical Management Corporation, an affiliate of the Alliance. See “PLAN OF FINANCE.”

Book-Entry Registration

The Series 2011 Bonds initially will be issued in the form of one registered bond in the aggregate principal amount of each maturity of each Series and will be registered in the name of Cede & Co., as nominee for The

Depository Trust Company, New York, New York (“DTC”). DTC will maintain a book-entry system for recording ownership interest in the Series 2011 Bonds. Purchasers will not receive certificates representing their ownership interest in the Series 2011 Bonds purchased. Principal of, any redemption price for, and interest on the Series 2011 Bonds will be payable by the Trustee to DTC for the account of DTC Participants (as defined herein), who are responsible for crediting the accounts of the beneficial owners. See Appendix H - “BOOK-ENTRY ONLY SYSTEM.”

Sources of Payment and Security for the Series 2011 Tax-Exempt Bonds

The Series 2011 Tax-Exempt Bonds shall not constitute a debt or obligation of the State of Tennessee or the Commonwealth of Virginia or any political subdivision or agency thereof or a pledge of the faith and credit of any state or any political subdivision or agency of any state, including the Tennessee Issuer and the Virginia Issuer. The Series 2011 Tennessee Bonds are special, limited obligations of the Tennessee Issuer and the Series 2011 Virginia Bonds are limited obligations of the Virginia Issuer, each payable from the respective Trust Estates as described in “THE SERIES 2011 BONDS - General” and “SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2011 BONDS - Trust Estate.”

To evidence the Alliance’s repayment obligations in connection with the Series 2011 Tax-Exempt Bonds, the Alliance will issue its \$65,260,000 Mountain States Health Alliance Note (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) Series 2011A (the “Series 2011A Obligation”), its \$20,000,000 Mountain States Health Alliance Note (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) Series 2011B (the “Series 2011B Obligation”), its \$49,875,000 Mountain States Health Alliance Note (Industrial Development Authority of Smyth County) Series 2011C (the “Series 2011C Obligation”), and its \$60,705,000 Mountain States Health Alliance Note (Industrial Development Authority of Smyth County) Series 2011D (the “Series 2011D Obligation” and, together with the Series 2011A Obligation, the Series 2011B Obligation and the Series 2011C Obligation, the “Series 2011 Tax-Exempt Obligations”), all pursuant to the Master Indenture.

The Series 2011 Taxable Bonds will also be issued pursuant to, and are secured by the Master Indenture and will constitute Obligations thereunder. The Series 2011 Tax-Exempt Obligations and the Series 2011 Taxable Bonds are referred to collectively as the “Series 2011 Obligations.”

In the Master Indenture, the Alliance and the other Obligated Issuers have covenanted, and any future Obligated Issuer would be required to covenant, to operate its facilities in such a manner and to charge such fees and rates as will be sufficient to provide funds (together with other available amounts) to pay debt service on its outstanding indebtedness, to pay certain other expenses and indebtedness of the Alliance and all future Obligated Issuers, and to maintain a coverage ratio of Income Available for Debt Service to Maximum Annual Debt Service equal to at least 1.30:1. For a description of such covenants, including exceptions thereto, see “SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2011 BONDS” and Appendix D - “SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE.”

Certain existing bonds of the Tennessee Issuer, the Virginia Issuer and other issuers, as well as bonds of the Alliance, previously have been issued and are secured by Master Obligations issued by the Alliance under the Master Indenture (“Master Obligations”) and therefore are secured on a parity with the Series 2011 Bonds. The reimbursement obligations of the Alliance with respect to the Letters of Credit will be secured under the Master Indenture. The Alliance and any future Obligated Issuer have the right, subject to specified conditions, to incur additional indebtedness on a parity with the Series 2011 Obligations and the Series 2011 Bonds.

No Debt Service Reserve Fund

The Series 2011 Bonds are not secured by any Debt Service Reserve Fund.

Tax Matters

In the opinion of Bass, Berry & Sims PLC, Bond Counsel, under existing law and subject to conditions described under “TAX MATTERS,” interest on the Series 2011 Tax-Exempt Bonds (a) will not be included in gross

income for federal income tax purposes and (b) will not be an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations; however, such interest on the Series 2011 Tax-Exempt Bonds is taken into account in determining a corporation's alternative minimum income tax. Holders of Series 2011 Tax-Exempt Bonds may be subject to other federal tax consequences, as described herein under "TAX MATTERS." Interest on the Series 2011 Taxable Bonds will be included in gross income for federal income tax purposes.

In the opinion of Bond Counsel, interest on the Series 2011 Tennessee Bonds will be exempt from all state, county, and municipal taxation in the State of Tennessee except inheritance, gift, and estate taxes and except that interest may not be exempt from Tennessee franchise and excise taxes, and income on the Series 2011 Virginia Bonds, including any profit made on the sale thereof, is exempt from all taxation by the Commonwealth of Virginia or any political subdivision thereof. In giving its opinion, Bond Counsel is relying on the opinion of Hunton & Williams LLP as to certain matters of Virginia law, including Virginia tax law.

Continuing Disclosure

To permit compliance with Rule 15c2-12 promulgated under the Securities Exchange Act of 1934 ("Rule 15c2-12"), the Alliance will execute a Continuing Disclosure Agreement in connection with the issuance of the Series 2011 Bonds in which it will agree for the benefit of the holders of the Series 2011 Bonds to provide certain annual financial information and operating data and certain quarterly financial data as to the Alliance and any future Obligated Issuer under the Master Indenture, and to provide notice of certain enumerated events, if material. See "CONTINUING DISCLOSURE AGREEMENT" for a more complete description of the Continuing Disclosure Agreement and the Alliance's performance under previous continuing disclosure agreements.

Professionals Involved in the Offering

Bass, Berry & Sims PLC will act as Bond Counsel in connection with the issuance of the Series 2011 Bonds. As to certain matters of Virginia law, Bond Counsel is relying on the opinion of Hunton & Williams LLP. In connection with the issuance of the Series 2011 Bonds, certain legal matters will be passed upon by Anderson, Fugate & Givens, Johnson City, Tennessee, as counsel to the Alliance, Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Tennessee Issuer, Gwyn & Tate, Marion, Virginia, as counsel to the Virginia Issuer, Thompson Coburn LLP, St. Louis, Missouri, as counsel to the Banks, and Hunton & Williams LLP, as Underwriters' Counsel. The Alliance's consolidated financial statements for the fiscal years ended June 30, 2010 and 2009, included in Appendix B hereto, have been audited by Pershing Yoakley & Associates, P.C.

Relationships of the Parties

The Alliance has entered into interest rate exchange agreements, or swap agreements, with Bank of America, which is an affiliate of Bank of America Merrill Lynch, underwriter for the Series 2011 Bonds.

Acceleration

Subject to certain conditions, the Series 2011 Bonds are subject to acceleration of the maturity date upon the happening of an Event of Default under the Indentures. See "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE INDENTURES" in Appendix D.

Bondholders' Risks

Payment of the Series 2011 Bonds is dependent on the ability of the Alliance and the other Obligated Issuers to make payments under the Loan Agreements and the Master Indenture. The Alliance's ability to make such payments may be adversely affected by many risk factors. There may also be legal and practical limitations on the enforcement of remedies and amounts that may be realized upon enforcement of remedies available to the Trustee and owners of the Series 2011 Bonds. See "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2011 BONDS" and "CERTAIN RISK FACTORS" herein and "SOURCES OF REVENUE" in Appendix A.

Legal Document Summaries and Definitions

Certain provisions of the Master Indenture, the Indentures and the Loan Agreements are summarized in Appendix D hereto. Other definitions of certain terms used in this Official Statement are also set forth in Appendix D hereto.

Other Information

This Official Statement speaks only as of its date, and the information contained herein is subject to change.

The quotations from, and summaries and explanations of, the statutes, regulations and documents referenced herein do not purport to be complete and reference is made to those statutes, regulations and documents for full and complete statements of their provisions. Copies, in reasonable quantity, of such documents may be obtained during the offering period, upon request to the Alliance and upon payment to the Alliance of a charge for copying, mailing and handling, at 400 North State of Franklin Road, Johnson City, TN 37604-6094, Attn: Legal Department.

Purchasers of the Series 2011 Bonds should note the use of forward-looking information and the covenants related thereto.

Any statements in this Official Statement involving matters of opinion, whether or not expressly so stated, are intended as such and not as representations of fact. This Official Statement is not to be construed as a contract or agreement between the Board or the Alliance and the purchasers or holders of any of the Series 2011 Bonds.

This introduction is not a summary of this Official Statement. It is only a summary description of and guide to, and is qualified by, more complete and detailed information contained in the entire Official Statement, including the cover page and appendices hereto, and the documents summarized or described herein. A full review should be made of the entire Official Statement. The offering of Series 2011 Bonds to potential investors is made only by means of the entire Official Statement.

THE ISSUERS

The Tennessee Issuer

The Tennessee Issuer is a public nonprofit corporation organized under the laws of the State of Tennessee. The Tennessee Issuer was incorporated on May 3, 1973, by the Board of Commissioners of the City of Johnson City, Tennessee, pursuant to the laws now codified under Tennessee Code Annotated Section 48-101-301, *et seq.* (the “Tennessee Act”). The Tennessee Act authorizes the Issuer, among other things, to issue its bonds, to acquire, improve, maintain, extend, equip and furnish hospital facilities either within or without the corporate limits of the City of Johnson City, and in certain other jurisdictions in Tennessee, to mortgage its projects, to pledge the revenues and receipt therefrom, and to sell, exchange, donate and convey any or all of its properties. The Tennessee Issuer has no taxing power.

The Virginia Issuer

The Virginia Issuer was created pursuant to the Virginia Industrial Development and Revenue Bond Act, Title 15.2, Chapter 49 of the Code of Virginia of 1950, as amended (the “Virginia Act”), by ordinance adopted by the Board of Supervisors of Smyth County, Virginia. The Virginia Issuer is a political subdivision of the Commonwealth of Virginia governed by a Board of Directors appointed by the Board of Supervisors of Smyth County, Virginia. Under the Virginia Act, the Virginia Issuer is empowered, among other things, to make loans for the purpose of financing or refinancing medical facilities, and to finance the same by the issuance of its revenue bonds and to refund bonds previously issued by it. The Virginia Issuer has no taxing power.

THE ALLIANCE

The Alliance is a Tennessee nonprofit corporation recognized by the Internal Revenue Service as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986 (the “Code”). Today, the Alliance directly and through related entities provides an integrated, comprehensive continuum of care to people in 29 counties in Tennessee, Virginia, Kentucky, and North Carolina. The Alliance was initially incorporated as Memorial Hospital on April 12, 1945, as a non-sectarian, general welfare, not-for-profit corporation. In connection with the relocation of its operations, it changed its name to Johnson City Medical Center Hospital, Inc. in 1983. In 1998, Johnson City Medical Center Hospital, Inc. assumed operating responsibility for five hospitals and related assets, which it acquired from Columbia/HCA. In recognition of its expanded facilities and scope of services resulting from the 1998 acquisition, Johnson City Medical Center Hospital, Inc. changed its name to Mountain States Health Alliance.

The Alliance currently operates 13 hospital facilities: Johnson City Medical Center (including The Children’s Hospital at Johnson City Medical Center), The James H. & Cecile C. Quillen Rehabilitation Hospital, Indian Path Medical Center, Sycamore Shoals Hospital, Johnson County Community Hospital, Woodridge Hospital, Smyth County Community Hospital, Norton Community Hospital, Dickenson Community Hospital, Russell County Medical Center and Johnston Memorial Hospital. The Alliance now has a total of 1,749 licensed beds serving a population of over 1,000,000 in 29 counties in the States of Tennessee, Virginia, Kentucky and North Carolina. In addition to its hospitals, the Alliance’s integrated health care delivery system includes 23 primary/preventive care centers and 12 outpatient care sites. The Alliance’s medical facilities provide a full spectrum of general and specialty medical services, including rehabilitative services for individuals with brain injuries, strokes and spinal cord injuries, in-patient psychiatric services and centers for health focusing on cardiovascular health, pulmonary medicine, women’s health and cancer therapy, among other services. The Alliance also serves as a clinical training facility for medical students, residents, and nursing students from the East Tennessee State University’s James H. Quillen College of Medicine and the School of Public and Allied Health. **For additional information regarding the Alliance, see Appendix A.**

The Alliance, Blue Ridge Medical Management Corporation (“Blue Ridge”), Norton Community Hospital (“Norton”) and Smyth County Community Hospital (“Smyth”) are each an Obligated Issuer as such term is used in the Master Indenture. Blue Ridge is a wholly-owned, for-profit subsidiary of the Alliance. Norton is a Virginia non-stock corporation in which the Alliance owns a 50.1% interest. Smyth is a Virginia non-stock corporation in which the Alliance owns an 80% interest. See Appendix A - “HISTORY AND OVERVIEW - Operations of Subsidiary and Other Affiliates.”

The Alliance also operates the Virginia hospital facilities in Dickenson County and Washington County through ownership of a majority interest in the membership of the corporations owning such facilities. None of such corporations are an Obligated Issuer or otherwise are responsible for repayment of amounts due from the Alliance with respect to the Series 2011 Bonds, and none of the assets of such corporations are pledged as security for the Alliance’s payment obligations.

Only the Obligated Issuers are obligated to pay the Series 2011 Bonds. The audited and unaudited financial statements of the Alliance included as Appendices B and C reflect the assets, liabilities, revenues and expenses of related organizations that are not Obligated Issuers. See Appendix A – “CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS.”

THE SERIES 2011 BONDS

Set forth below is a summary of certain provisions of the Series 2011 Bonds. General information describing the Series 2011 Bonds appears elsewhere in this Official Statement. That information should be read in conjunction with this summary, which is qualified in its entirety by reference to the Indentures, and the forms of the Series 2011 Bonds. See “SUMMARY OF THE FINANCING DOCUMENTS” in Appendix D hereto.

General

The Series 2011 Bonds shall be initially issued as fully registered bonds without coupons in denominations of \$100,000 or any integral multiple of \$5,000 in excess thereof. The Series 2011 Bonds will mature, subject to prior redemption as described herein, on July 1, in the years noted below, and will bear interest payable on the first Business Day of each month so long as the Series 2011 Bonds bear interest at the Weekly Rate, as defined below. In the event the interest on any Series of Series 2011 Bonds is converted to the Medium-Term Rate or the Fixed Rate, as defined below, interest will be payable semiannually on January 1 and July 1 of each year (each such date referred to herein as an "Interest Payment Date"). The Weekly Rate for Series 2011 Bonds of different Series may be different rates at any time.

The Series 2011 Tennessee Bonds will mature on July 1, 2033. The Series 2011 Virginia Bonds will mature on July 1, 2031. The Series 2011 Taxable Bonds will mature on July 1, 2026.

Interest on the Series 2011 Bonds shall be computed from the Interest Payment Date to which interest on the Series 2011 Bonds has been paid or duly provided for next preceding the date of authentication thereof, unless (a) such date of authentication shall be prior to the first Interest Payment Date, in which case interest shall be computed from the Closing Date, or (b) such date of authentication shall be an Interest Payment Date to which interest on the Series 2011 Bonds has been paid or duly provided for, in which case interest shall be computed from such Interest Payment Date, or (c) such date of authentication shall be after any Record Date and before the next succeeding Interest Payment Date, in which case interest shall be computed from the next succeeding Interest Payment Date.

The principal and premium, if any, of the Series 2011 Bonds, and the purchase price for any Series 2011 Bonds shall be payable at the office of the Trustee in East Syracuse, New York, upon surrender of the Series 2011 Bonds at such office. Interest on the Series 2011 Bonds (other than Defaulted Interest) shall be payable by check drawn upon the Trustee and paid to the Persons in whose names the Series 2011 Bonds are registered on the Bond Register as of the close of business on the Record Date next preceding the relevant Interest Payment Date, provided that during Weekly Rate Periods, on written request to the Trustee by any Person who is the registered owner of Series 2011 Bonds of a Series in a principal amount of \$1,000,000 or more received by the Trustee on or before 15 days prior to such Record Date (which instructions shall remain in effect until revoked by subsequent written instructions), interest on such Series 2011 Bonds shall be payable by wire transfer of immediately available funds to an account at a bank located in the continental United States specified by the person in whose name such Series 2011 Bonds are registered. Any interest on any Series 2011 Bond which is payable but which is not punctually paid or duly provided for ("Defaulted Interest") shall cease being payable to the person in whose name such Series 2011 Bond is registered on the Record Date and instead shall be payable to the person in whose name such Series 2011 Bond is registered at close of business on a Special Record Date selected by the Trustee and which shall be at least 10 days but not more than 30 days before the date selected by the Trustee for payment of such Defaulted Interest. The Trustee shall give Notice by Mail of the Special Record Date and date for payment of Defaulted Interest at least 10 days before the Special Record Date.

THE SERIES 2011 TENNESSEE BONDS ARE, AND ARE TO BE, EQUALLY AND RATABLY SECURED, TO THE EXTENT PROVIDED IN THE APPLICABLE TENNESSEE BOND INDENTURE, SOLELY BY A PLEDGE OF THE REVENUES AND OTHER FUNDS PLEDGED UNDER SUCH TENNESSEE BOND INDENTURE. THE SERIES 2011 TENNESSEE BONDS, TOGETHER WITH PREMIUM, IF ANY, AND THE INTEREST THEREON, ARE SPECIAL AND LIMITED OBLIGATIONS OF THE TENNESSEE ISSUER. THE SERIES 2011 TENNESSEE BONDS AND THE INTEREST THEREON SHALL NOT BE DEEMED TO CONSTITUTE A DEBT OR A PLEDGE OF THE FAITH AND CREDIT OF THE STATE OF TENNESSEE OR ANY POLITICAL SUBDIVISION THEREOF, INCLUDING THE CITY OF JOHNSON CITY, TENNESSEE. THE CITY OF JOHNSON CITY, TENNESSEE, SHALL NOT IN ANY EVENT BE LIABLE FOR THE PAYMENT OF THE PRINCIPAL OF, PREMIUM, IF ANY, OR INTEREST ON THE SERIES 2011 TENNESSEE BONDS, OR FOR THE PERFORMANCE OF ANY PLEDGE, MORTGAGE, OBLIGATION OR AGREEMENT OF ANY KIND WHATSOEVER THEREIN OR INDEBTEDNESS BY THE TENNESSEE ISSUER, AND NEITHER THE SERIES 2011 TENNESSEE BONDS NOR ANY OF THE TENNESSEE ISSUERS AGREEMENTS OR OBLIGATIONS DESCRIBED IN THE SERIES 2011 TENNESSEE BONDS OR OTHERWISE SHALL BE CONSTRUED TO CONSTITUTE AN INDEBTEDNESS OF THE CITY OF

JOHNSON CITY, TENNESSEE, WITHIN THE MEANING OF ANY CONSTITUTIONAL OR STATUTORY PROVISIONS WHATSOEVER. THE TENNESSEE ISSUER HAS NO TAXING AUTHORITY.

THE SERIES 2011 VIRGINIA BONDS AND THE PREMIUM, IF ANY, AND THE INTEREST THEREON SHALL NOT BE DEEMED TO CONSTITUTE A DEBT OR A PLEDGE OF THE FAITH AND CREDIT OF THE COMMONWEALTH OF VIRGINIA, OR ANY POLITICAL SUBDIVISION THEREOF, INCLUDING THE VIRGINIA ISSUER OR SMYTH COUNTY, VIRGINIA. NEITHER THE COMMONWEALTH OF VIRGINIA, NOR ANY POLITICAL SUBDIVISION THEREOF, INCLUDING THE VIRGINIA ISSUER OR SMYTH COUNTY, VIRGINIA, SHALL BE OBLIGATED TO PAY PRINCIPAL OF OR PREMIUM, IF ANY, OR INTEREST ON THE SERIES 2011 VIRGINIA BONDS OR OTHER COSTS INCIDENT THERETO, AND NEITHER THE FAITH AND CREDIT NOR THE TAXING POWER OF THE COMMONWEALTH OF VIRGINIA OR ANY POLITICAL SUBDIVISION THEREOF, INCLUDING THE VIRGINIA ISSUER IS PLEDGED TO THE PAYMENT OF PRINCIPAL OF THE SERIES 2011 VIRGINIA BONDS OR INTEREST THEREON OR OTHER COSTS INCIDENT THERETO. THE VIRGINIA ISSUER HAS NO TAXING POWER.

Interest Rate on the Series 2011 Bonds

The Remarketing Agent shall determine the interest rate on the Series 2011 Bonds of a Series for each Weekly Rate Period, as defined in the next sentence. "Weekly Rate Periods" shall mean any period from and commencing on any Wednesday (or in certain circumstances on a Proposed Conversion Date) and ending on the earliest of (a) the next succeeding Tuesday (including such Tuesday), (b) the Conversion Date to the Fixed Rate, (c) the Interest Payment Date on which a Medium-Term Rate Period begins or (d) maturity of the Series 2011 Bonds of that Series. The interest rate on the Series 2011 Bonds of a series shall be determined by the Remarketing Agent for each Weekly Rate Period as the rate equal to the lowest rate which, having due regard for general financial conditions and such other special conditions as in the judgment of the Remarketing Agent may have a bearing on the rate, would produce as nearly as possible a par bid for the Series 2011 Bonds of a series (without regard to accrued interest) in the secondary market on the first day of such Weekly Rate Period. The rate for any Weekly Rate Period shall be determined prior to 10:00 a.m., New York City time on the first day for any Weekly Rate Period. The first day of any Weekly Rate Period is referred to herein as an "Adjustment Date." On the Adjustment Date, the Remarketing Agent shall notify the Trustee no later than 10:00 a.m., New York City time of the rate applicable for such Weekly Rate Period. Any time after 10:00 a.m., New York City time on the Adjustment Date, any Bondholder may contact the Remarketing Agent to obtain such rate.

In the event the Remarketing Agent fails to determine the rate for any Weekly Rate Period, the rate of interest borne by (1) the Series 2011 Tax-Exempt Bonds for such Weekly Rate Period shall be the SIFMA Municipal Swap Index and (2) the Series 2011 Taxable Bonds for such Weekly Rate Period shall be the one-month LIBOR rate.

In no event shall the interest rate borne by the Series 2011 Bonds during any Weekly Rate Period exceed the lesser of 12% per annum or the maximum contract rate of interest permitted by the laws of the (1) State of Tennessee for the Series 2011 Tennessee Bonds and the Series 2011 Taxable Bonds or the (2) Commonwealth of Virginia for the Series 2011 Virginia Bonds. During the Weekly Rate Periods, (1) interest on the Series 2011 Tax-Exempt Bonds will be computed on the basis of a 365- or 366-day year, as the case may be, and the actual days elapsed and (2) interest on the Series 2011 Taxable Bonds will be computed on the basis of a 360-day year and actual days elapsed.

The determination of any interest rate in accordance with the provisions of the Indentures shall be conclusive and shall be binding upon the Trustee, the Issuers, the Alliance, the Bank, the Remarketing Agent and the Bondholders.

Effective on any Interest Payment Date while the Weekly Rate Periods are in effect, the Alliance shall have the option, with the written approval of the Bank, the applicable Issuer, if any, and the Remarketing Agent, to change the Rate Periods for a Series of the Series 2011 Bonds from the Weekly Rate Periods then in effect to the Medium-Term Rate Periods or to a Fixed Rate Period. Upon such event, the Trustee shall notify the holders of the Series 2011 Bonds of such conversion, and the Series 2011 Bonds shall be subject to mandatory tender for purchase

as described herein. The date on which the interest rate on the Series 2011 Bonds is converted to a Fixed Rate is referred to herein as the “Conversion Date.”

Registration and Transfer of Series 2011 Bonds

The Indentures contain the following provisions with respect to registration of transfer and exchange of Series 2011 Bonds. Such provisions do not apply while the Series 2011 Bonds are held by DTC. See Appendix H - “BOOK-ENTRY ONLY SYSTEM.”

Any holder of a Series 2011 Bond, in person or by his duly authorized attorney, may register the transfer of his Series 2011 Bond on the Bond Register, upon surrender thereof at the office of the Trustee in East Syracuse, New York, together with a written instrument of transfer (in such form as shall be reasonably satisfactory to the Trustee) executed by the holder or his duly authorized attorney; and upon surrender for registration of transfer of any Series 2011 Bond, an Issuer shall execute and the Trustee shall authenticate and deliver in the name of the designated transferee or transferees a new Series 2011 Bond or Bonds of the same Stated Maturity, aggregate principal amount and tenor as the Series 2011 Bond surrendered and of any Authorized Denomination.

Series 2011 Bonds may be exchanged at the office of the Trustee in East Syracuse, New York, for an equal aggregate principal amount of Series 2011 Bonds of the same Series, Stated Maturity, interest rate, aggregate principal amount and tenor as the Series 2011 Bonds being exchanged and of any Authorized Denomination. The Issuer or the Alliance, as applicable, shall execute and the Trustee shall authenticate and deliver Series 2011 Bonds which the Bondholder making the exchange is entitled to receive, bearing numbers not contemporaneously then outstanding.

Such registrations of transfers or exchanges of Series 2011 Bonds shall be without charge to the holders of such Series 2011 Bonds, but any taxes or other governmental charges required to be paid with respect to the same shall be paid by the Holder of the Series 2011 Bond requesting such registration of transfer or exchange as a condition precedent to the exercise of such privilege. The Trustee shall not be required (a) to transfer or exchange any Series 2011 Bond during the period from a Record Date to an Interest Payment Date or from the Business Day prior to a Special Record Date to the date for payment of Defaulted Interest, or (b) to make any exchange or registration of transfer of any Series 2011 Bonds called for redemption in whole or in part.

The person in whose name any Series 2011 Bond shall be registered shall be deemed and regarded as the absolute owner thereof for all purposes, and payment of, or on account of, either principal or interest shall be made only to or upon the order of such person or his duly authorized attorney, but such registration may be changed as hereinabove described. All such payments shall be valid and effectual to satisfy and discharge the liability upon such Series 2011 Bond to the extent of the sum or sums so paid.

Redemption

The Series 2011 Bonds may not be called for redemption during the Weekly Rate Periods except as described below. This Official Statement does not describe any redemption provisions for Series 2011 Bonds during the Medium Term Period or after the Conversion Date. The Letters of Credit do not secure the payment of any premium due to the optional redemption of Series 2011 Bonds by the Alliance.

Optional Redemption

While the Weekly Rate Periods are in effect, the Series 2011 Bonds of each Series are subject to optional redemption by the Issuer or the Alliance, as applicable, in whole or in part on any Business Day, at the direction of the Alliance, with the prior written consent of the Bank if proceeds drawn under any Letter of Credit will be used for redemption of Series 2011 Bonds, at a redemption price equal to the principal amount thereof plus accrued interest to the Redemption Date.

Extraordinary Optional Redemption

The Series 2011 Bonds are callable for redemption prior to maturity in the event of damage to or destruction of the Property of any member of the Obligated Group or any part thereof or condemnation of the Facilities or any part thereof, if the Net Proceeds of insurance or condemnation received in connection therewith to the extent such Net Proceeds are not applied either to any lawful purposes of the Obligated Group or to the repair, replacement, restoration or reconstruction of the affected Facilities pursuant to the Master Indenture, but only to the extent of the funds provided for in the Master Indenture. If thus called for redemption, Series 2011 Bonds shall be subject to redemption by the Issuer or the Alliance, as applicable, at any time, in whole or in part, and if in part, the Alliance may decide the amount of each Series of Series 2011 Bonds to be redeemed. Such redemption shall be at the principal amount thereof plus accrued interest to the redemption date, and without premium, from the proceeds of such insurance or condemnation award or such sale but not in excess of the amount of such proceeds applied to such purpose. If no direction is given by the Alliance, the Trustee will redeem Series 2011 Bonds of each Series then outstanding pro rata based on the then outstanding principal amount of each Series.

Mandatory Sinking Fund Redemption

Subject to the credit described following the tables below, the Series 2011 Bonds of each Series are subject to Mandatory Sinking Fund Redemption prior to maturity on July 1 in the years and in the principal amounts specified below for each Series of Series 2011 Bonds, at a redemption price equal to 100% of the principal amount thereof plus accrued interest:

<u>Series 2011A Bonds</u>		<u>Series 2011B Bonds</u>	
<u>July 1,</u>	<u>Principal Amount</u>	<u>July 1,</u>	<u>Principal Amount</u>
2012	\$4,075,000	2012	\$ 0
2013	4,240,000	2013	15,000
2014	2,110,000	2014	25,000
2015	2,415,000	2015	95,000
2016	2,540,000	2016	100,000
2017	2,630,000	2017	115,000
2018	3,035,000	2018	470,000
2019	0	2019	695,000
2020	0	2020	735,000
2021	3,555,000	2021	785,000
2022	3,150,000	2022	830,000
2023	3,085,000	2023	940,000
2024	4,225,000	2024	0
2025	3,980,000	2025	0
2026	1,030,000	2026	0
2027	1,020,000	2027	0
2028	780,000	2028	0
2029	590,000	2029	0
2030	330,000	2030	0
2031	410,000	2031	0
2032	17,775,000	2032	0
2033	4,285,000	2033	15,195,000

<u>Series 2011C Bonds</u>		<u>Series 2011D Bonds</u>	
<u>July 1,</u>	<u>Principal Amount</u>	<u>July 1,</u>	<u>Principal Amount</u>
2012	\$ 900,000	2012	\$ 0
2013	755,000	2013	50,000
2014	800,000	2014	90,000
2015	1,000,000	2015	360,000
2016	1,050,000	2016	395,000
2017	1,110,000	2017	445,000
2018	2,035,000	2018	1,825,000
2019	2,625,000	2019	2,685,000
2020	2,755,000	2020	2,840,000
2021	2,905,000	2021	3,035,000
2022	3,060,000	2022	3,215,000
2023	3,365,000	2023	3,640,000
2024	3,640,000	2024	6,140,000
2025	4,035,000	2025	6,815,000
2026	1,965,000	2026	3,320,000
2027	2,090,000	2027	3,530,000
2028	2,180,000	2028	3,675,000
2029	2,340,000	2029	3,945,000
2030	2,445,000	2030	4,130,000
2031	8,820,000	2031	10,570,000

<u>Series 2011 Taxable Bonds</u>	
<u>July 1,</u>	<u>Principal Amount</u>
2012	\$ 0
2013	15,000
2014	25,000
2015	95,000
2016	105,000
2017	120,000
2018	1,420,000
2019	5,505,000
2020	5,145,000
2021	795,000
2022	845,000
2023	755,000
2024	420,000
2025	505,000
2026	210,000

At its option, to be exercised on or before the forty-fifth (45th) day next preceding any such redemption date, the Alliance may (i) deliver to the Trustee for cancellation bonds of the applicable Series of Series 2011 Bonds to be redeemed, in any aggregate principal amount desired, and/or (ii) receive a credit in respect of its redemption obligation under this mandatory redemption provision for any bonds of the applicable Series of Series 2011 Bonds

of the maturity to be redeemed which prior to said date have been purchased or redeemed (otherwise than through the operation of this mandatory sinking fund redemption provision) and canceled by the Trustee and not theretofore applied as a credit against any redemption obligation under this mandatory sinking fund provision. Each Series 2011 Bond so delivered or previously purchased or redeemed shall be credited by the Trustee at 100% of the principal amount thereof on the obligation of the Issuer or the Alliance, as applicable, on such payment date and any excess shall be credited on future redemption obligations in such order as the Alliance directs, and the principal amount of Series 2011 Bonds of the applicable Series to be redeemed by operation of the mandatory sinking fund provision shall be accordingly reduced. The Alliance shall on or before the forty-fifth (45th) day next preceding each payment date furnish the Trustee with its certificate indicating whether or not and to what extent the provisions of clauses (i) and (ii) of this paragraph are to be availed of with respect to such payment and confirm that funds for the balance of the next succeeding prescribed payment will be paid on or before the next succeeding payment date.

Notice of Redemption

The Trustee shall cause notice of the call for any such redemption identifying the Series 2011 Bonds to be redeemed to be sent not less than 30 nor more than 60 days prior to the Redemption Date (a) by first-class mail postage prepaid, to the holder of each such Series 2011 Bond to be redeemed at his address as it appears on the registration books of the Trustee, (b) by first-class mail, to at least two organizations registered with the Securities and Exchange Commission as securities depositories, (c) to at least one information service of national recognition which disseminates redemption information with respect to municipal securities, and (d) if a Letter of Credit is in effect, to the Bank. Failure to give any notice described in (a), or any defect therein, shall not affect the validity of any proceedings for the redemption of any Series 2011 Bonds with respect to which no such failure has occurred and failure to give any notice described in (b) or (c), or any defect therein, shall not affect the validity of any proceedings for the redemption of any Series 2011 Bonds with respect to which the notice specified in (a) is correctly given. Any notice mailed as described above shall conclusively be presumed to have been given whether or not actually received by any Holder. All Series 2011 Bonds called for redemption shall cease to bear interest on the specified redemption date, provided funds for their redemption are on deposit at the place of payment on the date fixed for redemption.

Partial Redemption of Series 2011 Bonds

If less than all the Series 2011 Bonds of a Series are to be redeemed, the particular Series 2011 Bonds of a Series or portions thereof to be redeemed shall be selected by the Trustee by lot or in such other manner as the Trustee shall deem appropriate, which shall be deemed to include pro rata redemption of Series 2011 Bonds of a Series, and which may provide for the selection for redemption of portions (equal to Authorized Denominations) of the principal of Series 2011 Bonds of a Series; provided that (a) if at the time of selection of any Series 2011 Bonds for redemption any Series 2011 Bonds of a Series are Pledged Bonds or Borrower Bonds, such Pledged Bonds or Borrower Bonds shall be selected for redemption prior to any other Series 2011 Bonds of such Series, and (b) if at the time of selection, the Trustee has received notice of tender of any Series 2011 Bonds for which the Optional Tender Date will be on or after the Redemption Date, the Trustee (after redeeming all Series 2011 Bonds to which clause (a) applies) shall select such Tendered Bonds for redemption prior to any Series 2011 Bonds of such Series, other than Pledged Bonds or Borrower Bonds.

Any Series 2011 Bond which is to be redeemed only in part shall be surrendered to the Trustee (a) for payment of the Redemption Price (including accrued interest thereon to the Redemption Date) of the portion thereof called for redemption and (b) for exchange for Series 2011 Bonds in any Authorized Denomination or denominations in aggregate principal amount equal to the unredeemed portion of such Series 2011 Bond, without charge therefor.

Notwithstanding the foregoing, in the event that the depository for the Series 2011 Bonds is DTC, the Trustee will follow the procedure for redemption, and selection of Series 2011 Bonds for redemption, prescribed by DTC.

Purchase of Series 2011 Bonds in Lieu of Redemption

In lieu of redeeming Series 2011 Bonds, the Trustee may, at the request of the Alliance, use funds otherwise available under the Indenture for redemption of Series 2011 Bonds to purchase Series 2011 Bonds identified by the Alliance in the open market for cancellation at a price specified by the Alliance not exceeding the Redemption Price then applicable under the Indenture. In the case of any extraordinary redemption or any purchase and cancellation of the Series 2011 Bonds, the Alliance shall receive credit against its required deposits to the Bond Sinking Fund with respect to Series 2011 Bonds of the Series and maturity redeemed or purchased in such order as the Alliance elects prior to such extraordinary redemption or purchase and cancellation or, if no election is made, in the inverse order thereof.

Tender and Purchase of Series 2011 Bonds

Purchase of Series 2011 Bonds at Option of Holder

While the Weekly Rate Periods are in effect, the Trustee, as Tender Agent and acting on behalf of the Alliance and for the benefit of the Bondholders, shall purchase any Series 2011 Bond (other than Pledged Bonds and Borrower Bonds), in whole or in part in Authorized Denominations upon the demand of the holder thereof at a purchase price equal to the principal amount thereof plus accrued interest, if any, to the date of purchase, for the account of the Alliance, but only upon (a) delivery to the Trustee and the Remarketing Agent at their respective principal offices (St. Louis, Missouri for the Trustee) of a written notice, or at the option of the Trustee or the Remarketing Agent (with respect to their respective notices), telephonic notice confirmed in writing, from the Holder of such Series 2011 Bond (an "Optional Tender Notice") which shall state (1) the principal amount or portions of such Series 2011 Bond being tendered, the number of the Series 2011 Bond being tendered and the name of the Holder thereof and (2) the date such Series 2011 Bond or portion thereof shall be purchased pursuant to the Indenture (the "Optional Tender Date"), which date shall be a Business Day not later than 3:00 p.m., New York City time on the Business Day that is five Business Days prior to the date of receipt of such Optional Tender Notice by the Remarketing Agent and the Trustee and (b) delivery of such Series 2011 Bond (with all necessary endorsements) to the Trustee, at its office in East Syracuse, New York, at or prior to 10:00 a.m., New York City time, on the first Business Day prior to the date of purchase specified in the aforesaid notice; provided, however, that payment of the purchase price of such Series 2011 Bonds shall be made only if the Series 2011 Bonds so delivered to the Trustee, as Tender Agent, shall conform in all respects to the description thereof in the aforesaid notice. Payment of such purchase price shall be made by check unless the Bondholder's Optional Tender Notice contains instructions to the Trustee to wire such purchase price to a particular account. If the date that a Series 2011 Bond is to be purchased is after a Record Date but before the next succeeding Interest Payment Date, the owner of such Series 2011 Bond shall also be required to deliver to the Trustee a due bill instructing that the interest due on the next succeeding Interest Payment Date be paid to the person who purchases such Series 2011 Bond on the purchase date.

On the Optional Tender Date, the Trustee, as Tender Agent, shall purchase the Series 2011 Bond or portion thereof identified in such Optional Tender Notice from the Holder thereof for the account of the Alliance, at a purchase price equal to the principal amount or portion thereof being tendered plus accrued interest, but only from funds provided by the Alliance, including moneys drawn under the Letter of Credit.

Any Series 2011 Bonds which are not tendered on an Optional Tender Date pursuant to an Optional Tender Notice (the "Untendered Bonds"), for which there has been irrevocably deposited in trust with the Trustee an amount sufficient to pay the purchase price thereof, shall be deemed to have been tendered for purchase and purchased as described herein. Holders of Untendered Bonds shall not be entitled to any payment (including any interest to accrue subsequent to the Optional Tender Date) other than the purchase price for such Untendered Bonds, and the Holders of such Untendered Bonds shall no longer be entitled to the benefits of the Indenture, except for the purpose of payment of the purchase price thereof. Replacement Bonds shall be issued in place of such Untendered Bonds and after the issuance of such Replacement Bonds, such Untendered Bonds shall be deemed to have been purchased and shall no longer be Outstanding under the Indenture.

Mandatory Purchase Upon Conversion Date

The Series 2011 Bonds are required to be tendered for purchase on each Conversion Date or any Proposed Conversion Date. Upon receipt of notice from the Alliance establishing the Proposed Conversion Date and certain other documentation required by the Indenture, the Trustee shall give Notice by Mail to the Bondholders at least 30 days before the Proposed Conversion Date that the Proposed Conversion Date is a Mandatory Tender Date. Such notice shall state (a) that the interest rate on the Series 2011 Bonds will be converted to a Fixed Rate; (b) the Conversion Date; (c) the date by which (1) the Preliminary Fixed Rate that is required to be determined pursuant to the Indenture is to be determined and (2) the Bondholders may contact the Trustee (and the name and telephone number of the person whom the Bondholders may contact) to obtain the Preliminary Fixed Rate; (d) the date by which (1) the Remarketing Agent is required to determine the Fixed Rate, (2) the Bondholders may contact the Trustee (and the name and telephone number of the person whom the Bondholders may contact) to obtain the Fixed Rate, and (3) the Trustee will notify upon request the Bondholders of the Fixed Rate; (e) that subsequent to the conversion to a Fixed Rate (1) any ratings of the Rating Agency or Agencies then rating the Series 2011 Bonds may be withdrawn or changed (if such is the case) and (2) the Bondholders will no longer have the right to tender their Series 2011 Bonds to the Trustee for purchase under the Indenture; (f) the last date on which the Bondholders' right to tender Series 2011 Bonds may be exercised; (g) that the Series 2011 Bonds will not be entitled to the benefit of the Letter of Credit or a Substitute Letter of Credit after the Conversion Date, if such is the case; (h) that there will be a failure of conversion (1) if the Fixed Rate is less than the Preliminary Fixed Rate, (2) if the Opinion of Bond Counsel required in connection with such a conversion is withdrawn prior to the Conversion Date, (3) if the Remarketing Agent fails to determine the Preliminary Fixed Rate or Fixed Rate or (4) if the Alliance revokes its request to convert the interest rate on the Series 2011 Bonds to a Fixed Rate; (i) that such failure of conversion shall result in the Series 2011 Bonds bearing interest at a Weekly Rate; (j) the Termination Date of the Letter of Credit; and (k) that, on the Proposed Conversion Date, the Bondholder shall have no further rights under such Series 2011 Bond or Bonds except to receive the principal of the Series 2011 Bond or Bonds upon presentation and surrender of such Series 2011 Bond or Bonds to the Trustee.

On the Proposed Conversion Date, whether or not a Failed Conversion as described below has occurred, the Trustee shall purchase all outstanding Series 2011 Bonds (except Pledged Bonds and Borrower Bonds) from the Holders thereof, who shall also have delivered such Series 2011 Bonds to the Trustee, all as above described.

If (i) the Fixed Rate as determined by the Remarketing Agent is less than the Preliminary Fixed Rate, (ii) the Remarketing Agent fails to determine the Preliminary Fixed Rate or Fixed Rate, (iii) the Opinion of Bond Counsel required with respect to the conversion to the Fixed Rate is withdrawn prior to the Conversion Date or, (iv) the Alliance revokes its request to convert the interest rate on the Series 2011 Bonds to a Fixed Rate, then a failed conversion shall be deemed to have occurred (a "Failed Conversion"). In the event of a Failed Conversion, the interest rate on the Series 2011 Bonds will be the Weekly Rate, and the Weekly Rate Periods shall be in effect. If the Weekly Rate Periods were not in effect prior to the Proposed Conversion Date, the Proposed Conversion Date shall be deemed to be an Adjustment Date for a Weekly Rate Period beginning on such date.

Mandatory Purchase Upon Conversion to Medium-Term Rate Periods

The Series 2011 Bonds are required to be tendered for purchase on the first day of each period at which the Series 2011 Bonds bear interest at the Medium-Term Rate, each such date being an Adjustment Date for the Medium-Term Rate Periods. The Trustee shall give Notice by Mail to the Bondholders, the Remarketing Agent, the Issuer and the Bank at least 30 days before each Adjustment Date for the Medium-Term Rate Periods that such date is a Mandatory Tender Date. Such notice shall state (a) the Mandatory Tender Date; (b) the date on which the Remarketing Agent is required to determine the length of the Medium-Term Rate Period that begins on such Date; (c) the date by which the Remarketing Agent is required to determine the interest rate for such Medium-Term Rate Period; (d) that the Bondholders may contact the Trustee (and the name and telephone number of the person whom the Bondholders may contact) to obtain the length of the Medium-Term Rate Period and the interest rate for such Medium-Term Rate Period on or after the date of its determination; (e) the Interest Payment Date and Record Date for such Medium-Term Rate Period; (f) that during the Medium-Term Rate Period, the Bondholders will no longer have the right to tender their Series 2011 Bonds to the Trustee for purchase under the Indenture and the last day on which the Bondholders' right to tender Series 2011 Bonds may be exercised; (g) the rating of the Series 2011 Bonds by each Rating Agency, if the Series 2011 Bonds are to be rated, after the Mandatory Tender Date; and (h) that, on

such Mandatory Tender Date, the Bondholder shall have no further rights under such Series 2011 Bond or Bonds except to receive the principal of the Series 2011 Bond or Bonds upon presentation and surrender of such Series 2011 Bond or Bonds to the Trustee.

Mandatory Purchase Upon Substitution Tender Date

The Series 2011 Bonds of a Series are required to be tendered for purchase on the fifth Business Day prior to the effective date of any Substitute Letter of Credit (the “Substitution Tender Date”) for such Series. The Trustee shall give Notice by Mail to the Bondholders, the Remarketing Agent, the Issuer, the Alliance and the Bank at least 30 days before the Substitution Tender Date that such date will be a Mandatory Tender Date. Such notice shall state: (i) the Substitution Tender Date; (ii) the identity of the bank that is issuing the Substitute Letter of Credit; (iii) the rating of the Series 2011 Bonds by each Rating Agency, if the Series 2011 Bonds are to be rated, after the delivery of the Substitute Letter of Credit; and (iv) that, on such Mandatory Tender Date, interest shall cease to accrue with respect to such Bondholder’s Series 2011 Bond or Bonds on such date and the Bondholder shall have no further rights under such Series 2011 Bond or Bonds except to receive the principal of the Series 2011 Bond or Bonds upon presentation and surrender of such Series 2011 Bond or Bonds to the Trustee.

Mandatory Purchase on Termination of Letter of Credit

The Series 2011 Bonds of each Series are subject to mandatory tender for purchase in whole on the second Business Day prior to the Termination Date of the Letter of Credit securing such Series.

No Purchase After Event of Default

Anything in the Indentures to the contrary notwithstanding, there shall be no purchases of Series 2011 Bonds pursuant to such Indenture if there shall have occurred and be continuing an Event of Default of which the Trustee has knowledge that immediately requires the acceleration of the Series 2011 Bonds under such Indenture.

Defeasance

If the applicable Issuer deposits with the applicable Bond Trustee funds, evidenced by moneys or Defeasance Investments (as defined in Appendix D) the principal of and interest on which, when due, will be sufficient to pay the principal or Redemption Price of any Series of Series 2011 Bonds, by call for redemption or otherwise, together with interest accrued to the due date or the redemption date, as appropriate, in accordance with the terms of the Indentures, such Series of Series 2011 Bonds shall no longer be deemed to be Outstanding under the applicable Indenture. Interest on such Series of Series 2011 Bonds, as appropriate, will cease to accrue on the due date or the redemption date, as appropriate, and from and after the date of such deposit of funds with the Bond Trustee the holders of such Series of Series 2011 Bonds will be restricted to the funds so deposited as provided in the Indentures.

PLAN OF FINANCE

Application of Proceeds

The proceeds of the Series 2011 Tennessee Bonds will be loaned by the Tennessee Issuer to the Alliance pursuant to Loan Agreements dated as of October 1, 2011, and used (1) to finance certain capital improvements and equipment acquisitions at the facilities owned and/or operated by the Alliance in the State of Tennessee, and (2) to pay certain expenses incurred in connection with the issuance of the Series 2011 Tennessee Bonds.

The proceeds of the Series 2011C Bonds will be loaned by the Virginia Issuer to the Alliance, Smyth and Norton pursuant to a Loan Agreement dated as of October 1, 2011. The proceeds of the Series 2011C Bonds will be used (1) to refinance \$11,200,000 of the Hospital Refunding and Improvement Revenue Bonds (Norton Community Hospital, Inc.), Series 2001 (the “Refunded Norton Bonds”), issued by the Industrial Development Authority of the City of Norton, Virginia, for the benefit of Norton; (2) to finance certain capital improvements and equipment acquisitions at the facilities owned and/or operated by Smyth and Norton; and (3) to pay certain expenses incurred in connection with the issuance of the Series 2011C Bonds.

The proceeds of the Series 2011D Bonds will be loaned by the Virginia Issuer to the Alliance, Smyth and Johnston Memorial Hospital (“JMH”) pursuant to a Loan Agreement dated as of October 1, 2011. The proceeds of the Series 2011D Bonds will be used (1) to finance certain capital improvements and equipment acquisitions at the facilities owned and/or operated by Smyth and JMH and (2) to pay certain expenses incurred in connection with the issuance of the Series 2011D Bonds.

The proceeds of the Series 2011 Taxable Bonds will be loaned to the Alliance pursuant to a Bond Purchase Agreement dated as of October 19, 2011, between the Alliance and Merrill Lynch, Pierce, Fenner & Smith Incorporated. The proceeds of the Series 2011 Taxable Bonds will be used (1) to finance capital improvements and equipment acquisitions at facilities owned by Smyth and Blue Ridge Medical Management Corporation, an affiliate of the Alliance; and (2) to pay certain expenses incurred in connection with the issuance of the Series 2011 Taxable Bonds.

Refunding of Refunded Norton Bonds

A portion of the proceeds of the Series 2011C Bonds will be deposited in an escrow fund (the “Escrow Fund”) to be held by U.S. Bank National Association, as escrow agent for the Refunded Norton Bonds, pursuant to a Refunding Trust Agreement (the “Refunding Agreement”) to be dated the date of delivery of the Series 2011C Bonds. The Refunding Agreement will provide that cash will be deposited in the Escrow Fund in an amount sufficient to pay the redemption price of the Refunded Bonds on the date of redemption, December 1, 2011.

Verification of Mathematical Computations

The Arbitrage Group, Inc., independent arbitrage consultants, will verify the arithmetical accuracy of certain mathematical computations relating to the sufficiency of the moneys deposited in the Escrow Fund to pay the redemption prices of the Refunded Norton Bonds at redemption prices equal to the respective principal amounts of the Refunded Bonds to be redeemed, plus interest accrued and unpaid to such redemption date, plus the applicable premium based on information provided by the Alliance, and such verification will be relied upon by Bond Counsel to support its opinion that interest on the Series 2011 Tax-Exempt Bonds will not be included in gross income for federal income tax purposes. Such computations were based solely upon information supplied by the Financial Advisor. The Arbitrage Group, Inc. has restricted its procedures to verifying the arithmetical accuracy of certain computations and has not made any study or evaluation of the assumptions and information upon which the computations are based and, accordingly, has not expressed an opinion on the data used, the reasonableness of the assumptions, or the achievability of future events.

Sources and Uses of Funds

<u>Sources of Funds</u>	<u>2011A</u>	<u>2011B</u>	<u>2011C</u>	<u>2011D</u>	<u>2011E</u>	<u>Total</u>
Principal Amount	\$65,260,000	\$20,000,000	\$49,875,000	\$60,705,000	\$15,960,000	\$211,800,000
Funds on Hand	<u>0</u>	<u>0</u>	<u>2,283,559</u>	<u>0</u>	<u>0</u>	<u>2,283,559</u>
	65,260,000	20,000,000	52,158,559	60,705,000	15,960,000	\$214,083,559
<u>Uses of Funds</u>	<u>2011A</u>	<u>2011B</u>	<u>2011C</u>	<u>2011D</u>	<u>2011E</u>	<u>Total</u>
Projects	\$19,446,502	\$12,314,067	\$37,432,000	\$57,801,008	\$0	\$126,993,577
Equipment	21,659,647	7,450,648	1,716,490	2,150,304	0	32,977,089
Refunding of Long-term Debt	0	0	12,377,475	0	0	12,377,475
Refinancing of Loans and Leases	23,421,513	0	0	0	15,782,533	39,204,046
Costs of Issuance	<u>732,338</u>	<u>235,285</u>	<u>632,594</u>	<u>753,688</u>	<u>177,467</u>	<u>2,531,372</u>
	\$65,260,000	\$20,000,000	\$52,158,559	\$60,705,000	\$15,960,000	\$214,083,559

Current and Pro Forma Long-Term Debt

The left column of the following table reflects the total outstanding debt of the Alliance under the Master Indenture as of June 30, 2011, prior to the issuance of the Series 2011 Bonds. The right column of the following table shows the outstanding debt of the Alliance under the Master Indenture as of June 30, 2011, but adjusted to show the effect of the issuance of the Series 2011 Bonds and the planned redemption of (1) \$115,135,000 of the outstanding principal amount of the Tennessee Issuer's Hospital Revenue Bonds, Series 2007B-1, and (2) \$29,405,000 of the outstanding principal amount of the Tennessee Issuer's Hospital Revenue Bonds, Series 2007B-3. The table below and in the immediate following section does not include the indebtedness of certain entities controlled by the Alliance that are not Obligated Issuers.

Outstanding Long-Term Debt (at June 30, 2011)		Pro Forma Long-Term Debt (at June 30, 2011)	
Description	Principal Amount	Description	Principal Amount
Debt:		Debt:	
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Refunding Bonds, Series 2000A	\$38,607,500 ⁽¹⁾	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Refunding Bonds, Series 2000A	\$38,607,500 ⁽¹⁾
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2000C	34,325,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2000C	34,325,000
Mountain States Health Alliance Taxable Note, Series 2000D	14,790,000	Mountain States Health Alliance Taxable Note, Series 2000D	14,790,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2001A	23,100,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2001A	23,100,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2006A	169,630,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2006A	169,630,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-1	144,400,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-1	29,265,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-2	105,000,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-2	105,000,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-3	58,500,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-3	29,095,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2008A	13,245,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2008A	13,245,000
Industrial Development Authority of Russell County Hospital Revenue Bonds, Series 2008B	53,855,000	Industrial Development Authority of Russell County Hospital Revenue Bonds, Series 2008B	53,855,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2009A	5,560,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2009A	5,560,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2009B	5,535,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2009B	5,535,000
Industrial Development Authority of Washington County, Virginia, Hospital Revenue Bonds, Series 2009C	115,955,000	Industrial Development Authority of Washington County, Virginia, Hospital Revenue Bonds, Series 2009C	115,955,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2010A	168,080,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2010A	168,080,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2010B	35,935,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2010B	35,935,000
		The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011A	65,260,000
		The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011B	20,000,000
		Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011C	49,875,000
		Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011D	60,705,000
		Mountain States Health Alliance Taxable Bonds, Series 2011E	15,960,000
Total Long-Term Debt	\$986,517,500	Total Long-Term Debt	\$1,053,777,500
Less: 2000 Reserve Fund	\$ 7,000,000	Less: 2000 Reserve Fund	\$7,000,000
2006A Reserve Fund	17,303,000	2006A Reserve Fund	17,303,000
2009A, B and C Reserve Funds	12,131,762	2009A, B and C Reserve Funds	12,131,762
2010A and B Reserve Funds	18,352,884	2010A and B Reserve Funds	18,352,884
NET TOTAL LONG-TERM DEBT	\$931,729,854	NET TOTAL LONG-TERM DEBT	\$998,989,854

⁽¹⁾ Value of CABS accreted to June 30, 2011.

⁽²⁾ Amounts in this reserve fund may be withdrawn at any time prior to an event requiring funding of Debt Service Reserve Funds.

Estimated Annual Debt Service Requirements

The following table reflects the estimated outstanding debt service obligations of the Alliance on all long term indebtedness secured under the Master Indenture following the issuance of the Series 2011 Bonds. The estimated annual debt service with respect to outstanding indebtedness assumes a 3.50% interest rate on all variable rate bonds, and does not take into account any interest rate hedges that may exist or may be executed in the future.

Year Ending July 1	Estimated Annual Debt Service Requirements Series 2011 Bonds			Estimated Annual Debt Service on Outstanding Indebtedness	Estimated Total Annual Long- Term Debt Service Requirements
	Principal	Interest	Annual Debt Service		
	2012	\$ 4,975,000	\$7,413,000		
2013	5,075,000	7,238,875	12,313,875	63,911,294	76,225,169
2014	3,050,000	7,061,250	10,111,250	63,813,281	73,924,531
2015	3,965,000	6,954,500	10,919,500	63,731,169	74,650,669
2016	4,190,000	6,815,725	11,005,725	63,636,844	74,642,569
2017	4,420,000	6,669,075	11,089,075	63,543,156	74,632,231
2018	8,785,000	6,514,375	15,299,375	59,294,481	74,593,856
2019	11,510,000	6,206,900	17,716,900	56,802,156	74,519,056
2020	11,475,000	5,804,050	17,279,050	56,592,913	73,871,963
2021	11,075,000	5,402,425	16,477,425	56,342,863	72,820,288
2022	11,100,000	5,014,800	16,114,800	56,080,694	72,195,494
2023	11,785,000	4,626,300	16,411,300	55,817,100	72,228,400
2024	14,425,000	4,213,825	18,638,825	52,797,156	71,435,981
2025	15,335,000	3,708,950	19,043,950	51,708,156	70,752,106
2026	6,525,000	3,172,225	9,697,225	60,670,569	70,367,794
2027	6,640,000	2,943,850	9,583,850	60,459,681	70,043,531
2028	6,635,000	2,711,450	9,346,450	60,386,894	69,733,344
2029	6,875,000	2,479,225	9,354,225	60,251,281	69,605,506
2030	6,905,000	2,238,600	9,143,600	60,134,594	69,278,194
2031	19,800,000	1,996,925	21,796,925	46,943,263	68,740,188
2032	17,775,000	1,303,925	19,078,925	46,069,300	65,148,225
2033	19,480,000	681,800	20,161,800	45,138,300	65,300,100
2034	-	-	-	66,714,488	66,714,488
2035	-	-	-	66,685,563	66,685,563
2036	-	-	-	66,656,063	66,656,063
2037	-	-	-	66,621,338	66,621,338
2038	-	-	-	66,529,213	66,529,213

JMH Financing

Shortly after the issuance of the Series 2011 Bonds, it is expected that the Virginia Issuer will issue its approximately \$25,000,000 Hospital Facility Revenue Refunding and Improvement Bonds (Johnston Memorial Hospital Project), Series 2011 (the “JMH Bonds”), for the benefit of JMH. JMH is not a member of the Obligated Group and the Obligated Issuers will not be required to pay debt service on the JMH Bonds. The JMH Bonds are not included in the tables in the sections “Current and Pro Forma Long Term Debt” and “Estimated Annual Debt Service Requirements” above.

SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2011 BONDS

Special, Limited Obligations of the Issuers

The Series 2011 Tennessee Bonds will be issued under and secured by the Tennessee Bond Indentures and are payable from moneys received by the Tennessee Bond Trustee from the Alliance, as further described in “Trust Estate” below. The Series 2011 Virginia Bonds will be issued under and secured by the Virginia Bond Indentures and are payable from moneys received by the Virginia Bond Trustee from the Alliance, as further described in “Trust Estate” below.

Contemporaneously with the issuance of the Series 2011 Tennessee Bonds and the Series 2011 Virginia Bonds, the Alliance will issue the Series 2011 Taxable Bonds, which are secured on a parity with the Series 2011 Tax-Exempt Obligations.

Trust Estate

The Series 2011 Bonds of each Series are payable from the respective Trust Estates under the Bond Indentures, which consist of (i) payments or prepayments to be made on the Series 2011 Obligations, and any additional obligations of the Alliance to the respective Issuer to the extent such additional obligations may be pledged under the Bond Indentures in the future; (ii) other payments under the Loan Agreements (other than fees and expenses payable to the Issuers and the Issuers' rights to indemnification in certain circumstances); (iii) all moneys and investments held under the applicable Bond Indenture, but not including amounts required to be paid into the funds established under the applicable Bond Indenture; and (iv) in certain circumstances, proceeds from certain insurance and condemnation awards.

Pursuant to the Series 2011 Obligations, the Alliance is required to make payments to the applicable Bond Trustee for deposit into the Debt Service Fund established under the applicable Bond Indenture, at the times and in amounts sufficient to pay the principal of and interest on the Series 2011 Bonds.

Payment of principal and interest on the Series 2011 Bonds will not be secured by any encumbrance, mortgage or other pledge of any property of any Issuer. **The Series 2011 Bonds will not constitute a debt or indebtedness of any state or any political subdivision or agency thereof, including The Health and Educational Facilities Board of the City of Johnson City, Tennessee, and the Industrial Development Authority of Smyth County (Virginia) within the meaning of any constitutional or statutory provision or limitation. The Issuers do not have taxing power.**

Master Indenture Covenants

In the Master Indenture, the Alliance has made certain covenants, on behalf of itself and the Obligated Group (as defined in the Master Indenture), regarding maintenance of fees and rates, and any future Obligated Issuer would be required to make similar covenants upon joining the Obligated Group. These covenants provide, among other matters, that each Obligated Issuer (including the Alliance) will continue to impose such fees as are included within the Gross Revenues, operate on a revenue producing basis, and charge such fees and rates for its facilities and services and exercise such skill and diligence as to provide income from its property together with other available funds sufficient to pay promptly all payments of principal and interest on its indebtedness secured by the Master Indenture, all expenses of operation, maintenance, and repair of its property subject to the Master Indenture, and all other payments required to be made by it under the Master Indenture to the extent permitted by law. Each Obligated Issuer (including the Alliance) also covenants to use its best efforts to maintain in each Fiscal Year a ratio of total Income Available for Debt Service to Maximum Annual Debt Service for all Obligated Issuers at least equal to 1.30 to 1. Each Obligated Issuer (including the Alliance) further covenants that it will from time to time as often as necessary and to the extent permitted by law, revise its rates, fees and charges in such manner as may be necessary or proper to comply with the provisions of the Master Indenture described in this paragraph. See Appendix D - "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE - Rates and Charges."

The Master Indenture defines "Income Available for Debt Service" of the Alliance or other Obligated Issuer to mean, with respect to any period of time, the excess of revenues over expenses, or, in the case of for-profit entities, net income after tax, as determined in accordance with generally accepted accounting principals, to which shall be added, in either case, (i) depreciation, (ii) amortization, (iii) interest expense on Long-Term Indebtedness (as defined in the Master Indenture) and (iv) to the extent not already included, contributions and donations and from which shall be excluded any extraordinary items, any impairment losses, any gain or loss resulting from either the extinguishment of indebtedness or the sale, exchange or other disposition of assets not made in the ordinary course of business, provided, however, that (a) no determination of Income Available for Debt Service will take into account any gains or losses resulting from the periodic valuation of investments or Hedge Agreements that do not involve the sale, transfer or other disposition of any such investment or Hedge Agreement or the termination of any Hedge Agreement and (b) a person may include in its net income such person's share of the net income of any

person controlled by such person or in whom such person has a legal interest. The Master Indenture contains provisions relating to the calculation of Maximum Annual Debt Service that provides for reallocation of amounts due on balloon indebtedness and assumptions as to the interest rates on variable rate indebtedness and payment of guaranties. For financial information of the Alliance, see Appendix A and the Alliance's audited consolidated financial statements for the fiscal year ended June 30, 2010 and June 30, 2009, included as Appendix B and its unaudited consolidated financial statements for the fiscal year ended June 30, 2011, included as Appendix C. For a more complete description of the covenants under the Master Indenture, see "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE - Rates and Charges" in Appendix D.

Only Obligated Issuers are obligated to make payments on the Series 2011 Bonds and to abide by the covenants under the Master Indenture. The audited and unaudited financial statements included as Appendices B and C reflect the assets and operations of entities that are not Obligated Issuers. See Appendix A – "CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS."

Amendment of Master Indenture

By purchasing the Series 2011 Bonds, the initial holders thereof will consent to an amendment to the definition of "Debt Service Requirement" in the Master Indenture. Such amendment will not become effective immediately and will become effective only upon receipt of the consent of the required percentage of bondholders and credit enhancers under the terms of the Master Indenture.

Both the existing definition and the proposed amended definition are set forth in Appendix D, "SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS." The definition of "Debt Service Requirement" is utilized in calculations under both the additional debt test and the rate covenant under the Master Indenture, and such amendment may in certain circumstances increase or decrease the amount of the Debt Service Requirement in any required calculation. See "Additional Long-Term Indebtedness" and "Rates and Charges" in "SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE" in Appendix D.

Pledged Assets; Mortgage

Currently, the Series 2011 Bonds are secured by the applicable Trust Estate, including the assignment of the applicable Series 2011 Obligation. As security for its Master Obligations, the Alliance has granted to the Master Trustee a security interest in its Pledged Assets, subject to Permitted Liens. The Pledged Assets consist of: Receivables, Inventory, Equipment, General Intangibles, Contracts and Contract Rights, Government Approvals, Fixtures and other personal property, goods, instruments, chattel paper, documents, credits, claims, demands and assets. For a definition of these terms see Appendix D - "SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS." Financing statements will be filed in the appropriate records of the Office of the Tennessee Secretary of State to perfect the security interest in Pledged Assets and Equipment to the extent possible by such filing. Continuation statements meeting the requirements of the Uniform Commercial Code of Tennessee (the "UCC") must be filed every five years to continue the perfection of such security interest. The security interest in the Pledged Assets and Equipment is subject to Permitted Liens that exist prior to or may be created subsequent to the time the security interest granted by the Master Indenture attaches.

The security interest in any item of inventory will be inferior to the interest of a buyer in the ordinary course of business and will be inferior to a purchase money security interest, as defined in the UCC, perfected in connection with the sale to an Obligated Issuer of such item. The lien on certain other Pledged Assets may not be enforceable against third parties unless such other Pledged Assets are transferred to the Master Trustee (which transfer Obligated Issuers are not required by the Master Indenture to make prior to an Event of Default thereunder and which transfer may be set aside if it occurs within 90 days of the filing of a petition in bankruptcy) and is subject to exception under the UCC. The federal government may in the future proscribe or restrict the assignment of rights arising out of Medicare, Medicaid or other federal programs.

As a condition to becoming a Member of the Obligated Group, an entity must grant to the Master Trustee a security interest in its Pledged Assets.

Pursuant to the Master Indenture, the Obligated Issuers agree that they will not create or suffer to be created or exist any Lien other than Permitted Liens, as defined under “SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS” in Appendix D, upon any of their facilities now owned or hereafter acquired.

The Series 2011 Obligations are also secured by a mortgage on the Johnson City Medical Center located in Johnson City, Tennessee, and the Sycamore Shoals Hospital facility in Elizabethton, Tennessee (together, the “Mortgaged Property”). Such mortgage secures all Master Obligations issued under the Master Indenture.

Subject to certain conditions, in case of the failure of the Obligated Issuers to make any payment on the Master Obligations when due or upon any other event of default under the Master Indenture, the Master Trustee may, after such notice as is required by the Master Indenture and the applicable security instruments, take possession of Mortgaged Property or, upon such public notice as required by Tennessee statute, sell the Mortgaged Property, and apply the proceeds to payment of principal of and interest on the Master Obligations (and thereby on the Series 2011 Bonds) on a parity basis with any other Master Obligation.

Additional Indebtedness

The Alliance has certain debt outstanding under the Master Indenture. The Master Indenture permits the Alliance and any other members of the Obligated Group to incur Additional Indebtedness (including Guaranties), all upon the terms and subject to the conditions specified therein. Such Additional Indebtedness may, but need not, be evidenced or secured by a Master Obligation. Additional Indebtedness may be issued to the Issuer or to persons other than the Issuer.

The reimbursement obligations of the Alliance with respect to the Letters of Credit will also be secured under the Master Indenture.

Except as noted in the preceding paragraph, the Master Indenture, the Alliance and each other Obligated Issuer agrees that it will not incur other Additional Indebtedness unless it can demonstrate that certain coverage ratios have been and will be met between debt service obligations and Income Available for Debt Service. Under the Master Indenture, Additional Indebtedness may be Long-Term Indebtedness or Short-Term Indebtedness. The Master Indenture allows any future Obligated Issuer to incur Additional Indebtedness under the Master Indenture as a Master Obligation constituting the joint and several obligation of the Alliance and all other Obligated Issuers and subject to cross-guarantees of all Obligated Issuers, including the Alliance. Except to the extent entitled to the benefits of additional security as permitted by the Master Indenture and except for Subordinated Indebtedness, all Master Obligations will be equally and ratably secured by the Master Indenture. See Appendix D - “SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE.”

Subject to certain conditions set forth in the Master Indenture, Additional Indebtedness incurred by any Member of the Obligated Group may be secured by security which does not extend to any other Indebtedness. Such security may include Liens on the Property (including health care facilities) of the Members of the Obligated Group, letters or lines of credit or insurance, and could also consist of Liens on cash or securities deposited or held in any depreciation reserve, debt service or interest reserve, debt service or similar fund established pursuant to the terms of any Supplemental Master Indenture, Related Bond Indenture or Related Loan Document. The Master Indenture provides that Supplemental Master Indentures pursuant to which one or more series of Master Obligations entitled to additional security are issued may provide for such amendments to provisions of the Master Indenture, including the provisions thereof relating to the exercise of remedies upon the occurrence of an event of default, as are necessary to provide for such security and to permit realization upon such security solely for the benefit of the Master Obligation secured thereby.

Defeasance

If the interest on, and the principal or redemption price (as the case may be) of a Series of the Series 2011 Bonds have been paid, or the required amount of money and/or Defeasance Investment (see “SUMMARY OF THE

FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS” in Appendix D) have been deposited with the applicable Bond Trustee to provide sufficient amounts to pay the principal of, and premium, if any, and interest due and to become due on such Series of Series 2011 Bonds on or prior to the redemption date or maturity date thereof, such Series of Series 2011 Bonds shall no longer be deemed outstanding under the applicable Bond Indenture and will no longer be secured thereby. If all Series 2011 Bonds of a Series have been so provided for, the applicable Bond Trustee shall cancel and discharge the applicable Bond Indenture. See “SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURE - Defeasance” in Appendix D.

Bankruptcy

The lien on the Pledged Assets and Equipment given for the benefit of holders of Master Obligations (and thereby the Series 2011 Bonds) are generally superior to the claims of other creditors (subject to the limitations set forth above). However, bankruptcy and similar proceedings and usual equity principles may affect the enforcement of rights to such security. If such security is inadequate for payment in full of the Bonds, bankruptcy proceedings and usual equity principles may also limit any attempt by the Master Trustee to seek payment from other property of the Alliance or future Obligated Issuers. In particular, federal bankruptcy law permits adoption of a reorganization plan even though it has not been accepted by the holders of a majority in aggregate principal amount of the Bonds if the holders are provided with the benefit of their original lien or the “indubitable equivalent.” In addition, if the bankruptcy court concludes that the holders have “adequate protection,” it may (1) substitute other security for the security subject to the lien of the holders and (2) subordinate the lien of the holders to claims by entities or persons supplying post petition financing to the Alliance after bankruptcy. Furthermore, the reasonable and necessary costs and expenses of preserving or disposing of the Pledged Assets and Equipment in a bankruptcy may, in certain circumstances, reduce the value of the lien on the Pledged Assets and Equipment to the extent such costs and expenses benefit the Master Trustee (and holders). In the event of the bankruptcy of the Alliance, the amount realized by the holders might depend on the bankruptcy court’s interpretation of “indubitable equivalent” and “adequate protection” under the then existing circumstances, which may result in a reduction in the security for or proceeds available to the holders.

THE LETTERS OF CREDIT

Terms of the Letters of Credit

The timely payment of the principal of and interest on the Series 2011 Bonds and the purchase price of each Series of the Series 2011 Bonds will be secured by a corresponding irrevocable transferable direct-pay letter of credit (each, a “Letter of Credit”) issued by the respective Bank in a stated amount equal to the aggregate principal amount of the respective Series 2011 Bonds outstanding at any time plus 37 days’ interest thereon, calculated at the rate of 12% per annum (the “Maximum Rate”). Each Letter of Credit will be issued pursuant to a Reimbursement Agreement dated as of October 19, 2011 (each a “Reimbursement Agreement” and, together, the “Reimbursement Agreements”), among the Obligated Issuers and the respective Bank and any syndicate lenders. The obligations on the part of the Alliance to reimburse the Bank for draws made under each respective Letter of Credit, and to pay to the Bank all other amounts due under the Reimbursement Agreement, will be evidenced by Obligations (as defined in the Master Indenture) issued and secured under the Master Indenture.

Each respective Letter of Credit will expire on October 19, 2014, unless otherwise terminated or extended. Each Letter of Credit shall expire earlier than such expiration date upon the first to occur of (a) the Business Day following a Conversion Date (b) the date of receipt by the Bank of notice from the Trustee that a Substitute Letter of Credit, as described below, has been issued in substitution for the Letter of Credit; (c) the date on which the Bank honors the final drawing or drawings available; and (d) the date on which the Trustee certifies that no Series 2011 Bonds of the Series are outstanding. At the request of the Alliance, and the consent of the Bank and any syndicate lenders, the term of the respective Letter of Credit may be extended by one year. Such consent shall be at the sole discretion of the Bank and any syndicate lenders, subject to earlier termination or extension at the option of the Bank. Pursuant to the Indentures and subject to certain conditions described herein, prior to the expiration of the Letter of Credit or any other Letter of Credit, the Alliance may deliver to the Trustee a substitute Letter of Credit. Each respective Letter of Credit and any substitute Letter of Credit are herein referred to as a “Letter of Credit”; the Bank and the issuer of any other Letter of Credit are herein referred to as a “Letter of Credit Provider.”

In the case of a drawing to pay the principal or the purchase price of the Series 2011 Bonds of a Series, the stated amount of the Letter of Credit will be reduced by the principal amount of such drawing plus a corresponding amount of the interest portion of the Letter of Credit. In the case of a drawing to pay principal of the Series 2011 Bonds of a Series, the stated amount of the Letter of Credit will be reduced to the extent of any such drawing thereunder. Reductions in the Letter of Credit resulting from a drawing to pay the purchase price of Series 2011 Bonds of a Series shall be reinstated upon receipt by the Trustee of remarketing proceeds or other funds sufficient to reimburse the Bank for such drawing. Drawings to pay interest on the Series 2011 Bonds on an Interest Payment Date shall be automatically reinstated in an amount equal to the amount of such drawing following the honoring of such drawing.

Trustee Draws on Letters of Credit

The Indentures provide that, while any Letter of Credit is in effect, the Trustee shall draw moneys under such Letter of Credit in the following circumstances:

(i) on or before 4:00 p.m., New York City time, on the Business Day prior to any date any payment referred to in this paragraph is required to be made under the Indenture, the Trustee shall, without making any prior demand or claim upon the Alliance, make a drawing under and in accordance with the Letter of Credit so as to receive moneys thereunder on the next Business Day in an amount which will be sufficient for the payment in full of (i) accrued interest on the Series 2011 Bonds on any Interest Payment Date, (ii) the principal of and accrued interest on the Series 2011 Bonds upon the Stated Maturity of the Series 2011 Bonds, and (iii) the principal of and accrued interest on the Series 2011 Bonds upon the redemption of the Series 2011 Bonds.

(ii) on or before 11:30 a.m., New York City time, on the Business Day any payment referred to in this paragraph is required to be made under the Indenture, the Trustee shall, without making any prior demand or claim upon the Alliance, make a drawing under and in accordance with the Letter of Credit so as to receive moneys thereunder on such Business Day in an amount which will be sufficient, together with any proceeds of the remarketing of the Series 2011 Bonds by the Remarketing Agent then in the Bond Purchase Fund and available for application to the Series 2011 Bonds, for the payment in full of the purchase price (including, if applicable, accrued interest due in connection with a purchase on a Mandatory Tender Date or an Optional Tender Date, as the case may be) of all Series 2011 Bonds to be purchased under the terms of the Indenture.

(iii) on or before 4:00 p.m., New York City time, on the Business Day prior to the payment date of the Series 2011 Bonds upon acceleration of the Series 2011 Bonds after an event of default under the Indenture, the Trustee shall, without making any prior demand or claim upon the Alliance, make a drawing under and in accordance with the Letter of Credit so as to receive moneys thereunder in an amount which will be sufficient for the payment in full of the principal of and interest due on the Series 2011 Bonds on such payment date.

The Alliance has agreed pursuant to the Reimbursement Agreement to reimburse the Bank for amounts paid under and otherwise owing with respect to the Letters of Credit.

Extensions of Letter of Credit and Substitute Letter of Credit

Pursuant to the Loan Agreement for each Series of Series 2011 Tax-Exempt Bonds, and pursuant to the Thirtieth Supplement for the Series 2011 Taxable Bonds, the Alliance is required to maintain with the Trustee during the Weekly Rate Periods a Letter of Credit in an amount at least equal to the aggregate principal amount of Series 2011 Bonds then Outstanding plus 37 days' interest thereon. Prior to the expiration of a Letter of Credit, the Alliance shall deliver to the Trustee a Substitute Letter of Credit or cause an extension of such Letter of Credit. The extension of a Letter of Credit may be effected by the Bank's allowance of the Letter of Credit to renew automatically, delivery of an amendment to the Letter of Credit or by the delivery of a new Letter of Credit in the same form as the expiring Letter of Credit with an extended expiration date. The Alliance may also deliver a Substitute Letter of Credit to the Trustee at any time prior to the Conversion Date in the manner described below.

The Series 2011 Bonds shall be subject to mandatory tender for purchase on any Substitution Tender Date. A Substitute Letter of Credit must be an irrevocable letter of credit, having a term of at least one year, issued by a commercial bank organized or doing business in the United States, the terms of which shall in all material respects be the same as the initial Letter of Credit. Pursuant to the Indenture, the Trustee shall accept a Substitute Letter of Credit and surrender the previously held Letter of Credit if the Trustee receives (a) the Substitute Letter of Credit, (b) an Opinion of Counsel to the effect that the Substitute Letter of Credit has been duly authorized, executed and delivered by the issuer thereof and is a valid and binding obligation of the issuer thereof and (c) in the case of a Series of Series 2011 Tax-Exempt Bonds, an Opinion of Bond Counsel that the delivery of such Substitute Letter of Credit will not adversely affect the exclusion from gross income of interest on such Series of Series 2011 Tax-Exempt Bonds for federal income tax purposes. Upon the date the Trustee is permitted to draw under such Substitute Letter of Credit, the Trustee shall promptly surrender the previously held Letter of Credit to the issuer thereof for cancellation. At least 40 days prior to the effective date of such substitution, the Alliance is required to give the Trustee notice of such proposed substitution, and at least 30 days prior to the effective date of such substitution the Trustee will mail notice of such proposed substitution to the holders of all Series 2011 Bonds, advising them of the identity of the Bank giving the Substitute Letter of Credit.

THE BANKS

The timely payment of the principal of and interest on the Series 2011A Bonds and the Series 2011C Bonds and the purchase price thereof will be secured by irrevocable transferable direct-pay letters of credit issued by U.S. Bank National Association. For information on U.S. Bank National Association, see Appendix G-3.

The timely payment of the principal of and interest on the Series 2011B Bonds and the purchase price thereof will be secured by an irrevocable transferable direct-pay letter of credit issued by PNC Bank, National Association. For information on PNC Bank, National Association, see Appendix G-2.

The timely payment of the principal of and interest on the Series 2011D Bonds and the Series 2011 Taxable Bonds and the purchase price thereof will be secured by an irrevocable transferable direct-pay letter of credit issued by Mizuho Corporate Bank, Ltd. For information on Mizuho Corporate Bank, Ltd., see Appendix G-1.

INTEREST RATE SWAPS

The Alliance has various interest rate swaps and related derivatives currently in place, as described in Appendix A. Some of the existing arrangements have been entered into with affiliates of the Underwriters. The Alliance may in the future enter into swap agreements with respect to some or all of its obligations issued under the Master Indenture. See “MANAGEMENT’S DISCUSSION OF FINANCIAL PERFORMANCE – Interest Rate Swaps and Derivatives” in Appendix A.

CERTAIN RISK FACTORS

The purchase of the Series 2011 Bonds involves certain risks that are discussed throughout this Official Statement. Each prospective purchaser of the Series 2011 Bonds should make an independent evaluation of all of the information presented in this Official Statement in order to make an informed investment decision. Certain of these risks are described below.

General

The ability of the Obligated Group to make payments on the Series 2011 Bonds is dependent upon the ability of the Members thereof to generate revenue sufficient to cover collective operating expenses and debt service on the Series 2011 Bonds and other indebtedness of the Obligated Group. Health care providers, especially hospitals, face increasing economic pressures from both governmental health care programs and private purchasers of health care such as insurance companies and health maintenance organizations (collectively, “third-party payors”). The dependence of hospitals on governmental programs requires hospitals to accept both limitations on payments and regulations and other restrictions and requirements triggered by participation in such programs. Many

governmental and private third-party payors have required healthcare providers to accept “capitated” or other fixed payments, which have the affect of shifting significant economic risk to healthcare providers.

Health care, especially at the hospital level, is a highly regulated industry with complicated and frequently changing regulations arising both from payment programs and governmental police power generally. Health care providers are increasingly subject to audits, investigations, fines and litigation that may threaten access to governmental reimbursement programs, require substantial payments, generate adverse publicity and create significant legal and other transaction costs. See below “Health Care Revenues.” In addition, because the Alliance and a number of its affiliates are tax-exempt charitable organizations under the Internal Revenue Code (“Exempt Organizations”), they are subject to increasing regulation and restrictions that may have adverse effects on their economic performance or threaten their tax-exempt status and the economic benefits derived from it. In particular, such regulations and restrictions may require the facilities of the Alliance or such affiliates to provide health care services for which they do not receive payment. In addition, Congress is likely to consider imposing additional regulations and restrictions on Exempt Organizations.

Future economic and other conditions, including inflation, demand for health care services, the ability of the Alliance and other members of the Obligated Group to provide the services required or requested by patients, physicians’ confidence in the Alliance, economic developments in the applicable service areas, employee relations and unionization, competition, the level of rates or charges, increased costs, availability of professional liability insurance, casualty losses, third-party reimbursement and changes in governmental regulation may adversely affect revenues and, consequently, the ability of the Alliance and other members of the Obligated Group to generate revenues sufficient for the payment of the principal of and interest on the Series 2011 Obligations.

Certain more specific factors that could affect the Series 2011 Bonds and the future financial condition of the Alliance and any future members of the Obligated Group are described below. This discussion of risk factors is not intended to be exhaustive.

Discretion of the Board and Management

The Master Indenture does not significantly restrict the ability of the Alliance to enter into transactions that could materially affect the business, organizational structure and control of the Alliance and any future members of the Obligated Group. Such transactions could include, for example, such things as divestitures of Affiliates, substantial new joint ventures, and mergers, consolidations or other forms of affiliations in which control of the Alliance and any future members of the Obligated Group could be materially changed. As a substantial health system, the Alliance regularly considers and analyzes opportunities for such undertakings. The ability of the Alliance to generate revenues sufficient to pay debt service on the Series 2011 Obligations is dependent in large measure on the decisions of the Board of Directors and management of the Alliance with respect to such opportunities.

Voting Control Under Master Indenture

Certain amendments and waivers to the provisions of the Master Indenture may be made with the consent of the owners of 75% of the aggregate principal amount of the Master Obligations then outstanding. Certain other amendments may be made with the consent of the owners of two-thirds (2/3) in aggregate principal amount of Master Obligations related to bonds that are not the beneficiaries of certain municipal bond insurance policies and the consent of the provider of certain municipal bond insurance policies. Such amendments may adversely affect the security of the holders of the Series 2011 Bonds.

For a discussion of what actions may be taken with the consent or direction of a majority percent or more of the holders of outstanding Master Obligations under the Master Indenture, see the discussion under “SUMMARY OF THE FINANCING DOCUMENTS” in Appendix D.

Matters Relating to Enforceability of the Master Indenture

The practical realization of any rights upon any default under the Loan Agreements or under the Master Indenture may depend upon the exercise of various remedies specified in such instruments, as restricted by federal and state laws. The federal bankruptcy laws may adversely affect the ability of the Trustees and the owners of the Series 2011 Bonds to enforce their claims granted by the Bond Indentures, the Loan Agreements or the Master Indenture. The obligation of the Alliance on the Series 2011 Obligations and other Master Obligations will be limited to the same extent as the obligations of debtors typically are affected by bankruptcy, reorganization, insolvency, fraudulent conveyance, moratorium or other similar laws affecting the enforcement of creditors' rights and by the availability of equitable remedies.

The remedies available to the Bond Trustees, the Master Trustee, the Issuers or the owners of the Series 2011 Bonds upon an event of default under the Master Indenture, the Bond Indentures, the Loan Agreements or the Series 2011 Obligations are in many respects dependent upon judicial actions, which are often subject to discretion and delay. Under existing constitutional and statutory law and judicial decisions, including, specifically, Title 11 of the United States Code (the "Bankruptcy Code"), the remedies provided in the Master Indenture, the Bond Indentures, the Loan Agreements and the Series 2011 Obligations and other Master Obligations may not be readily available or may be limited.

There is no clear precedent in the law as to whether transfers from an Affiliate in order to pay debt service on the Master Obligations issued for the benefit of another Affiliate may be voided by a trustee in bankruptcy in the event of a bankruptcy of the transferring Affiliate or by third-party creditors in an action brought pursuant to state fraudulent conveyances statutes. Under the United States Bankruptcy Code, a trustee in bankruptcy and, under state fraudulent conveyances statutes, a creditor of a related guarantor, may avoid any obligation incurred by a related guarantor, if, among other bases therefor, (i) the guarantor has not received fair consideration or reasonably equivalent value in exchange for the guaranty and (ii) the guaranty renders the guarantor insolvent, as defined in the United States Bankruptcy Code or state fraudulent conveyances statutes, or the guarantor is undercapitalized.

Limited Value at Foreclosure

The Mortgaged Property was constructed for the provision of hospital care. The number of entities that could be expected to purchase or lease the Mortgaged Property are limited, and thus, the ability of the Master Trustee to realize funds from the sale or rental of the Mortgaged Property upon an event of default may be limited.

Bond Ratings

There is no assurance that the ratings assigned to the Series 2011 Bonds will not be lowered or withdrawn at any time, the effect of which could adversely affect the market price for and marketability of the Series 2011 Bonds. See the information in "RATINGS."

Market for the Series 2011 Bonds

The relative buying and selling interest of market participants in securities such as the Series 2011 Bonds, and in the market for such securities as a whole, will vary over time, and such variations may be affected by, among other things, news relating to the Alliance and the other Obligated Issuers, the attractiveness of alternative investments, the perceived risk of owning the security (whether related to credit, liquidity or any other risk), the tax treatment accorded the instruments, the accounting treatment accorded such securities, reactions to regulatory actions or press reports, financial reporting cycles and marketing sentiment generally. Shifts of demand in response to any one or simultaneous particular events cannot be predicted and may be short-lived or exist for longer periods. See below "Tax Matters."

Health Care Revenues

There are a number of factors that could adversely affect both revenues and expenses of the Alliance. Some but not all such factors are discussed briefly below. Governmental payment provisions, regulations and other restrictions change frequently and may be altered or expanded while the Series 2011 Bonds are outstanding.

Dependence on Governmental and Other Third-Party Payors. The Alliance receives a substantial portion of its revenues from Medicare, Medicaid, TennCare and other third-party health care programs. See in Appendix A - "SOURCES OF REVENUE." Receipt of such revenues subjects the Alliance to extensive regulation and the risks of enforcement as described below. Both governmental payment programs and private third-party payors such as insurance and managed care programs have increasingly imposed limitations on the payment for services. These limitations often require hospitals to provide certain services below cost. Congress in the past has imposed substantial restrictions on federal health care programs that have adversely affected the financial condition of hospitals, and it may do so in the future.

TennCare. In 1994, the State of Tennessee, with the approval of the federal government, withdrew from the Medicaid program and began providing services to Medicaid eligible and uninsurable or uninsured persons through TennCare. Like traditional Medicaid programs, TennCare is funded with a combination of federal and State of Tennessee funds. The federal government has approved the TennCare Program through June 30, 2010. The Alliance is a significant provider of health care services to TennCare enrollees and as a result thereof has incurred substantial losses serving beneficiaries of the program. Approximately 8.3% of the Alliance's gross patient service charges for the fiscal year ended June 30, 2011, was derived from patients covered by TennCare.

Because of problems with managed care organizations through which TennCare operates, the State assumed total medical risk for the program in 2002 and implemented changes designed to reduce costs and fraud. The State of Tennessee initiated a plan to disenroll 323,000 individuals statewide from TennCare and to institute significant benefit cuts resulting in the disenrollment of 28,000 individuals in the Alliance's market and a decrease in the level of benefits for 40,000 individuals in the Alliance's market. The disenrollment changes took place on August 1, 2005, however, the benefit cuts have not been implemented.

On April 1, 2007, the State of Tennessee began placing the managed care organizations back at risk, starting with the Middle Tennessee Region. The State of Tennessee placed the East Tennessee Region's managed care organizations (where the Alliance operates its Tennessee facilities) back at risk on January 1, 2009. It cannot be predicted whether the funding sources for TennCare or other states' Medicaid programs will be adequate to meet the funding needs of such programs. In addition, it cannot be predicted whether funding pressures or other factors will lead to decreased TennCare and Medicaid reimbursement to providers, including the Members of the Obligated Group, or to an increase in uninsured patients seeking care from the Members of the Obligated Group.

A number of proposals have been made for changes in funding for TennCare, some of which could substantially reduce the amounts payable to the Alliance's facilities in Tennessee. There remains substantial risk that TennCare will continue to impose substantial financial burdens on the Alliance or that changes in the program could lead to further burdens or increase the cost of uncompensated care provided by the Alliance.

Virginia Medicaid Program. The hospitals of the Alliance located in Virginia receive a substantial portion of their revenues under the federal Medicare Program. Reimbursement under this program is controlled by extensive regulations and procedures. Under the current Medicare payment system payment for inpatient hospital services is been tied to predetermined amounts based on national averages of costs for categories of treatments and conditions known as diagnosis related groups ("DRGs"). DRG reimbursement may provide a hospital less than its actual costs in providing services. The Medicare Program reimburses for outpatient hospital services through a similar prospective payment system based on ambulatory payment classifications ("APCs") of clinically-related and resource-similar items and services. Reimbursement for outpatient services under the APC system and for other services provided by the hospitals of the Alliance may not reflect the actual costs incurred in providing such services or items.

Medicare reimbursement in recent years has been subject to changes that have adversely affected hospitals, and the Alliance cannot predict how future limitations, cutbacks or modifications by Congress or regulatory agencies to such reimbursement may affect the financial condition of the Alliance.

Hospital Regulation. The operation of hospitals is extensively regulated by the federal and state governments. These regulations affect virtually every aspect of hospital operations, including (1) imposing procedures that increase costs (including complicated billing and other record-keeping procedures), (2) requiring the provision of services free or below cost, (3) limiting the ability to make decisions based on economic best interest and (4) restricting the ability to pursue advantageous business opportunities with physicians and other health care providers.

Significant restrictions include (1) the Physicians Self-Referral (“Stark”) and “Anti-Kickback” laws, which severely restrict financial relationships with and referrals by private physicians; (2) the Emergency Medical Treatment and Active Labor Act (“EMTALA”), imposing operating requirements on emergency rooms; and (3) the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the Health Information Technology for Economic and Clinical Health Act (HITECH), enacted as part of the American Recovery and Reinvestment Act of 2009 and both affecting the privacy and security of personal health information. Compliance with HIPAA, HITECH and related regulations has imposed substantial financial burdens on the Alliance and related entities in such areas as electronic billing and other electronic transactions and in implementing procedures and altering facilities to promote privacy of patient records.

Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate violations of existing laws and regulations, including criminal fines, civil monetary penalties, repayment of erroneously paid claims, prison terms and exclusion from the Medicare, Medicaid, TennCare and/or other governmental payment programs. Because of the complexity of the regulations and the increased enforcement, there are numerous circumstances where alleged violations may trigger investigations, audits and inquiries that could result in expensive and prolonged enforcement actions against the Alliance. Enforcement actions may be initiated and prosecuted by one or more government entities and/or private individuals, and in some circumstances more than one of the available penalties may be imposed for each violation. An exclusion from participation in Medicare, Medicaid, TennCare or other governmental health programs likely would result in a loss of substantial revenues.

National Healthcare Reform

Comprehensive health care reform legislation was enacted by the federal government in March 2010 through the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the “Healthcare Reform Act”). The Healthcare Reform Act provides for fundamental changes to the health care system and the manner in which services are provided and paid for generally, including substantial increases in health care insurance for persons not currently covered, new requirements on employers who provide health benefits to their employees, reimbursement reductions and methodology changes, and the imposition of further restrictions and requirements adversely affecting tax-exempt hospitals such as the Alliance and its related entities.

Implementation of the Healthcare Reform Act is to take place over an eight year time horizon, and over that time the Healthcare Reform Act is likely to have a variety of effects on both the operations and financial performance of all hospitals. In particular, extension of health insurance to those not currently insured and the costs associated therewith may result in (1) inadequate reimbursement to cover costs under such new coverage, (2) offsetting reductions in reimbursements for the provision of services under Medicare, Medicaid and other federally funded programs and (3) increased costs of compliance generally. In addition to its direct effects on the Alliance and related hospitals, the Healthcare Reform Act is likely to have significant indirect effects on the Alliance and related hospitals as a result of the Act’s effects on other healthcare industry participants, including pharmaceutical and medical device companies, health insurers, and others with which the Alliance and related hospitals do business.

The Healthcare Reform Act imposes substantial and costly additional requirements on nonprofit hospitals. Failure of any hospital with 501(c)(3) status to comply with such requirements will result in significant penalties

including, but not limited to, the loss of tax-exempt status. See below “Tax Matters – Tax Exemption for Non-profit Corporations.”

The future of the Healthcare Reform Act is uncertain. The Healthcare Reform Act has been subject to numerous legal challenges in federal court, some but not all of which have been successful at the District Court and the Court of Appeals levels. Moreover, the 2010 Congressional elections, which resulted in a Republican majority in the U.S. House of Representatives, have resulted in legislative efforts to repeal the Healthcare Reform Act, to amend or defund it, or otherwise to block its implementation.

Thus, it is impossible to predict the extent to which the Healthcare Reform Act will be implemented or the effects the Healthcare Reform Act will have to the extent it is implemented. The current uncertainties are likely to continue at least until the 2012 elections and the final resolution of the constitutional challenges to the Healthcare Reform Act by the United States Supreme Court.

Competition. The Alliance faces competition not only from other area hospitals (see in Appendix A -“SERVICE AREA, MARKET SHARE AND COMPETITION”), but also from other forms of health care providers, including health maintenance organizations, preferred provider organizations, specialty hospitals, home health agencies, surgical centers, rehabilitation and therapy centers, physician group practices and other alternative delivery systems and non-hospital providers of medical services. Increasing costs of health care services are likely to stimulate additional forms of competition. Many new forms of health care providers may not be subject to the restrictions imposed on the Alliance by its participation in governmental health care programs and as part of a tax-exempt organization. The application of federal and state antitrust laws to health care is still evolving, and enforcement and other developments in this area could adversely affect the Alliance’s competitive position.

Other Economic Developments. Other economic developments that could adversely affect operations at the Alliance include (1) unexpected increases in costs of labor and equipment (including new technologies) that cannot be recovered through charges, (2) increased costs of maintaining malpractice and general liability insurance, and (3) availability of, or the cost of, required specialty employees, including nurses and other health care professionals.

Tax Matters

Tax Exemption for Non-profit Corporations

Loss of tax-exempt status by the Alliance could result in loss of tax exemption for interest on the Series 2011 Bonds and of other tax-exempt debt issued for the benefit of the Alliance, and defaults in covenants regarding the Series 2011 Bonds and other tax-exempt debt would likely be triggered. Such an event would have material adverse consequences on the financial condition of the Alliance.

The maintenance by the Alliance of its tax-exempt status and that of its related entities depends, in part, upon its maintenance of status as an organization (an “Exempt Organization”) described in Section 501(c)(3) of the Code. The maintenance of such status is contingent upon compliance with provisions of the Code and related regulations and administrative interpretations regarding the organization and operation of tax-exempt entities, including its operation for charitable and educational purposes and its avoidance of transactions that may cause its assets to inure to the benefit of private individuals.

The Internal Revenue Service (the “IRS”) has announced that it intends to closely scrutinize transactions between Exempt Organizations and for-profit entities and has issued audit guidelines for tax-exempt hospitals. In March 1998, the IRS issued a revenue ruling that places restrictions upon the participation of Exempt Organizations (including hospitals) in joint venture arrangements with for-profit entities. Although specific activities of hospitals, such as medical office building leases and compensation arrangements and other contracts with physicians, have been the subject of interpretations by the IRS in the form of Private Letter Rulings, many activities have not been addressed in any official opinion, interpretation or policy of the IRS. Because the Alliance conducts large-scale and diverse operations involving private parties, there can be no assurances that certain of its transactions would not be challenged by the IRS.

The IRS has taken the position that hospitals that violate the federal Anti-kickback Law may also be subject to revocation of their tax-exempt status. As a result, tax-exempt hospitals, such as those of the Alliance, which have and will continue to have, extensive transactions with physicians are subject to an increased degree of scrutiny and perhaps enforcement by the IRS.

Periodically, Congress considers options and recommendations in the area of taxation of unrelated business income of Exempt Organizations. The scope and effect of legislation, if any, that may be adopted at the federal and state levels with respect to unrelated business income cannot be predicted at this time. However, any such legislation could have the effect of subjecting a portion of the income of the Alliance to federal or state income taxes.

In addition to the foregoing proposals with respect to income by Exempt Organizations, various state and local governmental bodies have challenged the tax-exempt status of such institutions and have sought to remove the exemption of property from real estate taxes of part or all of the property of various nonprofit institutions on the grounds that a portion of such property was not being used to further the charitable purposes of the institutions or that the institutions did not provide sufficient care to indigent persons so as to warrant exemption from taxation as a charitable institution. Several of these disputes have been determined in favor of the taxing authorities or have resulted in settlements.

It is not possible to predict the scope or effect of future legislative or regulatory actions with respect to taxation of Exempt Organizations. There can be no assurance that future changes in the laws and regulations of federal, state or local governments, or the interpretation of such laws by courts or other governmental entities, will not materially adversely affect the operations and financial condition of the Alliance by requiring any of its entities to pay income or local property taxes.

Tax-Exempt Status of the Series 2011 Tax-Exempt Bonds

Any failure by the Alliance or related entities to remain qualified as tax-exempt under Section 501(c)(3) of the Code could affect the amount of funds that would be available to pay debt service on the Series 2011 Bonds. If the Alliance or the respective Issuer fails to comply continuously with certain covenants contained in the Bond Indentures and the Loan Agreements after delivery of the Series 2011 Tax-Exempt Bonds, interest on the Series 2011 Tax-Exempt Bonds could become taxable from the date of delivery of the Series 2011 Tax-Exempt Bonds regardless of the date on which the event causing such taxability occurs.

In recent years, the IRS has undertaken an extensive audit program that involves review of both the general tax-exempt status of non-profit hospitals and the tax-exempt status of bonds issued for their benefit.

Legislative Proposals

Current and future legislative proposals, if enacted into law, could cause interest on the Series 2011 Tax-Exempt Bonds to be subject, directly or indirectly, to federal income taxation or otherwise prevent owners thereof from realizing the full current benefit of the tax-exempt status of such interest. On September 12, 2011, the Obama Administration announced a legislative proposal, the “American Jobs Act of 2011,” (the “Jobs Act”). If enacted in the form proposed, the Jobs Act would limit the exclusion from gross income of interest on obligations like the Series 2011 Tax-Exempt Bonds for individual taxpayers whose income is subject to higher marginal tax rates. The enactment of the Jobs Bill or similar provisions could adversely affect the tax treatment of interest on the Series 2011 Tax-Exempt Bonds for holders thereof and adversely affect the market price of the Series 2011 Tax-Exempt Bonds.

Other Risk Factors Generally Affecting Health Care Facilities

In the future, the following factors, among others, may adversely affect the operations of the Alliance to an extent that cannot be determined at this time:

1. Health care systems are major employers, combining a complex mix of professional, quasi-professional, technical, clerical, housekeeping, maintenance, dietary and other types of workers in a single

operation. As with all large employers, the Alliance bears a wide variety of risks in connection with its employees. These risks include strikes and other related work actions, contract disputes, discrimination claims, personal tort actions, work-related injuries, exposure to hazardous materials, interpersonal torts (such as between employees, between physicians or management and employees, or between employees and patients), and other risks that may flow from the relationships between employer and employee or between physicians, patients and employees. Many of these risks are not covered by insurance, and certain of them cannot be anticipated or prevented in advance. The Alliance is subject to all of the risks listed above. Such risks, alone or in combination, could have material adverse consequences to the financial condition or operations of the Alliances.

2. Competition from other health care systems and other competitive facilities now or hereafter located in the respective service areas of the Alliance's facilities may adversely affect revenues. Development of health maintenance and other alternative health delivery programs could result in decreased usage of inpatient hospital facilities and other facilities operated by the Alliance.

3. Cost and availability of any insurance, such as malpractice, fire, automobile, and general comprehensive liability, that hospitals and other health care facilities of similar size and type as the facilities generally carry may adversely affect revenues, as would any losses that exceed amounts covered.

4. The occurrences of natural disasters may damage some or all of the facilities, interrupt utility service to some or all of the facilities, significantly increase the demand on some or all of the facilities or otherwise impair the operation of some or all of the facilities or the generation of revenues from some or all of the facilities.

5. Scientific and technological advances, new procedures, drugs and appliances, preventive medicine, occupational health and safety and outpatient health care delivery may reduce utilization and revenues of the facilities. Technological advances in recent years have accelerated the trend toward the use by hospitals of sophisticated and costly equipment and services for diagnosis and treatment. The acquisition and operation of certain equipment or services may continue to be a significant factor in hospital utilization, but the ability of the Alliance to offer such equipment or services may be subject to the availability of equipment or specialists, governmental approval or the ability to finance such acquisitions or operations.

6. Reduced demand for the services of the Alliance that might result from decreases in population in the services areas of facilities operated by the Alliance.

7. Increased unemployment or other adverse economic conditions in the service areas of the Alliance that would increase the proportion of patients who are unable to pay fully for the cost of their care.

8. Any increase in the quantity or cost of indigent care provided that is mandated by law or required due to increase needs of the community in order to maintain the charitable status of the Alliance.

9. Regulatory actions that might limit the ability of the Alliance to undertake capital improvements to their respective facilities or to develop new institutional health services.

LITIGATION

There is no action, suit, or proceeding pending or, to the knowledge of the Issuers, threatened restraining or enjoining the execution or delivery of the Series 2011 Bonds, or in any way contesting or affecting the validity of the Series 2011 Bonds, the Bond Indentures, the Master Indenture, or any proceedings of the Issuers or the Alliance, as applicable, taken with respect thereto. No securities of any Issuer have been in default as to principal or interest payments or in any other material respect, and no agreements or legal proceedings of any Issuer relating to its securities have been declared invalid or unenforceable since the formation of each Issuer. Each Issuer will provide a certificate to this effect at the time of delivery of the Series 2011 Bonds.

There is no action, suit, or proceeding pending or threatened restraining or enjoining the execution or delivery of the Series 2011 Obligations, or in any way contesting or affecting the validity of the Series 2011 Obligations, the Master Indenture, the Loan Agreements or any proceedings of the Alliance taken with respect thereto. No securities of the Alliance have been in default as to principal or interest payments or in any other material respect, and no agreements or legal proceedings of the Alliance relating to its securities have been declared

invalid or unenforceable since the original formation of the corporation now called Mountain States Health Alliance. The Alliance will provide a certificate to this effect at the time of delivery of the Series 2011 Bonds.

For other litigation matters involving the Alliance, see “HISTORY AND OVERVIEW - Insurance; Litigation” in Appendix A hereto.

LEGAL MATTERS

Legal matters relating to the authorization and issuance of the Series 2011 Tax-Exempt Bonds are subject to the approving opinion of Bass, Berry & Sims PLC of Nashville and Knoxville, Tennessee, as Bond Counsel, which will be delivered with the Series 2011 Bonds. Bond Counsel’s opinion with respect to the Series 2011 Virginia Bonds is being given in reliance on the opinion of Hunton & Williams LLP with respect to certain matters of Virginia law. Certain legal matters relating to the Series 2011 Bonds will also be passed upon by Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Tennessee Issuer, by Gwyn & Tate, Marion, Virginia, as counsel to the Virginia Issuer, and by Anderson, Fugate & Givens, Johnson City, Tennessee, as counsel to the Alliance. Certain legal matters will be passed upon by Thompson Coburn LLP, St. Louis, Missouri, as counsel to the Banks. Certain legal matters will be passed upon by Hunton & Williams LLP, as counsel to the Underwriters.

TAX MATTERS

Tennessee State Tax Exemption

Under existing law, the Series 2011 Tennessee Bonds and the income therefrom are exempt from all present state, county and municipal taxes in Tennessee except (a) inheritance, transfer and estate taxes, (b) Tennessee excise taxes on interest on the Series 2011 Tennessee Bonds during the period the Series 2011 Tennessee Bonds are held or beneficially owned by any organization or entity, other than a sole proprietorship or general partnership doing business in the State, and (c) Tennessee franchise taxes by reason of the inclusion of the book value of the Series 2011 Tennessee Bonds in the Tennessee franchise tax base of any organization or entity, other than a sole proprietorship or general partnership, doing business in the State.

Virginia State Tax Exemption

In the opinion of Bond Counsel, under current law, interest on the Series 2011 Virginia Bonds is exempt from income taxation by the Commonwealth of Virginia.

Series 2011 Tax-Exempt Bonds

General. Bass, Berry & Sims PLC, Nashville, Tennessee, is Bond Counsel for the Series 2011 Tax-Exempt Bonds. Bond Counsel is the opinion that, under existing law, relying on certain statements by the Alliance and assuming compliance by the Alliance with certain covenants, interest on the Series 2011 Tax-Exempt Bonds is:

- an S corporation,
- not a preference item for a bondholder under the federal alternative minimum tax; but
- however, taken into account in determining the adjusted current earnings of certain corporations for purposes of the federal corporate alternative minimum tax.

The Code imposes requirements on the Series 2011 Tax-Exempt Bonds that the Alliance must continue to meet after the Series 2011 Tax-Exempt Bonds are issued. These requirements generally involve the way that Series 2011 Tax-Exempt Bond proceeds must be invested and ultimately used. If the Alliance does not meet these requirements, it is possible that a bondholder may have to include interest on the Series 2011 Tax-Exempt Bonds in its federal gross income on a retroactive basis to the date of issue. The Alliance has covenanted to do everything necessary to meet these requirements of the Code.

A bondholder who is a particular kind of taxpayer may also have additional tax consequences from owning the Series 2011 Tax-Exempt Bonds. This is possible if a bondholder is:

- an S corporation,
- a United States branch of a foreign corporation,
- a financial institution,
- a property and casualty or a life insurance company,
- an individual receiving Social Security or railroad retirement benefits,
- an individual claiming the earned income credit, or
- a borrower of money to purchase or carry the Series 2011 Tax-Exempt Bonds.

If a bondholder is in any of these categories, it should consult its tax advisor.

Bond Counsel is not responsible for updating its opinion in the future. It is possible that future events or changes in applicable law could change the tax treatment of the interest on the Series 2011 Tax-Exempt Bonds or affect the market price of the Series 2011 Tax-Exempt Bonds.

Bond Counsel expresses no opinion on the effect of any action taken or not taken in reliance upon an opinion of other counsel on the federal income tax treatment of interest on the Series 2011 Tax-Exempt Bonds, or under state, local or foreign tax law.

Possible Legislative Changes. Certain recent legislative proposals, if enacted, could adversely affect both the market value of the Series 2011 Tax-Exempt Bonds and the treatment of interest thereon for holders of the Series 2011 Tax-Exempt Bonds. See above “CERTAIN RISK FACTORS – Tax Matters – Legislative Proposals.”

Series 2011 Taxable Bonds

Disclaimer. Any discussion of the tax issues relating to the Series 2011 Taxable Bonds in this Official Statement was written to support the promotion or marketing of the Series 2011 Taxable Bonds. Such discussion was not intended or written to be used, and it cannot be used, by any person for the purpose of avoiding any tax penalties that may be imposed on such person. Each investor should seek advice with respect to the Series 2011 Taxable Bonds based on its particular circumstances from an independent tax advisor.

General. The following is a summary of certain anticipated United States federal income tax consequences of the purchase, ownership and disposition of the Series 2011 Taxable Bonds. The summary is based upon the provisions of the Code, the regulations promulgated thereunder and the judicial and administrative rulings and decisions now in effect, all of which are subject to change. The summary generally addresses Series 2011 Taxable Bonds held as capital assets and does not purport to address all aspects of federal income taxation that may affect particular investors in light of their individual circumstances or certain types of investors subject to special treatment under the federal income tax laws, including but not limited to financial institutions, insurance companies, dealers in securities or currencies, those holding such bonds as hedge against currency risks or as a position in a “straddle” for tax purposes, or those whose functional currency is not the United States dollar. Potential purchasers of the Series 2011 Taxable Bonds should consult their own tax advisors in determining the federal, state or local consequences to them of the purchase, ownership and disposition of the Series 2011 Taxable Bonds.

Interest on the Series 2011 Taxable Bonds is not excluded from gross income for federal income tax purposes. Purchasers other than those who purchase Series 2011 Taxable Bonds in the initial offering at their stated principal amounts will be subject to federal income tax accounting rules affecting the timing and/or characterization of payments received with respect to such Series 2011 Taxable Bonds. In general, interest paid on the Series 2011 Taxable Bonds and accrual of market discount, if any, will be treated as ordinary income to an owner of Series 2011 Taxable Bonds and, after adjustment for the foregoing, principal payments will be treated as a return of capital.

Market Discount. Any owner who purchases a Series 2011 Taxable Bond at a price which includes market discount in excess of a prescribed de minimis amount (*i.e.*, at a purchase price that is less than its adjusted issue price in the hands of an original owner) will be required to recharacterize all or a portion of the gain as ordinary income upon receipt of each scheduled or unscheduled principal payment or upon other disposition. In particular, such owner will generally be required either (a) to allocate each such principal payment to accrued market discount

not previously included in income and to recognize ordinary income to that extent and to treat any gain upon sale or other disposition of such a Series 2011 Taxable Bond as ordinary income to the extent of any remaining accrued market discount (under this caption) or (b) to elect to include such market discount in income currently as it accrues on all market discount instruments acquired by such owner on or after the first day of the taxable year to which such election applies.

The Code authorizes the Treasury Department to issue regulations providing for the method for accruing market discount on debt instruments the principal of which is payable in more than one installment. Until such time as regulations are issued by the Treasury Department, certain rules described in the legislative history of the Tax Reform Act of 1986 will apply. Under those rules, market discount will be included in income either (a) on a constant interest basis or (b) in proportion to the accrual of stated interest.

An owner who acquires a Series 2011 Taxable Bond at a market discount also may be required to defer, until the maturity date of such Series 2011 Taxable Bond or the earlier disposition in a taxable transaction, the deduction of a portion of the amount of interest that the owner paid or accrued during the taxable year on indebtedness incurred or maintained to purchase or carry a Series 2011 Taxable Bond in excess of the aggregate amount of interest (including original issue discount) includable in such owner's gross income for the taxable year with respect to such Series 2011 Taxable Bond. The amount of such net interest expense deferred in a taxable year may not exceed the amount of market discount accrued on the Series 2011 Taxable Bonds for the days during the taxable year on which the owner held the Series 2011 Taxable Bond and, in general, would be deductible when such market discount is includable in income. The amount of any remaining deferred deduction is to be taken into account in the taxable year in which the Series 2011 Taxable Bond matures or is disposed of in a taxable transaction. In the case of a disposition in which gain or loss is not recognized in whole or in part, any remaining deferred deduction will be allowed to the extent gain is recognized on the disposition. This deferral does not apply if the bondowner elects to include such market discount in income currently as described above.

Bond Premium. A purchaser who purchases a Series 2011 Taxable Bond at a cost greater than its then principal amount will have amortizable bond premium. If the holder elects to amortize the premium under Section 171 of the Code (which election will apply to all bonds held by the holder on the first day of the taxable year to which the election applies, and to all bonds thereafter acquired by the holder), such a purchaser must amortize the premium using constant yield principles based on the purchaser's yield to maturity. Amortizable bond premium is generally treated as an offset to interest income, and a reduction in basis is required for amortizable bond premium that is applied to reduce interest payments. Purchasers of any Series 2011 Taxable Bonds who acquire such Series 2011 Taxable Bonds at a premium should consult with their own tax advisors with respect to the determination and treatment of such premium for federal income tax purposes and with respect to state and local tax consequences of owning such Series 2011 Taxable Bonds.

Sale or Redemption of Series 2011 Taxable Bonds. A bondowner's tax basis for a Series 2011 Taxable Bond is the price such owner pays for the Series 2011 Taxable Bond plus the amount of any original issue discount and market discount previously included in income, reduced on account of any payments received (other than "qualified stated interest" payments) and any amortized bond premium. Gain or loss recognized on a sale, exchange or redemption of a Series 2011 Taxable Bond, measured by the difference between the amount realized and the basis of the Series 2011 Taxable Bond as so adjusted, will generally give rise to capital gain or loss if the Series 2011 Taxable Bond is held as a capital asset (except as discussed above under "Market Discount"). The legal defeasance of Series 2011 Taxable Bonds may result in a deemed sale or exchange of such Series 2011 Taxable Bonds under certain circumstances; owners of such Series 2011 Taxable Bonds should consult their tax advisors as to the federal income tax consequences of such an event.

Backup Withholding. A bondowner may, under certain circumstances, be subject to "backup withholding" (currently the rate of this withholding obligation is 28%, but the rate may change in the future) with respect to interest or original issue discount on the Series 2011 Taxable Bonds. This withholding generally applies if the owner of a Series 2011 Taxable Bond (a) fails to furnish the Registration Agent or other payor with its taxpayer identification number; (b) furnishes the Registration Agent or other payor an incorrect taxpayer identification number; (c) fails to report properly interest, dividends or other "reportable payments" as defined in the Code; or (d) under certain circumstances, fails to provide the Registration Agent or other payor with certified statement, signed under penalty of perjury, that the taxpayer identification number provided is its correct number and that holder is not

subject to backup withholding. Backup withholding will not apply, however, with respect to certain payments made to bondowners, including payments to certain exempt recipients (such as certain exempt organizations) and to certain Nonresidents. Owners of the Series 2011 Taxable Bonds should consult their tax advisors as to their qualification for exemption from backup withholding and the procedure for obtaining the exemption.

Backup withholding is not an additional tax. Any amount paid as backup withholding would be credited against the bondholder's U.S. federal income tax liability, provided that the requisite information is timely provided to the Internal Revenue Service. The amount of "reportable payments" for each calendar year and the amount of tax withheld, if any, with respect to payments on the Series 2011 Taxable Bonds will be reported to the bondowners and to the Internal Revenue Service.

Nonresident Borrowers. Under the Code, interest and original issue discount income with respect to Series 2011 Taxable Bonds held by nonresident alien individuals, foreign corporations or other non-United States persons ("Nonresidents") generally will not be subject to the United States withholding tax (or backup withholding) if the Borrower (or other who would otherwise be required to withhold tax from such payments) is provided with an appropriate statement that the beneficial owner of the Series 2011 Taxable Bond is a Nonresident. Notwithstanding the foregoing, if any such payments are effectively connected with a United States trade or business conducted by a Nonresident bondowner, they will be subject to regular United States income tax, but will ordinarily be exempt from United States withholding tax.

Interest on the Series 2011 Taxable Bonds is not tax-exempt under either federal or state law.

RATINGS

Moody's Investors Services, Inc. ("Moody's") and Standard & Poor's Rating Services, a division of The McGraw Hill Companies, Inc. ("S&P") have assigned the Series 2011A Bonds and the Series 2011C Bonds the respective ratings set forth below:

Moody's:	Aa2/VMIG1
Standard & Poor's:	AA-/A-1+

Moody's and S&P have assigned the Series 2011B Bonds the respective ratings set forth below:

Moody's:	A1/VMIG1
Standard & Poor's:	A+/A-1

Moody's and S&P have assigned the Series 2011D Bonds and the Series 2011E Bonds the respective ratings set forth below:

Moody's:	Aa3*/VMIG1
Standard & Poor's:	A+/A-1

* The long-term ratings of Series 2010D Bonds and the Series 2011E Bonds are on review for downgrade in connection with Moody's ongoing review of Mizuho Corporate Bank, Ltd.

Each such rating is based on the availability of the Letters of Credit and reflects only the views of the rating agency assigning such rating and an explanation of the significance of such rating should be obtained from the applicable rating agency itself. Certain materials and information relating to the Series 2011 Bonds, the Banks and the Alliance that may not be described in this Official Statement were furnished to the rating agencies in connection with the issuance of the ratings. Generally, rating agencies base their ratings on such materials and information and on their own investigations, studies and assumptions. There is no assurance that any rating will remain in effect for any given period of time or that any rating will not be lowered or withdrawn entirely if, in the judgment of the rating agency, circumstances so warrant.

No information is provided regarding the ratings of other outstanding bonds issued for the benefit of the Alliance and related entities.

UNDERWRITING

Merrill Lynch, Pierce, Fenner & Smith Incorporated (“Merrill Lynch”) and U.S. Bank Municipal Securities Group, a division of U.S. Bank National Association (“US Bancorp” and, together with Merrill Lynch, the “Underwriters”) have agreed to purchase (1) the Series 2011A Bonds at a price of \$64,998,960, representing the par amount of the Series 2011A Bonds less an underwriters’ discount of \$261,040 (0.40% of the principal amount thereof); and (2) the Series 2011C Bonds at a price of \$49,675,000, representing the par amount of the Series 2011C Bonds less an underwriters’ discount of \$199,500 (0.40% of the principal amount thereof). Merrill Lynch and U.S. Bancorp are committed to take and pay for all of the Series 2011A Bonds and the Series 2011C Bonds if any are taken.

Merrill Lynch has agreed to purchase (x) the Series 2011B Bonds at a price of \$19,920,000, representing the par amount of the Series 2011B Bonds less an underwriters’ discount of \$80,000 (0.40% of the principal amount thereof); (y) the Series 2011D Bonds at a price of \$60,462,180, representing the par amount of the Series 2011D Bonds less an underwriters’ discount of \$242,820 (0.40% of the principal amount thereof); and (z) the Series 2011 Taxable Bonds at a price of \$15,896,160, representing the par amount of the Series 2011 Taxable Bonds less an underwriters’ discount of \$63,840 (0.40% of the principal amount thereof). Merrill Lynch is committed to take and pay for all of the Series 2011B Bonds, the Series 2011D Bonds and the Series 2011 Taxable Bonds if any are taken.

The prices at which the Series 2011 Bonds are offered to the public (and the yields resulting therefrom) may vary from the initial public offering prices. In addition, the Underwriters may allow commissions or discounts to dealers and others from the initial offering prices appearing on the cover page of this Official Statement. From time to time, the Underwriters may enter into other transactions with the Alliance, including interest rate swaps and options, for which it receives other compensation.

“US Bancorp” is the marketing name of U.S. Bancorp and its subsidiaries, including (1) U.S. Bank Municipal Securities Group, a division of U.S. Bank National Association (“USB MSG”), which is serving as Co-Manager of the Series 2011A Bonds and the Series 2011C Bonds, (2) U.S. Bancorp Investments, Inc. (“USBII”), which, along with USB MSG, is serving as Remarketing Agent for the Series 2011C Bonds, and (3) U.S. Bank National Association (“USBNA”), which is providing the Letter of Credit for the Series 2011A Bonds and the Series 2011C Bonds.

INDEPENDENT AUDITORS

The consolidated financial statements of the Alliance as of and for the years ended June 30, 2010 and 2009, included in Appendix B to this Official Statement, have been audited by Pershing Yoakley & Associates, P.C.

CONTINUING DISCLOSURE AGREEMENT

The Agreement

To permit compliance by the Underwriters with the continuing disclosure requirements of Rule 15c2-12 (the “Rule”) promulgated by the Securities and Exchange Commission, the Alliance will execute a Continuing Disclosure Agreement (the “Continuing Disclosure Agreement”) at closing pursuant to which the Alliance will agree to provide certain quarterly and annual financial information and material event notices required by the Rule. Such information will be filed through the Electronic Municipal Market Access System (“EMMA”) maintained by the Municipal Securities Rulemaking Board and may be accessed through the Internet at emma.mrsb.org. The proposed form of the Continuing Disclosure Agreement is set forth in Appendix F. It requires the Alliance to provide **only limited information at specific times, and the information provided may not be all the information necessary to value the Series 2011 Bonds at any particular time.** The Alliance may from time to time disclose certain information and data in addition to that required by the Continuing Disclosure Agreement. If

the Alliance chooses to provide any additional information, the Alliance shall have no obligation to continue to update such information or to include it in any future disclosure filing.

Failure by the Alliance to comply with the Continuing Disclosure Agreement is not an Event of Default under the Loan Agreements. The Continuing Disclosure Agreement provides that the only remedy for its violation is a lawsuit seeking specific performance.

Prior Undertakings

In connection with the issuance of previous bonds, the Alliance has entered into continuing disclosure undertakings similar to the Continuing Disclosure Agreement. Prior to July 1, 2009, the Alliance's filings under such undertakings were made through the then existing national recognized municipal securities information repositories. Since then filings have been made through EMMA.

The Alliance failed to make certain filings previously scheduled under previous continuing disclosure undertakings. In November, 2008, the Alliance submitted Annual Financial Information for the fiscal years ended June 30, 2000 through June 30, 2008 and Quarterly Financial Information for the quarters ended March 31, 2000 through June 30, 2008. Such filings were not timely under the Alliance's existing continuing disclosure undertakings. The Alliance has made timely filings of the Quarterly Financial Information for the quarters September 30, 2008, through June 30, 2011. The Alliance believes it has now made all filings required under all of its continuing disclosure undertakings.

RELATIONSHIPS OF PARTIES

As noted above, the Alliance or its affiliates have entered into interest rate swaps and other financial transactions with affiliates of the Underwriters.

From time to time, Bond Counsel and Hunton & Williams LLP (1) have represented the Alliance in other matters, and may do so in the future and (2) have represented and continue to represent certain of the Banks in unrelated matters. Bond Counsel also has represented one or more of the Underwriters in unrelated transactions. Anderson, Fugate & Givens, counsel to the Alliance, receives a substantial portion of its annual legal fee income from the Alliance. The Alliance typically engages in bidding to select the contractors for its capital projects. Whether or not such projects are bid, from time to time the contractor selected may be one in which members of the board of directors of either of the Issuers or the Alliance have an interest.

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APPENDIX A

MOUNTAIN STATES HEALTH ALLIANCE

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HISTORY AND OVERVIEW

Background

Mountain States Health Alliance (the “Alliance”), a Tennessee not-for-profit corporation headquartered in Johnson City, Tennessee, was originally incorporated as Memorial Hospital on April 12, 1945. In January 1951, the corporation acquired Appalachian Hospital and Training School, an 82-bed acute care facility in Johnson City, and simultaneously opened a 120-bed acute care facility in Johnson City. By 1977 its facilities had expanded to include 369 acute care beds and a 52-bed nursing home. In September 1980, the facilities were relocated and began operating as the Johnson City Medical Center (“JCMC”). In 1983 the corporation changed its name to the Johnson City Medical Center Hospital, Inc. The corporation has been determined to be an organization described in Section 501(c) (3) of the Internal Revenue Code of 1986, as amended.

In 1998, the Alliance purchased the assets and assumed certain liabilities of five hospitals and related assets from Columbia/HCA (the “1998 Acquisition”) located in Johnson City, Kingsport and Elizabethton, Tennessee. In 1999, the corporation changed its name to Mountain States Health Alliance. On May 1, 2005, the Alliance purchased the assets of Woodridge Hospital, a 75-bed, acute inpatient psychiatric facility. On November 1, 2006, the Alliance purchased an 80% membership interest in Smyth County Community Hospital, which owns a 279-bed general acute care and long-term care facility in southwest Virginia. On October 31, 2007, the Alliance purchased a 50.1% membership interest in Norton Community Hospital, which owns and operates both Norton Community Hospital and Dickenson County Community Hospital in Southwest Virginia. On January 31, 2008, the Alliance acquired the assets and liabilities of Russell County Medical Center in Lebanon, Virginia. On April 1, 2009, the Alliance acquired a 50.1% interest in Johnston Memorial Hospital, which owns a 116-bed facility in Abingdon, Virginia. Listed below are facilities currently owned or controlled by the Alliance:

<u>Facility</u>	<u>Location</u>	<u>Licensed Beds</u>
Johnson City Medical Center (“JCMC”)*	Johnson City, TN	514
James H. & Cecile Quillen Rehabilitation Hospital (“Quillen”) *	Johnson City, TN	60
Woodridge Hospital (“Woodridge”)*	Johnson City, TN	84
Franklin Woods Community Hospital (“Franklin Woods”)	Johnson City, TN	80
Indian Path Medical Center (“Indian Path”)	Kingsport, TN	261
Sycamore Shoals Hospital (“Sycamore Shoals”)	Elizabethton, TN	121
Johnson County Community Hospital (“Johnson County Community”)	Mountain City, TN	2
Smyth County Community Hospital (“Smyth County Community”) ⁽¹⁾	Marion, VA	279
Norton Community Hospital (“Norton Community”) ⁽²⁾	Norton, VA	129
Dickenson Community Hospital (“Dickenson Community”) ⁽²⁾	Clintwood, VA	25
Russell County Medical Center (“Russell”)	Lebanon, VA	78
Johnston Memorial Hospital (“Johnston Memorial”) ⁽²⁾	Abingdon, VA	116
		1,749

*JCMC, Quillen and Woodridge are operated under a single 658-bed hospital license.

⁽¹⁾ 80% membership interest held by the Alliance.

⁽²⁾ 50.1% membership interest held by the Alliance.

In addition to the above-described hospital facilities, the Alliance owns directly or through wholly-owned subsidiaries, medical office buildings, physician practices, undeveloped land and outpatient surgery centers.

Operations of the Alliance

The facilities of the Alliance are naturally divided geographically into two groupings: (i) the “Tennessee Facilities,” which include JCMC, Quillen, Woodridge, and Franklin Woods Community Hospital, all in Washington County; Indian Path, in Sullivan County; Sycamore Shoals, in Carter County; and Johnson County Community, in Johnson County; and (ii) the “Virginia Facilities,” which include Smyth County Community, in Smyth County; Norton Community, in the City of Norton; Dickenson Community, in Dickenson County; Russell, in Russell County; and Johnston Memorial, in Washington County. All of the Tennessee hospital facilities and Russell County Medical Center are owned by the Alliance, which is an Obligated Issuer under the Master Indenture. Smyth County Community is owned by Smyth County Community Hospital, and Norton Community is owned by Norton Community Hospital, both of which corporations will become Obligated Issuers upon the issuance of the Series

2011 Bonds. The remaining Virginia hospital facilities are all owned by entities that are not Obligated Issuers. The only other Obligated Issuer is Blue Ridge Medical Management Corporation, which is described further below.

Johnson City Medical Center is a 514 licensed bed, general acute care facility located on a 75-acre site on State of Franklin Road, a major regional thoroughfare in Johnson City. JCMC provides a wide array of acute care services on an inpatient and outpatient basis, including a complete range of cardiovascular, neurology, oncology, skilled nursing, and rehabilitation services. JCMC also operates a 69 licensed bed children's hospital with the region's only pediatric-specific emergency department. JCMC is designated as a Level III Perinatal Center and a Level I trauma center. JCMC earned international recognition as a Magnet Hospital by the American Nurses Credentialing Center. On or adjacent to JCMC's main campus are seven physician office buildings providing office space for approximately 75 physicians.

The James H. & Cecile C. Quillen Rehabilitation Hospital (formerly Northeast Tennessee Rehabilitation Hospital) is a 60 licensed bed rehabilitation and skilled nursing hospital in Johnson City, operated under the JCMC license. This facility provides a complete array of skilled nursing services as well as rehabilitative services for individuals with brain injury, stroke, or spinal cord injury. These rehabilitative services include respiratory, occupational and physical therapy, as well as outpatient services. The facility was constructed in 1991.

Woodridge Hospital is an 84 licensed bed, acute-care facility located in Johnson City, offering psychiatric and substance abuse services. This facility was purchased in May, 2005 and is operated under the JCMC license.

Franklin Woods Community Hospital is an 80 licensed bed facility offering a full array of primary care and some specialty services. Franklin Woods opened in July 2010 (replacing Johnson City Specialty and North Side) and was the first "green" hospital in the state.

Indian Path Medical Center is a 261 licensed bed facility in Kingsport. This facility provides a complete range of medical/surgical, acute care, psychiatric and skilled nursing services on an inpatient basis and a full complement of outpatient services. The facility is located on an 80 acre campus that also includes nine medical office buildings. Indian Path Medical Center was constructed in 1974.

Sycamore Shoals Hospital is a 121 licensed bed general acute care hospital in Elizabethton, Tennessee (Carter County). The facility provides inpatient, geropsychiatric, and outpatient services for acute care and medical/surgical patients. Sycamore Shoals was founded in 1955 as Carter County Memorial Hospital. It was moved to a newly constructed facility in 1986. A medical office building constructed in 2010 is also located on the main campus.

Johnson County Community Hospital is a facility located in Mountain City with two licensed beds and critical access designation. Johnson County offers inpatient care, emergency care and outpatient services.

Smyth County Community Hospital is a 279 licensed bed, general acute, skilled and long term care hospital in Marion, Virginia, owned by Smyth County Community Hospital (the "Smyth County Corporation"), a Virginia non-stock corporation in which the Alliance owns an 80% interest. The current facility was built in 1945, and provides a full range of acute inpatient and outpatient care, including OB/GYN, general surgery, urology, ENT, orthopedics, cardiology, oncology, and skilled nursing services. Nursing home services provided by Francis Marion Manor, a 109 licensed bed long term care facility, are included as part of Smyth County Community's bed complement. Smyth County Corporation will be joining the Obligated Group upon the issuance of the Series 2011 Bonds.

A new Smyth County Community Hospital facility is under construction off U.S. Interstate 81 at Exit 47 along Highway 11. The new facility will have 44 private rooms (30 acute care beds and 14 rehabilitation beds). The new facility will offer all of the services offered at the current facility with some improvements, including three modern surgery rooms. The new facility is expected to open in the spring of 2012 and meet U.S. Green Building Council's LEED standards to create a "green" facility.

Norton Community Hospital, located in the City of Norton, Virginia, is a 129 licensed bed, acute-care facility, serving Southwest Virginia and Southeastern Kentucky since 1949. Norton Community is owned and operated by Norton Community Hospital (the "Norton Corporation"), a Virginia non-stock corporation in which the Alliance owns a 50.1% interest. The largest healthcare facility in the coalfield region, Norton Community provides

a wide array of services through highly trained physicians and support staff. Norton Community is a member of the Virginia Hospital and Healthcare Association and is accredited by the American Osteopathic Association. Norton Community was the first AOA accredited teaching facility in the state of Virginia. The Norton Corporation will be joining the Obligated Group upon the issuance of the Series 2011 Bonds.

Dickenson Community Hospital, located in Clintwood, Virginia, opened in November 2003. It is a 25 licensed bed critical access hospital owned and operated by the Norton Corporation. A recent expansion included a 5,700 square foot physician office building on the hospital campus. Dickenson Community offers laboratory, imaging, inpatient acute care and a wide array of therapy services. Dickenson Community is not an Obligated Issuer.

Russell County Medical Center is a 78-bed acute care hospital located in Lebanon, Virginia, which includes a 20-bed inpatient psychiatric unit. Russell offers cardiac, home health, hospice, surgical and behavioral healthcare services. Russell is wholly owned by the Alliance, which is an Obligated Issuer.

Johnston Memorial Hospital is a 116 licensed bed, general acute care hospital in Abingdon, Virginia, which can trace its history back to a 12 bed facility started in 1905. Johnston Memorial provides a wide array of healthcare services in a newly constructed facility that opened in 2011. Johnston Memorial is owned and operated by Johnston Memorial Hospital, Inc. (the "Johnston Corporation"), in which the Alliance owns a 50.1% interest. Simultaneously with the issuance of the Series 2011 Bonds, the Industrial Development Authority of Smyth County will issue its Hospital Facility Revenue Refunding and Improvement Bonds (Johnston Memorial Hospital Project), Series 2011 (the "JMH Bonds"), for the benefit of Johnston Memorial. The Johnston Corporation is not a member of the Obligated Group and the Obligated Issuers are not required to pay debt service on the JMH Bonds.

Operations of Subsidiary and Other Affiliates

The Alliance directly owns and operates the hospital facilities listed above that are located in Tennessee, and directly owns and operates Russell in Lebanon, Virginia. It has controlling membership interests in the corporations that own Smyth County Community, Norton Community, Dickinson Community and Johnston Memorial. Additionally, the Alliance owns or otherwise controls a number of for-profit and not-for-profit affiliates that provide complementary health care services and help support the health care needs of the region. The principal affiliates are Mountain States Foundation, Inc., Mountain States Health Alliance Auxiliary and Blue Ridge Medical Management Corporation ("Blue Ridge").

Blue Ridge is a Tennessee for profit stock corporation, and the Alliance owns 100% of its stock. Blue Ridge in turn owns all of the stock or other ownership interest in the following entities (collectively, the "Blue Ridge Affiliates"): Mountain States Physician Group, Inc., Mountain States Properties, Inc., Mediserve Medical Equipment of Kingsport, Inc., Wilson Pharmacy, Inc., and Synergy Health Group LLC. While Blue Ridge is an Obligated Issuer under the Master Indenture along with the Alliance, none of the Blue Ridge Affiliates are an Obligated Issuer. Blue Ridge provides, directly or through Blue Ridge Affiliates, management services for 36 primary care facilities, 40 specialty care facilities, five urgent care and occupational management services facilities in 81 separate locations in ten counties. Through the 81 sites, Blue Ridge provides management services to a total of 181 practicing physicians, 50 nurse practitioners, nine physician assistants and five nurse anesthetists. Blue Ridge has various levels of ownership in five surgery centers and owns and/or manages a total of 26 medical office buildings, six of which are held in condominium-ownership form.

Inpatient Bed Complement

The following table shows the Alliance’s licensed bed capacity by service line as of September 1, 2011:

<u>Service</u>	<u>Licensed Beds</u>	<u>Distribution</u>
Medical/Surgical	1,110	63%
OB/GYN	85	5
Critical Care	133	8
Neonatal	51	3
Psychiatry	136	8
Rehabilitation	55	3
Skilled Nursing / Nursing Home	<u>179</u>	<u>10</u>
Total	<u>1,749</u>	<u>100%</u>

Source: The Alliance.

Educational Programs

Pursuant to an agreement with the Division of Health Sciences at East Tennessee State University (“ETSU”), the Alliance provides JCMC as a site for clinical and other training of medical students and residents from ETSU’s James H. Quillen College of Medicine (“QCM”), nursing students at the associate, baccalaureate and master’s level from the School of Nursing and students from the School of Public and Allied Health. Woodridge provides sites for clinical training for QCM psychiatric residents. Approved medical residencies are offered by ETSU in Family Medicine, Internal Medicine/Psychiatry, OB/GYN, Pathology, Pediatrics, Cardiology, Infectious Disease, Pulmonary/Critical Care, Sleep and General Surgery. Approved fellowships are offered by ETSU in Gastroenterology and Medical Oncology. JCMC is also a clinical site for various health professional and allied health programs located in Tennessee, Kentucky, Virginia and North Carolina.

QCM, which is located adjacent to JCMC, has made a commitment to promote medical educational programs in Johnson City, Tennessee. With QCM’s location adjacent to JCMC and the Veteran Affairs Medical Center at Mountain Home, a large portion of QCM’s clinical training occurs at JCMC. An ETSU facility housing clinical training programs is located across the street from JCMC. QCM’s presence promotes the presence of substantial numbers of physicians in private practice. Additionally, the concentration of medical specialists, researchers and medical educators in Johnson City make the Alliance competitively stronger in patient care opportunities in the region and also provides a good source of nurses for Alliance facilities.

Licenses and Accreditation

The Tennessee Facilities are licensed by the State of Tennessee Department of Health and Environment; the Virginia Facilities are licensed by the Virginia Department of Health; Norton Community Hospital and Dickenson Community Hospital are accredited through the Healthcare Facilities Accreditation Program (“HFAP”) and all other facilities are accredited by The Joint Commission (“TJC”). Norton and Quillen are accredited by the Commission of Accreditation of Rehabilitation Facilities. The Alliance facilities are accredited by the College of American Pathologists. JCMC is also accredited by the American College of Surgeons Commission on Cancer and is designated as a Regional Perinatal Center by the Tennessee Department of Health and Environment.

Employees

As of August 31, 2011, the Alliance employs a staff of 9,146 persons (equal to approximately 7,758 full-time equivalent employees), including 2,275 registered/licensed practical nurses. The Alliance’s employees are covered for a variety of employee benefits, including a qualified defined contribution pension plan, health and dental insurance, life insurance and vacation, holiday and sick time benefits. Certain employees at Norton Community and Dickenson Community are represented by a union. The Alliance has never experienced a strike or other work stoppage by its employees. The Alliance considers its employee relations to be excellent.

Pension Plan

The Alliance has a qualified defined contribution pension plan covering substantially all of its employees. Benefits payable to an employee under the terms of the pension plan are determined at the time of employee retirement. Contributions to the pension plan are current.

Insurance; Litigation

The Alliance is self-insured and has established self-insurance reserves to provide for professional and general liability claims and related expenses in amounts based upon an annual actuarial valuation. The self-insurance program currently has the following limits: \$10,000,000 per claim; with an annual aggregate of \$15,000,000. The Alliance has never had a claim to exceed the self-insurance limits. The Alliance maintains a \$25,000,000 excess/umbrella policy, which attaches over the self-insurance fund's \$10,000,000 per claim, \$15,000,000 annual aggregate retention.

Additionally, the Alliance is self-insured for employee health and worker's compensation claims for the Tennessee Facilities. For the Virginia Facilities, the Alliance is self-insured for employee health and maintains a large deductible policy for worker's compensation claims with limits of \$750,000 per employee per accident, \$2,500,000 aggregate, \$5,000,000 all covered bodily injury aggregate maximum for the policy period. The Alliance recognizes expense each year based upon actual claims paid and an estimate of claims incurred, but not yet paid. The Alliance has established a reserve for reported and unreported worker's compensation claims based upon an annual actuarial valuation.

The Alliance and related entities are defendants in litigation relating to medical malpractice, worker's compensation and other claims arising in the ordinary course of business. Based on an evaluation of pending and threatened actions, management of the Alliance does not believe that any existing litigation, individually or collectively, would materially and adversely affect the financial resources of the Alliance or the business or continuous operation of the Alliance. Furthermore, the Alliance has accrued amounts in its self-insurance reserves at levels that it believes are sufficient to provide for payments reasonably projected to be due in connection with pending and potential claims and liabilities of the Alliance.

MEDICAL SERVICES

The Alliance provides a wide range of general and specialty medical services for the residents of Northeast Tennessee and Southwest Virginia and the surrounding states of Kentucky and North Carolina. The majority of tertiary care provided by the Alliance is concentrated at Johnson City Medical Center. Some highlights of the medical services and programs offered by the Alliance are described below.

Surgical Services. The Alliance has approximately 60 operating rooms located in eight facilities. The Alliance's surgical facilities are equipped with state-of-the-art technologies to meet the health care needs of the region. The Alliance provides services in all major surgical specialties including orthopedics, vascular, cardiothoracic, neurological, general, gynecological, laparoscopic, laser, urological, oncological, pediatric, plastic, ear, nose and throat, dental and transplant services.

Cardiovascular Services. The Alliance offers comprehensive regional cardiac services and highly advanced equipment for the detection, treatment, care and rehabilitation of those with heart problems. Advanced services include a wide range of non-invasive tests, cardiac catheterization, angioplasty and open-heart surgery. The Center for Cardiovascular Health at JCMC is known throughout the region for its medical expertise in cardiac care and has been recognized as the region's top hospital for cardiovascular services by US News and World Report in 2010 and 2011. Indian Path provides cardiovascular services including interventional cardiology and Johnston Memorial has recently expanded services to include cardiac catheterization.

Pulmonary Medicine. Respiratory therapy services are provided at each of the Alliance's facilities. The Center for Pulmonary Medicine at JCMC diagnoses and manages disorders of the respiratory and the pulmonary vascular systems, including emphysema and black-lung disease. A state-of-the-art metabolic laboratory assesses heart and respiratory problems. Pulmonary outreach services are provided at JCMC.

Comprehensive Wound Care is provided at JCMC, Norton Community, and Johnston Memorial. JCMC is the home to three hyperbaric oxygen chambers and Norton Community and Johnston Memorial each have one chamber

Women's Services. The Alliance provides specially designed women's services equipped to meet the unique health needs of women. Locations for obstetric and newborn care include The Family Birth Centers at JCMC, Franklin Woods, Indian Path, Sycamore Shoals, Norton Community, and Johnston Memorial. Gynecologic care is provided at each of the preceding facilities as well as Smyth County Community. The complement of women's services includes: routine and high-risk obstetrical care, gynecological surgery, breast disease diagnosis and treatment, fertility services, laser and microscopic surgery, plastic surgery, wellness/fitness programs, and educational sessions covering a wide spectrum of women's concerns. The Family Birth Center at JCMC includes the region's only State-designated Perinatal Center for pregnancy and newborn medical complications and a transport team to bring critically ill infants to JCMC.

Children's Services. The Niswonger Children's Hospital at JCMC is the only children's hospital in northeast Tennessee. More than 20 pediatric subspecialties provide specialty care through this 69 licensed bed "hospital within a hospital" and pediatric emergency department. The Children's Hospital has met stringent criteria to become a member of the National Association of Children's Hospitals and Related Institutions (NACHRI), linking providers and staff with more than 130 of the nation's leading pediatric facilities. Also located on the campus of JCMC is the region's only *Ronald McDonald House*, with the mission of meeting the support needs of pediatric patients and family members. In addition, in October 1999, the Alliance entered into a clinical affiliation with St. Jude's Children's Research Hospital to provide pediatric cancer and other catastrophic disease treatment services.

Diabetes Services. The Alliance provides diabetes management programs with specialized healthcare providers able to address the needs of the diabetic patient. The diabetes services emphasizes the importance of patient education and support with both patient and family involvement in the treatment process and provides education in all aspects of diabetes management.

Rehabilitation Services. The James H. and Cecile C. Quillen Rehabilitation Hospital provides a complete range of physical rehabilitative services for the region, including specialized rehabilitative services for individuals with brain injuries, strokes and spinal cord injuries. The Alliance also provides outpatient physical, occupational, and speech therapies at eight locations for individuals with physical disabilities.

Cancer Services. The Alliance provides comprehensive cancer treatment services throughout the system with four tertiary care facilities in Johnson City, Kingsport, Abingdon, and Marion. The Regional Cancer Center at JCMC serves as a referral center and education host for students, and is the only facility within several hours travel time with specialized infrastructure capable of supporting the treatment of complex cases such as pediatric cancers and acute leukemia. The St. Jude's Children's Research Hospital, Tri-Cities Affiliate, is located on JCMC's campus. It is a collaborative effort between the Alliance, East Tennessee State University, and St. Jude's Children's Research Hospital in Memphis to provide pediatric oncology services in the region. Regional Cancer Centers at Indian Path, Johnston Memorial, and Smyth County Community provide surgical and chemotherapy treatments to patients from northeast Tennessee and southwest Virginia. Outpatient radiation services are provided at Regional Cancer Centers at Indian Path and Johnston Memorial. The program emphasizes the use of market-leading facility design, multi-specialty team-based care, highly trained and certified sub-specialty staff and an emphasis on patient-centered care.

Behavioral Health Services. Respond/Crisis Line provides information, assessment, and referral assistance to patients in need of psychiatric services. Services are provided at three locations. Woodridge provides inpatient care for children, adolescents, adults, and geriatric populations and outpatient services, including Intensive Outpatient Program for adults. Sycamore Shoals provides inpatient Geropsych services. Russell provides inpatient acute psychiatry and outpatient services for adults.

In addition to the services described above, the Alliance offers many other services throughout the region including emergency departments and urgent care centers, skilled nursing facilities, and the medical air transport service called *WINGS Air Rescue*.

Medical Staff

As of June 30, 2011, there were 1,027 physicians and dentists on the Alliance's active, courtesy and consulting medical staffs. Of the 1,027 physicians on staff, 880 are board certified in their specialty. The average age of the medical staff is 49 years.

Medical staff appointment is available to licensed physicians, dentists, podiatrists and certain other professionals who are licensed to practice in the State of Tennessee or Virginia, as applicable, and who meet other specific requirements of the medical staff by-laws. Appointments and re-appointments are made by the Alliance Board of Directors upon the recommendations of the various medical staffs and the Alliance's administrative staff. Associate staff members are persons who have applied for active staff membership, but have been on the staff for less than two years.

The Alliance conducts a recruitment program to support the recruiting efforts of the affiliated medical staff. Recruiting assistance is provided to both private and university affiliated physicians as requested, and includes contracting and interaction with recruiting firms, receipt and screening of candidates' curriculum vitae, candidate site visit, and relocation and initial practice management assistance to the new physicians.

GOVERNANCE AND MANAGEMENT

Board of Directors

The management of the Alliance's affairs is vested in a Board of Directors consisting of not less than 9 and not more than 14 members, including the President/CEO, who serves as an ex-officio member. Except for the ex-officio member, directors serve for staggered three-year terms. Standing committees of the Board of Directors include Executive, Governance/Nominating, Corporate Audit and Compliance, and Quality. Special committees may be appointed by the Chairman of the Board for specific assignments. Current officers and members of the Board of Directors and their occupations and dates of expiration of their terms are set forth below:

<u>Name and Office Held</u>	<u>Business Affiliation</u>	<u>Term Expiration</u>
Robert Feathers Chairperson	President Workspace Interiors, Inc	2012
Barbara Allen Vice Chairperson	Owner, Manager Stowaway Storage	2013
Clem Wilkes, Jr. Treasurer	Financial Advisor Raymond James Financial Services	2014
Joanne Gilmer Secretary	Retired General Shale	2014
Don Jeanes Past-Chair	Retired Milligan College	2015
Sandra Brooks, M.D.	Pathologist Watauga Pathology Associates	2012
Mike Christian	Retired Banker	2012
Jeff Farrow, M.D.	Pulmonologist Johnson City Medical Center	2015
Tom Fowlkes	General Counsel The United Company	2015
Linda Garceau	Dean, College of Business & Technology East Tennessee State University	2015
David May, M.D.	Anesthesiologist Sycamore Shoals Anesthesia Assoc.	2014
Gary Peacock	Retired Royal Mouldings Ltd.	2014
Dennis Vonderfecht <i>Ex-Officio</i>	President and CEO Mountain States Health Alliance	n/a

Further, five community-based boards serve as advisory boards for the Alliance's Board of Directors. The community-based boards represent the communities serviced by the following facilities: (1) Sycamore Shoals), (2) Johnson County Community, (3) Russell, (4) Indian Path and (5) Franklin Woods and JCMC. Four governing boards serve the Alliance's joint-ventured facilities and include: (1) Dickenson Community, (2) Johnston Memorial, (3) Norton Community, and (4) Smyth County Community. One other governing board oversees the operations of Blue Ridge Medical Management Corporation. The bylaws of the community boards are rooted in the Alliance's bylaws and the remaining boards are distinguished through separate bylaws. The bylaws of each of the community boards provide that their boards consist of no fewer than nine and no more than 18 persons. No more than thirty-three percent of the directors of each Community Board may consist of physicians. Terms vary for the remaining boards, but are predominately staggered for three-year terms.

Management of the Corporation

The President and Chief Executive Officer, selected by the Board of Directors, manages the Alliance's administrative staff and has the authority and responsibility of system-wide direction of the Alliance's facilities, subject to policies adopted by the Board of Directors or any of its committees to which it has delegated power for such action. The principal members of the administrative staff of the Alliance are described below.

Dennis Vonderfecht (60) – President and Chief Executive Officer. Mr. Vonderfecht has served as President and CEO since January 1990. Prior to joining the Alliance, he was employed by Research Health Services System in Kansas City, Missouri, where he held the position of Regional Vice President. Mr. Vonderfecht worked for Humana, Inc. for approximately eight years in capacities such as: Administrative Specialist at Humana Hospital, Greensboro, North Carolina; Associate Administrator at Gibson General Hospital, Trenton, Tennessee; Associate Executive Director for Humana Hospital, Brandon, Florida; Associate Executive Director, Humana Hospital, Greensboro, North Carolina; Project Manager for Parkway Medical Center, Cary, North Carolina; and as Executive Director, Humana Hospital, Newnan, Georgia. Mr. Vonderfecht's undergraduate study was at Colorado State University, and the University of Nebraska, where he was awarded a B.S. degree in Business Administration. He obtained two master's degrees from the University of Missouri, one in Business Administration and the other in Hospital Administration. He also holds an honorary doctorate from Milligan College. He presently serves on the Boards of Directors of Premier, Inc., ETSU Foundation, Tennessee Hospital Association, Tennessee Business Roundtable, Tennessee Valley Corridor Inc., and the Tennessee Center for Performance Excellence. Mr. Vonderfecht currently serves as Chairman of the Board for the Tennessee Center for Performance Excellence and has previously served as Chairman of the Tennessee Hospital Association Board of Directors and Chairman of the Board of Hospital Alliance of Tennessee. Mr. Vonderfecht is a Fellow in the American College of Healthcare Executives. He has been the recipient of the Distinguished Service Award and the Meritorious Service Award from the Tennessee Hospital Association and was awarded the American College of Healthcare Executives Regent's Award. He has also been recognized with the Health Care Heroes Award, as well as the Cup of Kindness Award through the Tri-Cities Business Journal. In addition, Mr. Vonderfecht was presented with a "Leaders in Christian Service" award by Milligan College and has received recognition as an "Honorary Alumni" by East Tennessee State University.

Marvin Eichorn (55) - Senior Vice President and Chief Financial Officer. Mr. Eichorn has served the Alliance since August 1998, when he joined as Senior Vice President/Regional Operations. He was named Chief Financial Officer in January 1999. As Senior Vice President/Chief Financial Officer, he is responsible for all of the financial operations and services of the Alliance as well as managed care and physician operation activities for the Alliance. Prior to joining the Alliance, he was employed by Covenant Health/Fort Sanders Health System in Knoxville, Tennessee in various positions over a 14 year period including Executive Vice President/Non-Hospital Operations and Executive Vice President/Chief Financial Officer. Mr. Eichorn is a Certified Public Accountant and is a member of various health care and finance organizations. His educational background includes a bachelor's degree in finance from the University of West Florida and a master's degree in business administration from Milligan College. In 2000, Mr. Eichorn received the Meritorious Service Award for an Executive Staff member from the Tennessee Hospital Association. He also serves on the board or key committees of various national and regional healthcare related organizations.

Candace Jennings (57) - Senior Vice President for Tennessee Operations. Ms. Jennings joined the Alliance in 2007 as Vice President and Chief Operating Officer for Washington County, Tennessee operations. Her current responsibilities include the strategy development and operation of the Alliance's eight Tennessee hospitals, including a critical access hospital (Johnson County Community Hospital), a children's hospital (Niswonger

Children's Hospital) and a new, LEED certified hospital, Franklin Woods Community Hospital which opened in July 2010. Prior to joining Mountain States Health Alliance, she was Chief Nursing Officer for St. John's Hospital in Springfield, Illinois. As a consultant with Ernst and Young, she led organizations through transformational change specializing in organizational resizing and patient focused care. She has served as a health care leader for over 20 years in tertiary teaching hospitals in Alabama, Texas, Illinois and Tennessee. Her educational background includes bachelors and master's degrees in Nursing and a master's in Health Services Administration from the University of Alabama at Birmingham (UAB). Ms. Jennings has been a Fellow in ACHE since 2001.

Ann Fleming (63) – Senior Vice President of Virginia Operations and System Cardiovascular and Oncology Strategic Service Units. Since joining the Alliance in March 2007, Ms. Fleming has served as an examiner for the Tennessee Center for Performance Excellence and a board member for the Senate Productivity and Quality Award. Prior to joining the Alliance, Ms. Fleming most recently served as VP Clinical Service Lines, Merrillville Hospital Administrator and Chief Nursing Officer at The Methodist Hospitals Inc., Gary and Merrillville, Indiana. As part of her work there, she launched the Cardiovascular, Oncology, Rehabilitation/Ortho/Neuro, Women's and Children Service Lines. Ms. Fleming also served as Rehabilitation Consultant at Porter Memorial Hospital, Valparaiso, Indiana, and served as an operating room nurse with the 475th MASH during Operation Desert Storm in Saudi Arabia and Iraq. She received a bachelor's degree in nursing from the University of Kentucky, and a master's degree in Public Administration from Kentucky State University. Ms. Fleming is a member of the American College of Health Care Executives, the Association of Nursing Executives and the Medical Group Management Association. She received the Army Commendation Medal in 1991. Ms. Fleming is a Registered Nurse, currently licensed in Tennessee, Kentucky, Virginia and Indiana.

Morris Seligman (55) – Senior Vice President and Chief Medical Officer. Dr. Seligman joined the Alliance in January 2010, and has responsibility on a system-wide basis for Medical Staff Services, Graduate Medical Education, Continuing Medical Education, Patient Resource Management (case management), Clinical Research, Accreditation, Infection Prevention, Patient Safety, Quality, Information Systems, Telecommunications, and Clinical Informatics. Prior to joining the Alliance, Dr. Seligman was employed by Trinity Regional Health System Quad Cities-Senior Affiliate of Iowa Health System, Illinois and Iowa, where he served as the Chief Medical Officer and Vice President for Physician Services. Dr. Seligman is a diplomat of the American Board of Quality Assurance Utilization Review Physicians, a Fellow of the American Institute of Healthcare Quality certified in Healthcare Quality Management (CHCQM), a Fellow of the American College of Physicians (FACP), a Fellow of the American College of Healthcare Executives (FACHE), and a Certified Physician Executive (CPE). Dr. Seligman also has a two year degree in Engineering Sciences. Dr. Seligman is a board certified internist by training and has practiced Internal Medicine, Emergency Medicine and Occupational Medicine. Dr. Seligman received his MD from the University of Missouri-Columbia and his BSBA/MBA from Washington University. Dr. Seligman also earned his CPA Certificate and previously worked at Arthur Andersen & Co.

John Schario (53), Senior Vice President, Consumer Health Services/Innovation. Prior to joining the Alliance in July 2011, Mr. Schario most recently served as Chief Executive Officer of Nueterra Holdings LLC, a privately held health care equity and management company that specializes in acquiring and developing ambulatory surgery centers, surgical hospitals and physical therapy centers. Under Mr. Schario's leadership, the company grew from nine surgical facilities to 62 surgical facilities and 30 physical therapy clinics over a ten year period. Prior to Mr. Schario's involvement with Nueterra, he held various junior and senior level management positions over a twenty-one year period with Health Midwest, a large integrated health care system in Kansas City. These positions included leadership of various business development enterprises, including mobile services, clinical outreach services, diagnostic imaging services, and employer health services. During his tenure with Health Midwest, he also served as administrator of a small, rural hospital and Vice President of the large, flagship tertiary hospital with responsibilities for cardiology, neurology, radiology, laboratory, pharmacy, physical therapy, occupational therapy and respiratory therapy. Mr. Schario holds bachelors and master's degrees from Rockhurst University in Kansas City.

SERVICE AREA, MARKET SHARE AND COMPETITION

Patient Origin

The Alliance operates hospital facilities located in the Counties of Washington, Sullivan, Carter, and Johnson in the northeastern region of Tennessee. In the southwestern region of Virginia, the Alliance operates facilities in the Counties of Smyth, Wise, Dickenson, Russell and Washington, and in the City of Norton. The core service area for the Alliance (the "Core Service Area") consists of Washington, Sullivan, Carter, Johnson, Greene,

Hawkins, and Unicoi Counties in Tennessee and Smyth, Russell, Wise (including the City of Norton), Dickenson, Scott, and Washington Counties (including Bristol City) in Virginia. Approximately 93.3% of the Alliance's discharges originated from the Core Service Area for the fiscal year ended June 30, 2010. The patient origin analysis from all service areas (i.e., both the Core Service Area and the Non-Core Service Area, as defined below) as a percent of the Alliance's discharges for fiscal years 2007, 2008, 2009 and 2010 is presented in the following table:

**Alliance Facilities Patient Origin
By Fiscal Year (June 30)**

	<u>2007</u>		<u>2008</u>		<u>2009</u>		<u>2010</u>	
	<u>Discharges</u>	<u>Percent</u>	<u>Discharges</u>	<u>Percent</u>	<u>Discharges</u>	<u>Percent</u>	<u>Discharges</u>	<u>Percent</u>
<u>Core Counties</u>								
Washington, TN	16,435	34.2%	16,455	30.3%	15,196	26.6%	16,167	26.9%
Sullivan, TN	8,121	16.9	8,092	14.9	7,312	12.8	7,753	12.9
Carter, TN	6,728	14.0	6,625	12.2	5,884	10.3	6,371	10.6
Wise, VA ¹	865	1.8	4,453	8.2	4,170	7.3	4,327	7.2
Greene, TN	2,643	5.5	2,661	4.9	2,514	4.4	2,644	4.4
Smyth, VA	2,307	4.8	2,498	4.6	3,485	6.1	3,606	6.0
Unicoi, TN	2,259	4.7	2,172	4.0	1,942	3.4	1,863	3.1
Johnson, TN	2,018	4.2	2,009	3.7	1,771	3.1	1,923	3.2
Hawkins, TN	1,730	3.6	1,738	3.2	1,542	2.7	1,503	2.5
Russell, VA	192	0.4	1,303	2.4	3,142	5.5	3,306	5.5
Dickenson, VA	240	0.5	1,195	2.2	1,200	2.1	1,442	2.4
Scott, VA	865	1.8	923	1.7	914	1.6	902	1.5
Washington, VA ²	673	1.4	760	1.4	4,170	7.3	4,207	7.0
Core Subtotal	45,076	93.8%	50,886	93.7%	53,242	93.2%	56,015	93.2%
Non-Core Subtotal	1,874	3.9%	2,444	4.5%	2,856	5.0%	3,005	5.0%
Other Areas Subtotal	1,105	2.3%	978	1.8%	1,028	1.8%	1,082	1.8%
Total	48,055	100.0%	54,307	100.0%	57,127	100.0%	60,102	100.0%

Source: The Alliance – Fiscal year data excludes normal newborns. Acquired facilities have been included from date of acquisition forward.

(1) Includes City of Norton, Virginia, data.

(2) Includes City of Bristol, Virginia, data.

The Alliance has a strong extended market encompassing numerous counties in northeastern Tennessee, western North Carolina, southwestern Virginia, and southeastern Kentucky (the “Non-Core Service Area” and, together with the Core Service Area, the “Service Area”), as shown in the map in “Service Areas and Facility Locations” herein. As the table above shows, approximately 5.0% of discharges for the fiscal year ended June 30, 2010, were from the Non-Core Service Area, and approximately 1.8% of discharges were from beyond the Service Area. With the addition of Smyth County Community, Norton Community, Dickenson Community, Russell, and Johnston Memorial, the percentage of discharges from Virginia has increased. The Alliance is also a referral center for numerous advanced services such as high-risk obstetrics, perinatology, neonatology, cardiology, oncology and medical surgeries (including transplants and laparoscopies), and therefore serves many patients from outside the Service Area and outside Tennessee.

Service Area Facilities

The principal competitor of the Alliance in the Core Service Area is Wellmont Health System (“Wellmont”), which operates six of its eight hospitals within the Alliance’s Core Service Area: Holston Valley Medical Center, in Kingsport, Tennessee; Bristol Regional Medical Center, in Bristol, Tennessee; Hawkins County Memorial Hospital, in Rogersville, Tennessee; Lonesome Pine Hospital, in Big Stone Gap, Virginia; Mountainview Regional, in Norton, Virginia; Hancock County Hospital, in Sneedville, Tennessee; and Takoma Adventist Hospital, in Greeneville, Tennessee. Certain operating statistics for the facilities of the Alliance and Wellmont located within Tennessee are set forth below:

Tennessee Service Area Hospitals and Related Facilities – Fiscal 2010

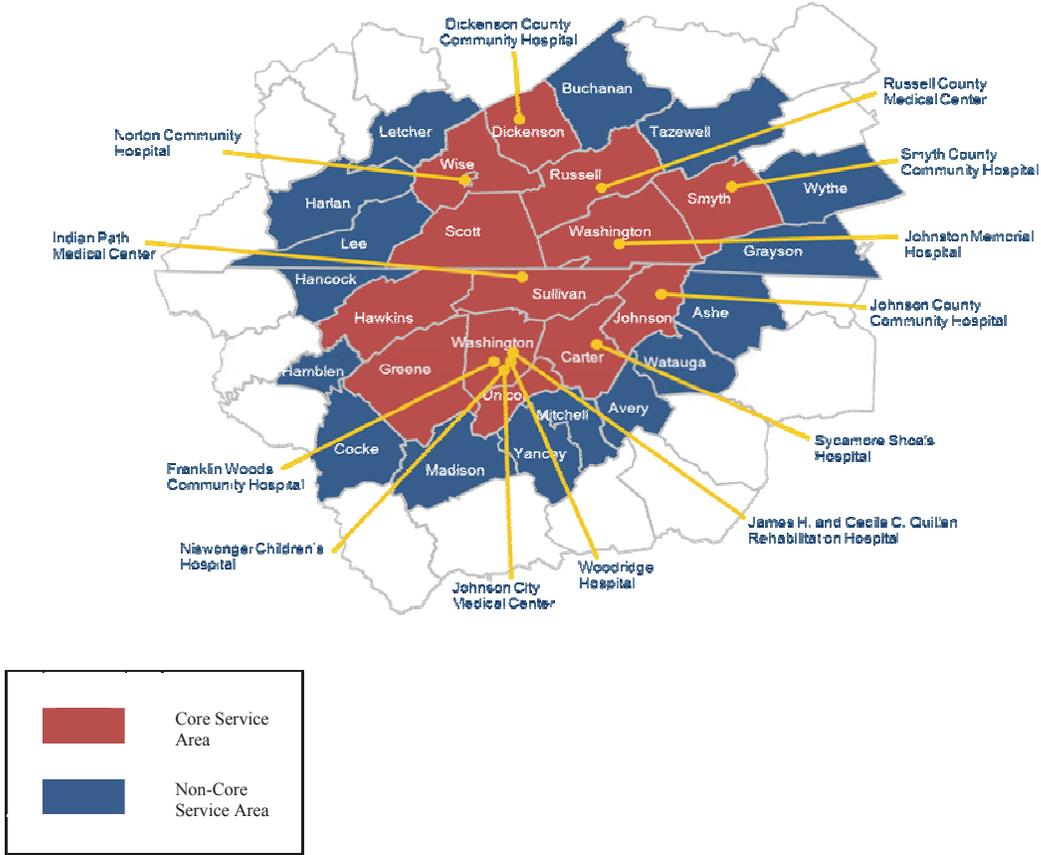
	County in Tennessee	Licensed Beds	Staffed Beds	Total Discharges	Total Patient Days	Average Daily Census
<u>Mountain States Health Alliance</u>						
Johnson City Medical Center	Washington	514	514	27,129	138,664	380
Quillen Rehabilitation Hospital	Washington	60	60	691	9,923	27
Woodridge Hospital	Washington	84	84	3,310	19,572	54
North Side Hospital	Washington	91	72	1,885	15,980	44
Johnson City Specialty Hospital	Washington	23	23	1,077	2,346	6
Indian Path Medical Center	Sullivan	261	191	6,549	28,532	78
Indian Path Pavilion	Sullivan	61	48	17	59	0
Sycamore Shoals Hospital	Carter	121	79	3,448	15,334	42
Johnson County Community Hospital	Johnson	2	2	29	69	0
MSHA Subtotal		1,217	1,073	44,135	230,479	631
<u>Wellmont Health System</u>						
Holston Valley Medical Center	Sullivan	455	339	19,531	87,488	240
Bristol Regional Medical Center	Sullivan	312	261	14,827	62,531	171
Hawkins County Memorial Hospital	Hawkins	50	46	1,710	5,165	14
Hancock County Hospital	Hancock	10	10	327	1,003	3
Takoma Regional Hospital	Greene	121	100	2,606	12,274	34
Wellmont Subtotal		948	756	39,001	168,461	462
<u>Other Core Service Area Facilities</u>						
Laughlin Memorial Hospital	Greene	140	140	4,531	18,302	50
Healthsouth Rehabilitation Hospital	Sullivan	50	50	947	14,500	40
Unicoi County Memorial Hospital	Unicoi	48	25	1,223	4,499	12
Other Core Service Area Facilities		238	215	6,701	37,301	102
Core Service Area Total		2,403	2,044	89,837	436,241	1,195

Source: 2010 Tennessee Joint Annual Reports.

Service Areas and Facility Locations

The Alliance’s Core and Non-Core Service Areas are depicted in the map set forth below:

**Mountain States Health Alliance
Service Area**



Market Share

Market share represents the proportion of service area residents discharged from each of the service area hospitals. Market share by hospital for the defined service area was calculated using data published by the Tennessee Hospital Association, the Virginia Hospital and Healthcare Association and the North Carolina Hospital Association. Hospital specific discharges are divided by service area specific discharges to estimate market share for each of the service area hospitals.

The Alliance maintains the largest market share of its core service area, capturing over 51.8% of the market for the calendar year ended 2010. Wellmont’s facilities had a market share for the same period of approximately 37.8%. The following tables present calendar years 2006, 2007, 2008, 2009, and 2010, Core Service Area and total Service Area market share information for facilities currently owned or controlled by the Alliance and Wellmont.

Core Service Area Market Share Summary

System	Hospital Name	Calendar 2006		Calendar 2007		Calendar 2008		Calendar 2009		Calendar 2010	
		Discharges	% of Total	Discharges	% of Total						
<u>MSHA</u>	Johnson City Medical Center	24,520	24.3%	24,427	24.3%	25,095	24.9%	25,168	25.9%	25,048	25.8%
	Indian Path Medical Center	5,495	5.4	5,340	5.3	5,867	5.8	5,526	5.7	6,035	6.2
	Sycamore Shoals Hospital	4,062	4.0	4,031	4.0	3,724	3.7	3,206	3.3	3,225	3.3
	Franklin Woods Community Hospital	3,515	3.5	3,106	3.1	2,655	2.6	2,384	2.5	2,683	2.8
	Johnson County Community Hospital	34	0.0	40	0.0	44	0.0	31	0.0	24	0.0
	Smyth County Community Hospital	2,115	2.1	2,139	2.1	2,113	2.1	2,164	2.2	1,958	2.0
	Norton Community Hospital	5,170	5.1	4,793	4.8	4,139	4.1	3,980	4.1	3,636	3.8
	Dickenson Community Hospital	805	0.8	757	0.8	366	0.4	7	0.0	2	0.0
	Russell County Medical Center	2,582	2.6	2,270	2.3	2,242	2.2	2,298	2.4	2,099	2.2
	Johnston Memorial Hospital	<u>4,612</u>	<u>4.6</u>	<u>4,979</u>	<u>4.9</u>	<u>5,656</u>	<u>5.6</u>	<u>5,496</u>	<u>5.6</u>	<u>5,534</u>	<u>5.7</u>
MSHA Total	52,910	52.4%	51,882	51.5%	51,901	51.4%	50,260	51.7%	50,244	51.8%	
<u>Wellmont</u>	Wellmont Holston Valley Medical Center	15,693	15.5	16,556	16.4	16,057	15.9	16,260	16.7	16,724	17.3
	Wellmont Bristol Regional Medical Center	11,851	11.7	12,288	12.2	12,676	12.6	12,455	12.8	12,831	13.2
	Wellmont Lonesome Pine Hospital	2,630	2.6	2,745	2.7	2,656	2.6	2,181	2.2	2,005	2.1
	Wellmont Hawkins County Memorial Hospital	1,517	1.5	1,699	1.7	1,778	1.8	1,639	1.7	1,521	1.6
	Wellmont Hancock County Hospital	9	0.0	11	0.0	9	0.0	10	0.0	10	0.0
	Takoma Regional Hospital	2,103	2.1	2,227	2.2	2,320	2.3	2,093	2.2	1,827	1.9
	Lee Regional Medical Center	146	0.1	136	0.1	151	0.1	153	0.2	146	0.2
	Mountain View Regional Medical Center	<u>1,915</u>	<u>1.9</u>	<u>1,880</u>	<u>1.9</u>	<u>2,058</u>	<u>2.0</u>	<u>1,597</u>	<u>1.6</u>	<u>1,601</u>	<u>1.7</u>
Wellmont Total	35,864	35.5%	37,542	37.3%	37,705	37.4%	36,388	37.4%	36,665	37.8%	
<u>All Other</u>	<u>12,194</u>	<u>12.1%</u>	<u>11,271</u>	<u>11.2%</u>	<u>11,272</u>	<u>11.2%</u>	<u>10,628</u>	<u>10.9%</u>	<u>10,022</u>	<u>10.3%</u>	
Grand Total	100,968	100.0%	100,695	100.0%	100,878	100.0%	97,276	100.0%	96,931	100.0%	

Source: Tennessee Hospital Association, the Virginia Hospital and Healthcare Association, and the North Carolina Hospital Association.

Notes:

Information based on calendar year and excludes normal newborns, psych, substance abuse, and rehab.

Acquired facilities are fully included retrospectively.

JCMC, Quillen, and Woodridge are reported together as "Johnson City Medical Center" because they operate under a single license.

Franklin Woods reflects historical values for North Side Hospital and Johnson City Specialty Hospital prior to June 2010.

Total Service Area Market Share Summary

System	Hospital Name	Calendar 2006		Calendar 2007		Calendar 2008		Calendar 2009		Calendar 2010	
		Discharges	% of Total	Discharges	% of Total						
<u>MSHA</u>	Johnson City Medical Center	25,755	17.1%	25,677	17.2%	26,404	17.6%	26,472	18.2%	26,259	18.3%
	Indian Path Medical Center	5,658	3.8	5,547	3.7	6,091	4.1	5,711	3.9	6,242	4.4
	Sycamore Shoals Hospital	4,078	2.7	4,048	2.7	3,736	2.5	3,214	2.2	3,239	2.3
	Franklin Woods Community Hospital	3,563	2.4	3,133	2.1	2,686	1.8	2,398	1.7	2,714	1.9
	Johnson County Community Hospital	35	0.0	40	0.0	46	0.0	31	0.0	24	0.0
	Smyth County Community Hospital	2,374	1.6	2,417	1.6	2,348	1.6	2,399	1.7	2,197	1.5
	Norton Community Hospital	5,531	3.7	5,085	3.4	4,337	2.9	4,174	2.9	3,807	2.7
	Dickenson Community Hospital	814	0.5	765	0.5	369	0.2	7	0.0	2	0.0
	Russell County Medical Center	2,870	1.9	2,563	1.7	2,478	1.7	2,587	1.8	2,368	1.7
	Johnston Memorial Hospital	<u>4,960</u>	<u>3.3</u>	<u>5,342</u>	<u>3.6</u>	<u>6,094</u>	<u>4.1</u>	<u>5,978</u>	<u>4.1</u>	<u>5,928</u>	<u>4.1</u>
MSHA Total	55,638	37.0	54,617	36.5	54,589	36.4	52,971	36.5	52,780	36.8	
<u>Wellmont</u>	Wellmont Holston Valley Medical Center	17,333	11.5	18,504	12.4	17,984	12.0	18,155	12.5	18,723	13.1
	Wellmont Bristol Regional Medical Center	12,635	8.4	13,160	8.8	13,831	9.2	13,696	9.4	14,102	9.8
	Wellmont Lonesome Pine Hospital	3,183	2.1	3,377	2.3	3,266	2.2	2,681	1.8	2,421	1.7
	Wellmont Hawkins County Memorial Hospital	1,581	1.1	1,808	1.2	1,866	1.2	1,704	1.2	1,597	1.1
	Wellmont Hancock County Hospital	237	0.2	375	0.3	360	0.2	303	0.2	243	0.2
	Takoma Regional Hospital	2,274	1.5	2,358	1.6	2,441	1.6	2,219	1.5	1,935	1.3
	Lee Regional Medical Center	2,565	1.7	2,768	1.9	2,509	1.7	2,370	1.6	2,398	1.7
	Mountain View Regional Medical Center	<u>1,996</u>	<u>1.3</u>	<u>1,977</u>	<u>1.3</u>	<u>2,132</u>	<u>1.4</u>	<u>1,652</u>	<u>1.1</u>	<u>1,661</u>	<u>1.2</u>
	Wellmont Total	41,804	27.8%	44,327	29.6%	44,389	29.6%	42,780	29.5%	43,080	30.0%
<u>All Other</u>	<u>52,771</u>	<u>35.1%</u>	<u>50,651</u>	<u>33.9%</u>	<u>51,003</u>	<u>34.0%</u>	<u>49,314</u>	<u>34.0%</u>	<u>47,553</u>	<u>33.2%</u>	
Grand Total	150,213	100.0%	149,595	100.0%	149,981	100.0%	145,065	100.0%	143,413	100.0%	

Source: Tennessee Hospital Association, the Virginia Hospital and Healthcare Association, and the North Carolina Hospital Association.

Notes:

JCMC, Quillen, and Woodridge are reported together as "Johnson City Medical Center" because they operate under a single license.

Franklin Woods reflects historical values for North Side Hospital and Johnson City Specialty Hospital prior to June 2010.

Demographic and Socio-Economic Characteristics of the Service Area

The following table provides information on major employers in the region:

Major Employers in the PSA/SSA

<u>Rank</u>	<u>Employer</u>	<u>Headquarters</u>	<u>Estimated Employees</u>	<u>Industry</u>
1	K-VA-T Food Stores	Abingdon, VA	12,600	Retail Supermarkets
2	Mountain States Health Alliance	Johnson City, TN	9,000	Health Care
3	Eastman Chemical Co.	Kingsport, TN	6,800	Manufacturer
4	Wellmont Health System	Kingsport, TN	6,500	Health Care
5	East Tennessee State University	Johnson City, TN	2,330	Higher Education
6	James H. Quillen VA Medical Center	Mountain Home, TN	2,000	Gov't Health Care Facility
7	Sullivan County Dept. of Ed	Blountville, TN	1,646	Public Education
8	Advanced Call Center Technologies	Berwyn, PA	1,500	Call Center
9	Washington County Dept. of Ed	Jonesborough, TN	1,300	Public Education
10	Hawkins County Board of Ed	Rogersville, TN	1,200	Public Education
11	DTR Tennessee, Inc.	Midway, TN	1,195	Manufacturer
12	A.O. Smith	Johnson City, TN	1,140	Manufacturer
13	Kingsport City Schools	Kingsport, TN	1,050	Public Education
14	Frontier Health	Johnson City, TN	996	Health Care
15	Bristol Compressors	Bristol, VA	950	Manufacturer

Source: 2010 Book of Lists (A supplement to The Business Journal).

SOURCES OF REVENUE

Patient service payments are made to the Alliance by commercial insurance carriers, the federal government under the Medicare program, the State of Tennessee under the TennCare program and surrounding states under their Medicaid programs. The table below shows the percentage of gross patient revenues received by the Alliance from each program and from private pay.

Gross Patient Revenues by Source of Payment (Payor Mix)

	<u>Audited</u>				<u>Unaudited</u>
	<u>Fiscal Years Ended June 30</u>				<u>June 30</u>
	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>
Medicare	40.7%	41.3%	42.0%	43.4%	43.7%
TennCare/Medicaid	15.7	15.3	15.0	14.2	13.7
Managed Care/ Commercial and Other	36.6	36.4	35.7	34.2	34.2
Private Pay	7.0	7.0	7.3	8.2	8.4
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Source: The Alliance.

Medicaid and Medicare

Approximately 44% and 14% of the gross patient service charges of the Alliance for the fiscal year ended June 30, 2011, were derived from the Medicare and TennCare/Medicaid programs, respectively. Medicare provides certain health care benefits to beneficiaries who generally are 65 years of age and older, are long term disabled, or qualify for the end stage renal disease (“ESRD”) program. Medicare Part A covers, among other things, inpatient hospital services, skilled nursing care, hospice and some home health care. Medicare Part B covers, among other things, physician services, outpatient hospital services and some supplies. TennCare/Medicaid is designed to pay providers for care given to the medically indigent and others who receive federal aid.

TennCare/Medicaid

The State of Tennessee transferred a portion of its Medicaid program to a managed care program (“TennCare”) under a Section 1115 Waiver effective January 1, 1994. The long term care and ESRD Medicaid programs were not transferred to TennCare. The TennCare program also covers a number of uninsured non-Medicaid beneficiaries.

Medicare

Medicare pays acute care hospitals for most services provided to inpatients under a payment system known as the Prospective Payment System (“PPS”). Separate PPS payments are made for inpatient operating costs and inpatient capital costs.

Inpatient Operating Costs. Under PPS, acute care hospitals are reimbursed for inpatient operating costs on a per-discharge basis at fixed rates established for identified Diagnosis Related Groups (“DRGs”). DRG classification is based on the diagnosis at discharge and major procedures and other factors for each particular Medicare patient. The amount to be paid for each DRG is established prospectively by the Centers for Medicare and Medicaid Services (“CMS”), an agency of the United States Department of Health and Human Services (“HHS”), and is not related to a hospital’s actual costs. For certain Medicare beneficiaries who have unusually costly hospital stays (referred to as “outliers”), CMS will provide additional payments above those specified for the DRG.

The prospective payment rate is updated annually based upon the hospital “market basket” index, which generally measures changes in the cost of providing health care services. Future adjustments are subject to change by Congress. There is no assurance that these or any future increases in the prospective payment rates will keep pace with the increases in the cost of providing hospital services.

CMS reviews and publishes changes in the DRG classification system at least annually. This process is intended to ensure that each DRG is clinically coherent and represents an acceptable range of resource consumption. There is no assurance that the Alliance will be paid amounts which will reflect adequately changes in the cost of providing health care or in the cost of health care technology being made available to patients.

Costs of Medical Education. Medicare pays for certain direct and indirect costs associated with medical education. Payment for the indirect costs of medical education will be made as an adjustment to the federal rate for capital-related costs during the transition to PPS for inpatient capital-related costs. The indirect medical education adjustment for capital-related costs is based in part on the ratio of a hospital’s number of full-time equivalent (“FTE”) residents to its average daily census. Medicare also adjusts the inpatient operating PPS payment for indirect costs of medical education. This adjustment is based in part on the ratio of FTE residents to beds. Payment for direct medical education is based on a per resident rate adjusted by inflation and the number of current-year reimbursable resident positions.

Disproportionate Share. Section 402 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) provided for payments to hospitals serving a large number of low-income patients which qualifies them for a Medicare Disproportionate Share (“DSH”) payment adjustment. Payment is based on the SSI% plus Medicaid Eligible Patient Days to Total Patient Days. There is no assurance in the future that the Alliance will be paid amounts to adequately offset the cost of providing services to low income patients to Acute and Rehabilitation services.

Costs of Outpatient Services. Ambulatory payment classifications (“APCs”) form the basis for outpatient PPS. Services in each APC are similar clinically and with respect to the resources necessary to provide the services. Generally, the primary classification variable under the APC system is the procedure performed rather than the patient’s diagnosis, as is the case with the DRG system. Each APC is assigned a payment rate based on median (or, if the Secretary of HHS so chooses, mean) hospital costs for procedures performed, weighted by procedure volume. Beneficiary coinsurance amounts are established for each APC based on 20 percent of the national median of charges for APC services. The APC payment and beneficiary’s coinsurance amounts for outpatient services will be adjusted to reflect geographic wage variations and other factors determined to be necessary by the Secretary of HHS. Annual payment updates are based on the hospital market basket index. As with inpatient hospital services,

there is no assurance that future increases in the prospective payment rates will reflect adequately the changes in the costs of providing outpatient services.

Costs of Inpatient Rehabilitation Facilities (IRF). Under IRF PPS, Federal rates are adjusted to reflect patient case mix, resource intensity associated with the patients clinical condition, and facility characteristics. Cases are grouped into case-mix groups (CMGs) and are further classified into 4 tiers driven by conditions that are secondary to the principal diagnosis. Rates are paid to reflect all costs of furnishing IRF services for routine, ancillary, and capital. There is no assurance that the alliance will be paid amounts that will sufficiently match all costs associated with care.

Costs of Psychiatric Facilities (IPF). Under the IPF PPS, services are reimbursed under Federal Per Diem rates to include Operating and Capital costs. Payment is based on Geographic factors, patient characteristics (DRG, age, length of stay and presence of specified comorbidities), facility characteristics, and services for received in a qualified Emergency Department and also Electroconvulsive Therapy.

Costs of Skilled Nursing Facilities. Medicare reimbursed for skilled nursing facility (“SNF”) stays are also based on a prospective payment system which requires “bundling” of virtually all SNF services, similar to the current practice for hospital inpatient services. A SNF therefore is responsible for providing or arranging to provide all Medicare services (subject to certain exceptions) needed by a SNF patient, and could potentially receive less than it costs the SNF to provide or arrange to provide those services. Accordingly, there can be no assurance that the aggregate amount of payments under SNF PPS will be sufficient to cover all of the Alliance’s actual costs of providing SNF services to Medicare beneficiaries.

Physician Services. Physicians are reimbursed under Medicare based on their professional services according to the lesser of the actual charge or the amount determined from a resource-based relative value scale (RBRVS) fee schedule. The fee schedule is subject to update by the Secretary of HHS and Congress on an annual basis.

Electronic Health Records (EHR) Costs. The American Recovery Act of 2009 provides for incentive payments for Medicare and Medicaid Eligible Professionals and Hospitals to purchase and implement meaningful use certified EHR technology. Payments provide an incentive for the “meaningful use” of certified EHR technology and to achieve health care and efficiency goals. The incentive payment will be paid out over a period of 5 years, which offsets the costs of purchase and implementation of the products. There is no indication that future rule making will extend payments beyond the five years.

Audits, Exclusions, Fines and Enforcement Action. Hospitals participating in Medicare are subject to audits and retroactive audit adjustments by a Medicare Audit Contractor under the Medicare program. From an audit, a Medicare Audit Contractor may conclude, for example, that a patient has been discharged under an incorrect DRG, that services may not have been provided under the direct supervision of a physician (to the extent so required), that a patient should not have been characterized as an inpatient, that certain services provided prior to an admission as an inpatient should not have been billed as outpatient services or that certain required procedures or processes were not satisfied. As a consequence, payments may be retroactively disallowed. Under certain circumstances, payments made may be determined to have been made as a consequence of improper claims subject to the federal False Claims Act or other federal statutes, subjecting the hospital to civil or criminal sanctions. Generally, the Alliance maintains limited reserves for anticipated or proposed audit adjustments which are likely to be contested. Nevertheless, such adjustments may exceed such reserves and may be substantial. Medicare regulations also provide for withholding Medicare payment in certain circumstances, and such withholdings could have a substantial adverse effect on the financial condition of the Alliance.

Management of the Alliance is not aware of any situation in which reserves are inadequate or a material amount of Medicare payments is being withheld. The Alliance utilizes internal and external resources to review and audit practice compliance with policies, procedures, applicable laws and regulations. Whenever such reviews identify practice deviation from policies, procedures, applicable rules and regulations, management is obligated to refund any overpayments as part of the Alliance’s continuous improvement processes. Currently, management is unaware of any deviations that may have a material adverse effect on the results of the operations or financial condition of the Alliance.

Commercial Managed Care and Other

The Alliance contracts with certain private third party payors. Contractual agreements with these payors include reimbursement arrangements such as discounted charges, per diem amounts and capitated payments. The Alliance actively manages these contracts and negotiates terms that are in the best interest of the Alliance and its patients. While not participating in all commercial contracts, the Alliance participates in the vast majority of contracts covering the population of its primary service area.

Additionally, the Alliance treats patients with no insurance coverage. Those meeting certain income requirements are treated at no cost to the patient. Those not qualifying for this classification are classified as “self-pay” and reimburse the Alliance privately for the services rendered.

HISTORICAL UTILIZATION INFORMATION

The table below provides a historic system-wide patient utilization for the Alliance for the fiscal years ended June 30, 2007 through 2011. The number reflects the inclusion of the following facilities as of the following dates: Smyth County Community - 11/1/06; Norton Community - 11/1/07; Dickenson Community - 11/1/07; Russell - 1/31/08; and Johnston Memorial - 4/1/09.

	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>
Occupancy Rate (licensed)	46%	49%	45%	46%	47%
Patient Days	246,572	268,965	283,555	291,986	288,167
Admissions	48,055	54,307	57,127	60,102	61,035
Average Daily Census	676	735	777	800	789
Avg Length of Stay (days)	5.1	5.0	5.0	4.9	4.7
Outpatient Visits	953,704	1,239,440	1,511,699	1,604,036	1,590,962
ER Visits	160,972	190,771	219,983	250,942	242,677
Surgical Cases	31,061	35,988	38,812	39,313	39,230
Births	3,849	4,270	4,371	4,684	4,511
Newborn Days	7,616	8,504	8,569	9,112	9,287
Licensed Beds	1,467	1,699	1,841	1,789	1,749

Source: The Alliance.

CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS

The following Condensed Summary of Revenue and Expenses (the “Condensed Summary”) for each of the five Fiscal Years ended June 30, 2006 through 2010, is derived from the Alliance’s audited financial statements for those Fiscal Years. The annual financial statements were audited by Pershing Yoakley & Associates, P.C. The financial information for the twelve month period ended June 30, 2011, is unaudited and reflects, in the opinion of the Alliance, all adjustments necessary to summarize fairly the results for such period on a basis consistent with that used in preparing the annual financial statements for the years ended June 30, 2006, 2007, 2008, 2009, and 2010. The financial statements include the assets and liabilities and reflect the revenue and expenses of the Alliance and all consolidated entities, including those that are not Obligated Issuers.

The Condensed Summary as well as the audited financial statements included in Appendix B and the unaudited financial statements included as Appendix C are for all entities consolidated with the Alliance for accounting purposes (the “Consolidated Entities”) and therefore reflect the assets, liabilities, revenues and expenses of entities that are not Obligated Issuers (see “THE ALLIANCE” in the front half of this Official Statement). For the fiscal year ended June 30, 2011, the Obligated Issuers (excluding the Smyth Corporation and the Norton Corporation, which will not become Obligated Issuers until the issuance of the Series 2011 Bonds) accounted for approximately 83% of the total assets and 75% of the total revenue of the Consolidated Entities.

The following Condensed Summary of Consolidated Revenue and Expenses should be read in conjunction with the audited financial statements and notes contained in Appendix B hereto.

Condensed Summary of Revenue and Expenses

	Audited Fiscal Years Ended June 30 (In Thousands)					(Unaudited) Fiscal Year Ended June 30 (In Thousands)
	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011⁽⁹⁾</u>
Revenues:						
Net patient service revenue	\$586,155	\$661,744	\$726,542	\$822,898	\$928,270	\$960,129
Other revenue	14,969	16,711	16,098	17,046	16,009	15,871
Total Revenue, Gains and Support	601,124	678,455	742,640	839,944	944,279	976,000
Expenses:						
Operating expenses	508,600	580,059	633,842	719,193	804,865	822,435
Depreciation and Amortization	42,702	49,807	60,048	68,523	81,559	90,058
Interest and Taxes	38,230	44,387	44,581	45,225	42,264	45,233
Total Expenses	589,532	674,252	738,471	832,941	928,688	957,726
Operating Income (loss)	11,592	4,203	4,169	7,003	15,591	18,274
Net non-operating gains (losses) ⁽¹⁾	49,320 ⁽²⁾	67,184 ⁽³⁾	(74,343) ⁽⁴⁾	(89,683) ⁽⁵⁾	29,084 ⁽⁶⁾	66,809 ⁽⁷⁾
Excess of Revenue, Gains and Support Over Expenses and Losses ⁽⁸⁾	\$ 60,912	\$ 71,387	\$ (70,174)	\$ (82,680)	\$ 44,675	\$ 85,083

Source: The Alliance.

⁽¹⁾ Net non-operating gains and losses include the change in fair value of derivatives and realized and unrealized gains and losses on investments. Recent clarification to generally accepted accounting principles require the unrealized gains and losses on certain investments to be included as part of the Excess of Revenue, Gains and Support over Expenses and Losses and such approach was used for the audited financial statements for fiscal years 2008, 2009, 2010, and unaudited 2011. For ease of comparison, management has reclassified such unrealized gains and losses for fiscal years 2006 and 2007 in a manner consistent with the clarification.

⁽²⁾ Includes \$14.2 million of unrealized gains on derivatives.

⁽³⁾ Includes \$2.1 million of unrealized gains on derivatives.

⁽⁴⁾ Includes \$20.6 million of unrealized losses on derivatives, and \$57.7 million loss on early extinguishment of debt and \$33.4 million of unrealized losses on investments.

⁽⁵⁾ Includes \$42.1 million of unrealized losses on derivatives and \$62.6 million of unrealized losses on investments.

⁽⁶⁾ Includes \$8.6 million of unrealized losses on derivatives, and \$15.0 million of unrealized gains on investments.

⁽⁷⁾ Includes \$21.2 million of unrealized gains on derivatives and \$22.2 million of unrealized gains on investments.

⁽⁸⁾ An entry was posted in the 2008, 2009, 2010, and 2011 financial statements to eliminate certain employee health related patient service revenue and employee benefits expense (approximately \$12.9 million in 2008, \$14.9 million in 2009, \$20.0 million in 2010, and \$23.1 million in 2011). The eliminating entry had no effect on the Excess of Revenue, Gains and Support Over Expenses and Losses in these periods. The 2006 and 2007 financial data does not reflect this eliminating entry.

⁽⁹⁾ In Fiscal 2011, the Alliance adopted Financial Accounting Standards Board ASC 350, which requires goodwill be tested for impairment annually. Management is in the process of performing the initial impairment testing on its recorded goodwill, totaling approximately \$151.6 million as of June 30, 2011. The unaudited financial results for Fiscal 2011 do not include the impact of goodwill impairment losses, if any, related to the adoption of this standard.

TRENDS IN UNRESTRICTED LIQUIDITY AND LEVERAGE

The following table provides information on unrestricted liquidity and leverage for the fiscal years ended June 30, 2006 through 2011.

	Fiscal 2006	Fiscal 2007	Fiscal 2008	Fiscal 2009	Fiscal 2010	Unaudited Fiscal 2011
Total Unrestricted Cash (\$ in Thousands)	\$343,946	\$452,225	\$466,478	\$515,066	\$551,608	\$592,920
Total Days' Cash on Hand	230	264	246	249	240	253
Unrestricted Net Assets (\$ in Thousands)	342,777	416,850	349,081	272,049	317,433	399,347
Net Long Term Debt to Capitalization⁽¹⁾	57.7%	53.6%	68.0% ⁽²⁾	74.7%	71.2%	67.6%

⁽¹⁾ For purposes of calculating the ratio, Net Long-Term Debt is determined net of debt service reserve funds and moneys held in principal and interest funds.

⁽²⁾ The increase in Net Long Term Debt to Capitalization in Fiscal Year 2008 was due in part to the \$57.7 million loss on early extinguishment of debt. The Net Long Term Debt to Capitalization, excluding the loss on early extinguishment of debt, was 65.1%.

MANAGEMENT'S DISCUSSION OF FINANCIAL PERFORMANCE

Overview

The Alliance has maintained a positive operating income for each of the last six fiscal years, reflecting rises in net patient service revenues that have generally kept pace with increases in expenses. However, non-operating losses from derivatives and other investments resulted in deficits of revenue, gains, and support over expenses for Fiscal 2008 and 2009. The losses from derivatives are discussed further below. The losses from other investments resulted from losses in market value reflecting primarily the general market decline in the value of securities in the Alliance's investment portfolio. Beginning in Fiscal 2007, operating income or losses for recent acquisitions is included (Fiscal 2007: Smyth County - 8 months, Fiscal 2008: Norton/Dickenson – 8 months and Russell 5 months, Fiscal 2009: Johnston Memorial – 3 months).

Fiscal 2009

The Operating Income for Fiscal 2009 was \$7.003 million, reflecting increases in net patient service revenue and expenses resulting primarily from the addition of Johnston Memorial Hospital in April, 2009. This resulted in an Operating Margin (net operating income as a percentage of total operating revenue) of 0.8%. However, an overall loss, i.e. an excess of expenses and losses over revenue, gains and support, resulted from net non-operating losses totaling \$89.683 million. The non-operating losses reflected primarily (1) \$62.582 million of unrealized losses on investments and (2) \$42.128 million of losses derived from interest rate swaps and derivatives, as discussed below in "Interest Rate Swaps and Derivatives." Such losses resulted in a deficit of revenue, gains, and support over expenses of \$82.680 million.

Fiscal 2010

The Operating Income for Fiscal 2010 was \$15.591 million compared with \$7.003 million for the same period in Fiscal 2009. The Operating Margin for Fiscal, 2010 was 1.7%, compared with 0.8% for the same period in Fiscal 2009. This reflected among other things increases in revenues and expenses resulting from the addition of Johnston Memorial (April, 2009) that are included for a full year in the Fiscal 2010 but included for only three months in Fiscal 2009. Moreover, net non-operating gains of \$29.084 million, reflecting primarily \$24.083 million of income realized from investments, \$15.018 million of unrealized income from investments, and \$8.607 million in losses derived from interest rate swaps and derivatives, produced a \$44.675 million excess of revenue, gains and support over expenses.

Fiscal 2011

The Operating Income for Fiscal 2011 was \$18.274 million compared with \$15.591 million for the same period in Fiscal 2010. The Operating Margin for Fiscal 2011 was 1.9%, compared with 1.7% for the same period in Fiscal 2010. Moreover, net non-operating gains of \$66.809 million, reflecting primarily \$23.216 million of income realized from investments, \$22.168 million of unrealized income from investments, and \$21.165 million in gains derived from interest rate swaps and derivatives, produced a \$85.083 million excess of revenue, gains and support over expenses.

Interest Rate Swaps and Derivatives

The Alliance has utilized several forms of derivative financial instruments, including interest rate swaps, constant maturity swaps, total return swaps and swaptions, in order to lower the cost of debt and reduce interest rate risk.

As of August 31, 2011, the Alliance had a total of approximately \$592,400,000 (notional amount) of total return swaps, basis swaps, and constant maturity basis swaps with Bank of America, which swaps have been implemented as part of a carefully managed program. Through this program, the Alliance has realized approximately \$37,400,000 of savings since 2001. In January and May of 2011, the Alliance “locked in” approximately \$16,000,000 of future cash payments through April 2014 on \$438,000,000 (notional amount) of the constant maturity basis swaps. In January 2011, the Alliance converted two fixed payor swaps, totaling \$132,000,000 (notional amount), to basis swaps. As of August 31, 2011, the market value of all these swaps was (\$14,200,000). The amount of collateral posted to Bank of America, as of August 31, 2011, was \$330,000. Funds that have been posted as collateral are not included in the reporting of unrestricted cash and investments.

In August 2011, the Alliance entered into two forward starting interest rate swaps with Bank of America, totaling \$96,800,000 (notional amount). The counterparties expect that the swaps will terminate on or about November 4, 2011 and May 3, 2012 with any related termination payment to be made by the owing party on or about January 1, 2012 and July 1, 2012 respectively. As of August 31, 2011, the market value of these swaps was \$282,000.

Additionally, the Alliance has \$106,000,000 (notional amount) of total return and fixed payor swaps with Lehman Brothers Special Financing, Inc. (“Lehman”). As of August 31, 2011, the Alliance had posted \$13,800,000 of collateral under the Lehman swap agreements. In the Fall of 2008, the Alliance was notified by Lehman that these transactions were going to be terminated as of January 1, 2009. The termination did not occur, due to a dispute between counterparties regarding the amount of the cost of the termination. The Alliance believes that the amount of the collateral that has been posted is sufficient to pay the cost of the termination. In late 2011 or 2012, the counterparties may schedule a mediation to settle the termination amount.

In 2003 and 2004, the Alliance implemented \$224,400,000 (notional amount) of swaptions with Bear Stearns Capital Markets, now J.P. Morgan, as part of a synthetic refunding of its Series 2000 outstanding debt. Amounts received by the Alliance as upfront payments on the swaptions and related forward sale agreements were deposited in a guaranteed investment contract (“GIC”) with Bear Stearns, now J.P. Morgan, that served as collateral under the related agreements. On October 13, 2011, the Alliance terminated the swaptions using the entire proceeds of the GIC. No additional funds of the Alliance were utilized. The forward sale agreements remain in place. As of August 31, 2011, the mark-to-market of the forward sale agreements with J.P. Morgan was (\$15,891,644). The Alliance is required to post collateral to J.P. Morgan only if the total mark-to-market exposure exceeds \$17,500,000.

Additional Indebtedness

The Alliance has several significant capital expenditures planned or in process for the near future. Some of the larger projects include a new surgical services facility at JCMC. Funding for these projects is expected to come from cash flow and the proceeds of this and a future revenue bond issue.

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APPENDIX B

**AUDITED CONSOLIDATED FINANCIAL STATEMENTS
FOR FISCAL YEARS ENDED JUNE 30, 2010 AND 2009**

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MOUNTAIN STATES HEALTH ALLIANCE

*Audited Consolidated Financial Statements
(and Supplemental Schedules)*

Years Ended June 30, 2010 and 2009

MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Schedules)

Years Ended June 30, 2010 and 2009

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CERTIFIED PUBLIC ACCOUNTANTS

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited the accompanying consolidated balance sheets of Mountain States Health Alliance and subsidiaries (the Alliance) as of June 30, 2010 and 2009 and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Alliance's management. 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 of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing 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 over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe our audits provide a reasonable basis for our 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 subsidiaries as of June 30, 2010 and 2009 and the results of their operations, changes in net assets and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The supplemental schedules, as listed in the accompanying index, are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Knoxville, Tennessee
October 25, 2010

Pershing Yoakley & Associates, P.C.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets
(Dollars in Thousands)

	<i>June 30,</i>	
	<i>2010</i>	<i>2009</i>
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 234,526	\$ 239,836
Current portion of investments	28,467	27,317
Patient accounts receivable, less estimated allowances for uncollectible accounts of \$45,941 in 2010 and \$42,587 in 2009	125,580	128,812
Other receivables, net	17,926	16,108
Inventories and prepaid expenses	29,163	27,135
TOTAL CURRENT ASSETS	435,662	439,208
INVESTMENTS, less amounts required to meet current obligations	586,756	597,440
PROPERTY, PLANT AND EQUIPMENT, net	695,598	590,569
OTHER ASSETS		
Goodwill, net of accumulated amortization of \$95,760 in 2010 and \$84,687 in 2009	151,352	162,620
Net deferred financing, acquisition costs and other charges, less current portion	30,819	31,473
Other assets	29,313	34,765
TOTAL OTHER ASSETS	211,484	228,858
	\$ 1,929,500	\$ 1,856,075

	<i>June 30,</i>	
	<i>2010</i>	<i>2009</i>
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	\$ 16,039	\$ 12,050
Current portion of long-term debt and capital lease obligations	28,131	31,306
Current portion of estimated fair value of derivatives	10,740	10,921
Accounts payable and accrued expenses	99,227	94,712
Accrued salaries, compensated absences and amounts withheld	47,280	49,569
Estimated amounts due to third-party payors, net	10,155	6,398
TOTAL CURRENT LIABILITIES	211,572	204,956
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	1,054,842	1,040,944
Estimated fair value of derivatives, less current portion	123,560	115,296
Deferred revenue	20,445	21,078
Estimated professional liability self-insurance	9,541	10,012
Other long-term liabilities	12,628	13,885
TOTAL LIABILITIES	1,432,588	1,406,171
MINORITY INTERESTS	168,410	165,500
COMMITMENTS AND CONTINGENCIES - Notes D, F, G, and N		
NET ASSETS		
Unrestricted net assets	317,434	272,049
Temporarily restricted net assets	10,941	12,178
Permanently restricted net assets	127	177
TOTAL NET ASSETS	328,502	284,404
	\$ 1,929,500	\$ 1,856,075

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

*Consolidated Statements of Operations and Changes in Net Assets
(Dollars in Thousands)*

	<i>Year Ended June 30,</i>	
	<i>2010</i>	<i>2009</i>
CHANGES IN UNRESTRICTED NET ASSETS:		
Revenue, gains and support:		
Net patient service revenue	\$ 928,270	\$ 822,898
Other operating revenue	16,009	17,046
TOTAL REVENUE, GAINS AND SUPPORT	944,279	839,944
Expenses:		
Salaries and wages	325,663	296,073
Physician salaries and wages	54,489	38,240
Contract labor	6,546	16,899
Employee benefits	68,362	61,134
Fees	82,542	71,896
Supplies	175,469	156,418
Utilities	16,193	15,548
Other	67,640	57,974
Depreciation	68,436	56,373
Amortization	13,123	12,150
Estimated provision for bad debts	7,961	5,011
Interest and taxes	42,264	45,225
TOTAL EXPENSES	928,688	832,941
OPERATING INCOME	15,591	7,003
Nonoperating gains (losses):		
Interest and dividend income	17,298	19,105
Net realized gains (losses) on the sale of securities	2,385	(6,552)
Net unrealized gains (losses) on securities	15,018	(62,582)
Derivative related income	4,394	4,772
Loss on termination of derivatives - Note D	-	(2,785)
Loss on early extinguishment of debt - Note F	(3,029)	-
Change in estimated fair value of derivatives	(8,607)	(42,128)
Other nonoperating gains (losses)	512	(306)
Net assets released from restrictions used for operations	1,113	793
NET NONOPERATING GAINS (LOSSES)	29,084	(89,683)

	<i>Year Ended June 30,</i>	
	<i>2010</i>	<i>2009</i>
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES, BEFORE DISCONTINUED OPERATIONS AND MINORITY INTERESTS	44,675	(82,680)
Gain on sale of and deficit of revenue, gains and support over expenses and losses from discontinued operations	-	2,519
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES BEFORE MINORITY INTERESTS	44,675	(80,161)
Minority interest in consolidated subsidiaries' net (gain) loss	(3,162)	546
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	41,513	(79,615)
Other changes in unrestricted net assets:		
Pension and other defined benefit plan adjustments	1,589	(512)
Net assets released from restrictions used for the purchase of property, plant and equipment	2,283	3,095
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	45,385	(77,032)
CHANGES IN TEMPORARILY RESTRICTED NET ASSETS:		
Restricted grants and contributions	2,159	3,929
Net assets released from restrictions	(3,396)	(3,888)
(DECREASE) INCREASE IN TEMPORARILY RESTRICTED NET ASSETS	(1,237)	41
CHANGES IN PERMANENTLY RESTRICTED NET ASSETS:		
Net assets released from restrictions by donor	(50)	-
INCREASE (DECREASE) IN TOTAL NET ASSETS	44,098	(76,991)
NET ASSETS, BEGINNING OF YEAR	284,404	361,395
NET ASSETS, END OF YEAR	\$ 328,502	\$ 284,404

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2010</i>	<i>2009</i>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase (decrease) in net assets	\$ 44,098	\$ (76,991)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	81,982	68,967
Loss on early extinguishment of debt	3,029	-
Loss on termination of derivatives	-	3,245
Change in estimated fair value of derivatives	8,607	42,128
Equity in net income of joint ventures	(1,117)	(723)
Gain on sale of assets held for resale and disposal of assets	(548)	(568)
Amounts received on interest rate swap settlements	(4,394)	(4,772)
Minority interest in consolidated subsidiaries' net (gain) loss	3,162	(546)
Income recognized through forward sale agreements	(864)	(796)
Capital Appreciation Bond accretion and other	2,071	1,678
Restricted contributions	(2,159)	(3,929)
Pension and other defined benefit plan adjustments	598	512
Increase (decrease) in cash due to change in:		
Net patient accounts receivable	3,232	724
Other receivables, net	(1,246)	(4,107)
Inventories and prepaid expenses	(4,640)	1,843
Trading securities	(13,368)	183,450
Other assets	(1,159)	(4,144)
Accrued interest payable	3,989	1,900
Accounts payable and accrued expenses	(855)	8,551
Accrued salaries, compensated absences and amounts withheld	(2,289)	3,500
Estimated amounts due from/to third-party payors, net	3,757	6,492
Other long-term liabilities	(201)	(1,363)
Estimated professional liability self-insurance	(471)	(610)
Total adjustments	<u>77,116</u>	<u>301,432</u>
NET CASH PROVIDED BY OPERATING ACTIVITIES	121,214	224,441
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property, plant and equipment, property held for resale and property held for expansion, net	(172,240)	(119,741)
Additions to goodwill	-	(16,097)
Net decrease (increase) in assets limited as to use	50,362	(28,152)
Purchases of held-to-maturity securities	(28,175)	-
Net sale or distribution from joint ventures and unconsolidated affiliates	1,162	384

	<i>Year Ended June 30,</i>	
	<i>2010</i>	<i>2009</i>
Proceeds from sale of property, plant and equipment and property held for resale	9,565	2,056
NET CASH USED IN INVESTING ACTIVITIES	(139,326)	(161,550)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt and capital lease obligations, including deposits to escrow	(226,315)	(36,820)
Payment of acquisition and financing costs	(3,565)	(3,214)
Proceeds from issuance of long-term debt and other financing arrangements	235,158	135,780
Net amounts received on interest rate swap settlements	4,394	4,772
Restricted contributions received	3,382	5,767
Distribution to minority shareholders and other	(252)	(158)
NET CASH PROVIDED BY FINANCING ACTIVITIES	12,802	106,127
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	(5,310)	169,018
CASH AND CASH EQUIVALENTS, beginning of year	239,836	70,818
CASH AND CASH EQUIVALENTS, end of year	\$ 234,526	\$ 239,836

SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:

Cash paid for interest	\$ 38,666	\$ 45,218
Cash paid for federal and state income taxes	\$ 446	\$ 664
Construction related payables in accounts payable and accrued expenses	\$ 14,847	\$ 9,246
Increase in receivable from sale of property	\$ 1,483	\$ -
Decrease in land held for expansion related to property exchange transaction	\$ 3,432	\$ -

During the years ended June 30, 2010 and 2009, the Alliance refinanced previously issued debt of \$184,050 and \$9,445, respectively.

As discussed in Note A, the Alliance acquired a 50.1% interest in Johnston Memorial Hospital, Inc. (JMH) in fiscal year 2009. JMH is consolidated within the accompanying financial statements as of the acquisition date, April 1, 2009. The consolidated cash flows include JMH's cash flows since the acquisition date.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE A--ORGANIZATION AND OPERATIONS

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The initial funds for the establishment of the Alliance in 1945 were provided by individuals and various institutions. Membership of the Alliance consists of individuals and institutions who have contributed at least \$100 to the capital fund of the Alliance and are entitled to vote at the annual election of the Board of Directors.

The primary operations of the Alliance consist of eleven acute and specialty care hospitals, as follows:

- Johnson City Medical Center (JCMC) - licensed for 645 beds
- Indian Path Medical Center (IPMC) - licensed for 322 beds
- Smyth County Community Hospital (SCCH) - licensed for 279 beds
- Johnston Memorial Hospital (JMH) - licensed for 135 beds
- Norton Community Hospital (NCH) - licensed for 129 beds
- Sycamore Shoals Hospital (SSH) - licensed for 121 beds
- North Side Hospital (NSH) - licensed for 91 beds
- Russell County Medical Center (RCMC) - licensed for 78 beds
- Johnson City Specialty Hospital (JCSH) - licensed for 23 beds
- Dickenson Community Hospital (DCH) - licensed for 25 beds
- Johnson County Community Hospital (JCCH) - licensed for 2 beds

Effective April 1, 2009, the Alliance acquired an interest in Johnston Memorial Hospital, Inc. (JMH), a 135 bed general acute care hospital located in Abingdon, Virginia. JMH is also the sole member of Abingdon Physician Partners (APP), a non-taxable corporation that owns and manages physician practices. The Alliance acquired a 50.1% interest in JMH by providing \$132,000 to JMH (designated for capital). Johnston Memorial Healthcare Foundation, Inc. (JMHF), a hospital supporting organization, retained a 49.9% interest in JMH. The assets and liabilities of JMH at April 1, 2009 have been consolidated by the Alliance at their carrying value as of that date. The following is condensed, unaudited financial information related to JMH as of March 31, 2009:

Current Assets	\$	23,516
Other Assets		139,576
		<hr/>
Total	\$	163,092
		<hr/>
Liabilities	\$	47,440
Net Assets (initial membership interest of JMHF)		115,652
		<hr/>
	\$	163,092
		<hr/>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE A--ORGANIZATION AND OPERATIONS - Continued

The activities and accounts of JMH since April 1, 2009 are included in the accompanying consolidated financial statements.

The Alliance has a 50.1% interest in NCH. NCH is also the sole member or shareholder of DCH and Norton Community Physician Services, LLC (NCPS), a taxable corporation that consists of physician practices and a pharmacy and; Community Home Care (CHC), a taxable corporation that provides home medical equipment. The activities and accounts of NCH are included in the accompanying consolidated financial statements.

The Alliance also has an 80% interest in SCCH. SCCH is the sole shareholder of Southwest Community Health Services, Inc. (SWCH), a taxable entity that operates a pharmacy and provides other health services. The activities and accounts of SCCH are included in the accompanying consolidated financial statements.

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices and provides other healthcare services to patients in Tennessee and Virginia. BRMM also operates as a medical office real estate developer by owning, selling and leasing real estate to physician practices and other entities. BRMM is either the sole shareholder, a significant shareholder, or member of the following organizations:

Blue Ridge Physician Group, Inc. (BRPG): A company that contracts with physicians to provide services to BRMM physician practices.

Mountain States Properties, Inc. (MSPI): An entity that owns and manages certain real estate (primarily medical office buildings) and provides rehabilitation and fitness services. In addition, MSPI is a counter-party to various financing transactions, including interest rate swaps.

Mediserve Medical Equipment of Kingsport, Inc. (Mediserve): A company that provides durable medical equipment services.

Kingsport Ambulatory Surgery Center (KASC) (d.b.a. Kingsport Day Surgery): A joint venture operating as an outpatient surgery center which performs procedures primarily in otolaryngology, orthopedics, ophthalmology, and general surgery. BRMM has a 43% ownership of KASC at June 30, 2010 and 2009; however, BRMM maintains control over KASC. As such, the accounts and activities of KASC are included in the accompanying consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE A--ORGANIZATION AND OPERATIONS - Continued

Piney Flats Urgent Care (PFUC): A for-profit entity that provides urgent care patient services.

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc. (MSF), a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance. The Alliance is also the beneficiary of Mountain States Health Alliance Auxiliary (Auxiliary), a not-for-profit organization formed to coordinate volunteer activities of the Alliance. The activities and accounts of MSF and the Auxiliary are included in the accompanying consolidated financial statements.

Prior to 2010, the Alliance was a majority shareholder of PHP of Tri-Cities, LLC (PHPT). PHPT's primary purpose was to hold an equity interest in another organization engaged in and related to the financing and/or delivery of healthcare services. During 2009, PHPT's equity interest in this other entity was reacquired by that entity (PHP Companies, Inc. (PHP)). PHPT sold the interest to PHP for a net gain of \$2,519. The activities of PHPT and gain on sale are included in the accompanying 2009 consolidated financial statements as "discontinued operations". During 2009, PHPT was reorganized under the business name of Integrated Solutions Health Network, LLC (ISHN). Concurrent with the reorganization, the Alliance purchased the remaining ownership interest of Health Alliance PHO, Inc. (PHO), an entity in which the Alliance previously held a minority interest. The net assets of the PHO were merged into ISHN on June 30, 2009. The primary function of ISHN is to establish, operate and administer a provider-sponsored health care delivery network.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation: The accompanying consolidated financial statements include the accounts of the Alliance and its subsidiaries after elimination of all significant intercompany accounts and transactions. The Alliance classifies those activities directly associated with its mission of providing healthcare services, as well as other activities deemed significant to its operations, as operating activities.

A minority interest is recorded to recognize the ownership or membership interests of third parties with respect to JMH, NCH, SCCH, KASC, PFUC and ISHN.

In 2011, the Alliance will adopt recently issued accounting standards, which change the accounting for, and the financial statement presentation of, noncontrolling interests in a subsidiary within consolidated financial statements. This new standard requires that a noncontrolling interest in the equity of a subsidiary be accounted for and reported as equity, provides revised guidance on the treatment of net income and losses attributable to the noncontrolling interest and changes in ownership interests in a subsidiary and requires additional disclosures that identify and distinguish between the interests of the controlling and noncontrolling owners. Management of the

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Alliance is currently assessing the potential impact of the adoption of this new guidance on the consolidated financial statements.

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.

Accounting Standards Codification: In June 2009, the Financial Accounting Standards Board (FASB) issued Statement of Financial Accounting Standard (SFAS) No. 168, *The FASB Accounting Standards Codification and the Hierarchy of Generally Accepted Accounting Principles (GAAP) - a Replacement of FASB Statement No. 162*. This Statement modifies the GAAP hierarchy by establishing only two levels of GAAP, authoritative and nonauthoritative literature. Effective September 2009, the FASB Accounting Standards Codification (ASC), also known collectively as the "Codification," is considered the single source of authoritative U.S. accounting and reporting standards. FASB ASC 105-10, *Generally Accepted Accounting Principles*, became applicable during fiscal year 2010. All accounting references have been updated, and therefore SFAS references have been replaced with ASC references. The adoption of the ASC did not have an impact on the consolidated financial statements.

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 on the Consolidated Balance Sheets.

Investments: Investments as reported in the Consolidated Balance Sheets includes trading securities, held-to-maturity securities and assets limited as to use (Note C). FASB ASC 958-320, *Investments—Debt and Equity Securities*, allows not-for-profit organizations to report in a manner similar to business entities by identifying securities as available-for-sale or held-to-maturity and to exclude the unrealized gains and losses on those securities from the Performance Indicator (as defined below). Investments which the Alliance has the positive intent and ability to hold to maturity are considered as held-to-maturity. Substantially all other investments (including assets limited as to use) are considered as trading securities. Management annually evaluates the held-to-maturity investment portfolio and recognizes any "other-than-temporary" losses as deductions from the Performance Indicator. Management's 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, 2010.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

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 fair market value pursuant to FASB ASC 825, *Financial Instruments*. Guaranteed investment contracts are reported at contract value.

Realized gains and losses on trading securities and assets limited as to use are computed using the specific identification method for cost determination. Interest and dividend income is reported net of related investment fees.

Investments in joint ventures are reported under the equity method of accounting, which approximates the Alliance's equity in the underlying net book value, unless the ownership structure requires consolidation. Other assets include investments in joint ventures of \$2,418 and \$2,463 at June 30, 2010 and 2009, respectively.

Inventories: Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market.

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 equipment held under capital lease is shown as a part of depreciation expense and accumulated depreciation in the accompanying consolidated financial statements.

Interest costs incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The amount capitalized is net of investment earnings on assets limited as to use derived from borrowings designated for capital assets. Renewals and betterments are capitalized and depreciated over their useful life, whereas costs of maintenance and repairs are expensed as incurred.

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 2010 and 2009.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Property held for resale and property held for expansion primarily represent land contributed to, or purchased by, the Alliance plus costs incurred to develop the infrastructure of such land. Other assets include property held for resale and property held for expansion of \$9,135 and \$12,542, respectively, at June 30, 2010 and 2009. 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 2010 and 2009.

Goodwill: Goodwill represents the difference between the acquisition cost of assets and the estimated fair value of net tangible and any separately identified intangible assets. The Alliance amortizes goodwill associated with its not-for-profit subsidiaries under the straight-line method over various estimated useful lives. For goodwill acquired by its for-profit subsidiaries, the Alliance does not amortize the goodwill and annually performs impairment testing in accordance with FASB ASC 350, *Intangibles – Goodwill and Other*. At June 30, 2010, management does not believe any goodwill so tested to be impaired.

FASB ASC 350, *Intangibles - Goodwill and Other*, will require, among other things, that goodwill associated with not-for-profit entities be evaluated annually for impairment, including a transitional impairment test upon adoption, and that such goodwill no longer be amortized. The Alliance will be required to adopt this standard in 2011 and will perform such transitional testing as of July 1, 2010 prior to December 31, 2010. While the Alliance is evaluating the potential impact of the adoption of this standard, including the transitional impairment testing, it is currently not possible to determine the effects, if any, the adoption of this standard will have on the consolidated financial statements.

Deferred Financing, Acquisition Costs and Other Charges: Deferred financing costs are amortized over the life of the respective bond issue principally using the average bonds outstanding method. Other intangible assets include licenses and similar assets and are being amortized over the intangible's estimated useful life under the straight-line method.

Prior to 2009, the Alliance routinely financed interest rate swap and other derivative transaction issuance costs through modification of future settlement terms. As such, the unamortized issuance costs of these derivatives are included as deferred financing costs in the accompanying Consolidated Balance Sheets and are being amortized over the term of the respective derivative instrument. The unpaid issuance costs are included as a part of the estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. Beginning in 2009, interest rate swap and derivative transaction issuance costs are expensed as incurred, in accordance with FASB ASC 820, *Fair Value Measurements and Disclosures* (FASB ASC 820). No such costs were incurred in 2010 and 2009.

Derivative Financial Instruments: As further described in Note D, the Alliance is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

and have been presented at estimated fair market value in the accompanying Consolidated Balance Sheets. These fair values are based on the estimated amount the Alliance would receive, or be required to pay, to enter into equivalent agreements at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims (Note G) 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 payors. 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 payors 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, TennCare and other third-party payment programs. Current operations include a provision for bad debts in the Consolidated Statements of Operations and Changes in Net Assets estimated based upon the age of the patient accounts receivable, prior experience 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 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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

which no payment is anticipated and, as such, charges at established rates are not included in net patient service revenue.

In addition to the charity care services described above, the Alliance provides a number of other services to benefit the poor for which little or no payment is received. Medicare, 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 (Deficit) of Revenue, Gains and Support Over Expenses and Losses: The Consolidated Statements of Operations and Changes in Net Assets includes the caption *Excess (Deficit) 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 transfers of assets to and from affiliates and contributions of long-lived assets or amounts restricted to the purchase of long-lived assets, as well as pension and related adjustments.

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. Taxable entities account for income taxes in accordance with FASB ASC 740, *Income Taxes* (Note L). The Alliance has no significant uncertain tax positions at June 30, 2010 and 2009.

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 Statements of Operations and Changes in Net Assets as net assets released from restrictions. Permanently restricted net assets have been restricted by donors to be maintained by the Alliance in perpetuity.

Fair Value Measurement: In 2009, the Hospital adopted FASB ASC 820, *Fair Value Measurements and Disclosures*, which defines fair value, establishes a framework for measuring fair value under generally accepted accounting principles and expands disclosures about fair value measurements. There was no significant impact on the consolidated financial statements as a result of adopting this standard (Note Q).

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

In January 2010, the FASB issued ASU 2010-06, *Fair Value Measurements and Disclosures (Topic 820) - Improving Disclosures about Fair Value Measurements* (ASU 2010-06). ASU 2010-06 requires new disclosures regarding significant transfers in and out of Levels 1 and 2, as well as information about activity in Level 3 fair value measurements, including presenting information about purchases, sales, issuances and settlements on a gross versus a net basis in the Level 3 activity roll forward. In addition, ASU 2010-06 clarifies existing disclosures regarding input and valuation techniques, as well as the level of disaggregation for each class of assets and liabilities. The Alliance will adopt ASU 2010-06 in 2011, except for the disclosures related to purchases, sales, issuance and settlements, which will be effective for the Alliance beginning July 1, 2012. The adoption of ASU 2010-06 is not expected to have an impact on the Alliance's consolidated financial statements.

Subsequent Events: The Alliance evaluated all events or transactions that occurred after June 30, 2010, through October 25, 2010, the issuance date of the consolidated financial statements. During this period management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2010 consolidated financial statements, other than as discussed in Note D and in Note F.

Reclassifications: Certain 2009 amounts have been reclassified to conform with the 2010 presentation in the accompanying consolidated financial statements.

NOTE C--INVESTMENTS

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

	<u>2010</u>	<u>2009</u>
Designated or restricted:		
Under safekeeping agreements	\$ 52,050	\$ 40,604
Under guarantee agreements	89,486	86,364
By Board for capital improvements	2,776	-
Under bond indenture agreements:		
For debt service and interest payments	78,612	60,828
For capital acquisitions	76,241	161,731
	<u>299,165</u>	<u>349,527</u>
Less: amount required to meet current obligations	<u>(25,092)</u>	<u>(22,492)</u>
	<u>\$ 274,073</u>	<u>\$ 327,035</u>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE C--INVESTMENTS- Continued

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

	<u>2010</u>		<u>2009</u>
Cash, cash equivalents and money market funds	\$ 170,897	\$	173,859
U.S. Government securities	1,795		1,795
U.S. Agency securities	12,319		18,827
Guaranteed investment contracts	114,154		155,046
	<u>\$ 299,165</u>	\$	<u>349,527</u>

Trading securities consist of the following at June 30:

	<u>2010</u>		<u>2009</u>
Cash, cash equivalents and money market funds	\$ 4,799	\$	14,622
U.S. Government securities	3,137		-
U.S. Agency securities	13,760		16,013
Corporate and foreign bonds	15,063		10,014
Municipal obligations	1,461		3,101
U.S. equity securities	142,816		161,284
Other	28,608		30,031
	209,644		235,065
Less: amount classified as current	(3,375)		(4,825)
	<u>\$ 206,269</u>	\$	<u>230,240</u>

Held-to-Maturity securities consist of the following at June 30:

	<u>2010</u>		<u>2009</u>
Cash, cash equivalents and money market funds	\$ 1,131	\$	452
Corporate and foreign bonds	103,968		39,504
Municipal obligations	1,315		209
	<u>\$ 106,414</u>	\$	<u>40,165</u>

Held-to-maturity securities had gross unrealized gains and losses of \$5,525 and \$607, respectively, at June 30, 2010 and \$831 and \$110, respectively at June 30, 2009. At June 30, 2010, the Alliance held one security within the held-to-maturity portfolio with a fair value and unrealized loss of \$591

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE C--INVESTMENTS- Continued

and \$166, respectively, which had been at an unrealized loss position for over one year. At June 30, 2009, no securities held in the held-to-maturity portfolio had been in an unrealized loss position for over one year. At June 30, 2010, the contractual maturities of held-to-maturity securities were \$13,389 due in one year or less, \$48,447 due from one to five years and \$44,578 due after five years. At June 30, 2009, the contractual maturities of held-to-maturity securities were \$733 due in one year or less, \$21,190 due from one to five years and \$18,242 due after five years.

At June 30, 2010 and 2009, the Alliance held investments in certain limited partnerships and hedge funds of \$28,608 and \$30,031, respectively, that have a wide range of investment strategies with various levels of risk. These funds are included within trading securities and do not have readily determinable fair values. The funds are reported at fair market value pursuant to FASB ASC 825, *Financial Instruments*.

The Alliance has investments in several joint ventures and corporations which are accounted for under the equity method of accounting.

As a part of the acquisition of membership interests in JMH, SCCH and NCH, the Alliance has committed to invest \$132,000, \$48,100, and \$45,000, respectively. Cumulative amounts expended at June 30, 2010 under these commitments are approximately \$73,600.

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is a party to a number of derivative transactions. These derivatives have not been designated as hedges and, as such, are valued at estimated fair value in the accompanying Consolidated Balance Sheets. Management's primary objective in holding such derivatives is to introduce a variable rate component into its fixed rate debt structure. Under the terms of these agreements, changes in the interest rate environment could have a significant effect on the Alliance.

These derivative agreements require that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. Such investments are included as assets limited as to use. As of June 30, 2010, management believes the Alliance was fully collateralized with respect to the derivative agreements and management does not believe such collateral is exposed to third-party credit risk. Further, certain of the agreements contain requirements regarding maintenance of financial and liquidity ratios. Management has represented the Alliance is in compliance with all such covenants at June 30, 2010.

Interest Rate Swaps: The Alliance is a party to six interest rate swap agreements with Merrill Lynch as the counterparty. A liability, representing the estimated fair value of these swaps, of \$33,910 and \$37,274 was recognized by the Alliance as of June 30, 2010 and 2009, respectively.

MOUNTAIN STATES HEALTH ALLIANCE

*Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE D--DERIVATIVE TRANSACTIONS - Continued

The following is a summary of five of these interest rate swap agreements at June 30, 2010:

<i>Swap</i>	<i>Notional Amount</i>	<i>Term</i>	<i>Payments by:</i>	
			<i>Counterparty</i>	<i>Alliance</i>
A	\$ 170,000	4/2008-4/2026	0.51% through April 2011, then 71.10% of USD-ISDA Swap Rate	0.00% through April 2011, then USD-SIFMA Municipal Swap Index
B	95,000	4/2008-4/2026	0.52% through April 2011, then 71.18% of USD-ISDA Swap Rate	0.00% through April 2011, then USD-SIFMA Municipal Swap Index
C	173,030	4/2008-4/2034	0.53% through April 2011, then 72.35% of USD-ISDA Swap Rate	0.00% through April 2011, then USD-SIFMA Municipal Swap Index
D	82,055	12/2007-7/2033	USD-LIBOR-BBA through June 2012, then 67.00% USD-LIBOR-BBA	4.411% through June 2012, then 3.805%
E	50,000	2/2008-7/2038	67.00% of USD-LIBOR-BBA less 0.07%	3.41%

Deferred financing and acquisition costs, net of amortization, include \$6,823 and \$7,167 at June 30, 2010 and 2009, respectively, related to these swaps.

In addition to the swaps described above, the Alliance and Merrill Lynch are also parties to a total return swap in the notional amount of \$23,900. No deferred financing and acquisition costs were recorded as a result of this transaction. The agreement consists of the following:

- An agreement that requires the Alliance to pay a variable rate of USD-SIFMA Municipal Swap Index through July 1, 2012 (or termination of the swap) on a notional amount equal to the outstanding 2001A Hospital Revenue and Improvement Bonds (the 2001A Reference Bonds). The Alliance receives a fixed rate of 6.25% on the outstanding 2001A Reference Bonds.
- A “total return provision” under which the Alliance will pay (or receive) an amount equal to the product of the outstanding 2001A Reference Bonds multiplied by the difference between the outstanding 2001A Reference Bonds and the 2001A Reference Bonds’ market price at termination, as defined in the agreement. In the event the swap does not terminate prior to July 1, 2012, there would be no settlement of this component as there would be no outstanding 2001A Reference Bonds.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE D--DERIVATIVE TRANSACTIONS - Continued

During 2009, the Alliance terminated an interest rate swap with a notional amount of \$318,315 to which Merrill Lynch was the counterparty. As a result of the termination, the Alliance wrote-off deferred financing and issuance costs of \$3,220 and recognized a gain on termination of \$3,054, which are included in loss on termination of derivatives in the accompanying 2009 Consolidated Statement of Operations and Changes in Net Assets.

The Alliance is party to a total return swap with Lehman Brothers as the counterparty. Lehman Brothers filed for bankruptcy in September 2008. The Alliance subsequently received notification from Lehman Brothers Special Financing, Inc. indicating the intent of the counterparty to terminate this agreement effective January 1, 2009. As of October 25, 2010, the Alliance and Lehman Brothers Special Financing, Inc. have been unable to reach a settlement agreement. In September 2010, the Alliance was issued a subpoena to furnish certain documentation related to the transaction. A protocol has been put into place by the bankruptcy court whereby the parties are to undergo alternate dispute resolution. If a settlement is not reached through the alternate dispute resolution process, the matter will be subject to non-binding arbitration. Legal counsel has advised management that the court ordered process may take several years.

The fair value of these swaps is undeterminable at January 1, 2009, as prior to the termination date Lehman Brothers liquidated the underlying referenced securities, making a valuation not commercially viable. An estimated liability of \$10,740 and \$10,921 was recognized by the Alliance as of June 30, 2010 and 2009, respectively. Management believes that the liability as recorded at June 30, 2010 is sufficient to cover any exposure arising from litigation in this matter. However, it is reasonably possible management's estimate may change in the near term, although the amount of any change cannot be estimated. Due to the termination of this agreement, the estimated liability is included as a current liability in the accompanying Consolidated Balance Sheets.

A third party holds collateral with a fair market value of approximately \$13,570 and \$13,252, respectively, at June 30, 2010 and 2009, with respect to these derivative agreements. Such collateral is included as current assets limited as to use. Additionally, during 2009 the Alliance wrote-off deferred financing and issuance costs related to these swaps of \$2,619 which is included in loss on termination of derivatives in the accompanying 2009 Consolidated Statement of Operations and Changes in Net Assets.

The arrangement consists of nine agreements each with three separate components (described below) with notional values of \$23,600, \$8,000, and \$8,750 each. The swaps generally consist of the following:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE D--DERIVATIVE TRANSACTIONS - Continued

- An arrangement that calls for the Alliance to pay a variable rate (SIFMA Municipal Swap Index) plus certain fixed payment amounts and receive a payment equal to the interest paid by the Alliance on a portion of its early extinguished, but still outstanding, 2000A and 2000B Hospital Mortgage Revenue Refunding Bonds (the Reference Bonds) (whose fixed rates range from 7.50% to 7.75%).
- An arrangement that requires the Alliance to pay a fixed rate of 4.211% through either July 1, 2025, 2029 or 2033 (or termination of the swap) on the outstanding Reference Bonds and receive a variable rate of 67% of USD-LIBOR-BBA on the outstanding Reference Bonds; and
- A “total return provision” under which the Alliance will pay (or receive) the difference between the outstanding Reference Bonds, multiplied by 132%, less the fair value of the Reference Bonds on the date of termination and any fixed interest payments made under the arrangements described above. In the event the swaps do not terminate prior to their stated termination dates (2025, 2029 or 2033), there would be no settlement of this component as there would be no outstanding Reference Bonds.

The swap also contains an agreement that consists of two separate components:

- An arrangement that requires the Alliance to pay a fixed rate of 2.98% through July 1, 2016 (or termination of the swap) on the outstanding, but previously defeased, 1991 Hospital Revenue and Improvement Bonds (the 1991 Reference Bonds) and receive a variable rate of 67% of USD-LIBOR-BBA on the outstanding 1991 Reference Bonds; and
- A “fixed payor provision” under which the Alliance will pay (or receive) the difference between the outstanding 1991 Reference Bonds multiplied by 100% and any fixed interest payments made as required under the agreement minus the outstanding 1991 Reference Bonds multiplied by the average market price at termination. In the event the swaps do not terminate prior to their stated termination date (2016), there would be no settlement of this component as there would be no outstanding 1991 Reference Bonds.

Interest Rate Swap Option: In June 2004, the Alliance entered into an agreement with Bear Stearns (acquired by JP Morgan) whereby Bear Stearns has purchased from the Alliance an option to enter into an interest rate swap agreement (swaption) with the Alliance on July 1, 2011, which is an optional redemption date related to the Alliance’s early extinguished 2000A and 2000B Bonds (Note F). The purpose of this agreement was to effectively sell the call features related to the early extinguished Series 2000A and 2000B Bonds. As consideration under this agreement, the Alliance

MOUNTAIN STATES HEALTH ALLIANCE

*Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE D--DERIVATIVE TRANSACTIONS - Continued

received a total of \$42,500 in upfront payments as the swaption premium. Such amounts were initially recorded as estimated fair value of derivatives in the Consolidated Balance Sheets. Beginning 30 calendar days prior to July 1, 2011 and terminating 30 calendar days prior to July 1, 2015, the counterparty has the periodic right to exercise the swaption.

The underlying interest rate swap transactions to which the swaption transaction relates have the following terms:

<i>Swap</i>	<i>Notional Amount</i>	<i>Term</i>	<i>Payments by:</i>	
			<i>Counterparty</i>	<i>Alliance</i>
2000A	Ranging from \$148,170 through July 1, 2018 to \$23,000 through July 2033	30 days following the exercise date through July 2033	64% of USD-LIBOR-BBA	Fixed amounts ranging from 7.13% upon execution to 7.50% through July 2033, based on notional amount
2000B	Ranging from \$76,240 through July 1, 2021 to \$8,800 through July 2033	30 days following the exercise date through July 2033	64% of USD-LIBOR-BBA	Fixed amounts ranging from 7.54% upon execution to 8.00% through July 2033, based on notional amount

Management anticipates the swaption will be settled by a payment of cash and not by the execution of an actual interest rate swap transaction, should the counterparty not elect to terminate.

The Alliance retains the right to terminate the swaption at any time prior to May 17, 2011 at its fair market value. A liability of \$89,650 and \$78,022, representing the estimated fair value of the swaption at June 30, 2010 and 2009, respectively, is included in estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. As a derivative financial instrument, this swaption is extremely sensitive to changes in long-term interest rates and other elements in the financial marketplace. As such, estimates of fair value are subject to significant changes in the near term.

Deferred financing and acquisition costs include \$434 and \$868 at June 30, 2010 and 2009, respectively, related to the costs of this transaction. The change in estimated fair value of derivatives in the accompanying Statement of Operations and Changes in Net Assets for 2010 and 2009 includes an unrealized loss of \$11,628 and \$9,195, respectively, related to this derivative.

Forward Sale Agreements: In June 2004, the Alliance entered into two related forward sale agreements with the counterparty to the swaption agreements and the Master Trustee of the Series 2000 Bonds. The forward sale agreements originally related to the Debt Service Reserve Fund and to the Debt Service Fund, respectively, (collectively, the "Funds"), as established under provisions

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE D--DERIVATIVE TRANSACTIONS - Continued

of the Master Trust Indenture related to the issuance of the Series 2000 Bonds. In consideration of the future earnings on the Funds, the counterparty paid the Master Trustee a total of \$30,000 during 2005, to be held on behalf of the Alliance. In June 2006, one of these agreements was amended to also relate to the Series 2000C, 2000D, 2006A and 2006B Bonds, and to remove the Series 2000A Bonds from consideration under the agreement. As the original intent of these Funds was to secure debt service payments under the above referenced Bonds, the agreement requires these funds to be held under a guaranty agreement as further described below.

In connection with the issuance of the Series 2007 Bonds and the derecognition of a portion of the Series 2000A Bonds, all of the outstanding Series 2000B Bonds, and all of the outstanding 2006B Bonds (Note F), one of these agreements as it relates to the Series 2000A and 2000B Bonds was partially terminated. As such, during 2008 the Alliance reduced its liability with respect to the portion related to the Series 2000A and 2000B Bonds, and paid the counterparty \$6,186 under the terms of the agreement. Management has represented that the other agreement will be amended in fiscal year 2011 to include the Series 2010A Bonds and to remove the Series 2000B and 2006B Bonds. As such, the Alliance has not reduced its liability for the portion related to the Series 2000B or 2006B Bonds under this agreement.

A liability of \$19,864 and \$20,728 representing the unamortized payments from the counterparty is included as part of deferred revenue in the accompanying Consolidated Balance Sheets as of June 30, 2010 and 2009, respectively. Amounts are being recognized as investment income over the life of the agreements.

Pursuant to these agreements, the counterparty required that the Alliance's obligations under the swaption and forward sale agreements be collateralized under a guarantee agreement in favor of the counterparty. Due to various requirements of the Master Trust Indenture, the Alliance transferred to MSF a total of \$42,500 that was in turn deposited with the counterparty as collateral in a Guaranteed Investment Contract (GIC). Amounts received under the forward sale agreements were also deposited into the GIC. All GIC deposits earn interest compounded at 4.14% for the first year, and at 3.5% thereafter through July 1, 2011. The GIC deposits as of June 30, 2010 and 2009 totaled \$89,486 and \$86,364, respectively.

In the event the counterparty does not exercise the swaption, the Alliance will realize the swaption premium, forward sale amounts, and earnings on the GIC when the swaption expires on July 1, 2015. In the event the Alliance settles with the counterparty, the Alliance would in effect lose the earnings on these funds.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE E--PROPERTY, PLANT AND EQUIPMENT

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

	<u>2010</u>	<u>2009</u>
Land	\$ 60,351	\$ 51,484
Buildings and leasehold improvements	404,790	407,063
Property and improvements held for leasing	84,421	96,457
Equipment	479,523	424,738
Equipment held under capital lease	22,679	25,032
	<u>1,051,764</u>	<u>1,004,774</u>
Less: Allowances for depreciation and amortization	(569,913)	(505,600)
	481,851	499,174
Construction in progress (Note N)	213,747	91,395
	<u>\$ 695,598</u>	<u>\$ 590,569</u>

Accumulated depreciation and amortization on property and improvements held for leasing purposes is \$21,543 and \$21,829 at June 30, 2010 and 2009, respectively. Net interest capitalized was \$11,117 and \$3,744 for the years ended June 30, 2010 and 2009, respectively.

The Alliance is constructing two new hospital facilities, including Franklin Woods Community Hospital (FWCH) in Washington County, Tennessee and a replacement facility for JMH and has plans to construct a replacement facility at SCCH which will commence in 2011. The Alliance is also performing various renovations on existing hospital facilities. These projects may have a significant impact on the remaining useful life of the existing hospital facilities. Where commitments to construct new facilities have been finalized, management has adjusted the estimated useful lives of existing hospital facilities.

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

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

Description	Maturities	Rates	Outstanding Balance	
			2010	2009
2010A Hospital Refunding Revenue Bonds, net of unamortized premium of \$1,096 at June 30, 2010	\$38,660 uninsured serially, through 2020 \$14,985 uninsured term bonds, due July 1, 2025 \$19,385 uninsured term bonds, due July 1, 2030 \$39,570 uninsured term bonds, due July 1, 2038 \$55,480 uninsured term bonds, due July 1, 2038	3.00% to 5.00% 5.38% 5.63% 6.50% 6.00%	\$ 169,176	\$ -
2010B Hospital Refunding Revenue Bonds, net of unamortized premium of \$753 at June 30, 2010	\$27,330 uninsured serially, through 2020 \$4,355 uninsured term bonds, due July 1, 2023 \$4,250 uninsured term bonds, due July 1, 2028	2.50% to 5.00% 5.00% 5.50%	36,688	-

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

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

Description	Maturities	Rates	Outstanding Balance	
			2010	2009
2009A Hospital Revenue Bonds, net of unamortized discount of \$126 and \$129 at June 30, 2010 and 2009, respectively	\$725 uninsured term bonds, due July 1, 2019 \$1,730 uninsured term bonds, due July 1, 2029 \$3,105 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	5,434	5,431
2009B Hospital Revenue Bonds	\$5,535 uninsured term bonds, due July 1, 2038	8.00%	5,535	5,535
2009C Hospital Revenue Bonds, net of unamortized discount of \$2,508 and \$2,595 at June 30, 2010 and 2009, respectively	\$21,100 uninsured term bonds, due July 1, 2019 \$20,000 uninsured term bonds, due July 1, 2029 \$74,855 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	113,447	113,360
2008A Hospital Revenue Bonds	\$13,245 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.91% at June 30, 2010	13,245	72,770
2008B Hospital Revenue Bonds	\$4,050 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.91% at June 30, 2010	54,050	54,230
2007A Hospital Revenue Bonds	\$4,305 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.91% at June 30, 2010	4,305	100,220
2007B Taxable Hospital Revenue Bonds	\$314,190 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 2.42% at June 30, 2010	314,190	320,170
2007C Hospital Revenue Bonds	\$1,900 uninsured term bonds, due July 1, 2032, subject to early redemption or tender	Variable, 0.91% at June 30, 2010	1,900	36,575
2006A Hospital First Mortgage Revenue Bonds, net of unamortized premium of \$153 and \$159 at June 30, 2010 and 2009, respectively	\$7,265 uninsured serially, through 2019 \$7,375 uninsured term bonds, due July 1, 2026 \$20,505 uninsured term bonds, due July 1, 2031 \$135,175 uninsured term bonds, due July 1, 2036	4.50% to 5.00% 5.25% 5.50% 5.50%	170,473	171,149
2001A Hospital First Mortgage Revenue Bonds	\$23,900 term bonds, due July 1, 2026, subject to early redemption or tender	6.85%	23,900	24,600
2001 Hospital Refunding and Improvement Revenue Bonds (NCH), net of unamortized discount of \$43 and \$38 at June 30, 2010 and 2009, respectively	\$675 insured term bonds, due December 1, 2010 \$1,465 insured term bonds, due December 1, 2012 \$1,635 insured term bonds, due December 1, 2014 \$8,815 insured term bonds, due December 1, 2022	5.13% 5.75% 6.00% 6.00%	12,547	13,183
2000A Hospital First Mortgage Revenue Refunding Bonds	\$28,417 insured Capital Appreciation Bonds, interest and principal due July 1, 2026 through 2030	6.63%	28,417	26,601
2000C Hospital First Mortgage Revenue Taxable Bonds	\$35,335 insured term bonds, due July 1, 2026	8.50%	35,335	36,270
2000D First Mortgage Taxable Bonds	\$15,225 insured term bonds, due July 1, 2026	8.50%	15,225	15,630
1998 Hospital Refunding and Improvement Revenue Bonds (JMH)	\$1,125 uninsured serially, through 2011 \$6,495 uninsured term bonds, due July 1, 2016 \$7,620 uninsured term bonds, due July 1, 2028	5.00% 5.25% 5.38%	15,240	16,310
Capitalized lease obligations secured by buildings and equipment	Maturing through 2027	3.18% to 13.01%	16,715	17,211
Note payable secured by assets of Kingsport Ambulatory Surgery Center	Monthly principal and interest payments maturing through June 2010	5.50%	-	334
Note payable secured by property	Monthly principal and interest payments of \$7 beginning March 2007 maturing February 2012. Note was paid-off in 2010	LIBOR + 1.25%	-	204
\$7,500 promissory note secured by assets of Mediserve Medical Equipment of Kingsport, Inc.	Monthly principal and interest payments of \$56 beginning February 2007 maturing December 2011; remaining principal of \$6,473 due January 2012	LIBOR + 1.10%	6,064	6,647
Capitalized lease obligations secured by equipment	Various monthly payments of monthly principal and interest	Various	1,325	1,526
\$7,482 promissory note secured by property and unsecured letter of credit	Monthly interest-only payments through maturity on December 31, 2010; paid off in 2010	\$32 interest per month	-	7,450
Master installment payment agreement	\$2,194 due August 1, 2010	Unspecified	2,194	3,140
\$1,409 unsecured promissory note	Monthly principal and interest payments of \$23 beginning July 2008 through September 2013; remaining principal and accrued interest due October 2014	LIBOR + 1.25%	920	1,202

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

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

Description	Maturities	Rates	Outstanding Balance	
			2010	2009
\$1,800 note payable secured by property	Monthly interest-only payments through maturity in July 2009	3.74%	-	1,800
\$10,221 note payable secured by property	Various annual principal and interest payments through April 2013	6.25%	7,836	10,221
\$5,000 line of credit secured by investments	Payable on demand	LIBOR + 1.25%	-	5,039
\$4,600 note payable secured by property	Monthly principal and interest payments of \$50 beginning February 2009 maturing December 2013; remaining principal due January 2014. Note was paid-off in 2010	5.47%	-	4,377
\$1,065 note payable secured by land	Monthly interest-only payments through April 2011; remaining principal and accrued interest due May 2011	5.50%	1,065	1,065
\$6,332 promissory note secured by substantially all assets of the Alliance	Monthly principal payments of \$35 plus accrued interest beginning July 2010 maturing June 2015; remaining principal due July 2015	LIBOR + 2.00%	6,332	-
\$3,955 note payable secured by property	Monthly principal and interest payments of \$27 beginning July 2010 maturing May 2015; remaining principal due June 2015	3.00%	3,955	-
Note payable under Master Financing Agreement, secured by Equipment	Monthly principal and interest payments of \$166 beginning July 2010 maturing June 2017	4.62%	11,900	-
Note payable under Master Financing Agreement, secured by Equipment	Monthly principal and interest payments of \$56 beginning July 2010 maturing June 2017	3.75%	4,100	-
\$4,926 convertible construction loan secured by property and assigned rents	Monthly interest-only payments through January 2011 followed by monthly principal and interest payments of \$25 maturing December 2014; remaining principal and accrued interest due January 2015	Prime (stated minimum and maximum interest rates of 3.75% and 6.75%, respectively)	1,195	-
\$1,885 line of credit secured by property	Monthly interest-only payments through March 2011 followed by monthly principal and interest payments of \$9 maturing February 2015; remaining principal and accrued interest due March 2015	Prime - 0.50% (stated minimum and maximum interest rates of 3.50% and 6.25%, respectively)	265	-
			1,082,973	1,072,250
	Less current portion		(28,131)	(31,306)
			<u>\$ 1,054,842</u>	<u>\$ 1,040,944</u>

Series 2010 Bonds: In April 2010, the Alliance issued \$168,080 (Series 2010A) and \$35,935 Series 2010B fixed rate Hospital Refunding Revenue Bonds (collectively, the Series 2010 Bonds). Proceeds of the Series 2010A and the Series 2010B Bonds were used to refinance outstanding indebtedness, specifically related to the Alliance's facilities in Tennessee and in Virginia, respectively, fund debt service reserve funds and pay costs of issuance. The Alliance recognized a \$3,029 loss on early extinguishment of debt representing the write off of previously deferred and unamortized financing costs related to the refinanced Series 2008A and the Series 2007A and 2007C debt issues discussed below.

Series 2009 Bonds

In March 2009, the Alliance issued \$5,560 (Series 2009A), \$5,535 (Series 2009B) and \$115,955 (Series 2009C) fixed rate Hospital Revenue Bonds (collectively, the Series 2009 Bonds). The proceeds of Series 2009 Bonds were used to refinance a portion of the outstanding Series 2006C

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

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

Taxable Notes, which were originally issued to finance a capital commitment to SCCH and purchase certain leased assets, finance the acquisition of a majority ownership in JMH, fund a debt service reserve fund and pay costs of issuance. The portion of the 2006C taxable notes which were not refinanced with the Series 2009 Bonds were repaid with cash on hand.

In connection with its acquisition of a majority ownership in JMH, the Alliance assumed the then outstanding long-term debt of JMH, totaling \$33,906, including the JMH Series 1998 Hospital Refunding and Improvement Revenue Bonds as further described in the table above.

Series 2008 Bonds

In February 2008, the Alliance issued \$72,770 (Series 2008A) and \$54,230 (Series 2008B) variable rate Hospital Revenue Bonds (collectively, the Series 2008 Bonds). The proceeds of Series 2008 Bonds were primarily used to finance certain future capital projects for the Alliance's hospital facilities and for the repayment of previously issued 2008 Taxable Notes used for the acquisition of RCMC. The payment of principal and interest on the Series 2008 Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit (the Letters of Credit). The Letters of Credit entitle the Master Trustee to draw amounts equal to the principal amounts of the Series 2008 Bonds outstanding and up to 35 days interest at a rate of 12%. The Letters of Credit expire on December 14, 2012 unless renewed or replaced. A portion (\$59,525) of the Series 2008A Bonds were repaid from proceeds of the Series 2010 Bonds.

The variable rate of interest on the Series 2008 Bonds is determined weekly by the Remarketing Agent (Merrill Lynch), as the rate equal to the lowest rate which, in regard to general financial conditions and other special conditions bearing on the rate, would produce as nearly as possible a par bid for the Series 2008 Bonds in the secondary market. In no event shall the variable rate on the Series 2008 Bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the State of Tennessee for the Series 2008A Bonds or the Commonwealth of Virginia for the Series 2008B Bonds. The Alliance has the option, upon written approval of the holder of the Letters of Credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate.

The Series 2008 Bonds are subject to optional and mandatory tender for purchase prior to maturity at the option of the holder, upon conversion to a fixed rate, upon conversion to a medium-term rate period, prior to the effective date of any substitute letter of credit, or upon the termination of the Letters of Credit. The optional and mandatory tender provisions generally call for the Master Trustee to purchase the outstanding Series 2008 Bonds at a purchase price equal to the principal amount thereof plus accrued interest upon a stated date as described in the tender notice delivered to the bond holders.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

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

Series 2007 Bonds

In December 2007, the Alliance issued \$104,355 (Series 2007A), \$327,170 (Series 2007B taxable) and \$36,575 (Series 2007C) variable rate Hospital Revenue Bonds (collectively, the Series 2007 Bonds). The proceeds of Series 2007 Bonds were primarily used to early extinguish a portion of the outstanding Series 2000A Bonds, all of the outstanding 2000B Bonds, all of the outstanding Series 1994 Bonds, and all of the outstanding Series 2006B Bonds; to finance the acquisition of a majority ownership in NCH, and to finance certain capital improvements and equipment acquisitions for the Alliance's hospital facilities. The payment of principal and interest on the Series 2007 Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit (the Letters of Credit). The Letters of Credit entitle the Master Trustee to draw amounts equal to the principal amounts of the Series 2007 Bonds outstanding and up to 35 days interest at a rate of 12%. The Letters of Credit expire on December 14, 2012 unless renewed or replaced. A portion of the outstanding Series 2007A (\$91,685) and Series 2007C (\$32,840) Bonds were repaid from proceeds of the Series 2010 Bonds.

The variable rate of interest on the Series 2007 Bonds is determined weekly in the same manner as described above for the Series 2008 Bonds. In no event shall the variable rate on the Series 2007 Bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the State of Tennessee for the Series 2007A and 2007B Bonds or the Commonwealth of Virginia for the 2007C Bonds. The Alliance has the option, upon written approval of the holder of the Letters of Credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate. Upon such conversion, the Series 2007 Bonds become subject to mandatory tender for purchase.

The Series 2007 Bonds are subject to optional and mandatory tender in the same manner as described above for the Series 2008 Bonds. In addition, the Series 2007B Bonds are subject to a special mandatory tender with respect to its conversion from taxable debt to tax-exempt debt.

Series 2006 Bonds

During 2006, the Alliance issued \$173,030 Hospital First Mortgage Revenue Bonds (Series 2006A) and \$66,500 Hospital First Mortgage Variable Rate Revenue Bonds (Series 2006B). The proceeds from the sale of the Series 2006A Bonds were used to finance certain future and prior capital projects for the Alliance's hospital facilities and to refund certain existing indebtedness, specifically the Series 2001B Bonds (discussed below) and certain existing short and intermediate term loans and leases, as well as fund a debt service reserve fund. The Series 2006B Bond proceeds were substantially used to refund the remaining outstanding principal of the Series 2001B Bonds and establish a debt service reserve fund.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

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

Series 2001 Bonds

During 2001, the Alliance issued \$26,000 Hospital First Mortgage Revenue Bonds (Series 2001A) and \$60,175 Hospital First Mortgage Revenue Bonds (Series 2001B). The Series 2001A Bonds were subject to optional tender by Bond holders. Effective July 1, 2007, the Alliance entered into an agreement whereby the beneficial owners of the Series 2001A Bonds have irrevocably waived their rights to tender the Bonds under the provisions of the respective Bond Indenture. The waiver will continue in effect through the maturity of the 2001A Bonds. The Series 2001B Bonds were refunded and redeemed in 2006.

Series 2000 Bonds

The Hospital First Mortgage Revenue Refunding (Series 2000A Bonds) and First Mortgage Revenue Refunding Bonds (Series 2000B Bonds), were used to advance refund previously existing indebtedness as well as fund a required debt service reserve fund. The Hospital First Mortgage Revenue Bonds (Series 2000C Taxable Bonds) were intended to refinance certain mortgage indebtedness of BRMM, and to refund other previously existing indebtedness. The proceeds from the sale of the First Mortgage Bonds (Series 2000D Taxable Bonds) were used primarily to fund working capital for the Alliance.

The Series 2000A Bonds included at issue date \$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.

The advance refunding of previously issued debt requires funds to be placed in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments. 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, and the debt and escrowed securities are not considered liabilities or assets of the Alliance. Therefore, such debt has been derecognized.

Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2010 due to previous advance refundings of the Series 2000A Bonds, Series 2000B Bonds, Series 1998C Bonds, and Series 1991 Bonds, totaled approximately \$585,960.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

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

documents, including United States Treasury obligations, an investment contract with MBIA Insurance Corporation (MBIA) in the 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.

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.

Other Bonds, Notes Payable and Financing Arrangements

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 NCH Series 2001 Hospital Refunding and Improvement Revenue Bonds are secured by revenues and a lien on certain real and personal property of NCH. The JMH Series 1998 Hospital Refunding and Improvement Revenue Bonds are secured by pledged gross receipts of JMH, as defined in the Master Trust indenture.

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, 2010 are as follows:

<i>Year Ending June 30,</i>		
2011	\$	28,131
2012		35,002
2013		30,312
2014		28,035
2015		31,898
Thereafter		<u>930,227</u>
		1,083,605
	Net discount	<u>(632)</u>
	\$	<u><u>1,082,973</u></u>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

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

The Alliance, NCH 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, NCH and JMH are in compliance with all such covenants at June 30, 2010.

In connection with the tax-exempt bonds, the Alliance is required every five years, and at maturity, to remit to the Internal Revenue Service amounts which are due related to positive arbitrage on the borrowed funds. The Alliance performs such computations when required and recognizes any liability at that time. Management does not believe there are any significant arbitrage liabilities at June 30, 2010 or 2009.

In September 2010, in order to reduce credit risk and expenses, the Alliance replaced the existing letters of credit related to the Series 2007B, Series 2008A and Series 2008B Bonds with letters of credit held by several different financial institutions. The term of the letter of credit facility is for three years. As a part of this restructuring, the existing Bonds in these series were repaid through a remarketing of sub-series of each respective bond issue created per the mandatory tender and letter of credit substitution provisions.

NOTE G--SELF-INSURANCE PROGRAMS

The Alliance is 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 also provides professional liability coverage for certain affiliates and joint ventures.

The Alliance is 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 and \$1,000 annual aggregate retention. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

At June 30, 2010, 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, 2010 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Alliance

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE G--SELF-INSURANCE PROGRAMS - Continued

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, 2010 and 2009 was \$12,601 and \$12,887, respectively. The discount rate utilized was 5% at June 30, 2010 and 2009.

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, including a catastrophic claims reserve based on historical claims in excess of \$75.

NOTE H--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates to net patient service revenue as presented in the accompanying Consolidated Statements of Operations and Changes in Net Assets is as follows for the years ended June 30:

	<u>2010</u>	<u>2009</u>
Inpatient service charges	\$ 1,848,590	\$ 1,630,110
Outpatient service charges	1,669,705	1,253,097
Gross patient service charges	3,518,295	2,883,207
Less:		
Estimated contractual adjustments and other discounts	2,417,082	1,929,061
Estimated uncollectible self-pay - Note B	111,565	86,760
Charity care	61,378	44,488
	<u>2,590,025</u>	<u>2,060,309</u>
Net patient service revenue	<u>\$ 928,270</u>	<u>\$ 822,898</u>

NOTE I--THIRD-PARTY REIMBURSEMENT

The Alliance renders services to patients under contractual arrangements with Medicare, Medicaid, TennCare, Blue Cross and various other commercial payors. 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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE I--THIRD-PARTY REIMBURSEMENT - Continued

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. The amount recognized totaled \$8,700 and \$11,137 for the years ended June 30, 2010 and 2009, respectively. Such payments are not guaranteed in future periods.

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 based on Medicare cost reimbursement principles and settled through the filing of an annual Medicaid cost report.

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. 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. 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 2011, although the amount of any change cannot be estimated. The impact of final settlements of cost reports or changes in estimates decreased net patient service revenue by \$3,540 in 2009. The impact of final settlements of cost reports or changes in estimates were not significant in 2010.

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, 2010.

The Alliance has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, preferred provider organizations and employer groups. The basis

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE I--THIRD-PARTY REIMBURSEMENT - Continued

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 retirement plan (the Plan) which covers substantially all employees. The Plan is a defined contribution plan which consists mainly of employer-funded contributions. During 2010 and 2009, the Alliance made contributions to the Plan under a stratified system, whereby the Alliance's contribution percentage is based on each employee's years of service. In addition, the Alliance sponsors a 403(b) plan which is funded solely by employees' contributions. The Alliance does not make any discretionary or matching contributions into the 403(b) plan. 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, 2010 and 2009 was \$13,311 and \$10,590, respectively.

NCH maintains a defined benefit pension plan and a post-retirement employee benefit plan. The accrued unfunded pension liability was \$1,942 and \$1,972, and the accrued unfunded post-retirement liability was \$3,843 and \$4,821 at June 30, 2010 and 2009, 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 date, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed \$1,303 and \$1,716 to the plan during 2010 and 2009, respectively. Other assets at June 30, 2010 and 2009 include \$7,077 and \$5,827, 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. The benefits for substantially all employees previously participating in the SEBP plan have been transferred into the 457(f) plan.

NOTE K--CONCENTRATIONS OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia which is considered a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. Net patient service revenue from Washington County, Tennessee operations were approximately 54% and 59% of total net patient service revenue for 2010 and 2009, respectively.

The mix of receivables from patients and third-party payors based on charges at established rates is as follows as of June 30:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE K--CONCENTRATIONS OF RISK - Continued

	<u>2010</u>	<u>2009</u>
Medicare	42%	40%
TennCare/Medicaid	15%	17%
Commercial	25%	31%
Other third-party payors	10%	5%
Patients	8%	7%
	<u>100%</u>	<u>100%</u>

Approximately 98% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2010 and 2009. Admitting physicians are primarily practitioners in the regional area.

Two of the Alliance's Virginia hospitals' employees are covered under collective bargaining agreements. These agreements expire in January 2011.

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 and notes, 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, 2010 and 2009, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of \$32,447 and \$35,448, respectively, related to operating losses which expire through 2025. BRMM had state net operating loss carryforwards of \$59,860 and \$58,771, respectively, which expire through 2025. 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.

At June 30, 2010 and 2009, SWCH had federal and state net operating loss carryforwards of \$4,376 and \$3,923, respectively, which expire through 2029. CHC files separate federal and state tax returns. CHC had a net deferred tax liability of \$58 at June 30, 2010 and a net deferred tax asset of \$55 at June 30, 2009; the differences are due primarily to temporary timing differences related to depreciation and net operating loss carryforwards. The net operating loss carryforwards may be offset against future taxable income to the extent permitted by the Internal Revenue Code and tax codes of the Commonwealth of Virginia.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE L--INCOME TAXES - Continued

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--RELATED PARTY TRANSACTIONS

The Alliance enters into transactions with entities affiliated with certain members of the Board of Directors including transactions to construct Alliance facilities and provide professional services to the Alliance. Board members refrain from discussion and abstain from voting on transactions with entities with which they are related.

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES

Construction in Progress: Construction in progress at June 30, 2010 represents costs incurred related to various hospital and medical office building facility renovations and additions. 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 approximately \$223,847 at June 30, 2010. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

Physician Contracts: BRMM employs physicians to provide services to BRMM's physician practices through employment agreements which provide annual compensation, plus incentives based upon specified productivity levels. These contracts have various terms.

In addition, the Alliance has entered into contractual relationships with non-employed physicians to provide services in Upper East Tennessee and Southwest Virginia. These contracts guarantee certain base payments and allowable expenses and have terms of varying lengths. Upon completion of the respective guarantee period, amounts drawn and outstanding under each agreement are treated as a loan bearing interest at various rates and are subject to repayment over a specified period. The physician note may also be amortized by virtue of the physician's continued practice in the specified community during the repayment period. A net receivable of \$1,818 and \$2,770 related to these agreements is included in the accompanying Consolidated Balance Sheets at June 30, 2010 and 2009, respectively.

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 degree. 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 June 30, 2010 and 2009 includes \$5,571 and \$3,880, respectively, related to students in

MOUNTAIN STATES HEALTH ALLIANCE

*Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

school, graduates working at the Alliance and amounts due from others who are no longer in the scholarship program.

Promises to Give: The Alliance has recorded certain unconditional promises to give to unrelated organizations. At June 30, 2010, \$1,768 is due within one year, and an additional \$644 is due within five years and is included in other long-term liabilities.

Operating Leases and Maintenance Contracts: Total lease expense for the years ended June 30, 2010 and 2009 was \$10,216 and \$9,412, 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:

<u>Year Ending June 30,</u>		
2011	\$	1,686
2012		1,560
2013		1,345
2014		1,000
2015		835
Thereafter		3,808
	<u>\$</u>	<u>10,234</u>

Estimated future minimum payments under various noncancellable maintenance contracts with remaining terms in excess of one year at June 30, 2010 total in the aggregate \$3,720 through 2015.

Asset Retirement Obligation: The Alliance has identified asbestos in certain facilities and is required by law to dispose of it in a special manner if the facility undergoes major renovations or is demolished; otherwise, the Alliance is not required to remove the asbestos from the facility. The Alliance has complied with regulations by treating the asbestos so that it presents no known immediate or future safety concerns. An asset retirement obligation has been established to the extent that sufficient information exists upon which to estimate the liability.

Other: During 2007, the Alliance received a Certificate of Need (CON) application to build a new 80-bed hospital in Washington County, Tennessee. When this new facility (FWCH) is opened in 2011, acute care services are planned to be discontinued or reduced at both NSH and JCSH. Management anticipates that the NSH and JCSH facilities will continue to be fully utilized by the

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

Alliance in its operations and, therefore, no change to their estimated useful lives is anticipated. However, it is reasonably possible management's estimates related to the continuing use of these facilities could change in the near term. The carrying value of buildings and improvements related to these facilities is \$12,493 at June 30, 2010.

During 2007, the Alliance filed a Certificate of Public Need (COPN) application to build a new 57-bed hospital in Smyth County, Virginia. The COPN has been approved by the applicable Commonwealth of Virginia agencies. Construction is expected to begin in 2011 and total costs are expected to be \$68,216.

The Alliance is a party to various transactions and agreements in the normal course of business, which include purchase and re-purchase agreements, put arrangements and other commitments, which may bind the Alliance to undertake additional transactions or activities in the future.

NOTE O--RENTAL INCOME UNDER OPERATING LEASES

The Alliance leases rental properties to third parties, most of whom are physician practices, for various terms, generally five years. The following is a schedule by year and in the aggregate of minimum future rental income due under noncancellable operating leases at June 30, 2010:

<u>Year Ending June 30,</u>	
2011	\$ 1,648
2012	1,545
2013	995
2014	730
2015	615
Thereafter	<u>858</u>
Total minimum future rentals	<u>\$ 6,391</u>

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2010 and 2009, 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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS - Continued

Investment in Joint Ventures: It is not practical to estimate the fair market value of the investments in joint ventures.

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 due to uncertainty of when these amounts may be paid. Other long-term liabilities are not discounted.

Long-Term Debt and Capital Leases: 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.

The Alliance's significant capital leases and vendor contracts were negotiated with various entities and are considered unique. It is not practicable to estimate the fair value of these obligations under current conditions. Other capital lease obligations are not significant.

The estimated fair value of the Alliance's financial instruments that have carrying values different from fair value is as follows at June 30:

	2010		2009	
	<i>Carrying Value</i>	<i>Estimated Fair Value</i>	<i>Carrying Value</i>	<i>Estimated Fair Value</i>
FINANCIAL LIABILITIES:				
Long-term debt	\$ 1,082,973	\$ 1,105,778	\$ 1,072,250	\$ 988,263

NOTE Q--FAIR VALUE MEASUREMENT

FASB ASC 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 be corroborated by observable market data.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE Q--FAIR VALUE MEASUREMENT - Continued

- 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 assets and liabilities recorded at fair value on a recurring basis as of June 30, 2010 and 2009:

	<i>June 30, 2010</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>
Trading securities	\$ 209,644	\$ 164,510	\$ 16,526	\$ 28,608
Assets whose use is limited	177,180	177,180	-	-
Total assets	<u>\$ 386,824</u>	<u>\$ 341,690</u>	<u>\$ 16,526</u>	<u>\$ 28,608</u>
Fair value of derivative agreements	<u>\$ (134,300)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ (134,300)</u>
	<i>June 30, 2009</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>
Trading securities	\$ 235,065	\$ 191,918	\$ 13,116	\$ 30,031
Assets whose use is limited	186,414	186,414	-	-
Total assets	<u>\$ 421,479</u>	<u>\$ 378,332</u>	<u>\$ 13,116</u>	<u>\$ 30,031</u>
Fair value of derivative agreements	<u>\$ (126,217)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ (126,217)</u>

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 observable market-based inputs, including forward interest rate curves. The fair values of interest rate swap 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 based on observable market forward interest rate curves and the underlying notional amount. The Alliance also

MOUNTAIN STATES HEALTH ALLIANCE

*Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE Q--FAIR VALUE MEASUREMENT - Continued

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, 2010 and 2009 resulted in a decrease in the fair value of the related liability of \$10,085 and \$7,914, 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.

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, 2010 and 2009:

	<i>Trading Securities</i>	<i>Derivatives, Net</i>
July 1, 2008	\$ 32,187	\$ (87,295)
Total unrealized/realized losses in the performance indicator, net	(9,298)	(42,128)
Purchases, issuance and settlements and other, net	1,015	3,206
Transfers in (out), net	6,127	-
June 30, 2009	30,031	(126,217)
Total unrealized/realized losses in the performance indicator, net	(1,546)	(8,607)
Purchases, issuance and settlements and other, net	1,446	524
Transfers in (out), net	(1,323)	-
June 30, 2010	<u>\$ 28,608</u>	<u>\$ (134,300)</u>
Net losses included in the performance indicator which are attributable to the change in unrealized gains or losses relating to assets still held at June 30, 2009	<u>\$ (9,298)</u>	<u>\$ (43,172)</u>
Net losses included in the performance indicator which are attributable to the change in unrealized gains or losses relating to assets still held at June 30, 2010	<u>\$ (1,920)</u>	<u>\$ (27,116)</u>

On July 1, 2009, the Alliance adopted the provisions of FASB ASC 820 related to non-financial assets and liabilities recognized or disclosed at fair value on a non-recurring basis. The Alliance does not have any non-financial liabilities recognized or disclosed at fair value on a non-recurring basis. Assets subject to this guidance primarily include certain goodwill, property and equipment

MOUNTAIN STATES HEALTH ALLIANCE

*Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE Q--FAIR VALUE MEASUREMENT - Continued

and investments in unconsolidated affiliates. There were no significant assets or liabilities that were re-measured at fair value on a non-recurring basis during the fiscal year ended June 30, 2010.

NOTE R--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION

Direct expenses by functional classification are as follows for the years ended June 30:

	<i>2010</i>		<i>2009</i>
Healthcare services	\$ 795,725	\$	686,779
Administrative and general	124,338		135,994
Other	8,625		10,168
	<u>\$ 928,688</u>	<u>\$</u>	<u>832,941</u>

Supplemental Schedules

MOUNTAIN STATES HEALTH ALLIANCE

**Consolidating Balance Sheet
(Dollars in Thousands)**

June 30, 2010

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Mountain States Properties	Other Entities	Eliminations	Total
ASSETS								
CURRENT ASSETS								
Cash and cash equivalents	\$ 1,043	\$ 204,966	\$ -	\$ 206,009	\$ 7,566	\$ 20,951	\$ -	\$ 234,526
Current portion of investments	-	9,588	-	9,588	14,120	4,759	-	28,467
Patent accounts receivable, less estimated allowances for contractual adjustments and uncollectible accounts	4,457	84,416	-	88,873	-	36,707	-	125,580
Other receivables, net	352	10,277	-	10,629	788	6,509	-	17,926
Inventories and prepaid expenses	192	18,977	-	19,169	183	9,811	-	29,163
TOTAL CURRENT ASSETS	6,044	328,224	-	334,268	22,657	78,737	-	435,662
INVESTMENTS, less amounts required to meet current obligations	17,166	266,104	-	283,270	18,765	284,721	-	586,756
PROPERTY, PLANT AND EQUIPMENT, net	9,152	463,652	-	472,804	66,295	156,499	-	695,598
EQUITY IN AFFILIATES	138,930	391,644	(160,670)	369,904	-	-	(369,904)	-
OTHER ASSETS	6,246	143,276	-	149,522	-	1,830	-	151,352
Goodwill, net of accumulated amortization	176	28,458	-	28,634	1,540	645	-	30,819
Net deferred financing, acquisition costs and other charges, less current portion	10,695	8,087	-	18,782	3,608	6,923	-	29,313
Other assets	17,117	179,821	-	196,938	5,148	9,398	-	211,484
TOTAL OTHER ASSETS	\$ 188,409	\$ 1,629,445	\$ (160,670)	\$ 1,657,184	\$ 112,865	\$ 529,355	\$ (369,904)	\$ 1,929,500

* Management Services Organization only

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

**Consolidating Balance Sheet - Continued
(Dollars in Thousands)**

June 30, 2010

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Mountain States Properties	Other Entities	Eliminations	Total
LIABILITIES AND NET ASSETS								
CURRENT LIABILITIES								
Accrued interest payable	\$ -	\$ 15,550	\$ -	\$ 15,550	\$ 4	\$ 485	\$ -	\$ 16,039
Current portion of long-term debt and capital lease obligations	550	23,743	-	24,293	50	3,788	-	28,131
Current portion of estimated fair value of derivatives	-	-	-	-	10,740	-	-	10,740
Accounts payable and accrued expenses	2,159	76,098	-	78,257	1,317	19,653	-	99,227
Accrued salaries; compensated absences and amounts withheld	2,695	31,604	-	34,299	-	12,981	-	47,280
Payables to (receivables from) affiliates, net	9,392	(10,146)	-	(754)	(33,334)	34,088	-	-
Estimated amounts due to third-party payors, net	-	7,983	-	7,983	-	2,172	-	10,155
TOTAL CURRENT LIABILITIES	14,796	144,832	-	159,628	(21,223)	73,167	-	211,572
OTHER LIABILITIES								
Long-term debt and capital lease obligations, less current portion	5,515	1,006,038	-	1,011,553	1,144	42,145	-	1,054,842
Estimated fair value of derivatives, less current portion	-	123,308	-	123,308	252	-	-	123,560
Deferred revenue	-	20,092	-	20,092	-	353	-	20,445
Estimated professional liability self-insurance	2,229	5,075	-	7,304	-	2,237	-	9,541
Other long-term liabilities	5,199	1,598	-	6,797	-	5,831	-	12,628
TOTAL LIABILITIES	27,739	1,300,943	-	1,328,682	(19,827)	123,733	-	1,432,588
MINORITY INTERESTS								
	-	-	-	-	-	168,410	-	168,410
NET ASSETS								
Unrestricted net assets	160,670	317,434	(160,670)	317,434	132,692	226,356	(359,048)	317,434
Temporarily restricted net assets	-	10,941	-	10,941	-	10,729	(10,729)	10,941
Permanently restricted net assets	-	127	-	127	-	127	(127)	127
TOTAL NET ASSETS	160,670	328,502	(160,670)	328,502	132,692	237,212	(369,904)	328,502
	\$ 188,409	\$ 1,629,445	\$ (160,670)	\$ 1,657,184	\$ 112,865	\$ 529,355	\$ (369,904)	\$ 1,929,500

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Operations and Changes in Net Assets
(Dollars in Thousands)

Year Ended June 30, 2010

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Mountain States Properties	Other Entities	Eliminations	Total
CHANGES IN UNRESTRICTED NET ASSETS:								
Revenue, gains and support:								
Net patient service revenue	\$ 32,979	\$ 657,122	\$ (1,556)	\$ 688,545	\$ -	\$ 239,921	\$ (196)	\$ 928,270
Other operating revenue	24,046	3,914	(18,087)	9,873	7,430	32,519	(33,813)	16,009
Equity in net gain of affiliates	6,702	4,959	(5,460)	6,201	-	15	(6,216)	-
TOTAL REVENUE, GAINS AND SUPPORT	63,727	665,995	(25,103)	704,619	7,430	272,455	(40,225)	944,279
Expenses:								
Salaries and wages	15,053	225,269	-	240,322	139	87,975	(2,773)	325,663
Physician salaries and wages	28,752	1,133	-	29,885	-	49,009	(24,405)	54,489
Contract labor	873	3,460	-	4,333	-	2,499	(286)	6,546
Employee benefits	5,152	43,758	(1,615)	47,295	39	22,587	(1,559)	68,362
Fees	2,206	76,192	(18,018)	60,380	830	21,867	(535)	82,542
Supplies	2,200	132,563	-	134,763	1	40,898	(193)	175,469
Utilities	510	10,078	-	10,588	1,010	4,595	-	16,193
Other	4,024	39,787	(11)	43,800	2,611	25,482	(4,253)	67,640
Depreciation	1,059	42,890	-	43,949	2,585	21,902	-	68,436
Amortization	266	12,711	-	12,977	-	146	-	13,123
Estimated provision for bad debts	1,522	3,822	-	5,344	-	2,617	-	7,961
Interest and taxes	(1,279)	41,601	-	40,322	1,409	4,787	(4,254)	42,264
TOTAL EXPENSES	60,338	633,264	(19,644)	673,958	8,624	284,364	(38,258)	928,688
OPERATING INCOME	3,389	32,731	(5,459)	30,661	(1,194)	(11,909)	(1,967)	15,391
Nonoperating gains (losses):								
Interest and dividend income	546	10,904	-	11,450	791	9,311	(4,254)	17,298
Net realized gains on the sale of securities	128	1,543	-	1,671	-	714	-	2,385
Net unrealized gains on securities	596	8,083	-	8,679	1,312	5,027	-	15,018
Derivative related income	-	2,622	-	2,622	1,772	-	-	4,394
Loss on early extinguishment of debt	-	(3,029)	-	(3,029)	-	-	-	(3,029)
Change in estimated fair value of derivatives	-	(10,865)	-	(10,865)	2,258	-	-	(8,607)
Other nonoperating gains (losses)	800	2,502	-	3,302	533	(3,323)	-	512
Net assets released from restrictions used for operations	-	-	-	-	-	1,113	-	1,113
NET NONOPERATING GAINS	2,070	11,760	-	13,830	6,666	12,842	(4,254)	29,084
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES, BEFORE MINORITY INTERESTS	5,459	44,491	(5,459)	44,491	5,472	933	(6,221)	44,675

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Operations and Changes in Net Assets - Continued
(Dollars in Thousands)

Year Ended June 30, 2010

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Mountain States Properties	Other Entities	Eliminations	Total
Minority interest in consolidated subsidiaries' net gain	-	-	-	-	-	(3,162)	-	(3,162)
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	5,459	44,491	(5,459)	44,491	5,472	(2,229)	(6,221)	41,513
Other changes in unrestricted net assets:								
Pension and other defined benefit plan adjustments	-	-	-	-	-	1,589	-	1,589
Net assets released from restrictions used for the purchase of property, plant and equipment	-	-	-	-	-	2,283	-	2,283
INCREASE IN UNRESTRICTED NET ASSETS	5,459	44,491	(5,459)	44,491	5,472	1,643	(6,221)	45,385
DECREASE IN TEMPORARILY RESTRICTED NET ASSETS	-	(393)	-	(393)	-	(844)	-	(1,237)
DECREASE IN PERMANENTLY RESTRICTED NET ASSETS	-	-	-	-	-	(50)	-	(50)
INCREASE IN TOTAL NET ASSETS	5,459	44,098	(5,459)	44,098	5,472	749	(6,221)	44,098
NET ASSETS, BEGINNING OF YEAR	155,211	284,404	(155,211)	284,404	127,220	236,463	(363,683)	284,404
NET ASSETS, END OF YEAR	\$ 160,670	\$ 328,502	\$ (160,670)	\$ 328,502	\$ 132,692	\$ 237,212	\$ (369,904)	\$ 328,502

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Note to Supplemental Schedules

Year Ended June 30, 2010

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. In accordance with Article Six, Section 6.6 of the Amended and Restated Master Trust Indenture between Mountain States Health Alliance and the Bank of New York Trust Company, NA as Master Trustee, those members pledged include Johnson City Medical Center Hospital, Indian Path Medical Center and Pavilion, North Side Hospital, Sycamore Shoals Hospital, Johnson City Specialty Hospital, Johnson County Community Hospital, Russell County Medical Center and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group (Obligated Group).

The supplemental consolidating schedules include the accounts of the members of the Obligated Group after elimination of all significant intergroup accounts and transactions. Certain other subsidiaries of the Alliance, Mountain States Properties, Inc. (MSP) and all other affiliates (Other Entities), 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.

**UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS
FOR FISCAL YEAR ENDED JUNE 30, 2011**

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MOUNTAIN STATES
HEALTH ALLIANCE

FINANCIAL REPORT

June 2011

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended June 30, 2011

	MONTH OF JUNE			TWELVE MONTHS YEAR TO DATE			PY Var
	Actual	Budget	Prior Yr	Actual	Budget	Prior Yr	
		Bud Var			Bud Var		
<i>Revenue</i>							
Patient Revenue	169,472,892	161,121,386	150,826,676	1,983,339,667	2,024,448,109	1,848,589,674	7.3%
Inpatient Revenue	155,608,467	153,142,228	145,449,767	1,806,960,043	1,836,520,529	1,669,704,738	8.2%
Outpatient Revenue	325,081,759	314,263,615	296,276,443	3,790,299,709	3,860,978,637	3,516,294,412	7.7%
Total Gross Patient Revenue							
<i>Expenses from Revenue</i>							
Contractual Adjustments	215,554,023	215,547,506	200,750,371	2,647,862,693	2,685,018,483	2,417,082,491	-9.5%
Charity	7,773,093	5,562,583	6,417,602	72,431,617	62,968,971	61,377,910	-18.0%
Contra Revenue - Self Pay	10,724,999	11,068,902	2,770,398	109,876,805	128,614,923	111,564,516	1.5%
Cost of Goods Sold	176,370	147,793	189,544	1,485,076	1,707,215	1,687,793	11.4%
Total Deductions	234,228,385	232,326,725	210,127,916	2,831,666,192	2,878,309,593	2,591,712,650	-9.3%
Net Patient Service Revenue							
	90,852,774	81,936,890	86,148,527	958,633,517	982,669,045	926,581,762	3.5%
Other Operating Revenue	2,124,395	1,830,541	1,862,235	17,366,079	20,459,578	17,732,528	-2.1%
Total Operating Revenue							
	92,977,169	83,767,431	88,010,761	975,999,596	1,003,128,623	944,314,290	3.4%
<i>Operating Expense</i>							
Salaries	28,029,298	27,832,877	28,410,205	336,039,676	339,257,503	325,657,566	-3.2%
Physician Salaries	4,890,399	4,753,677	4,443,016	59,248,821	57,333,537	54,488,895	-6.7%
Contract Labor	501,615	191,321	719,344	5,963,680	2,850,824	6,546,022	8.9%
Employee Benefits	6,492,574	7,248,777	5,300,324	67,209,284	87,478,304	68,361,501	1.7%
Fees	7,596,997	6,941,212	7,169,396	85,918,912	83,111,663	82,541,487	-4.1%
Supplies	12,859,262	14,512,738	11,676,758	159,362,052	180,628,404	175,469,374	3.5%
Utilities	1,552,329	1,424,650	1,418,312	17,300,334	17,258,274	16,192,488	-6.8%
Other Expense	1,835,571	6,129,536	4,079,879	88,894,786	73,944,247	67,640,314	-1.9%
Depreciation	9,606,960	5,788,929	6,092,293	87,499,453	78,723,483	68,436,438	-27.9%
Amortization	393,655	180,507	1,120,232	2,559,141	2,194,779	13,122,700	80.5%
Bad Debt	562,814	664,970	970,420	6,327,970	7,828,581	7,960,501	20.5%
Interest & Taxes	2,774,534	5,019,373	3,129,953	45,233,433	51,518,474	42,264,136	-7.0%
Consolidation Allocation	1	0	0	(1)	(0)	0	4900.0%
Total Operating Expense							
	77,076,719	80,685,567	74,530,132	951,557,540	982,228,072	928,681,421	-2.5%
Net Operating Income							
	15,900,450	3,078,864	13,480,629	24,442,056	20,900,551	15,632,869	56.4%
Net Investment Income	3,344,352	1,384,467	2,806,888	21,257,492	18,125,952	21,698,030	-2.0%
Realized Gain on Investments	28,126	(666,667)	114,991	1,956,856	(8,000,000)	2,395,122	-18.0%
Gain / (Loss) from Affiliates	44,348	69,157	72,827	829,906	829,889	802,540	3.4%
Gain / (Loss) on Disposal	156,500	0	657,619	517,406	0	689,707	-25.0%
Loss on Extinguishment of LTD / Derivatives	0	0	(3,028,733)	0	0	(3,028,733)	100.0%
Minority Interest	(97,483)	(133,676)	(2,294,112)	(3,346,513)	(919,311)	(3,046,908)	-9.9%
Taxes - Non Operating	(8,013)	(6,342)	(96,025)	(97,510)	(100,101)	(187,790)	48.1%
Incentive Pay	(6,118,763)	(250)	42,616	(6,166,474)	(4,395)	(5,127)	-
Other Non Operating Income / (Expense)	(353,881)	(477,872)	960,820	(985,856)	1,026,574	1,686,371	-158.4%
Total Revenue Over Expense Before CFV of Derivatives							
	12,866,135	3,245,682	12,717,520	38,403,281	31,859,159	36,628,078	4.8%
Change in Fair Value of Interest Rate Swaps	(4,643,746)	0	(3,518,988)	23,556,934	0	3,021,250	579.7%
Change in Fair Value of Call Option	(408,776)	0	1,996,319	(2,393,596)	0	(1,628,330)	79.4%
Total Excess Revenue Over Expense							
	7,893,613	3,245,682	11,194,841	59,566,619	31,859,159	28,020,998	112.6%
Net Unrealized Gain / (Loss) on Investments	(1,895,906)	666,667	(367,300)	22,188,046	8,000,000	177,116	177.1%
Total Increase in Unrestricted Net Assets							
	5,957,707	3,912,349	10,827,541	61,734,665	39,859,160	43,039,463	89.9%
EBITDA							
	25,659,307	14,242,833	26,184,757	173,792,818	164,495,996	153,667,875	6.2%

Mountain States Health Alliance
Comparative Balance Sheet

	June 30 2011	May 31 2011	Month Activity	June 30 2010	YTD Activity
ASSETS					
CURRENT ASSETS					
Cash and Cash Equivalents	112,832,971	127,654,537	(14,721,566)	240,872,146	(127,939,175)
Current Portion AWUIL	23,454,508	22,839,602	614,905	25,092,125	(1,637,618)
Accounts Receivable (Net)	135,023,319	137,803,753	(2,780,434)	125,579,502	9,443,817
Other Receivables	19,604,661	18,264,131	1,340,530	17,926,485	1,678,175
Due From Affiliates	28,533	(0)	28,533	(0)	28,533
Due From Third Party Payors	10,876,496	(0)	10,876,498	0	10,878,497
Inventories	23,092,574	22,046,796	1,045,778	21,593,059	1,499,515
Prepaid Expense	5,843,619	5,703,981	139,638	7,569,767	(1,726,148)
	<u>330,658,681</u>	<u>334,314,799</u>	<u>(3,456,116)</u>	<u>438,633,084</u>	<u>(107,774,403)</u>
ASSETS WHOSE USE IS LIMITED					
	194,326,848	203,695,968	(9,369,120)	274,073,320	(79,746,472)
OTHER INVESTMENTS					
	479,966,878	432,485,841	47,501,037	310,736,035	169,250,842
PROPERTY, PLANT AND EQUIPMENT					
Land, Buildings and Equipment	1,376,617,815	1,403,326,557	(24,508,742)	1,266,510,481	113,307,334
Less Allowances for Depreciation	586,470,519	643,365,634	(56,895,115)	569,912,724	16,557,795
	<u>792,347,296</u>	<u>759,960,923</u>	<u>32,386,374</u>	<u>695,597,758</u>	<u>96,749,539</u>
OTHER ASSETS					
Pledges Receivable	5,098,134	5,919,390	(821,256)	4,617,267	480,867
Long Term Compensation Investment	16,800,250	15,892,308	907,941	13,143,765	3,656,485
Investments in Unconsolidated Subsidiaries	2,366,851	2,508,752	(141,900)	2,417,968	(51,117)
Land / Equipment Held for Resale	57,635	57,635	0	57,635	0
Assets Held for Expansion	4,172,572	4,172,572	0	9,076,673	(4,904,101)
Investments in Subsidiaries	(0)	(0)	0	(0)	0
Goodwill	151,630,733	151,626,699	3,834	151,351,899	278,834
Deferred Charges and Other	29,192,400	29,412,702	(220,302)	29,796,050	(603,650)
	<u>209,318,575</u>	<u>209,590,257</u>	<u>(271,683)</u>	<u>210,461,256</u>	<u>(1,142,682)</u>
TOTAL ASSETS	<u>2,006,638,277</u>	<u>1,940,047,788</u>	<u>66,790,489</u>	<u>1,929,501,454</u>	<u>77,336,824</u>
LIABILITIES AND FUND BALANCE					
CURRENT LIABILITIES					
Accounts Payable and Accrued Expense	95,243,819	62,677,385	32,566,434	99,213,661	(3,869,842)
Accrued Salaries, Benefits, and PTO	57,786,998	49,221,614	8,567,384	47,280,030	10,508,968
Accrued Interest	20,079,964	16,969,509	3,110,455	15,038,509	4,041,455
Due to Affiliates	0	17,514	(17,514)	15,689	(15,689)
Due to Third Party Payors	25,914,943	23,269,210	2,645,733	10,154,973	15,759,970
Current Portion of Long Term Debt	28,050,459	29,906,635	(1,856,376)	28,131,238	(80,779)
	<u>227,075,183</u>	<u>182,062,968</u>	<u>45,016,115</u>	<u>200,634,110</u>	<u>26,244,073</u>
OTHER NON-CURRENT LIABILITIES					
Long Term Compensation Payable	8,796,085	8,788,144	7,941	6,068,300	2,727,785
Long Term Debt	1,040,629,529	1,027,695,405	13,027,123	1,054,840,985	(13,918,457)
Estimated Fair Value of Interest Rate Swaps	20,573,187	15,372,101	4,601,086	44,648,145	(24,075,958)
Call Option Liability	92,044,033	91,635,257	408,776	89,650,437	2,393,596
Deferred Income	19,533,126	19,269,089	270,038	20,445,258	(906,132)
Professional Liability Self-Insurance and Other	1,188,054,849	1,162,279,721	15,785,128	1,231,755,025	(33,690,178)
	<u>1,425,143,032</u>	<u>1,364,341,789</u>	<u>60,801,243</u>	<u>1,432,589,136</u>	<u>(7,446,104)</u>
TOTAL LIABILITIES	<u>171,608,431</u>	<u>171,510,948</u>	<u>97,463</u>	<u>188,410,318</u>	<u>3,198,113</u>
MINORITY INTEREST					
	10,739,628	11,210,361	(470,734)	10,935,552	(195,924)
FUND BALANCE					
Restricted Fund Balance	398,947,168	392,984,690	5,962,467	317,566,449	81,760,739
Unrestricted Fund Balance	410,066,615	404,195,052	5,891,764	328,502,000	81,584,615
	<u>2,006,638,277</u>	<u>1,940,047,788</u>	<u>66,790,489</u>	<u>1,929,501,454</u>	<u>77,336,824</u>
TOTAL LIABILITIES AND FUND BALANCE					

SUMMARY OF THE FINANCING DOCUMENTS

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SUMMARY OF THE FINANCING DOCUMENTS

Brief descriptions of the Master Indenture, each Bond Indenture and each Loan Agreement are included in this Appendix C to the Official Statement. Such descriptions do not purport to be comprehensive or definitive. All references herein to the Master Indenture, the Bond Indenture and the Loan Agreement are qualified in their entirety by reference to each such document, copies of which are available for review at the offices of the Mountain States Health Alliance, Legal Department, 400 North State of Franklin Road, Johnson City, Tennessee. All references to the Bonds of any Series are qualified in their entirety by reference to the definitive forms thereof and the information with respect thereto included in the Master Indenture or the Bond Indenture.

DEFINITIONS OF CERTAIN TERMS

The following are definitions of certain terms used in the Master Indenture, the Bond Indenture, the Loan Agreement and this Official Statement.

“Act of Bankruptcy” means any of the following events:

(a) The Alliance or the Issuer shall (1) apply for or consent to the appointment of, or the taking of possession by, a receiver, custodian, trustee, liquidator or the like of the Alliance or the Issuer or a substantial part of the property of either of them, (2) commence a voluntary case under the Federal Bankruptcy Code (as now or hereafter in effect) or (3) file a petition seeking to take advantage of any other law relating to bankruptcy, insolvency, reorganization, winding-up or composition or adjustment of debts; or

(b) A proceeding or case shall be commenced, without the application or consent of the Alliance or the Issuer, as the case may be, in any court of competent jurisdiction, seeking (1) the liquidation, reorganization, dissolution, winding-up, or the composition or adjustment of debts, of the Alliance or the Issuer, (2) the appointment of a trustee, receiver, custodian, liquidator or the like of the Alliance or the Issuer or of all or any substantial part of the assets of either the Alliance or the Issuer, or (3) similar relief in respect of the Alliance or the Issuer under any law relating to bankruptcy, insolvency, reorganization, winding-up or composition or adjustment of debts, and such proceeding or case shall continue undismissed, or an order, judgment or decree approving or ordering any of the foregoing shall be entered and continue unstayed and in effect for a period of 30 days from the commencement of such proceeding or case.

“Additional Indebtedness” means any Indebtedness (including all Obligations, other than the Initial Obligation) incurred by any Obligated Issuer, subsequent to its becoming an Obligated Issuer.

“Adjustment Date” means the first day of each Weekly Rate Period and each Medium-Term Rate Period.

“Affiliate” of any specified person means any other person directly or indirectly controlling or controlled by or under direct or indirect common control with such specified person. For purposes of this definition, (i) “control” when used with respect to any specified person means the power to direct the management and policies of such person, directly or indirectly, whether through the power to appoint and remove its directors, the ownership of voting securities, by contract, membership or otherwise; and (ii) the terms “controlling” and “controlled” have meanings correlative to the foregoing.

“Authorized Denominations” means prior to the Conversion Date, \$100,000 or any integral multiple of \$5,000 in excess thereof, provided that, with the written consent of the Issuer, “Authorized Denominations” shall mean after the Conversion Date, \$5,000 or any integral multiple thereof.

“Balloon Indebtedness” means: (a) Long-Term Indebtedness as to which, when issued, 25% or more of the debt service thereon is due in a single year, or (b) Long-Term Indebtedness as to which, when issued, 25% or more of the original principal amount thereof may, at the option of the holder or registered owner thereof, be redeemed or repurchased at one time, which portion of the principal is not required by the documents pursuant to which such

Indebtedness is issued to be amortized by redemption prior to such date, or (c) any Guaranty of Long-Term Indebtedness that is Balloon Indebtedness.

“Bank” means each bank identified on the cover page, in its capacity as issuer of the Original Letter of Credit, its successors in such capacity and their assigns, until the Termination Date of the Original Letter of Credit and the payment in full to the Bank of all amounts owed to it under the Reimbursement Agreement and other related documents; provided, however, that upon the effective date of a Substitute Letter of Credit, “Bank” means the issuer of such Substitute Letter of Credit, its successors in such capacity and their assigns until the Termination Date of such Substitute Letter of Credit and the payment in full to such Bank of all amounts owed to it under the Reimbursement Agreement, if any, relating to such Substitute Letter of Credit.

“Bond Indenture” means the Bond Trust Indenture dated as of October 1, 2011, between the Issuer and the Bond Trustee, as amended and supplemented.

“Bond Index” means the "Bond Buyer Revenue Bond Index" as published from time to time in The Bond Buyer, or, if such index shall no longer be published, a comparable index designated by the Bond Insurer during the period that any Related Bonds are outstanding that are insured by the Bond Insurer and thereafter by the Obligated Group Agent.

“Bond Trustee” means The Bank of New York Mellon Trust Company, N.A. or any successor trustee under the Bond Indenture.

“Bondholder”, “Owner”, “owner”, “Holder” or “holder” or any similar term, when used with reference to any of the Bonds, means (i) in the event that the book-entry system of evidence and transfer of ownership of the Bonds is employed pursuant to the Bond Indenture, Cede & Co., as nominee for DTC, or its nominee, and (ii) in all other cases, the registered owner or owners of any Bond as shown on the registration books maintained by the Bond Trustee.

“Book Value,” when used in connection with Property of any member of the Obligated Group, means the cost of such Property, net of accumulated depreciation, calculated in conformity with generally accepted accounting principles, and when used in connection with Property of the Obligated Group, means the aggregate of the values so determined with respect to such Property of all members of the Obligated Group determined in such a manner that no portion of such value of Property of any member of the Obligated Group is included more than once.

“Borrower Bond” means any Bond registered in the name of the Alliance; provided, however, that in no event shall a Pledged Bond be deemed to be a Borrower Bond.

“Business Day” means any day other than (a) a Saturday or Sunday, (b) a day on which banking institutions in Tennessee, or in any other city where the principal United States office of the Bank, the Bond Trustee, the Remarketing Agent or any Paying Agent is located are required or authorized by law (including executive order) to close or on which the principal United States office of the Bank, the Bond Trustee, the Remarketing Agent, or any Paying Agent is closed for a reason not related to financial condition, or (c) a day on which The New York Stock Exchange is closed, provided that during the Fixed Rate Period, all references to the Bank or Remarketing Agent shall be ignored for purposes of this definition.

“Cash to Debt Ratio” means the ratio of Unrestricted Liquid Funds to Long Term Indebtedness.

“Chattel Paper” shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

“Code” means the Internal Revenue Code of 1986, as amended, as it applies to the Bonds, including applicable regulations and revenue rulings thereunder. Reference herein to sections of the Code are to the sections thereof as they exist on the date of execution of the Bond Indenture, but include any successor provisions thereof.

“Collateral” means (i) all Receivables, (ii) all Inventory, (iii) all Equipment, (iv) all General Intangibles, (v) all Contracts and all Contract rights, (vi) all amounts from time to time held in any checking, savings, deposit or other account of any Obligated Issuer, (vii) all Government Approvals, provided, that any Government Approval which by its terms or by the operation of law would become void, voidable, terminable or revocable if mortgaged, pledged or signed under the Master Indenture or if a security interest therein were granted under the Master Indenture or expressly accepted and excluded from the security interest by the Master Indenture granted to the extent necessary so as to avoid such voidness, voidability, terminability or revocability, (viii) all Fixtures, including but not limited to those now or hereafter attached to, placed on or incorporated in the Land, (ix) all Revenues, (x) without limiting the generality of the foregoing, all other personal property, goods, Instruments, Chattel Paper, Documents, credits, claims, demands and assets of any Obligated Issuer, whether now existing or hereafter acquired from time to time, and (xi) any and all additions and accessions to any of the foregoing, all improvements thereto, all substitutions and replacements therefor and all products and Proceeds thereof.

“Commitment Indebtedness” means the obligation of any person to repay amounts disbursed pursuant to a Credit Facility to pay when due such person’s obligations under Indebtedness incurred in accordance with the provisions of the Master Indenture.

“Completion Indebtedness” means any Long-Term Indebtedness (i) incurred by any person for the purpose of financing the completion of constructing or equipping Facilities with respect to which Long-Term Indebtedness was theretofore incurred in accordance with the provisions hereof, and (ii) with a principal amount not in excess of the amount required (a) to provide a completed and equipped Facility of substantially the type and scope contemplated at the time such prior Long-Term Indebtedness was incurred, (b) to provide for capitalized interest during the period of construction, (c) to capitalize a reserve with respect to such Completion Indebtedness and (d) to pay the costs and expenses of issuing such Completion Indebtedness.

“Construction Index” means the health care component of the implicit price deflator for the gross national product as most recently reported prior to the date in question by the United States Department of Commerce or its successor agency, or, if such index is no longer published, such other index which is certified to be comparable and appropriate by the Obligated Group Agent in an Officer’s Certificate delivered to the Master Trustee.

“Contract Rights” means all rights under any Contract to make determinations, to exercise any election (including, but not limited to, election of remedies) or option or to give or receive any notice, consent, waiver or approval together with full power and authority with respect to any Contract to demand, receive, enforce, collect or receipt for any of the foregoing rights or any property the subject of any of the Contracts, to enforce or execute any checks, or other instruments or orders, to file any claims and to take any action which, in the reasonable opinion of a secured party, may be necessary or advisable in connection with any of the foregoing.

“Contracts” means all contracts to which any Obligated Issuer now is, or hereafter will be, bound, or a party, beneficiary or assignee, including, without limitation, all instruments, agreements and documents executed and delivered with respect to such contracts, and all revenues, rentals, Proceeds and other sums of money due and to become due from any of the foregoing, as the same may be modified, supplemented or amended from time to time in accordance with their terms.

“Consultant” means a person who or which is appointed by the Obligated Group Agent for the purpose of passing on questions relating to the financial affairs, management or operations of one or more members of the Obligated Group or the entire Obligated Group and, in the good faith opinion of the Obligated Group Agent, has a favorable reputation for skill and experience in performing similar services in respect of entities engaged in reasonably comparable endeavors. If any Consultant’s report or opinion is required to be given with respect to matters partly within and partly without the expertise of such Consultant, such Consultant may rely upon the report or opinion of another Consultant, which other Consultant shall be reasonably satisfactory to the relying Consultant and the Obligated Group Agent.

“Conversion Date” means the Interest Payment Date on which the Bonds begin to bear interest at the Fixed Rate.

“Corporation” or “Alliance” means Mountain States Health Alliance, a Tennessee not-for-profit corporation, and its successors and assigns and any surviving, resulting or transferee corporation.

“Counsel” means an attorney, or firm thereof, admitted to practice law before the highest court of any state in the United States of America or the District of Columbia.

“Credit Facility” means any letter of credit, line of credit, insurance policy, guaranty or other agreement constituting a credit enhancement or liquidity facility which is issued by a bank, trust company, savings and loan association or other institutional lender, insurance company or surety company for the benefit of the holder of any Indebtedness in order to provide a source of funds for, the payment of all or any portion of an Obligated Issuer’s payment obligations under such Indebtedness.

“Days’ Cash-on-Hand Ratio,” as of the end of any Fiscal Year, means the product obtained by multiplying 365 times (i) the Unrestricted Liquid Funds of the Obligated Group as of the last day of such Fiscal Year, divided by (ii) the total operating expenses of the Obligated Group for such Fiscal Year, excluding depreciation and amortization expense and bad debt expense, as shown on the financial statements of the Obligated Group for such Fiscal Year.

“Debt Service Requirement” of any person means, for any period of time, the amounts payable or the payments required to be made by such person in respect of principal and interest on outstanding Long-Term Indebtedness during such period (calculated in such a manner that no portion of Long-Term Indebtedness is included more than once), taking into account (for purposes of calculating any projected debt service requirements) (i) that any Indebtedness represented by a Guaranty shall be deemed payable on the dates and in the amounts contemplated in the Master Indenture (concerning the assumptions to be used in including debt service requirements of the guaranteed obligations), (ii) that any payments to be made in respect of Balloon Indebtedness and Variable Rate Indebtedness shall be calculated in accordance with the provisions of the Master Indenture, (iii) that, with respect to Indebtedness refunded or refinanced during such period, only an amount of principal and interest equal to the principal and interest not payable from the proceeds of Indebtedness shall be taken into account during such period, (iv) any amounts payable from funds available under an Escrow Deposit (other than amounts so payable solely by reason of the obligor’s failure to make payments from other sources), shall be excluded from the determination of the Debt Service Requirement, and (v) that with respect to any Indebtedness which is the subject of a Hedge Agreement, any Regular Scheduled Qualified Swap Payments under such Hedge Agreement (provided, however, that if the Regular Scheduled Qualified Swap Payments are variable rate payments, interest shall be calculated as if the indebtedness was Variable Rate Indebtedness) payable or receivable with respect to such Indebtedness shall be taken into account in determining the interest payable with respect to such Indebtedness.*

* By their purchase of the Bonds, the initial holders thereof will consent to an amendment of this definition as described in "SECURITY AND SOURCES OF PAYMENT FOR THE BONDS – Amendment of the Master Indenture" in the front part of this Official Statement. The proposed amended definition is as follows:

"Debt Service Requirement" of any Person shall mean, for any period of time, the amounts payable or the payments required to be made by such Person in respect of principal and interest on Outstanding Long-Term Indebtedness during such period (calculated in such a manner that no portion of the Long-Term Indebtedness is included more than once), taking into account (for purposes of calculating any projected debt service requirements) (i) that any Indebtedness represented by a Guaranty shall be deemed payable on the dates and in the amounts contemplated in Section 4.3 (concerning the assumptions to be used in including debt service requirements of the guaranteed obligations), (ii) that any payments to be made in respect of Balloon Indebtedness and Variable Rate Indebtedness shall be calculated in accordance with the provisions of Section 4.4, (iii) that, with respect to Indebtedness refunded or refinanced during such period, only an amount of principal and interest equal to the principal and interest not payable from the proceeds of Indebtedness shall be taken into account during such period, (iv) any amounts payable from funds available under an Escrow Deposit (other than amounts payable solely by reason of the obligor’s failure to make payments from other sources), shall be excluded from the determination of the Debt Service Requirement, and (v) that with respect to any Indebtedness which is the subject of a Hedge Agreement, the rate payable under such Hedge Agreement, rather than the actual interest payable on such Indebtedness, shall be taken into account in determining the interest payable with respect to such Indebtedness.

“Default” means any event which with the giving of notice or lapse of time, or both, would constitute an Event of Default.

“Defeasance Investments” means non-redeemable direct obligations of the United States of America or obligations for which the full faith and credit of the United States of America are pledged for the timely payment of principal and interest, including evidences of a direct ownership interest in future interest or principal payments on such obligations, which obligations are held in a custody account by a custodian pursuant to the terms of a custody agreement.

“Discounted Indebtedness” means Indebtedness sold to the original purchaser thereof (other than any underwriter or other similar intermediary) at a discount from the par amount of such Indebtedness.

“Document” shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

“Eligible Moneys” means (a) proceeds of Bonds not sold to the Alliance or the Issuer or an affiliate of the Alliance or the Issuer, (b) moneys irrevocably drawn under the Letter of Credit, (c) moneys deposited with the Bond Trustee by the Alliance for the benefit of the Bondholders for 123 days during which no Act of Bankruptcy has occurred as evidenced by a certificate of the Alliance or Issuer, (d) moneys with respect to which the Alliance delivers to the Bond Trustee an Opinion of Counsel with nationally recognized expertise in bankruptcy acceptable to the Bond Trustee and Moody’s that such payments will not constitute a voidable transfer or preference under and pursuant to Section 547 of the Federal Bankruptcy Code and (e) investment income on the foregoing types of money.

“Equipment” means any “equipment,” as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction, now or hereafter owned or leased by any Obligated Issuer and, in any event, shall include, but shall not be limited to, all equipment used in connection with the facilities constructed from time to time on the Land, all machinery, tools, office equipment, furniture, furnishings, fixtures, vehicles, motor vehicles, and any manuals, instructions, blueprints, computer software and similar items which relate to the above, and any and all additions, substitutions and replacements of any of the foregoing, wherever located, together with all improvements thereon and all attachments, components, parts, equipment and accessories installed thereon or affixed thereto.

“Escrow Deposit” means a segregated escrow fund or other similar fund, account or deposit in trust of cash in an amount (or Defeasance Investments the principal of and interest on which will be in an amount), and under terms, sufficient to pay all or a portion of the principal of, and premium, if any, and interest on, the indebtedness secured by such escrow fund or other similar fund, account or deposit as the same shall become due or payable upon redemption.

“Event of Default” shall, with respect to the Bond Indenture and Loan Agreement, respectively, have the meanings described under this Appendix C in “SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURE - Events of Default” and “THE LOAN AGREEMENT- Events of Default And Remedies on Default.”

“Facilities” means all land, leasehold interests and buildings and all fixtures and equipment of a person.

“Fair Value Net Worth” of a person as of any date means:

(i) the fair value or fair saleable value (as the case may be, determined in accordance, with applicable federal and state laws affecting creditors rights and governing determinations of insolvency of debtors) of such person’s assets (including such person’s rights to contribution and subrogation under Sections 2.3(d) and (f) of the Master Indenture or in respect of any other guarantee) as of such date, minus

(ii) the amount of all liabilities of such person (determined in accordance with such laws) as of such date, excluding (x) such person’s Cross Guarantee and (y) any liabilities subordinated in right of payment to such Cross Guarantee, minus

(iii) \$1.00.

“Fiscal Year” means a period of twelve consecutive months ending on June 30 or on such other date as may be specified in an Officer’s Certificate of the Obligated Group Agent executed and delivered to the Master Trustee.

“Fitch” means Fitch Ratings, Inc., its successors and assigns; and if such corporation shall be dissolved or liquidated or shall no longer perform the function of a municipal securities rating agency, “Fitch” shall be deemed to refer to any other recognized municipal securities rating agency designated by the Alliance.

“Fixed Rate Period” means the period from and including the Conversion Date to and including the date next preceding the payment in full of the Bonds.

“Fixtures” shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction and in any event shall include all goods now or hereafter attached to, placed on, or incorporated in the Land.

“General Intangibles” means “general intangibles” as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction, now or hereafter owned by any Obligated Group Issuer and shall include, but not be limited to, all trademarks, trademark applications, trademark registrations, trade names, fictitious business names, business names, company names, business identifiers, prints, labels, trade styles and service marks (whether or not registered), including logos and/or designs, copyrights, patents, patent applications, goodwill of any Obligated Issuer’s business symbolized by any of the foregoing, trade secrets, license rights, license agreements, permits, franchises, and any rights to tax refunds to which any Obligated Issuer is now or hereafter may be entitled.

“Governing Body” means, when used with respect to any person, its board of directors, board of trustees, or other board, committee or group of individuals in which the powers of a board of directors or board of trustees is vested generally or for the specific matters under consideration.

“Government Issuer” means any federal, state or municipal corporation or political subdivision thereof or any instrumentality of any of the foregoing empowered to issue obligations on behalf thereof.

“Government Obligations” means (i) for purposes of the Master Indenture, direct obligations of, or obligations the principal of and interest on which are unconditionally guaranteed by, the United States of America, including evidences of a direct ownership interest in future interest or principal payments on obligations issued or guaranteed by the United States of America, which obligations are held in a custody account by a custodian pursuant to the terms of a the terms of a custody agreement, and (ii) for purposes of the Bond Indenture, means direct general obligations of, or obligations the prompt payment of the principal of and the interest on which are fully and unconditionally guaranteed by, the United States of America. In addition, investments having a maturity of seven days or less in a money market fund rated Aaa by Moody's, investments of which fund are exclusively in Government Obligations, shall be considered investments in Government Obligations for purposes of the Bond Indenture.

“Gross Receipts” means all Revenues, operating revenues and non-operating revenues, receipts, rentals and income of, or received by, any Obligated Issuer, under generally accepted accounting principles, and all rights to receive the same, whether in the form of accounts receivable, Receivables, accounts, Documents, Investment Property, Contract Rights, Chattel Paper, Instruments, General Intangibles or other rights and all Proceeds thereof, including insurance proceeds and condemnation awards payable or paid in respect of the Facilities, whether now existing or hereafter coming into existence and whether now owned or hereafter acquired, and the proceeds thereof including, without limitation, revenues derived from the ownership, operation or leasing of the Facilities; provided, however, that there shall be excluded from Gross Receipts (i) all gifts, grants, bequests, donations or contributions (collectively, “gifts”), which gifts may not be pledged or applied to the payment of principal or interest on the Obligations as a result of restrictions or designations imposed by the donor or maker of the gift in question at the time of the making thereof and income therefrom if such income may not be pledged or applied to the payment of principal or interest on the Obligations as a result of a restriction or designation described in this clause (i), and (ii) any proceeds of any additional indebtedness incurred or assumed by the Obligated Issuer pursuant to the terms of

the Master Indenture, to the extent required by the terms of the documentation evidencing such additional indebtedness.

“Guaranty” means any obligation of a Obligated Group member guaranteeing any obligation of any other person other than a Obligated Group member, whether or not issued under the Master Indenture as an Indenture Guaranty, which obligation would, if such other person were a member of the Obligated Group, constitute Indebtedness under the Master Indenture.

“Hedge Agreement” means (a) any contract known as or referred to or which performs the function of an interest rate swap agreement, currency swap agreement, forward payment conversion agreement or futures contract; (b) any contract providing for payments based on levels of, or changes or differences in, interest rates, currency exchange rates, or stock or other indices; (c) any contract to exchange cash flows or payments or series of payments; (d) any type of contract called, or designed to perform the function of, interest rate floors, collars, or caps, options, puts, or calls, to hedge or minimize any type of financial risk, including, without limitation, payment, currency, rate or other financial risk; and (e) any other type of contract or arrangement that the Obligated Group Agent determines is to be used, to manage or reduce the cost of an Indebtedness, to convert any element of any Indebtedness from one form to another, to maximize or increase investment return, to minimize investment return risk, or to protect against any type of financial risk or uncertainty.

“Historical Debt Service Coverage Ratio” means, for any period of time, the ratio determined by dividing Total Income Available For Debt Service for such period by the Debt Service Requirement of the Obligated Group for such period.

“Historical Maximum Annual Debt Service Coverage Ratio” means, for any period of time, the ratio determined by dividing Total Income Available for Debt Service for such period by the Maximum Annual Debt Service of the Obligated Group.

“Historical Pro Forma Debt Service Coverage Ratio” means for any period of time, the ratio determined by dividing Total Income Available for Debt Service for such period by the Maximum Annual Debt Service of the Obligated Group for all Long Term Indebtedness then outstanding and the Long-Term Indebtedness then proposed to be issued.

“Holder” means, as the context requires, the registered owner of any Note, the beneficiary of any Indenture Guaranty in whose name an Indenture Guaranty is issued or the holder or beneficiary of any other type of Obligation. In the case of an Obligation issued to a trustee or other fiduciary acting on behalf of the holders of any bonds, notes or other similar obligations which are secured by such Obligation, including any registered securities depository then in the business of holding (for the benefit of beneficial owners whose interests may be evidenced by book-entry registration) substantial amounts of obligations of types comprising the Obligations, the term Holder shall mean the trustee or other fiduciary or, if so provided in the Related Financing Documents, the holders of the Related Bonds in proportion to their respective interests therein, including any registered securities depository then in the business of holding (for the benefit of beneficial owners whose interests may be evidenced by book-entry registration) substantial amounts of obligations of types comprising the Obligations. For purposes of determining the Holders of the two largest principal amounts of Uninsured Obligations, any Holder of Related Bonds relating to Uninsured Obligations shall be deemed to be the owner of a proportionate amount of the Uninsured Obligations, and any such Uninsured Obligations owned by affiliated entities shall be treated as owned by one Holder.

“Immediate Notice” means notice (a) by telecopier or telephone, or delivery by hand, (b) promptly followed by written notice by first class mail, postage prepaid, and (c) to such address or such telex, telecopier or telephone number as the person receiving such notice shall have previously furnished to the Bond Trustee in writing.

“Income Available For Debt Service” of a person means, with respect to any period of time, the excess of revenues over expenses, or, in the case of for-profit entities, net income before tax, as determined in accordance with generally accepted accounting principles, to which shall be added, in either case, (i) depreciation, (ii) amortization, (iii) interest expense on Long-Term Indebtedness, and, to the extent not already included, and (iv) to the extent not already included contributions and donations and from which shall be excluded any extraordinary items, any impairment losses, any gain or loss resulting from either the extinguishment of indebtedness or the sale, exchange or

other disposition of assets not made in the ordinary course of business, provided, however, that (a) no determination of Income Available for Debt Service will take into account any gains or losses resulting from the periodic valuation of investments or Hedge Agreements that do not involve the sale, transfer or other disposition of any such investment or Hedge Agreement or the termination of any Hedge Agreement and (b) a person may include in its net income such person's share of the net income of any person controlled by such person or in whom such person has a legal interest.

"Indebtedness" of a person means (i) all Notes and Guaranties, (ii) all liabilities (exclusive of reserves such as those established for deferred taxes or litigation) recorded on the audited financial statements of such person as of the end of the most recent Fiscal Year for which financial statements reported upon by an Accountant are available, and (iii) all other obligations for borrowed money; provided that Indebtedness shall not include (1) Subordinated Indebtedness, (2) Hedge Agreements, (3) any other Indebtedness of any member of the Obligated Group to any other member of the Obligated Group, (4) rentals payable under leases which are not properly capitalized under generally accepted accounting principles or (5) any Guaranty by any member of the Obligated Group of Indebtedness of any other member of the Obligated Group.

"Indenture Guaranty" means any Guaranty issued under the Master Indenture by an Obligated Issuer.

"Instrument" shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

"Interest Payment Date" means (a) during Weekly Rate Periods, the first Business Day of each calendar month and any Conversion Date, Proposed Conversion Date or the maturity of the Bonds, and (b) during any Medium-Term Rate Periods and any Fixed Rate Period, each Long-Term Interest Payment Date.

"Interest Rate Swap Obligations" means obligations of any person pursuant to any arrangement with any other person whereby, directly or indirectly, such person is entitled to receive from time-to-time periodic payments calculated by applying either a floating or a fixed rate of interest on a stated principal amount in exchange for periodic payments made by such other person calculated by applying a fixed or a floating rate of interest on the same amount.

"Inventory" means all of the inventory of any Obligated Issuer of every type or description, including all inventory as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction, now owned or hereafter acquired and wherever located, whether raw, in process or finished, all materials usable in processing the same and all documents of title covering any inventory, including but not limited to work in process, materials used or consumed in such Obligated Issuer's business, now owned or hereafter acquired or manufactured by such Obligated Issuer and held for sale in the ordinary course of its business; all present and future substitutions therefor, parts and accessories thereof and all additions thereto; and all proceeds thereof and products of such inventory in any form whatsoever.

"Investment Property" shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

"Investment Securities" means, to the extent permitted by applicable law:

(i) Certificates or interest-bearing notes or obligations of the United States, or those for which the full faith and credit of the United States are pledged for the payment of principal and interest.

(ii) Investments in any of the following obligations, provided such obligations are backed by the full faith and credit of the United States: (a) the Export-Import Bank of the United States, (b) the Federal Housing Administration, (c) the Government National Mortgage Association ("GNMA"), (d) the Rural Economic Community Development Administration (formerly known as the Farmers Home Administration), (e) the Federal Financing Bank, (f) the Department of Housing and Urban Development, (g) the General Services Administration, (h) the U.S. Maritime Administration or (i) the Small Business Administration.

(iii) Investments in direct obligations in any of the following agencies, which obligations are not fully guaranteed by the full faith and credit of the United States: (a) senior obligations by the Federal Home Loan Bank System, (b) senior debt obligations and participation certificates (excluding stripped mortgage securities which are purchased at prices exceeding their principal amounts) issued by the Federal Home Loan Mortgage Corporation (“FHLMC”) or senior debt obligations and mortgage-backed securities (excluding stripped mortgage securities which are purchased at prices exceeding their principal amounts) of the Federal National Mortgage Association (“FNMA”), (c) obligations of the Resolution Funding Corporation (“REFCORP”), or (d) senior debt obligations of the Student Loan Marketing Association (“SLMA”) (excluding securities that do not have a fixed par value or whose terms do not promise a fixed dollar amount at maturity or call date).

(iv) Investments in (a) U.S. dollar denominated deposit accounts, federal funds, bankers acceptances, and certificates of deposit of any bank whose short-term debt obligations are rated A-1+ by S&P and P-1 by Moody’s and maturing no more than 360 calendar days after the date of purchase (holding company ratings are not considered as rating of the bank) or (b) certificates of deposit of any bank, which certificates are fully insured by the Federal Deposit Insurance Corporation (“FDIC”).

(v) Investments in money market funds rated “AAAm” or “AAAm-G” by S&P.

(vi) Commercial paper which is rated at the time of purchase in the single highest classification, “P-1” by Moody’s, Inc. and “A-1+” by S&P and which matures not more than 270 calendar days after the date of purchase.

(vii) Pre-refunded municipal obligations defined as follows: any bonds or other obligations rated “AAA” by S&P and “Aaa” by Moody’s (based on an irrevocable escrow account or fund) of any state of the United States of America or any agency, instrumentality or local governmental unit of any such state which are not callable at the option of the obligor prior to maturity or as to which irrevocable instructions have been given by the obligor to call on the date specified in the notice.

(viii) Municipal obligations rated “Aaa/AAA” or general obligations of states with a rating of “A1/A+” or higher by both Moody’s and S&P at the time of purchase.

(ix) Repurchase agreements with (a) any domestic bank, or domestic branch of a foreign bank, the long-term debt which is rated at least “A” by S&P and “A2” by Moody’s; or (b) any broker-dealer with “retail customers” or a related affiliate thereof, which broker-dealer has, or the parent company (which guarantees the provider) of which has, long-term debt rated at least “A” by S&P and “A2” by Moody’s, which broker-dealer falls under the jurisdiction of the Securities Investors Protection Corporation; or (c) any other entity rated at least “A” by S&P and “A2” by Moody’s; provided that:

(a) the repurchase agreement is collateralized with the obligations described in paragraphs (i) or (ii) above, or with obligations described in paragraph (iii)(a) and (b) above.

(b) the trustee will value the collateral securities at least weekly and will liquidate the collateral securities if any deficiency in the required collateral percentage is not restored within two (2) business days.

(c) the market value of the collateral must be maintained at: 104% of the total principal of the repurchase agreement for obligations described in paragraphs (i) and (ii); 105% of the total principal of the repurchase agreement for obligations described in paragraph (iii)(a) and (b) above.

(d) the trustee or a third party acting solely as agent therefor or for the issuer (the “Holder of the Collateral”) has possession of the collateral or the collateral has been transferred to the Holder of the Collateral in accordance with applicable state and federal laws (other than by means of entries on the transferor’s books).

(e) the repurchase agreement shall state, and an opinion of counsel shall be rendered at the time such collateral is delivered, that the Holder of the Collateral has a perfected first priority security interest in the collateral, and substituted collateral and all proceeds thereof.

(f) the repurchase agreement shall provide that if during its term the provider's rating by either Moody's or S&P is withdrawn or suspended or falls below "A-" by S&P or "A3" by Moody's, as appropriate, the provider must, at the direction of the Issuer or the trustee, within 10 days of receipt of such direction, repurchase all collateral and terminate the agreement, with no penalty or premium to the issuer or trustee.

(x) Investment agreements with (a) a domestic or foreign bank or corporation (other than a life or property casualty insurance company), the long-term debt of which, or, in the case of a guaranteed corporation, the long-term debt is rated at least "AA" by S&P and "Aa2" by Moody's at the time of purchase; or (b) a monoline municipal bond insurance company or a subsidiary thereof whose claims paying ability is rated at least "AA" by S&P and "Aa2" by Moody's at the time of purchase; provided, that in all cases, by the terms of the investment agreement:

(a) interest payments are to be made to the Bond Trustee at least one business day prior to debt service payment dates on the Bonds and in such amounts as are necessary to pay debt service (or, if the investment agreement is for the construction fund, construction draws) on the Bonds;

(b) the invested funds are available for withdrawal, without penalty or premium, at any time upon not more than seven days' prior notice (which notice may be amended or withdrawn at any time prior to the specified withdrawal date); provided that the [Indenture] specifically requires the Issuer or the Bond Trustee to give notice in accordance with the terms of the investment agreement so as to receive funds thereunder with no penalty or premium paid;

(c) the investment agreement shall state that it is the unconditional and general obligation of, and is not subordinated to any other obligation of, the provider thereof;

(d) a fixed guaranteed rate of interest is to be paid on invested funds and all future deposits, if any, required to be made to restore the amount of such funds to the level specified under the Bond Indenture;

(e) the term of the investment agreement does not exceed seven years;

(f) the Issuer or the Bond Trustee receives the opinion of domestic counsel that such investment agreement is legal, valid, binding and enforceable upon the provider in accordance with its terms and of foreign counsel (if applicable);

(g) the Bond Indenture and investment agreement shall provide that if, during its term:

(1) the provider's rating by either S&P or Moody's falls below "AA" or "Aa3," respectively, the provider must, at the direction of the Issuer or the Bond Trustee, within 10 days of receipt of such direction, either (i) collateralize the investment agreement by delivering or transferring in accordance with applicable state and federal laws (other than by means of entries on the provider's books) to the Issuer, the Bond Trustee or a third party acting solely as agent therefor Permitted Collateral which are free and clear of any third-party liens or claims at the Collateral Levels set forth below; or (ii) repay the principal of and accrued but unpaid interest on the investment (the choice of (i) or (ii) above shall be that of the Issuer or Trustee, as appropriate); and

(2) the provider's rating by either Moody's or S&P is withdrawn or suspended or falls below "A-" or "A3" by S&P or Moody's, as appropriate, the provider must, at the direction of the Issuer or the Bond Trustee, within 10 days of receipt of such direction, repay

the principal of and accrued but unpaid interest on the investment, in either case with no penalty or premium to the Issuer or Bond Trustee;

(h) The investment agreement shall state and an opinion of counsel shall be rendered that the Bond Trustee has a perfected first priority security interest in the Permitted Collateral, any substituted collateral and all proceeds thereof (in the case of bearer securities, this means the trustee is in possession); and

(i) the investment agreement must provide that if, during its term:

(1) the provider shall default in its payment obligations, the provider's obligations under the investment agreement shall, at the direction of the Issuer or the Bond Trustee, be accelerated and amounts invested and accrued but unpaid interest thereon shall be repaid to the Issuer or Bond Trustee, as appropriate;

(2) the provider shall become insolvent, not pay its debts as they become due, be declared or petition to be declared bankrupt, etc. ("event of insolvency"), the provider's obligations shall automatically be accelerated and amounts invested and accrued but unpaid interest thereon shall be repaid to the Issuer or Bond Trustee, as appropriate;

(3) the provider fails to perform any of its obligations under the investment agreement (other than obligations related to payment or rating) and such breach continues for ten (10) business days or more after written notice thereof is given by the Bond Trustee to the provider, it shall be an Event of Default; or

(4) a representation or warranty made by the provider proves to have been incorrect or misleading in any material respect when made, it shall be an Event of Default.

Permitted Collateral for Investment Agreements ("Permitted Collateral"):

(A) U.S. direct Treasury obligations;

(B) Senior debt and/or mortgage-backed obligations of GNMA, FNMA or FHLMC and other government-sponsored agencies backed by the full faith and credit of the U.S. government;

(C) Collateral levels must be 104% of the total principal deposited under the investment agreement for U.S. direct Treasury obligations, GNMA obligations and full faith and credit U.S. government obligations and 105% of the total principal deposited under the investment agreement for FNMA and FHLMC;

(D) The collateral must be held by a third party, segregated and marked to market at least weekly.

"Land" means the land subject to the Master Deed of Trust.

"Letter of Credit" means the Original Letter of Credit or, upon the effective date of any Substitute Letter of Credit, such Substitute Letter of Credit.

"Letter of Credit Period" means any period that a Letter of Credit is in effect with respect to the Bonds.

"Lien" means any mortgage or pledge of, security interest in or lien or encumbrance on any Property of any member of the Obligated Group in favor of, or which secures any Indebtedness or any other obligation of any member of the Obligated Group to any person other than another member of the Obligated Group, but specifically excluding subordination arrangements among creditors.

“Loan Agreement” means the Loan Agreement dated as of October 1, 2011, between the Issuer and the Alliance.

“Long-Term Indebtedness” means (i) all Indebtedness which, at the time of incurrence or issuance, has a final maturity or term greater than one year or which is renewable at the option of the obligor thereof for a term greater than one year from the date of original incurrence or issuance; and (ii) Short-Term Indebtedness which is incurred as interim financing and which is intended to be repaid out of the proceeds of other Long-Term Indebtedness, provided that any one of the applicable conditions described in the Master Indenture are met with respect to such Short-Term Indebtedness on the date of incurrence, assuming for purposes of compliance therewith that such Short-Term Indebtedness is Long Term Indebtedness characterized as Balloon Indebtedness for purposes of meeting any of the applicable conditions in the Master Indenture; provided, that, Long-Term Indebtedness shall not include (a) Non-Recourse Indebtedness or Subordinated Indebtedness; (b) current obligations payable out of current revenues, including current payments for the funding of pension plans and contributions to self insurance programs; (c) obligations under contracts for supplies, services or pensions, allocated to the current operating expenses of future years in which the supplies are to be furnished, the services rendered or the pensions paid; and (d) rentals payable under leases which are not properly capitalized under generally accepted accounting principles.

“Long-Term Interest Payment Date” means the first January 1 or July 1 next succeeding the Medium-Term Adjustment Date or Conversion Date, as the case may be, and each January 1 and July 1 thereafter until the earlier of payment of the Bonds or the date that the Weekly Rate Periods begin.

“Long-Term Rate Period” means any Medium-Term Rate Period and the Fixed Rate Period.

“Master Deed of Trust” means the Deed of Trust and Security Agreement dated as of February 1, 2000 from the Alliance to an individual, as trustee, granting a deed of trust lien on and a security interest in the Land and the other collateral described therein for the benefit of the Master Trustee, to secure the payment and performance of outstanding Obligations.

“Master Indenture” means the Amended and Master Trust Indenture dated as of February 1, 2000 between the Alliance and the Master Trustee, as it may from time to time be amended or supplemented in accordance with the terms thereof.

“Master Trustee” means The Bank of New York Mellon Trust Company, N.A., or any successor trustee under the Master Indenture.

“Maximum Annual Debt Service” of the Obligated Group means the highest annual Debt Service Requirement of the Obligated Group for the current or any succeeding Fiscal Year during the remaining term of all outstanding Obligations.

“Maximum Guaranty Liability” of a person as of any date means the greater of either (i) or (ii) below:

(i) the greater of (A) or (B) as of such date:

(A) the outstanding amount of all Obligations issued by such person or

(B) the fair market value of all property acquired, in whole or part, with the proceeds of such Obligations by such person.

(ii) The greatest of the Fair Value Net Worth of such person as of (1) the latest fiscal year-end of such person, (2) each fiscal quarter-end of such person thereafter occurring on or prior to the date of the determination of Maximum Guaranty Liability, (3) the date on which enforcement of the pertinent Cross Guarantee is sought, and (4) the date on which a case under the U.S. Bankruptcy Code is commenced with respect to any Obligated Issuer.

“MBIA” means MBIA Insurance Corporation and its successor or successors, as insurer of certain Related Bonds.

“Medium-Term Rate Period” means any period of time from one year to five years as determined by the Remarketing Agent pursuant to the Bond Indenture.

“Moody’s” means Moody’s Investors Service, Inc., its successors and assigns; and if such corporation shall be dissolved or liquidated or shall no longer perform the function of a municipal securities rating agency, “Moody’s” shall be deemed to refer to any other recognized municipal securities rating agency designated by the Alliance.

“Net Operating Revenues” of a person means, with respect to any period of time, operating revenues less estimated contractual allowances, free care, discounts and bad debt expense, all determined, except as is specifically provided in the Master Indenture, in accordance with generally accepted accounting principles.

“Net Property, Plant and Equipment” means the Value of all Property, Plant and Equipment less accumulated depreciation.

“Non-Recourse Indebtedness” means any Indebtedness secured by a Lien on Property of any Obligated Issuer, liability for which is effectively limited to the Property subject to such Lien, with no recourse, directly or indirectly, to any other Property of any Obligated Issuer.

“Note” means any note issued under the Master Indenture by an Obligated Issuer to evidence Long-Term Indebtedness or Short-Term Indebtedness incurred pursuant to the terms of the Master Indenture.

“Notice by Mail” or “notice” of any action or condition “by Mail” means a written notice meeting the requirements of the Bond Indenture mailed by first-class mail, postage prepaid, to the Holders of specified Bonds at the addresses shown in the Bond Register. If, because of the temporary or permanent suspension of mail service or for any other reason, it is impossible or impracticable to mail any such notice in the manner described, then such notification in lieu thereof as shall be made with the approval of the Bond Trustee shall constitute a sufficient notice.

“Obligated Group” means all Obligated Issuers.

“Obligated Group Agent” means the Alliance and any successor Obligated Group Agent appointed pursuant to the Master Indenture.

“Obligated Issuer” means (i) the Alliance, Blue Ridge Medical Management Corporation, Norton Community Hospital, Smyth County Community Hospital and each other person which becomes an Obligated Issuer in accordance with the provisions of the Master Indenture, whether or not such person has issued any obligations thereunder, and which has not withdrawn from the Obligated Group pursuant to the Master Indenture, and (ii) when used in respect of any particular Obligation or other Indebtedness, means the obligor thereunder.

“Obligations” means all Notes and Indenture Guaranties issued under the Master Indenture, any lease, contractual agreement to pay money or other obligations of any Obligated Group Member issued thereunder and any additional forms of Obligations created pursuant to the Master Indenture.

“Officer’s Certificate” means a certificate signed, in the case of a corporation, by the Chairman, Vice Chairman, President or Chief Financial Officer or, in the case of a certificate delivered by any other person, the chief executive or chief financial officer of such person, in either case whose authority to execute such certificate shall be evidenced to the satisfaction of the Master Trustee. When an Officer’s Certificate is required under the Master Indenture to set forth matters relating to one or more Obligated Issuers, such Officer’s Certificate may be given in reliance upon another certificate, or other certificates, and supporting materials, if any, provided by any duly authorized officer of the applicable Obligated Issuer.

“Opinion of Bond Counsel” means an opinion in writing signed by an attorney or firm of attorneys experienced in the field of municipal bonds whose opinions are generally accepted by purchasers of municipal bonds.

“Opinion of Counsel” means a written opinion of Counsel, who may (except as otherwise expressly provided in the Loan Agreement or the Bond Indenture) be counsel for the Issuer or the Alliance or both.

“Original Letter of Credit” means the Letter of Credit delivered by the Bank to the Bond Trustee on the date of original issuance of the Bonds in accordance with the Loan Agreement, and all amendments, modifications and supplements thereto.

“Paying Agent” means the bank or banks, if any, designated pursuant to a Related Bond Indenture to receive and disburse the principal of and interest on any Related Bonds or designated pursuant to the Master Indenture to receive and disburse the principal of and interest on any Obligations.

“Permitted Liens” means the Master Indenture, all Related Financing Documents and, as of any particular time:

(i) Any lien from any member of the Obligated Group to any other member of the Obligated Group;

(ii) Any judgment lien or notice of pending action against any member of the Obligated Group so long as (1) such judgment or pending action is being contested and execution thereon has been stayed or the period for responsive pleading or appeal has not lapsed, or (2) in the absence of such contest, neither the pledge and security interest of this Indenture nor any Property of any member of the Obligated Group will be materially impaired or subject to material loss or forfeiture;

(iii) (A) Rights reserved to or vested in any municipality or public authority by the terms of any right, power, franchise, grant, license, permit or provision of law affecting any Property, to (1) terminate such right, power, franchise, grant, license or permit, provided that the exercise of such right would not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof, or (2) purchase, condemn, appropriate or recapture, or designate a purchaser of, such Property; (B) any liens (or deposits to obtain the release of such liens) on any Property for taxes, assessments, levies, fees, water and sewer charges, and other governmental and similar charges and any liens of mechanics, materialmen, laborers, suppliers or vendors for work or services performed or materials furnished in connection with such Property, which are not due and payable or which are not delinquent or which, or the amount or validity of which, are being contested and execution thereon is stayed; (C) easements, rights-of-way, servitudes, restrictions and other minor defects, encumbrances, and irregularities in the title to any Property which do not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof; (D) rights reserved to or vested in any municipality or public authority to control or regulate any Property or to use such Property in any manner, which rights do not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof; and (E) to the extent that it affects title to any Property, the Master Indenture;

(iv) Any lease which relates to Property of the Obligated Group which is of a type that is customarily the subject of such leases, including but not limited to any leasehold interest required under any Related Financing Documents, leases with respect to office space for physicians and educational institutions, food service facilities, gift shops and radiology or other hospital-based specialty services, pharmacy and similar departments and statutory landlord’s liens with respect to such leases;

(v) Any Lien securing Indebtedness provided such Lien also secures all Obligations (other than Obligations representing Subordinated Indebtedness or Non-Recourse indebtedness) on a parity basis;

(vi) Any Lien arising by reason of good faith deposits in connection with leases of real estate, bids or contracts (other than contracts for the payment of money), deposits by any member of the Obligated Group to

secure public or statutory obligations, or to secure, or in lieu of, surety, stay or appeal bonds, and deposits as security for the payment of taxes or assessments or other similar charges;

(vii) Any Lien arising by reason of deposits with, or the giving of any form of security to, any governmental agency or any body created or approved by law or government regulation for any purpose at any time as required by law or governmental regulation as a condition to the transaction of any business or the exercise of any privilege or license, or to enable any member of the Obligated Group to maintain self insurance or to participate in any funds established to cover any insurance risks or in connection with workers compensation, unemployment insurance, pension or profit sharing plans or other similar social security plans, or to share in the privileges or benefits required for companies participating in such arrangements;

(viii) Any Lien arising by reason of an Escrow Deposit;

(ix) (A) Any Lien in favor of a trustee or the holder of a Note on the proceeds of Indebtedness or cash or investments deposited with such trustee and acquired with such proceeds prior to the application of such proceeds or cash or investments and (B) Liens in favor of a trustee, including the Master Trustee, to secure obligations to compensate, reimburse or indemnify such trustees;

(x) Any Lien on moneys deposited by patients or others with any member of the Obligated Group as security for or as prepayment for the cost of patient care;

(xi) Any Lien on Property received by any member of the Obligated Group through gifts, grants or bequests, such Lien being due to restrictions on such gifts, grants or bequests of property or the income thereon;

(xii) Statutory rights of the United States of America by reason of federal funds made available under 42 U.S.C. §§ 291 *et seq.* and similar rights under other federal and state statutes;

(xiii) Liens existing at the time of a Consolidation or Merger permitted under the Master Indenture, on the date of acquisition of any Property or at the time a person becomes an Obligated Issuer; provided that no such Lien (or the amount of indebtedness secured thereby) may be increased, extended, renewed or modified to apply to any Property of any member of the Obligated Group not subject to such Lien on such date, unless such Lien as so extended, renewed or modified shall be offered as security for all Obligations hereunder;

(xiv) Any Lien described in Exhibit A to the Master Indenture, provided that no such Lien (or the amount of indebtedness secured thereby) may be increased, extended, renewed or modified to apply to any Property of any member of the Obligated Group not subject to such Lien on such date, unless such Lien as so extended, renewed or modified otherwise qualifies as a Permitted Lien under the Master Indenture;

(xv) A security interest in any funds or accounts established pursuant to the provisions of any Related Financing Documents;

(xvi) Liens in the form of purchase money security interests in Property financed with the proceeds of Indebtedness secured thereby;

(xvii) Liens securing any Indebtedness permitted under the Master Indenture, provided that the Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that not more than 20% of the Value of all Net Property Plant and Equipment of the Obligated Group would be subject to a Lien (excluding any purchase money security interest permitted under subsection (xvi) above and the Lien created under the Master Deed of Trust for the purpose of making such calculation);

(xviii) Liens on accounts receivable arising as a result of sale of such accounts receivable with recourse, provided that such liens shall be limited to 25% of net accounts receivable outstanding; and

(xix) Options granted by any member of the Obligated Group to others to purchase real property or other assets of such member; provided, however, that the sale pursuant to such option would be permitted under the conditions described in the Master Indenture.

(xx) Liens on any Property that is not encumbered by the Master Deed of Trust so long as the aggregate amount secured by such Liens does not exceed \$5,000,000.

“Pledged Bonds” means any Bonds purchased with the proceeds of a drawing under and in accordance with the provisions of the Letter of Credit until such time as such Bonds are released from the security interest created by the Reimbursement Agreement in accordance with the provisions thereof.

“Proceeds” means “proceeds” as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction or under other relevant law and, in any event, shall include, but shall not be limited to, (i) any and all proceeds of any insurance, indemnity, warranty or guaranty payable to any Obligated Issuer from time to time, and claims for insurance, indemnity, warranty or guaranty effected or held for the benefit of the Corporation, with respect to any of the Collateral, (ii) any and all payments (in any form whatsoever) made or due and payable to the any Obligated Issuer from time to time in connection with any requisition, confiscation, condemnation, seizure or forfeiture of all or any part of the Collateral by any Government Authority (or any person acting under color of Government Authority) and (iii) any and all other amounts from time to time paid or payable under or in connection with any of the Collateral.

“Projected Debt Service Coverage Ratio” means for any future period of time, the ratio determined by dividing projected Total Income Available for Debt Service for such period by Maximum Annual Debt Service of the Obligated Group.

“Property” means any and all rights, titles and interests in and to any and all assets of a person, including all real or personal property, all tangible or intangible property, and all cash, wherever such assets are situated.

“Property, Plant and Equipment” means all Property which is classified as property, plant and equipment under generally accepted accounting principles.

“Proposed Tax Conversion Date” shall have the meaning set forth in the Bond Indenture.

“Rate Period” or “Rate Periods” means any of (a) the Weekly Rate Periods, (b) the Medium-Term Rate Periods or (c) the Fixed Rate Period.

“Rating Agency” means, severally or collectively, if applicable (i) Standard & Poor’s Ratings Group and any successor thereto, if it has assigned a rating to any Obligation issued and outstanding under the Master Indenture or any Related Bonds issued and outstanding pursuant to any Related Financing Documents, (ii) Moody’s Investors Service, Inc. and any successor thereto, if it has assigned a rating to any Obligation issued and outstanding under the Master Indenture or any Related bonds issued and outstanding pursuant to any Related Financing Documents, and (iii) Fitch’s IBCA Inc. and any successor thereto, if it has assigned a rating to any Obligation issued and outstanding pursuant to any Related Financing Documents. If any such Rating Agency shall no longer perform the functions of a securities rating service for whatever reason, the term “Rating Agency” shall thereafter be deemed to refer to the others, but if both of the others shall no longer perform the functions of a securities rating service for whatever reason, term “Rating Agency” shall thereafter be deemed to refer to any other nationally recognized rating service or services as shall be designated in writing by the Obligated Group Agent to the Master Trustee; provided that such designee shall not be unsatisfactory to the Master Trustee.

“Receivables” means any “Account” as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction and in any event shall include, but not be limited to, all of any Obligated Issuer’s rights to payment for goods (including, without limitation, steam and electricity) sold or leased, or for services performed, by such Obligated Issuer, whether now in existence or arising from time to time hereafter, including, without limitation, rights evidenced by an account, note, contract, security agreement, chattel paper, or other evidence of indebtedness or security, together with (i) all security pledged, assigned, hypothecated or granted to or held by any

Obligated Issuer to secure the foregoing, (ii) all of such Obligated Issuer's right, title and interest in and to any goods (including, without limitation, steam and electricity), the sale of which gave rise thereto, (iii) all guarantees, endorsements and indemnifications on, or of, any of the foregoing, (iv) all powers of attorney for the execution of any evidence of indebtedness or security or other writing in connection therewith, (v) all books, correspondence, credit files, records, ledger cards, invoices, and other papers relating thereto, including without limitation all similar information stored on a magnetic medium or other similar storage device and other papers and documents in the possession or under the control of any Obligated Issuer or any computer bureau from time to time acting for such Obligated Issuer, (vi) all evidences of the filing of financing statements and other statements and the registration of other instruments in connection therewith and amendments thereto, notices to other creditors or secured parties, and certificates from filing or other registration officers, (vii) all credit information, reports and memoranda relating thereto, and (viii) all other writings related in any way to the foregoing.

"Record Date" means (a) during Weekly Rate Periods, the Business Day preceding any Interest Payment Date, and (b) during any Medium-Term Rate Periods or Fixed Rate Periods, the fifteenth day of the month preceding any Interest Payment Date.

"Redemption Date" when used with respect to any Bond to be redeemed means the date on which it is to be redeemed pursuant hereto.

"Redemption Price" when used with respect to any Bond to be redeemed means the price at which it is to be redeemed pursuant thereto.

"Regularly Scheduled Qualified Swap Payments" means the regularly scheduled payments under the terms of an Hedge Agreement which are due or receivable absent any termination, default or dispute in connection with such Hedge Agreement.

"Reimbursement Agreement" means the Reimbursement Agreement dated as of the date hereof among the Obligated Group, the Bank and other Lenders Parties thereto, including any amendments or supplements thereto; and upon the effective date of any Substitute Letter of Credit, "Reimbursement Agreement" shall mean a similar agreement, if any, between the issuer of such Substitute Letter of Credit and the Alliance.

"Related Bond Indenture" means any indenture, bond resolution or other comparable instrument pursuant to which a series of Related Bonds is issued.

"Related Bond Issuer" means the Government Issuer of any issue of Related Bonds.

"Related Bond Trustee" means the trustee and its successors in the trust created under any Related Bond Indenture, and if there is no such trustee, shall mean the Related Bond Issuer.

"Related Bonds" means the revenue bonds, notes, other evidences of indebtedness or any other obligations issued by a Government Issuer, pursuant to a single Related Bond Indenture, the proceeds of which are loaned or otherwise made available to an Obligated Issuer in consideration of the execution, authentication and delivery of a Note to or for the order of such Government Issuer.

"Related Financing Documents" means:

(a) in the case of any Note, (i) all documents, including any Related Bond Indenture, pursuant to which the proceeds of the Note are made available to an Obligated Issuer, the payment obligations evidenced by the Note are created and any security for the Note (if permitted under this Indenture) is granted, and (ii) all documents creating any additional payment or other obligations on the part of an Obligated Issuer which are executed in favor of the Holder in consideration of the Note proceeds being loaned or otherwise made available to the Obligated Issuer;

(b) in the case of any Indenture Guaranty, all documents creating the indebtedness being guaranteed pursuant to the Indenture Guaranty and providing for the loan or other disposition of the proceeds of the

indebtedness and all documents pursuant to which any security for the Indenture Guaranty (if permitted under the Master Indenture) is granted; and

(c) in the case of Indebtedness other than Notes and Indenture Guaranties, all documents relating thereto which are of the same nature and for the same purpose as the documents described in clauses (a) and (b) above.

“Revenues” means all revenues, income, receipts and other money received or accrued by or on behalf of any Obligated Issuer from any source whatsoever, including, without limitation, proceeds derived from (i) insurance except where otherwise provided herein, (ii) all accounts and assignable general intangibles now owned or hereafter acquired by any Obligated Issuer, and all proceeds therefrom whether cash or noncash, all as defined in Article 9 of the Uniform Commercial Code, as enacted by the State of Tennessee, (iii) the sale of goods, inventory and other tangible and intangible property, (iv) agreements respecting Medicare, Medicaid and Blue Cross or similar or successor programs, and (v) all gifts, grants, bequests, contributions and donations made to any Obligated Issuer, including the income and profits therefrom.

“S&P” means Standard & Poor’s Rating Group, a division of McGraw-Hill Financial Services Company, its successors and assigns; and if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a municipal securities rating agency, Standard & Poor’s Corporation shall be deemed to refer to any other nationally recognized municipal securities rating agency designated by the Alliance.

“Series” means, individually, the Series 2011A Bonds, the Series 2011B Bonds, the Series 2011C Bonds, the Series 2011D Bonds or the Series 2011E Bonds.

“Series 2011 Obligations” means the Mountain States Health Alliance Notes being issued by the Alliance under the Master Indenture in connection with the issuance of the Bonds.

“Short-Term Indebtedness” means all Indebtedness other than Long-Term indebtedness.

“Subordinated Indebtedness” means any promissory note, guaranty, lease, contractual agreement to pay money or other obligation of any Obligated Issuer which is expressly made subordinate and junior in right of payment of principal of, redemption premium, if any, and interest on, (i) all Obligations issued pursuant to the Master Indenture, and (ii) all other obligations of the Obligated Group under the Master Indenture, on terms and conditions which substantially require that (1) no payment on account of principal of, redemption premium, if any, or interest on such Subordinated Indebtedness shall be made, nor shall any property or assets be applied to the purchase or other acquisition or retirement of such Subordinated Indebtedness, unless full payment of all amounts when due and payable upon maturity of Obligations issued under the Master Indenture have been made or duly provided for in accordance with the terms of such Obligations; (2) no payment on account of principal of, redemption premium, if any, or interest on such Subordinated Indebtedness shall be made, nor shall any property or assets be applied to the purchase or other acquisition or retirement of such Subordinated Indebtedness if, at the time of such payment or application, or immediately after giving effect thereto, (i) there shall exist a default in the payment of the principal of, redemption premium, if any, or interest on any Obligations (whether at maturity or upon mandatory redemption), or (ii) there shall have occurred an Event of Default with respect to any Obligations, as defined therein and in this Indenture, and such Event of Default shall not have been cured or waived or shall not have ceased to exist; and (3) in the event that any Subordinated Indebtedness is declared or otherwise becomes due and payable because of the occurrence of an event of default with respect thereto, (x) the Holders at such time shall be entitled to receive payment in full thereon before the holders of the Subordinated Indebtedness shall be entitled to receive any payment on account of such Subordinated Indebtedness as a result of such event of default, and (y) no holder of Subordinated Indebtedness, or a trustee acting on such holder’s behalf, shall be entitled to exercise any control over proceedings to enforce the terms and conditions of the Master Indenture.

“Tax-Exempt Bonds” means, together, the Tennessee Bonds and the Virginia Bonds.

“Tax-Exempt Organization” means a person organized under the laws of the United States of America or any state thereof which is an organization described in Section 501(c)(3) of the Code, which is exempt from federal

income taxes under Section 501(a) of the Code, and which is not a “private foundation” within the meaning of Section 509(a) of the Code, or corresponding provisions of federal income tax laws from time to time in effect.

“Termination Date” means the stated expiration date of the Letter of Credit or the immediately preceding Business Day if such date is not a Business Day but shall not include the expiration date of the Letter of Credit due to a conversion to the Fixed Rate.

“Total Income Available for Debt Service” means, as to any period, (a) the aggregate of Income Available for Debt Service of each member of the Obligated Group for such period, determined in such a manner that no portion of Income Available for Debt Service of any member of the Obligated Group is included more than once.

“Total Net Operating Revenues” means, as to any period, the aggregate of Net Operating Revenues of each member of the Obligated Group for such period, determined in such a manner that no portion of Net Operating Revenues of any member of the Obligated Group is included more than once.

“Unrestricted Liquid Funds” as of any date means the aggregate of the unrestricted and unencumbered/unpledged cash and unrestricted and unencumbered/unpledged liquid securities (valued at fair market value) of the Obligated Group as of such date (including board-designated funds) from which there shall be subtracted each of the following: (i) the value of all self-insured professional and general liability insurance obligations of the Obligated Group determined by an independent actuary as of such date, (ii) any funds held by the lender or trustee with respect to any Long Term Indebtedness (including any debt service reserve fund, any debt service or bond fund or any construction or project fund), (iii) any proceeds drawn from a line of credit, liquidity facility or other similar facility and (iv) any grantor or donor restricted funds.

“Value,” when used in connection with any Property, means either (a) Book Value, or (b) at the election of the Obligated Group Agent evidenced by an Officer’s Certificate delivered to the Master Trustee, the aggregate fair market value of such Property, as reflected in the most recent written report of an appraiser selected by the Obligated Group Agent and, in the case of real property, who or which is a member of the American Institute of Real Estate Appraisers (MAI), delivered to the Master Trustee (which report shall be dated not more than three years prior to the date as of which value is to be calculated) (i) increased or decreased by the cost of any Property acquired, or the fair market value of any Property disposed of, since the date of such report and (ii) increased or decreased by a percentage equal to the aggregate percentage increase or decrease in the Construction Index from the date of such report to the date as of which value is to be calculated.

“Variable Rate Indebtedness” means any portion of Indebtedness the interest rate on which fluctuates subsequent to the time of incurrence.

SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE

Each Obligation will be issued pursuant to the Master Indenture and will entitle each holder thereof to the protection of the covenants, restrictions and other obligations imposed upon the Corporation and each Obligated Issuer by the Master Indenture and the security provided for therein.

Accounting Principles

Where the character or amount of any asset or liability or item of income or expense is required to be determined or any consolidation, combination or other accounting computation is required to be made for the purposes of the Master Indenture or any agreement, document or certificate executed and delivered in connection with or pursuant to the Master Indenture, such determination or computation shall be done in accordance with generally accepted accounting principles in effect on (i) the date of the delivery of the Master Indenture, or (ii) at the election of the Obligated Group Agent, as specified in an Officer’s Certificate delivered to the Master Trustee, the date such determination or computation is made for any purpose of the Master Indenture, such accounting principles, to the extent applicable, consistently applied; provided that intercompany balances and liabilities among

the Obligated Issuers shall be disregarded and that the requirements set forth in this paragraph shall prevail, if inconsistent with generally accepted accounting principles. In the event that the fiscal year of any Obligated Issuer ends on a date other than the last day of a Fiscal Year, the character or amount of any asset or liability or item of income or expense of such Obligated Issuer for its fiscal year ending within any Fiscal Year under consideration shall be deemed to be the character or amount of the appropriate asset or liability or item of income or expense for such Fiscal Year. For purposes of calculating Total Income Available for Debt Service and Total Net Operating Revenues for any period, if any Obligated Issuer shall have become a member of the Obligated Group during such period, such calculations shall be made assuming that such Obligated Issuer became a member of the Obligated Group at the beginning of such period.

Master Indenture Obligations

Each Obligated Issuer is permitted to issue one or more series of Obligations under the Master Indenture on which all Obligated Issuers will be jointly and severally liable. The terms of each Obligation shall be set forth in a Supplemental Indenture.

The principal of, premium, if any, and interest on the Obligations shall be payable in any currency of the United States of America which is legal tender for the payment of public and private debts. Such payment shall be made at the principal corporate trust office of the Master Trustee or, if an Obligated Issuer so elects, by check, draft or wire transfer to such Holder. In the case of all payments made directly to a Holder, the Obligated Issuer shall give notice of such payment to the Master Trustee concurrently with the making thereof.

Each Obligated Issuer, jointly and severally, unconditionally guarantees to the Holders of the Obligations and to the Master Trustee the due and punctual payment of the principal of, and interest on, the Obligations and all other amounts due and payable under the Master Indenture; provided, however, that the maximum aggregate liability of each Obligated Issuer, as of any date, shall be its Maximum Guaranty Liability as of such date.

Each Obligated Issuer shall be subrogated to all rights of the Holders of the Obligations and the Master Trustee against the other Obligated Issuers in respect of any amounts paid pursuant to the Master Indenture.

If any person ceases to be an Obligated Issuer, such person shall cease to be a “Cross Guarantor” under the Master Indenture, and its Obligations as such shall be terminated and released; provided, however, that the foregoing provision is inapplicable (i) if such person ceases to be an Obligated Issuer as a result of a transaction which is prohibited by the terms of the Master Indenture or (ii) if, at the time such person would otherwise have been released under the provisions of this paragraph, there has occurred and is continuing a default in the payment of principal, or interest, on any Obligation.

If an Obligated Issuer is called upon to make a payment under its Cross Guarantee, each of the Obligated Issuers shall contribute to such paying Obligated Issuer their pro rata share, determined pursuant to the Master Indenture, of the amount of such payment.

All Obligations shall be executed for and on behalf of an Obligated Group Member by the officer as specified in the Master Indenture or such other officer designated in writing. A resolution of the Governing Body of the Obligated Group Agent shall also be joined thereto. Further, each Obligation shall be manually authenticated, in the form provided in the Master Indenture, by an authorized signer of the Master Trustee, without which authentication no Obligation shall be valid or entitled to the benefits of the Master Indenture.

The Master Trustee shall maintain at its principal corporate trust office a registration book relating to Obligations of the Obligated Group. These registration books shall contain (i) the names and addresses of Holders of Obligations, and (ii) any other information which may be necessary for the proper discharge of the Master Trustee’s duties under the Master Indenture. The Supplemental Indenture, providing for the issuance thereof, shall govern the transfer or exchange of any Obligation.

If any Obligation is mutilated, lost, stolen or destroyed, the Holder thereof shall be entitled to the issuance of a substitute Obligation only as follows:

(i) In the case of a lost, stolen or destroyed Obligation, the Holder shall: provide notice of the loss to the Obligated Group Agent, or to the Master Trustee; request the issuance of a substitute Obligation before the Obligated Group Agent receives notice of the transfer of the original Obligation to a bona fide purchaser for value without notice; provide indemnity to the Master Trustee against any and all claims arising out of, or otherwise related to, the issuance of substitute Obligations; and shall surrender any Obligation which have not been lost, stolen or destroyed and provide evidence of the ownership of the affected Obligation and the loss, theft or destruction thereof;

(ii) In the case of a mutilated Obligation the Holder shall: surrender the Obligation to the Master Trustee for cancellation; and provide indemnity to the Master Trustee against any and all claims arising out of, or otherwise related to, the issuance of substitute Obligations.

Every substituted Obligation shall constitute an additional contractual obligation of the Obligated Group, whether or not the Obligation alleged to have been destroyed, lost or stolen shall be at any time enforceable by anyone, and shall be entitled to all the benefits of the Master Indenture equally and proportionately with any and all other Obligations, unless the Obligation alleged to have been destroyed, lost or stolen shall be at any time enforceable by a bona fide purchaser for value without notice.

The preceding provisions regarding substitute Obligations are exclusive with respect to the replacement or payment of mutilated, destroyed, lost or stolen Obligations and shall preclude any and all other rights or remedies, notwithstanding any law or statute existing or later enacted to the contrary.

The Master Trustee shall establish and maintain a revenue or similar debt service fund for the purpose of accumulating and paying amounts due on outstanding Obligations (i) if the applicable Supplemental Indenture provides for the making of deposits directly with the Master Trustee in respect of an Obligation, or (ii) upon the occurrence of an Event of Default under the Master Indenture and the exercise of any remedies by the Master Trustee for the benefit of all Holders of outstanding Obligations. All money held in any fund established under the Master Indenture, in the case of (i) above, shall, upon written request and direction of the Obligated Group Agent, be invested in Investment Securities, and any money realized by the Master Trustee in the case of (ii) above, shall be invested by the Master Trustee, without need of any further authorization or direction, only in Government Obligations with maturities not in excess of ninety days, unless the Master Trustee is otherwise directed by Holder. The Master Trustee shall not be liable or responsible for any loss resulting from any such investment.

Any Obligated Issuer and the Master Trustee may enter into a Supplemental Indenture to create an Obligation issued under the Master Indenture. The Supplemental Indenture shall (i) with respect to Obligations created thereby, set forth the date thereof, and the date or dates on which principal of, premium, if any, and interest on such Obligations shall be payable, and (ii) provide for the form of such Obligations and shall contain such other terms and provisions as shall not be inconsistent with the provisions of the Master Indenture.

Simultaneously with or prior to the execution, authentication and delivery of the Obligations pursuant to the Master Indenture:

(a) All requirements and conditions to the issuance of such Obligations, if any, set forth in the Master Indenture and the Supplemental Indenture shall have been complied with and satisfied;

(b) The applicable Obligated Issuer or the Obligated Group Agent shall have delivered to the Master Trustee such opinions, certificates, proceedings, instruments and other documents as the Master Trustee or the Related Bond Issuer, if any, may reasonably request;

(c) The requirements of the Master Indenture with respect to the incurrence of Additional Indebtedness shall have been satisfied if such Obligations constitute Indebtedness;

(d) Each Supplemental Indenture shall specify the purpose or purposes for which such Obligations are being issued, which may be any purpose within the corporate power of the applicable Obligated Issuer; and

(e) The Obligated Group Agent shall have delivered to the Master Trustee an opinion of counsel, regarding the Securities Act of 1933 and the Trust Indenture Act of 1939, as required pursuant to the Master Indenture.

Security For Obligations

As security for the payment and performance of all outstanding Obligations, the Obligated Issuers shall grant the Master Trustee a security interest in (i) all money and Investment Securities which may at any time be held by the Master Trustee in any fund or account which may be established by the Master Trustee under the Master Indenture in connection with the administration of the trusts created thereby, (ii) all Gross Receipts, (iii) all Receivables, (iv) all Inventory, (v) all Equipment, (vi) all General Intangibles, (vii) all Contracts and all Contract Rights, (viii) all amounts from time to time held in any checking, savings, deposit or other account of any Obligated Issuer, (ix) all Government Approvals, provided, that any Government Approval which by its terms or by the operation of law would become void, voidable, terminable or revocable if mortgaged, pledged or signed under the Master Indenture or if a security interest therein were granted thereunder or expressly accepted and excluded from the security interest hereby granted to the extent necessary so as to avoid such voidness, voidability, terminability or revocability, (x) all Fixtures, including but not limited to those now or hereafter attached to, placed on or incorporated in the Land, (xi) all Revenues, (xii) without limiting the generality of the foregoing, all other personal property, goods, Instruments, Investment Property, Chattel Paper, Documents, credits, claims, demands and assets of any Obligated Issuer, whether now existing or hereafter acquired from time to time, and (xiii) any and all additions and accessions to any of the foregoing, all improvements thereto, all substitutions and replacements therefor and all products and Proceeds thereof (all of the above collectively, the "Collateral"), to have and to hold in trust for the benefit of the Holders from time to time of all Obligations issued and outstanding under the Master Indenture, without preference or priority of any one Obligation over any other Obligation except as otherwise expressly provided therein. The security interest granted to the Master Trustee pursuant to the Master Indenture extends to all Collateral of the kind which is subject to such security interest which any Obligated Issuer may acquire at any time during the continuation of the Master Indenture, whether such Collateral is in transit or in such Obligated Issuer, the Issuer's or any other person's constructive, actual or exclusive occupancy or possession.

To further secure the payment of and performance under all outstanding Obligations, the Corporation has, on even date herewith, executed and delivered to the Master Trustee the Master Deed of Trust.

If (i) in any Fiscal Year beginning with the Fiscal Year ending June 30, 2006, the Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group is less than 1.50 to 1, (ii) the Obligated Group is not in compliance with the liquidity covenant described under the caption "Liquidity Covenant" herein, or (iii) an Event of Default has occurred and is continuing, the Obligated Group Agent shall cause a special trust fund (the "Revenue Fund") to be created with one or more banking institutions and each Obligated Issuer shall on a daily basis deposit all of its Gross Receipts therein.

The Obligated Group Agent shall cause each banking institution with which the Revenue Fund has been established to enter into a written depository agreement, which shall be satisfactory in form and substance to the Master Trustee and shall be in substantially the form of such agreement heretofore delivered to the Master Trustee (or with such changes therein as shall have been approved by the Holders of not less than 75% in aggregate principal amount of Obligations then outstanding) pursuant to which such banking institution shall agree to hold any and all Gross Receipts from time to time on deposit with such banking institution as assets of a trust for the Holders of the Obligations and to transfer such Gross Receipts to the Master Trustee upon receipt from the Master Trustee of a notice stating that delivery of such Gross Receipts is required pursuant to the Master Indenture. Prior to its receipt of a request from the Master Trustee, any Obligated Group member may transfer or expend all or any part of its Gross Receipts free of any security interest, subject, however, to the provisions of the Master Indenture. Deposits of Gross Receipts shall be made into the Revenue Fund on a daily basis, insofar as practicable, for the benefit of the Master Trustee and the Holders of the Obligations. Upon the request of the Obligated Group Agent, the Master

Trustee will provide to such agent a written certifications as to whether there is currently outstanding a request from the Master Trustee.

Each Obligated Issuer agrees that except as may be otherwise provided in the Master Indenture, it will not pledge or grant a security interest in any of the Gross Receipts.

Each Obligated Issuer agrees that, if an Event of Default shall have occurred and be continuing, it will, upon request of the Master Trustee, deliver or direct to be delivered to the Master Trustee all Gross Receipts until such Event of Default has been cured, such Gross Receipts to be applied in accordance with the Master Indenture.

The Master Trustee shall establish and maintain a revenue or similar debt service fund hereunder for the purpose of accumulating and paying amounts due on outstanding Obligations (i) if the applicable Supplemental Indenture specifically provides for the making of deposits directly with the Master Trustee in respect of an Obligation, or (ii) upon the occurrence of an Event of Default and the exercise of any remedies by the Master Trustee for the benefit of all Holders of outstanding Obligations; provided, however, if neither (i) nor (ii) are at the time applicable but deposits to the Revenue Fund are then required under subsection (a) above, the Obligated Group Agent may deposit the Gross Receipts with one or more banking institutions (other than the Master Trustee) and such revenues shall, upon the request and direction of the Obligated Group Agent, be invested in Investment Securities. In the case of (i) above, deposits to any such fund and payments therefrom shall be made in accordance with the terms and provisions of the applicable Supplemental Indenture for the making of deposits into and payments from such fund. In the case of (ii) above, any moneys realized by the Master Trustee upon the exercise of any such remedies shall be applied in accordance with the provisions of the Master Indenture. All money held at any time in any fund in the case of (i) above, shall, upon written request and direction of the Obligated Group Agent, be invested in Investment Securities and any money realized by the Master Trustee in the case of (ii) above, shall be invested by the Master Trustee, without need of any further authorization or direction, only in Government Obligations having maturities not in excess of 90 days, unless the Master Trustee is otherwise directed by Holders in the manner provided in the Master Indenture.

Persons Becoming Obligated Issuers; Withdrawal from Obligated Group

The Master Indenture permits persons other than the Corporation to become members of the Obligated Group subject to the satisfaction of certain conditions. The conditions include the following:

First, such person shall execute and deliver to the Master Trustee an appropriate instrument, satisfactory to the Obligated Group Agent, containing (i) the agreement of such person to become an Obligated Issuer under the Master Indenture and thereby to become subject to compliance with all provisions of the Master Indenture pertaining to an Obligated Issuer, including the performance and observance of all covenants and obligations of an Obligated Issuer under the Master Indenture; (ii) the agreement of such person to consult with each other member of the Obligated Group prior to incurring any Obligations; and (iii) such other restrictions on the ability of such person to incur Obligations as shall be imposed by the Obligated Group. Such person shall execute and deliver to the Master Trustee such security agreements, financing statements and other documents as are necessary to grant to the Master Trustee a perfected lien in all Collateral in which such person has an interest.

Second, each instrument executed and delivered to the Master Trustee in accordance with the preceding paragraph shall be accompanied by an Officer's Certificate from the Obligated Group Agent to the effect that the Obligated Group Agent consents to such person becoming an Obligated Issuer and an opinion of Counsel to the effect that (a) the conditions contained in the Master Indenture relating to such person's membership in the Obligated Group have been satisfied; (b) under then existing law, such person becoming an Obligated Issuer will not subject any Obligation to the registration provisions of the Securities Act of 1933, as amended, or that such Obligation has been so registered if so required, or the qualification of the Master Indenture pursuant to the Trust Indenture Act of 1939, as amended, or that the Master Indenture has been so qualified if qualification is required; and (c) each such instrument has been duly authorized, executed and delivered by such person and constitutes a legal, valid and binding agreement, enforceable in accordance with its terms, except as limited by then-existing laws relating to bankruptcy and insolvency and other standards and customary legal exceptions.

If all amounts due or to become due on any outstanding Related Bond which bears interest that is not includable in gross income under the Code has not been paid to the holder thereof (or provision for such payment has not been made in such manner as to have resulted in the defeasance of the Related Financing Documents), the Master Trustee shall receive an Opinion of Bond Counsel to the effect that under then existing law such person becoming an Obligated Issuer would not adversely affect the validity of such Related Bond or cause the interest payable on such Related Bond to become includable in gross income under the Code.

As a further condition to a person becoming a member of the Obligated Group, the Master Trustee shall receive an Officer's Certificate from the Obligated Group Agent to the effect that (A) no Event of Default then exists under the Master Indenture, nor to such officer's knowledge, does there then exist any event which, with the passage of time or giving of notice or both, would or might become an Event of Default under the Master Indenture, and (B) either (1) if one dollar of Additional Indebtedness were incurred immediately following such person's admission, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to subsection (a)(i) or (ii) under the heading "Additional Long-Term Indebtedness" (assuming, for purposes of such certificate, that the Income Available for Debt Service and Indebtedness of such person were Income Available for Debt Service and Indebtedness of an Obligated Issuer), or (2) such person becoming a member of the Obligated Group will cure any Event of Default then in existence under the Master Indenture, or (3) by reason of such membership, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years following such entry into the Obligated Group will be greater than the projected Debt Service Coverage Ratio for such Fiscal Years had such entry into the Obligated Group not occurred, and (C) immediately after such person's admission, the combined fund balance and net worth, as the case may be, of the Obligated Group is not less than 90% of such combined fund balance and net worth immediately prior to such admission, and (D) the Historical Pro Forma Debt Service Coverage Ratio of the Obligated Group (taking into account the admission of such person) for each of the two most recent Fiscal Years for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available was not less than 1.30:1.

As a further condition to a person becoming a member of the Obligated Group, the Master Trustee shall receive a Consultant's report to the effect that the Projected Debt Service Coverage Ratio of the Obligated Group (taking into account the admission of such person) for each of the two Fiscal Years following the admission of such person is not less than 1.30:1.

The Corporation shall not withdraw from the Obligated Group. No other Obligated Issuer may withdraw from the Obligated Group unless:

(i) If the Obligated Issuer is other than the Obligated Group Agent, the Obligated Group Agent consents to the withdrawal;

(ii) If all amounts due on any outstanding Related Bond which bears interest that is not includable in gross income under the Code have not been paid to the holder thereof (or provision for such payments has not been made in such manner as to have resulted in the defeasance of the Related Financing Documents), the Master Trustee shall have received an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law such person's withdrawal from the Obligated Group would not adversely affect the validity of such Related Bond or cause the interest payable on such Related Bond to become includable in gross income under the Code;

(iii) The Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that either (1) after giving effect to such withdrawal, if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to subsection (a)(i) or (ii) under the heading "Additional Long-Term Indebtedness," or (2) such person's withdrawal from the Obligated Group will cure any Event of Default then in existence under the Master Indenture, or (3) by reason of such withdrawal, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years immediately following withdrawal of such Obligated Issuer from the Obligated Group will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such withdrawal not occurred;

(iv) The Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that, immediately after the withdrawal of such person from the Obligated Group, no Event of Default then exists under the Master Indenture, nor to such officer's knowledge, does there then exist any event which, with the passage of time or giving of notice or both, would or might become an Event of Default; and

(v) The Master Trustee shall have received a Consultant's report to the effect that the Projected Debt Service Coverage Ratio of the Obligated Group (taking into account the withdrawal of such person) for each of the two Fiscal Years following the withdrawal of such person is not less than 1.3:1;

(vi) The Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that the Historical Pro Forma Debt Service Coverage Ratio of the Obligated Group (taking into account the withdrawal of such Obligated Issuer) for each of the two most recent Fiscal Years for which consolidated or combined financial statements reported upon an independent certified public Accountant are available was not less than 1.30 to 1; and

(vii) The Obligated Group Agent shall have received an opinion of Counsel to the effect that following such person's withdrawal from the Obligated Group no member of the Obligated Group will have any liability for the payment of any indebtedness of such person.

Upon compliance with the above conditions, the Master Trustee shall execute any documents reasonably requested by the withdrawing Obligated Issuer to evidence the termination of such Issuer's obligations under the Master Indenture, under any Supplemental Indenture and under all Obligations.

Short-Term Indebtedness

Each Obligated Issuer agrees that it will not incur, nor permit any of its Restricted Affiliates to incur, any Additional Indebtedness constituting Short-Term Indebtedness unless immediately after the incurrence of such Short-Term Indebtedness:

(a) (i) the principal amount of all Short-Term Indebtedness of the Obligated Group then outstanding does not exceed 20% of the Total Net Operating Revenues for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available, or

(ii) any such Short-Term Indebtedness could be incurred under the tests set forth in the Master Indenture (relating to Long-Term Indebtedness) treating such Short-Term Indebtedness as Long-Term Indebtedness, and

(b) For a period of not fewer than 15 consecutive days within each Fiscal Year, the Obligated Group shall reduce the aggregate principal amount of all outstanding Short-Term Indebtedness described in (a)(i) above to less than 5% of the Total Net Operating Revenues for the immediately preceding Fiscal Year.

Additional Long-Term Indebtedness

Each Obligated Issuer agrees that it will not incur nor permit any of its Restricted Affiliates to incur, any Additional Indebtedness constituting Long-Term Indebtedness unless such Long-Term Indebtedness consists of one or more of the following:

(a) Long-Term Indebtedness of any member of the Obligated Group, if prior to the incurrence thereof, there is delivered to the Master Trustee:

(i) an Officer's Certificate of the Obligated Group Agent demonstrating that the Historical Pro Forma Debt Service Coverage Ratio for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available, was not less than 1.35; or

(ii) (A) an Officer's Certificate of the Obligated Group Agent demonstrating that the Historical Maximum Annual Debt Service Coverage Ratio for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available, was not less than 1.25 and (B) a Consultant's report (or, in lieu thereof, an Officer's Certificate of the Obligated Group Agent if the Projected Debt Service Coverage Ratio described in this subsection (B) is 1.75 or greater) to the effect that the Projected Debt Service Coverage Ratio, taking the proposed Additional Indebtedness into account, (x) in the case of Additional Indebtedness (other than a Guaranty) to finance capital improvements, for each of the two Fiscal Years succeeding the date on which such capital improvements are expected to be in operation, or (y) in the case of Long-Term Indebtedness not financing capital improvements or in the case of a Guaranty, for each of the two Fiscal Years succeeding the date on which the Indebtedness or Guaranty is incurred, is not less than 1.40.

The requirements of (a)(ii)(A) and (B) will be deemed satisfied if (i) a Consultant's report filed with the Master Trustee states that applicable laws or regulations have prevented or will prevent the achievement of such debt service coverage ratios, (ii) the Obligated Group has generated Total Income Available for Debt Service in an amount which, in the opinion of such Consultant, the Obligated Group could reasonably have generated given such laws and regulations during the period affected thereby.

(b) Completion Indebtedness of any member of the Obligated Group without limit if there is delivered to the Master Trustee: (i) an Officer's Certificate of the applicable member of the Obligated Group stating that at the time the original Long-Term Indebtedness for the Facilities to be completed was incurred, such Obligated Group member had reason to believe that the proceeds of such Long-Term Indebtedness, together with other moneys then expected to be available, would provide sufficient moneys for the completion of such Facilities; (ii) a statement of an Architect or an expert setting forth the amount estimated to be needed to complete the Facilities, and (iii) an Officer's Certificate of such member of the Obligated Group stating that the proceeds of such Completion Indebtedness to be applied to the completion of the Facilities, together with a reasonable estimate of investment income to be earned on such proceeds and the amount of moneys, if any, committed to such completion by such Obligated Group member or through enumerated bank loans (including letters or lines of credit) or through federal or state grants, will be in an amount not less than the amount set forth in the statement of an architect or other expert referred to in (ii).

(c) Commitment Indebtedness of any member of the Obligated Group or any Guaranty of any Commitment Indebtedness of any member of the Obligated Group without limit.

(d) Long-Term Indebtedness of any member of the Obligated Group incurred for the purpose of refunding, repurchasing or refinancing (whether in advance or otherwise) any outstanding Long-Term Indebtedness; provided, however, that additional Long-Term Indebtedness permitted under this paragraph (d) shall not result in an increase in Maximum Annual Debt Service in excess of 10%.

(e) The conversion without limit of Long-Term Indebtedness of any member of the Obligated Group that is convertible from one interest or payment made to another interest or payment (e.g., weekly to monthly or to a fixed rate) from one mode to another pursuant to the terms of the documentation authorizing such Long-Term Indebtedness.

(f) Subordinated Indebtedness without limit of any member of the Obligated Group or Non-Recourse Indebtedness without limit of any member of the Obligated Group; provided, however, that in the case of Subordinated Indebtedness, the Obligated Group Agent shall have furnished the Master Trustee with a certificate showing that prior to the issuance of such Subordinated Indebtedness, the debt to capitalization ratio of the Obligated Group does not exceed 60%.

(g) Indebtedness incurred in connection with a sale of not more than 25% of accounts receivable with recourse by any member of the Obligated Group consisting of an obligation to repurchase all or a portion of such accounts receivable upon certain conditions, provided that the principal amount of such Indebtedness permitted shall not exceed the aggregate sales price of such accounts receivable received by such Obligated Group member.

(h) Long-Term Indebtedness of any member of the Obligated Group, the principal amount of which at the time incurred, together with the aggregate principal amount of all other Long-Term Indebtedness and Short-Term Indebtedness of the Obligated Group then outstanding, does not exceed 25% of the Total Net Operating Revenues for the most recent Fiscal year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available.

(i) Long-Term Indebtedness of any member of the Obligated Group if prior to the incurrence thereof an Officer's Certificate of the Obligated Group Agent is delivered to the Master Trustee certifying that, immediately following the incurrence of such Long-Term Indebtedness, the total outstanding Long-Term Indebtedness of the Obligated Group will not exceed 66-2/3% of the sum of the principal amount of all outstanding Long-Term Indebtedness of the Obligated Group, plus the equity accounts of the Obligated Group (i.e., unrestricted fund balances, including any shareholder equity or partnership equity).

Guaranties

Each Obligated Issuer agrees that it will not enter into, or become liable in respect of, or permit any Restricted Affiliate to enter into, or become liable in respect of, any Guaranty dated after the date of the Master Indenture unless the principal amount of the indebtedness being guaranteed could then be incurred as Indebtedness described under the heading "Additional Long-Term Indebtedness," taking into account the assumptions as to calculating the aggregate annual principal and interest payments on, and the principal amount of, the indebtedness being guaranteed, contained in the immediately succeeding paragraph.

In the case of Guaranties of indebtedness that would, if such indebtedness were incurred by a member of the Obligated Group, constitute Long-Term Indebtedness, the aggregate annual principal and interest payments on, and the principal amount of, the Guaranty shall be deemed to be equal to 20% of the principal and interest payments which would be payable on the indebtedness being guaranteed as if such indebtedness were Long-Term Indebtedness of the Guarantor. If at any time the Guaranty becomes due and payable, or if any payment has been made under the Guaranty during the two immediately preceding Fiscal Years, the aggregate annual principal and interest payments on, and the principal amount of, the Guaranty shall, for purposes of this paragraph, be deemed to equal 100% of the principal and interest payable on, and the principal amount of, the indebtedness being guaranteed for the Fiscal Year for which such determination is being made.

Debt Service on Balloon Indebtedness and Variable Rate Indebtedness

For purposes of the covenants and computations required or permitted pursuant to the Master Indenture, it shall be assumed that (A) the interest rate on Variable Rate Indebtedness is equal to the higher of (a) the current rate on the Variable Rate Indebtedness or (b) that rate that is the average of the rate of interest which was in effect on the last day of each of the twelve preceding full calendar months immediately preceding the month in which such calculation is made, provided that if the Variable Rate Indebtedness has not been outstanding for at least twelve full calendar months, the assumed rate of interest for such Variable Rate Indebtedness shall be the rate of interest borne on the date such Variable Rate Indebtedness was issued and (B) the principal of Balloon Indebtedness is amortized:

(i) from the date of calculation thereof over a term equal to twenty (20) years, with level annual debt service payments at an assumed interest rate equal to the Bond Index (provided if the Balloon Indebtedness is also Variable Rate Indebtedness, the assumed interest rate may, at the option of the Obligated Group Agent, be the assumed interest rate applicable to Variable Rate Indebtedness); or

(ii) during the term to the maturity thereof by deposits made to a sinking fund therefor pursuant to the terms of such Balloon Indebtedness or in accordance with a sinking fund schedule established by resolution of the Governing Body of the applicable Obligated Issuer adopted at or subsequent to the time of incurrence of such Balloon Indebtedness, as certified in an Officer's Certificate, provided that, at the time of such calculation, all deposits required to have been made prior to such date shall have been made; or

(iii) the principal of Balloon Indebtedness is due and payable on the specified due date or due dates thereof; or

(iv) with respect to Balloon Indebtedness for which there exists a Credit Facility, the principal of such Balloon Indebtedness is due and payable in the amounts and at the times specified in the Credit Facility or related documents.

Insurance

Each Obligated Issuer will maintain, or cause to be maintained, insurance covering such risks and in such amounts as, in its reasonable judgment, is adequate to protect it and its Property and operations, including (to the extent that such Obligated Issuer is a health care institution) professional liability or medical malpractice insurance, one year's business interruption insurance (if commercially available) and extended coverage property insurance in an amount sufficient to avoid co-insurance. The Master Trustee shall be named as an additional insured on all such insurance policies. The Obligated Group Agent shall retain an Insurance Consultant who will prepare and file with the Master Trustee a report showing the adequacy of such insurance once every two years (such report to be filed as soon as practicable but in no event later than five months after the end of the applicable second Fiscal Year). Each Obligated Issuer will follow any recommendations of the Insurance Consultant to the extent feasible in the opinion of the Obligated Group Agent.

In lieu of maintaining the insurance policies required above, the Obligated Group, or any member thereof, may self-insure any of the required coverages (or a portion thereof), provided that the Obligated Group may not self-insure any required coverage with respect to Property, Plant and Equipment and provided further that the Master Trustee receives a report (as soon as practicable but in no event later than five months after the end of each Fiscal Year) of an Insurance Consultant to the effect that such self-insurance is consistent with proper management and insurance practices. If any member of the Obligated Group elects to self-insure in lieu of maintaining medical liability and malpractice insurance, a report of an Insurance Consultant shall be filed with the Master Trustee annually stating that such Insurance Consultant has reviewed the self-insurance program and that the self-insured Obligated Group Member has available the estimated amount required for the payment of claims and associated claims expenses with respect to such Fiscal Year.

In the event of damage to or destruction of all or any part of the Facilities of the Obligated Group with a Value in excess of five percent (5%) of the Value of all Property of the Obligated Group, the affected Obligated Group member or the Obligated Group Agent shall exercise its best efforts to recover any applicable insurance. Such proceeds shall be paid to the Obligated Group Agent for the payment or reimbursement of reasonable expenses of obtaining the recovery. The Obligated Group Agent shall then give notice to the Master Trustee of such expenses and of the amount of the remaining proceeds (herein called the "Net Proceeds").

Subject to the provisions of any Related Financing Document pertaining to a Permitted Lien, the affected Obligated Group member shall apply the Net Proceeds for any lawful corporate purpose as such Obligated Group member determines, if the Obligated Group Agent shall first have delivered to the Master Trustee an Officer's Certificate stating that the Projected Debt Service Coverage Ratio for each of the next two full succeeding Fiscal Years immediately following the date of such certificate(s), taking into account such damage or destruction and the proposed use of the Net Proceeds is at least 1.10. If the Obligated Group Agent is unable to deliver the foregoing Officer's Certificate, the affected Obligated Group member shall apply the Net Proceeds or so much thereof as may be needed to the repair, replacement, restoration or reconstruction of the affected Facilities or, at the option of the applicable Obligated Group member, to any other capital project of equivalent value and utility, to the acquisition of any Property or to the repayment in whole or in part of any outstanding Obligations in such order of maturity or maturities or proportions as the Obligated Group Agent shall determine.

Any Net Proceeds remaining after compliance by the affected Obligated Group member and the Obligated Group Agent with the immediately preceding paragraph shall be transferred by the Obligated Group Agent to the Master Trustee and applied to the redemption of the outstanding Obligations that directly finance the damaged or condemned facilities and are secured thereby, second to other direct outstanding Obligations of the affected Member of the Obligated Group, and third to the redemption of other outstanding Obligations in such order of maturity or maturities or proportions as the Obligated Group Agent shall determine.

In the event of a taking by eminent domain of all or any part of the Facilities of the Obligated Group with a Value in excess of five percent (5%) of the Value of all Property of the Obligated Group, the affected Obligated Group member or the Obligated Group Agent shall exercise its best efforts to recover any applicable proceeds. Such proceeds shall be paid to the Obligated Group Agent. The Obligated Group Agent shall make appropriate deductions from such proceeds and give notice to the Master Trustee of such deductions and of the amount of the remaining proceeds (also, "Net Proceeds"). The Net Proceeds shall be applied in the same manner as insurance proceeds are applied pursuant to the two immediately preceding paragraphs.

Certain Covenants of the Obligated Issuers

Each Obligated Issuer covenants, among other things, to maintain its corporate or other separate legal existence and to be qualified to do business where such qualification is necessary, to maintain and keep its Facilities in good repair, to conduct its affairs in compliance with all applicable laws and regulations, to pay all lawful taxes and governmental charges and assessments levied or assessed upon or against it or its Property (except that each Obligated Issuer may withhold such payments where the validity of such taxes and assessments is being contested in good faith), to comply with any covenants and provisions of any Liens upon its property or securing any of its Indebtedness, to procure and maintain all necessary licenses and permits, to maintain accreditation of its health care Facilities and its status as a provider of health care services eligible for reimbursement under government programs (provided, however, that it need not comply with the requirements pertaining to licenses, permits, accreditation and its status as a provider if and to the extent its Governing Body shall have determined in good faith, evidenced by an Officer's Certificate that such compliance is not in its best interests and that lack of such compliance would not materially impair its ability to pay its indebtedness when due).

In addition, each Obligated Issuer covenants not to merge with or consolidate with any other person not a member of the Obligated Group or sell or convey all or substantially all of its assets to any person not a member of the Obligated Group unless: (a) the successor corporation (if other than the Obligated Issuer) shall be a person organized and existing under the laws of the United States of America or a state thereof and such person shall become an Obligated Issuer and shall expressly assume the due and punctual payment of the principal of, premium, if any, and interest on all outstanding Obligations according to their tenor, and the due and punctual performance and observance of all of the covenants and conditions of the Master Indenture by a Supplemental Indenture satisfactory to the Master Trustee, executed and delivered to the Master Trustee by such person; (b) if all amounts due or to become due on any outstanding Related Bonds which bear interest that is not includable in gross income under the Code have not been fully paid to the holders thereof (or provision for such payment has not been made in such manner as will result in the defeasance of the Related Financing Documents), the Master Trustee shall have received an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law the consummation of such merger, consolidation, sale or conveyance, whether or not contemplated on the date of the delivery of any such Related Bonds, would not cause the interest payable on such Related Bonds to become includable in gross income under the Code or adversely affect the validity of such Related Bonds; and (c) there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent to the effect that immediately following such transaction, (A) no Event of Default then exists nor, to such officer's knowledge, does there exist any event which, with the passage of time or the giving of notice or both, would or might become an Event of Default under the Master Indenture, and (B) either (1) if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the tests providing for the incurrence of Long-Term Indebtedness described in subsection (a)(i) or (ii) under the heading Additional Long-Term Indebtedness (assuming for purposes of such Certificate that the Income Available for Debt Service and Indebtedness of such person were Income Available for Debt Service and Indebtedness of an Obligated Issuer), or (2) such transaction will cure any Event of Default then in existence under the Master Indenture, or (3) by reason of such transaction, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years following such release will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such transaction not occurred, and (C) the combined fund balance and net worth, as the case may be, of the Obligated Group will not be less than 90% of such combined fund balance and net worth immediately prior to such transaction.

In case of any such consolidation, merger, sale or conveyance and upon any such assumption by the successor corporation, such successor corporation shall succeed to and be substituted for its predecessor.

In case of any such consolidation, merger, sale or conveyance, such changes in phraseology and form (but not in substance) may be made in Obligations thereafter to be issued as may be appropriate.

Permitted Encumbrances

No Obligated Issuer will create or suffer to be created or to exist (or permit any Restricted Affiliate to create or suffer to be created or to exist) any Lien upon any of their Property including, without limitation, all proceeds thereof, whether cash or non-cash, now owned or after acquired by any of them, other than Permitted Liens.

Disposition of Property

Each Obligated Issuer agrees that neither it will sell, lease or otherwise dispose of any Property, except for sales, leases or other dispositions of Property:

- (a) To another member of the Obligated Group;
- (b) To any person if prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate stating that, in the judgment of the officer executing such certificate, such Property has become, or within the next succeeding 24 calendar months is reasonably expected to become, inadequate, obsolete, worn out, unsuitable, unprofitable, undesirable or unnecessary and sale, lease, removal or other disposition thereof will not impair the structural soundness, efficiency or economic value of the remaining Property;
- (c) To any person provided that prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent certifying (1) that Property transferred pursuant to this section in the then-current Fiscal Year by all Obligated Issuers does not exceed 5% of the Value of all Property of the Obligated Group for the immediately preceding Fiscal Year and (2) that Property transferred pursuant to this section in the then-current Fiscal Year and in each of the immediately preceding three Fiscal Years by all Obligated Issuers does not in the aggregate exceed 15% of the Value of all Property of the Obligated Group for the immediately preceding Fiscal Year;
- (d) To any person provided that prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent, to the effect that immediately after the transfer in question, either (1) if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to subsection (a)(i) or (ii) above contained under the heading Additional Long-Term Indebtedness or (2) such disposition will increase the Projected Debt Service Coverage Ratio in the Fiscal Year immediately following such disposition over what such ratio would have been in such Fiscal Year had such disposition not occurred;
- (e) As part of a merger, consolidation, sale or conveyance permitted under the heading "Certain Covenants of the Obligated Issuers";
- (f) In the ordinary course of business;
- (g) To any person in connection with an operating lease of Property to such person;
- (h) Upon fair and reasonable terms no less favorable than would be obtained in a comparable arm's-length transaction;
- (i) To any person if the transfer involves any Property received as restricted gifts, grants, bequests or other similar sums or the income thereon, to the extent that such sums may not be pledged or applied to the payment of any Debt Service Requirement or operating expenses generally as a result of restrictions or designations imposed by the donor or maker of the gift, grant, bequest or other sums in question; or

(j) To any person so long as such Property is not encumbered by the Master Deed of Trust and the amount of Property transferred pursuant to this subsection (j) in any Fiscal Year shall not exceed \$5,000,000.

To the extent that any Property of the Corporation that is permitted to be sold, leased or otherwise disposed of under the foregoing is encumbered by the Master Deed of Trust or the Master Indenture, upon receipt of an Officer's Certificate directing the Master Trustee to execute a release and/or termination statement with respect to such property to be sold, the Master Trustee shall execute and deliver to the Corporation a release and/or termination statement with respect to such property; provided, however, that no real property encumbered by the Master Deed of Trust shall be sold, leased or otherwise disposed of unless (1) such sale, lease or disposition is permitted under one of the provisions above and the Value of the Property being sold, leased or otherwise disposed of does not exceed \$2,500,000 or (2) such Property is sold for fair market value (as determined by an appraisal delivered to the Master Trustee), provided that if such sale is of real property having an aggregate Book Value in excess of \$15,000,000, the Corporation shall deliver to the Master Trustee an Officer's Certificate of the Obligated Group Agent to the effect that immediately after the transaction in question the Obligated Group (i) will have a Days Cash on Hand Ratio equal to or greater than 50 and (ii) will be in compliance with the provisions of the Master Indenture relating to rates and charges. In the event that any Property is released from the Master Deed of Trust pursuant to clause (2) of the immediately preceding sentence, the consideration received by the Corporation from the sale of such Property shall be applied to acquisition, construction or equipping of facilities for use by the Obligated Group or to the optional redemption or defeasance of outstanding Related Bonds, provided, however, that if outstanding Related Bonds are insured by the Bond Insurer at the time of such sale, the Bond Insurer shall be entitled to approve the application of any such consideration that is not used to redeem or defease Related Bonds and may in connection with any such approval required the Obligated Group to encumber additional real property pursuant to the Master Deed of Trust with a Value not less than the Value of the Property being released.

Filing of Financial Statements, Certificate of No Default, Other Information

The Obligated Group Agent covenants that it will:

(a) As soon as practicable but in no event later than four months after the end of each Fiscal Year, file, or cause to be filed, with the Master Trustee and, if such persons are then providing a rating with respect to Obligations or any Related Bonds, with each Rating Agency, (i) a combined or consolidated revenue and expense statement of the Corporation, and each other Obligated Issuer, for such Fiscal Year and (ii) a combined or consolidated balance sheet of the Corporation and each other Obligated Issuer as of the end of such Fiscal Year, each accompanied by the required report of an Accountant.

(b) As soon as practicable but in no event later than four months after the end of each Fiscal Year, file with the Master Trustee, an Officer's Certificate of the Obligated Group Agent stating the Historical Debt Service Coverage Ratio and the Historical Maximum Annual Debt Service Coverage Ratio for such Fiscal year, stating that all insurance required by the Master Indenture has been obtained and is in full force and effect, and stating whether or not to the best knowledge of the signers, any Obligated Issuer is in default in the performance of any covenant contained in the Master Indenture, and, if so, specifying each such default of which the signers may have knowledge, and an Officer's Certificate stating the Historical Debt Service Coverage Ratio and the Historical Maximum Annual Debt Service Coverage Ratio for such fiscal year, provided, if either such ratio is less than 1.75 to 1.00, such Officer's Certificate shall be accompanied by a certificate of the accountant whose report accompanies the financial statements referred to in (a) above stating such ratios.

(c) If an Event of Default shall have occurred and be continuing, (i) file with the Master Trustee such other financial statements and information concerning its operations and financial affairs (or of any consolidated group of companies of which it is a member) as the Master Trustee may from time to time reasonably request, excluding specifically donor records, patient records and personnel records and (ii) provide access to its Facilities for the purpose of inspection by the Master Trustee during regular business hours or at such other times as the Master Trustee may reasonably request.

(d) Within 10 days after its receipt thereof, file with the Master Trustee a copy of each report which any provision of the Master Indenture requires to be prepared by a Consultant or an insurance consultant.

(e) As soon as practicable, but in no event later than 45 days after the end of each fiscal quarter, file, or cause to be filed, with the Master Trustee (i) a combined or consolidated revenue and expense statement of the Corporation and each other Obligated Issuer for such quarter, and (ii) a combined consolidated balance sheet presented on the basis described in (i) above as of the end of such quarter.

(f) Cause the information described in subsections (a), (b) and (e) above, including the calculations described in subsections (b) and (e) above, in each case any holder of \$1,000,000 or more in aggregate principal amount of Related Bonds who has requested such of the Corporation in writing (it being understood that such request may be a standing request).

Rates and Charges

Each Obligated Issuer covenants and agrees to operate, and to cause each of its Restricted Affiliates to operate on a revenue producing basis and to charge, and to cause each of its Restricted Affiliates to charge, such fees and rates for its Facilities and services and to exercise, and to cause each of its Restricted Affiliates to exercise, such skill and diligence as to provide income from its Property together with other available funds sufficient to pay promptly all payments of principal and interest on its Indebtedness, all expenses of operation, maintenance and repair of its Property and all other payments required to be made by it under the Master Indenture to the extent permitted by law, and to use its best efforts to maintain in each Fiscal Year beginning with the Fiscal Year ending June 30, 2001 a ratio of Total Income Available For Debt Service to Maximum Annual Debt Service at least equal to 1.30. Each Obligated Issuer further covenants and agrees that it will from time to time as often as necessary and to the extent permitted by law, revise its rates, fees and charges in such manner as may be necessary or proper to comply with the provisions of this Section.

If in any Fiscal Year beginning with the Fiscal Year ending June 30, 2001 the Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group is less than 1.30, the Master Trustee shall require the Obligated Group, at the expense of the Obligated Group, to retain a Consultant to make recommendations with respect to the rates, fees and charges of the Obligated Group and its methods of operation and other factors affecting its financial condition in order to increase such Historical Maximum Annual Debt Service Coverage Ratio to at least 1.30.

A copy of the Consultant's report and recommendations, if any, and any written responses from management of the Corporation, shall be filed with each Obligated Issuer, the Master Trustee, each Related Bond Trustee and each Related Issuer and, upon written request to the Corporation, any holder of at least \$1,000,000 in aggregate principal amount of Related Bonds. Each Obligated Issuer shall follow each recommendation of the Consultant applicable to it to the extent feasible (as determined by the Governing Body of such Obligated Issuer) and permitted by law. This Section shall not be construed to prohibit any Obligated Issuer from serving indigent patients to the extent required for such Obligated Issuer to continue its qualification as a Tax-Exempt Organization or from serving any other class or classes of patients without charge or at reduced rates so long as such service does not prevent the Obligated Group from satisfying the other requirements of this Section. So long as the Obligated Group shall retain a Consultant and shall follow such Consultant's recommendations to the extent permitted by law, this Section shall be deemed to have been complied with even if such ratio for any subsequent Fiscal Year is below 1.30:1; provided, however, that in no event shall the Historical Maximum Annual Debt Service Coverage Ratio for any year be less than 1.00:1.

Notwithstanding the provisions of the immediately preceding paragraph, if by the end of the second Fiscal Year after the Fiscal Year (beginning with the Fiscal Year ending June 30, 2001) for which the Obligated Group failed to achieve a Historical Maximum Annual Debt Service Coverage Ratio of at least 1.30:1 the Obligated Group has not achieved a Historical Maximum Annual Debt Service Coverage Ratio of at least 1.30:1, the Obligated Group shall be deemed to be in violation of the provisions of the Master Indenture.

The selection of any Consultant retained pursuant to this section and the scope of such Consultant's activities and recommendations shall be subject to the approval of the MBIA and ratification by each of the Holders of the two largest principal amounts of Uninsured Obligations; provided that the ratification by such Holders shall not be unreasonably withheld.

Liquidity Covenant

The Obligated Group shall maintain Unrestricted Liquid Funds as of the last day of each Fiscal Year to produce a Days Cash on Hand Ratio equal to or greater than 75 as of the last day of each Fiscal Year.

Accreditation

The Corporation shall not fail to maintain any accreditation status currently held by the Corporation with respect to its hospital facilities unless it provides the Master Trustee with a Consultant's opinion to the effect that failure to maintain any such accreditation will not adversely affect the Corporation's hospital facilities. Notwithstanding the foregoing, this Section shall not be construed to require the Corporation to continue to operate any hospital facility or to maintain any accreditation for any hospital facility that is closed.

Interest Rate Swap Obligations

The members of the Obligated Group may not enter into a Hedge Agreement without the prior written consent of the Bond Insurer (so long as any outstanding Related Bonds are insured by the Bond Insurer) unless the following conditions are met:

(a) The Hedge Agreement must be entered into as a hedge against (i) swaps currently outstanding (as in basis swaps or reverse swaps), or (ii) debt then outstanding or to be issued, or (iii) as a means of achieving forward transactions, or (iv) against assets held at the time of the execution of the Hedge Agreement;

(b) The Hedge Agreement does not contain any element of leverage or multiplier component in excess of 1.0x unless there is a matching hedge arrangement which effectively offsets the exposure from any such element or component;

(c) If an amount equal to the Maximum Adverse Termination Payment (as defined below) of all of the Hedge Agreements of the Obligated Group, then in effect and those to be executed, determined as noted in (i) and (ii) below, at the time the new Hedge Agreement is to be entered into were excluded from unrestricted cash and investments, the Days Cash on Hand Ratio would still be satisfied;

(i) The Obligated Group Agent shall calculate the Maximum Adverse Termination Amount in three steps. First, the Obligated Group Agent will determine the actual mark-to-market value of all existing Hedge Agreements of the Obligated Group using standard mark-to-market methodology. Second, the Obligated Group Agent will calculate the Adverse Termination Amount (as defined below) of the contemplated derivative based on (ii) below. Third, the Adverse Termination Amount of the contemplated Hedge Agreement will be added to the actual mark-to-market value of all existing Hedge Agreements.

(ii) The methodology for calculating the Adverse Termination Amount for the contemplated Hedge Agreement depends on the type of swap it is. If the contemplated swap is a floating-to-fixed interest rate swap, a fixed-to-floating interest rates swap, or an option to enter into or cancel either of those structures, the Obligated Group Agent will calculate the present value of a 150 basis point loss using standard mark-to-market methodology and will assume taxable and tax-exempt rates both shift 150 basis points on the day of the calculation. This will result in the Adverse Termination Amount for the new swap. If the contemplated swap is a basis swap, a fixed spread basis swap, a constant maturity swap, a spread swap, or a similar structure (with or without an option), the Obligated Group Agent will calculate a 50 basis point loss by multiplying the absolute present value of one basis point in the then current market by -50 (negative fifty), to reflect an adverse change in ratios, spreads, rates, and other market conditions. This will result in the Adverse Termination Amount for the new swap.

(d) The Obligated Group's counterparty (or its guarantor) shall be rated at least "A+" or "A1" by a Rating Agency at the time the Hedge Agreement is entered into and a Credit Support Annex shall, or is required to,

be executed to provide for collateral on a schedule that incorporates a zero threshold amount if any rating is below BBB+/Baa1;

(e) Termination payments are payable only if and to the extent that after such payment the Obligated Group: (a) would still be in compliance with its Days Cash on Hand Ratio, assuming such payment had been excluded from unrestricted cash and investments in making such liquidity calculation and (b) would not be in default;

(f) Collateral for the payments due under the Hedge Agreement can be posted only to the extent that after such posting the Obligated Group would still be in compliance with the Days Cash on Hand Ratio assuming such posting had been excluded from unrestricted cash and investments in making such liquidity calculation; and

(g) The uninsured payment due upon termination of any Hedge Agreement shall be subordinate in right of payment to all Obligations under the Master Indenture issued with respect to the Insured Bonds.

(h) The term "Adverse Termination Amount" shall mean the amount if positive that would be required to be paid by a member of the Obligated Group that is the party to a Hedge Agreement upon the termination of the Hedge Agreement calculated in the manner provided in subsection (c)(ii) above, and the term "Maximum Adverse Termination Amount" shall be determined in accordance with subsection (c)(i) above.

Projected Debt Service Coverage Ratio

Anything in the Master Indenture to the contrary notwithstanding, in each instance in the Master Indenture in which the Projected Debt Service Coverage Ratio is to be evidenced by an Officer's Certificate, such Projected Debt Service Coverage Ratio must also be evidenced by a Consultant's report unless the Projected Debt Service Coverage Ratio in such Officer's Certificate is greater than 1.75:1.00.

Defaults and Remedies

The following events are "Events of Default" under the Master Indenture:

(a) failure of any Obligated Issuer to make any payment of principal, redemption price or interest when due under the terms of any Obligations and such failure continues to exist as of the end of any applicable grace period; or

(b) failure of any Obligated Issuer to observe or perform any covenant or agreement contained in the Master Indenture or any Related Financing Documents for any Obligations for a period of 30 days after written notice of such failure, requiring the same to be remedied, has been given by the Master Trustee to each of the Obligated Issuers, the giving of which notice shall be at the discretion of the Master Trustee unless the Master Trustee is requested in writing to do so by the holders of at least 25% in aggregate principal amount of all outstanding Obligations, in which event such notice shall be given; provided, however, that if such observance or performance requires work to be done, actions to be taken, or conditions to be remedied, which by their nature cannot reasonably be done, taken or remedied, within such 30-day period, no Event of Default shall be deemed to have occurred or to exist if, and so long as, the defaulting Obligated Issuer shall commence such observance or performance within such 30-day period and shall diligently and continuously prosecute the same to completion; or

(c) (i) default of any Obligated Issuer in the payment of any Indebtedness (other than Obligations issued and outstanding under the Master Indenture), the principal amount of which in the aggregate exceeds 5% of the Book Value of all Property of the Obligated Group for the immediately preceding Fiscal Year, whether such Indebtedness now exists or shall be created after the date of the Master Indenture and any grace period with respect thereto shall have expired, or (ii) any event of default as defined in any Related Financing Documents under which any such Indebtedness may be issued, secured or evidenced shall occur, which default in payment or event of default results in such Indebtedness becoming or being declared due and payable unless within the time allowed for service of a responsive pleading in any proceeding to enforce payment of the Indebtedness under the laws governing such

proceeding (i) the Obligated Issuers commence proceedings to contest the existence or payment of such Indebtedness, and (ii) in the absence of such contest, neither the pledge and security interest created under the Master Indenture nor any Property of the Obligated Group will be materially impaired or subject to material loss or forfeiture; or

(d) bankruptcy, dissolution, liquidation or reorganization in bankruptcy of any Obligated Issuer or other similar events; or

(e) if the Hospital Maximum Annual Debt Service Coverage Ratio of the Obligated Group for any Fiscal Year is less than 1.0 to 1; or

(f) a breach of the Alliance's covenant to file audited financial statements as described above under "Filing of Financial Statements, Certificate of No Default, Other Information" under paragraph (a) thereof shall have occurred and be continuing; or

(g) a breach of the Alliance's "Liquidity Covenant" as described above shall have occurred and be continuing; or

(h) receipt by the Master Trustee of a written notice from the Bank issuing the Letter of Credit securing the 2011E Bonds of an event of default under the Reimbursement Agreement relating to such Bonds and a demand by such Bank for the acceleration of such Bonds.

Upon the occurrence of an Event of Default, the Master Trustee may, by notice in writing to the Obligated Issuers, declare the principal of all (but not less than all) outstanding Obligations to be immediately due and payable provided that the Master Trustee shall be required to make such a declaration (i) if an Event of Default has occurred under subsection (a) above, or (ii) if the Master Trustee is requested to make such a declaration by the Holders of not less than 25% in aggregate principal amount of all outstanding Obligations. If all Events of Default other than nonpayment of amounts that have become due as a result of such declaration are remedied, the Holders of 25% in aggregate principal amount of all Obligations may waive all Events of Default and rescind and annul such declaration of acceleration.

Any acceleration of the principal shall be subject to the condition that if, at any time after the principal of all outstanding Obligations shall have been accelerated, and before any judgment or decree for the payment of the moneys due shall have been obtained or entered: (i) one or more Obligated Issuers shall deposit with the Master Trustee an aggregate sum sufficient to pay (A) all matured installments of interest upon all outstanding Notes and the principal and premium, if any, of all outstanding Notes due otherwise than by acceleration (with interest on overdue installments of interest, to the extent permitted by law and on such principal and premium, if any, at the respective rates borne by such Notes to the date of such deposit) and any other amounts required to be paid pursuant to such Notes, (B) all amounts due under each Indenture Guaranty other than by reason of acceleration, (C) all sums due under any Obligations other than Notes and Indenture Guaranties, other than by reason of acceleration, and (D) the expenses and fees of the Master Trustee; and (ii) any and all Events of Default under the Master Indenture, other than the nonpayment of principal of and accrued interest on outstanding Obligations that have become due by acceleration, shall have been remedied, then and in every such case, the Master Trustee shall, if requested by the Holders of twenty-five percent in aggregate principal amount of all Obligations then outstanding, waive all Events of Default and rescind and annul such declaration and its consequences, but no such waiver or rescission and annulment shall extend to or effect any subsequent Event of Default.

The Master Trustee may, at any time that an Event of Default exists, (i) by written notice to the banking institutions in which any Gross Receipts are deposited pursuant to the requirements of the Master Indenture, direct that such funds be immediately transferred to the Master Trustee, and upon receipt of such funds the same shall be held in trust by the Master Trustee and disbursed as provided in the Master Indenture, and (ii) by written notice to the Obligated Issuers direct that all subsequent deposits of Gross Receipts be made with the Master Trustee.

Upon the occurrence of an Event of Default, as described in the Master Indenture, and upon demand of the Master Trustee, each Obligated Issuer will pay to the Master Trustee, for the benefit of the Holders of all

outstanding Obligations, (a) the amount then due and payable on all Obligations for principal or interest, or both, and such other amounts as may be required to be paid on all such Obligations, with interest on the overdue principal and installments of interest (to the extent permitted by law) at the respective rates of interest borne by such Obligations or as is provided in the applicable Supplemental Indenture, and (b) such further amounts sufficient to cover the cost and expenses of collection, including a reasonable compensation to the Master Trustee, its agents, attorneys and counsel, and any expenses incurred by the Master Trustee other than as a result of its gross negligence or bad faith.

The Master Trustee may institute any actions or proceedings at law or in equity for the collection of the sums due and may collect such sums in the manner provided by law out of the Property of the Obligated Issuer wherever situated.

In case there shall be pending proceedings for the bankruptcy or for the reorganization of any Obligated Issuer, or in case a receiver or trustee shall have been appointed for its Property, the Master Trustee shall be entitled and empowered, by intervention in such proceedings or otherwise, to file and prove a claim or claims for the whole amount of principal, premium, if any, interest and any other amounts owing and unpaid in respect of Obligations, and, in case of any judicial proceedings, to file such proofs of claim and other papers as may be necessary or advisable in order to have the claims of the Master Trustee and of the Holders of the Obligations allowed in such judicial proceedings relative to such member of the Obligated Group, its creditors or its Property, and to collect and receive any moneys or other Property payable or deliverable on any such claim and to distribute the same after the deduction of its charges and expenses.

All rights of action and rights to assert claims under any Obligation may be enforced by the Master Trustee without the possession of such Obligation. In any proceedings brought by the Master Trustee (and also any proceedings involving the interpretation of any provision of the Master Indenture to which the Master Trustee shall be a party) the Master Trustee shall be held to represent all the Holders of Obligations, and it shall not be necessary to make any Holders of Obligations parties to such proceedings.

Application of Moneys Collected

Any amounts collected by the Master Trustee in connection with the exercise of any rights and remedies following an Event of Default and, except as otherwise provided in the Master Indenture, all money and Investment Securities on deposit in any funds which the Master Trustee may establish under the Master Indenture from time to time shall be applied for the equal and ratable benefit of the Holders of Obligations in the following order at the date or dates fixed by the Master Trustee for the distribution of such moneys, upon presentment of such Obligations, and stamping thereon the payment, if only partially paid, and upon surrender thereof if fully paid:

(a) to the payment of costs and expenses of collection, including fees of Counsel and reasonable compensation to the Master Trustee; and, thereafter,

(b) whether or not the principal of all outstanding Obligations shall have become or have been declared due and payable to Holders of the outstanding Obligations for amounts due and unpaid on the Obligations, ratably, without preference or priority of any kind, according to the amounts due and payable on the Obligations; provided that for the purpose of determining the unpaid amount of any Obligation, there shall be deducted the amount, if any, which has been realized by the Holder by exercise of its rights as a secured party with respect to any Liens permitted pursuant to the Master Indenture or is on deposit in any fund established pursuant to any Related Financing Documents for such Obligations (other than amounts consisting of payments of principal and interest previously made and credited against the payments due under such Obligations) as of the date of payment by the Master Trustee pursuant to this subsection (b), all as certified to the Master Trustee by the Holder; and

(c) to the payment of the remainder, if any, to the Obligated Group Agent, its successors or assigns, or to whomsoever may be lawfully entitled to receive the same, or as a court of competent jurisdiction may direct.

All money drawn under the Letter of Credit securing the Series 2011E Bonds in connection with any Event of Default shall be applied only to the payment of principal and interest on the Series 2011E Bonds.

Actions by Holders

(a) No Holder of an Obligation shall have any right by virtue of or by availing of any provision of the Master Indenture to institute any suit, action or proceeding in equity or at law upon or under or with respect to the Master Indenture or for the appointment of a receiver or trustee, or any other remedy, unless the Holders of not less than 25% in aggregate principal amount of Obligations then outstanding shall have made written request upon the Master Trustee to institute such action, suit or proceeding in its own name as Master Trustee and shall have offered to the Master Trustee such reasonable indemnity as it may require against the costs, expenses and liabilities which may be incurred therein or thereby, and the Master Trustee, for 30 days after its receipt of such notice, request and offer of indemnity, shall have neglected or refused to institute any such action, suit or proceeding and no direction inconsistent with such written request shall have been given to the Master Trustee; it being understood and intended, and being expressly covenanted by the Holder of an Obligation and the Master Trustee, that no one or more Holders of Obligations shall have any right in any manner whatever by virtue of or by availing of any provision of the Master Indenture to affect, disturb or prejudice the rights of any other Holder of an Obligation or to obtain or seek to obtain priority over or preference to any other such Holder, or to enforce any right under the Master Indenture, except in the manner therein provided and for the equal, ratable and common benefit of all Holders of Obligations. For the protection and enforcement of these provisions, each and every Holder of an Obligation and the Master Trustee shall be entitled to such relief as can be given either at law or in equity.

(b) The Holder of an Obligation instituting a suit, action or proceeding in compliance with the provisions outlined herein and more fully set forth in the Master Indenture shall be entitled to such suit, action or proceeding to such amounts as shall be sufficient to cover the costs and expenses of collection, including to the extent permitted by applicable law, a reasonable compensation to its Counsel.

(c) Notwithstanding any other provision of the Master Indenture, the right of a Holder of an Obligation to receive payment of the principal of and interest on any Obligation and any other amounts payable thereunder, on or after the respective due dates expressed in such Obligation, or to institute suit for the enforcement of any such payment on or after such respective dates, shall not be impaired or affected without the consent of such Holder, provided that any moneys collected through the exercise of rights and remedies of any Holder against any Obligated Issuer pursuant to the Related Financing Documents for an Obligation (other than rights and remedies relating to Liens permitted pursuant to the Master Indenture or to funds and accounts established under such Related Financing Documents) shall be paid over to the Master Trustee or, with the consent of the Holder, collected directly by the Master Trustee.

Direction of Proceedings by Holders

The Holders of 75% in aggregate principal amount of Obligations then outstanding shall have the right to direct the time, method, and place of conducting any proceeding for any remedy available to the Master Trustee, or exercising any trust or power conferred on the Master Trustee; provided, however, that, subject to its right to be indemnified in the Master Indenture, the Master Trustee shall have the right to decline to follow any such direction if the Master Trustee, being advised by Counsel, determines that the action so directed may not lawfully be taken, or if the Master Trustee in good faith shall, by a responsible officer or officers of the Master Trustee, determine that the proceedings so directed would be illegal or involve it in personal liability, and provided further that nothing in the Master Indenture shall impair the right of the Master Trustee in its direction to take any action deemed proper by the Master Trustee and which is not inconsistent with such direction by the Holders.

Delay or Omission of Master Trustee

No delay or omission of the Master Trustee, or of any Holder of an Obligation, to exercise any right or power accruing upon an Event of Default shall impair any such right or power, or be construed as a waiver of any Event of Default or an acquiescence therein, nor shall the action of the Master Trustee or of the Holders of Obligations in case of any Event of Default, or in case of any Event of Default and subsequent waiver of such Event of Default, affect or impair the rights of the Master Trustee or of such Holders in respect of any subsequent Event of Default or any right resulting therefrom.

Remedies Cumulative

No remedy under the Master Indenture is intended to be exclusive of any other remedy, but each and every other such remedy shall be cumulative, and shall be in addition to the remedies pursuant to the Master Indenture; and the employment of any remedy under the Master Indenture or otherwise, shall not prevent the concurrent employment of any such other appropriate remedy or remedies. In the pursuit of any such remedies, the Master Trustee shall have and be vested with the rights of a secured creditor under the Tennessee Uniform Commercial Code (or similar laws of other jurisdictions as applicable) with respect to moneys collected by the Master Trustee pursuant to any provision of the Master Indenture, and shall have the power to foreclose any Lien which may be granted to it as Master Trustee under the Master Indenture, all to the extent permitted by law.

Notice of Default

The Master Trustee shall, within 10 days after the occurrence of an Event of Default known to the Trustee, mail to all Holders of Obligations, as the names and addresses of such Holders appear upon the books maintained by the Master Trustee, and, as long as the Initial Obligation remains outstanding, to the MBIA, notice of such Event of Default under the Master Indenture known to the Master Trustee, unless such Event of Default shall have been cured before the giving of such notice; provided that, except above under "Defaults and Remedies," the Master Trustee shall be protected in withholding such notice if and so long as the Master Trustee in good faith determines that the withholding of such notice is in the interest of the Holders of the Obligations. For purposes of the Master Indenture, matters shall not be considered to be known to the Master Trustee unless an officer of its corporate trust department located at its principal corporate trust office has actual knowledge thereof.

Concerning the Master Trustee

Prior to the occurrence of an Event of Default and after the curing or waiving of all Events of Default which may have occurred, the Master Trustee undertakes to perform only those duties specifically set forth in the Master Indenture. In case an Event of Default has occurred, the Master Trustee shall exercise the rights and powers vested in it by the Master Indenture, and use the same degree of care and skill as a prudent man under the circumstances in the conduct of its own affairs.

No provision of the Master Indenture shall be construed to relieve the Master Trustee from liability for its own grossly negligent action, its own grossly negligent failure to act, or its own willful misconduct; provided, however, that:

(i) the Master Trustee shall not be liable for any error of judgment made in good faith by a responsible officer or officers of the Master Trustee, unless it is provided that the Master Trustee was grossly negligent in ascertaining the pertinent facts; and

(ii) the Master Trustee shall not be liable with respect to any action taken or admitted to be taken by it in good faith in accordance with the direction of the Holders of the majority in aggregate principal amount of Obligations then outstanding relating to the time, method and place of conducting any proceeding for any remedy available to the Master Trustee, or exercising any trust or power conferred upon the Master Trustee, under the Master Indenture.

Except as otherwise provided in the immediately preceding paragraph:

(a) The Master Trustee may rely and shall be protected in acting or refraining from acting upon various papers or documents believed by it to be genuine and to have been signed or presented by the proper party or parties.

(b) An Officer's Certificate (unless otherwise specifically prescribed) shall be sufficient evidence of any request, direction, order or demand of any Obligated Issuer mentioned under the Master Indenture. Any resolution of the Governing Body of an Obligated Issuer may be evidenced to the Master Trustee by copy thereof, certified by the Secretary or an Assistant Secretary of such Obligated Issuer.

(c) The Master Trustee may consult with Counsel, and the advice of such counsel shall be full and complete authorization and protection. The Master Trustee shall be relieved of liability to the Holders of the Obligations and to the Obligated Issuers in respect of any action taken, suffered or omitted by it under the Master Indenture in good faith and in accordance with Counsel's advice.

(d) Prior to the occurrence of an Event of Default under the Master Indenture and after the curing of all Events of Default, the Master Trustee is not bound to make any investigation into facts or matters stated in various papers or documents, unless requested in writing to do so by the Holders of a majority in aggregate principal amount of Obligations then outstanding. As a condition to proceeding with the requested investigation, the Master Trustee, in accordance with the terms of the Master Indenture, may require indemnity against various costs, expenses or liabilities.

(e) The Master Trustee may execute any of the trusts or powers under the Master Indenture or perform any duties under the Master Indenture either directly or by or through agents or attorneys.

(f) The Master Trustee shall be under no responsibility for the approval by it in good faith by an expert or other skilled person for any of the purposes expressed in the Master Indenture.

The recitals contained in the Master Indenture and in the Obligations (other than the Certificate of Authentication on such Obligations) shall be taken as the statements of the Obligated Issuer, and the Master Trustee assumes no responsibility for the correctness thereof. Further, the Master Trustee makes no representations as to the validity or sufficiency of the Master Indenture or the liens and security created thereunder or of the Obligations. The Master Trustee shall not be accountable for the use or application of: any of the Notes or the proceeds of such Obligations, any moneys paid over by the Master Trustee, or any moneys received by any paying agent other than the Master Trustee.

The Master Trustee, in its individual or any other capacity, may become the owner or pledgee of Obligations with the same rights it would have if it were not the Master Trustee under the Master Indenture. Further, the Master Indenture shall not prohibit the Master Trustee from serving as Trustee under any Related Financing Documents or for maintaining a banking relationship with any Obligated Issuer; provided that if the Master Trustee determines that there is a conflict with its duties under the Master Indenture, it shall eliminate the conflict or resign as Master Trustee.

Each Obligated Issuer shall pay, and shall be jointly and severally liable to pay, to the Master Trustee reasonable compensation, reimbursement for all reasonable expenses, disbursement and advances. Each Obligated Issuer shall indemnify, defend and shall be jointly and severally liable to indemnify, the Master Trustee and its officers, directors, employees and agents for, and to hold them harmless against, any loss, liability or expense incurred without gross negligence or willful misconduct on the part of the Master Trustee and arising out of or in connection with the acceptance or administration of such trusts, including the costs and expenses of defending itself against any claim of liability in the premises. The Obligated Issuers' joint and several obligations described in this paragraph shall survive the satisfaction and discharge of the Master Indenture and the resignation, removal and succession of the Master Trustee. Subject only to the rights of any Holder, the Master Trustee shall have an express first and prior lien on any moneys or Investment Securities on the deposit in any funds as security for the payment of all such obligations.

Subject to the first paragraph under this section entitled "Concerning the Master Trustee," any matter may be conclusively proved and established by an Officer's Certificate delivered to the Master Trustee. In the absence of bad faith on the part of the Master Trustee, any such Officer's Certificate shall be full ratification of any action taken, suffered or omitted by the Master Trustee under the provisions of the Master Indenture upon the faith thereof, and the Master Trustee shall not be obligated to make any investigation into the facts stated therein.

The Master Trustee may resign at any time without cause by giving notice as required under the Master Indenture. Further, the Master Trustee may be removed (a) with cause at the direction of the Holders of not less than 66-2/3% in aggregate principal amount of Obligations then outstanding, delivered to the Obligated Group and the Master Trustee, or (b) for any reason at the direction of the Obligation Group Agent if no Event of Default then exists under the Master Indenture. The Master Trustee shall promptly give notice of any removal pursuant to the

previous sentence in writing to each Holder of an Obligation then outstanding. In the case of the resignation and removal of the Master Trustee, a successor Master Trustee may be appointed by the Obligated Group unless an Event of Default exists under the Master Indenture. If an Event of Default exists under the Master Indenture, or if the Obligated Group otherwise fails to appoint a successor in accordance with the terms of the Master Indenture, a successor may be appointed at the direction of the Holders of not less than 66-2/3% in aggregate principal amount of Obligations then outstanding.

Any successor Master Trustee, however appointed, in accordance with the terms of the Master Indenture, shall accept such appointment, and, without further act, shall become vested with all the estates, properties, rights, powers and duties of its predecessor under the Master Indenture as if originally named the Master Trustee. The successor Master Trustee may, however, request that its predecessor execute and deliver an instrument transferring the above and assigning, transferring, delivering and paying over to such successor Master Trustee all moneys or other property then held by the predecessor under the Master Indenture.

Any successor Master Trustee, however appointed, shall be a bank or trust company having together with its Affiliates a combined capital and surplus on a consolidated basis of at least \$50,000,000.

Any corporation into which the Master Trustee may be merged or converted or with which it may be consolidated, or any corporation resulting from any merger, conversion or consolidation to which the Master Trustee shall be a party, or any corporation to which substantially all the business of the Master Trustee may be transferred, shall, subject to the immediately preceding paragraph, be the Master Trustee under the Master Indenture without further act.

Subject to the terms and conditions as set forth in the Master Indenture, the Master Trustee shall have the power to appoint one or more persons not unsatisfactory to the Obligated Group Agent to act as Co-Master Trustee.

Modifications

Each Obligated Issuer, when authorized by a resolution of its Governing Body, and the Master Trustee may, without the consent of the holders of the Obligations then outstanding, enter into a Supplemental Indenture to the Master Indenture to (a) provide for the issuance of any Obligations under the Master Indenture, (b) evidence the addition of an Obligated Issuer or the succession of another corporation to any Obligated Issuer, (c) add additional covenants for the protection of the holders of Obligations, (d) cure any ambiguity or defective provision of the Master Indenture or any Supplemental Indenture in such manner as is not inconsistent with and does not impair the security of the Master Indenture or adversely affect the holders of Obligations of any series of Obligations issued under the Master Indenture, (e) qualify the Master Indenture under the Trust Indenture Act of 1939 or under any similar federal statute hereafter enacted, (f) provide for the establishment of additional funds and accounts, (g) permit the issuance of additional forms of Obligations provided such Obligations are equally and ratably secured with all other Obligations issued under the Master Indenture (except as provided herein), and (h) reflect a change in applicable law.

With the consent of the Holders of not less than a majority in aggregate principal amount of Obligations then outstanding, each Obligated Issuer, when authorized by its Governing Body, and the Master Trustee, may from time to time and at any time enter into a Supplemental Indenture for the purpose of adding any provisions to or changing in any manner or eliminating any of the provisions of the Master Indenture or of any Supplemental Indenture or of modifying in any manner the rights of the Holders of Obligations; provided, however, that (i) without the consent of the Holders of all Obligations whose Obligations are proposed to be modified, no such supplemental indenture shall effect a change in the times, amounts or currency of payment of the principal of, premium, if any, or interest on any Obligation or a reduction in the principal amount or redemption price of any Obligation or the rate of interest thereon or permit the preference or priority of any Obligation over any other Obligation; (ii) without the consent of the Holders of all Obligations then outstanding, no such supplemental indenture shall reduce the aforesaid percentage or affected class of Obligations, the Holders of which are required to consent to any such Supplemental Indenture; (iii) without the consent of the Holders of all Obligations then outstanding, no such supplemental indenture shall effect a change in the conditions for withdrawal as a Member of the Obligated Group; (iv) without the consent of the Holders of all Obligations then outstanding, no such supplemental indenture shall effect a change in the provisions permitting the Holders of 25% in aggregate principal

amount of all outstanding Obligations to direct acceleration upon the occurrence of an Event of Default; and (v) without the consent of the Holders of all Obligations then outstanding, any provision hereof which specifies a percentage of Holders required to take any action hereunder.

Effect of Supplemental Indenture

Upon the execution of any Supplemental Indenture, the Master Indenture shall be modified and amended in accordance therewith, and the respective rights, limitation of rights, obligations, duties, and immunities under the Master Indenture of the Master Trustee, each Obligated Issuer and the Holders of Obligations issued under the Master Indenture shall thereafter be determined, exercised and enforced under the Master Indenture subject in all respects to such modifications and amendments, and all the terms and conditions of any such Supplemental Indenture shall be deemed to be part of the terms and conditions of the Master Indenture.

Satisfaction and Discharge of Indenture

If the Master Trustee receives: (a) an amount which is (i) in the form of (A) cash, or (B) Government Obligations, and (ii) in a principal amount sufficient, together with the interest thereon and any funds on deposit under the Master Indenture and available for such purpose, to provide for the payment of the principal of and premium, if any, and interest on all outstanding Obligations to and including the maturity date or prior redemption or prepayment date thereof; (b) irrevocable instructions to redeem all Obligations to be redeemed prior to maturity and to notify the Holders of each such redemption; and (c) an amount sufficient to pay or provide for the payment of all other sums payable under the Master Indenture by the Obligated Issuers or any thereof, then the Master Indenture shall cease to be of further effect, and the Master Trustee, on demand of the Obligated Group Agent, shall execute all such instruments acknowledging satisfaction of and discharging the Master Indenture as requested by the Obligated Group Agent.

Similarly, the Obligated Issuer of any particular Obligation may provide for the payment thereof at or prior to maturity, and the Obligation so provided for shall thereupon cease to be outstanding under the Master Indenture.

In lieu of the foregoing, the Obligated Issuer of any particular Obligation may deliver to the Holder thereof the amount required under the Related Financing Documents to provide for the payment of the principal, premium, if any, and interest due or to become due in respect of such Obligation and such Obligation shall, upon surrender to the Master Trustee for cancellation, no longer be deemed outstanding under the Master Indenture.

SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURE

Security and Pledge

The Bonds will be secured by the Issuer's grant and assignment under the Bond Indenture of (i) the Issuer's interest in the Series 2011 Obligation and the Loan Agreement, including but not limited to all revenues and receipts derived by the Issuer therefrom but excluding certain rights of the Issuer to (a) receive attorney fees under the terms of the Loan Agreement, (b) certain indemnification from the Alliance, (c) receive notices under the Loan Agreement, (d) to make advances under the Loan Agreement and (e) to inspect the projects financed with the Bonds, and (ii) all monies and securities in funds held by the Bond Trustee under the Bond Indenture (other than certain funds to be used to make rebate payments to the United States to preserve the tax-exempt status of the Bonds).

During the occurrence and continuation of an Event of Default under the Bond Indenture, the Bond Trustee will have a claim prior to the Bondholders on the moneys derived from the exercise of remedies under the Bond Indenture for payment of its costs and expenses and the repayment of advances made by it to effect performance of certain covenants in the Bond Indenture. The Bond Trustee, however, shall not have any claim or lien upon or with respect to moneys drawn under the Letter of Credit or the proceeds from the remarketing of Bonds.

Provisions for the Bonds

The Bond Indenture provides for the issuance of the Bonds, their redemption and all other terms pertaining to the Bonds. The Bonds will only be authenticated by the Bond Trustee upon the delivery of certain documents, including the original executed Bond Indenture, the Loan Agreement and the Original Letter of Credit.

Mutilated, lost or destroyed Bonds may be replaced subject to certain conditions specified in the Bond Indenture.

General Covenants and Provisions

The Issuer covenants that it will promptly pay the principal and purchase price of premium, if any, and interest on the Bonds subject to the limited nature of such obligations. The Issuer agrees that the Bond Trustee may enforce all rights of the Issuer under the Loan Agreement whether or not the Issuer is in default under the Bond Indenture.

Creation of Funds

The Bond Indenture provides for the creation of certain trust funds into which the proceeds from the sale of the Bonds, payments made by the Alliance under the Loan Agreement and proceeds from drawings on the Letter of Credit are to be deposited. These trust funds are the Bond Fund, the Construction Fund, the Bond Purchase Fund, and the Rebate Fund. Each of these funds is described below.

Bond Fund. Within the Bond Fund, the Bond Trustee is to create a General Account and a Letter of Credit Account. There is to be deposited in the General Account of the Bond Fund all payments made pursuant to the provisions of the Bond Indenture or the Loan Agreement for credit to the Bond Fund and all income derived from the investment of such amounts. The Bond Trustee will also establish a subaccount within the General Account in the Bond Fund for the purpose of holding all Eligible Moneys therein. Moneys held in the Eligible Money Subaccount of the Bond Fund shall not be commingled with any other funds or accounts. The Bond Trustee will credit to the Letter of Credit Account all moneys drawn by the Bond Trustee under the Letter of Credit to pay the principal of and interest on the Bonds and all income derived from the investment of such moneys. Moneys in the Letter of Credit Account shall not be commingled with any other funds or accounts. Moneys in the Bond Fund shall be used to pay principal, premium, if any, and interest on the Bonds and the redemption price of Bonds.

Project Fund. The moneys in the Project Fund shall be held in trust by the Bond Trustee, shall be applied to the payment of the costs of the projects being financed except to the extent required to be transferred to the Rebate Fund and, pending such application, shall be held as trust funds under the Bond Indenture in favor of holders of the outstanding bonds and for the further security of such holders until paid out or transferred as provided in the Bond Indenture.

Bond Purchase Fund. Within the Bond Purchase Fund, the Bond Trustee is to create a General Account and a Letter of Credit Account. There shall also be established a subaccount within the General Account for the purpose of holding Eligible Moneys therein. Moneys in the Bond Purchase Fund shall be used solely for the payment of the purchase price of the Bonds in the event of any purchase of Bonds at the option of the holder or on a Mandatory Tender Date. Payments received from the proceeds of the remarketing of the Bonds by the Remarketing Agent and all other moneys received by the Bond Trustee under the terms of the Bond Indenture or the Loan Agreement which are required to be deposited in the Bond Purchase Fund shall be credited to the General Account. All moneys drawn by the Bond Trustee under the Letter of Credit for the purchase of Bonds pursuant to the terms of the Bond Indenture and all income derived from the investment of such moneys shall be credited to the Letter of Credit Account. All moneys in the Bond Purchase Fund remaining on any Optional Tender Date or Mandatory Tender Date after payment of the purchase price of the Bonds purchased shall be paid to the Bank if the Bond Trustee receives prior notice from the Bank stating that certain specified amounts are due and payable to the Bank under the Reimbursement Agreement and any balance remaining after payment to the Bank shall be paid to the Alliance.

Rebate Fund. Any arbitrage profits to be rebated to the United States are to be held in the Rebate Fund. The Bond Indenture contains provisions regarding the responsibility of an independent rebate analyst to calculate the amount of such arbitrage profits.

Investment of Funds. Moneys (other than Eligible Moneys) held in the General Accounts of the Bond Fund and the Bond Purchase Fund (other than remarketing proceeds) and in the Construction Fund shall be invested by the Bond Trustee as directed by the Alliance in Investment Securities. Moneys held in the Letter of Credit Accounts of the Bond Fund and Bond Purchase Fund for more than two days and Eligible Moneys held in the General Accounts of the Bond Fund and the Bond Purchase Fund (other than remarketing proceeds) shall be invested by the Bond Trustee as directed by the Alliance in Government Obligations. Remarketing proceeds shall not be invested. The Bond Trustee shall sell and reduce to cash a sufficient amount of such investments whenever the cash balance in any fund or account is insufficient for the purposes thereof. The Bond Trustee shall not be responsible for any losses on investments made in accordance with the Bond Indenture. The Bond Trustee may make any investments through its own bond department or trust investments department.

Events of Default

The Bond Indenture provides that any of the following events shall constitute an Event of Default:

- (a) default in the due and punctual payments of any interest on any Bond when the same shall become due and payable; or
- (b) default in the due and punctual payment of the principal of any Bond at its maturity or upon mandatory redemption; or
- (c) default in the due and punctual payment of the purchase price of Bonds required to be purchased pursuant to the Bond Indenture when payment of such amount has become due and payable; or
- (d) receipt by the Bond Trustee of a written notice from the Bank of an event of default under the Reimbursement Agreement and a demand by the Bank for acceleration of the Bonds; or
- (e) the occurrence of an “Event of Default” under the Loan Agreement.

Acceleration

Subject to the rights of the Bank to control remedies, upon the occurrence of any Event of Default described in paragraphs (a), (b), (c) or (f) above, the Bond Trustee may, and at the written request of the Bank or the holders of more than 50% in aggregate principal amount of the outstanding Bonds shall, and, upon the occurrence and continuance of an Event of Default described in paragraphs (d) or (e) above, the Bond Trustee shall, by notice in writing delivered to the Issuer, the Alliance and the Bank, declare the principal of all the Bonds immediately due and payable, whereupon the same shall become immediately due and payable, anything in the Bond Indenture or in the Bonds to the contrary notwithstanding. Upon any such acceleration, the Bonds and the interest thereon shall forthwith be paid in accordance with the Bond Indenture. Upon any declaration of acceleration under the Bond Indenture, the Bond Trustee shall immediately declare the payments required to be made by the Alliance under the Loan Agreement to be immediately due and payable in accordance with the Loan Agreement and, if during the Letter of Credit Period, shall draw on the Letter of Credit. Upon such a drawing on the Letter of Credit, the Bond Trustee shall immediately pay to the bondholders an amount equal to the principal of and accrued interest on the Bonds.

Other Remedies

Subject to the rights of the Bank to control remedies, upon the occurrence of an Event of Default under the Bond Indenture, the Bond Trustee shall have the power to proceed with any right or remedy available at law or in equity or by statute, as it may deem best, including any suit, action or special proceeding in equity or at law for the collection of amounts due and to become due under the Bond Indenture and under the Bonds or the performance of any covenant or agreement contained in the Bond Indenture or for the enforcement of any proper legal or equitable remedy as the Bond Trustee shall deem most effectual to protect the rights aforesaid, insofar as such may be authorized by law. The rights specified in the Bond Indenture are to be cumulative to all other available rights, remedies or powers.

No delay or omission to exercise any right or remedy accruing upon any Event of Default under the Bond Indenture shall impair any such right or remedy or shall be construed to be a waiver of any such Event of Default or acquiescence therein; and every such right and remedy may be exercised from time to time and as often as may be deemed expedient.

No waiver of any Event of Default under the Bond Indenture, whether by the Bond Trustee or by the bondholders, shall extend to or shall affect any subsequent event of default or shall impair any rights or remedies consequent thereon.

Rights of Bondholders

Upon the occurrence of an Event of Default and if requested to do so by more than two-thirds (2/3) in aggregate principal amount of Bonds then outstanding and being indemnified as provided in the Bond Indenture, the Bond Trustee subject to the provisions of the Bond Indenture, shall be obligated to exercise such one or more of the rights and remedies conferred heretofore as the Bond Trustee, being advised by counsel, shall deem most expedient in the interests of the bondholders and the Bank.

Right of Bondholders to Direct Proceedings

Except in the case of a default under paragraphs (d) and (e) under "Events of Default" and subject to the rights of the Bank to control remedies, the holders of more than two-thirds (2/3) in principal amount of Bonds then outstanding shall have the right, at any time, by an instrument or instruments in writing executed and delivered to the Bond Trustee, to direct the time, method and place of conducting all proceedings to be taken in connection with the enforcement of the terms and conditions of the Bond Indenture, or for the appointment of a receiver or any other proceedings under the Bond Indenture.

Application of Moneys

All moneys drawn by the Bond Trustee under the Letter of Credit in connection with any Event of Default shall be deposited in the Letter of Credit Account in the Bond Fund and all other moneys received by the Bond Trustee pursuant to any right given or remedy or action taken under the provisions of the Bond Indenture shall, after payment of all fees and expenses of the Bond Trustee, including, without limitation, the costs and expenses of the proceedings resulting in the collection of such other moneys and of the related expenses, liabilities and advances incurred or made by the Bond Trustee, be deposited in the General Account in the Bond Fund, and all such moneys shall be paid to the Bond Trustee and applied by it as follows:

(a) Unless the principal of all the Bonds shall have become or shall have been declared due and payable, all such moneys shall be applied:

FIRST - to the payment to the persons entitled thereto of all installments of interest then due on the outstanding Bonds (other than Borrower Bonds and Pledged Bonds), in the order of the maturity of the installments of such interest and, if the amount available shall not be sufficient to pay in full any particular installment, then to the payment of such installment ratably, according to the amounts due on such installment, to the persons entitled thereto, without any discrimination or privilege;

SECOND - to the payment to the persons entitled thereto of the unpaid principal of any of the outstanding Bonds which shall have become due (other than Borrower Bonds and Pledged Bonds), in the order of their due dates, with interest on such Bonds at the rate last borne by the Bonds from the respective dates upon which they became due and, if the amount available shall not be sufficient to pay in full the principal which became due on such Bonds on any particular date, together with such interest, then to the payment thereof ratably, according to the amount of principal due on such date, to the persons entitled thereto, without any discrimination or privilege;

THIRD - to the payment of any amounts owed with respect to Pledged Bonds or owed by the Alliance to the Bank under the Reimbursement Agreement or other related documents or by the Issuer to the Bank under this Bond Indenture in such order as the Bank directs; and

FOURTH - to the payment of the principal of and interest on the Borrower Bonds in the same order of priority as specified in the first and second clauses.

(b) If the principal of all the Bonds shall have become due or shall have been declared due and payable, all such moneys shall be applied FIRST, to the payment of the principal and the interest then due and unpaid on the outstanding Bonds (other than Borrower Bonds and Pledged Bonds), without preference or priority of principal over interest or of interest over principal, or of any installment of interest over any other installment of interest, or of any such Bond over any other such Bond, ratably, according to the amounts due respectively for principal and interest, to the persons entitled thereto without any discrimination or privilege, SECOND, to the payment of any amounts owed with respect to Pledged Bonds or owed by the Alliance to the Bank under the Reimbursement Agreement or other related documents or by the Issuer to the Bank under this Bond Indenture in such order as the Bank directs and THIRD to the payment of the principal of and interest on the Borrower Bonds in the same manner as other outstanding Bonds.

(c) If the principal of all the Bonds shall have been declared due and payable, and if such declaration shall thereafter have been rescinded and annulled under the provisions of this Bond Indenture, in the event that the principal of all the Bonds shall later become due or be declared due and payable, the moneys to be applied shall be applied in accordance with the provisions of paragraph (b) above.

Subject to the provisions regarding acceleration, whenever moneys are to be applied pursuant to the provisions of this Section, such moneys shall be applied at such times, and from time to time, as the Bond Trustee shall determine, having due regard to the amount of such moneys available for application and the likelihood of additional moneys becoming available for such application in the future. Whenever the Bond Trustee shall apply such funds, it shall fix the date (which shall be an Interest Payment Date unless it shall deem another date more suitable or unless the principal of all of the Bonds has been declared immediately due and payable, in which case application shall be made immediately) upon which such application is to be made and upon such date interest on the amounts of principal to be paid on such dates shall cease to accrue provided that such amount of principal is in fact paid on such date. The Bond Trustee shall give such notice to the Holders of the Bonds and the Bank as it may deem appropriate of the deposit with it of any such moneys and of the fixing of any such date, and shall not be required to make payment from such moneys to the Holder of any Bonds until such Bond shall be presented to the Bond Trustee.

Rights and Remedies of Bondholders

No Holder of any Bond shall have any right to institute any suit, action or proceeding in equity or at law for the enforcement hereof, for the execution of any trust hereof or for the appointment of a receiver or to enforce any other right or remedy under the Bond Indenture, except subject to the rights of the Bank to control remedies and unless (a) a Default has occurred of which the Bond Trustee has been notified as provided in the Bond Indenture or of which it is deemed to have notice, (b) such Default shall have become an Event of Default and the Holders of more than two-thirds (2/3) in aggregate principal amount of Bonds then outstanding shall have made written request to the Bond Trustee and shall have offered reasonable opportunity to the Bond Trustee either to proceed to exercise the powers granted in the Bond Indenture or to institute such action, suit or proceeding in its own name, and (c) such Bondholders have offered to the Bond Trustee indemnity as provided in the Bond Indenture and the Bond Trustee shall thereafter fail or refuse to exercise the powers granted in the Bond Indenture, or to institute such action, suit or

proceeding in its own name. Such notification, request and offer of indemnity are at the option of the Bond Trustee conditions precedent to the execution of the powers and trusts hereof, and to any action or cause of action for the enforcement hereof, or for the appointment of a receiver or for any other right or remedy under the Bond Indenture. Nothing in the Bond Indenture shall, however, affect or impair the right of any Bondholder to enforce the payment of the principal and purchase price of, and interest on, any Bond at and after the date such payment is due, or the obligation of the Issuer or the Bond Trustee to pay the principal and purchase price of, and interest on, each of the Bonds to the respective Holders thereof at the time, place, from the source and in the manner expressed in the Bonds.

Waivers of Events of Default

Subject to the rights of the Bank to control remedies, the Bond Trustee shall waive any Event of Default under the Bond Indenture and its consequences upon the written request of the holders of more than 50% in aggregate principal amount of all Bonds then outstanding, provided, however, that there shall not be waived

(a) any Event of Default pertaining to the payment of the principal or purchase price of any Bond at its maturity, Redemption Date, or Tender Date, or

(b) any Event of Default pertaining to the payment when due of the interest on any Bond unless prior to such waiver, all arrears of interest and all principal or purchase price payments in respect of which such Event of Default shall have occurred, with interest thereon (to the extent permitted by law) for the period from the occurrence of such Event of Default until paid in full at a rate per annum equal to the interest rate payable on the Bonds from time to time during such period in accordance with the terms of the Bonds, and all expenses of the Bond Trustee in connection with such Event of Default, shall have been paid or provided for, and in case of any such waiver, or in case any proceeding taken by the Bond Trustee on account of any such Event of Default shall have been discontinued or abandoned or determined adversely to the Bond Trustee, then and in every such case the Issuer, the Bond Trustee, the Bank and the Bondholders shall be restored to their former positions and rights under the Bond Indenture, respectively, but no such waiver shall extend to any subsequent or other Event of Default, or impair any right consequent thereon, or

(c) any Event of Default described in paragraphs (d) or (e) under “Events of Default.”

If a declaration of acceleration is made pursuant to the Bond Indenture, then and in every such case, the Bond Trustee shall upon the written request of more than two-thirds (2/3) in principal amount of all Bonds then outstanding rescind and annul such declaration, and the consequences thereof, provided that at the time such declaration is rescinded and annulled:

(1) no judgment or decree has been entered for the payment of any moneys due pursuant to the Bonds;

(2) all arrears of interest on all of the Bonds and all other sums payable under the Bonds (except as to principal of, and interest on, the Bonds which have become due and payable by reason of such declaration) shall have been duly paid;

(3) each and every Event of Default under the Bond Indenture shall have been waived pursuant to the preceding paragraph or otherwise made good or cured; and

(4) no drawing shall have been made under the Letter of Credit in connection with or as a result of such declaration of acceleration;

and, provided further, that no such rescission and annulment shall extend to or affect any subsequent Event of Default or impair any right consequent thereon. Notwithstanding the foregoing, neither the Bond Trustee nor the Bondholders shall have the right to waive an Event of Default described in paragraphs (d) or (e) under “Events of Default.”

Rights of Bank to Control Remedies and Other Proceedings

Subject to the next paragraph, the Bank shall be entitled to control and direct the enforcement of all remedies and rights granted to the Holders of the Bonds and to the Bond Trustee under the Bond Indenture and all proceedings related thereto, including, without limitation,

(a) the right of the Holders of more than two-thirds (2/3) in aggregate principal amount of outstanding Bonds to request the acceleration of the principal of the Bonds;

(b) the right of the Holders of more than 50% in aggregate principal amount of outstanding Bonds to request the Bond Trustee to exercise certain remedies and direct the time, method and place of conducting all proceedings;

(c) the right to institute any suit, action or proceeding, pursuant to the Bond Indenture; and

(d) the right of the Holders of more than two-thirds (2/3) in aggregate principal amount of outstanding Bonds to waive any Event of Default or to rescind a declaration of acceleration of the principal of the Bonds;

provided that notwithstanding anything in the Bond Indenture to the contrary, the Bank may not direct the Bond Trustee not to accelerate the principal amount of the Bonds and draw on the Letter of Credit upon an Event of Default specified in paragraphs (a), (b) or (c) under "Events of Default."

All rights and remedies given to the Bank in the Bond Indenture and the Loan Agreement are expressly conditioned upon the Bank not being in default in the performance of its obligations under the Letter of Credit, and the Bank shall have no rights or remedies under the Bond Indenture or under the Loan Agreement if it is in default in such performance.

The Bond Trustee

After any Event of Default, the Bond Trustee shall exercise the rights and powers vested in it by the Bond Indenture with the degree of care and skill in their exercise as a prudent man would exercise in the conduct of his own affairs. Otherwise, the Bond Trustee undertakes to perform such duties and only such duties as are specifically set forth in the Bond Indenture, and no implied agreements or obligations shall be read into the Bond Indenture against the Bond Trustee. The Bond Trustee may execute its trusts through its employees, agents or attorneys, and the Bond Trustee shall not be responsible for any misconduct or negligence on the part of any agent or attorney appointed with due care by it. In carrying out its duties, the Bond Trustee may rely on any document believed by it to be genuine and to have been signed by the proper person and in determining the existence or nonexistence of any fact or the validity of any instrument, the Bond Trustee may rely on certificates provided by the Issuer or the Alliance.

The Bond Trustee is not required to take notice of any Event of Default under the Bond Indenture except failure by the Issuer to make payments on the Bonds, an Act of Bankruptcy of which it is given notice or Events of Default described in paragraphs (d) or (e) under "Events of Default." Before taking any action under the Bond Indenture or the Loan Agreement other than making a draw on the Letter of Credit, the Bond Trustee may require that a satisfactory indemnity bond be furnished. The Bond Trustee is not responsible for the tax-exempt status of the Bonds. The Bond Trustee is entitled to the payment of its reasonable fees and expenses.

The Bond Trustee may resign by giving written notice to the Issuer, the Alliance, the Bank and the Bondholders, provided that such resignation will not take effect until a successor trustee is appointed. The Bond Trustee may be removed at the written request of the holders of more than two-thirds (2/3) in the principal amount of the outstanding Bonds or by the Alliance (provided no Default or Event of Default has occurred under the Bond Indenture). The holders of more than two-thirds (2/3) in the principal amount of the outstanding Bonds may appoint a successor trustee.

The Bond Trustee will serve as Paying Agent under the Bond Indenture. The Paying Agent may resign by giving written notice to the Issuer, the Trustee, the Alliance, the Bank and the Bondholders, provided that such resignation will not take effect until a successor paying agent is appointed. The Paying Agent may be removed at the written request of the holders of more than [50%] in the principal amount of the outstanding Bonds or by the Alliance (provided no Default or Event of Default has occurred under the Bond Indenture). The holders of more than [50%] in the principal amount of the outstanding Bonds may appoint a successor paying agent.

The Remarketing Agent

The Remarketing Agent will set the interest rate on the Bonds, will remarket the Bonds upon purchase and will perform such other duties as are required under the Bond Indenture. The Remarketing Agent may resign by giving 30 days' notice to the Issuer, the Alliance, Bank and Bond Trustee provided that no such resignation shall take effect until a successor Remarketing Agent has been appointed. The Remarketing Agent may be removed from time to time by the Alliance.

Supplemental Bond Indentures

The Issuer and the Bond Trustee, without the consent of any of the bondholders may enter into an indenture or indentures supplemental to the Bond Indenture, as shall not be inconsistent with the terms and provisions thereof for any one or more of the following purposes: (a) to cure any ambiguity or formal defect or omission in the Bond Indenture or between the terms and provisions of the Bond Indenture and the terms and provisions of any other instrument or document executed in connection therewith or with the issuance of the Bonds; (b) to grant or confer upon the Bond Trustee for the benefit of the Bondholders any additional rights, remedies, power or authority; (c) to subject to the lien of the Bond Indenture additional payments, revenues or collateral; (d) to modify, amend or supplement the Bond Indenture or the bonds in such a manner as to permit qualification thereof under the Trust Indenture Act of 1939 or any federal or state securities law; (e) to evidence the appointment of a co-Bond Trustee or the succession of a new Bond Trustee; (f) to make any other supplement to the Bond Indenture which will not adversely affect the interest of the Bondholders; (g) to obtain or maintain a rating on the Bonds from S&P or Moody's as high as the debt rating of the Bank; (h) to modify or supplement the Bond Indenture in such manner as may be necessary, in the Opinion of Bond Counsel, to comply fully with all applicable rules, rulings, policies, procedures, regulations or other official statements promulgated or proposed by the Department of the Treasury or the Internal Revenue Service; or (i) as may be necessary in connection with the provision of a Substitute Letter of Credit meeting the requirements of the Bond Indenture.

Exclusive of supplemental indentures for the purposes described in the preceding paragraph and subject to the terms and provisions of the Bond Indenture, the holders of not less than two-thirds in aggregate principal amount of the bonds then outstanding shall have the right, from time to time, to consent to and approve the execution by the Issuer and the Bond Trustee of such other indenture or indentures supplemental to the Bond Indenture for the purpose of modifying, amending, adding to or rescinding, in any particular, any of the terms of provisions contained in the Bond Indenture; provided, however, that such modification or amendment shall not permit or be construed as permitting without the consent of the holders of all the Bonds outstanding (a) an extension of the maturity of the principal of, premium, if any, or interest on any of the Bonds, (b) a reduction in the principal amount of, premium, if any, or interest rate on, any Bond (c) a privilege or priority of any Bond or Bonds over any other Bond or Bonds, (d) a reduction in the aggregate principal amount of the bonds the holders of which are required to consent to any such supplemental indenture, (e) the creation of a lien ranking prior to or on a parity with the lien of the Bond Indenture on the property conveyed and mortgaged pursuant to the Bond Indenture or the deprivation of such lien or (f) the elimination of any mandatory redemption or mandatory purchase of Bonds, extension of the due date for the purchase of the Bonds or call for mandatory redemption or the reduction of the purchase price or Redemption Price for the Bonds.

Any supplemental indenture that affects the rights of the Alliance must be consented to by the Alliance. The Bond Trustee shall also not be required to enter into any supplemental indenture if such action might adversely affect its rights or liabilities. All supplemental indentures entered into during the Letter of Credit Period must be consented to by the Bank.

Amendments to the Loan Agreement

The Issuer may enter into, and the Bond Trustee may consent to, any amendment of or supplement to the Loan Agreement without notice to or consent of any Bondholder, if the amendment or supplement is required (a) by the provisions of the Loan Agreement or the Bond Indenture, (b) to cure any ambiguity, inconsistency or formal defect or omission in the Loan Agreement or between the terms and provisions of the Loan Agreement and the terms and provisions of any other instrument or document executed in connection therewith or with the issuance of the Bonds, (c) to identify more precisely any collateral securing the Bonds, (d) to effect any amendment that does not adversely affect the interests of the Bondholders or (e) to obtain or maintain a rating on the Bonds from S&P or Moody's as high as the debt rating on the Bank.

If an amendment of or supplement to the Loan Agreement without the consent of the Bondholders is not permitted as described in the foregoing paragraph, the Issuer may enter into, and the Bond Trustee may consent to, such amendment or supplement with notice to the Bondholders and with the consent of the holders of at least a two-thirds in principal amount of the Bonds then outstanding. However, no amendment to the Loan Agreement is permitted that would decrease the Trust's unconditional obligation to make payments under the Loan Agreement or that would affect the Trust's obligations as to the use of the proceeds of the Bonds. All amendments to the Loan Agreement entered into during the Letter of Credit Period must be consented to by the Bank.

SUMMARY OF CERTAIN PROVISIONS OF THE LOAN AGREEMENT

Payments

The Alliance covenants to make all payments required by the Loan Agreement, as and when the same become due. Pursuant to the Loan Agreement, the Alliance agrees to make payments of principal, interest and purchase price identical to payments (including payments of principal upon redemption and acceleration) due by the Issuer under the Bonds. The obligations of the Alliance to make payments under the Loan Agreement shall be deemed satisfied to the extent of a corresponding payment made by the Bank to the Bond Trustee under the Letter of Credit. The Alliance also covenants to pay the reasonable fees and expenses of the Bond Trustee and the Issuer.

Special Representations and Covenants

Indemnification. The Alliance agrees that it will indemnify and save harmless the Issuer, City of Johnson, Tennessee, the Bond Trustee, the Remarketing Agent and the Bank from and against all liabilities, losses, expenses and damages arising generally from the operation of the projects financed with the Bonds or the failure of the Alliance to comply with its covenants or any term or condition contained in the Loan Agreement and any documents relating thereto.

Sale of Facilities. The Alliance may not sell, convey or lease the facilities financed or refinanced with the proceeds of the Bonds or any significant portion thereof unless the Alliance delivers to the Bond Trustee an Opinion of Bond Counsel that such sale, conveyance or lease will not adversely affect the exclusion from gross income of interest on the Bonds for federal income tax purposes. In connection with any such sale during the Letter of Credit Period, another party may assume the obligations of the Alliance under the Borrower Documents, and the Alliance may be released from liability therefrom with the written consent of the Bank.

Miscellaneous Covenants. The Alliance agrees to notify the Bank, the Issuer and the Bond Trustee if a petition in bankruptcy is filed against it.

Events of Default and Remedies on Default

The occurrence of any of the following events shall constitute an event of default under the Loan Agreement:

(a) If the Alliance shall fail to make any payment with respect to the principal and purchase price of or interest on the Bonds when the same becomes due and payable.

(b) If the Alliance shall fail to observe or perform any of its other covenants, conditions, or agreements under the Loan Agreement for a period of 30 days after notice (unless the Bank shall consent to an extension of such time), or in the case of any such default that cannot be cured within such 30-day period, if the Alliance shall fail to take corrective action to cure such default and diligently pursue such action until such failure is cured.

(c) If the Alliance shall (1) fail to pay generally its debts as they become due, (2) commence a voluntary case under the Federal bankruptcy laws, as now or hereafter constituted, or any other applicable Federal or state bankruptcy, insolvency or other similar law, (3) consent or fail to object to the appointment of a receiver, liquidator, assignee, trustee, custodian, sequestrator or other similar official for the Alliance or any substantial part of its property, or to the taking possession by any such official of any substantial part of the property of the Alliance, (4) make any assignment for the benefit of creditors, or (5) take corporate action in contemplation or in furtherance of any of the foregoing.

(d) If there shall occur the commencement of a voluntary or involuntary case by or against the Alliance under the Federal bankruptcy laws, as now or hereinafter constituted, provided, however, that if an involuntary case in bankruptcy is commenced against the Alliance prior to the 120th day before payment of the

Bonds (whether at maturity, by acceleration, demand for prepayment, call for redemption or otherwise), the filing of such petition shall not constitute an Event of Default if such petition is dismissed, subject to no further review, within 60 days thereafter.

(e) If any warranty, representation or other statement by or on behalf of the Alliance contained in the Loan Agreement or in any instrument furnished in connection with the issuance or sale of the Bonds shall prove to have been false or misleading in any material respect at the time it was made or delivered.

(f) If an Event of Default under the Bond Indenture shall occur and continue.

Upon an occurrence of an Event of Default, the Bond Trustee shall immediately notify the Bank and may:

(a) With the written consent of the Bank (provided such written consent shall not be required (1) if there is no Letter of Credit, or (2) if the Event of Default is due to the fact that there has been a default in the payment of the principal and purchase price or interest on the Bonds), declare all payments under the Loan Agreement and the Bonds to be immediately due and payable in an amount sufficient to pay all the principal of and premium, if any, and accrued interest on the Bonds, whereupon the same shall become immediately due and payable.

(b) Take whatever action at law or in equity may appear necessary or desirable to collect the amounts then due and thereafter to become due under the Loan Agreement or to enforce observance or performance of any covenant, condition or agreement of the Alliance.

Option to Prepay Obligations under Loan Agreement

The Alliance shall have the option to prepay its obligations under the Loan Agreement in whole or in part to the extent that the Bonds are redeemable under the provisions of the Bond Indenture. If the Alliance intends that such prepayment shall result in a redemption in whole or in part of the Bonds, the Alliance shall take such action as is required under the Bond Indenture to cause the Bonds to be redeemed. In the event the Alliance intends that such prepayment to cause the discharge of the lien of the Bond Indenture under the provisions thereof, the Alliance shall comply with such provisions.

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APPENDIX E

PROPOSED FORMS OF OPINIONS OF BOND COUNSEL

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[Opinion of Bass Berry Sims]

October 19, 2011

The Health and Educational Facilities Board
of the City of Johnson City, Tennessee
Johnson City, Tennessee

The Bank of New York Mellon Trust Company, N.A.,
Bond Trustee and Master Trustee
St. Louis, Missouri

U.S. Bank National Association
St. Louis, Missouri

PNC Bank, National Association
Pittsburgh, Pennsylvania

Merrill Lynch, Pierce, Fenner & Smith Incorporated
New York, New York

Re: The Health and Educational Facilities Board of the City of Johnson City, Tennessee \$ _____
Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011A and \$ _____
Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011B

Ladies and Gentlemen:

We have acted as bond counsel in connection with the issuance by The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the "Issuer") of its \$ _____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011A (the "Series 2011A Bonds") and its \$ _____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011B (the "Series 2011B Bonds" and together with the Series 2011A Bonds, the "Series 2011 Bonds"). We have examined the law and such certified proceedings and other papers as we deem necessary to render this opinion. Reference is made to the forms of the Series 2011 Bonds for additional information concerning their details, payment and redemption provisions and the proceedings pursuant to which they were issued.

The Series 2011A Bonds are issued pursuant to a Bond Trust Indenture dated as of October 1, 2011 (the "Series 2011A Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Series 2011A Bond Trustee"). The proceeds from the sale of the Series 2011A Bonds will be loaned by the Board to Mountain States Health Alliance, a not-for-profit corporation incorporated under the laws of the State of Tennessee (the "Alliance"), under a Loan Agreement dated as of October 1, 2011 (the "Series 2011A Loan Agreement"), between the Issuer and the Alliance, which loan will be evidenced by the \$ _____ Mountain States Health Alliance Note, Series 2011A (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) (the "Series 2011A Obligation") issued pursuant to an Amended and Restated Master Trust Indenture dated as of February 1, 2000, as heretofore amended and as amended by a Thirty-First Supplemental Master Trust Indenture dated as of October 1, 2011 (collectively, the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"). Under the Series 2011A Loan Agreement and the Series 2011A Obligation, the Alliance has agreed to make payments to be used to pay when due the principal of and premium, if any, and interest on the Series 2011A Bonds, and such payments and other revenues under the Series 2011A Loan Agreement and the Series 2011A Obligation (collectively, the "2011A Revenues") and the rights of the Issuer under the Series 2011A Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) are pledged and assigned by the Issuer as security for the Series 2011A Bonds.

U.S. Bank National Association, a national banking association (the "U.S. Bank"), has issued an irrevocable letter of credit dated the date hereof (the "2011A Letter of Credit") to secure payment of the principal of and up to 37 days' accrued interest on the Series 2011A Bonds which expires, unless extended, on _____.

The Series 2011A Bonds are payable solely from the 2011A Revenues and draws on the 2011A Letter of Credit.

The Series 2011B Bonds are issued pursuant to a Bond Trust Indenture, dated as of October 1, 2011 (the "Series 2011B Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Series 2011B Bond Trustee"). The proceeds from the sale of the Series 2011B Bonds will be loaned by the Board to Mountain States Health Alliance, a not-for-profit corporation incorporated under the laws of the State of Tennessee (the "Alliance"), under a Loan Agreement dated as of October 1, 2011 (the "Series 2011B Loan Agreement"), between the Issuer and the Alliance, which loan will be evidenced by the \$_____ Mountain States Health Alliance Note, Series 2011B (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) (the "Series 2011B Obligation") issued pursuant to an Amended and Restated Master Trust Indenture dated as of February 1, 2000, as heretofore amended and as amended by a Thirty-First Supplemental Master Trust Indenture dated as of October 1, 2011 (collectively, the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"). Under the Series 2011B Loan Agreement and the Series 2011B Obligation, the Alliance has agreed to make payments to be used to pay when due the principal of and premium, if any, and interest on the Series 2011B Bonds, and such payments and other revenues under the Series 2011B Loan Agreement and the Series 2011B Obligation (collectively, the "2011B Revenues") and the rights of the Issuer under the Series 2011B Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) are pledged and assigned by the Issuer as security for the Series 2011B Bonds.

PNC Bank, National Association, a national banking association (the "PNC"), has issued an irrevocable letter of credit dated the date hereof (the "2011B Letter of Credit") to secure payment of the principal of and up to 37 days' accrued interest on the Series 2011B Bonds which expires, unless extended, on _____.

The Series 2011B Bonds are payable solely from the 2011B Revenues and draws on the 2011B Letter of Credit.

Reference is made to an opinion of even date of Anderson, Fugate & Givens, counsel to the Alliance, with respect, among other matters, to the corporate status, good standing and qualification to do business of the Alliance, the corporate power of the Alliance to enter into and perform the Loan Agreements, the Series 2011 Obligations and the Master Indenture and the authorization, execution and delivery of the Loan Agreements, the Series 2011 Obligations and the Master Indenture by the Alliance and with respect to the Loan Agreements, the Series 2011 Obligations and the Master Indenture being binding and enforceable upon the Alliance.

As to questions of fact material to our opinion, we have relied upon representations of the Issuer and the Alliance contained in the Bond Indentures and the Loan Agreements, the certified proceedings and other certifications of public officials furnished to us, and certifications furnished to us by or on behalf of the Alliance (including certifications as to the use of bond proceeds and other bond issues which are material to paragraph 4 below), without undertaking to verify the same by independent investigation.

Based upon the foregoing, we are of the opinion that, under existing law:

1. The Issuer is duly created and validly existing as a public, nonprofit corporation, organized and existing under the laws of the State of Tennessee with the corporate power to enter into and perform the Bond Indenture and issue the Series 2011 Bonds.

2. Each Bond Indenture has been duly authorized, executed and delivered by the Issuer and is a valid and binding obligation of the Issuer enforceable against the Issuer. Each Bond Indenture creates a valid lien on the Revenues and on the rights of the Issuer under the corresponding Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) for the benefit of the corresponding Series 2011 Bonds.

3. The Series 2011 Bonds have been duly authorized, executed and delivered by the Issuer and are valid and binding special obligations of the Issuer, payable solely from the Revenues and draws on the applicable Letter of Credit.

4. Interest on the Series 2011 Bonds (a) will not be included in gross income for federal income tax purposes and (b) will not be an item of tax preference for purposes of the federal alternative minimum income tax imposed on individuals and corporations; however, with respect to corporations (as defined for federal income tax purposes) such interest is taken into account in determining adjusted current earnings for purposes of computing the alternative minimum income tax on corporations. The foregoing opinion is given in reliance upon certifications by representatives of the Issuer and the Alliance as to certain facts relevant to both the opinion and the requirements of the Internal Revenue Code of 1986, as amended (the "Code"). The Issuer and/or the Alliance have covenanted to comply with the provisions of the Code regarding, among other matters, the use, expenditure and investment of the proceeds of the Series 2011 Bonds and the timely payment of arbitrage profits with respect to the Series 2011 Bonds to the United States. Failure by the Issuer or the Alliance to comply with such covenants could cause interest on the Series 2011 Bonds to be included in gross income for federal income tax purposes retroactively to their date of issue. We express no opinion regarding other federal tax consequences arising with respect to the Series 2011 Bonds.

5. The Series 2011 Bonds and the income therefrom shall be exempt from all state, county and municipal taxation in Tennessee except (a) inheritance, gift and estate taxes, (b) excise taxes on all or a portion of the interest on any of the Series 2011 Bonds during the period such Series 2011 Bonds are held or beneficially owned by any organization or entity, other than a sole proprietorship or general partnership, and (c) Tennessee franchise taxes by reason of the inclusion of the book value of the Series 2011 Bonds in the Tennessee franchise tax base of any organization or entity, other than a sole proprietorship or general partnership.

It is to be understood that the rights of the holders of the Series 2011 Bonds and the enforceability of the Series 2011 Bonds and each Bond Indenture may be subject to bankruptcy, insolvency, reorganization, moratorium and other laws affecting creditors' rights heretofore and hereafter enacted to the extent constitutionally applicable and that their enforcement may also be subject to the exercise of judicial discretion in appropriate cases.

Our services as bond counsel have been limited to rendering the foregoing opinion based on our review of such proceedings and documents as we deem necessary to approve the validity of the Series 2011 Bonds and the excludability of the interest on the Series 2011 Bonds from gross income for federal income tax purposes. We have not made any investigation concerning the financial resources of the Alliance and, therefore, we express no opinion as to the business or financial resources of the Alliance, its ability to provide for the payment of the Series 2011 Bonds or the accuracy or completeness of any information, including the Preliminary Official Statement dated _____ and the Official Statement dated _____, as both have been supplemented, that may have been relied on by anyone in making the decision to purchase the Series 2011 Bonds.

Very truly yours,

[Opinion of Bass Berry Sims]

October 19, 2011

Industrial Development Authority of Smyth County
Marion, Virginia

The Bank of New York Mellon Trust Company, N.A.,
Bond Trustee and Master Trustee
St. Louis, Missouri

U.S. Bank National Association
St. Louis, Missouri

Merrill Lynch, Pierce, Fenner & Smith Incorporated
New York, New York

Mizuho Corporate Bank, Ltd.,
New York Branch
New York, New York

Re: Industrial Development Authority of Smyth County \$_____ Hospital Revenue Bonds
(Mountain States Health Alliance), Series 2011C and \$_____ Hospital Revenue Bonds
(Mountain States Health Alliance), Series 2011D

Ladies and Gentlemen:

We have acted as bond counsel in connection with the issuance by Industrial Development Authority of Smyth County (the "Issuer") of its \$_____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011C (the "Series 2011C Bonds") and its \$_____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011D (the "Series 2011D Bonds" and together with the Series 2011C Bonds, the "Series 2011 Bonds"). We have examined the law and such certified proceedings and other papers as we deem necessary to render this opinion. Reference is made to the forms of the Series 2011 Bonds for additional information concerning their details, payment and redemption provisions and the proceedings pursuant to which they were issued.

The Series 2011C Bonds are issued pursuant to a Bond Trust Indenture dated as of October 1, 2011 (the "Series 2011C Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Series 2011C Bond Trustee"). The proceeds from the sale of the Series 2011C Bonds will be loaned by the Board to Mountain States Health Alliance, a not-for-profit corporation incorporated under the laws of the State of Tennessee (the "Alliance"), under a Loan Agreement dated as of October 1, 2011 (the "Series 2011C Loan Agreement"), between the Issuer and the Alliance, which loan will be evidenced by the \$_____ Mountain States Health Alliance Note, Series 2011C (Industrial Development Authority of Smyth County) (the "Series 2011C Obligation") issued pursuant to an Amended and Restated Master Trust Indenture dated as of February 1, 2000, as heretofore amended and as amended by a Thirty-First Supplemental Master Trust Indenture dated as of October 1, 2011 (collectively, the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"). Under the Series 2011C Loan Agreement and the Series 2011C Obligation, the Alliance has agreed to make payments to be used to pay when due the principal of and premium, if any, and interest on the Series 2011C Bonds, and such payments and other revenues under the Series 2011C Loan Agreement and the Series 2011C Obligation (collectively, the "2011C Revenues") and the rights of the Issuer under the Series 2011C Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) are pledged and assigned by the Issuer as security for the Series 2011C Bonds.

U.S. Bank National Association, a national banking association (the "U.S. Bank"), has issued an irrevocable letter of credit dated the date hereof (the "2011C Letter of Credit") to secure payment of the principal of

and up to 37 days' accrued interest on the Series 2011C Bonds which expires, unless extended, on _____.

The Series 2011C Bonds are payable solely from the 2011C Revenues and draws on the 2011C Letter of Credit.

The Series 2011D Bonds are issued pursuant to a Bond Trust Indenture, dated as of October 1, 2011 (the "Series 2011D Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Series 2011D Bond Trustee"). The proceeds from the sale of the Series 2011D Bonds will be loaned by the Board to Mountain States Health Alliance, a not-for-profit corporation incorporated under the laws of the State of Tennessee (the "Alliance"), under a Loan Agreement dated as of October 1, 2011 (the "Series 2011D Loan Agreement"), between the Issuer and the Alliance, which loan will be evidenced by the \$_____ Mountain States Health Alliance Note, Series 2011D (Industrial Development Authority of Smyth County) (the "Series 2011D Obligation") issued pursuant to an Amended and Restated Master Trust Indenture dated as of February 1, 2000, as heretofore amended and as amended by a Thirty-First Supplemental Master Trust Indenture dated as of October 1, 2011 (collectively, the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"). Under the Series 2011D Loan Agreement and the Series 2011D Obligation, the Alliance has agreed to make payments to be used to pay when due the principal of and premium, if any, and interest on the Series 2011D Bonds, and such payments and other revenues under the Series 2011D Loan Agreement and the Series 2011D Obligation (collectively, the "2011D Revenues") and the rights of the Issuer under the Series 2011D Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) are pledged and assigned by the Issuer as security for the Series 2011D Bonds.

Mizuho Corporate Bank, Ltd., New York Branch (the "Mizuho"), has issued an irrevocable letter of credit dated the date hereof (the "2011D Letter of Credit") to secure payment of the principal of and up to 37 days' accrued interest on the Series 2011D Bonds which expires, unless extended, on _____.

The Series 2011D Bonds are payable solely from the 2011D Revenues and draws on the 2011D Letter of Credit.

Reference is made to an opinion of even date of Anderson, Fugate & Givens, counsel to the Alliance, with respect, among other matters, to the corporate status, good standing and qualification to do business of the Alliance, the corporate power of the Alliance to enter into and perform the Loan Agreements, the Series 2011 Obligations and the Master Indenture and the authorization, execution and delivery of the Loan Agreements, the Series 2011 Obligations and the Master Indenture by the Alliance and with respect to the Loan Agreements, the Series 2011 Obligations and the Master Indenture being binding and enforceable upon the Alliance.

As to questions of fact material to our opinion, we have relied upon representations of the Issuer and the Alliance contained in the Bond Indentures and the Loan Agreements, the certified proceedings and other certifications of public officials furnished to us, and certifications furnished to us by or on behalf of the Alliance (including certifications as to the use of bond proceeds and other bond issues which are material to paragraph 4 below), without undertaking to verify the same by independent investigation.

As to all matters of Virginia law, we have relied upon the attached opinion of Hunton & Williams LLP, Virginia bond counsel.

Based upon the foregoing, we are of the opinion that, under existing law:

1. The Issuer is duly created and validly existing as a public, nonprofit corporation, organized and existing under the laws of the State of Tennessee with the corporate power to enter into and perform the Bond Indenture and issue the Series 2011 Bonds.

2. Each Bond Indenture has been duly authorized, executed and delivered by the Issuer and is a valid and binding obligation of the Issuer enforceable against the Issuer. Each Bond Indenture creates a valid lien on the Revenues and on the rights of the Issuer under the corresponding Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) for the benefit of the corresponding Series 2011 Bonds.

3. The Series 2011 Bonds have been duly authorized, executed and delivered by the Issuer and are valid and binding special obligations of the Issuer, payable solely from the Revenues and draws on the applicable Letter of Credit.

4. Interest on the Series 2011 Bonds (a) will not be included in gross income for federal income tax purposes and (b) will not be an item of tax preference for purposes of the federal alternative minimum income tax imposed on individuals and corporations; however, with respect to corporations (as defined for federal income tax purposes) such interest is taken into account in determining adjusted current earnings for purposes of computing the alternative minimum income tax on corporations. The foregoing opinion is given in reliance upon certifications by representatives of the Issuer and the Alliance as to certain facts relevant to both the opinion and the requirements of the Internal Revenue Code of 1986, as amended (the "Code"). The Issuer and/or the Alliance have covenanted to comply with the provisions of the Code regarding, among other matters, the use, expenditure and investment of the proceeds of the Series 2011 Bonds and the timely payment of arbitrage profits with respect to the Series 2011 Bonds to the United States. Failure by the Issuer or the Alliance to comply with such covenants could cause interest on the Series 2011 Bonds to be included in gross income for federal income tax purposes retroactively to their date of issue. We express no opinion regarding other federal tax consequences arising with respect to the Series 2011 Bonds.

5. Under current law, interest on the Series 2011 Bonds is exempt from income taxation by the Commonwealth of Virginia and any political subdivision thereof.

It is to be understood that the rights of the holders of the Series 2011 Bonds and the enforceability of the Series 2011 Bonds and each Bond Indenture may be subject to bankruptcy, insolvency, reorganization, moratorium and other laws affecting creditors' rights heretofore and hereafter enacted to the extent constitutionally applicable and that their enforcement may also be subject to the exercise of judicial discretion in appropriate cases.

Our services as bond counsel have been limited to rendering the foregoing opinion based on our review of such proceedings and documents as we deem necessary to approve the validity of the Series 2011 Bonds and the excludability of the interest on the Series 2011 Bonds from gross income for federal income tax purposes. We have not made any investigation concerning the financial resources of the Alliance and, therefore, we express no opinion as to the business or financial resources of the Alliance, its ability to provide for the payment of the Series 2011 Bonds or the accuracy or completeness of any information, including the Preliminary Official Statement dated _____ and the Official Statement dated _____, as both have been supplemented, that may have been relied on by anyone in making the decision to purchase the Series 2011 Bonds.

Very truly yours,

October __, 2011

Industrial Development Authority of
Smyth County
Marion, Virginia

Bass, Berry & Sims PLC
Nashville, Tennessee

**Industrial Development Authority of Smyth County
Hospital Revenue Bonds
(Mountain States Health Alliance)**

Series 2011C
\$ _____

Series 2011D
\$ _____

Ladies and Gentlemen:

We have examined the applicable law, including the Industrial Development and Revenue Bond Act, Chapter 49, Title 15.2, Code of Virginia of 1950, as amended (the “Act”), and certified copies of proceedings and documents relating to the organization of the Industrial Development Authority of Smyth County (the “Authority”) and the issuance and sale by the Authority of its \$ _____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011C (the “Series 2011C Bonds”), and its \$ _____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011D (the “Series 2011D Bonds” and, together with the Series 2011C Bonds, the “Bonds”). Reference is made to the form of the Bonds for additional information concerning their details, payment and redemption provisions and the proceedings pursuant to which they are issued. Terms used but not defined herein are defined in the Bond Indentures, as defined below.

The Series 2011C Bonds are issued pursuant to the provisions of a Bond Trust Indenture dated as of October 1, 2011 (the “Series 2011C Bond Indenture”), between the Authority and The Bank of New York Mellon Trust Company, N.A., as Bond Trustee (the “Bond Trustee”). The proceeds of the Series 2011C Bonds are being loaned by the Authority to Mountain States Health Alliance (the “Alliance”), Norton Community Hospital (“Norton”) and Smyth County Community Hospital (“Smyth”), pursuant to a Loan Agreement dated as of October 1, 2011 (the “Series 2011C Loan Agreement”).

The Series 2011D Bonds are issued pursuant to the provisions of a Bond Trust Indenture dated as of October 1, 2011 (the “Series 2011D Bond Indenture” and, together with the Series 2011C Bond Indenture, the “Bond Indentures”), between the Authority and the Bond Trustee. The proceeds of the Series 2011D Bonds are being loaned by the Authority to the Alliance, Johnston Memorial Hospital (“JMH”) and Smyth pursuant to a Loan Agreement dated as of October 1, 2011 (the “Series 2011D Loan Agreement” and, together with the Series 2011C Loan Agreement, the “Loan Agreements”). Pursuant to the Loan Agreements, the Authority assigns to the Bond Trustee (a) as security for the Series 2011C Bonds, a \$ _____ promissory note of the Alliance dated October __, 2011 (the “Series 2011C Note”), (b) as security for the Series 2011D Bonds, a \$ _____ promissory note of the Alliance dated October __, 2011 (the “Series 2011D Note” and, together with the Series 2011C Note, the “Notes”), and (c) the Authority’s rights (except for its rights to indemnification, payment of fees and expenses and receipt of certain notices).

The Notes state that they are issued pursuant to and governed by an Amended and Restated Master Trust Indenture dated as of February 1, 2000 (the “Master Indenture”), between the Alliance and The Bank of New York

Mellon Trust Company, N.A., as Master Trustee, as supplemented by a Thirty-First Supplemental Master Indenture dated as of October 1, 2011.

As further security for the Series 2011C Bonds, U.S. Bank National Association (the "Series 2011C Bank") has issued its irrevocable letter of credit (the "Series 2011C Letter of Credit") in an amount not to exceed \$_____ authorizing the Bond Trustee to draw on the Series 2011C Bank, in accordance with the terms and conditions therein set forth, for payment of principal of, premium, if any, and up to 37 days' interest on the Series 2011C Bonds. Reference is also made to the opinion of Thompson Coburn LLP, counsel to the Series 2011C Bank, dated today, as to the validity and enforceability of the Series 2011C Letter of Credit against the Series 2011C Bank, upon which you are relying as to matters therein.

As further security for the Series 2011D Bonds, Mizuho Corporate Bank, Ltd. (the "Series 2011D Bank" and, together with the Series 2011C Bank, the "Banks") has issued its irrevocable letter of credit (the "Series 2011D Letter of Credit" and, together with the Series 2011C Letter of Credit, the "Letters of Credit") in an amount not to exceed \$_____ authorizing the Bond Trustee to draw on the Series 2011D Bank, in accordance with the terms and conditions therein set forth, for payment of principal of, premium, if any, and up to 37 days' interest on the Series 2011D Bonds. Reference is also made to the opinion of Thompson Coburn LLP, counsel to the Series 2011D Bank, dated today, as to the validity and enforceability of the Series 2011D Letter of Credit against the Series 2011D Bank, upon which you are relying as to matters therein.

Without undertaking to verify the same by independent investigation, we have relied on certifications by representatives of the Alliance, Norton, Smyth, JMH, Smyth County, Virginia, and the Authority as to certain facts relevant to our opinion. We have not been requested to express, and therefore do not express, any opinion herein as to the treatment of interest on the Bonds under federal tax law, the necessity of registration of the Bonds under the Securities Act of 1933, as amended, or any state "Blue Sky" law, or any required qualification or registration under the Trust Indenture Act of 1939, as amended.

Based on the foregoing and assuming the due authorization, execution and delivery of all documents by parties other than the Authority, we are of the opinion that:

1. The Authority is duly organized and validly existing as an industrial development authority under the Act and has authority under the Act to issue and sell the Bonds.

2. The Bonds have been duly authorized and issued in accordance with the Act and constitute valid and binding limited obligations of the Authority, payable as to principal, premium, if any, and interest solely from the revenues and receipts derived from the Loan Agreements, including payments received under the Notes, and draws under the Letters of Credit. The Bonds do not create or constitute a debt or pledge of the faith and credit of the Commonwealth of Virginia or any political subdivision thereof, including the Authority and Smyth County, Virginia.

3. The Loan Agreements have been duly authorized, executed and delivered by the Authority, constitute valid and binding agreements of the Authority, and are enforceable against the Authority in accordance with their terms.

4. The Bond Indentures have been duly authorized, executed and delivered by the Authority, constitute valid and binding agreements of the Authority, assign and pledge to the Bond Trustee, as security for the Bonds, the Notes and all rights of the Authority under the Loan Agreements (except for its rights to indemnification, payment of fees and expenses and receipt of certain notices), and are enforceable against the Authority in accordance with their terms.

5. The rights of the holders of the Bonds and the enforceability of such rights, including enforcement by the Bond Trustee of the obligations of the Authority under the Loan Agreements and the Bond Indentures, may be limited or otherwise affected by (a) bankruptcy, insolvency, reorganization, moratorium, fraudulent conveyance and other laws affecting the rights of creditors generally, and (b) principles of equity, whether considered at law or in equity.

6. Under current law, interest on the Bonds is exempt from income taxation by the Commonwealth of Virginia and any political subdivision thereof.

Our services as bond counsel to the Authority have been limited to delivering the foregoing opinion based on our review of such proceedings and documents as we deem necessary to approve the validity of the Bonds. We express no opinion herein as to the financial resources of the Alliance and related entities, the Banks, their ability to provide for the payment of the Bonds or the accuracy or completeness of any information, including the Official Statement dated October __, 2011, that may have been relied on by anyone in making the decision to purchase the Bonds.

Very truly yours,

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APPENDIX F

PROPOSED FORM OF CONTINUING DISCLOSURE AGREEMENT

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CONTINUING DISCLOSURE AGREEMENT

This Continuing Disclosure Agreement (the “Agreement”) is executed by the Mountain States Health Alliance, a Tennessee nonprofit corporation (the “Alliance”), in connection with (i) the issuance by the Health and Educational Facilities Board of the City of Johnson City, Tennessee of its \$65,260,000 Hospital Revenue Bonds (Mountain States Health Alliance) Series 2011A, and its \$20,000,000 Hospital Revenue Bonds (Mountain States Health Alliance) Series 2011B, (ii) the issuance by the Industrial Development Authority of Smyth County of its \$49,875,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011C and its \$60,705,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011D and (iii) the issuance by the Alliance of its \$15,960,000 Taxable Bonds, Series 2011E (all such bonds, together the “Bonds”).

1. Purpose of the Agreement

This Agreement is being executed and delivered by the Alliance for the benefit of the Beneficial Owners of the Bonds and in order to assist the Underwriter in complying with the Rule (as hereinafter defined).

2. Definitions

Except as otherwise indicated, any capitalized terms used, but not defined herein shall have the meaning assigned to them in the bond indenture pursuant to which the Bonds were issued. The following capitalized terms when used in this Agreement will have the following meanings:

“Annual Disclosure” means the annual financial information, audited financial statements prepared in accordance with generally accepted accounting principles and the operating data, all to be provided by the Alliance with respect to itself and any future Obligated Issuer pursuant to the Rule and this Agreement, as provided in Section 4 hereof.

“Beneficial Owner” means any person who (a) has the power, directly or indirectly, to vote or consent with respect to, or to dispose of ownership of, any Bonds (including persons holding Bonds through nominees, depositories or other intermediaries) or (b) is treated as the owner of any Bonds for federal income tax purposes.

“Listed Events” means any of the events listed below under “Reporting of Significant Events.”

“MSRB” means the Municipal Securities Rulemaking Board, or any successor thereto. Currently, the MSRB’s address is: MSRB, 1900 Duke Street, Suite 600, Alexandria, Virginia 22314, Attn: Disclosure.

“Official Statement” means the Official Statement, dated October 14, 2011, pursuant to which the Bonds were sold.

“Quarterly Disclosure” means the provision of the Quarterly Financial Information and any other financial information as provided in Section 5, hereof.

“Quarterly Financial Information” means (i) the Alliance’s quarterly financial results in the form of its unaudited quarterly statement of excess of revenue over expenses and its unaudited quarterly balance sheet, each on a consolidated basis for the combined Obligated Group (as defined in the bond documents pursuant to which the Bonds are issued) and (ii) two calculations of the Historical Maximum Annual Debt Service Coverage Ratio (one utilizing a *pro forma* Total Income Available for Debt Service based upon the results of such quarter and the other utilizing Total Income Available for Debt Service over the rolling twelve month period ended with the end of such quarter).

“Rule” means Rule 15c2-12(b)(5) adopted by the Securities and Exchange Commission under the Securities Exchange Act of 1934, as previously amended and as the same may be amended from time to time.

“Underwriter” means Merrill Lynch & Co., as managing underwriter.

3. Provision of Annual Disclosure and Quarterly Disclosure

Not later than four months after the end of each fiscal year, the Alliance will file its Annual Disclosure with the MSRB. The Annual Disclosure may be submitted as a single document or as separate documents comprising a package, and may cross-reference other information as provided below.

Not later than 45 days after the end of each quarter of the Alliance's fiscal year the Alliance shall file its Quarterly Financial Information with the MSRB.

If the Annual Disclosure is not filed as provided in the preceding paragraph, the Alliance will send a notice to that effect to the MSRB.

4. Content of Annual Disclosure

The Alliance and any future Obligated Issuer shall provide and incorporate the following information in its Annual Disclosure:

- (a) The audited financial statements of the Alliance and any future Obligated Issuer; and
- (b) To the extent not included in the audited financial statements of the Alliance, the Alliance annually will make available the following financial and operating data:

- (i) The patient origin analysis from all service areas as a percent of the discharges in Alliance-owned facilities for the prior 12 month period, as set forth under the caption "SERVICE AREA, MARKET SHARE AND COMPETITION – Patient Origin -- Alliance-Owned Facilities Patient Origin by Fiscal Year" in Appendix A of the Official Statement.

- (ii) The percentage of gross patient revenues received by the Alliance from each program (i.e., Medicare, TennCare/Medicaid, Managed Care, Commercial and Other, and Private Pay) for the most recently concluded fiscal year, as set forth under the caption "SOURCES OF REVENUE – Gross Patient Revenues by Source of Payment (Payor Mix)" in Appendix A of the Official Statement.

- (iii) The historic patient utilization for the Alliance and aggregate utilization for all divisions for the prior 12 month period ending June 30, as set forth under the caption "HISTORICAL UTILIZATION INFORMATION – Utilization by Fiscal Year" in Appendix A of the Official Statement.

Any or all of the items listed above may be incorporated by reference from other documents, including official statements of debt issues with respect to which the Alliance is an "obligated person" (as defined by the Rule), which have been filed in accordance with the Rule and the other rules of the Securities and Exchange Commission. If the document incorporated by reference is a final official statement, it must have been filed with and be available from the MSRB. The Alliance must clearly identify each such other document so incorporated by reference.

5. Content of Quarterly Disclosure

The Alliance's Quarterly Disclosure will contain its Quarterly Financial Information.

6. Reporting of Significant Events

The following are Listed Events:

- (a) principal and interest payment delinquencies;
- (b) non-payment related defaults, if material;

- (c) unscheduled draws on debt service reserves reflecting financial difficulties;
- (d) unscheduled draws on any credit enhancement reflecting financial difficulties;
- (e) substitution of credit or liquidity providers, or their failure to perform;
- (f) adverse tax opinions; the issuance by the IRS of proposed or final determinations of taxability, Notices of Proposed Issue (IRS Form 5701-TEB) or other material notices or determinations with respect to the tax status of the Bonds, or other material events affecting the tax status of the Bonds;
- (g) modifications of rights of the holders of the Bonds, if material;
- (h) bond calls, if material, and tender offers;
- (i) defeasance of all or any portion of the Bonds;
- (j) release, substitution, or sale of property securing repayment of the Bonds, if material;
- (k) rating changes;
- (l) bankruptcy, insolvency, receivership or similar event of the Issuer;
- (m) the consummation of a merger, consolidation, or acquisition involving the Issuer or the sale of all or substantially all of the assets of the Issuer, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; and
- (n) appointment of a successor or additional trustee or the change of name of a trustee, if material.

If the Alliance obtains knowledge of the occurrence of a Listed Event, the Alliance will, in a timely manner, file a notice of such occurrence with the MSRB. Notice of Listed Events described in subsections (h) and (i) will be disseminated automatically, but will not be given any earlier than the notice (if any) of the underlying event is given to the Beneficial Owners of affected Bonds pursuant to the governing bond documents. The content of any notice of the occurrence of a Listed Event will be determined by the Alliance.

7. Filing Method

Any filing required hereunder shall be made by transmitting such disclosure, notice or other information in electronic format to the MSRB through the MSRB's Electronic Municipal Market Access (EMMA) system pursuant to procedures promulgated by the MSRB.

8. Termination of Reporting Obligation

The Alliance's obligations under this Agreement will terminate upon the defeasance (within the meaning of the Rule), prior redemption or payment in full of all of the Bonds. The Alliance will notify the MSRB that the Alliance's obligations under this Agreement have terminated. If the Alliance's obligations are assumed in full by some other entity, such person will be responsible for compliance with this Agreement in the same manner as if it were the Alliance and the Alliance will have no further responsibility hereunder.

9. Dissemination Agent

The Alliance may, from time to time, appoint a dissemination agent to assist it in carrying out its obligations under this Agreement, and the Alliance may, from time to time, discharge the dissemination agent, with

or without appointing a successor dissemination agent. If at any time there is not a designated dissemination agent, the Alliance will be the dissemination agent.

10. Amendment

This Agreement may not be amended unless independent counsel experienced in securities law matters has rendered an opinion to the Alliance to the effect that the amendment does not violate the provisions of the Rule.

In the event that this Agreement is amended or any provision of this Agreement is waived, the notice of a Listed Event pursuant to subsection (6) under the heading "Reporting of Significant Events" will explain, in narrative form, the reasons for the amendment or waiver and the impact of the change in the type of operating data or financial information being provided in the Annual Disclosure. If an amendment or waiver is made in this Agreement which allows for a change in the accounting principles to be used in preparing financial statements, the Annual Disclosure for the year in which allows for a change in the accounting principles to be used in preparing financial statements, the Annual Disclosure for the year in which the change is made will present a comparison between the financial statements or information prepared on the basis of the new accounting principles and those prepared on the basis of the former accounting principles. The comparison will include a qualitative discussion of the differences in the accounting principles and impact of the change in the accounting principles on the presentation of the financial information. A notice of the change in the accounting principles will be deemed to be material and will be filed with the MSRB.

11. Additional Information

Any registered owner of \$1,000,000 or more in principal amount of Bonds shall receive, upon written request, any of the Annual Financial Information, Audited Financial Information or Quarterly Financial Information directly from the Alliance, by sending such request to Mountain States Health Alliance, 400 North State of Franklin Road, Johnson City, Tennessee 37604, Attn: Chief Financial Officer.

Nothing in this Agreement will be deemed to prevent the Alliance from disseminating any other information, using the means of dissemination set forth in this Agreement or any other means of communication, or including any other information in any Annual Disclosure or notice of occurrence of a Listed Event, in addition to that which is required by this Agreement. If the Alliance chooses to include any information in any Annual Disclosure or notice of occurrence of a Listed Event, in addition to that which is specifically required by this Agreement, the Alliance will have no obligation under this Agreement to update such information or include it any future Annual Disclosure or notice of occurrence of a Listed Event.

12. Default

In the event of a failure of the Alliance to comply with any provision of this Agreement, the Underwriter or any Beneficial Owner may take such actions as may be necessary and appropriate, including seeking specific performance by court order, to cause the Alliance to comply with its obligations under this Agreement. A default under this Agreement will not be deemed an Event of Default under the bond documents, and the sole remedy under this Agreement in the event of any failure of any party to comply with this Agreement will be an action to compel performance.

Acting by and through its duly authorized officer, the Alliance has caused this Continuing Disclosure Agreement to be executed under seal as of the 1st day of October, 2011.

MOUNTAIN STATES HEALTH ALLIANCE

By: _____
Its: Senior Vice President and
Chief Financial Officer

THE BANKS

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**CERTAIN INFORMATION CONCERNING
MIZUHO CORPORATE BANK, LTD.**

The delivery of this Appendix to the Official Statement shall not create any implication that there has been no change in the affairs of Mizuho since the date hereof, or that the information contained or referred to in this Appendix G-1 is correct as of any time subsequent to its date.

Mizuho Corporate Bank, Ltd. (“Mizuho”) is a wholly-owned subsidiary of Mizuho Financial Group, Inc. (“MHFG”), a corporation organized under the laws of Japan.

MHFG is one of the largest financial institutions in the world, offering a broad range of financial services including banking, securities, trust and asset management, credit card, private banking, and venture capital through its group companies. MHFG’s principal banking subsidiaries include Mizuho, Mizuho Bank, Ltd., and Mizuho Trust & Banking Co., Ltd. Mizuho was established on April 1, 2002, following a split and merger process of The Dai-Ichi Kangyo Bank, Limited, The Fuji Bank, Limited and The Industrial Bank of Japan, Limited.

Mizuho’s New York branch (the “New York Branch”) is licensed by the Banking Department of the State of New York as a branch to transact banking business in New York. The New York Branch is subject to supervision, examination and regulation by the New York State Banking Department and the Federal Reserve Board.

The long-term credit ratings of Mizuho by Moody’s, Standard & Poor’s and Fitch are A1, A+ and A, respectively, and the short-term credit ratings of Mizuho by Moody’s, Standard & Poor’s, and Fitch are P-1, A-1 and F 1, respectively.

A security rating is not a recommendation to buy, sell or hold securities and should be evaluated independently of any other rating. The rating is subject to revision or withdrawal at any time by the assigning rating organization.

Additional information, including the most recent annual report on Form 20-F for the fiscal year ended March 31, 2011, of MHFG, and additional annual, quarterly and current reports filed with or furnished to the Securities and Exchange Commission (the “SEC”), may be obtained without charge by each person to whom this Official Statement is delivered upon the written request of any such person to Mizuho Corporate Bank, Ltd., 1251 Avenue of the Americas, New York, New York 10020. This information is also available at www.mizuho-fg.co.jp/english/ and at the SEC’s website at www.sec.gov.

THE MIZUHO LETTER OF CREDIT IS AN OBLIGATION OF MIZUHO AND IS NOT AN OBLIGATION OF MHFG. NO SUBSIDIARY OR AFFILIATE CONTROLLED BY MHFG, EXCEPT MIZUHO, IS OBLIGATED TO MAKE PAYMENTS UNDER THE MIZUHO LETTER OF CREDIT.

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August 10, 2011

PNC BANK, NATIONAL ASSOCIATION

This summary incorporates by reference certain Call Reports of PNC Bank, National Association (“PNC Bank”), filed with the Office of the Comptroller of the Currency (“OCC”), and certain reports of its parent, The PNC Financial Services Group, Inc. (“PNC Financial”), filed with the Securities and Exchange Commission (“SEC”), as set forth below under the heading “Incorporation of Certain Documents by Reference.” You should read those reports and the information set forth below under the headings “PNC Bank and PNC Financial” and “Supervision and Regulation.”

You should also understand that, except to the limited extent described herein, this summary does not describe the business or analyze the condition, financial or otherwise, of PNC Bank or otherwise describe any risks associated with PNC Bank or the Letter of Credit. You must rely on your own knowledge, investigation and examination of PNC Bank and PNC Bank’s creditworthiness.

Neither PNC Bank nor PNC Financial makes any representation regarding the Bonds or the advisability of investing in the Bonds, nor do they make any representation regarding, nor has PNC Bank or PNC Financial participated in the preparation of, any document of which this summary is a part other than the information supplied by PNC Bank or PNC Financial and presented in this summary headed “PNC Bank, National Association.”

THE LETTER OF CREDIT IS SOLELY AN OBLIGATION OF PNC BANK AND IS NEITHER AN OBLIGATION OF NOR GUARANTEED BY PNC FINANCIAL OR ANY OF ITS OTHER AFFILIATES.

PNC Bank and PNC Financial

PNC Bank is a national banking association with its headquarters in Pittsburgh, Pennsylvania and its main office in Wilmington, Delaware. PNC Bank is a wholly-owned indirect subsidiary of PNC Financial. PNC Bank’s origins as a national bank date to 1865. PNC Bank and its subsidiaries offer a wide range of commercial banking, retail banking, and trust and wealth management services to their customers. PNC Bank’s business is subject to examination and regulation by federal banking authorities. Its primary federal bank regulator is the OCC and its deposits are insured by the Federal Deposit Insurance Corporation (“FDIC”).

PNC Financial, the parent company of PNC Bank, is one of the largest diversified financial services companies in the United States and is headquartered in Pittsburgh, Pennsylvania. PNC Financial was incorporated under the laws of the Commonwealth of Pennsylvania in 1983 with the consolidation of Pittsburgh National Corporation and Provident National Corporation. Since 1983, PNC Financial has diversified its geographic presence, business mix and product capabilities through internal growth, strategic bank and non-bank acquisitions and equity investments, and the formation of various non-banking subsidiaries.

PNC Financial has businesses engaged in retail banking, corporate and institutional banking, asset management, and residential mortgage banking. PNC Financial provides many of its products and services nationally and others in PNC Financial’s primary geographic markets located in Pennsylvania, Ohio, New Jersey, Michigan, Maryland, Illinois, Indiana, Kentucky, Florida, Virginia, Missouri, Delaware, Washington, D.C., and Wisconsin. PNC Financial also provides certain products and services internationally.

On June 19, 2011, PNC Financial entered into a definitive agreement for PNC Financial to acquire RBC Bank (USA), the U.S. retail banking subsidiary of Royal Bank of Canada. Raleigh, N.C.-based RBC Bank (USA) has approximately \$25 billion of assets and 424 branches in North Carolina, Florida, Alabama, Georgia, Virginia and South Carolina. Based on RBC Bank (USA) balances as of April 30, 2011, the acquisition would add approximately \$19 billion of deposits and \$16 billion of loans, net of agreed upon loan and deposit transfers. PNC Financial has also agreed to acquire certain credit card accounts of RBC Bank (USA) customers issued by RBC Bank (Georgia), National Association, a wholly-owned subsidiary of Royal Bank of Canada. The transaction is expected to close in March 2012, subject to customary closing conditions including regulatory approvals. Upon

closing, PNC Financial intends to merge RBC Bank (USA) into PNC Bank, with PNC Bank continuing as the surviving entity.

On July 26, 2011, PNC Financial entered into a definitive agreement for the acquisition of 27 branches in metropolitan Atlanta, Georgia from Flagstar Bank, FSB, a subsidiary of Flagstar Bancorp, Inc., and the assumption of approximately \$240 million of deposits associated with those branches, based on balances as of June 30, 2011. No loans will be acquired in the transaction. This transaction is expected to close in December 2011, subject to customary closing conditions including regulatory approvals.

PNC Financial

in billions

	<u>June 30, 2011</u>	<u>December 31, 2010</u>
Total assets	\$263.1	\$264.3
Total deposits	\$181.9	\$183.4
Shareholders' equity	\$32.2	\$30.2

PNC Bank

in billions

	<u>June 30, 2011</u>	<u>December 31, 2010</u>
Total assets	\$254.8	\$256.6
Total loans (net of unearned income) and loans held for sale	\$153.2	\$154.2
Total deposits	\$188.1	\$191.9
Total equity capital	\$35.2	\$33.8

Supervision and Regulation

PNC Financial, the parent company of PNC Bank, is a bank and financial holding company and is subject to numerous governmental regulations involving both its business and organization. To a substantial extent, the purpose of the regulation and supervision of financial services institutions and their holding companies is not to protect shareholders and non-customer creditors, but rather to protect customers and the financial markets in general.

Applicable laws and regulations restrict permissible activities and investments and require compliance with protections for loan, deposit, brokerage, fiduciary, mutual fund and other customers, among other things. They also restrict PNC Financial's ability to repurchase its stock or to receive dividends from its subsidiaries that operate in the banking and securities businesses and impose capital adequacy requirements. The consequences of noncompliance can include substantial monetary and nonmonetary sanctions. In addition, PNC Financial and PNC Bank are subject to comprehensive examination and supervision by banking and other regulatory bodies. Examination reports and ratings (which often are not publicly available) and other aspects of this supervisory framework could materially impact the conduct, growth, and profitability of the company's operations.

There have been numerous legislative and regulatory developments and dramatic changes in the competitive landscape of the financial services industry over the last several years. The United States and other governments have undertaken major reform of the regulatory oversight structure of the financial services industry, including engaging in new efforts to impose requirements designed to protect consumers and investors from financial abuse. PNC Financial expects to face further increased regulation of the financial services industry as a result of current and future initiatives intended to provide economic stimulus, financial market stability, and enhanced regulation of financial services companies and to enhance the liquidity and solvency of financial institutions and markets. PNC Financial and PNC Bank also expect in many cases more intense scrutiny from bank supervisors in the examination process and more aggressive enforcement of regulations on both the federal and state levels. Compliance with regulations and other supervisory initiatives will likely increase the company's costs and reduce its revenue, and may limit its ability to pursue certain desirable business opportunities.

The Dodd-Frank Wall Street Reform and Consumer Protection Act (“Dodd-Frank”) mandates the most wide-ranging overhaul of financial industry regulation in decades. Dodd-Frank was signed into law on July 21, 2010. Although Dodd-Frank and other reforms will affect a number of the areas in which PNC Financial does business, it is not clear at this time the full extent of the adjustments that will be required and the extent to which PNC Financial will be able to adjust its businesses in response to the requirements. Many parts of the law are now in effect and others are now in the implementation stage, which is likely to continue for several years. The law requires that regulators, some of which are new regulatory bodies created by Dodd-Frank, draft, review and approve more than 300 implementing regulations and conduct numerous studies that are likely to lead to more regulations, a process that, while well underway, is proceeding somewhat slower than originally anticipated, thus extending the uncertainty surrounding the ultimate impact of Dodd-Frank on PNC Financial and its subsidiaries.

A number of reform provisions are likely to significantly impact the ways in which bank holding companies and banks, including PNC Financial and PNC Bank, do business. Additional information regarding a number of these provisions (including new consumer protection regulation, enhanced capital requirements, limitations on investment in and sponsorship of funds, risk retention by securitization participants, new regulation of derivatives, potential applicability of state consumer protection laws, and limitations on interchange fees) and some of their potential impacts on PNC Financial is provided in Item 1A Risk Factors included in Part II of PNC Financial’s second quarter 2011 Quarterly Report on Form 10-Q.

You will find a general discussion of some of the elements of the regulatory framework affecting PNC Financial and its subsidiaries, additional information discussing the regulatory environment for the financial services industry, and discussion of certain business and regulatory risks that affect PNC Financial in the following sections of PNC Financial’s 2010 Annual Report on Form 10-K and its 2011 Quarterly Reports on Form 10-Q, as applicable: for the 2010 Form 10-K, the Supervision And Regulation section included in Item 1 – Business, Item 1A – Risk Factors, and Note 21 Regulatory Matters, Note 22 Legal Proceedings, and Note 23 Commitments and Guarantees of the Notes To Consolidated Financial Statements included in Item 8 of that report; and for the 2011 Form 10-Qs, Item 1A – Risk Factors included in Part II, and the Legal Proceedings and Commitments and Guarantees Notes of the Notes To Consolidated Financial Statements included in Part I, of those respective reports as applicable.

Incorporation of Certain Documents by Reference

PNC Bank submits certain unaudited reports called “Consolidated Reports of Condition and Income” (“Call Reports”) to the OCC, its primary federal bank regulator, quarterly. Each Call Report consists of a balance sheet, income statement, changes in bank equity capital, and other supporting schedules as of the end of or for the period to which the report relates. The Call Reports are prepared in accordance with regulatory instructions issued by the Federal Financial Institutions Examination Council. Because of the special supervisory, regulatory and economic policy needs served by the Call Reports, those regulatory instructions do not in all cases follow accounting principles generally accepted in the United States, including the opinions and statements of the Accounting Principles Board or the Financial Accounting Standards Board (“U.S. GAAP”). While the Call Reports are supervisory and regulatory documents, not primarily financial accounting documents, and do not provide a complete range of financial disclosure about PNC Bank, the reports nevertheless provide important information concerning the financial condition and results of operations of PNC Bank.

The publicly available portions of the Call Reports are on file with, and publicly available on written request to, the FDIC, Public Information Center, 3501 North Fairfax Drive, Arlington, VA 22226, or by calling the FDIC Public Information Center at 877-275-3342 or 703-562-2200. The Call Reports are also available by accessing the FDIC’s website at <http://www.fdic.gov>.

PNC Financial, the parent company of PNC Bank, is subject to the informational requirements of the Securities Exchange Act of 1934 (“Exchange Act”). In accordance with the Exchange Act, PNC Financial files annual, quarterly and current reports, proxy statements, and other information with the SEC. PNC Financial’s SEC File Number is 001-09718. You may read and copy this information at the SEC’s Public Reference Room, located at 100 F Street, N.E., Room 1580, Washington, D.C. 20549. You can obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330 or 202-551-8090. You can also obtain copies of this information by mail from the public reference section of the SEC, 100 F Street, N.E., Washington, D.C. 20549, at prescribed rates.

The SEC also maintains an internet site that contains reports, proxy and information statements, and other information regarding issuers, like PNC Financial, who file electronically with the SEC. The address of that website is <http://www.sec.gov>. You can also inspect reports, proxy statements and other information about PNC Financial at the offices of the New York Stock Exchange, Inc., 20 Broad Street, New York, New York 10005.

We have included the web addresses of the FDIC and the SEC as inactive textual references only. Except as specifically incorporated by reference into this summary, information on those websites is not part hereof.

The publicly-available portions of PNC Bank's Call Reports for the years ended December 31, 2010, 2009, and 2008 and for the quarters ended March 31, 2011 and June 30, 2011, and of any amendments or supplements thereto, as filed by PNC Bank with the OCC, are incorporated herein by reference. The publicly-available portions of each other PNC Bank Call Report, and of any amendments or supplements thereto or to any of the PNC Bank Call Reports listed above, filed with the OCC after December 31, 2010 and prior to the expiration of the Letter of Credit are also incorporated herein by reference and will be deemed a part hereof from the date of filing of each such document. Subsequently filed reports, and amendments or supplements to reports, will automatically update and supersede prior information.

In addition to the Call Reports referred to above, PNC Bank incorporates herein by reference the following documents: PNC Financial's Annual Report on Form 10-K for the year ended December 31, 2010; PNC Financial's Quarterly Reports on Form 10-Q for the quarters ended March 31, 2011 and June 30, 2011; PNC Financial's Current Reports on Form 8-K filed with the SEC on February 15, 2011, March 1, 2011, March 7, 2011, April 14, 2011, May 2, 2011, June 20, 2011 (with respect to Item 1.01 and Exhibit 2.1 thereof), and July 27, 2011; and any amendments or supplements to those reports. Each other annual, quarterly and current report, and any amendments or supplements thereto or to any of the PNC Financial reports listed above, filed by PNC Financial with the SEC pursuant to Section 13(a) or 15(d) of the Exchange Act after December 31, 2010 and prior to the expiration of the Letter of Credit is also incorporated herein by reference and will be deemed a part hereof from the date of filing of each such document. Subsequently filed reports, and amendments or supplements to reports, will automatically update and supersede prior information. The information incorporated by reference herein does not include any report, document or portion thereof that PNC Financial furnishes to, but does not file with, the SEC unless otherwise specifically provided above.

Neither the delivery of this document nor the sale of any Bonds will imply that the information herein or in any document incorporated by reference is correct as of any time after its date. Any statement contained in a document incorporated or deemed to be incorporated by reference herein will be deemed to be modified or superseded for purposes hereof to the extent that a statement contained therein or in any other subsequently filed document which also is or is deemed to be incorporated by reference herein modifies or supersedes such statement. Any statement so modified or superseded will not be deemed, except as so modified or superseded, to constitute a part hereof.

Any of the above documents incorporated herein by reference (other than exhibits to such documents unless such exhibits are specifically incorporated by reference into such documents) are available upon request by holders of the Bonds or by prospective investors in the Bonds without charge: (1) in the case of PNC Bank documents, by written request addressed to Ronald Lewis, Manager of Regulatory Reporting, at The PNC Financial Services Group, Inc., One PNC Plaza, 249 Fifth Avenue, Pittsburgh, Pennsylvania 15222-2707; or (2) in the case of PNC Financial documents, (a) for copies without exhibits, by contacting Shareholder Services at 800-982-7652 or via the online contact form at www.computershare.com/contactus, and (b) for exhibits, by contacting Shareholder Relations at 800-843-2206 or via e-mail at investor.relations@pnc.com. The interactive data file ("XBRL") exhibit is only available electronically.

U. S. BANK NATIONAL ASSOCIATION

U.S. Bank National Association (“USBNA”) is a national banking association organized under the laws of the United States and is the largest subsidiary of U.S. Bancorp. At June 30, 2011, USBNA reported total assets of \$310 billion, total deposits of \$219 billion and total shareholders’ equity of \$34 billion. The foregoing financial information regarding USBNA has been derived from and is qualified in its entirety by the unaudited financial information contained in the Federal Financial Institutions Examination Council report Form 031, Consolidated Report of Condition and Income for a Bank with Domestic and Foreign Offices (“Call Report”), for the quarter ended June 30, 2011. The publicly available portions of the quarterly Call Reports with respect to USBNA are on file with, and available upon request from, the FDIC, 550 17th Street, NW, Washington, D.C. 20429 or by calling the FDIC at (877) 275-3342. The FDIC also maintains an Internet website at www.fdic.gov that contains reports and certain other information regarding depository institutions such as USBNA. Reports and other information about USBNA are available to the public at the offices of the Comptroller of the Currency at One Financial Place, Suite 2700, 440 South LaSalle Street, Chicago, IL 60605.

U.S. Bancorp is subject to the informational requirements of the Securities Exchange Act of 1934, as amended, and, in accordance therewith, files reports and other information with the Securities and Exchange Commission (the “SEC”). U.S. Bancorp is not guaranteeing the obligations of USBNA and is not otherwise liable for the obligations of USBNA.

Except for the contents of this appendix, USBNA and U.S. Bancorp assume no responsibility for the nature, contents, accuracy or completeness of the information set forth in this Official Statement.

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BOOK-ENTRY ONLY SYSTEM

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BOOK-ENTRY ONLY SYSTEM

The description which follows of the procedures and recordkeeping with respect to beneficial ownership interests in the Bonds, payments of principal of and premium, if any, and interest on the Bonds to The Depository Trust Company, New York, New York, its nominee, Participants or Beneficial Owners (each as hereinafter defined), confirmation and transfer of beneficial ownership interests in the Bonds and other bond-related transactions by and between DTC, Participants and Beneficial Owners is based solely on information furnished by DTC.

DTC will act as securities depository for the Bonds. The Bonds will be issued as fully-registered securities registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered Bond certificate will be issued for each Series of the Bonds, each in the aggregate principal amount of such issue, and will be deposited with DTC.

DTC, the world's largest depository, is a limited-purpose trust company organized under the New York Banking Law, a "banking organization" within the meaning of the New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.5 million issues of U.S. and non-U.S. equity, corporate and municipal debt issues, and money market instruments (from over 100 countries) that DTC's participants (the "Direct Participants") deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("Indirect Participants"). DTC has a Standard & Poor's rating of AA+. The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com.

Purchases of the Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Bonds on DTC's records. The ownership interest of each actual purchaser of each Bond (the "Beneficial Owner") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners, however, are expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Bonds are to be accomplished by entries made on the books of Direct or Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their ownership interests in the Bonds, except in the event that use of the book-entry system for the Bonds is discontinued.

To facilitate subsequent transfers, all Bonds deposited by Direct Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of the Bonds with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such Bonds are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holding on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time.

Redemption notices shall be sent to DTC. If less than all of the Bonds are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such issue to be redeemed.

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to the Bonds unless authorized by a Direct Participant in accordance with DTC's Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to each of the respective Issuer or the Alliance, as applicable, as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts the Bonds are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Redemption proceeds, distributions, and dividend payments on the Bonds will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding detail information from the Alliance or the Bond Trustee on a payment date in accordance with their respective holdings shown on DTC's records. Payments by Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Participant and not of DTC, the Bond Trustee, each of the Issuers or the Alliance, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of redemption proceeds, distributions, and dividend payments to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Alliance or the Bond Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

DTC may discontinue providing its services as securities depository with respect to the Bonds at any time by giving reasonable notice to the respective Issuer or the Alliance. Under such circumstances, in the event that a successor securities depository is not obtained, Bond certificates will be printed and delivered.

The respective Issuer or the Alliance may decide to discontinue the respective Issuer's use of the system of book-entry transfers through DTC (or a successor securities depository). In that event, Bond certificates will be printed and delivered.

The information in this section concerning DTC and DTC's book-entry system has been obtained from sources that the respective Issuer believes to be reliable, but the respective Issuer takes no responsibility for the accuracy thereof.

Neither the respective Issuer nor the Registrar has any responsibility or obligation to the Direct or Indirect Participants or the Beneficial Owners with respect to (a) the accuracy of any records maintained by DTC or any Direct or Indirect Participant; (b) the payment by any Direct or Indirect Participant of any amount due to any Beneficial Owner in respect of the principal of and interest on the Bonds; (c) the delivery or timeliness of delivery by any Direct or Indirect Participant of any notice to any Beneficial Owner that is required or permitted under the terms of the Bond Resolution to be given to Bondholders; or (d) any other action taken by DTC, or its nominee, Cede & Co., as Bondholder, including the effectiveness of any action taken pursuant to an Omnibus Proxy.

So long as Cede & Co. is the registered owner of the Bonds, as nominee of DTC, references in this Official Statement to the Owners of the Bonds shall mean Cede & Co. and shall not mean the Beneficial Owners, and Cede & Co. will be treated as the only holder of Bonds for all purposes under the Bond Resolution.

The respective Issuer may enter into amendments to the agreement with DTC or successor agreements with a successor securities depository, relating to the book-entry system to be maintained with respect to the Bonds without the consent of Beneficial Owners or Bondholders.



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Exhibit 11.4

Attachment B

Mountain States Bonds Official Statement for 2012 Bonds

In the opinion of Bass, Berry & Sims PLC, Bond Counsel, under existing law and subject to conditions described in "TAX MATTERS," interest on the Series 2012A Bonds (a) will not be included in gross income for federal income tax purposes, and (b) will not be an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations; such interest, however, is taken into account in determining the adjusted current earnings for purposes of the alternative minimum tax on corporations. Interest on the Series 2012A Bonds will be exempt from all state, county and municipal taxation in Tennessee except inheritance, transfer, estate taxes and except that interest may not be exempt from Tennessee franchise and excise taxes. A holder may be subject to other federal tax consequences as described in "TAX MATTERS."

\$55,000,000
THE HEALTH AND EDUCATIONAL FACILITIES BOARD
OF THE CITY OF JOHNSON CITY, TENNESSEE
HOSPITAL REVENUE BONDS
(MOUNTAIN STATES HEALTH ALLIANCE)
SERIES 2012A

Dated: Date of Delivery**Maturity: As shown on inside cover page**

At the request of Mountain States Health Alliance, a Tennessee non-profit corporation (the "Alliance"), The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the "Issuer") is issuing its \$55,000,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2012A (the "Series 2012A Bonds"), pursuant to a Bond Trust Indenture dated as of September 1, 2012 (the "Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Bond Trustee"). The Series 2012A Bonds are limited obligations of the Issuer, payable from payments to be made by the Alliance to the Bond Trustee pursuant to a Loan Agreement dated as of September 1, 2012 (the "Loan Agreement"), between the Issuer and the Alliance, and pursuant to the Series 2012A Obligation, hereinafter defined, which is issued under and secured by the Amended and Restated Master Trust Indenture dated as of February 1, 2000, as amended (the "Master Indenture"), between (1) the Alliance, Blue Ridge Medical Management Corporation, Norton Community Hospital, and Smyth County Community Hospital, and (2) The Bank of New York Mellon Trust Company, N.A., as master trustee, which provides the security for the Series 2012A Obligation.

Simultaneously with the issuance of the Series 2012A Bonds, the Issuer is issuing its approximately \$30,230,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2012B (the "Series 2012B Bonds"), and the Industrial Development Authority of Wise County (Virginia) is issuing its approximately \$9,790,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2012C (the "Series 2012C Bonds"), also for the benefit of the Alliance. The Series 2012B Bonds and the Series 2012C Bonds are being sold pursuant to a separate Official Statement.

The Series 2012A Bonds will be issued in denominations of \$5,000 or any integral multiple thereof and will bear interest from the date of delivery thereof until maturity as shown on the inside cover hereof. The Series 2012A Bonds will bear interest at the rates specified on the inside cover hereof, payable on each February 15 and August 15, commencing on February 15, 2013.

The Series 2012A Bonds will be subject to redemption prior to maturity, including optional redemption, mandatory sinking fund redemption and extraordinary redemption as described herein.

The Series 2012A Bonds, when issued, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York ("DTC"). DTC will act as securities depository for the Series 2012A Bonds. Purchasers will not receive certificates representing their ownership interest in the Series 2012A Bonds purchased. Interest on the Series 2012A Bonds will accrue from the date of issuance and be payable by the Bond Trustee to DTC for the account of DTC Participants, who are responsible for crediting the accounts of the beneficial owners.

The Series 2012A Bonds will be limited obligations of the Issuer, payable solely from the sources described in this Official Statement and will not constitute or create any debt, liability or obligation of the State of Tennessee or any political subdivision or agency thereof or a pledge of the faith and credit of the State of Tennessee or any political subdivision or agency thereof. Neither the faith and credit nor taxing power of any state or any political subdivision or agency thereof will be pledged to the payment of the Series 2012A Bonds.

This cover page contains certain information for quick reference only. It is not a summary of this issue. Investors must read the entire Official Statement to obtain information necessary to make an informed investment decision. For a description of certain risk factors relating to the Series 2012A Bonds, see "CERTAIN RISK FACTORS."

The Series 2012A Bonds are offered when, as and if issued, subject to the approving opinion of Bass, Berry & Sims PLC, Nashville and Knoxville, Tennessee, as Bond Counsel, and certain other conditions. In connection with the issuance of the Series 2012A Bonds, certain legal matters will be passed upon by Anderson & Fugate, Johnson City, Tennessee, as counsel to the Alliance, Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Issuer, and Hunton & Williams LLP, as Underwriter's Counsel. The Public Advisory Corporation serves as financial advisor to the Alliance. It is expected that the Series 2012A Bonds will be issued and available for delivery to DTC in New York, New York, on or about September 18, 2012.

BofA Merrill Lynch

SERIES 2012A BONDS

\$55,000,000 5.000% Term Bonds due August 15, 2042, priced at 103.391% to yield 4.570%*, CUSIP 478271 JV2**

*Yield calculated based on the Series 2012A Bonds being priced to the first optional redemption date (8/15/2022).

**CUSIP numbers have been assigned by an organization not affiliated with the Issuer or the Alliance and are included solely for the convenience of the holders of the Series 2012A Bonds. The Issuer and the Alliance are not responsible for the selection or use of these CUSIP numbers, nor is any representation made as to their correctness on the Series 2012A Bonds or as indicated above.

No dealer, salesperson, or other person has been authorized to give any information or to make any representation, other than the information contained in this Official Statement, in connection with the offering of the Series 2012A Bonds, and, if given or made, such information or representation must not be relied upon as having been authorized by the Issuer, the Alliance or the Underwriter. The information in this Official Statement is subject to change without notice, and neither the delivery of this Official Statement nor any sale hereunder shall, under any circumstances, create any implication that there has been no change in the affairs of the Issuer, the Alliance or others since the date hereof. This Official Statement does not constitute an offer or solicitation in any jurisdiction in which such offer or solicitation is not authorized, or in which any person making such offer or solicitation is not qualified to do so, or to any person to whom it is unlawful to make such offer or solicitation. The information set forth herein has been obtained from the Issuer, the Alliance and other sources that are believed to be reliable, but it is not guaranteed as to accuracy or completeness by the Underwriter.

THE PRICES AT WHICH THE SERIES 2012A BONDS ARE OFFERED TO THE PUBLIC BY THE UNDERWRITER MAY VARY FROM THE INITIAL PUBLIC OFFERING PRICES APPEARING ON THE FOREGOING PAGE. IN ADDITION, THE UNDERWRITER MAY ALLOW CONCESSIONS OR DISCOUNTS TO DEALERS AND OTHER FROM THE PRICES AT WHICH THE SERIES 2012A BONDS ARE OFFERED TO THE PUBLIC. IN CONNECTION WITH THE OFFERING OF THE SERIES 2012A BONDS, THE UNDERWRITER MAY EFFECT TRANSACTIONS THAT STABILIZE OR MAINTAIN THE MARKET PRICE OF THE SERIES 2012A BONDS AT A LEVEL ABOVE THAT WHICH MIGHT OTHERWISE PREVAIL IN THE OPEN MARKET. SUCH STABILIZING, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME.

THE SERIES 2012A BONDS WILL NOT BE REGISTERED BY THE ISSUER OR THE ALLIANCE UNDER THE SECURITIES ACT OF 1933, AS AMENDED, OR ANY STATE SECURITIES LAW AND WILL NOT BE LISTED ON ANY STOCK OR OTHER SECURITIES EXCHANGE. NEITHER THE SECURITIES AND EXCHANGE COMMISSION NOR ANY OTHER FEDERAL, STATE, MUNICIPAL, OR OTHER GOVERNMENTAL ENTITY OR AGENCY SHALL HAVE PASSED UPON THE ACCURACY OR ADEQUACY OF THIS OFFICIAL STATEMENT.

IN MAKING ANY INVESTMENT DECISION, INVESTORS MUST RELY ON THEIR OWN EXAMINATION OF THE TERMS OF THE OFFERING, INCLUDING THE MERITS AND RISKS INVOLVED. THESE SECURITIES HAVE NOT BEEN RECOMMENDED BY ANY FEDERAL OR STATE SECURITIES COMMISSION OR REGULATORY AUTHORITY. FURTHERMORE, THE FOREGOING AUTHORITIES HAVE NOT CONFIRMED THE ACCURACY OR DETERMINED THE ADEQUACY OF THIS OFFICIAL STATEMENT. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

THIS OFFICIAL STATEMENT CONTAINS FORWARD-LOOKING STATEMENTS THAT ARE SUBJECT TO A NUMBER OF RISKS AND UNCERTAINTIES, INCLUDING THOSE DESCRIBED IN "CERTAIN RISK FACTORS," MANY OF WHICH ARE BEYOND THE ISSUER'S AND THE ALLIANCE'S CONTROL. FORWARD-LOOKING STATEMENTS ARE TYPICALLY IDENTIFIED BY WORDS SUCH AS "BELIEVE," "EXPECT," "ANTICIPATE," "INTEND," "ESTIMATE" AND SIMILAR EXPRESSIONS. ACTUAL RESULTS COULD DIFFER MATERIALLY FROM THOSE CONTEMPLATED BY THESE FORWARD-LOOKING STATEMENTS AS A RESULT OF FACTORS ("CAUTIONARY STATEMENTS") SUCH AS THOSE DESCRIBED IN "CERTAIN RISK FACTORS" HEREIN. IN LIGHT OF THESE RISKS AND UNCERTAINTIES, THERE CAN BE NO ASSURANCE THAT THE RESULTS AND EVENTS CONTEMPLATED BY THE FORWARD-LOOKING INFORMATION CONTAINED IN THIS OFFICIAL STATEMENT WILL IN FACT TRANSPIRE. YOU ARE CAUTIONED NOT TO PLACE UNDUE RELIANCE ON THESE FORWARD-LOOKING STATEMENTS. NEITHER THE ISSUER NOR THE ALLIANCE UNDERTAKE ANY OBLIGATION TO UPDATE OR REVISE ANY FORWARD-LOOKING STATEMENTS. ALL SUBSEQUENT WRITTEN OR ORAL FORWARD-LOOKING STATEMENTS ATTRIBUTABLE TO THE ISSUER AND THE ALLIANCE OR PERSONS ACTING ON THEIR BEHALF ARE EXPRESSLY QUALIFIED IN THEIR ENTIRETY BY THE CAUTIONARY STATEMENTS.

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OFFICIAL STATEMENT

INTRODUCTION

The Series 2012A Bonds

This Official Statement, including its cover page and appendices, provides information in connection with the issuance and sale by The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the “Issuer”) of its \$55,000,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2012A (the “Series 2012A Bonds”), for the benefit of Mountain States Health Alliance (the “Alliance”). The Series 2012A Bonds are issued pursuant to a Bond Trust Indenture dated as of September 1, 2012 (the “Bond Indenture”), between the Issuer and The Bank of New York Mellon Trust Company, N.A., New York, New York, as bond trustee (the “Bond Trustee”), and the proceeds thereof will be loaned to the Alliance pursuant to a Loan Agreement dated as of September 1, 2012 (the “Loan Agreement”), between the Issuer and the Alliance.

This introduction is not a summary of this Official Statement. It is only a summary description of and guide to, and is qualified by, more complete and detailed information contained in the entire Official Statement, including the cover page and appendices hereto, and the documents summarized or described herein. A full review should be made of the entire Official Statement. The offering of the Series 2012A Bonds to potential investors is made only by means of the entire Official Statement.

The Alliance

The Mountain States Health Alliance (the “Alliance”) is a Tennessee nonprofit corporation that is an “exempt organization” under Section 501(c)(3) of the Internal Revenue Code of 1986 (the “Code”). The Alliance provides an integrated, comprehensive continuum of care to people in portions of Tennessee, Virginia, Kentucky, and North Carolina. The Alliance currently operates 13 hospital facilities containing a total of 1,623 licensed beds, and serves a population of more than 1,000,000 in 29 counties and two independent cities in the States of Tennessee, Virginia, Kentucky and North Carolina. Its integrated health care delivery system also includes 23 primary/preventive care centers and 12 outpatient care sites. **For additional information regarding the Alliance, see Appendix A.**

The Obligated Issuers

The Alliance, Blue Ridge Medical Management Corporation (“Blue Ridge”), Norton Community Hospital (“Norton”) and Smyth County Community Hospital (“Smyth”) are each an Obligated Issuer as such term is used in the Amended and Restated Master Trust Indenture dated as of February 1, 2000, as amended (the “Master Indenture”), between (1) the Alliance, Blue Ridge, Norton, and Smyth, and (2) The Bank of New York Mellon Trust Company, N.A., as master trustee (the “Master Trustee”). Only the Obligated Issuers are obligated to make payments on the Series 2012A Bonds. See Appendix A - “HISTORY AND OVERVIEW - Operations of Subsidiary and Other Affiliates” and “CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS.”

Plan of Finance

The proceeds of the Series 2012A Bonds are being loaned to the Alliance pursuant to the Loan Agreement and will be used by the Alliance to (1) finance a surgery center project at the Alliance hospital in Johnson City, Tennessee; and (2) pay certain expenses incurred in connection with the issuance of the Series 2012A Bonds. See “PLAN OF FINANCE.”

Book-Entry Registration

The Series 2012A Bonds initially will be issued in the form of one registered bond in the aggregate principal amount of each maturity of each Series and will be registered in the name of Cede & Co., as nominee for The Depository Trust Company, New York, New York (“DTC”). DTC will maintain a book-entry system for recording ownership interest in the Series 2012A Bonds. Purchasers will not receive certificates representing their

ownership interest in the Series 2012A Bonds purchased. Principal of, any redemption price for, and interest on the Series 2012A Bonds will be payable by the Bond Trustee to DTC for the account of DTC Participants (as defined herein), who are responsible for crediting the accounts of the beneficial owners. See Appendix F - "BOOK-ENTRY ONLY SYSTEM."

Sources of Payment and Security for the Series 2012A Bonds

The Series 2012A Bonds shall not constitute a debt or obligation of the State of Tennessee or any political subdivision or agency thereof or a pledge of the faith and credit of any state or any political subdivision or agency of any state, including the Issuer. The Series 2012A Bonds are special, limited obligations of the Issuer, payable from the Trust Estate as described in "THE SERIES 2012A BONDS - General" and "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012A BONDS - Trust Estate."

To evidence the Alliance's repayment obligations in connection with the Series 2012A Bonds, the Alliance will issue its \$55,000,000 Mountain States Health Alliance Note (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) Series 2012A (the "Series 2012A Obligation"), pursuant to the Master Indenture.

In the Master Indenture, the Alliance and the other Obligated Issuers have covenanted, and any future Obligated Issuer would be required to covenant, to operate its facilities in such a manner and to charge such fees and rates as will be sufficient to provide funds (together with other available amounts) to pay debt service on its outstanding indebtedness, to pay certain other expenses and indebtedness of the Alliance and all future Obligated Issuers, and to maintain a coverage ratio of Income Available for Debt Service to Maximum Annual Debt Service equal to at least 1.30:1. For a description of such covenants, including exceptions thereto, see "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012A BONDS" and Appendix C - "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE."

Certain existing bonds of the Issuer and other issuers, as well as bonds of the Alliance, previously have been issued and are secured by Obligations issued by the Alliance under the Master Indenture ("Master Obligations") and therefore are secured on a parity with the Series 2012A Bonds. The Alliance and any future Obligated Issuer have the right, subject to specified conditions, to incur additional indebtedness on a parity with the Series 2012A Obligation and the Series 2012A Bonds. See "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012A BONDS - Additional Indebtedness."

No Debt Service Reserve Fund

The Series 2012A Bonds are not secured by any Debt Service Reserve Fund.

Tax Matters

In the opinion of Bass, Berry & Sims PLC, Bond Counsel, under existing law and subject to conditions described under "TAX MATTERS," interest on the Series 2012A Bonds (a) will not be included in gross income for federal income tax purposes and (b) will not be an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations; however, such interest on the Series 2012A Bonds is taken into account in determining a corporation's alternative minimum income tax. In the opinion of Bond Counsel, interest on the Series 2012A Bonds will be exempt from all state, county, and municipal taxation in the State of Tennessee except inheritance, gift, and estate taxes and except that interest may not be exempt from Tennessee franchise and excise taxes. Holders of Series 2012A Bonds may be subject to other federal tax consequences, as described herein under "TAX MATTERS."

Continuing Disclosure

To permit compliance with Rule 15c2-12 promulgated under the Securities Exchange Act of 1934 ("Rule 15c2-12"), the Alliance will execute a Continuing Disclosure Agreement in connection with the issuance of the Series 2012A Bonds in which it will agree for the benefit of the holders of the Series 2012A Bonds to provide

certain annual financial information and operating data and certain quarterly financial data as to the Alliance and any future Obligated Issuer under the Master Indenture, and to provide notice of certain enumerated events, if material. See “CONTINUING DISCLOSURE AGREEMENT” for a more complete description of the Continuing Disclosure Agreement and the Alliance’s performance under previous continuing disclosure agreements.

Professionals Involved in the Offering

Bass, Berry & Sims PLC will act as Bond Counsel in connection with the issuance of the Series 2012A Bonds. In connection with the issuance of the Series 2012A Bonds, certain legal matters will be passed upon by Anderson & Fugate, Johnson City, Tennessee, as counsel to the Alliance, Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Issuer, and Hunton & Williams LLP, as Underwriter’s Counsel. The Alliance’s consolidated financial statements for the fiscal years ended June 30, 2011 and 2010, included in Appendix B hereto, have been audited by Pershing Yoakley & Associates, P.C.

Relationships of the Parties

The Alliance has entered into interest rate exchange agreements, or swap agreements, with Bank of America, which is an affiliate of Bank of America Merrill Lynch, underwriter for the Series 2012A Bonds.

Acceleration

Subject to certain conditions, the Series 2012A Bonds are subject to acceleration of the maturity date upon the happening of an Event of Default under the Master Indenture and the Bond Indenture. See “SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE” and “- SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURE” in Appendix C.

Bondholders’ Risks

Payment of the Series 2012A Bonds is dependent on the ability of the Alliance and the other Obligated Issuers to make payments under the Loan Agreement and the Master Indenture. The Alliance’s ability to make such payments may be adversely affected by many factors. There may also be legal and practical limitations on the enforcement of remedies and amounts that may be realized upon enforcement of remedies available to the Bond Trustee and owners of the Series 2012A Bonds. See “SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012A BONDS” and “CERTAIN RISK FACTORS” herein and “SOURCES OF REVENUE” in Appendix A.

Legal Document Summaries and Definitions

Certain provisions of the Master Indenture, the Bond Indenture and the Loan Agreement are summarized in Appendix C hereto. Other definitions of certain terms used in this Official Statement are also set forth in Appendix C hereto.

Other Information

This Official Statement speaks only as of its date, and the information contained herein is subject to change.

The quotations from, and summaries and explanations of, the statutes, regulations and documents referenced herein do not purport to be complete and reference is made to those statutes, regulations and documents for full and complete statements of their provisions. Copies, in reasonable quantity, of such documents may be obtained during the offering period, upon request to the Alliance and upon payment to the Alliance of a charge for copying, mailing and handling, at 400 North State of Franklin Road, Johnson City, TN 37604-6094, Attn: Legal Department.

Purchasers of the Series 2012A Bonds should note the use of forward-looking information and the covenants related thereto.

Any statements in this Official Statement involving matters of opinion, whether or not expressly so stated, are intended as such and not as representations of fact. This Official Statement is not to be construed as a contract or agreement between the Issuer or the Alliance and the purchasers or holders of any of the Series 2012A Bonds.

This introduction is not a summary of this Official Statement. It is only a summary description of and guide to, and is qualified by, more complete and detailed information contained in the entire Official Statement, including the cover page and appendices hereto, and the documents summarized or described herein. A full review should be made of the entire Official Statement. The offering of Series 2012A Bonds to potential investors is made only by means of the entire Official Statement.

THE ISSUER

The Issuer is a public nonprofit corporation organized under the laws of the State of Tennessee. The Issuer was incorporated on May 3, 1973, by the Board of Commissioners of the City of Johnson City, Tennessee, pursuant to the laws now codified under Tennessee Code Annotated Section 48-101-301, *et seq.* (the “Tennessee Act”). The Tennessee Act authorizes the Issuer, among other things, to issue its bonds, to acquire, improve, maintain, extend, equip and furnish hospital facilities either within or without the corporate limits of the City of Johnson City, and in certain other jurisdictions in Tennessee, to mortgage its projects, to pledge the revenues and receipt therefrom, and to sell, exchange, donate and convey any or all of its properties. The Issuer has no taxing power.

THE ALLIANCE

The Alliance is a Tennessee nonprofit corporation recognized by the Internal Revenue Service as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986 (the “Code”). Today, the Alliance directly and through related entities provides an integrated, comprehensive continuum of care to people in 29 counties and two independent cities in Tennessee, Virginia, Kentucky and North Carolina. The Alliance was initially incorporated as Memorial Hospital on April 12, 1945, as a non-sectarian, general welfare, not-for-profit corporation. In connection with the relocation of its operations, it changed its name to Johnson City Medical Center Hospital, Inc. in 1983. In 1998, Johnson City Medical Center Hospital, Inc. assumed operating responsibility for five hospitals and related assets acquired from Columbia/HCA. In recognition of its expanded facilities and scope of services resulting from the 1998 acquisition, Johnson City Medical Center Hospital, Inc. changed its name to Mountain States Health Alliance.

The Alliance currently owns or controls the following facilities:

<u>Facility</u>	<u>Location</u>
Johnson City Medical Center	Johnson City, TN
James H. & Cecile Quillen Rehabilitation Hospital	Johnson City, TN
Woodridge Hospital	Johnson City, TN
Franklin Woods Community Hospital	Johnson City, TN
Indian Path Medical Center	Kingsport, TN
Sycamore Shoals Hospital	Elizabethton, TN
Johnson County Community Hospital	Mountain City, TN
Smyth County Community Hospital ⁽¹⁾	Marion, VA
Norton Community Hospital ⁽²⁾	Norton, VA
Dickenson Community Hospital ⁽²⁾	Clintwood, VA
Russell County Medical Center	Lebanon, VA
Johnston Memorial Hospital ⁽²⁾	Abingdon, VA

⁽¹⁾ 80% membership interest held by the Alliance.

⁽²⁾ 50.1% membership interest held by the Alliance.

The Alliance now has a total of 1,623 licensed beds serving a population of more than 1,000,000. In addition to its hospitals, the Alliance's integrated health care delivery system includes 23 primary/preventive care centers and 12 outpatient care sites. The Alliance's medical facilities provide a full spectrum of general and specialty medical services, including rehabilitative services for individuals with brain injuries, strokes and spinal cord injuries, in-patient psychiatric services and centers for health focusing on cardiovascular health, pulmonary medicine, women's health and cancer therapy, among other services. The Alliance also serves as a clinical training facility for medical students, residents, and nursing students from the East Tennessee State University's James H. Quillen College of Medicine and the School of Public and Allied Health. **For additional information regarding the Alliance, see Appendix A.**

The Alliance, Blue Ridge, Norton and Smyth are each an Obligated Issuer as such term is used in the Master Indenture. Blue Ridge is a wholly-owned, for-profit subsidiary of the Alliance. Norton is a Virginia non-stock corporation in which the Alliance owns a 50.1% interest. Smyth is a Virginia non-stock corporation in which the Alliance owns an 80% interest. See Appendix A - "HISTORY AND OVERVIEW - Operations of Subsidiary and Other Affiliates."

The Alliance also operates the hospital facilities in Dickenson County and Washington County, Virginia, through ownership of a majority interest in the membership of the corporations owning such facilities. None of such corporations are an Obligated Issuer or otherwise are responsible for repayment of amounts due from the Alliance with respect to the Series 2012A Bonds, and none of the assets of such corporations are pledged as security for the Alliance's payment obligations.

Only the Obligated Issuers are obligated to pay the Series 2012A Bonds. The audited and unaudited financial statements of the Alliance included as Appendices B and C reflect the assets, liabilities, revenues and expenses of related organizations that are not Obligated Issuers. See Appendix A - "CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS."

THE SERIES 2012A BONDS

Set forth below is a summary of certain provisions of the Series 2012A Bonds. General information describing the Series 2012A Bonds appears elsewhere in this Official Statement. That information should be read in conjunction with this summary, which is qualified in its entirety by reference to the Bond Indenture, and the form of the Series 2012A Bonds. See "SUMMARY OF THE FINANCING DOCUMENTS" in Appendix C hereto.

General

The Series 2012A Bonds shall be initially issued as fully registered bonds without coupons in authorized denominations of \$5,000 and integral multiples thereof. The Series 2012A Bonds will mature, subject to prior redemption as described herein, on August 15, in the years and at the fixed interest rates set forth on the inside cover of this Official Statement, with such interest payable on February 15 and August 15 of each year, commencing February 15, 2013.

The Series 2012A Bonds initially will be dated the date of issuance thereof. Except as described in the next sentence, subsequently issued Series 2012A Bonds will be dated as of the later of the date of original issuance of the Series 2012A Bonds or the most recent preceding interest payment date to which interest has been paid thereon. Series 2012A Bonds issued on an interest payment date to which interest has been paid will be dated as of such date. For a description of method of payment of principal, premium, if any and interest on the Series 2012A Bonds and matters pertaining to transfers and exchange while registered in the name of Cede & Co., see "BOOK-ENTRY ONLY SYSTEM" in Appendix F.

The principal and premium, if any, of the Series 2012A Bonds shall be payable at the office of the Bond Trustee in East Syracuse, New York, upon surrender of the Series 2012A Bonds at such office. Interest on the Series 2012A Bonds (other than Defaulted Interest) shall be payable by check or draft drawn upon the Bond Trustee (or, as to any owner of \$1,000,000 or more in aggregate principal amount of Series 2012A Bonds who so elects, by wire transfer of funds to such wire transfer address within the continental United States as the registered owner shall

have furnished to the Bond Trustee in writing) and paid to the Persons in whose names the Series 2012A Bonds are registered on the Bond Register maintained by the Bond Trustee as of the close of business on the Record Date (each February 1 and August 1) next preceding the relevant interest payment date. Any interest on any Series 2012A Bond which is payable but which is not punctually paid or duly provided for on the due date (“Defaulted Interest”) shall cease being payable to the person in whose name such Bond is registered on the Record Date and instead shall be payable to the person in whose name such Bond is registered at close of business on a Special Record Date selected by the Bond Trustee and which shall be at least 10 days but not more than 15 days before the date selected by the Alliance for payment of such Defaulted Interest. The Bond Trustee shall give Notice by Mail of the Special Record Date and date for payment of Defaulted Interest at least 10 days before the Special Record Date.

THE SERIES 2012A BONDS ARE, AND ARE TO BE, EQUALLY AND RATABLY SECURED, TO THE EXTENT PROVIDED IN THE BOND INDENTURE, SOLELY BY A PLEDGE OF THE REVENUES AND OTHER FUNDS PLEDGED UNDER THE BOND INDENTURE. THE SERIES 2012A BONDS, TOGETHER WITH PREMIUM, IF ANY, AND THE INTEREST THEREON, ARE SPECIAL AND LIMITED OBLIGATIONS OF THE ISSUER. THE SERIES 2012A BONDS AND THE INTEREST THEREON SHALL NOT BE DEEMED TO CONSTITUTE A DEBT OR A PLEDGE OF THE FAITH AND CREDIT OF THE STATE OF TENNESSEE OR ANY POLITICAL SUBDIVISION THEREOF, INCLUDING THE CITY OF JOHNSON CITY, TENNESSEE. THE CITY OF JOHNSON CITY, TENNESSEE, SHALL NOT IN ANY EVENT BE LIABLE FOR THE PAYMENT OF THE PRINCIPAL OF, PREMIUM, IF ANY, OR INTEREST ON THE SERIES 2012A BONDS, OR FOR THE PERFORMANCE OF ANY PLEDGE, MORTGAGE, OBLIGATION OR AGREEMENT OF ANY KIND WHATSOEVER THEREIN OR INDEBTEDNESS BY THE ISSUER, AND NEITHER THE SERIES 2012A BONDS NOR ANY OF THE ISSUER’S AGREEMENTS OR OBLIGATIONS DESCRIBED IN THE SERIES 2012A BONDS OR OTHERWISE SHALL BE CONSTRUED TO CONSTITUTE AN INDEBTEDNESS OF THE CITY OF JOHNSON CITY, TENNESSEE, WITHIN THE MEANING OF ANY CONSTITUTIONAL OR STATUTORY PROVISIONS WHATSOEVER. THE ISSUER HAS NO TAXING AUTHORITY.

Registration of Transfer or Exchange of Series 2012A Bonds

The Bond Indenture contains the following provisions with respect to registration of transfer or exchange of Series 2012A Bonds. Such provisions do not apply while the Series 2012A Bonds are held by DTC. See Appendix F - “BOOK-ENTRY ONLY SYSTEM.”

Only upon surrender for transfer of any Series 2012A Bond at the corporate trust office of the Bond Trustee in East Syracuse, New York, shall the Issuer execute and the Bond Trustee authenticate and deliver in the name of the transferee or transferees a new fully registered Series 2012A Bond or Series 2012A Bonds of the same series and maturity and of authorized denomination for the aggregate principal amount which the registered owner is entitled to receive.

Any Series 2012A Bond or Series 2012A Bonds may be exchanged at said office of the Bond Trustee for a like aggregate principal amount of Series 2012A Bond or Series 2012A Bonds of the same series and maturity of other authorized denominations. The execution by the Issuer of any Series 2012A Bond shall constitute full and due authorization of such Series 2012A Bond, and the Bond Trustee shall thereby be authorized to authenticate, date and deliver such Series 2012A Bond.

All Series 2012A Bonds presented for transfer or exchange shall be accompanied by a written instrument or instruments of transfer or authorization for exchange, in form and with guaranty of signature satisfactory to the Bond Trustee, duly executed by the registered owner or by such owner’s duly authorized attorney.

No service charge shall be imposed for any exchange or transfer of Series 2012A Bonds. The Issuer and the Bond Trustee may, however, require payment by the person requesting an exchange or transfer of Series 2012A Bonds of a sum sufficient to cover any tax, fee or other governmental charge that may be imposed in relation thereto, except in the case of the issuance of a Series 2012A Bond or Series 2012A Bonds for the unredeemed portion of a Series 2012A Bond surrendered for redemption.

The Issuer and the Bond Trustee shall not be required to register the transfer of or exchange any Series 2012A Bond after notice calling such Series 2012A Bond or portion thereof for redemption has been mailed or

during the 15 day period next preceding the mailing of a notice of redemption of any Series 2012A Bonds of the same series and maturity.

New Series 2012A Bonds delivered upon any transfer or exchange shall be valid obligations of the Issuer, evidencing the same debt as the Series 2012A Bonds surrendered, shall be secured by the Bond Indenture and shall be entitled to all of the security and benefits thereof to the same extent as the Series 2012A Bond surrendered.

The Issuer and the Bond Trustee may treat the registered owner of any Series 2012A Bond as the absolute owner thereof for all purposes, whether or not such Series 2012A Bond shall be overdue, and shall not be bound by any notice to the contrary. All payments of or on account of the principal of and premium, if any, and interest on any such Series 2012A Bond as herein provided shall be made only to or upon the written order of the registered owner thereof or his legal representative, but such registration may be changed as herein provided. All such payments shall be valid and effectual to satisfy and discharge the liability upon such Series 2012A Bond to the extent of the sum or sums so paid.

Redemption

The Series 2012A Bonds may not be called for redemption except as described below. The Series 2012A Bonds are subject to optional redemption, extraordinary redemption and mandatory sinking fund redemption prior to maturity as described below.

Optional Redemption. The Series 2012A Bonds are subject to redemption prior to maturity on or after August 15, 2022, upon direction of the Alliance, in whole at any time, or in part (and, if in part, by maturities or portions thereof designated by the Alliance) from time to time on any interest payment date, at the redemption price of 100% of the outstanding principal amount thereof, plus accrued interest thereon to the date of redemption. No redemption of less than all of the Series 2012A Bonds at the time outstanding shall be made pursuant to the foregoing unless the aggregate principal amount to be redeemed is equal to or more than \$100,000.

Extraordinary Redemption. The Series 2012A Bonds are callable for extraordinary redemption prior to maturity in the event of damage to or destruction of the Property of any member of the Obligated Group or any part thereof or condemnation of the Facilities or any part thereof, if the net proceeds of insurance or condemnation received in connection therewith after expenses of recovery of such proceeds to the extent such net proceeds are not applied either to any lawful purposes of the Obligated Group or to the repair, replacement, restoration or reconstruction of the affected Facilities pursuant to the Master Indenture, but only to the extent of the funds provided for in the Master Indenture. If thus called for redemption, the Series 2012A Bonds shall be subject to redemption by the Issuer at any time, in whole or in part, and if in part, the Alliance may decide the amount of Series 2012A Bonds to be redeemed and the order of maturity or portion of each maturity within such Series to be redeemed, and within such maturity of such Series, the Bond Trustee shall select the bonds to be redeemed by lot. Such redemption shall be at the principal amount thereof plus accrued interest to the redemption date, and without premium, from the proceeds of such insurance or condemnation award or such sale but not in excess of the amount of such proceeds applied to such purpose. If no direction is given by the Alliance, the Bond Trustee will redeem Series 2012A Bonds and each Series of Additional Bonds then outstanding under the Bond Indenture pro rata based on the then outstanding principal amount of each Series under the Bond Indenture and within each Series will redeem bonds in the inverse order of maturity thereof. No redemption of less than all of the Series 2012A Bonds at the time outstanding shall be made pursuant to the foregoing unless the aggregate principal amount to be redeemed is equal to or more than \$100,000.

Purchase of Bonds. In lieu of redeeming Series 2012A Bonds, the Bond Trustee may, at the request of the Issuer, use such funds otherwise available under the Bond Indenture for optional or extraordinary redemption of Series 2012A Bonds to purchase such Bonds in the open market at a price not exceeding the redemption price then applicable under the Bond Indenture. In the case of any extraordinary redemption or any purchase and cancellation of the Series 2012A Bonds, the Issuer shall receive credit against its required deposits to the Bond Sinking Fund with respect to Series 2012A Bonds of the maturity redeemed or purchased in such order as the Issuer elects prior to such extraordinary redemption or purchase and cancellation or, if no election is made, in the inverse order thereof.

Credit Against Bond Sinking Fund Deposits. In the case of any extraordinary redemption or any purchase and cancellation of the Series 2012A Bonds, the Issuer shall receive credit against its required Bond Sinking Fund deposits with respect to Series 2012A Bonds in such order as the Alliance elects prior to such extraordinary redemption or purchase and cancellation or, if no election is made, in the inverse order thereof.

Mandatory Sinking Fund Redemption. With respect to the payment of the Series 2012A Bonds by maturities or mandatory redemption through the Bond Sinking Fund, the Issuer (to the extent funds are available through the Revenue Fund held under the Bond Indenture) shall cause the Alliance to have on deposit in the Bond Sinking Fund on August 15 of each of the following years moneys to be applied to the redemption of Series 2012A Bonds in the amounts and at the times, respectively, as follows:

<u>Year</u>	<u>Principal Amount</u>	<u>Year</u>	<u>Principal Amount</u>
2039	\$12,735,000	2041	14,075,000
2040	13,390,000	2042*	14,800,000

*At maturity

Such amounts set forth above shall be reduced (i) by the principal amount of Series 2012A Bonds acquired and delivered in satisfaction of such Bond Sinking Fund requirements and (ii) in connection with a redemption of all or a portion of the Series 2012A Bonds if the Alliance elects to reduce mandatory Bond Sinking Fund redemptions for the Series 2012A Bonds in the manner described in “THE SERIES 2012A BONDS—Redemption—*Credit Against Bond Sinking Fund Deposits*” above.

Moneys on deposit in the Bond Sinking Fund on August 15 of each of the years 2039 through 2041 shall be applied to redeem Series 2012A Bonds maturing August 15, 2042, in the respective amounts indicated in the table above, by lot in such manner as may be designated by the Bond Trustee, upon the notice, and in the manner provided in the Bond Indenture. Moneys on deposit in the Bond Sinking Fund on August 15, 2042, shall be applied to the payment of Series 2012A Bonds maturing on such date.

Payment or redemption of the Series 2012A Bonds through the Bond Sinking Fund shall be without premium. In the event the Series 2012A Bonds maturing on a specific date as aforesaid have been fully paid and moneys are on deposit in the Bond Sinking Fund to redeem the Series 2012A Bonds maturing on that specific maturity date, then such moneys on deposit in the Bond Sinking Fund shall be applied to Series 2012A Bonds maturing on the next succeeding maturity date in the order above set forth.

Notice of Redemption. The Bond Trustee shall cause notice of the call for any such redemption identifying the Series 2012A Bonds to be redeemed to be sent not less than 30 nor more than 60 days prior to the redemption date (a) by first-class mail postage prepaid, to the holder of each such Series 2012A Bond to be redeemed at his address as it appears on the registration books of the Bond Trustee, (b) by first-class mail, to at least two organizations registered with the Securities and Exchange Commission as securities depositories, and (c) to at least one information service of national recognition which disseminates redemption information with respect to municipal securities. Failure to give any notice described in (a), or any defect therein, shall not affect the validity of any proceedings for the redemption of any Series 2012A Bonds with respect to which no such failure has occurred and failure to give any notice described in (b) or (c), or any defect therein, shall not affect the validity of any proceedings for the redemption of any Series 2012A Bonds with respect to which the notice specified in (a) is correctly given. Any notice mailed as described above shall conclusively be presumed to have been given whether or not actually received by any holder. All Series 2012A Bonds called for redemption shall cease to bear interest on the specified redemption date provided funds for their redemption are on deposit at the place of payment on the date fixed for redemption.

With respect to optional redemption, such notice shall be conditional upon moneys being on deposit with the Bond Trustee on or prior to the redemption date in an amount sufficient to pay the redemption price on the redemption date. If moneys are not received, such notice shall be of no force and effect, the Bond Trustee shall not

redeem such Series 2012A Bonds and the Bond Trustee shall give notice, in the same manner in which the notice of redemption was given, that such moneys were not so received and that such Series 2012A Bonds will not be redeemed.

The notice of redemption may be in the form prepared by Bond Counsel or Counsel to the Bond Trustee. Any notice of the call for redemption of the Series 2012A Bonds shall state the following: (1) the name, including series designation, of the Series 2012A Bonds, (2) the CUSIP number, if any, and bond certificate number of the Series 2012A Bonds to be redeemed, (3) the original dated date of the Series 2012A Bonds, (4) the interest rate and stated maturity of the Series 2012A Bonds to be redeemed, (5) the date of the redemption notice, (6) the redemption date, (7) the redemption price, (8) if less than all of a Series 2012A Bond is to be redeemed, the amount of such Bond to be redeemed and (9) the address and telephone number of the principal offices of the Bond Trustee. In addition, in preparing such notice, the Bond Trustee shall take into account, to the extent applicable, the prevailing municipal securities industry standards and any regulatory statement of any federal industry standards and any regulatory statement of any federal or state administrative body having jurisdiction over the Issuer, or the municipal securities industry, including without limitation Release No. 34-23856 of the Securities and Exchange Commission, or any subsequent amending or superseding release.

Notwithstanding the foregoing, in the event that the depository for the Series 2012A Bonds is DTC, the Bond Trustee will follow the procedure for redemption, and selection of Bonds for redemption, prescribed by DTC.

Purchase of Bonds in Lieu of Redemption. In lieu of redeeming Series 2012A Bonds, the Bond Trustee may, at the request of the Alliance, use such funds otherwise available under the Bond Indenture for redemption of Bonds to purchase Bonds in the open market at a price not exceeding the redemption price then applicable under the Bond Indenture.

PLAN OF FINANCE

Application of Proceeds

The proceeds of the Series 2012A Bonds are being loaned to the Alliance pursuant to the Loan Agreement and will be used by the Alliance to (1) finance a surgery center project at the Alliance hospital in Johnson City, Tennessee; and (2) pay certain expenses incurred in connection with the issuance of the Series 2012A Bonds. The Alliance expects that, simultaneously with the issuance of the Series 2012A Bonds, (1) the Issuer will issue its \$30,230,000 Hospital Revenue Bonds (Mountain States Health Alliance) Series 2012B (the “Series 2012B Bonds”) and (2) the Industrial Development Authority of Wise County will issues its \$9,790,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2012C (the “Series 2012C Bonds”). The Series 2012B Bonds and the Series 2012C Bonds will be secured on a parity with the Series 2012A Bonds and all other bonds secured by Obligations under the Master Indenture.

Estimated Sources and Uses of Funds

The sources and uses of the proceeds of the Series 2012A Bonds are set forth below.

Sources of Funds

Principal Amount	\$55,000,00.00
Premium	1,865,050.00
TOTAL	\$56,865,050.00

Uses of Funds

Projects	\$55,727,749.00
Costs of Issuance	1,137,301.00
TOTAL	\$56,865,050.00

Current and Pro Forma Long-Term Debt

The left column of the following table reflects the total outstanding debt of the Alliance under the Master Indenture as of June 30, 2012, prior to the issuance of the Series 2012A Bonds, the Series 2012B Bonds and the Series 2012C Bonds (collectively, the “Series 2012 Bonds”). The right column of the following table shows the outstanding debt of the Alliance under the Master Indenture as of June 30, 2012, but adjusted to show the effect of the issuance of the Series 2012 Bonds. The table below and in the immediate following section does not include the indebtedness of certain entities controlled by the Alliance that are not Obligated Issuers.

Outstanding Long-Term Debt (at June 30, 2012)		Pro Forma Long-Term Debt (at June 30, 2012)	
Description	Principal Amount	Description	Principal Amount
Debt:		Debt:	
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Refunding Bonds, Series 2000A	\$32,885,459 ⁽¹⁾	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Refunding Bonds, Series 2000A	\$32,885,459 ⁽¹⁾
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2000C	33,230,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2000C	33,230,000
Mountain States Health Alliance Taxable Note, Series 2000D	14,315,000	Mountain States Health Alliance Taxable Note, Series 2000D	14,315,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2001A	22,300,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2001A	22,300,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2006A	168,990,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2006A	168,990,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-1	26,170,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-1	26,170,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-2	102,750,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-2	102,750,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-3	27,840,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2008A	13,245,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2008A	13,245,000	Industrial Development Authority of Russell County Hospital Revenue Bonds, Series 2008B	52,930,000
Industrial Development Authority of Russell County Hospital Revenue Bonds, Series 2008B	52,930,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2009A	5,560,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2009A	5,560,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2009B	5,535,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2009B	5,535,000	Industrial Development Authority of Washington County, Virginia, Hospital Revenue Bonds, Series 2009C	115,955,000
Industrial Development Authority of Washington County, Virginia, Hospital Revenue Bonds, Series 2009C	115,955,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2010A	161,935,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2010A	161,935,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2010B	32,460,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2010B	32,460,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011A	65,260,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011A	65,260,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011B	20,000,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011B	20,000,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011C	49,875,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011C	49,875,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011D	60,705,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011D	60,705,000	Mountain States Health Alliance Taxable Bonds, Series 2011E	15,960,000
Mountain States Health Alliance Taxable Bonds, Series 2011E	15,960,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2012A	55,000,000
		The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2012B ⁽²⁾	30,230,000
		Industrial Development Authority of Wise County Hospital Revenue Bonds, Series 2012C ⁽²⁾	9,790,000
Total Long-Term Debt	\$1,027,900,459	Total Long-Term Debt	\$1,095,080,459
Less: 2000 Reserve Fund	\$ 7,000,000	Less: 2000 Reserve Fund	\$ 7,000,000
2006A Reserve Fund	17,303,000	2006A Reserve Fund	17,303,000
NET TOTAL LONG-TERM DEBT	\$1,003,597,459	NET TOTAL LONG-TERM DEBT	\$1,070,777,459

Notes:
(1) Value of CABS accreted to July 1, 2012.
(2) Amount subject to change.

Estimated Annual Debt Service Requirements

The following table reflects the estimated outstanding debt service obligations of the Alliance on all long term indebtedness secured under the Master Indenture following the issuance of the Series 2012 Bonds. The estimated annual debt service with respect to outstanding indebtedness assumes a 3.50% interest rate on all variable rate bonds, and does not take into account any interest rate hedges that may exist or may be executed in the future.

Year Ending June 30	Estimated Annual Debt Service Requirements			Estimated Annual Debt Service on Other Long-Term Outstanding Indebtedness*	Estimated Total Annual Long- Term Debt Service Requirements
	Series 2012A		Series 2012B&C		
	Principal	Interest	Debt Service		
2013	-	\$ 1,122,917	\$ 490,245	\$ 22,993,434	\$ 24,606,596
2014	-	2,750,000	1,200,600	70,894,975	74,845,575
2015	-	2,750,000	1,963,975	68,626,588	73,340,563
2016	-	2,750,000	1,226,600	69,364,631	73,341,231
2017	-	2,750,000	1,175,850	69,408,888	73,334,738
2018	-	2,750,000	1,855,500	68,724,744	73,330,244
2019	-	2,750,000	1,854,500	68,725,406	73,329,906
2020	-	2,750,000	1,887,375	68,693,809	73,331,184
2021	-	2,750,000	2,484,975	68,095,825	73,330,800
2022	-	2,750,000	2,241,200	67,089,228	72,080,428
2023	-	2,750,000	2,200,575	66,523,184	71,473,759
2024	-	2,750,000	997,800	66,593,178	70,340,978
2025	-	2,750,000	1,303,150	68,597,894	72,651,044
2026	-	2,750,000	1,293,850	68,722,175	72,766,025
2027	-	2,750,000	1,368,275	68,673,150	72,791,425
2028	-	2,750,000	1,366,275	68,641,538	72,757,813
2029	-	2,750,000	1,359,050	68,359,638	72,468,688
2030	-	2,750,000	1,356,600	68,255,613	72,362,213
2031	-	2,750,000	1,348,925	67,953,091	72,052,016
2032	-	2,750,000	1,119,475	67,125,869	70,995,344
2033	-	2,750,000	1,443,300	63,715,113	67,908,413
2034	-	2,750,000	1,441,875	63,997,094	68,188,969
2035	-	2,750,000	1,440,000	65,088,725	69,278,725
2036	-	2,750,000	1,442,600	64,983,450	69,176,050
2037	-	2,750,000	1,439,675	64,873,100	69,062,775
2038	-	2,750,000	1,441,225	64,666,438	68,857,663
2039	-	2,750,000	1,442,175	64,773,706	68,965,881
2040	\$12,735,000	2,431,625	6,963,450	-	22,130,075
2041	13,390,000	1,778,500	6,962,500	-	22,131,000
2042	14,075,000	1,091,875	6,965,700	-	22,132,575
2043	14,800,000	370,000	6,962,900	-	22,132,900
	\$55,000,000	\$78,294,917	\$68,040,195	\$1,774,160,481	\$1,975,495,593

* Table does not include the debt service related to approximately \$43 million of outstanding long-term indebtedness of Johnston Memorial Hospital. Johnston Memorial Hospital is not a member of the Obligated Group and the Obligated Issuers will not be required to pay debt service on such indebtedness.

JMH Financing

It is expected that shortly after the issuance of the Series 2012A Bonds, Johnston Memorial Hospital (“JMH”) will enter into an approximately \$18,000,000 taxable loan (the “JMH Loan”) for the benefit of JMH. JMH is not a member of the Obligated Group and the Obligated Issuers will not be required to pay debt service on the JMH Loan. The JMH Loan is not included in the tables in the sections “Current and Pro Forma Long Term Debt” and “Estimated Annual Debt Service Requirements” above.

SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012A BONDS

Special, Limited Obligations of the Issuer

The Series 2012A Bonds will be issued under and secured by the Bond Indenture and are payable from moneys received by the Bond Trustee from the Alliance, as further described in “Trust Estate” below.

Trust Estate

The Series 2012A Bonds are payable from the Trust Estate under the Bond Indenture, which consists of (i) payments or prepayments to be made on the Series 2012A Obligation, and any additional obligations of the Alliance to the Issuer to the extent such additional obligations may be pledged under the Bond Indenture in the future; (ii) other payments under the Loan Agreement (other than fees and expenses payable to the Issuer and the Issuer’s rights to notices and indemnification in certain circumstances); (iii) all moneys and investments held under the Bond Indenture as security for the Series 2012A Bonds (excluding funds held in the Rebate Fund established in the Bond Indenture); and (iv) in certain circumstances, proceeds from certain insurance and condemnation awards.

Pursuant to the Series 2012A Obligation, the Alliance is required to make payments to the Bond Trustee for deposit into the Revenue Fund established under the Bond Indenture, at the times and in amounts sufficient to pay the principal of and interest on the Series 2012A Bonds.

Payment of principal and interest on the Series 2012A Bonds will not be secured by any encumbrance, mortgage or other pledge of any property of any Issuer. **The Series 2012A Bonds will not constitute a debt or indebtedness of any state or any political subdivision or agency thereof, including The Health and Educational Facilities Board of the City of Johnson City, Tennessee, within the meaning of any constitutional or statutory provision or limitation. The Issuer does not have taxing power.**

Master Indenture Covenants

In the Master Indenture, the Alliance has made certain covenants, on behalf of itself and the Obligated Group (as defined in the Master Indenture), regarding maintenance of fees and rates, and any future Obligated Issuer would be required to make similar covenants upon joining the Obligated Group. These covenants provide, among other matters, that each Obligated Issuer (including the Alliance) will continue to impose such fees as are included within the Gross Revenues, operate on a revenue producing basis, and charge such fees and rates for its facilities and services and exercise such skill and diligence as to provide income from its property together with other available funds sufficient to pay promptly all payments of principal and interest on its indebtedness secured by the Master Indenture, all expenses of operation, maintenance, and repair of its property subject to the Master Indenture, and all other payments required to be made by it under the Master Indenture to the extent permitted by law. Each Obligated Issuer (including the Alliance) also covenants to use its best efforts to maintain in each Fiscal Year a ratio of total Income Available for Debt Service to Maximum Annual Debt Service for all Obligated Issuers at least equal to 1.30 to 1. Each Obligated Issuer (including the Alliance) further covenants that it will from time to time as often as necessary and to the extent permitted by law, revise its rates, fees and charges in such manner as may be necessary or proper to comply with the provisions of the Master Indenture described in this paragraph. See Appendix C - “SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE - Rates and Charges.”

The Master Indenture defines “Income Available for Debt Service” of the Alliance or other Obligated Issuer to mean, with respect to any period of time, the excess of revenues over expenses, or, in the case of for-profit entities, net income after tax, as determined in accordance with generally accepted accounting principals, to which shall be added, in either case, (i) depreciation, (ii) amortization, (iii) interest expense on Long-Term Indebtedness (as defined in the Master Indenture) and (iv) to the extent not already included, contributions and donations and from which shall be excluded any extraordinary items, any impairment losses, any gain or loss resulting from either the extinguishment of indebtedness or the sale, exchange or other disposition of assets not made in the ordinary course of business, provided, however, that (a) no determination of Income Available for Debt Service will take into account any gains or losses resulting from the periodic valuation of investments or Hedge Agreements that do not

involve the sale, transfer or other disposition of any such investment or Hedge Agreement or the termination of any Hedge Agreement and (b) a person may include in its net income such person's share of the net income of any person controlled by such person or in whom such person has a legal interest. The Master Indenture contains provisions relating to the calculation of Maximum Annual Debt Service that provides for reallocation of amounts due on balloon indebtedness and assumptions as to the interest rates on variable rate indebtedness and payment of guaranties. For financial information of the Alliance, see Appendix A and the Alliance's audited consolidated financial statements for the fiscal years ended June 30, 2011 and June 30, 2010, included as Appendix B. For a more complete description of the covenants under the Master Indenture, see "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE - Rates and Charges" in Appendix C.

Only Obligated Issuers are obligated to make payments on the Series 2012A Bonds and to abide by the covenants under the Master Indenture. The audited and unaudited financial statements included as Appendices B and C reflect the assets and operations of entities that are not Obligated Issuers. See Appendix A – "CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS."

Amendment of Master Indenture

By purchasing the Series 2012A Bonds, the initial holders thereof will consent to an amendment to the definition of "Debt Service Requirement" in the Master Indenture and an amendment to the requirements applicable to interest rate swaps. Such amendments will not become effective immediately and will become effective only upon receipt of the consent of the required percentage of bondholders and credit enhancers under the terms of the Master Indenture.

Both the existing definition and the proposed definition are set forth in Appendix C, "SUMMARY OF THE FINANCING DOCUMENTS – DEFINITIONS OF CERTAIN TERMS." The definition of "Debt Service Requirement" is utilized in calculations under both the additional debt test and the rate covenant under the Master Indenture, and such amendment may in certain circumstances increase or decrease the amount of the Debt Service Requirement in any required calculation. See "Additional Long-Term Indebtedness" and "Rates and Charges" in "SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE" in Appendix C.

Both the existing requirements and the proposed new requirements for interest rate swaps are set forth in Appendix C.

Pledged Assets; Mortgage

Currently, the Series 2012A Bonds are secured by the Trust Estate, including the assignment of the Series 2012A Obligation. As security for its Master Obligations, the Alliance has granted to the Master Trustee a security interest in its Pledged Assets, subject to Permitted Liens. The Pledged Assets consist of: Receivables, Inventory, Equipment, General Intangibles, Contracts and Contract Rights, Government Approvals, Fixtures and other personal property, goods, instruments, chattel paper, documents, credits, claims, demands and assets. For a definition of these terms see Appendix C - "SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS." Financing statements will be filed in the appropriate records of the Office of the Tennessee Secretary of State to perfect the security interest in Pledged Assets and Equipment to the extent possible by such filing. Continuation statements meeting the requirements of the Uniform Commercial Code of Tennessee (the "UCC") must be filed every five years to continue the perfection of such security interest. The security interest in the Pledged Assets and Equipment is subject to Permitted Liens that exist prior to or may be created subsequent to the time the security interest granted by the Master Indenture attaches.

The security interest in any item of inventory will be inferior to the interest of a buyer in the ordinary course of business and will be inferior to a purchase money security interest, as defined in the UCC, perfected in connection with the sale to an Obligated Issuer of such item. The lien on certain other Pledged Assets may not be enforceable against third parties unless such other Pledged Assets are transferred to the Master Trustee (which transfer Obligated Issuers are not required by the Master Indenture to make prior to an Event of Default thereunder and which transfer may be set aside if it occurs within 90 days of the filing of a petition in bankruptcy) and is subject

to exception under the UCC. The federal government may in the future proscribe or restrict the assignment of rights arising out of Medicare, Medicaid or other federal programs.

As a condition to becoming a Member of the Obligated Group, an entity must grant to the Master Trustee a security interest in its Pledged Assets.

Pursuant to the Master Indenture, the Obligated Issuers agree that they will not create or suffer to be created or exist any Lien other than Permitted Liens, as defined under “SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS” in Appendix C, upon any of their facilities now owned or hereafter acquired.

The Series 2012A Obligation is also secured by a mortgage on the Johnson City Medical Center located in Johnson City, Tennessee, and the Sycamore Shoals Hospital facility in Elizabethton, Tennessee (together, the “Mortgaged Property”). Such mortgage secures all Master Obligations issued under the Master Indenture.

Subject to certain conditions, in case of the failure of the Obligated Issuers to make any payment on the Master Obligations when due or upon any other event of default under the Master Indenture, the Master Trustee may, after such notice as is required by the Master Indenture and the applicable security instruments, take possession of Mortgaged Property or, upon such public notice as required by Tennessee statute, sell the Mortgaged Property, and apply the proceeds to payment of principal of and interest on the Master Obligations (and thereby on the Series 2012A Bonds) on a parity basis with any other Master Obligation.

Additional Indebtedness

The Alliance has certain debt outstanding under the Master Indenture. The Master Indenture permits the Alliance and any other members of the Obligated Group to incur Additional Indebtedness (including Guaranties), all upon the terms and subject to the conditions specified therein. Such Additional Indebtedness may, but need not, be evidenced or secured by a Master Obligation. Additional Indebtedness may be issued to the Issuer or to persons other than the Issuer.

The reimbursement obligations of the Alliance with respect to the Letters of Credit will also be secured under the Master Indenture.

Except as noted in the preceding paragraph, the Master Indenture, the Alliance and each other Obligated Issuer agrees that it will not incur other Additional Indebtedness unless it can demonstrate that certain coverage ratios have been and will be met between debt service obligations and Income Available for Debt Service. Under the Master Indenture, Additional Indebtedness may be Long-Term Indebtedness or Short-Term Indebtedness. The Master Indenture allows any future Obligated Issuer to incur Additional Indebtedness under the Master Indenture as a Master Obligation constituting the joint and several obligation of the Alliance and all other Obligated Issuers and subject to cross-guarantees of all Obligated Issuers, including the Alliance. Except to the extent entitled to the benefits of additional security as permitted by the Master Indenture and except for Subordinated Indebtedness, all Master Obligations will be equally and ratably secured by the Master Indenture. See Appendix C - “SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE.”

Subject to certain conditions set forth in the Master Indenture, Additional Indebtedness incurred by any Member of the Obligated Group may be secured by security which does not extend to any other Indebtedness. Such security may include Liens on the Property (including health care facilities) of the Members of the Obligated Group, letters or lines of credit or insurance, and could also consist of Liens on cash or securities deposited or held in any depreciation reserve, debt service or interest reserve, debt service or similar fund established pursuant to the terms of any Supplemental Master Indenture, Related Bond Indenture or Related Loan Document. The Master Indenture provides that Supplemental Master Indentures pursuant to which one or more series of Master Obligations entitled to additional security are issued may provide for such amendments to provisions of the Master Indenture, including the provisions thereof relating to the exercise of remedies upon the occurrence of an event of default, as are necessary to

provide for such security and to permit realization upon such security solely for the benefit of the Master Obligation secured thereby.

Defeasance

If the interest on, and the principal or redemption price (as the case may be) of the Series 2012A Bonds have been paid, or the required amount of money and/or Defeasance Investment (see “SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS” in Appendix C) have been deposited with the Bond Trustee to provide sufficient amounts to pay the principal of, and premium, if any, and interest due and to become due on such Series 2012A Bonds on or prior to the redemption date or maturity date thereof, such Series 2012A Bonds shall no longer be deemed outstanding under the Bond Indenture and will no longer be secured thereby. If all Series 2012A Bonds have been so provided for, the Bond Trustee shall cancel and discharge the Bond Indenture. See “SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURE - Defeasance” in Appendix C.

Bankruptcy

The lien on the Pledged Assets and Equipment given for the benefit of holders of Master Obligations (and thereby the Series 2012A Bonds) are generally superior to the claims of other creditors (subject to the limitations set forth above). However, bankruptcy and similar proceedings and usual equity principles may affect the enforcement of rights to such security. If such security is inadequate for payment in full of the Bonds, bankruptcy proceedings and usual equity principles may also limit any attempt by the Master Trustee to seek payment from other property of the Alliance or future Obligated Issuers. In particular, federal bankruptcy law permits adoption of a reorganization plan even though it has not been accepted by the holders of a majority in aggregate principal amount of the Bonds if the holders are provided with the benefit of their original lien or the “indubitable equivalent.” In addition, if the bankruptcy court concludes that the holders have “adequate protection,” it may (1) substitute other security for the security subject to the lien of the holders and (2) subordinate the lien of the holders to claims by entities or persons supplying post petition financing to the Alliance after bankruptcy. Furthermore, the reasonable and necessary costs and expenses of preserving or disposing of the Pledged Assets and Equipment in a bankruptcy may, in certain circumstances, reduce the value of the lien on the Pledged Assets and Equipment to the extent such costs and expenses benefit the Master Trustee (and holders). In the event of the bankruptcy of the Alliance, the amount realized by the holders might depend on the bankruptcy court’s interpretation of “indubitable equivalent” and “adequate protection” under the then existing circumstances, which may result in a reduction in the security for or proceeds available to the holders.

INTEREST RATE SWAPS

The Alliance has various interest rate swaps and related derivatives currently in place, as described in Appendix A. Some of the existing arrangements have been entered into with affiliates of the Underwriter. The Alliance may in the future enter into swap agreements with respect to some or all of its obligations issued under the Master Indenture. See “MANAGEMENT’S DISCUSSION OF FINANCIAL PERFORMANCE – Interest Rate Swaps and Derivatives” in Appendix A.

CERTAIN RISK FACTORS

The purchase of the Series 2012A Bonds involves certain risks that are discussed throughout this Official Statement. Each prospective purchaser of the Series 2012A Bonds should make an independent evaluation of all of the information presented in this Official Statement in order to make an informed investment decision. Certain of these risks are described below.

General

The ability of the Obligated Issuers to make payments on the Series 2012A Bonds is dependent upon the ability of the Obligated Issuers to generate revenue sufficient to cover collective operating expenses and debt service on the Series 2012A Bonds and other indebtedness of the Obligated Issuers. Health care providers, especially

hospitals, face increasing economic pressures from both governmental health care programs and private purchasers of health care such as insurance companies and health maintenance organizations (collectively, “third-party payors”). The dependence of hospitals on governmental programs requires hospitals to accept both limitations on payments and regulations and other restrictions and requirements triggered by participation in such programs. Many governmental and private third-party payors have required healthcare providers to accept “capitated” or other fixed payments, which have the affect of shifting significant economic risk to healthcare providers.

Health care, especially at the hospital level, is a highly regulated industry with complicated and frequently changing regulations arising both from payment programs and governmental police power generally. Health care providers are increasingly subject to audits, investigations, fines and litigation that may threaten access to governmental reimbursement programs, require substantial payments, generate adverse publicity and create significant legal and other transaction costs. See below “Health Care Revenues.” In addition, because the Alliance and a number of its affiliates are tax-exempt charitable organizations under the Internal Revenue Code (“Exempt Organizations”), they are subject to increasing regulation and restrictions that may have adverse effects on their economic performance or threaten their tax-exempt status and the economic benefits derived from it. In particular, such regulations and restrictions may require the facilities of the Alliance or such affiliates to provide health care services for which they do not receive payment. In addition, Congress is likely to consider imposing additional regulations and restrictions on Exempt Organizations.

Future economic and other conditions, including inflation, demand for health care services, the ability of the Alliance and other members of the Obligated Group to provide the services required or requested by patients, physicians’ confidence in the Alliance, economic developments in the applicable service areas, employee relations and unionization, competition, the level of rates or charges, increased costs, availability of professional liability insurance, casualty losses, third-party reimbursement and changes in governmental regulation may adversely affect revenues and, consequently, the ability of the Alliance and other members of the Obligated Group to generate revenues sufficient for the payment of the principal of and interest on the Series 2012A Obligation.

Certain more specific factors that could affect the Series 2012A Bonds and the future financial condition of the Alliance and any future members of the Obligated Group are described below. This discussion of risk factors is not intended to be exhaustive.

Discretion of the Board and Management

The Master Indenture does not significantly restrict the ability of the Alliance to enter into transactions that could materially affect the business, organizational structure and control of the Alliance and any future members of the Obligated Group. Such transactions could include, for example, such things as divestitures of Affiliates, substantial new joint ventures, and mergers, consolidations or other forms of affiliations in which control of the Alliance and any future members of the Obligated Group could be materially changed. As a substantial health system, the Alliance regularly considers and analyzes opportunities for such undertakings. The ability of the Alliance to generate revenues sufficient to pay debt service on the Series 2012A Obligation is dependent in large measure on the decisions of the Board of Directors and management of the Alliance with respect to such opportunities.

Voting Control Under Master Indenture

Certain amendments and waivers to the provisions of the Master Indenture may be made with the consent of the owners of 75% of the aggregate principal amount of the Master Obligations then outstanding. Certain other amendments may be made with the consent of the owners of two-thirds (2/3) in aggregate principal amount of Master Obligations related to bonds that are not the beneficiaries of certain municipal bond insurance policies and the consent of the provider of certain municipal bond insurance policies. Such amendments may adversely affect the security of the holders of the Series 2012A Bonds.

For a discussion of what actions may be taken with the consent or direction of a majority percent or more of the holders of outstanding Master Obligations under the Master Indenture, see the discussion under “SUMMARY OF THE FINANCING DOCUMENTS” in Appendix C.

Matters Relating to Enforceability of the Master Indenture

The practical realization of any rights upon any default under the Loan Agreement or under the Master Indenture may depend upon the exercise of various remedies specified in such instruments, as restricted by federal and state laws. The federal bankruptcy laws may adversely affect the ability of the Bond Trustee, the Master Trustee and the owners of the Series 2012A Bonds to enforce their claims granted by the Bond Indenture, the Loan Agreement or the Master Indenture. The obligation of the Alliance on the Series 2012A Obligation and other Master Obligations will be limited to the same extent as the obligations of debtors typically are affected by bankruptcy, reorganization, insolvency, fraudulent conveyance, moratorium or other similar laws affecting the enforcement of creditors' rights and by the availability of equitable remedies.

The remedies available to the Bond Trustee, the Master Trustee, the Issuer or the owners of the Series 2012A Bonds upon an event of default under the Master Indenture, the Bond Indenture, the Loan Agreement or the Series 2012A Obligation are in many respects dependent upon judicial actions, which are often subject to discretion and delay. Under existing constitutional and statutory law and judicial decisions, including, specifically, Title 11 of the United States Code (the "Bankruptcy Code"), the remedies provided in the Master Indenture, the Bond Indenture, the Loan Agreement and the Series 2012A Obligation and other Master Obligations may not be readily available or may be limited.

There is no clear precedent in the law as to whether transfers from an Affiliate in order to pay debt service on the Master Obligations issued for the benefit of another Affiliate may be voided by a trustee in bankruptcy in the event of a bankruptcy of the transferring Affiliate or by third-party creditors in an action brought pursuant to state fraudulent conveyances statutes. Under the United States Bankruptcy Code, a trustee in bankruptcy and, under state fraudulent conveyances statutes, a creditor of a related guarantor, may avoid any obligation incurred by a related guarantor, if, among other bases therefor, (i) the guarantor has not received fair consideration or reasonably equivalent value in exchange for the guaranty and (ii) the guaranty renders the guarantor insolvent, as defined in the United States Bankruptcy Code or state fraudulent conveyances statutes, or the guarantor is undercapitalized.

Limited Value at Foreclosure

The Mortgaged Property was constructed for the provision of hospital care. The number of entities that could be expected to purchase or lease the Mortgaged Property are limited, and thus, the ability of the Master Trustee to realize funds from the sale or rental of the Mortgaged Property upon an event of default may be limited.

Bond Ratings

There is no assurance that the ratings assigned to the Series 2012A Bonds will not be lowered or withdrawn at any time, the effect of which could adversely affect the market price for and marketability of the Series 2012A Bonds. See "RATINGS."

Market for the Series 2012A Bonds

The relative buying and selling interest of market participants in securities such as the Series 2012A Bonds, and in the market for such securities as a whole, will vary over time, and such variations may be affected by, among other things, news relating to the Alliance and the other Obligated Issuers, the attractiveness of alternative investments, the perceived risk of owning the security (whether related to credit, liquidity or any other risk), the tax treatment accorded the instruments, the accounting treatment accorded such securities, reactions to regulatory actions or press reports, financial reporting cycles and marketing sentiment generally. Shifts of demand in response to any one or simultaneous particular events cannot be predicted and may be short-lived or exist for longer periods. See below "Matters Affecting Tax Exemption."

Health Care Revenues

There are a number of factors that could adversely affect both revenues and expenses of the Alliance. Some but not all such factors are discussed briefly below. Governmental payment provisions, regulations and other restrictions change frequently and may be altered or expanded while the Series 2012A Bonds are outstanding.

Dependence on Governmental and Other Third-Party Payors. The Alliance receives a substantial portion of its revenues from Medicare, Medicaid, TennCare and other third-party health care programs. See in Appendix A - "SOURCES OF REVENUE." Receipt of such revenues subjects the Alliance to extensive regulation and the risks of enforcement as described below. Both governmental payment programs and private third-party payors such as insurance and managed care programs have increasingly imposed limitations on the payment for services. These limitations often require hospitals to provide certain services below cost. Congress in the past has imposed substantial restrictions on federal health care programs that have adversely affected the financial condition of hospitals, and it may do so in the future.

TennCare. In 1994, the State of Tennessee, with the approval of the federal government, withdrew from the Medicaid program and began providing services to Medicaid eligible and uninsurable or uninsured persons through TennCare. Like traditional Medicaid programs, TennCare is funded with a combination of federal and State of Tennessee funds. The federal government has approved the TennCare Program through June 30, 2010. The Alliance is a significant provider of health care services to TennCare enrollees and as a result thereof has incurred substantial losses serving beneficiaries of the program. Approximately 8.3% of the Alliance's gross patient service charges for the fiscal year ended June 30, 2011, was derived from patients covered by TennCare.

Because of problems with managed care organizations through which TennCare operates, the State assumed total medical risk for the program in 2002 and implemented changes designed to reduce costs and fraud. The State of Tennessee initiated a plan to disenroll 323,000 individuals statewide from TennCare and to institute significant benefit cuts resulting in the disenrollment of 28,000 individuals in the Alliance's market and a decrease in the level of benefits for 40,000 individuals in the Alliance's market. The disenrollment changes took place on August 1, 2005, however, the benefit cuts have not been implemented.

On April 1, 2007, the State of Tennessee began placing the managed care organizations back at risk, starting with the Middle Tennessee Region. The State of Tennessee placed the East Tennessee Region's managed care organizations (where the Alliance operates its Tennessee facilities) back at risk on January 1, 2009. It cannot be predicted whether the funding sources for TennCare or other states' Medicaid programs will be adequate to meet the funding needs of such programs. In addition, it cannot be predicted whether funding pressures or other factors will lead to decreased TennCare and Medicaid reimbursement to providers, including the Members of the Obligated Group, or to an increase in uninsured patients seeking care from the Members of the Obligated Group.

A number of proposals have been made for changes in funding for TennCare, some of which could substantially reduce the amounts payable to the Alliance's facilities in Tennessee. There remains substantial risk that TennCare will continue to impose substantial financial burdens on the Alliance or that changes in the program could lead to further burdens or increase the cost of uncompensated care provided by the Alliance.

Virginia Medicaid Program. The hospitals of the Alliance located in Virginia receive a substantial portion of their revenues under the federal Medicare Program. Reimbursement under this program is controlled by extensive regulations and procedures. Under the current Medicare payment system payment for inpatient hospital services is been tied to predetermined amounts based on national averages of costs for categories of treatments and conditions known as diagnosis related groups ("DRGs"). DRG reimbursement may provide a hospital less than its actual costs in providing services. The Medicare Program reimburses for outpatient hospital services through a similar prospective payment system based on ambulatory payment classifications ("APCs") of clinically-related and resource-similar items and services. Reimbursement for outpatient services under the APC system and for other services provided by the hospitals of the Alliance may not reflect the actual costs incurred in providing such services or items.

Medicare reimbursement in recent years has been subject to changes that have adversely affected hospitals, and the Alliance cannot predict how future limitations, cutbacks or modifications by Congress or regulatory agencies to such reimbursement may affect the financial condition of the Alliance.

Hospital Regulation. The operation of hospitals is extensively regulated by the federal and state governments. These regulations affect virtually every aspect of hospital operations, including (1) imposing procedures that increase costs (including complicated billing and other record-keeping procedures), (2) requiring the provision of services free or below cost, (3) limiting the ability to make decisions based on economic best interest and (4) restricting the ability to pursue advantageous business opportunities with physicians and other health care providers.

Significant restrictions include (1) the Physicians Self-Referral (“Stark”) and “Anti-Kickback” laws, which severely restrict financial relationships with and referrals by private physicians; (2) the Emergency Medical Treatment and Active Labor Act (“EMTALA”), imposing operating requirements on emergency rooms; and (3) the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the Health Information Technology for Economic and Clinical Health Act (HITECH), enacted as part of the American Recovery and Reinvestment Act of 2009 and both affecting the privacy and security of personal health information. Compliance with HIPAA, HITECH and related regulations has imposed substantial financial burdens on the Alliance and related entities in such areas as electronic billing and other electronic transactions and in implementing procedures and altering facilities to promote privacy of patient records.

Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate violations of existing laws and regulations, including criminal fines, civil monetary penalties, repayment of erroneously paid claims, prison terms and exclusion from the Medicare, Medicaid, TennCare and/or other governmental payment programs. Because of the complexity of the regulations and the increased enforcement, there are numerous circumstances where alleged violations may trigger investigations, audits and inquiries that could result in expensive and prolonged enforcement actions against the Alliance. Enforcement actions may be initiated and prosecuted by one or more government entities and/or private individuals, and in some circumstances more than one of the available penalties may be imposed for each violation. An exclusion from participation in Medicare, Medicaid, TennCare or other governmental health programs likely would result in a loss of substantial revenues.

National Healthcare Reform

Comprehensive health care reform legislation was enacted by the federal government in March 2010 through the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the “Healthcare Reform Act”). The Healthcare Reform Act provides for fundamental changes to the health care system and the manner in which services are provided and paid for generally, including substantial increases in health care insurance for persons not currently covered, new requirements on employers who provide health benefits to their employees, reimbursement reductions and methodology changes, and the imposition of further restrictions and requirements adversely affecting tax-exempt hospitals such as the Alliance and its related entities.

Implementation of the Healthcare Reform Act is to take place over an eight year period, and over that time the Healthcare Reform Act is likely to have a variety of effects on both the operations and financial performance of all hospitals. In particular, extension of health insurance to those not currently insured and the costs associated therewith may result in (1) inadequate reimbursement to cover costs under such new coverage, (2) offsetting reductions in reimbursements for the provision of services under Medicare, Medicaid and other federally funded programs and (3) increased costs of compliance generally. In addition, the Healthcare Reform Act is likely to have significant indirect effects on the Alliance and related hospitals as a result of the Act’s effects on other healthcare industry participants, including pharmaceutical and medical device companies, health insurers, and others with which the Alliance and related hospitals do business.

The Healthcare Reform Act imposes substantial and costly additional requirements on nonprofit hospitals. Failure of any hospital with 501(c)(3) status to comply with such requirements may result in significant penalties

including, but not limited to, the loss of tax-exempt status. See below “Matters Affecting Tax Exemption – Tax Exemption for Non-profit Corporations.”

The United States Supreme Court recently upheld the constitutionality of the Health Care Reform Act. There have been, and will likely continue to be, legislative efforts in Congress to repeal, amend or defund the Healthcare Reform Act or otherwise block its implementation. The outcome of such efforts will be affected by the 2012 Congressional and Presidential elections. Thus it is impossible to predict the extent to which the Healthcare Reform Act will be implemented or the effects it will have to the extent it is implemented.

Competition

The Alliance faces competition not only from other area hospitals (see in Appendix A -“SERVICE AREA, MARKET SHARE AND COMPETITION”), but also from other forms of health care providers, including health maintenance organizations, preferred provider organizations, specialty hospitals, home health agencies, surgical centers, rehabilitation and therapy centers, physician group practices and other alternative delivery systems and non-hospital providers of medical services. Increasing costs of health care services are likely to stimulate additional forms of competition. Many new forms of health care providers may not be subject to the restrictions imposed on the Alliance by its participation in governmental health care programs and as part of a tax-exempt organization. The application of federal and state antitrust laws to health care is still evolving, and enforcement and other developments in this area could adversely affect the Alliance’s competitive position.

Other Economic Developments

Other economic developments that could adversely affect operations at the Alliance include (1) unexpected increases in costs of labor and equipment (including new technologies) that cannot be recovered through charges, (2) increased costs of maintaining malpractice and general liability insurance, and (3) availability of, or the cost of, required specialty employees, including nurses and other health care professionals.

Matters Affecting Tax Exemption

Tax Exemption for Non-profit Corporations. Loss of tax-exempt status by the Alliance could result in loss of tax exemption for interest on the Series 2012A Bonds and of other tax-exempt debt issued for the benefit of the Alliance, and defaults in covenants regarding the Series 2012A Bonds and other tax-exempt debt would likely be triggered. Such an event would have material adverse consequences on the financial condition of the Alliance. See “TAX MATTERS.”

The maintenance by the Alliance of its tax-exempt status and that of its related entities depends, in part, upon its maintenance of status as an organization (an “Exempt Organization”) described in Section 501(c)(3) of the Code. The maintenance of such status is contingent upon compliance with provisions of the Code and related regulations and administrative interpretations regarding the organization and operation of tax-exempt entities, including its operation for charitable and educational purposes and its avoidance of transactions that may cause its assets to inure to the benefit of private individuals.

The Internal Revenue Service (the “IRS”) has announced that it intends to closely scrutinize transactions between Exempt Organizations and for-profit entities and has issued audit guidelines for tax-exempt hospitals. In March 1998, the IRS issued a revenue ruling that places restrictions upon the participation of Exempt Organizations (including hospitals) in joint venture arrangements with for-profit entities. Although specific activities of hospitals, such as medical office building leases and compensation arrangements and other contracts with physicians, have been the subject of interpretations by the IRS in the form of Private Letter Rulings, many activities have not been addressed in any official opinion, interpretation or policy of the IRS. Because the Alliance conducts large-scale and diverse operations involving private parties, there can be no assurances that certain of its transactions would not be challenged by the IRS.

The IRS has taken the position that hospitals that violate the federal Anti-kickback Law may also be subject to revocation of their tax-exempt status. As a result, tax-exempt hospitals, such as those of the Alliance, which have

and will continue to have, extensive transactions with physicians are subject to an increased degree of scrutiny and perhaps enforcement by the IRS.

Also, under legislation passed by Congress in 2010, a hospital entity can lose its status as an Exempt Organization if it fails to comply with requirements under new Internal Revenue Code Section 501(r). Such requirements include conducting community health needs assessments, the development of written financial assistance policies, limiting the amounts charged for emergency or medically necessary care provided to individuals eligible for financial assistance, and limitations on certain “extraordinary” collections actions against such individuals. In some cases failure to comply with Section 501(r) will result in the imposition of an excise tax. Such requirements also could adversely affect the financial performance of the Obligated Group. The Alliance believes that it is currently in compliance with Section 501(r).

Periodically, Congress considers options and recommendations in the area of taxation of unrelated business income of Exempt Organizations. The scope and effect of legislation, if any, that may be adopted at the federal and state levels with respect to unrelated business income cannot be predicted at this time. However, any such legislation could have the effect of subjecting a portion of the income of the Alliance to federal or state income taxes.

In addition to the foregoing proposals with respect to income by Exempt Organizations, various state and local governmental bodies have challenged the tax-exempt status of such institutions and have sought to remove the exemption of property from real estate taxes of part or all of the property of various nonprofit institutions on the grounds that a portion of such property was not being used to further the charitable purposes of the institutions or that the institutions did not provide sufficient care to indigent persons so as to warrant exemption from taxation as a charitable institution. Several of these disputes have been determined in favor of the taxing authorities or have resulted in settlements.

It is not possible to predict the scope or effect of future legislative or regulatory actions with respect to taxation of Exempt Organizations. There can be no assurance that future changes in the laws and regulations of federal, state or local governments, or the interpretation of such laws by courts or other governmental entities, will not materially adversely affect the operations and financial condition of the Alliance by requiring any of its entities to pay income or local property taxes.

Tax-Exempt Status of the Series 2012A Bonds. Any failure by the Alliance or related entities to remain qualified as tax-exempt under Section 501(c)(3) of the Code could affect the amount of funds that would be available to pay debt service on the Series 2012A Bonds. If the Alliance or the respective Issuer fails to comply continuously with certain covenants contained in the Bond Indenture and the Loan Agreement after delivery of the Series 2012A Bonds, interest on the Series 2012A Bonds could become taxable from the date of delivery of the Series 2012A Bonds regardless of the date on which the event causing such taxability occurs. See “TAX MATTERS.”

In recent years, the IRS has undertaken an extensive audit program that involves review of both the general tax-exempt status of non-profit hospitals and the tax-exempt status of bonds issued for their benefit.

Legislative Proposals. Current and future legislative proposals, if enacted into law, could cause interest on the Series 2012A Bonds to be subject, directly or indirectly, to federal income taxation or otherwise prevent owners thereof from realizing the full current benefit of the tax-exempt status of such interest. On September 12, 2011, the Obama Administration announced a legislative proposal, the “American Jobs Act of 2011” (the “Jobs Act”). If enacted in the form proposed, the Jobs Act would limit the exclusion from gross income of interest on obligations like the Series 2012A Bonds for individual taxpayers whose income is subject to higher marginal tax rates. The enactment of the Jobs Bill or similar provisions could adversely affect the tax treatment of interest on the Series 2012A Bonds for holders thereof and adversely affect the market price of the Series 2012A Bonds.

Other Risk Factors Generally Affecting Health Care Facilities

In the future, the following factors, among others, may adversely affect the operations of the Alliance to an extent that cannot be determined at this time:

1. Health care systems are major employers, combining a complex mix of professional, quasi-professional, technical, clerical, housekeeping, maintenance, dietary and other types of workers in a single operation. As with all large employers, the Alliance bears a wide variety of risks in connection with its employees. These risks include strikes and other related work actions, contract disputes, discrimination claims, personal tort actions, work-related injuries, exposure to hazardous materials, interpersonal torts (such as between employees, between physicians or management and employees, or between employees and patients), and other risks that may flow from the relationships between employer and employee or between physicians, patients and employees. Many of these risks are not covered by insurance, and certain of them cannot be anticipated or prevented in advance. The Alliance is subject to all of the risks listed above. Such risks, alone or in combination, could have material adverse consequences to the financial condition or operations of the Alliances.

2. Competition from other health care systems and other competitive facilities now or hereafter located in the respective service areas of the Alliance's facilities may adversely affect revenues. Development of health maintenance and other alternative health delivery programs could result in decreased usage of inpatient hospital facilities and other facilities operated by the Alliance.

3. Cost and availability of any insurance, such as malpractice, fire, automobile, and general comprehensive liability, that hospitals and other health care facilities of similar size and type as the facilities generally carry may adversely affect revenues, as would any losses that exceed amounts covered.

4. The occurrences of natural disasters may damage some or all of the facilities, interrupt utility service to some or all of the facilities, significantly increase the demand on some or all of the facilities or otherwise impair the operation of some or all of the facilities or the generation of revenues from some or all of the facilities.

5. Scientific and technological advances, new procedures, drugs and appliances, preventive medicine, occupational health and safety and outpatient health care delivery may reduce utilization and revenues of the facilities. Technological advances in recent years have accelerated the trend toward the use by hospitals of sophisticated and costly equipment and services for diagnosis and treatment. The acquisition and operation of certain equipment or services may continue to be a significant factor in hospital utilization, but the ability of the Alliance to offer such equipment or services may be subject to the availability of equipment or specialists, governmental approval or the ability to finance such acquisitions or operations.

6. Reduced demand for the services of the Alliance that might result from decreases in population in the services areas of facilities operated by the Alliance.

7. Increased unemployment or other adverse economic conditions in the service areas of the Alliance that would increase the proportion of patients who are unable to pay fully for the cost of their care.

8. Any increase in the quantity or cost of indigent care provided that is mandated by law or required due to increase needs of the community in order to maintain the charitable status of the Alliance.

9. Regulatory actions that might limit the ability of the Alliance to undertake capital improvements to their respective facilities or to develop new institutional health services.

LITIGATION

There is no action, suit, or proceeding pending or, to the knowledge of the Issuer, threatened restraining or enjoining the execution or delivery of the Series 2012A Bonds, or in any way contesting or affecting the validity of the Series 2012A Bonds, the Bond Indenture, the Master Indenture, or any proceedings of the Issuer or the Alliance, as applicable, taken with respect thereto. No securities of any Issuer have been in default as to principal or interest payments or in any other material respect, and no agreements or legal proceedings of any Issuer relating to its

securities have been declared invalid or unenforceable since the formation of each Issuer. Each Issuer will provide a certificate to this effect at the time of delivery of the Series 2012A Bonds.

There is no action, suit, or proceeding pending or threatened restraining or enjoining the execution or delivery of the Series 2012A Obligation, or in any way contesting or affecting the validity of the Series 2012A Obligation, the Master Indenture, the Loan Agreement or any proceedings of the Alliance taken with respect thereto. No securities of the Alliance have been in default as to principal or interest payments or in any other material respect, and no agreements or legal proceedings of the Alliance relating to its securities have been declared invalid or unenforceable since the original formation of the corporation now called Mountain States Health Alliance. The Alliance will provide a certificate to this effect at the time of delivery of the Series 2012A Bonds.

For other litigation matters involving the Alliance, see “HISTORY AND OVERVIEW - Insurance; Litigation” in Appendix A hereto.

LEGAL MATTERS

Legal matters relating to the authorization and issuance of the Series 2012A Bonds are subject to the approving opinion of Bass, Berry & Sims PLC of Nashville and Knoxville, Tennessee, as Bond Counsel, which will be delivered with the Series 2012A Bonds. Certain legal matters relating to the Series 2012A Bonds will also be passed upon by Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Issuer, and by Anderson & Fugate, Johnson City, Tennessee, as counsel to the Alliance. Certain legal matters will be passed upon by Hunton & Williams LLP, as counsel to the Underwriter.

TAX MATTERS

In the opinion of Bond Counsel, under existing law, interest on the Series 2012A Bonds (a) will not be included in gross income for federal income tax purposes, and (b) will not be an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations; such interest, however, is taken into account in determining the adjusted current earnings for purposes of the alternative minimum tax on corporations (as defined for federal income tax purposes).

In the opinion of Bond Counsel, under existing laws of the State of Tennessee, the Series 2012A Bonds and the income therefrom shall be exempt from all state, county, and municipal taxation in the State of Tennessee except for inheritance, transfer, gift and estate taxes and except to the extent interest on the Series 2012A Bonds may be included within the measure of certain franchise and excise taxes imposed under Tennessee law.

Bond Counsel’s tax opinion is given in reliance upon certifications by representatives of the Issuer and the Alliance as to certain facts relevant to both the opinion and the requirements of the Code. The Issuer and/or the Alliance have covenanted to comply with the provisions of the Code regarding, among other matters, the use, expenditures, and investment of the proceeds of the Bonds and the timely payment of arbitrage profits with respect to the Bonds to the United States. Failure by the Issuer or the Alliance to comply with such covenants could cause interest on the Bonds to be included in gross income for federal income tax purposes retroactively to their date of issuance.

In addition to the matters addressed above, prospective purchasers of the Bonds should be aware that the ownership of tax-exempt obligations may result in collateral federal income tax consequences to certain taxpayers, including without limitation, financial institutions, property and casualty insurance companies, certain S corporations, certain foreign corporations subject to the branch profits tax, corporations subject to the environmental tax, recipients of Social Security or Railroad Retirement benefits and taxpayers who may be deemed to have incurred or continued indebtedness to purchase or carry tax-exempt obligations. Prospective purchasers of the Bonds should consult their tax advisors as to the applicability and impact of such consequences.

Particular Tax Situations

Prospective purchasers of Bonds should consult their own tax advisors as to the applicability and extent of federal, state, local or other tax consequences to the purchase, ownership and disposition of Bonds in light of their particular tax situation.

RATINGS

Fitch Ratings (“Fitch”), Moody’s Investors Services, Inc. (“Moody’s”) and Standard & Poor’s Rating Services, a division of The McGraw Hill Companies, Inc. (“S&P”) have assigned the Series 2012A Bonds the respective ratings set forth below:

Moody’s:	Baa1
Standard & Poor’s:	BBB+
Fitch:	BBB+

Certain materials and information relating to the Series 2012A Bonds and the Alliance that may not be described in this Official Statement were furnished to the rating agencies in connection with the issuance of the ratings. Generally, rating agencies base their ratings on such materials and information and on their own investigations, studies and assumptions. There is no assurance that any rating will remain in effect for any given period of time or that any rating will not be lowered or withdrawn entirely if, in the judgment of the rating agency, circumstances so warrant.

No information is provided regarding the ratings of other outstanding bonds issued for the benefit of the Alliance and related entities.

UNDERWRITING

The Series 2012A Bonds are being purchased by Merrill Lynch, Pierce, Fenner & Smith Incorporated, (the “Underwriter”) pursuant to a purchase contract with the Issuer dated August 24, 2012 (the “Bond Purchase Agreement”). The Bond Purchase Agreement sets forth the Underwriter’s obligation to purchase the Series 2012A Bonds at an aggregate purchase price of \$56,364,550.00, representing the par amount plus an original issue premium of \$1,865,050.00 and less an Underwriter’s discount of \$500,500.00 (0.91% of the principal amount thereof) and is subject to certain terms and conditions, including the approval of certain legal matters by counsel. The Bond Purchase Agreement provides that the Underwriter will purchase all of the Series 2012A Bonds if any are purchased. The Underwriter may offer and sell the Series 2012A Bonds to certain dealers (including dealers depositing the Series 2012A Bonds into investment trusts) and others at prices or yields different from the public offering prices and yields stated on the inside cover of this Official Statement. The public offering prices and yields may be changed from time to time at the discretion of the Underwriter. From time to time, the Underwriter may enter into other transactions with the Alliance, including interest rate swaps and options, for which it receives other compensation.

The Underwriter and its affiliates are full service financial institutions engaged in various activities, which may include securities trading, commercial and investment banking, financial advisory, investment management, principal investment, hedging, financing and brokerage services. The Underwriter and its affiliates may, from time to time, perform various financial advisory and investment banking services for the Alliance, for which they received or will receive customary fees and expenses. In the ordinary course of their various business activities, the Underwriter and its affiliates may make or hold a broad array of investments and actively trade debt and equity securities (or related derivative securities, which may include credit default swaps) and financial instruments (including bank loans) for their own account and for the accounts of their customers and may at any time hold long and short positions in such securities and instruments. Such investment and securities activities may involve securities and instruments of the Alliance. The Underwriter and its affiliates may also communicate independent investment recommendations, market color or trading ideas and/or publish or express independent research views in respect of such assets, securities or instruments and may at any time hold, or recommend to clients that they should acquire, long and/or short positions in such assets, securities and instruments.

INDEPENDENT AUDITORS

The consolidated financial statements of the Alliance as of and for the years ended June 30, 2011 and 2010, included in Appendix B to this Official Statement, have been audited by Pershing Yoakley & Associates, P.C.

CONTINUING DISCLOSURE AGREEMENT

The Agreement

To permit compliance by the Underwriter with the continuing disclosure requirements of Rule 15c2-12 (the “Rule”) promulgated by the Securities and Exchange Commission, the Alliance will execute a Continuing Disclosure Agreement (the “Continuing Disclosure Agreement”) at closing pursuant to which the Alliance will agree to provide certain quarterly and annual financial information and material event notices required by the Rule. Such information will be filed through the Electronic Municipal Market Access System (“EMMA”) maintained by the Municipal Securities Rulemaking Board and may be accessed through the Internet at emma.mrsb.org. The proposed form of the Continuing Disclosure Agreement is set forth in Appendix E. It requires the Alliance to provide **only limited information at specific times, and the information provided may not be all the information necessary to value the Series 2012A Bonds at any particular time.** The Alliance may from time to time disclose certain information and data in addition to that required by the Continuing Disclosure Agreement. If the Alliance chooses to provide any additional information, the Alliance shall have no obligation to continue to update such information or to include it in any future disclosure filing.

Failure by the Alliance to comply with the Continuing Disclosure Agreement is not an Event of Default under the Loan Agreement. The Continuing Disclosure Agreement provides that the only remedy for its violation is a lawsuit seeking specific performance.

Prior Undertakings

In connection with the issuance of previous bonds, the Alliance has entered into continuing disclosure undertakings similar to the Continuing Disclosure Agreement. Prior to July 1, 2009, the Alliance’s filings under such undertakings were made through the then existing national recognized municipal securities information repositories. Since then filings have been made through EMMA.

The Alliance failed to make certain filings previously scheduled under previous continuing disclosure undertakings. In November, 2008, the Alliance submitted Annual Financial Information for the fiscal years ended June 30, 2000, through June 30, 2008, and Quarterly Financial Information for the quarters ended March 31, 2000, through June 30, 2008. Such filings were not timely under the Alliance’s existing continuing disclosure undertakings. The Alliance has made timely filings of the Quarterly Financial Information for the quarters ending September 30, 2008, through June 30, 2012. The Alliance believes it has now made all filings required under all of its continuing disclosure undertakings.

RELATIONSHIPS OF PARTIES

As noted above, the Alliance or its affiliates have entered into interest rate swaps and other financial transactions with affiliates of the Underwriter.

From time to time, Bond Counsel and Hunton & Williams LLP have represented the Alliance in other matters, and may do so in the future. Bond Counsel also has represented the Underwriter in unrelated transactions. Anderson & Fugate, counsel to the Alliance, receives a substantial portion of its annual legal fee income from the Alliance. The Alliance typically engages in bidding to select the contractors for its capital projects. Whether or not such projects are bid, from time to time the contractor selected may be one in which members of the board of directors the Issuer or the Alliance have an interest.

MISCELLANEOUS

This Official Statement and its distribution and use by the Underwriter have been duly authorized and approved by the Issuer and by the Alliance. This Official Statement has been executed and delivered by the Chairman of each Issuer on behalf of each Issuer and by the Senior Vice President and Chief Financial Officer of the Alliance on behalf of the Alliance.

So far as any statements made in this Official Statement involve matters of opinion, forecasts or estimates, whether or not expressly stated, they are set forth as such and not as representations of fact.

The Appendices are an integral part of this Official Statement and must be read together with all other parts of this Official Statement.

**THE HEALTH AND EDUCATIONAL FACILITIES BOARD OF THE CITY OF JOHNSON CITY,
TENNESSEE MOUNTAIN STATES HEALTH ALLIANCE**

By /s/ W. Hanes Lancaster
Chairman

By /s/ Marvin H. Eichorn
Senior Vice President and Chief Financial Officer

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APPENDIX A

MOUNTAIN STATES HEALTH ALLIANCE

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HISTORY AND OVERVIEW

Background

Mountain States Health Alliance (the “Alliance”), a Tennessee not-for-profit corporation headquartered in Johnson City, Tennessee, was originally incorporated as Memorial Hospital on April 12, 1945. In January 1951, the corporation acquired Appalachian Hospital and Training School, an 82-bed acute care facility in Johnson City, and simultaneously opened a 120-bed acute care facility in Johnson City. By 1977 its facilities had expanded to include 369 acute care beds and a 52-bed nursing home. In September 1980, the facilities were relocated and began operating as the Johnson City Medical Center (“JCMC”). In 1983 the corporation changed its name to the Johnson City Medical Center Hospital, Inc. The corporation has been determined to be an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended.

In 1998, the Alliance purchased the assets and assumed certain liabilities of five hospitals from Columbia/HCA (the “1998 Acquisition”) located in Johnson City, Kingsport, and Elizabethton, Tennessee. In 1999, the corporation changed its name to Mountain States Health Alliance. On May 1, 2005, the Alliance purchased the assets of Woodridge Hospital, an acute inpatient psychiatric facility in Johnson City. On November 1, 2006, the Alliance purchased an 80% membership interest in Smyth County Community Hospital, which owns a general acute care facility and a 109-bed long-term care facility in Southwest Virginia. On October 31, 2007, the Alliance purchased a 50.1% membership interest in Norton Community Hospital, which owns and operates both Norton Community Hospital and Dickenson County Community Hospital in Southwest Virginia. On January 31, 2008, the Alliance acquired the assets and liabilities of Russell County Medical Center in Lebanon, Virginia. On April 1, 2009, the Alliance acquired a 50.1% interest in Johnston Memorial Hospital, which owns a 116-bed facility in Abingdon, Virginia. Listed below are facilities currently owned or controlled by the Alliance:

<u>Facility</u>	<u>Location</u>	<u>Licensed Beds (excludes nursery)</u>
Johnson City Medical Center (“JCMC”)*	Johnson City, TN	514
James H. & Cecile Quillen Rehabilitation Hospital (“Quillen”) *	Johnson City, TN	60
Woodridge Hospital (“Woodridge”)*	Johnson City, TN	84
Franklin Woods Community Hospital (“Franklin Woods”)	Johnson City, TN	80
Indian Path Medical Center (“Indian Path”)	Kingsport, TN	261
Sycamore Shoals Hospital (“Sycamore Shoals”)	Elizabethton, TN	121
Johnson County Community Hospital (“Johnson County Community”)	Mountain City, TN	2
Smyth County Community Hospital (“Smyth County Community”) ⁽¹⁾	Marion, VA	153
Norton Community Hospital (“Norton Community”) ⁽²⁾	Norton, VA	129
Dickenson Community Hospital (“Dickenson Community”) ⁽²⁾	Clintwood, VA	25
Russell County Medical Center (“Russell”)	Lebanon, VA	78
Johnston Memorial Hospital (“Johnston Memorial”) ⁽²⁾	Abingdon, VA	<u>116</u>
		1,623

*JCMC, Quillen and Woodridge are operated under a single 658-bed hospital license.

⁽¹⁾ 80% membership interest held by the Alliance.

⁽²⁾ 50.1% membership interest held by the Alliance.

In addition to the above-described hospital facilities, the Alliance owns directly or through wholly-owned subsidiaries, medical office buildings, physician practices, undeveloped land and outpatient surgery centers.

Operations of the Alliance

The facilities of the Alliance are naturally divided geographically into two groupings: (i) the “Tennessee Facilities,” which include JCMC, Quillen, Woodridge, and Franklin Woods, all in Washington County; Indian Path, in Sullivan County; Sycamore Shoals, in Carter County; and Johnson County Community, in Johnson County; and (ii) the “Virginia Facilities,” which include Smyth County Community, in Smyth County; Norton Community, in the City of Norton; Dickenson Community, in Dickenson County; Russell, in Russell County; and Johnston Memorial, in Washington County. All of the Tennessee hospital facilities and Russell are owned by the Alliance. Smyth

County Community is owned by Smyth County Community Hospital; Norton Community is owned by Norton Community Hospital; and Johnston Memorial is owned by Johnston Memorial Hospital.

Johnson City Medical Center is a 514 licensed bed, general acute care facility located on a 75-acre site on State of Franklin Road, a major regional thoroughfare in Johnson City. JCMC provides a wide array of acute care services on an inpatient and outpatient basis, including a complete range of cardiovascular, neurology, oncology, skilled nursing, and rehabilitation services. JCMC also operates a 69 licensed bed children's hospital with the region's only pediatric-specific emergency department. JCMC is designated as a Level III Perinatal Center and a Level I trauma center. JCMC earned international recognition as a Magnet Hospital by the American Nurses Credentialing Center. On or adjacent to JCMC's main campus are seven physician office buildings providing office space for approximately 75 physicians.

The James H. & Cecile C. Quillen Rehabilitation Hospital (formerly Northeast Tennessee Rehabilitation Hospital) is a 60 licensed bed rehabilitation and skilled nursing hospital in Johnson City, operated under the JCMC license. This facility provides a complete array of skilled nursing services as well as rehabilitative services for individuals with brain injury, stroke, or spinal cord injury, amputation and other orthopedic and neurological diagnosis. These rehabilitative services include respiratory, occupational, physical, and speech therapy. The facility also provides pediatric outpatient rehab services. The facility was constructed in 1991.

Woodridge Hospital is an 84 licensed bed, acute-care facility located in Johnson City, offering psychiatric and substance abuse services. This facility was purchased in May, 2005 and is operated under the JCMC license.

Franklin Woods Community Hospital is an 80 licensed bed facility offering a full array of primary care and some specialty services. Franklin Woods opened in July 2010 (replacing Johnson City Specialty and North) and was the first "green" hospital in the state.

Indian Path Medical Center is a 261 licensed bed facility in Kingsport. This facility provides a complete range of medical/surgical, acute care, psychiatric and skilled nursing services on an inpatient basis and a full complement of outpatient services. The facility is located on an 80 acre campus that also includes nine medical office buildings. Indian Path Medical Center was constructed in 1974.

Sycamore Shoals Hospital is a 121 licensed bed general acute care hospital in Elizabethton, Tennessee (Carter County). The facility provides inpatient, geropsychiatric, and outpatient services for acute care and medical/surgical patients. Sycamore Shoals was founded in 1955 as Carter County Memorial Hospital. It was moved to a newly constructed facility in 1986. A medical office building constructed in 2010 is also located on the main campus.

Johnson County Community Hospital is a facility located in Mountain City with two licensed beds and critical access designation. Johnson County offers inpatient care, emergency care, and outpatient services.

Smyth County Community Hospital is a 153 licensed bed, general acute, skilled and long term care hospital in Marion, Virginia, owned by Smyth County Community Hospital (the "Smyth County Corporation"), a Virginia non-stock corporation in which the Alliance controls an 80% interest. The current facility was built in 2012, and provides a full range of acute inpatient and outpatient care, including OB/GYN, general surgery, urology, ENT, orthopedics, cardiology, oncology, and skilled nursing services. The new facility meets LEED standards and is certified as a "green" facility. Nursing home services provided by Francis Marion Manor, a 109 licensed bed long term care facility, are included as part of Smyth County Community's bed complement. Smyth County Corporation is a member of the Obligated Group.

Norton Community Hospital, located in the City of Norton, Virginia, is a 129 licensed bed, acute-care facility, which has served Southwest Virginia and Southeastern Kentucky since 1949. Norton Community is owned and operated by Norton Community Hospital (the "Norton Corporation"), a Virginia non-stock corporation in which the Alliance controls a 50.1% interest. The largest healthcare facility in the coalfield region, Norton Community provides a wide array of services through highly trained physicians and support staff. Norton Community is a member of the Virginia Hospital and Healthcare Association and is accredited by the American Osteopathic

Association. Norton Community was the first AOA accredited teaching facility in the state of Virginia. The Norton Corporation is a member of the Obligated Group.

Dickenson Community Hospital, located in Clintwood, Virginia, opened in November 2003. It is a 25 licensed bed critical access hospital owned and operated by the Norton Corporation. A recent expansion included a 5,700 square foot physician office building on the hospital campus. Dickenson Community offers laboratory, imaging, inpatient acute care and a wide array of therapy services. Dickenson Community is not a member of the Obligated Group.

Russell County Medical Center is a 78-bed acute care hospital located in Lebanon, Virginia, which includes a 20-bed inpatient psychiatric unit. Russell offers cardiac, home health, hospice, surgical and behavioral healthcare services. Russell is wholly owned by the Alliance, which is an Obligated Issuer.

Johnston Memorial Hospital is a 116 licensed bed, general acute care hospital in Abingdon, Virginia, which can trace its history back to a 12 bed facility started in 1905. Johnston Memorial provides a wide array of healthcare services in a newly constructed facility that opened in 2011. Johnston Memorial is owned and operated by Johnston Memorial Hospital, Inc. (the "Johnston Corporation"), in which the Alliance owns a 50.1% interest. The Johnston Corporation is not a member of the Obligated Group and the Obligated Issuers are not required to pay debt service on the JMH Bonds.

Operations of Subsidiary and Other Affiliates

The Alliance directly owns and operates the hospital facilities listed above that are located in Tennessee, and directly owns and operates Russell in Lebanon, Virginia. It has controlling membership interests in the corporations that own Smyth County Community, Norton Community, Dickinson Community and Johnston Memorial. Additionally, the Alliance owns or otherwise controls a number of for-profit and not-for-profit affiliates that provide complementary health care services and help support the health care needs of the region. The principal affiliates are Mountain States Foundation, Inc., Mountain States Health Alliance Auxiliary, Integrated Solutions Health Network ("ISHN"), and Blue Ridge Medical Management Corporation ("Blue Ridge").

ISHN is a Tennessee for-profit limited liability company established in 2009 and 98% owned by the Alliance. ISHN has two lines of business: (1) an accountable care organization (the "ACO") and (2) CrestPoint Health ("CrestPoint"). The ACO has created a network of participating physicians, hospitals and other health care providers, and participates, pursuant to a contract with the Centers for Medicare and Medicaid Services, in the Medicare Shared Savings Program established pursuant to Section 3022 of the Patient Protection and Affordable Care Act and its implementing regulations. The ACO may enter into shared savings or other contracts with other third party payors. CrestPoint provides third party administrator services to the Alliance for its self-insured employee health plan.

Blue Ridge is a Tennessee for-profit stock corporation, and the Alliance owns 100% of its stock. Blue Ridge in turn owns all of the stock or other ownership interest in the following entities (collectively, the "Blue Ridge Affiliates"): Mountain States Physician Group, Inc., Mountain States Properties, Inc., Mediserve Medical Equipment of Kingsport, Inc., Wilson Pharmacy, Inc., and Synergy Health Group LLC. While Blue Ridge is an Obligated Issuer under the Master Indenture, none of the Blue Ridge Affiliates is an Obligated Issuer. Blue Ridge provides, directly or through the Blue Ridge Affiliates, management services for clinics in ten counties at 90 locations (46 specialty care, 34 primary care, and 10 urgent care and occupational medicine clinics). At the 90 locations, Blue Ridge provides management services to a total of 182 practicing physicians, 59 nurse practitioners, 12 physician assistants and five nurse anesthetists. Blue Ridge has various levels of ownership in five surgery centers and owns and/or manages a total of 26 medical office buildings, six of which are held in condominium-ownership form.

Obligated Issuers

The Obligated Issuers under the Amended and Restated Master Trust Indenture dated as of February 1, 2000, as amended (the “Master Indenture”), with The Bank of New York Mellon Trust Company, N.A., as master trustee, are the Alliance, Smyth County Community Hospital, Norton Community Hospital and Blue Ridge Medical Management Corporation.

Inpatient Bed Complement

The following table shows the Alliance’s licensed bed capacity by service line as of July 1, 2012:

<u>Service</u>	<u>Licensed Beds</u>	<u>Distribution</u>
Medical/Surgical	989	61%
OB/GYN	93	6
Critical Care	125	8
Neonatal	51	3
Psychiatry	136	8
Rehabilitation	51	3
Skilled Nursing / Nursing Home	<u>178</u>	<u>11</u>
Total	1,623	100%

Source: The Alliance.

Educational Programs

Pursuant to an agreement with the Division of Health Sciences at East Tennessee State University (“ETSU”), the Alliance provides JCMC as a site for clinical and other training of medical students and residents from ETSU’s James H. Quillen College of Medicine (“QCM”), nursing students at the associate, baccalaureate and master’s level from the School of Nursing and students from the School of Public and Allied Health. Woodridge provides sites for clinical training for QCM psychiatric residents. Approved medical residencies are offered by ETSU in Family Medicine, Internal Medicine/Psychiatry, OB/GYN, Pathology, Pediatrics, Cardiology, Infectious Disease, Pulmonary/Critical Care, Sleep and General Surgery. Approved fellowships are offered by ETSU in Gastroenterology and Medical Oncology. JCMC is also a clinical site for various health professional and allied health programs located in Tennessee, Kentucky, Virginia and North Carolina.

QCM, which is located adjacent to JCMC, has made a commitment to promote medical educational programs in Johnson City, Tennessee. With QCM’s location adjacent to JCMC and the Veteran Affairs Medical Center at Mountain Home, a large portion of QCM’s clinical training occurs at JCMC. An ETSU facility housing clinical training programs is located across the street from JCMC. QCM’s presence promotes the presence of substantial numbers of physicians in private practice. Additionally, the concentration of medical specialists, researchers, and medical educators in Johnson City make the Alliance competitively stronger in patient care opportunities in the region and also provides a good source of nurses for Alliance facilities.

Licenses and Accreditation

The Tennessee Facilities are licensed by the State of Tennessee Department of Health and Environment; the Virginia Facilities are licensed by the Virginia Department of Health. All facilities are accredited by The Joint Commission (“TJC”). Norton and Quillen are accredited by the Commission of Accreditation of Rehabilitation Facilities. The Alliance facilities are accredited by the College of American Pathologists. JCMC is also accredited by the American College of Surgeons Commission on Cancer and is designated as a Regional Perinatal Center by the Tennessee Department of Health and Environment.

Employees

As of June 30, 2012, the Alliance employed a staff of 9,130 persons (equal to approximately 7,735 full-time equivalent employees), including 3,634 registered/licensed practical nurses. The Alliance's employees are covered for a variety of employee benefits, including a qualified defined contribution pension plan, health and dental insurance, life insurance and vacation, holiday and sick time benefits. Certain employees at Norton Community and Dickenson Community are represented by a union. The Alliance has never experienced a strike or other work stoppage by its employees. The Alliance considers its employee relations to be excellent.

Pension Plan

The Alliance has a qualified defined contribution pension plan covering substantially all of its employees. Contributions to the defined contribution pension plan are current. The Norton Corporation has a defined benefit plan that was terminated and all benefit accruals were frozen effective December 31, 2006. The Norton Corporation's defined benefit plan has met the ERISA minimum funding requirements.

Insurance; Litigation

The Alliance is substantially self-insured and has established self-insurance reserves to provide for professional and general liability claims and related expenses in amounts based upon an annual actuarial valuation. The self-insurance program currently has the following limits: \$10,000,000 per claim; with an annual aggregate of \$15,000,000. The Alliance has never had a claim to exceed the self-insurance limits. The Alliance maintains a \$25,000,000 excess/umbrella policy, which attaches over the self-insurance fund's \$10,000,000 per claim, \$15,000,000 annual aggregate retention.

Additionally, the Alliance is self-insured for employee health and worker's compensation claims for the Tennessee Facilities. For the Virginia Facilities, the Alliance is self-insured for employee health and maintains a large deductible policy for worker's compensation claims with limits of \$750,000 per employee per accident, \$2,500,000 aggregate, \$5,000,000 all covered bodily injury aggregate maximum for the policy period. The Alliance recognizes expense each year based upon actual claims paid and an estimate of claims incurred, but not yet paid. The Alliance has established a reserve for reported and unreported worker's compensation claims based upon an annual actuarial valuation.

The Alliance and related entities are defendants in litigation relating to medical malpractice, worker's compensation and other claims arising in the ordinary course of business. Based on an evaluation of pending and threatened actions, management of the Alliance does not believe that any existing litigation, individually or collectively, would materially and adversely affect the financial resources of the Alliance or the business or continuous operation of the Alliance. Furthermore, the Alliance has accrued amounts in its self-insurance reserves at levels that it believes are sufficient to provide for payments reasonably projected to be due in connection with pending and potential claims and liabilities of the Alliance.

MEDICAL SERVICES

The Alliance provides a wide range of general and specialty medical services for the residents of Northeast Tennessee and Southwest Virginia and the surrounding states of Kentucky and North Carolina. The majority of tertiary care provided by the Alliance is concentrated at Johnson City Medical Center. Some highlights of the medical services and programs offered by the Alliance are described below.

Surgical Services. The Alliance has approximately 60 operating rooms located in eight facilities. The Alliance's surgical facilities are equipped with state-of-the-art technologies to meet the health care needs of the region. The Alliance provides services in all major surgical specialties including orthopedics, vascular, cardiothoracic, neurological, general, gynecological, laparoscopic, laser, urological, oncological, pediatric, plastic, ear, nose and throat, dental and transplant services.

Cardiovascular Services. The Alliance offers comprehensive regional cardiac services and highly advanced equipment for the detection, treatment, care and rehabilitation of those with heart problems. Advanced services include a wide range of non-invasive tests, cardiac catheterization, angioplasty and open-heart surgery. JCMC is known throughout the region for its medical expertise in cardiac care and has been recognized as the region's top hospital for cardiovascular services by US News and World Report for three consecutive years, most recently in 2012. Indian Path provides a full complement of cardiovascular services including interventional cardiology. Johnston Memorial's services include diagnostic cardiac catheterization.

Pulmonary Medicine. Respiratory therapy services are provided at each of the Alliance's facilities. The Center for Pulmonary Medicine at JCMC diagnoses and manages disorders of the respiratory and the pulmonary vascular systems, including emphysema and black-lung disease. A state-of-the-art metabolic laboratory assesses heart and respiratory problems. Pulmonary outreach services are provided at JCMC.

Comprehensive Wound Care is provided at JCMC, Norton Community, and Johnston Memorial. JCMC is the home to three hyperbaric oxygen chambers and Norton Community and Johnston Memorial each have one chamber

Women's Services. The Alliance provides specially designed women's services equipped to meet the unique health needs of women. Locations for obstetric and newborn care include The Family Birth Centers at JCMC, Franklin Woods, Indian Path, Norton Community, and Johnston Memorial. Gynecologic care is provided at each of the preceding facilities as well as Smyth County Community and Sycamore Shoals. The complement of women's services includes: routine and high-risk obstetrical care, gynecological surgery, breast disease diagnosis and treatment, fertility services, laser and microscopic surgery, plastic surgery, wellness/fitness programs, and educational sessions covering a wide spectrum of women's concerns. The Family Birth Center at JCMC includes the region's only State-designated Perinatal Center for pregnancy and newborn medical complications and a transport team to bring critically ill infants to the Niswonger Children's Hospital at JCMC.

Children's Services. The Niswonger Children's Hospital at JCMC is the only children's hospital in northeast Tennessee. More than 20 pediatric subspecialties provide specialty care through this 69 licensed bed "hospital within a hospital" and pediatric emergency department. The Children's Hospital has met stringent criteria to become a member of the National Association of Children's Hospitals and Related Institutions (NACHRI), linking providers and staff with more than 130 of the nation's leading pediatric facilities. Also located on the campus of JCMC is the region's only *Ronald McDonald House*, with the mission of meeting the support needs of pediatric patients and family members. In addition, in October 1999, the Alliance entered into a clinical affiliation with St. Jude's Children's Research Hospital to provide pediatric cancer and other catastrophic disease treatment services.

Diabetes Services. The Alliance provides diabetes management programs with specialized healthcare providers able to address the needs of the diabetic patient. The diabetes services emphasizes the importance of patient education and support with both patient and family involvement in the treatment process and provides education in all aspects of diabetes management.

Rehabilitation Services. The James H. and Cecile C. Quillen Rehabilitation Hospital provides a complete range of physical rehabilitative services for the region, including specialized rehabilitative services for individuals with brain injuries, strokes and spinal cord injuries. The Alliance also provides outpatient physical, occupational, and speech therapies at eight locations for individuals with physical disabilities.

Cancer Services. The Alliance provides comprehensive cancer treatment services throughout the system with four tertiary care facilities in Johnson City, Kingsport, Abingdon, and Marion. The Regional Cancer Center at JCMC serves as a referral center and education host for students, and is the only facility within several hours travel time with specialized infrastructure capable of supporting the treatment of complex cases such as pediatric cancers and acute leukemia. The St. Jude's Children's Research Hospital, Tri-Cities Affiliate, is located on JCMC's campus. It is a collaborative effort between the Alliance, East Tennessee State University, and St. Jude's Children's Research Hospital in Memphis to provide pediatric oncology services in the region. Regional Cancer Centers at Indian Path, Johnston Memorial, and Smyth County Community provide surgical and chemotherapy treatments to patients from northeast Tennessee and Southwest Virginia. Outpatient radiation services are provided at Regional

Cancer Centers at Indian Path and Johnston Memorial. The program emphasizes the use of market-leading facility design, multi-specialty team-based care, highly trained and certified sub-specialty staff and an emphasis on patient-centered care.

Behavioral Health Services. Respond/Crisis Line provides information, assessment, and referral assistance to patients in need of psychiatric services. Services are provided at three locations. Woodridge provides inpatient care for children, adolescents, adults, and geriatric populations and outpatient services, including Intensive Outpatient Program for adults. Sycamore Shoals provides inpatient Geropsych services. Russell provides inpatient acute psychiatry and outpatient services for adults.

In addition to the services described above, the Alliance offers many other services throughout the region including emergency departments and urgent care centers, skilled nursing facilities, and the medical air transport service called *WINGS Air Rescue*.

Medical Staff

As of June 30, 2012, there were 1,067 physicians and dentists on the Alliance’s active, courtesy and consulting medical staffs. Of the 1,067 physicians on staff, 753 are board certified in their specialty. The average age of the medical staff is 50.34 years.

Medical staff appointment is available to licensed physicians, dentists, podiatrists and certain other professionals who are licensed to practice in the State of Tennessee or Virginia, as applicable, and who meet other specific requirements of the medical staff by-laws. Appointments and re-appointments are made by the Alliance Board of Directors upon the recommendations of the various medical staffs and the Alliance’s administrative staff. Associate staff members are persons who have applied for active staff membership, but have been on the staff for less than two years.

The Alliance conducts a recruitment program to support the recruiting efforts of the affiliated medical staff. Recruiting assistance is provided to both private and university affiliated physicians as requested, and includes contracting and interaction with recruiting firms, receipt and screening of candidates’ curriculum vitae, candidate site visit, and relocation and initial practice management assistance to the new physicians.

GOVERNANCE AND MANAGEMENT

Board of Directors

The management of the Alliance’s affairs is vested in a Board of Directors consisting of not less than 9 and not more than 14 members, including the President/CEO, who serves as an ex-officio member. Except for the ex-officio member, directors serve for staggered three-year terms. Directors may be reappointed twice for a total of nine years on the Board before rotating off for at least one year before being reappointed. Standing committees of the Board of Directors include Executive, Finance, Governance/Nominating, and Corporate Audit and Compliance. Special committees may be appointed by the Chairman of the Board for specific assignments. Current officers and members of the Board of Directors and their occupations and dates of expiration of their terms are set forth below:

<u>Name and Office Held</u>	<u>Business Affiliation</u>	<u>Term Expiration</u>
Don Jeanes, Chairperson	Retired, Milligan College	2015
Joanne Gilmer, Vice Chairperson	Retired, General Shale Brick	2013
Clem Wilkes, Jr., Treasurer	Financial Advisor, Raymond James Financial Services	2014
Michael Christian, Secretary	Retired, Banker	2015
Bob Feathers, Past-Chair	President, Workspace Interiors, Inc.	2015
Sandra Brooks, M.D.	Pathologist, Watauga Pathology Associates	2015
Jeff Farrow, M.D.	Pulmonologist, Johnson City Medical Center	2015

Tom Fowlkes	General Counsel, The United Company	2015
Linda Garceau	Dean, College of Business & Technology, East Tennessee State University	2015
David May, M.D.	Anesthesiologist, Sycamore Shoals Anesthesia Assoc.	2013
Gary Peacock	Retired, Royal Mouldings Ltd.	2014
Rick Storey	Banker, Citizens Bank	2013
Dennis Vonderfecht, <i>Ex-Officio</i>	President and CEO of the Alliance	n/a

Further, five community-based boards serve as advisory boards for the Alliance’s Board of Directors. The community-based boards represent the communities serviced by the following facilities: (1) Sycamore Shoals, (2) Johnson County Community, (3) Russell, (4) Indian Path and (5) Franklin Woods and JCMC. Four governing boards serve the Alliance’s joint-ventured facilities and include: (1) Dickenson Community, (2) Johnston Memorial, (3) Norton Community, and (4) Smyth County Community. One other governing board oversees the operations of Blue Ridge Medical Management Corporation. The bylaws of the community boards are rooted in the Alliance’s bylaws and the remaining boards are distinguished through separate bylaws. The bylaws of each of the community boards provide that their boards consist of no fewer than nine and no more than 18 persons. No more than thirty-three percent of the directors of each Community Board may consist of physicians. Terms vary for the remaining boards, but are predominately staggered for three-year terms.

Management of the Corporation

The President and Chief Executive Officer, selected by the Board of Directors, manages the Alliance’s administrative staff and has the authority and responsibility of system-wide direction of the Alliance’s facilities, subject to policies adopted by the Board of Directors or any of its committees to which it has delegated power for such action. The principal members of the administrative staff of the Alliance are described below.

Dennis Vonderfecht (61) – President and Chief Executive Officer. Mr. Vonderfecht has served as President and CEO since January 1990. Prior to joining the Alliance, he was employed by Research Health Services System in Kansas City, Missouri, where he held the position of Regional Vice President. Mr. Vonderfecht worked for Humana, Inc. for approximately eight years in capacities such as: Administrative Specialist at Humana Hospital, Greensboro, North Carolina; Associate Administrator at Gibson General Hospital, Trenton, Tennessee; Associate Executive Director for Humana Hospital, Brandon, Florida; Associate Executive Director, Humana Hospital, Greensboro, North Carolina; Project Manager for Parkway Medical Center, Cary, North Carolina; and as Executive Director, Humana Hospital, Newnan, Georgia. Mr. Vonderfecht’s undergraduate study was at Colorado State University, and the University of Nebraska, where he was awarded a B.S. degree in Business Administration. He obtained two master’s degrees from the University of Missouri, one in Business Administration and the other in Hospital Administration. He also holds an honorary doctorate from Milligan College. He presently serves on the Boards of Directors of Premier, Inc., ETSU Foundation, Tennessee Hospital Association, Tennessee Business Roundtable, Tennessee Valley Corridor Inc., and the Tennessee Center for Performance Excellence. Mr. Vonderfecht currently serves as Chairman of the Board for the Tennessee Center for Performance Excellence and has previously served as Chairman of the Tennessee Hospital Association Board of Directors and Chairman of the Board of Hospital Alliance of Tennessee. Mr. Vonderfecht is a Fellow in the American College of Healthcare Executives. He has been the recipient of the Distinguished Service Award and the Meritorious Service Award from the Tennessee Hospital Association and was awarded the American College of Healthcare Executives Regent’s Award. He has also been recognized with the Health Care Heroes Award, as well as the Cup of Kindness Award through the Tri-Cities Business Journal. In addition, Mr. Vonderfecht was presented with a “Leaders in Christian Service” award by Milligan College and has received recognition as an “Honorary Alumni” by East Tennessee State University. Mr. Vonderfecht has announced his intention to retire as of December 31, 2013. A search committee of the Board of Directors has been formed to find replacement candidates.

Marvin Eichorn (56) - Senior Vice President and Chief Financial Officer. Mr. Eichorn has served the Alliance since August 1998, when he joined as Senior Vice President/Regional Operations. He was named Chief Financial Officer in January 1999. As Senior Vice President/Chief Financial Officer, he is responsible for all of the financial operations and services of the Alliance as well as managed care and physician operation activities for the Alliance. Prior to joining the Alliance, he was employed by Covenant Health/Fort Sanders Health System in Knoxville, Tennessee in various positions over a 14 year period including Executive Vice President/Non-Hospital Operations and Executive Vice President/Chief Financial Officer. Mr. Eichorn is a Certified Public Accountant and is a member of various health care and finance organizations. His educational background includes a bachelor's degree in finance from the University of West Florida and a master's degree in business administration from Milligan College. In 2000, Mr. Eichorn received the Meritorious Service Award for an Executive Staff member from the Tennessee Hospital Association. He also serves on the board or key committees of various national and regional healthcare related organizations.

Candace Jennings (58) - Senior Vice President for Tennessee Operations. Ms. Jennings joined the Alliance in 2007 as Vice President and Chief Operating Officer for Washington County, Tennessee operations. Her current responsibilities include the strategy development and operation of the Alliance's eight Tennessee hospitals, including a critical access hospital (Johnson County Community Hospital), a children's hospital (Niswonger Children's Hospital) and a new, LEED certified hospital, Franklin Woods Community Hospital which opened in July 2010. Prior to joining Mountain States Health Alliance, she was Chief Nursing Officer for St. John's Hospital in Springfield, Illinois. As a consultant with Ernst and Young, she led organizations through transformational change specializing in organizational resizing and patient focused care. She has served as a health care leader for over 20 years in tertiary teaching hospitals in Alabama, Texas, Illinois and Tennessee. Her educational background includes bachelors and master's degrees in Nursing and a master's in Health Services Administration from the University of Alabama at Birmingham (UAB). Ms. Jennings has been a Fellow in ACHE since 2001.

Ann Fleming (64) – Senior Vice President of Virginia Operations and System Cardiovascular and Oncology Strategic Service Units. Since joining the Alliance in March 2007, Ms. Fleming has served as an examiner for the Tennessee Center for Performance Excellence and a board member for the Senate Productivity and Quality Award. Prior to joining the Alliance, Ms. Fleming most recently served as VP Clinical Service Lines, Merrillville Hospital Administrator and Chief Nursing Officer at The Methodist Hospitals Inc., Gary and Merrillville, Indiana. As part of her work there, she launched the Cardiovascular, Oncology, Rehabilitation/Ortho/Neuro, Women's and Children Service Lines. Ms. Fleming also served as Rehabilitation Consultant at Porter Memorial Hospital, Valparaiso, Indiana, and served as an operating room nurse with the 475th MASH during Operation Desert Storm in Saudi Arabia and Iraq. She received a bachelor's degree in nursing from the University of Kentucky, and a master's degree in Public Administration from Kentucky State University. Ms. Fleming is a member of the American College of Health Care Executives, the Association of Nursing Executives and the Medical Group Management Association. She received the Army Commendation Medal in 1991. Ms. Fleming is a Registered Nurse, currently licensed in Tennessee, Kentucky, Virginia and Indiana.

Morris Seligman (56) – Senior Vice President and Chief Medical Officer. Dr. Seligman joined the Alliance in January 2010, and has responsibility on a system-wide basis for Medical Staff Services, Graduate Medical Education, Continuing Medical Education, Patient Resource Management (case management), Clinical Research, Accreditation, Infection Prevention, Patient Safety, Quality, Information Systems, Telecommunications, and Clinical Informatics. Prior to joining the Alliance, Dr. Seligman was employed by Trinity Regional Health System Quad Cities-Senior Affiliate of Iowa Health System, Illinois and Iowa, where he served as the Chief Medical Officer and Vice President for Physician Services. Dr. Seligman is a diplomat of the American Board of Quality Assurance Utilization Review Physicians, a Fellow of the American Institute of Healthcare Quality certified in Healthcare Quality Management (CHCQM), a Fellow of the American College of Physicians (FACP), a Fellow of the American College of Healthcare Executives (FACHE), and a Certified Physician Executive (CPE). Dr. Seligman also has a two year degree in Engineering Sciences. Dr. Seligman is a board certified internist by training and has practiced Internal Medicine, Emergency Medicine and Occupational Medicine. Dr. Seligman received his MD from the University of Missouri-Columbia and his BSBA/MBA from Washington University. Dr. Seligman also earned his CPA Certificate and previously worked at Arthur Andersen & Co.

John Schario (54), Senior Vice President, Consumer Health Services/Innovation. Prior to joining the Alliance in July 2011, Mr. Schario most recently served as Chief Executive Officer of Nueterra Holdings LLC, a privately held health care equity and management company that specializes in acquiring and developing ambulatory surgery centers, surgical hospitals and physical therapy centers. Under Mr. Schario's leadership, the company grew from nine surgical facilities to 62 surgical facilities and 30 physical therapy clinics over a ten year period. Prior to Mr. Schario's involvement with Nueterra, he held various junior and senior level management positions over a twenty-one year period with Health Midwest, a large integrated health care system in Kansas City. These positions included leadership of various business development enterprises, including mobile services, clinical outreach services, diagnostic imaging services, and employer health services. During his tenure with Health Midwest, he also served as administrator of a small, rural hospital and Vice President of the large, flagship tertiary hospital with responsibilities for cardiology, neurology, radiology, laboratory, pharmacy, physical therapy, occupational therapy and respiratory therapy. Mr. Schario holds bachelors and master's degrees from Rockhurst University in Kansas City.

SERVICE AREA, MARKET SHARE AND COMPETITION

Patient Origin

The Alliance operates hospital facilities located in the Counties of Washington, Sullivan, Carter, and Johnson in the northeastern region of Tennessee. In the southwestern region of Virginia, the Alliance operates facilities in the Counties of Smyth, Wise, Dickenson, Russell and Washington, and in the City of Norton. The core service area for the Alliance (the "Core Service Area") consists of Washington, Sullivan, Carter, Johnson, Greene, Hawkins, and Unicoi Counties in Tennessee and Smyth, Russell, Wise (including the City of Norton), Dickenson, Scott, and Washington Counties (including Bristol City) in Virginia. Approximately 93.2% of the Alliance's discharges originated from the Core Service Area for the fiscal year ended June 30, 2011. The patient origin analysis from all service areas (*i.e.*, both the Core Service Area and the Non-Core Service Area, as defined below) as a percent of the Alliance's discharges for fiscal years 2008, 2009, 2010 and 2011 is presented in the following table:

Alliance Facilities Patient Origin By Fiscal Year (June 30)

	<u>2008</u>		<u>2009</u>		<u>2010</u>		<u>2011</u>	
	<u>Discharges</u>	<u>Percent</u>	<u>Discharges</u>	<u>Percent</u>	<u>Discharges</u>	<u>Percent</u>	<u>Discharges</u>	<u>Percent</u>
<u>Core Counties</u>								
Washington, TN	16,455	30.3%	15,196	26.6%	16,167	26.9%	16,920	27.4%
Sullivan, TN	8,092	14.9	7,312	12.8	7,753	12.9	7,732	12.5
Carter, TN	6,625	12.2	5,884	10.3	6,371	10.6	6,762	10.9
Wise, VA ¹	4,453	8.2	4,170	7.3	4,327	7.2	4,224	6.8
Greene, TN	2,661	4.9	2,514	4.4	2,644	4.4	2,547	4.1
Smyth, VA	2,498	4.6	3,485	6.1	3,606	6.0	3,707	6.0
Unicoi, TN	2,172	4.0	1,942	3.4	1,863	3.1	2,094	3.4
Johnson, TN	2,009	3.7	1,771	3.1	1,923	3.2	1,914	3.1
Hawkins, TN	1,738	3.2	1,542	2.7	1,503	2.5	1,539	2.5
Russell, VA	1,303	2.4	3,142	5.5	3,306	5.5	3,134	5.1
Dickenson, VA	1,195	2.2	1,200	2.1	1,442	2.4	1,479	2.4
Scott, VA	923	1.7	914	1.6	902	1.5	943	1.5
Washington, VA ²	760	1.4	4,170	7.3	4,207	7.0	4,595	7.4
Core Subtotal	50,886	93.7%	53,242	93.2%	56,015	93.2%	57,590	93.2%
Non-Core Subtotal	2,444	4.5%	2,856	5.0%	3,005	5.0%	2,874	4.6%
Other Areas Subtotal	978	1.8%	1,028	1.8%	1,082	1.8%	1,360	2.2%
Total	54,307	100.0%	57,127	100.0%	60,102	100.0%	61,824	100.0%

Source: The Alliance – Fiscal year data excludes normal newborns. Acquired facilities have been included from date of acquisition forward.

⁽¹⁾ Includes City of Norton, Virginia, data.

⁽²⁾ Includes City of Bristol, Virginia, data.

The Alliance has a strong extended market encompassing numerous counties in northeastern Tennessee, western North Carolina, southwestern Virginia, and southeastern Kentucky (the “Non-Core Service Area” and, together with the Core Service Area, the “Service Area”), as shown in the map in “Service Areas and Facility Locations” below. As the table above shows, approximately 4.6% of discharges for the fiscal year ended June 30, 2011, were from the Non-Core Service Area, and approximately 2.2% of discharges were from beyond the Service Area. With the addition of Smyth County Community, Norton Community, Dickenson Community, Russell, and Johnston Memorial, the percentage of discharges from Virginia has increased. The Alliance is also a referral center for numerous advanced services such as high-risk obstetrics, perinatology, neonatology, cardiology, oncology and medical surgeries (including transplants and laparoscopies), and therefore serves many patients from outside the Service Area.

Service Area Facilities

The principal competitor of the Alliance in the Core Service Area is Wellmont Health System (“Wellmont”), which operates eight hospitals within the Alliance’s Core Service Area: Holston Valley Medical Center, in Kingsport, Tennessee; Bristol Regional Medical Center, in Bristol, Tennessee; Hawkins County Memorial Hospital, in Rogersville, Tennessee; Lonesome Pine Hospital, in Big Stone Gap, Virginia; Mountain View Regional Medical Center, in Norton, Virginia; Hancock County Hospital, in Sneedville, Tennessee; Takoma Regional Hospital, in Greeneville, Tennessee; and Lee Regional Medical Center, in Pennington Gap, Virginia. Certain operating statistics for the facilities of the Alliance and Wellmont located within Tennessee are set forth below:

**Core Service Area - Tennessee Hospitals
Facility Information and Selected Utilization Data – Fiscal 2011**

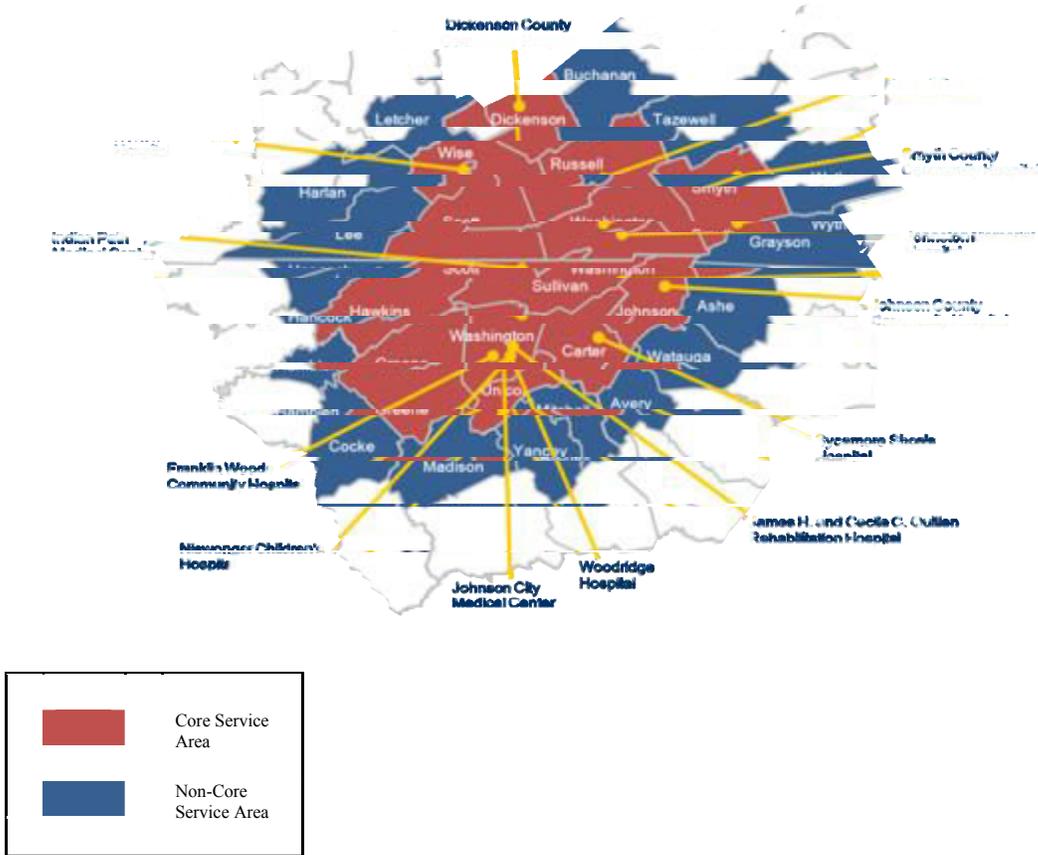
	County in Tennessee	Licensed Beds	Staffed Beds	Total Discharges	Total Patient Days	Average Daily Census
<u>Mountain States Health Alliance</u>						
Johnson City Medical Center	Washington	514	514	26,111	133,256	365
Quillen Rehabilitation Hospital	Washington	60	60	654	8,453	23
Woodridge Hospital	Washington	84	84	3,412	19,827	54
Franklin Woods Community Hospital	Washington	80	80	4,431	24,785	68
Indian Path Medical Center	Sullivan	261	189	6,823	29,534	81
Sycamore Shoals Hospital	Carter	121	79	3,640	15,299	42
Johnson County Community Hospital	Johnson	2	2	20	43	0
MSHA Subtotal		1,122	1,008	45,091	231,197	633
<u>Wellmont Health System</u>						
Holston Valley Medical Center	Sullivan	505	339	19,931	91,756	251
Bristol Regional Medical Center	Sullivan	312	261	15,293	66,214	181
Hawkins County Memorial Hospital	Hawkins	50	46	1,603	5,153	14
Hancock County Hospital	Hancock	10	10	245	808	2
Takoma Regional Hospital	Greene	100	100	2,494	11,508	32
Wellmont Subtotal		977	756	39,566	175,439	480
<u>Other Core Service Area Facilities</u>						
Laughlin Memorial Hospital	Greene	140	140	3,813	16,131	44
Healthsouth Rehabilitation Hospital	Sullivan	50	50	947	14,500	40
Unicoi County Memorial Hospital	Unicoi	48	15	1,214	4,568	13
Other Core Service Area Facilities		238	205	5,974	35,199	96
Core Service Area Total		2,337	1,969	90,631	441,835	1,209

Source: 2011 Tennessee Joint Annual Reports.

Service Areas and Facility Locations

The Alliance’s Core and Non-Core Service Areas are depicted in the map set forth below:

**Mountain States Health Alliance
Service Area**



Market Share

Market share represents the proportion of service area residents discharged from each of the service area hospitals. Market share by hospital for the defined service area was calculated using data published by the Tennessee Hospital Association, the Virginia Hospital and Healthcare Association and the North Carolina Hospital Association. Hospital specific discharges are divided by service area specific discharges to estimate market share for each of the service area hospitals.

The Alliance maintains the largest market share of its core service area, capturing over 52.6% of the market for the calendar year ended 2011. Wellmont’s facilities had a market share for the same period of approximately 37.0%. The following tables present calendar years 2007, 2008, 2009, 2010 and 2011, Core Service Area and total Service Area market share information for facilities currently owned or controlled by the Alliance and Wellmont.

Core Service Area Market Share Summary

System	Hospital Name	Calendar 2007		Calendar 2008		Calendar 2009		Calendar 2010		Calendar 2011	
		Discharges	% of Total	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total
<u>MSHA</u>	Johnson City Medical Center	24,427	24.3%	25,095	24.9%	25,168	25.9%	25,048	25.8%	23,996	24.7%
	Indian Path Medical Center	5,340	5.3	5,867	5.8	5,526	5.7	6,035	6.2	5,970	6.1
	Sycamore Shoals Hospital	4,031	4.0	3,724	3.7	3,206	3.3	3,225	3.3	3,556	3.7
	Franklin Woods Community Hospital	3,106	3.1	2,655	2.6	2,384	2.5	2,683	2.8	3,920	4.0
	Johnson County Community Hospital	40	0.0	44	0.0	31	0.0	24	0.0	26	0.0
	Smyth County Community Hospital	2,139	2.1	2,113	2.1	2,164	2.2	1,958	2.0	1,664	1.7
	Norton Community Hospital	4,793	4.8	4,139	4.1	3,980	4.1	3,636	3.8	3,696	3.8
	Dickenson Community Hospital	757	0.8	366	0.4	7	0.0	2	0.0	1	0.0
	Russell County Medical Center	2,270	2.3	2,242	2.2	2,298	2.4	2,099	2.2	1,993	2.0
	Johnston Memorial Hospital	4,979	4.9	5,656	5.6	5,496	5.6	5,534	5.7	6,400	6.6
MSHA Total		51,882	51.5%	51,901	51.4%	50,260	51.7%	50,244	51.8%	51,222	52.6%
<u>Wellmont</u>	Wellmont Holston Valley Medical Center	16,556	16.4	16,057	15.9	16,260	16.7	16,724	17.3	16,308	16.7
	Wellmont Bristol Regional Medical Center	12,288	12.2	12,676	12.6	12,455	12.8	12,831	13.2	12,827	13.2
	Wellmont Lonesome Pine Hospital	2,745	2.7	2,656	2.6	2,181	2.2	2,005	2.1	1,785	1.8
	Wellmont Hawkins County Memorial Hospital	1,699	1.7	1,778	1.8	1,639	1.7	1,521	1.6	1,419	1.5
	Wellmont Hancock County Hospital	11	0.0	9	0.0	10	0.0	10	0.0	9	0.0
	Takoma Regional Hospital	2,227	2.2	2,320	2.3	2,093	2.2	1,827	1.9	1,939	2.0
	Lee Regional Medical Center	136	0.1	151	0.1	153	0.2	146	0.2	127	0.1
	Mountain View Regional Medical Center	1,880	1.9	2,058	2.0	1,597	1.6	1,601	1.7	1,605	1.6
Wellmont Total		37,542	37.3%	37,705	37.4%	36,388	37.4%	36,665	37.8%	36,019	37.0%
<u>All Other</u>		11,271	11.2%	11,272	11.2%	10,628	10.9%	10,022	10.3%	10,076	10.4%
Grand Total		100,695	100.0%	100,878	100.0%	97,276	100.0%	96,931	100.0%	97,317	100.0%

Source: Tennessee Hospital Association, the Virginia Hospital and Healthcare Association, and the North Carolina Hospital Association.

Notes:

Information based on calendar year and excludes normal newborns, psych, substance abuse, and rehab.

Acquired facilities are fully included retrospectively.

JCMC, Quillen, and Woodridge are reported together as "Johnson City Medical Center" because they operate under a single license.

Franklin Woods reflects historical values for North Side Hospital and Johnson City Specialty Hospital prior to June 2010.

Total Service Area Market Share Summary

System	Hospital Name	Calendar 2007		Calendar 2008		Calendar 2009		Calendar 2010		Calendar 2011	
		Discharges	% of Total								
<u>MSHA</u>	Johnson City Medical Center	25,677	17.2%	26,404	17.6%	26,472	18.2%	26,259	18.3%	25,213	17.6%
	Indian Path Medical Center	5,547	3.7	6,091	4.1	5,711	3.9	6,242	4.4	6,162	4.3
	Sycamore Shoals Hospital	4,048	2.7	3,736	2.5	3,214	2.2	3,239	2.3	3,576	2.5
	Franklin Woods Community Hospital	3,133	2.1	2,686	1.8	2,398	1.7	2,714	1.9	3,941	2.8
	Johnson County Community Hospital	40	0.0	46	0.0	31	0.0	24	0.0	26	0.0
	Smyth County Community Hospital	2,417	1.6	2,348	1.6	2,399	1.7	2,197	1.5	1,855	1.3
	Norton Community Hospital	5,085	3.4	4,337	2.9	4,174	2.9	3,807	2.7	3,887	2.7
	Dickenson Community Hospital	765	0.5	369	0.2	7	0.0	2	0.0	1	0.0
	Russell County Medical Center	2,563	1.7	2,478	1.7	2,587	1.8	2,368	1.7	2,237	1.6
	Johnston Memorial Hospital	<u>5,342</u>	<u>3.6</u>	<u>6,094</u>	<u>4.1</u>	<u>5,978</u>	<u>4.1</u>	<u>5,928</u>	<u>4.1</u>	<u>6,820</u>	<u>4.8</u>
MSHA Total		54,617	36.5	54,589	36.4	52,971	36.5	52,780	36.8	53,718	37.6
<u>Wellmont</u>	Wellmont Holston Valley Medical Center	18,504	12.4	17,984	12.0	18,155	12.5	18,723	13.1	18,453	12.9
	Wellmont Bristol Regional Medical Center	13,160	8.8	13,831	9.2	13,696	9.4	14,102	9.8	14,180	9.9
	Wellmont Lonesome Pine Hospital	3,377	2.3	3,266	2.2	2,681	1.8	2,421	1.7	2,215	1.5
	Wellmont Hawkins County Memorial Hospital	1,808	1.2	1,866	1.2	1,704	1.2	1,597	1.1	1,487	1.0
	Wellmont Hancock County Hospital	375	0.3	360	0.2	303	0.2	243	0.2	202	0.1
	Takoma Regional Hospital	2,358	1.6	2,441	1.6	2,219	1.5	1,935	1.3	2,056	1.4
	Lee Regional Medical Center	2,768	1.9	2,509	1.7	2,370	1.6	2,398	1.7	2,172	1.5
	Mountain View Regional Medical Center	<u>1,977</u>	<u>1.3</u>	<u>2,132</u>	<u>1.4</u>	<u>1,652</u>	<u>1.1</u>	<u>1,661</u>	<u>1.2</u>	<u>1,661</u>	<u>1.2</u>
Wellmont Total		44,327	29.6%	44,389	29.6%	42,780	29.5%	43,080	30.0%	42,426	29.6%
<u>All Other</u>		<u>50,651</u>	<u>33.9%</u>	<u>51,003</u>	<u>34.0%</u>	<u>49,314</u>	<u>34.0%</u>	<u>47,553</u>	<u>33.2%</u>	<u>46,974</u>	<u>32.8%</u>
Grand Total		149,595	100.0%	149,981	100.0%	145,065	100.0%	143,413	100.0%	143,118	100.0%

Source: Tennessee Hospital Association, the Virginia Hospital and Healthcare Association, and the North Carolina Hospital Association.

Notes:

JCMC, Quillen, and Woodridge are reported together as "Johnson City Medical Center" because they operate under a single license.

Franklin Woods reflects historical values for North Side Hospital and Johnson City Specialty Hospital prior to June 2010.

Demographic and Socio-Economic Characteristics of the Service Area

The following table provides information on major employers in the region:

Major Employers in the PSA/SSA

<u>Rank</u>	<u>Employer</u>	<u>Headquarters</u>	<u>Estimated Employees</u>	<u>Industry</u>
1	K-VA-T Food Stores	Abingdon, VA	12,810	Retail Supermarkets
2	Mountain States Health Alliance	Johnson City, TN	9,036	Health Care
3	Wellmont Health System	Kingsport, TN	7,087	Health Care
4	Eastman Chemical Co.	Kingsport, TN	7,000	Manufacturer
5	East Tennessee State University	Johnson City, TN	2,330	Higher Education
6	James H. Quillen VA Medical Center	Mountain Home, TN	2,000	Gov't Health Care Facility
7	Sullivan County Dept. of Ed	Blountville, TN	1,646	Public Education
8	Citi Cards	Gray, TN	1,500	Retail/Call Center
9	Advanced Call Center Technologies	Berwyn, PA	1,389	Call Center
10	Washington County Dept. of Ed	Jonesborough, TN	1,300	Public Education
11	Hawkins County Board of Ed	Rogersville, TN	1,200	Public Education
12	DTR Tennessee, Inc.	Midway, TN	1,150	Manufacturer
13	A.O. Smith	Johnson City, TN	1,120	Manufacturer
14	Kingsport City Schools	Kingsport, TN	1,050	Public Education
15	Frontier Health	Johnson City, TN	983	Health Care

Source: The Business Journal of Tri-Cities/Virginia, Book of Lists, 2011

SOURCES OF REVENUE

Patient service payments are made to the Alliance by commercial insurance carriers, the federal government under the Medicare program, the State of Tennessee under the TennCare program and surrounding states under their Medicaid programs. The table below shows the percentage of gross patient revenues received by the Alliance from each program and from private pay.

Gross Patient Revenues by Source of Payment (Payor Mix)

	<u>Audited</u> <u>Fiscal Years Ended June 30</u>				<u>Unaudited</u> <u>Fiscal Year</u> <u>Ended June 30</u>
	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>
Medicare	41.3%	42.0%	43.4%	43.7%	44.1%
TennCare/Medicaid Managed Care/	15.3	15.0	14.2	13.7	14.1
Commercial and Other	36.4	35.7	34.2	34.2	33.3
Private Pay	7.0	7.3	8.2	8.4	8.5
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Source: The Alliance.

Medicaid and Medicare

Approximately 44% and 14% of the gross patient service charges of the Alliance for the fiscal year ended June 30, 2012, were derived from the Medicare and TennCare/Medicaid programs, respectively. Medicare provides certain health care benefits to beneficiaries who generally are 65 years of age and older, are long term disabled, or qualify for the end stage renal disease (“ESRD”) program. Medicare Part A covers, among other things, inpatient hospital services, skilled nursing care, hospice and some home health care. Medicare Part B covers, among other things, physician services, outpatient hospital services and some supplies. TennCare/Medicaid is designed to pay providers for care given to the medically indigent and others who receive federal aid.

TennCare/Medicaid

The State of Tennessee transferred a portion of its Medicaid program to a managed care program (“TennCare”) under a Section 1115 Waiver effective January 1, 1994. The long term care and ESRD Medicaid programs were not transferred to TennCare. The TennCare program also covers a number of uninsured non-Medicaid beneficiaries.

Medicare

Medicare pays acute care hospitals for most services provided to inpatients under a payment system known as the Prospective Payment System (“PPS”). Separate PPS payments are made for inpatient operating costs and inpatient capital costs.

Inpatient Operating Costs. Under PPS, acute care hospitals are reimbursed for inpatient operating costs on a per-discharge basis at fixed rates established for identified Diagnosis Related Groups (“DRGs”). DRG classification is based on the diagnosis at discharge and major procedures and other factors for each particular Medicare patient. The amount to be paid for each DRG is established prospectively by the Centers for Medicare and Medicaid Services (“CMS”), an agency of the United States Department of Health and Human Services (“HHS”), and is not related to a hospital’s actual costs. For certain Medicare beneficiaries who have unusually costly hospital stays (referred to as “outliers”), CMS will provide additional payments above those specified for the DRG.

The prospective payment rate is updated annually based upon the hospital “market basket” index, which generally measures changes in the cost of providing health care services. Future adjustments are subject to change by Congress. There is no assurance that these or any future increases in the prospective payment rates will keep pace with the increases in the cost of providing hospital services.

CMS reviews and publishes changes in the DRG classification system at least annually. This process is intended to ensure that each DRG is clinically coherent and represents an acceptable range of resource consumption. There is no assurance that the Alliance will be paid amounts which will reflect adequately changes in the cost of providing health care or in the cost of health care technology being made available to patients.

Costs of Medical Education. Medicare pays for certain direct and indirect costs associated with medical education. Payment for the indirect costs of medical education will be made as an adjustment to the federal rate for capital-related costs during the transition to PPS for inpatient capital-related costs. The indirect medical education adjustment for capital-related costs is based in part on the ratio of a hospital’s number of full-time equivalent (“FTE”) residents to its average daily census. Medicare also adjusts the inpatient operating PPS payment for indirect costs of medical education. This adjustment is based in part on the ratio of FTE residents to beds. Payment for direct medical education is based on a per resident rate adjusted by inflation and the number of current-year reimbursable resident positions.

Disproportionate Share. Section 402 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) provided for payments to hospitals serving a large number of low-income patients which qualifies them for a Medicare Disproportionate Share (“DSH”) payment adjustment. Payment is based on the SSI% plus Medicaid Eligible Patient Days to Total Patient Days. There is no assurance in the future that the Alliance will be paid amounts to adequately offset the cost of providing services to low income patients to Acute and Rehabilitation services.

Costs of Outpatient Services. Ambulatory payment classifications (“APCs”) form the basis for outpatient PPS. Services in each APC are similar clinically and with respect to the resources necessary to provide the services. Generally, the primary classification variable under the APC system is the procedure performed rather than the patient’s diagnosis, as is the case with the DRG system. Each APC is assigned a payment rate based on median (or, if the Secretary of HHS so chooses, mean) hospital costs for procedures performed, weighted by procedure volume. Beneficiary coinsurance amounts are established for each APC based on 20 percent of the national median of charges for APC services. The APC payment and beneficiary’s coinsurance amounts for outpatient services will be adjusted to reflect geographic wage variations and other factors determined to be necessary by the Secretary of HHS. Annual payment updates are based on the hospital market basket index. As with inpatient hospital services,

there is no assurance that future increases in the prospective payment rates will reflect adequately the changes in the costs of providing outpatient services.

Costs of Inpatient Rehabilitation Facilities (IRF). Under IRF PPS, Federal rates are adjusted to reflect patient case mix, resource intensity associated with the patients clinical condition, and facility characteristics. Cases are grouped into case-mix groups (CMGs) and are further classified into four tiers driven by conditions that are secondary to the principal diagnosis. Rates are paid to reflect all costs of furnishing IRF services for routine, ancillary, and capital. There is no assurance that the alliance will be paid amounts that will sufficiently match all costs associated with care.

Costs of Psychiatric Facilities (IPF). Under the IPF PPS, services are reimbursed under Federal Per Diem rates to include Operating and Capital costs. Payment is based on geographic factors, patient characteristics (DRG, age, length of stay and presence of specified comorbidities), facility characteristics, and services for received in a qualified Emergency Department and also Electroconvulsive Therapy.

Costs of Skilled Nursing Facilities. Medicare reimbursed for skilled nursing facility (“SNF”) stays are also based on a prospective payment system which requires “bundling” of virtually all SNF services, similar to the current practice for hospital inpatient services. A SNF therefore is responsible for providing or arranging to provide all Medicare services (subject to certain exceptions) needed by a SNF patient, and could potentially receive less than it costs the SNF to provide or arrange to provide those services. Accordingly, there can be no assurance that the aggregate amount of payments under SNF PPS will be sufficient to cover all of the Alliance’s actual costs of providing SNF services to Medicare beneficiaries.

Physician Services. Physicians are reimbursed under Medicare based on their professional services according to the lesser of the actual charge or the amount determined from a resource-based relative value scale (RBRVS) fee schedule. The fee schedule is subject to update by the Secretary of HHS and Congress on an annual basis.

Electronic Health Records (EHR) Costs. The American Recovery Act of 2009 provides for incentive payments for Medicare and Medicaid eligible professionals and hospitals to purchase and implement meaningful use certified EHR technology. Payments provide an incentive for the “meaningful use” of certified EHR technology and to achieve health care and efficiency goals. The incentive payment will be paid out over a period of 5 years, which offsets the costs of purchase and implementation of the products. There is no indication that future rule making will extend payments beyond the five years.

Audits, Exclusions, Fines and Enforcement Action. Hospitals participating in Medicare are subject to audits and retroactive audit adjustments by a Medicare Audit Contractor under the Medicare program. From an audit, a Medicare Audit Contractor may conclude, for example, that a patient has been discharged under an incorrect DRG, that services may not have been provided under the direct supervision of a physician (to the extent so required), that a patient should not have been characterized as an inpatient, that certain services provided prior to an admission as an inpatient should not have been billed as outpatient services or that certain required procedures or processes were not satisfied. As a consequence, payments may be retroactively disallowed. Under certain circumstances, payments made may be determined to have been made as a consequence of improper claims subject to the federal False Claims Act or other federal statutes, subjecting the hospital to civil or criminal sanctions. Generally, the Alliance maintains limited reserves for anticipated or proposed audit adjustments which are likely to be contested. Nevertheless, such adjustments may exceed such reserves and may be substantial. Medicare regulations also provide for withholding Medicare payment in certain circumstances, and such withholdings could have a substantial adverse effect on the financial condition of the Alliance.

Management of the Alliance is not aware of any situation in which reserves are inadequate or a material amount of Medicare payments is being withheld. The Alliance utilizes internal and external resources to review and audit practice compliance with policies, procedures, applicable laws and regulations. Whenever such reviews identify practice deviation from policies, procedures, applicable rules and regulations, management is obligated to refund any overpayments as part of the Alliance’s continuous improvement processes. Currently, management is unaware of any deviations that may have a material adverse effect on the results of the operations or financial condition of the Alliance.

Commercial Managed Care and Other

The Alliance contracts with certain private third party payors. Contractual agreements with these payors include reimbursement arrangements such as discounted charges, per diem amounts and capitated payments. The Alliance actively manages these contracts and negotiates terms that are in the best interest of the Alliance and its patients. While not participating in all commercial contracts, the Alliance participates in the vast majority of contracts covering the population of its primary service area.

Additionally, the Alliance treats patients with no insurance coverage. Those meeting certain income requirements are treated at no cost to the patient. Those not qualifying for this classification are classified as “self-pay” and reimburse the Alliance privately for the services rendered.

HISTORICAL UTILIZATION INFORMATION

The table below provides historic system-wide patient utilization for the Alliance for the fiscal years ended June 30, 2008 through 2012. The number reflects the inclusion of the following facilities as of the following dates: Smyth County Community - 11/1/06; Norton Community - 11/1/07; Dickenson Community - 11/1/07; Russell - 1/31/08; and Johnston Memorial - 4/1/09.

	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>
Occupancy Rate (licensed)	49%	45%	46%	47%	48%
Patient Days	268,965	283,555	291,986	288,167	292,910
Admissions	54,307	57,127	60,102	61,035	61,154
Average Daily Census	735	777	800	789	800
Avg Length of Stay (days)	5.0	5.0	4.9	4.7	4.8
Outpatient Visits	1,239,440	1,511,699	1,604,036	1,546,325	1,592,335
ER Visits	190,771	219,983	250,942	242,677	246,821
Surgical Cases	35,988	38,812	39,313	38,521	36,971
Births	4,270	4,371	4,684	4,511	4,288
Newborn Days	8,504	8,569	9,112	9,287	9,116
Licensed Beds	1,699	1,841	1,789	1,749	1,623

Source: The Alliance.

CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS

The following Condensed Summary of Revenue and Expenses (the “Condensed Summary”) for each of the five Fiscal Years ended June 30, 2007 through 2011, is derived from the Alliance’s audited financial statements for those Fiscal Years. The annual financial statements were audited by Pershing Yoakley & Associates, P.C. The financial information for the twelve month period ended June 30, 2012, is unaudited and reflects, in the opinion of the Alliance, all adjustments necessary to summarize fairly the results for such period on a basis consistent with that used in preparing the annual financial statements for the years ended June 30, 2007, 2008, 2009, 2010, and 2011. The financial statements include the assets and liabilities and reflect the revenue and expenses of the Alliance and all consolidated entities, including those that are not Obligated Issuers.

The Condensed Summary as well as the audited financial statements included in Appendix B and the unaudited financial statements included as Appendix C are for all entities consolidated with the Alliance for accounting purposes (the “Consolidated Entities”) and therefore reflect the assets, liabilities, revenues and expenses of entities that are not Obligated Issuers (see “THE ALLIANCE” in the front half of this Official Statement). For the fiscal year ended June 30, 2012, the Obligated Issuers accounted for approximately 74% of the total assets and 89% of the total revenue of the Consolidated Entities.

The following Condensed Summary of Consolidated Revenue and Expenses should be read in conjunction with the audited financial statements and notes contained in Appendix B hereto.

Condensed Summary of Revenue and Expenses

	Audited Fiscal Years Ended June 30					(Unaudited) Fiscal Year Ended June 30
	(In Thousands)					(In Thousands)
	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012⁽⁹⁾</u>
Revenues:						
Net patient service revenue	\$661,744	\$726,542	\$822,898	\$928,270	\$960,254	\$950,946
Other revenue	16,711	16,098	17,046	16,009	15,871	37,559
Total Revenue, Gains and Support	<u>678,455</u>	<u>742,640</u>	<u>839,944</u>	<u>944,279</u>	<u>976,125</u>	<u>988,504</u>
Expenses:						
Operating expenses	580,059	633,842	719,193	806,379	822,962	860,249
Depreciation and Amortization	49,807	60,048	68,523	81,559	90,058	75,055
Interest and Taxes	44,387	44,581	45,225	42,264	44,153	45,903
Total Expenses	<u>674,252</u>	<u>738,471</u>	<u>832,941</u>	<u>930,202</u>	<u>957,173</u>	<u>981,207</u>
Operating Income (loss)	4,203	4,169	7,003	14,077	18,952	7,297
Net non-operating gains (losses) ⁽¹⁾	67,184 ⁽²⁾	(74,343) ⁽³⁾	(89,683) ⁽⁴⁾	30,598 ⁽⁵⁾	67,710 ⁽⁶⁾	26,622 ⁽⁷⁾
Excess of Revenue, Gains and Support Over Expenses and Losses ⁽⁸⁾	<u>\$ 71,387</u>	<u>\$ (70,174)</u>	<u>\$ (82,680)</u>	<u>\$ 44,675</u>	<u>\$86,662</u>	<u>\$33,919</u>

Source: The Alliance.

⁽¹⁾ Net non-operating gains and losses include the change in fair value of derivatives and realized and unrealized gains and losses on investments. Recent clarification to generally accepted accounting principles require the unrealized gains and losses on certain investments to be included as part of the Excess of Revenue, Gains and Support over Expenses and Losses and such approach was used for the audited financial statements for fiscal years 2008, 2009, 2010 and 2011, and unaudited 2012. For ease of comparison, management has reclassified such unrealized gains and losses for fiscal year 2007 in a manner consistent with the clarification.

⁽²⁾ Includes \$2.1 million of unrealized gains on derivatives.

⁽³⁾ Includes \$20.6 million of unrealized losses on derivatives, and \$57.7 million loss on early extinguishment of debt and \$33.4 million of unrealized losses on investments.

⁽⁴⁾ Includes \$42.1 million of unrealized losses on derivatives and \$62.6 million of unrealized losses on investments.

⁽⁵⁾ Includes \$8.6 million of unrealized losses on derivatives, and \$15.0 million of unrealized gains on investments.

⁽⁶⁾ Includes \$23.0 million of unrealized gains on derivatives and \$22.2 million of unrealized gains on investments.

⁽⁷⁾ Includes \$6.2 million of unrealized losses on derivatives and \$2.9 million of unrealized losses on investments.

⁽⁸⁾ An entry was posted in the 2008, 2009, 2010, 2011 and 2012 financial statements to eliminate certain employee health related patient service revenue and employee benefits expense (approximately \$12.9 million in 2008, \$14.9 million in 2009, \$20.0 million in 2010, \$23.1 million in 2011, and \$23.3 million in 2012). The eliminating entry had no effect on the Excess of Revenue, Gains and Support Over Expenses and Losses in these periods. The 2007 financial data does not reflect this eliminating entry.

⁽⁹⁾ In Fiscal 2012, the Alliance early adopted Financial Accounting Standards Board Update 2011-07, which requires reclassification of bad debt expense from an operating expense to a deduction from patient service revenue. For 2012, bad debt of \$7.057 million is classified as a deduction from net revenue and for all years prior to 2012, bad debt is classified as an operating expense. In Fiscal 2012, revenue of \$5.611 million related to durable medical equipment and retail pharmacy is included in other revenue. Prior to 2012, this revenue was included in net patient service revenues.

TRENDS IN UNRESTRICTED LIQUIDITY AND LEVERAGE

The following table provides information on unrestricted liquidity and leverage for the fiscal years ended June 30, 2007 through 2012.

	Fiscal <u>2007</u>	Fiscal <u>2008</u>	Fiscal <u>2009</u>	Fiscal <u>2010</u>	Fiscal <u>2011</u>	Unaudited Fiscal <u>2012</u>
Total Unrestricted Cash (\$ in Thousands)	\$452,225	\$466,478	\$515,066	\$551,608	\$592,537	\$531,151
Total Days' Cash on Hand	264	246	249	240	253	214
Unrestricted Net Assets (\$ in Thousands)	\$416,850	\$349,081	\$272,049	\$317,433	\$400,395	\$436,330
Net Long Term Debt to Capitalization⁽¹⁾	53.6%	68.0% ⁽²⁾	74.7%	71.2%	67.5%	65.4%

⁽¹⁾ For purposes of calculating the ratio, Net Long-Term Debt is determined net of debt service reserve funds and moneys held in principal and interest funds.

⁽²⁾ The increase in Net Long Term Debt to Capitalization in Fiscal Year 2008 was due in part to the \$57.7 million loss on early extinguishment of debt. The Net Long Term Debt to Capitalization, excluding the loss on early extinguishment of debt, was 65.1%.

MANAGEMENT'S DISCUSSION OF FINANCIAL PERFORMANCE

Overview

The Alliance has maintained a positive operating income for each of the last six fiscal years, reflecting rises in net patient service revenues that have generally kept pace with increases in expenses. However, non-operating losses from derivatives and other investments resulted in deficits of revenue, gains, and support over expenses for Fiscal 2008 and 2009. The losses from derivatives are discussed further below. The losses from other investments resulted from losses in market value reflecting primarily the general market decline in the value of securities in the Alliance's investment portfolio. Beginning in Fiscal 2007, operating income or losses for recent acquisitions is included (Fiscal 2007: Smyth County - 8 months, Fiscal 2008: Norton/Dickenson – 8 months and Russell 5 months, Fiscal 2009: Johnston Memorial – 3 months).

Fiscal 2010

Operating Income for Fiscal 2010 was \$14.077 million compared with \$7.003 million for the same period in Fiscal 2009. This produced an "Operating Margin" (excess of total revenue, gains and support over total expense divided by total revenue, gains and support) of 1.5%, compared with 0.8% for the same period in Fiscal 2009. This reflected among other things increases in revenues and expenses resulting from the addition of Johnston Memorial (April, 2009) that are included for a full year in the Fiscal 2010 but included for only three months in Fiscal 2009. Moreover, net non-operating gains of \$30.598 million, reflecting primarily \$24.083 million of income realized from investments, \$15.018 million of unrealized income from investments, and \$8.607 million in losses derived from interest rate swaps and derivatives, produced a \$44.675 million excess of revenue, gains and support over expenses.

Fiscal 2011

Operating Income for Fiscal 2011 was \$18.952 million compared with \$14.077 million for the same period in Fiscal 2010. The Operating Margin for Fiscal 2011 was 1.9%, compared with 1.5% for the same period in Fiscal 2010. Moreover, net non-operating gains of \$67.710 million, reflecting primarily \$23.214 million of income realized from investments, \$22.168 million of unrealized income from investments, and \$23.049 million in gains derived from interest rate swaps and derivatives, produced an \$86.662 million excess of revenue, gains and support over expenses.

Fiscal 2012 (Unaudited)

Operating Income for Fiscal 2012 was \$7.297 million compared with \$18.952 million for the same period in Fiscal 2011. The Operating Margin for Fiscal 2012 was 0.7%, compared with 1.9% for the same period in Fiscal 2011. Moreover, net non-operating gains of \$26.622 million, reflecting primarily \$27.938 million of income realized from investments, \$2.921 million of unrealized losses from investments, and \$6.198 million in losses derived from interest rate swaps and derivatives, produced a \$33.919 million excess of revenue, gains and support over expenses.

Net patient revenue in Fiscal 2012 declined \$9.3 million as compared to Fiscal 2011. This decline in net patient revenue is mainly attributable to a decline in surgical admissions and a decreased length of stay for commercial patients. Operating expenses in Fiscal 2012 increased \$37.3 million as compared to Fiscal 2011. The increase in operating expenses is mainly due to an increase in expenses related to physician salaries and fees. Days Cash on Hand declined from 253 days in Fiscal 2011 to 214 days for Fiscal 2012. The Alliance had anticipated Days Cash on Hand to decrease by 21 days due to planned capital expenditures. The additional 18 day decline is due to the decrease in operating income and an increase in net accounts receivable.

Interest Rate Swaps and Derivatives

The Alliance has utilized several forms of derivative financial instruments, including interest rate swaps, constant maturity swaps and total return swaps, in order to lower the cost of debt and reduce interest rate risk.

As of June 30, 2012, the Alliance had a total of approximately \$592,400,000 (notional amount) of total return swaps, basis swaps, and constant maturity basis swaps with Bank of America, which swaps have been implemented as part of a carefully managed program. Through this program, the Alliance has realized approximately \$43,800,000 of savings since 2001. In January and May of 2011, the Alliance “locked in” approximately \$16,000,000 of future cash payments through April 2014 on \$438,000,000 (notional amount) of the constant maturity basis swaps. In January 2011, the Alliance converted two fixed payor swaps, totaling \$132,000,000 (notional amount), to basis swaps. As of June 30, 2012, the market value of all these swaps was a negative \$14,490,000 with no collateral currently posted to Bank of America.

Additionally, the Alliance has \$106,000,000 (notional amount) of total return and fixed payor swaps with Lehman Brothers Special Financing, Inc. (“Lehman”). As of June 30, 2012, the Alliance had posted \$13,800,000 of collateral under the Lehman swap agreements. In the fall of 2008, the Alliance was notified by Lehman that these transactions were going to be terminated as of January 1, 2009. The termination did not occur, due to a dispute between counterparties regarding the amount of the cost of the termination. The Alliance believes that the amount of the collateral that has been posted is sufficient to pay the cost of the termination. Since late 2011, the counterparties have been involved in mediation to settle the termination amount.

In 2003 and 2004, the Alliance implemented \$224,400,000 (notional amount) of swaptions with Bear Stearns Capital Markets, now J.P. Morgan, as part of a synthetic refunding of its Series 2000 outstanding debt. The Alliance also entered into two forward sale agreements originally related to the Series 2000 Debt Service Reserve Fund and Debt Service Funds. Amounts received by the Alliance as upfront payments on the swaptions and related forward sale agreements were deposited in a guaranteed investment contract (“GIC”) with Bear Stearns, now J.P. Morgan, that served as collateral under the related agreements. On October 13, 2011, the Alliance terminated the swaptions using the entire proceeds of the GIC. No additional funds of the Alliance were utilized. On June 29, 2012, the Alliance terminated the forward sale agreements. There are no remaining derivatives or forward sale agreements with J.P. Morgan.

Additional Indebtedness

Other than the surgical services improvements at JCMC, the Alliance has no significant capital expenditures planned or in process for the near future. Funding for the surgical services project is expected to come from cash flow and the proceeds of this bond issue. Other capital improvements are expected to be funded from cash flow.

APPENDIX B

**AUDITED CONSOLIDATED FINANCIAL STATEMENTS
FOR FISCAL YEARS ENDED JUNE 30, 2011 AND 2010**

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MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Schedules)

Years Ended June 30, 2011 and 2010



MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements and Supplemental Schedules

Years Ended June 30, 2011 and 2010

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited the accompanying consolidated balance sheets of Mountain States Health Alliance and subsidiaries (the Alliance) as of June 30, 2011 and 2010 and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Alliance's management. 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 of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing 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 over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe our audits provide a reasonable basis for our 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 subsidiaries as of June 30, 2011 and 2010 and the results of their operations, changes in net assets and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The supplemental schedules, as listed in the accompanying index, are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

As discussed in Note B, the Alliance adopted Financial Accounting Standards Board Accounting Standards Codification 958-10, *Consolidation*, and applicable portions of 958-805, *Not-for-Profit Entities*, during 2011.

Peeling Yeobly; Amundt PC

Knoxville, Tennessee
October 26, 2011

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets
(Dollars in Thousands)

	<i>June 30,</i>	
	<i>2011</i>	<i>2010</i>
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 112,768	\$ 234,526
Current portion of investments	116,175	25,092
Patient accounts receivable, less estimated allowances for uncollectible accounts of \$53,366 in 2011 and \$45,941 in 2010	134,611	125,580
Other receivables, net	19,614	17,926
Inventories and prepaid expenses	28,965	29,163
TOTAL CURRENT ASSETS	412,133	432,287
INVESTMENTS, less amounts required to meet current obligations	581,376	590,131
PROPERTY, PLANT AND EQUIPMENT, net	797,418	695,598
OTHER ASSETS		
Goodwill - Note B	148,666	151,352
Net deferred financing, acquisition costs and other charges, less current portion	29,844	30,819
Other assets	28,448	29,313
TOTAL OTHER ASSETS	206,958	211,484
	\$ 1,997,885	\$ 1,929,500

	<i>June 30,</i>	
	<i>2011</i>	<i>2010</i>
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	\$ 20,047	\$ 16,039
Current portion of long-term debt and capital lease obligations	28,162	28,131
Current portion of estimated fair value of derivatives	102,609	10,740
Accounts payable and accrued expenses	98,819	99,227
Accrued salaries, compensated absences and amounts withheld	57,800	47,280
Estimated amounts due to third-party payors, net	14,813	10,155
TOTAL CURRENT LIABILITIES	322,250	211,572
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	1,040,923	1,054,842
Estimated fair value of derivatives, less current portion	8,123	123,560
Deferred revenue	19,267	20,445
Estimated professional liability self-insurance	9,692	9,541
Other long-term liabilities	14,352	12,628
TOTAL LIABILITIES	1,414,607	1,432,588
COMMITMENTS AND CONTINGENCIES -		
Notes D, F, G, and N		
NET ASSETS		
Unrestricted net assets		
Mountain States Health Alliance	400,395	317,485
Noncontrolling interests in subsidiaries - Note B	171,984	168,359
TOTAL UNRESTRICTED NET ASSETS	572,379	485,844
Temporarily restricted net assets		
Mountain States Health Alliance	10,715	10,890
Noncontrolling interests in subsidiaries - Note B	57	51
TOTAL TEMPORARILY RESTRICTED NET ASSETS	10,772	10,941
Permanently restricted net assets		
	127	127
TOTAL NET ASSETS	583,278	496,912
	\$ 1,997,885	\$ 1,929,500

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2011</i>	<i>2010</i>
Revenue, gains and support:		
Net patient service revenue	\$ 960,254	\$ 928,270
Other operating revenue	15,871	16,009
TOTAL REVENUE, GAINS AND SUPPORT	<u>976,125</u>	<u>944,279</u>
Expenses:		
Salaries and wages	342,208	325,663
Physician salaries and wages	59,249	54,489
Contract labor	5,964	6,546
Employee benefits	67,139	68,362
Fees	85,919	82,542
Supplies	169,362	175,469
Utilities	17,300	16,193
Other	69,647	69,154
Depreciation	87,499	68,436
Amortization - Note B	2,559	13,123
Estimated provision for bad debts	6,174	7,961
Interest and taxes	44,153	42,264
TOTAL EXPENSES	<u>957,173</u>	<u>930,202</u>
OPERATING INCOME	18,952	14,077
Nonoperating gains (losses):		
Interest and dividend income	16,224	17,298
Net realized gains on the sale of securities	1,957	2,385
Net unrealized gains on securities	22,168	15,018
Derivative related income	5,072	4,394
Loss on early extinguishment of debt - Note F	-	(3,029)
Change in estimated fair value of derivatives	23,049	(8,607)
Other nonoperating gains (losses)	(2,653)	512
Net assets released from restrictions used for operations	1,893	2,627
NET NONOPERATING GAINS	<u>67,710</u>	<u>30,598</u>
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	<u>\$ 86,662</u>	<u>\$ 44,675</u>

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

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

Year Ended June 30, 2011

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	\$ 83,269	\$ 3,393	\$ 86,662
Pension and other defined benefit plan adjustments	620	617	1,237
Cumulative effect of a change in accounting principle - Note B	(2,965)	-	(2,965)
Net assets released from restrictions used for the purchase of property, plant and equipment	1,946	-	1,946
Distributions to noncontrolling interests	-	(270)	(270)
Repurchases of noncontrolling interests and other	40	(115)	(75)
INCREASE IN UNRESTRICTED NET ASSETS	82,910	3,625	86,535
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	3,612	58	3,670
Net assets released from restrictions	(3,787)	(52)	(3,839)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	(175)	6	(169)
INCREASE IN TOTAL NET ASSETS	82,735	3,631	86,366
NET ASSETS, BEGINNING OF YEAR	328,502	168,410	496,912
NET ASSETS, END OF YEAR	\$ 411,237	\$ 172,041	\$ 583,278

MOUNTAIN STATES HEALTH ALLIANCE

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

Year Ended June 30, 2010

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over			
Expenses and Losses	\$ 42,372	\$ 2,303	\$ 44,675
Pension and other defined benefit plan adjustments	796	793	1,589
Net assets released from restrictions used for the			
purchase of property, plant and equipment	2,283	-	2,283
Distributions to noncontrolling interests	-	(151)	(151)
Repurchases of noncontrolling interests and other	(63)	(38)	(101)
INCREASE IN UNRESTRICTED NET ASSETS	45,388	2,907	48,295
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	3,585	88	3,673
Net assets released from restrictions	(4,825)	(85)	(4,910)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	(1,240)	3	(1,237)
PERMANENTLY RESTRICTED NET ASSETS:			
Net assets released from restrictions by donor	(50)	-	(50)
INCREASE IN TOTAL NET ASSETS	44,098	2,910	47,008
NET ASSETS, BEGINNING OF YEAR	284,404	165,500	449,904
NET ASSETS, END OF YEAR	\$ 328,502	\$ 168,410	\$ 496,912

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2011</i>	<i>2010</i>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase in net assets	\$ 86,366	\$ 47,008
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	90,472	81,982
Loss on early extinguishment of debt	-	3,029
Cumulative effect of a change in accounting principle	2,965	-
Change in estimated fair value of derivatives	(23,049)	8,607
Equity in net income of joint ventures, net	(898)	(1,117)
Gain on sale of assets held for resale and disposal of assets	(367)	(548)
Amounts received on interest rate swap settlements	(5,072)	(4,394)
Income recognized through forward sale agreements	(864)	(864)
Capital Appreciation Bond accretion and other	2,738	2,071
Restricted contributions	(3,670)	(2,159)
Pension and other defined benefit plan adjustments	(1,237)	598
Increase (decrease) in cash due to change in:		
Net patient accounts receivable	(9,031)	3,232
Other receivables	(2,802)	(1,246)
Inventories and prepaid expenses	(643)	(4,640)
Trading securities	(123,966)	(13,368)
Other assets	(3,632)	(1,159)
Accrued interest payable	4,008	3,989
Accounts payable and accrued expenses	2,741	(855)
Accrued salaries, compensated absences and amounts withheld	11,361	(2,289)
Estimated amounts due from/to third-party payors, net	4,658	3,757
Other long-term liabilities	2,961	(201)
Estimated professional liability self-insurance	151	(471)
Total adjustments	(53,176)	73,954
NET CASH PROVIDED BY OPERATING ACTIVITIES	33,190	120,962
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property, plant and equipment, property held for resale and property held for expansion, net	(172,786)	(172,240)
Additions to goodwill	(279)	-
Net decrease in assets limited as to use	81,383	50,362
Purchases of held-to-maturity securities	(41,060)	(28,175)
Net distribution from joint ventures and unconsolidated affiliates	1,057	1,162
Proceeds from sale of property, plant and equipment and property held for resale	812	9,565
NET CASH USED IN INVESTING ACTIVITIES	(130,873)	(139,326)

	<i>Year Ended June 30,</i>	
	<i>2011</i>	<i>2010</i>
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt and capital lease obligations, including deposits to escrow	(37,735)	(226,315)
Payment of acquisition and financing costs	(1,716)	(3,565)
Proceeds from issuance of long-term debt and other financing arrangements	5,954	235,158
Net amounts received on interest rate swap settlements	5,072	4,394
Restricted contributions received	4,350	3,382
NET CASH (USED IN) PROVIDED BY FINANCING ACTIVITIES	(24,075)	13,054
NET DECREASE IN CASH AND CASH EQUIVALENTS	(121,758)	(5,310)
CASH AND CASH EQUIVALENTS, beginning of year	234,526	239,836
CASH AND CASH EQUIVALENTS, end of year	\$ 112,768	\$ 234,526

SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:

Cash paid for interest	\$ 39,507	\$ 38,666
Cash paid for federal and state income taxes	\$ 739	\$ 446
Construction related payables in accounts payable and accrued expenses	\$ 11,384	\$ 14,847
Property purchased through capital lease arrangement	\$ 15,951	\$ -
Increase in receivable from sale of property	\$ -	\$ 1,483
Decrease in land held for expansion related to property exchange transaction	\$ -	\$ 3,432
Land held for expansion placed in use	\$ 4,904	\$ -

During the year ended June 30, 2010, the Alliance refinanced previously issued debt of \$184,050.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

NOTE A--ORGANIZATION AND OPERATIONS

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The initial funds for the establishment of the Alliance in 1945 were provided by individuals and various institutions. Membership of the Alliance consists of individuals and institutions who have contributed at least \$100 to the capital fund of the Alliance and are entitled to vote at the annual election of the Board of Directors.

The primary operations of the Alliance consist of ten acute and specialty care hospitals, as follows:

- Johnson City Medical Center (JCMC) - licensed for 658 beds
- Smyth County Community Hospital (SCCH) - licensed for 279 beds
- Indian Path Medical Center (IPMC) - licensed for 261 beds
- Norton Community Hospital (NCH) - licensed for 129 beds
- Sycamore Shoals Hospital (SSH) - licensed for 121 beds
- Johnston Memorial Hospital (JMH) - licensed for 116 beds
- Franklin Woods Community Hospital (FWCH) - licensed for 80 beds
- Russell County Medical Center (RCMC) - licensed for 78 beds
- Dickenson Community Hospital (DCH) - licensed for 25 beds
- Johnson County Community Hospital (JCCH) - licensed for 2 beds

FWCH opened in July 2010, replacing operations at North Side Hospital (NSH) and Johnson City Specialty Hospital (JCSH). NSH and JCSH were licensed for 91 beds and 23 beds, respectively, prior to the opening of FWCH and a total of 64 beds were transferred within the Alliance.

The Alliance has a 50.1% interest in JMH. JMH is also the sole member of Abingdon Physician Partners (APP), a non-taxable corporation that owns and manages physician practices.

The Alliance has a 50.1% interest in NCH. NCH is also the sole member or shareholder of DCH and Norton Community Physician Services, LLC (NCPS), a taxable corporation that consists of physician practices and a pharmacy and; Community Home Care (CHC), a taxable corporation that provides home medical equipment.

The Alliance has an 80% interest in SCCH. SCCH is the sole shareholder of Southwest Community Health Services, Inc. (SWCH), a taxable entity that operates a pharmacy and provides other health services.

The activities and accounts of JMH, NCH and SCCH are included in the accompanying consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

NOTE A--ORGANIZATION AND OPERATIONS - Continued

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices and provides other healthcare services to patients in Tennessee and Virginia. BRMM also operates as a medical office real estate developer by owning, selling and leasing real estate to physician practices and other entities. BRMM is either the sole shareholder, a significant shareholder, or member of the following organizations:

Mountain States Physician Group, Inc. (MSPG): A company that contracts with physicians to provide services to BRMM physician practices.

Mountain States Properties, Inc. (MSPI): An entity that owns and manages certain real estate (primarily medical office buildings) and provides rehabilitation and fitness services. In addition, MSPI is a counter-party to various financing transactions, including interest rate swaps.

Mediserve Medical Equipment of Kingsport, Inc. (Mediserve): A company that provides durable medical equipment services.

Synergy Health Group LLC: An affiliation of member hospitals that work together to maximize cost savings opportunities through aggregated buying power.

Kingsport Ambulatory Surgery Center (KASC) (d.b.a. Kingsport Day Surgery): A joint venture operating as an outpatient surgery center which performs procedures primarily in otolaryngology, orthopedics, ophthalmology, and general surgery. BRMM has a 43% ownership of KASC at June 30, 2011 and 2010; however, BRMM maintains control over KASC through a management agreement. As such, the accounts and activities of KASC are included in the accompanying consolidated financial statements.

Piney Flats Urgent Care (PFUC): A for-profit entity that provides urgent care patient services. BRMM has a 75% ownership of PFUC. The accounts and activities of PFUC are included in the accompanying consolidated financial statements.

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc. (MSF), a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance. The Alliance is also the beneficiary of the Mountain States Health Alliance Auxiliary (Auxiliary), a not-for-profit organization formed to coordinate volunteer activities of the Alliance. The activities and accounts of MSF and the Auxiliary are included in the accompanying consolidated financial statements.

The Alliance is a majority shareholder of Integrated Solutions Health Network, LLC (ISHN). The primary function of ISHN is to establish, operate and administer a provider-sponsored health care

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE A--ORGANIZATION AND OPERATIONS - Continued

delivery network. The accounts and activities of ISHN are included in the accompanying consolidated financial statements.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation: The accompanying consolidated financial statements include the accounts of the Alliance and its subsidiaries after elimination of all significant intercompany accounts and transactions. The Alliance classifies those activities directly associated with its mission of providing healthcare services, as well as other activities deemed significant to its operations, as operating activities.

Noncontrolling Interests in Subsidiaries: Noncontrolling interests represent the portion of equity (net assets) in a subsidiary not attributable, directly or indirectly, to a parent organization. Effective July 1, 2010, the Alliance adopted Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958-810, *Consolidation*. ASC 958-810 amends the accounting for, and the financial statement presentation of, noncontrolling interests in a subsidiary within consolidated financial statements. ASC 958-810 requires that a noncontrolling interest in the net assets of a subsidiary be accounted for and reported as net assets and provides revised guidance on the treatment of income and losses attributable to the noncontrolling interest and changes in ownership interests in a subsidiary.

The Alliance adopted ASC 958-810 during 2011 and reclassified \$168,410 of noncontrolling interests from minority interest to net assets as of June 30, 2010. These amounts are reflected net of distributions and pension and other defined benefit plan adjustments within net assets in the Consolidated Balance Sheets. The Alliance attributed an Excess of Revenue, Gains and Support over Expenses and Losses of \$3,393 and \$2,303 for the years ending June 30, 2011 and 2010, respectively, to the noncontrolling interests in JMH, NCH, SCCH, KASC, PFUC and ISHN based on the noncontrolling interests' respective ownership percentage. None of the noncontrolling interests include redemption features.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

limited as to use or uninvested amounts included in investment portfolios are not included as cash and cash equivalents on the Consolidated Balance Sheets.

Investments: Investments as reported in the Consolidated Balance Sheets include trading securities, held-to-maturity securities and assets limited as to use (Note C). FASB ASC 958-320, *Investments – Debt and Equity Securities*, allows not-for-profit organizations to report in a manner similar to business entities by identifying securities as available-for-sale or held-to-maturity and to exclude the unrealized gains and losses on those securities from the Performance Indicator (as defined below). Investments which the Alliance has the positive intent and ability to hold to maturity are considered as held-to-maturity. Substantially all other investments (including assets limited as to use) are considered as trading securities. Management annually evaluates the held-to-maturity investment portfolio and recognizes any “other-than-temporary” losses as deductions from the Performance Indicator. Management’s 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, 2011.

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 pursuant to FASB ASC 825, *Financial Instruments*. Guaranteed investment contracts are reported at contract value.

Realized gains and losses on trading securities and assets limited as to use are computed using the specific identification method for cost determination. Interest and dividend income is reported net of related investment fees.

Investments in joint ventures are reported under the equity method of accounting, which approximates the Alliance’s equity in the underlying net book value, unless the ownership structure requires consolidation. Other assets include investments in joint ventures of \$2,367 and \$2,418 at June 30, 2011 and 2010, respectively.

Inventories: Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market.

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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Amortization of building and equipment held under capital lease is shown as a part of depreciation expense and accumulated depreciation in the accompanying consolidated financial statements.

Interest costs incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The amount capitalized is net of investment earnings on assets limited as to use derived from borrowings designated for capital assets. Renewals and betterments are capitalized and depreciated over their useful life, whereas costs of maintenance and repairs are expensed as incurred.

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 2011 and 2010.

Other assets include property held for resale and property held for expansion of \$4,230 and \$9,135, respectively, at June 30, 2011 and 2010. During 2011, property held for expansion totaling approximately \$4,905 was transferred to property, plant and equipment in conjunction with the construction of FWCH. Property held for resale and property held for expansion primarily represent 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 2011 and 2010.

Goodwill: Goodwill represents the difference between the acquisition cost of assets and the estimated fair value of net tangible and any separately identified intangible assets. Prior to July 1, 2010, the Alliance amortized goodwill associated with its not-for-profit subsidiaries under the straight-line method over various estimated useful lives ranging from 10 to 25 years. However, effective July 1, 2010, ASC 958-805, *Not-for-Profit Entities*, requires the not-for-profit entities within the Alliance to cease amortization of goodwill, perform a transitional impairment test and perform annual impairment testing in the future.

As a result of its transitional impairment testing as of July 1, 2010, management determined that approximately \$2,965 of goodwill associated with one of its reporting units was impaired, and such impairment has been reflected as the Cumulative Effect of a Change in Accounting Principle in the 2011 Consolidated Statement of Changes in Net Assets. Based upon this transitional testing, management does not believe any remaining goodwill acquired by its not-for-profit entities to be

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

impaired. The reporting unit for evaluation of substantially all such goodwill is the Alliance's aggregate acute-care operations.

For goodwill acquired by its for-profit subsidiaries, the Alliance does not amortize goodwill and annually performs impairment testing. Based upon this annual impairment testing, management has determined that there is no impairment related to goodwill associated with its for-profit subsidiaries.

Deferred Financing, Acquisition Costs and Other Charges: Other assets, including deferred financing, acquisition costs and other charges, total \$29,844 and \$30,819 at June 30, 2011 and 2010, respectively. Deferred financing costs are amortized over the life of the respective bond issue principally using the average bonds outstanding method. Other intangible assets include licenses and similar assets and are being amortized over the intangible's estimated useful life under the straight-line method.

Prior to 2009, the Alliance routinely financed interest rate swap and other derivative transaction issuance costs through modification of future settlement terms. As such, the unamortized issuance costs of these derivatives are included as deferred financing costs in the accompanying Consolidated Balance Sheets and are being amortized over the term of the respective derivative instrument. The unpaid issuance costs are included as a part of the estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. Beginning in 2009, interest rate swap and derivative transaction issuance costs are expensed as incurred.

Derivative Financial Instruments: As further described in Note D, the Alliance is a party to interest rate swap and other derivative agreements. 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. Changes in the estimated fair value of these derivatives are included in the Consolidated Statements of Operations as part of nonoperating gains (losses). Net settlements and other related income of derivatives are also reflected as a part of the Performance Indicator (described below).

These fair values are based on the estimated amount the Alliance would receive, or be required to pay, to enter into equivalent agreements at the valuation date. The fair value of various derivatives are netted on the Consolidated Balance Sheets based on management's evaluation of the settlement provisions in the master contract. Gross positions of these derivatives are disclosed in Note D. Due to the nature of these financial instruments, such estimates of fair value are subject to significant change in the near term.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims (Note G) 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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

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 payors. 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 payors 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, prior experience 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 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.

In addition to the charity care services described above, 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*

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

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, pension and related adjustments, and distributions to, or contributions from, owners 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. Taxable entities account for income taxes in accordance with FASB ASC 740, *Income Taxes* (Note L). The Alliance has no significant uncertain tax positions at June 30, 2011 and 2010.

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 Consolidated Statements of Changes in Net Assets as net assets released from restrictions. Permanently restricted net assets have been restricted by donors to be maintained by the Alliance in perpetuity.

Fair Value Measurement: The Alliance had previously adopted FASB ASC 820, *Fair Value Measurements and Disclosures*, which defines fair value, establishes a framework for measuring fair value under generally accepted accounting principles and expands disclosures about fair value measurements.

In January 2010, the FASB issued ASU 2010-06, *Fair Value Measurements and Disclosures (Topic 820) - Improving Disclosures about Fair Value Measurements* (ASU 2010-06). ASU 2010-06 requires new disclosures regarding significant transfers in and out of Levels 1 and 2, as well as information about activity in Level 3 fair value measurements, including presenting information about purchases, sales, issuances and settlements on a gross versus a net basis in the Level 3 activity roll forward. In addition, ASU 2010-06 clarifies existing disclosures regarding input and valuation techniques, as well as the level of disaggregation for each class of assets and liabilities. The Alliance adopted ASU 2010-06 in 2011, except for the disclosures related to purchases, sales, issuance and settlements, which will be effective for the Alliance beginning July 1, 2012. The adoption of ASU 2010-06 did not, and is not expected to, have an impact on the Alliance's consolidated financial statements.

Subsequent Events: The Alliance evaluated all events or transactions that occurred after June 30, 2011, through October 26, 2011, the date the consolidated financial statements were available to be

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

issued. During this period management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2011 consolidated financial statements, other than as discussed in Notes D, F and S.

New Accounting Pronouncements: In August 2010, the FASB issued Accounting Standards Update (ASU) 2010-23, *Health Care Entities – Measuring Charity Care for Disclosure*. ASU 2010-23 is intended to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care. ASU 2010-23 requires that cost, identified as the direct and indirect costs of providing the charity care, be used as the measurement basis for disclosure purposes. ASU 2010-23 also requires disclosure of the method used to identify or determine such costs. The Hospital will adopt ASU 2010-23 in fiscal year 2012. Management does not expect the adoption of ASU 2010-23 to have a material impact on the consolidated financial statements.

In August 2010, the FASB issued ASU 2010-24, *Health Care Entities – Presentation of Insurance Claims and Related Insurance Recoveries*. The amendments in the ASU clarify that a health care entity may not net insurance recoveries against related claim liabilities. In addition, the amount of the claim liability must be determined without consideration of insurance recoveries. ASU 2010-24 is effective for the Alliance beginning July 1, 2011 and management is currently evaluating the impact of this ASU on the consolidated financial statements.

In July 2011, the FASB issued ASU 2011-07, *Healthcare Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and Allowance for Doubtful Accounts for Certain Healthcare Entities*, which will require certain healthcare entities to reclassify the provision for bad debts associated with providing patient care from an operating expense to a deduction from net patient service revenue in the Consolidated Statements of Operations. Additionally, ASU 2011-07 requires enhanced disclosures about an entity's policies for recognizing revenue and assessing bad debts and qualitative and quantitative information about changes in the allowance for doubtful accounts. The Alliance intends to adopt ASU 2011-07 in fiscal year 2013. Management does not expect the adoption of ASU 2011-07 to have a material impact on the consolidated financial statements.

Reclassifications: Certain 2010 amounts have been reclassified to conform with the 2011 presentation in the accompanying consolidated financial statements.

NOTE C--INVESTMENTS

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2011 and 2010

NOTE C--INVESTMENTS - Continued

	<u>2011</u>	<u>2010</u>
Designated or restricted:		
Under safekeeping agreements	\$ 28,349	\$ 52,050
Under guarantee agreements	92,720	89,486
By Board for capital improvements	4	2,776
Under bond indenture agreements:		
For debt service and interest payments	67,874	78,612
For capital acquisitions	28,835	76,241
	<u>217,782</u>	<u>299,165</u>
Less: amount required to meet current obligations	(116,175)	(25,092)
	<u>\$ 101,607</u>	<u>\$ 274,073</u>

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

	<u>2011</u>	<u>2010</u>
Cash, cash equivalents and money market funds	\$ 115,579	\$ 170,897
U.S. Government securities	1,795	1,795
U.S. Agency securities	7,688	12,319
Guaranteed investment contracts	92,720	114,154
	<u>\$ 217,782</u>	<u>\$ 299,165</u>

Trading securities consist of the following at June 30:

	<u>2011</u>	<u>2010</u>
Cash, cash equivalents and money market funds	\$ 29,159	\$ 4,799
U.S. Government securities	9,409	3,137
U.S. Agency securities	31,551	13,760
Corporate and foreign bonds	126,543	11,688
Municipal obligations	451	1,461
Preferred and asset backed securities	8,945	7,023
U.S. equity securities	94,834	139,168
Other	32,718	28,608
	<u>\$ 333,610</u>	<u>\$ 209,644</u>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

NOTE C--INVESTMENTS - Continued

Held-to-Maturity securities are carried at amortized cost and consist of the following at June 30:

	<u>2011</u>		<u>2010</u>
Cash, cash equivalents and money market funds	\$ 753	\$	1,131
Corporate and foreign bonds	135,745		103,968
Municipal obligations	9,661		1,315
	<u>\$ 146,159</u>	\$	<u>106,414</u>

Held-to-maturity securities had gross unrealized gains and losses of \$6,838 and \$276, respectively, at June 30, 2011 and \$5,525 and \$607, respectively at June 30, 2010. At June 30, 2011, the Alliance held nine securities within the held-to-maturity portfolio with a fair value and unrealized loss of \$549 and \$44, respectively, which had been at an unrealized loss position for over one year. At June 30, 2010, the Alliance held one security within the held-to-maturity portfolio with a fair value and unrealized loss of \$591 and \$166, respectively, which had been at an unrealized loss position for over one year. At June 30, 2011, the contractual maturities of held-to-maturity securities were \$13,816 due in one year or less, \$55,563 due from one to five years and \$76,780 due after five years. At June 30, 2010, the contractual maturities of held-to-maturity securities were \$13,389 due in one year or less, \$48,447 due from one to five years and \$44,578 due after five years.

At June 30, 2011 and 2010, the Alliance held investments in certain limited partnerships and hedge funds of \$32,718 and \$28,608, respectively, that have a wide range of investment strategies with various levels of risk. These funds are included within trading securities and do not have readily determinable fair values. The funds are reported at estimated fair market value pursuant to FASB ASC 825, *Financial Instruments*.

The Alliance has investments in several joint ventures and corporations which are accounted for under the equity method of accounting.

As a part of the acquisition of membership interests in JMH, SCCH and NCH, the Alliance has committed to invest \$132,000, \$48,100, and \$45,000, respectively. Cumulative amounts expended at June 30, 2011 under these commitments are approximately \$150,184.

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is a party to a number of derivative transactions. These derivatives have not been designated as hedges and are valued at estimated fair value in the accompanying Consolidated Balance Sheets. Management's primary objective in holding such derivatives is to introduce a variable rate component into its fixed rate debt structure. Under the terms of these agreements, changes in the interest rate environment could have a significant effect on the Alliance.

MOUNTAIN STATES HEALTH ALLIANCE

*Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE D--DERIVATIVE TRANSACTIONS - Continued

These derivative agreements require that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. Such investments are included as assets limited as to use. As of June 30, 2011, management believes the Alliance was fully collateralized with respect to the derivative agreements and management does not believe such collateral is exposed to third-party credit risk. Further, certain of the agreements contain requirements regarding maintenance of financial and liquidity ratios. Management has represented the Alliance is in compliance with all such covenants at June 30, 2011.

Interest Rate Swaps: The Alliance is a party to six interest rate swap agreements with Merrill Lynch as the counterparty. The terms of five of these agreements were modified without settlement during 2011 and no gain or loss was realized. However, such modifications did impact the estimated fair value of these interest rate swaps. A liability, representing the estimated net fair value of these swaps, of \$8,123 and \$33,910 was recognized by the Alliance as of June 30, 2011 and 2010, respectively.

The following is a summary of five of these interest rate swap agreements at June 30, 2011:

<i>Swap</i>	<i>Notional Amount</i>	<i>Term</i>	<i>Payments by:</i>		<i>Estimated Fair Value</i>
			<i>Counterparty</i>	<i>Alliance</i>	
A	\$ 170,000	4/2008-4/2026	1.265% through April 2013; 1.07% through April 2014; then 71.10% of USD-ISDA Swap Rate	0.00% through April 2014, then USD-SIFMA Municipal Swap Index	\$ 3,028
B	95,000	4/2008-4/2026	1.265% through April 2013; 1.08% through April 2014; then 71.18% of USD-ISDA Swap Rate	0.00% through April 2014, then USD-SIFMA Municipal Swap Index	1,729
C	173,030	4/2008-4/2034	1.315% through April 2013; 1.12% through April 2014; then 72.35% of USD-ISDA Swap Rate	0.00% through April 2014, then USD-SIFMA Municipal Swap Index	741
D	82,055	12/2007-7/2033	¹⁾ 3.493% through July 2012; then 0% ²⁾ USD-LIBOR-BBA through July 2012, then 67% USD- LIBOR-BBA	¹⁾ 4.41% through July 2012; then .312% ²⁾ USD-SIFMA	(9,363)
E	50,000	2/2008-7/2038	67.00% of USD-LIBOR-BBA plus .145%	USD-SIFMA	(3,918)

Deferred financing and acquisition costs, net of amortization, include \$6,480 and \$6,823 at June 30, 2011 and 2010, respectively, related to these swaps.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

NOTE D--DERIVATIVE TRANSACTIONS - Continued

In addition to the swaps described above, the Alliance and Merrill Lynch are also parties to a total return swap in the notional amount of \$23,100 which has an estimated fair value of \$(340) and \$(252) at June 30, 2011 and 2010, respectively. The agreement consists of the following:

- An agreement that requires the Alliance to pay a variable rate of USD-SIFMA Municipal Swap Index through July 1, 2012 (or termination of the swap) on a notional amount equal to the outstanding 2001A Hospital Revenue and Improvement Bonds (the 2001A Reference Bonds). The Alliance receives a fixed rate of 6.25% of the outstanding 2001A Reference Bonds.
- A “total return provision” under which the Alliance will pay (or receive) an amount equal to the product of the outstanding 2001A Reference Bonds multiplied by the difference between the outstanding 2001A Reference Bonds and the 2001A Reference Bonds’ market price at termination, as defined in the agreement. In the event the swap does not terminate prior to July 1, 2012, there would be no settlement of this component as there would be no outstanding 2001A Reference Bonds.

The Alliance is also party to a total return swap with Lehman Brothers as the counterparty. Lehman Brothers filed for bankruptcy in September 2008. The Alliance subsequently received notification from Lehman Brothers Special Financing, Inc. indicating the intent of the counterparty to terminate this agreement effective January 1, 2009. The Alliance and Lehman Brothers Special Financing, Inc. have been unable to reach a settlement agreement. In September 2010, the Alliance was issued a subpoena to furnish certain documentation related to the transaction. A protocol has been put into place by the bankruptcy court whereby the parties are to undergo alternate dispute resolution, including non-binding arbitration, which management anticipates will occur in 2012.

The fair value of these swaps is undeterminable at January 1, 2009, as prior to the termination date Lehman Brothers liquidated the underlying referenced securities, making a valuation not commercially viable. An estimated liability of \$10,565 and \$10,740 was recognized by the Alliance as of June 30, 2011 and 2010, respectively. Management believes that the liability as recorded at June 30, 2011 is sufficient to cover any exposure arising from litigation in this matter. However, it is reasonably possible management’s estimate may change in the near term, although the amount of any change cannot be estimated. Due to the termination of this agreement, the estimated liability is included as a current liability in the accompanying Consolidated Balance Sheets.

A third party holds collateral with a fair market value of approximately \$13,381 and \$13,570, respectively, at June 30, 2011 and 2010, with respect to these Lehman derivative agreements. Such collateral is included as current assets limited as to use.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE D--DERIVATIVE TRANSACTIONS - Continued

The arrangement consists of nine agreements each with three separate components (described below) with notional values of \$23,600, \$8,000, and \$8,750 each. The swaps generally consist of the following:

- An arrangement that calls for the Alliance to pay a variable rate (SIFMA Municipal Swap Index) plus certain fixed payment amounts and receive a payment equal to the interest paid by the Alliance on a portion of its early extinguished, but still outstanding, 2000A and 2000B Hospital Mortgage Revenue Refunding Bonds (the Reference Bonds) (whose fixed rates range from 7.50% to 7.75%).
- An arrangement that requires the Alliance to pay a fixed rate of 4.211% through either July 1, 2025, 2029 or 2033 (or termination of the swap) on the outstanding Reference Bonds and receive a variable rate of 67% of USD-LIBOR-BBA on the outstanding Reference Bonds; and
- A “total return provision” under which the Alliance will pay (or receive) the difference between the outstanding Reference Bonds, multiplied by 132%, less the fair value of the Reference Bonds on the date of termination and any fixed interest payments made under the arrangements described above. In the event the swaps do not terminate prior to their stated termination dates (2025, 2029 or 2033), there would be no settlement of this component as there would be no outstanding Reference Bonds.

The swap also contains an agreement that consists of two separate components:

- An arrangement that requires the Alliance to pay a fixed rate of 2.98% through July 1, 2016 (or termination of the swap) on the outstanding, but previously defeased, 1991 Hospital Revenue and Improvement Bonds (the 1991 Reference Bonds) and receive a variable rate of 67% of USD-LIBOR-BBA on the outstanding 1991 Reference Bonds; and
- A “fixed payor provision” under which the Alliance will pay (or receive) the difference between the outstanding 1991 Reference Bonds multiplied by 100% and any fixed interest payments made as required under the agreement minus the outstanding 1991 Reference Bonds multiplied by the average market price at termination. In the event the swaps do not terminate prior to their stated termination date (2016), there would be no settlement of this component as there would be no outstanding 1991 Reference Bonds.

Interest Rate Swap Option: In June 2004, the Alliance entered into an agreement with Bear Stearns (acquired by JP Morgan) whereby Bear Stearns has purchased from the Alliance an option to enter

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE D--DERIVATIVE TRANSACTIONS - Continued

into an interest rate swap agreement (swaption) with the Alliance on July 1, 2011, which is an optional redemption date related to the Alliance's early extinguished 2000A and 2000B Bonds (Note F). The purpose of this agreement was to effectively sell the call features related to the early extinguished Series 2000A and 2000B Bonds. As consideration under this agreement, the Alliance received a total of \$42,500 in upfront payments as the swaption premium. Such amounts were initially recorded as estimated fair value of derivatives in the Consolidated Balance Sheets. Beginning 30 calendar days prior to July 1, 2011 and terminating 30 calendar days prior to July 1, 2015, the counterparty has the periodic right to exercise the swaption.

The underlying interest rate swap transactions to which the swaption transaction relates have the following terms:

<i>Swap</i>	<i>Notional Amount</i>	<i>Term</i>	<i>Payments by:</i>	
			<i>Counterparty</i>	<i>Alliance</i>
2000A	Ranging from \$148,170 through July 1, 2018 to \$23,000 through July 2033	30 days following the exercise date through July 2033	64% of USD-LIBOR-BBA	Fixed amounts ranging from 7.13% upon execution to 7.50% through July 2033, based on notional amount
2000B	Ranging from \$76,240 through July 1, 2021 to \$8,800 through July 2033	30 days following the exercise date through July 2033	64% of USD-LIBOR-BBA	Fixed amounts ranging from 7.54% upon execution to 8.00% through July 2033, based on notional amount

The Alliance retained the right to terminate the swaption at any time prior to May 17, 2011 at its fair market value. A liability of \$92,044 and \$89,650, representing the estimated fair value of the swaption at June 30, 2011 and 2010, respectively, is included in estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. As a derivative financial instrument, this swaption is extremely sensitive to changes in long-term interest rates and other elements in the financial marketplace. As such, estimates of fair value are subject to significant changes in the near term.

Deferred financing and acquisition costs include \$0 and \$434 at June 30, 2011 and 2010, respectively, related to the costs of this transaction. The change in estimated fair value of derivatives in the accompanying Statements of Operations for 2011 and 2010 includes an unrealized loss of \$2,394 and \$11,628, respectively, related to this derivative.

The interest rate swap option, described above, was terminated on October 13, 2011. To effectuate this termination, the Alliance transferred a portion of a Guaranteed Investment Contract (GIC), described below, to the third party as a termination payment. A gain of approximately \$3,000 was recognized on this termination.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE D--DERIVATIVE TRANSACTIONS - Continued

Forward Sale Agreements: In June 2004, the Alliance entered into two related forward sale agreements with the counterparty to the swaption agreements and the Master Trustee of the Series 2000 Bonds. The forward sale agreements originally related to the Debt Service Reserve Fund and to the Debt Service Fund, respectively, (collectively, the "Funds"), as established under provisions of the Master Trust Indenture related to the issuance of the Series 2000 Bonds. In consideration of the future earnings on the Funds, the counterparty paid the Master Trustee a total of \$30,000 during 2005, to be held on behalf of the Alliance. In June 2006, one of these agreements was amended to also relate to the Series 2000C, 2000D, 2006A and 2006B Bonds, and to remove the Series 2000A Bonds from consideration under the agreement. As the original intent of these Funds was to secure debt service payments under the above referenced Bonds, the agreement requires these funds to be held under a guaranty agreement as further described below.

In connection with the issuance of the Series 2007 Bonds and the derecognition of a portion of the Series 2000A Bonds, all of the outstanding Series 2000B Bonds, and all of the outstanding 2006B Bonds (Note F), one of these agreements as it relates to the Series 2000A and 2000B Bonds was partially terminated. As such, during 2008 the Alliance reduced its liability with respect to the portion related to the Series 2000A and 2000B Bonds, and paid the counterparty \$6,186 under the terms of the agreement. The agreement was amended in fiscal year 2011 to include the Series 2010A Bonds and to remove the Series 2000B and 2006B Bonds.

A liability of \$19,001 and \$19,864 representing the unamortized payments from the counterparty is included as part of deferred revenue in the accompanying Consolidated Balance Sheets as of June 30, 2011 and 2010, respectively. Amounts are being recognized as investment income over the life of the agreements.

Pursuant to these agreements, the counterparty required that the Alliance's obligations under the swaption and forward sale agreements be collateralized under a guarantee agreement in favor of the counterparty. Due to various requirements of the Master Trust Indenture, the Alliance transferred to MSF a total of \$42,500 that was in turn deposited with the counterparty as collateral in a GIC. Amounts received under the forward sale agreements were also deposited into the GIC. All GIC deposits earn interest compounded at 4.14% for the first year, and at 3.5% thereafter through July 1, 2011. The GIC deposits as of June 30, 2011 and 2010 totaled \$92,720 and \$89,486, respectively. The GIC was substantially utilized on October 13, 2011 to terminate the interest rate swap option agreement discussed above and, as such, is included in the current portion of assets whose use is limited in the Consolidated Balance Sheet at June 30, 2011.

NOTE E--PROPERTY, PLANT AND EQUIPMENT

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2011 and 2010

NOTE E--PROPERTY, PLANT AND EQUIPMENT - Continued

	<i>2011</i>	<i>2010</i>
Land	\$ 63,749	\$ 58,037
Buildings and leasehold improvements	454,852	407,104
Property and improvements held for leasing	80,568	84,421
Equipment	532,767	479,523
Buildings and equipment held under capital lease	42,720	22,679
	<u>1,174,656</u>	<u>1,051,764</u>
Less: Allowances for depreciation and amortization	(586,471)	(569,913)
	588,185	481,851
Construction in progress (Note N)	209,233	213,747
	<u>\$ 797,418</u>	<u>\$ 695,598</u>

Accumulated depreciation and amortization on property and improvements held for leasing purposes is \$23,348 and \$21,543 at June 30, 2011 and 2010, respectively. Net interest capitalized was \$10,640 and \$11,117 for the years ended June 30, 2011 and 2010, respectively.

The Alliance is constructing replacement facilities for SCCH and JMH and is also performing various renovations on existing hospital facilities. During 2011 and 2010, management of the Alliance assessed the planned current and future use of the existing NSH, SCCH and JMH facilities as well as certain other facilities, and adjusted their estimated useful lives accordingly.

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

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

<i>Description</i>	<i>Maturities</i>	<i>Rates</i>	<i>Outstanding Balance</i>	
			<i>2011</i>	<i>2010</i>
2010A Hospital Revenue Bonds, net of unamortized premium of \$1,056 and \$1,096 at June 30, 2011 and 2010, respectively	\$38,660 uninsured serially, through 2020 \$14,985 unsecured term bonds, due July 1, 2025 \$19,385 unsecured term bonds, due July 1, 2030	3.00% to 5.00% 5.38% 5.63%	\$ 169,137	\$ 169,176
	\$39,570 unsecured term bonds, due July 1, 2038 \$55,480 unsecured term bonds, due July 1, 2038	6.50% 6.00%		
2010B Hospital Revenue Bonds, net of unamortized premium of \$711 and \$753 at June 30, 2011 and 2010, respectively	\$27,330 unsecured serially, through 2020 \$4,355 unsecured term bonds, due July 1, 2023 \$4,250 unsecured term bonds, due July 1, 2028	2.50% to 5.00% 5.00% 5.50%	36,646	36,688
2009A Hospital Revenue Bonds, net of unamortized discount of \$121 and \$126 at June 30, 2011 and 2010, respectively	\$725 unsecured term bonds, due July 1, 2019 \$1,730 unsecured term bonds, due July 1, 2029 \$3,105 unsecured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	5,439	5,434

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

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

Description	Maturities	Rates	Outstanding Balance	
			2011	2010
2009B Hospital Revenue Bonds	\$5,535 unsecured term bonds, due July 1, 2038	8.00%	5,535	5,535
2009C Hospital Revenue Bonds, net of unamortized discount of \$2,421 and \$2,508 at June 30, 2011 and 2010, respectively	\$21,100 unsecured term bonds, due July 1, 2019 \$20,000 unsecured term bonds, due July 1, 2029 \$74,855 unsecured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	113,534	113,447
2008A Hospital Revenue Bonds	\$13,245 unsecured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.07% at June 30, 2011	13,245	13,245
2008B Hospital Revenue Bonds	\$53,855 unsecured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.07% at June 30, 2011	53,855	54,050
2007A Hospital Revenue Bonds	Unsecured term bonds, due July 1, 2038, redeemed in 2011	NA	-	4,305
2007B Taxable Hospital Revenue Bonds, bifurcated into sub-series B-1, B-2 and B-3 during 2011	\$307,900 unsecured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 0.11% to 0.16% at June 30, 2011	307,900	314,190
2007C Hospital Revenue Bonds	Unsecured term bonds, due July 1, 2032, redeemed in 2011	NA	-	1,900
2006A Hospital First Mortgage Revenue Bonds, net of unamortized premium of \$147 and \$153 at June 30, 2011 and 2010, respectively	\$6,580 unsecured serially, through 2019 \$7,375 unsecured term bonds, due July 1, 2026 \$20,505 unsecured term bonds, due July 1, 2031 \$135,175 unsecured term bonds, due July 1, 2036	5.00% 5.25% 5.50% 5.50%	169,782	170,473
2001A Hospital First Mortgage Revenue Bonds	\$23,100 term bonds, due July 1, 2026, subject to early redemption or tender	6.85%	23,100	23,900
2001 Hospital Refunding and Improvement Revenue Bonds (NCH), net of unamortized discount of \$34 and \$38 at June 30, 2011 and 2010, respectively	\$1,465 insured term bonds, due December 1, 2012 \$1,635 insured term bonds, due December 1, 2014 \$8,815 insured term bonds, due December 1, 2022	5.75% 6.00% 6.00%	11,876	12,547
2000A Hospital First Mortgage Revenue Refunding Bonds	\$30,358 insured Capital Appreciation Bonds, interest and principal due July 1, 2026 through 2030	6.63%	30,358	28,417
2000C Hospital First Mortgage Revenue Bonds	\$34,325 insured term bonds, due July 1, 2026	8.50%	34,325	35,335
2000D First Mortgage Taxable Bonds	\$14,790 insured term bonds, due July 1, 2026	8.50%	14,790	15,225
1998 Hospital Refunding and Improvement Revenue Bonds (JMH)	\$6,495 unsecured term bonds, due July 1, 2016 \$7,620 unsecured term bonds, due July 1, 2028	5.25% 5.38%	14,115	15,240
Capitalized lease obligations secured by buildings and equipment	Maturing through 2027	3.18% to 13.01%	16,153	16,715
\$7,500 promissory note secured by assets of Mediserve Medical Equipment of Kingsport, Inc.	Monthly principal and interest payments of \$56 beginning February 2007 maturing December 2011; remaining principal due January 2012	LIBOR + 1.10%	5,473	6,064
Capitalized lease obligations secured by equipment	Various monthly payments of monthly principal and interest	Various	587	1,325
Master installment payment agreement	Paid-off in 2011	Unspecified	-	2,194
\$1,409 unsecured promissory note	Monthly principal and interest payments of \$23 beginning July 2008 through September 2013; remaining principal and accrued interest due October 2014; note was paid-off in 2011	LIBOR + 1.25%	-	920
\$10,221 note payable secured by property	Various annual principal and interest payments through April 2013; note was paid-off in 2011	6.25%	-	7,836
\$1,065 note payable secured by land	Monthly interest-only payments through October 2011; remaining principal and accrued interest due November 2011	5.50%	572	1,065
\$6,332 promissory note secured by substantially all assets of the Alliance	Monthly principal payments of \$35 plus accrued interest beginning July 2010 maturing June 2015; remaining principal due July 2015	LIBOR + 2.00%	5,945	6,332
\$3,955 note payable secured by property	Monthly principal and interest payments of \$27 beginning July 2010 maturing May 2015; remaining principal due June 2015	3.00%	3,743	3,955

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

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

Description	Maturities	Rates	Outstanding Balance	
			2011	2010
Note payable under Master Financing Agreement, secured by Equipment	Monthly principal and interest payments of \$166 beginning July 2010 maturing June 2017	4.62%	10,431	11,900
Note payable under Master Financing Agreement, secured by Equipment	Monthly principal and interest payments of \$56 beginning July 2010 maturing June 2017	3.75%	3,580	4,100
\$4,926 convertible construction loan secured by property and assigned rents	Monthly interest-only payments through January 2011 followed by monthly principal and interest payments of \$25 maturing December 2014; remaining principal and accrued interest due January 2015; note was paid-off in 2011	Prime (stated minimum and maximum interest rates of 3.75% and 6.75%, respectively)	-	1,195
\$1,885 line of credit secured by property	Monthly interest-only payments through March 2011 followed by monthly principal and interest payments of \$9 maturing February 2015; remaining principal and accrued interest due March 2015	Prime - 0.50% (stated minimum and maximum interest rates of 3.50% and 6.25%, respectively)	1,873	265
\$1,593 note payable, secured by equipment	Various annual principal payments through July 2014	Unspecified	1,593	-
Capitalized lease obligation secured by medical office building (JMH)	Maturing through 2026	9.72%	15,498	-
			1,069,085	1,082,973
	Less current portion		(28,162)	(28,131)
			<u>\$ 1,040,923</u>	<u>\$ 1,054,842</u>

In September 2010, in order to reduce credit risk and expenses, the Alliance replaced the existing letters of credit related to the Series 2007B, Series 2008A and Series 2008B Bonds with letters of credit held by several different financial institutions. The substitute letters of credit entitle the Master Trustee to draw amounts equal to the principal amounts of the respective series of Bonds outstanding and up to 37 days interest at a rate of 12%. The substitute letters of credit expire on September 29, 2013 unless renewed or replaced.

Series 2010 Bonds: In April 2010, the Alliance issued \$168,080 (Series 2010A) and \$35,935 Series 2010B fixed rate Hospital Refunding Revenue Bonds (collectively, the Series 2010 Bonds). Proceeds of the Series 2010A and the Series 2010B Bonds were used to refinance outstanding indebtedness, specifically related to the Alliance's facilities in Tennessee and in Virginia, respectively, fund debt service reserve funds and pay costs of issuance. The Alliance recognized a \$3,029 loss on early extinguishment of debt representing the write off of previously deferred and unamortized financing costs related to the refinanced Series 2008A and the Series 2007A and 2007C debt issues discussed below.

Series 2009 Bonds

In March 2009, the Alliance issued \$5,560 (Series 2009A), \$5,535 (Series 2009B) and \$115,955 (Series 2009C) fixed rate Hospital Revenue Bonds (collectively, the Series 2009 Bonds). The proceeds of Series 2009 Bonds were used to refinance a portion of the outstanding Series 2006C Taxable Notes, which were originally issued to finance a capital commitment to SCCH and purchase certain leased assets, finance the acquisition of a majority ownership in JMH, fund a debt service

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

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

reserve fund and pay costs of issuance. The portion of the 2006C taxable notes which were not refinanced with the Series 2009 Bonds were repaid with cash on hand.

In connection with its acquisition of a majority ownership in JMH, the Alliance assumed the then outstanding long-term debt of JMH, totaling \$33,906, including the JMH Series 1998 Hospital Refunding and Improvement Revenue Bonds as further described in the table above.

Series 2008 Bonds

In February 2008, the Alliance issued \$72,770 (Series 2008A) and \$54,230 (Series 2008B) variable rate Hospital Revenue Bonds (collectively, the Series 2008 Bonds). The proceeds of Series 2008 Bonds were primarily used to finance certain future capital projects for the Alliance's hospital facilities and for the repayment of previously issued 2008 Taxable Notes used for the acquisition of RCMC. As discussed above, the payment of principal and interest on the Series 2008 Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit. A portion (\$59,525) of the Series 2008A Bonds were repaid from proceeds of the Series 2010 Bonds.

The variable rate of interest on the Series 2008 Bonds is determined weekly by the Remarketing Agent (Merrill Lynch), as the rate equal to the lowest rate which, in regard to general financial conditions and other special conditions bearing on the rate, would produce as nearly as possible a par bid for the Series 2008 Bonds in the secondary market. In no event shall the variable rate on the Series 2008 Bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the State of Tennessee for the Series 2008A Bonds or the Commonwealth of Virginia for the Series 2008B Bonds. The Alliance has the option, upon written approval of the holder of the letters of credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate.

The Series 2008 Bonds are subject to optional and mandatory tender for purchase prior to maturity at the option of the holder, upon conversion to a fixed rate, upon conversion to a medium-term rate period, prior to the effective date of any substitute letter of credit, or upon the termination of the letters of credit. The optional and mandatory tender provisions generally call for the Master Trustee to purchase the outstanding Series 2008 Bonds at a purchase price equal to the principal amount thereof plus accrued interest upon a stated date as described in the tender notice delivered to the bond holders.

Series 2007 Bonds

In December 2007, the Alliance issued \$104,355 (Series 2007A), \$327,170 (Series 2007B taxable) and \$36,575 (Series 2007C) variable rate Hospital Revenue Bonds (collectively, the Series 2007 Bonds). The proceeds of Series 2007 Bonds were primarily used to early extinguish a portion of the

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

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

outstanding Series 2000A Bonds, all of the outstanding 2000B Bonds, all of the outstanding Series 1994 Bonds, and all of the outstanding Series 2006B Bonds; to finance the acquisition of a majority ownership in NCH, and to finance certain capital improvements and equipment acquisitions for the Alliance's hospital facilities. A portion of the outstanding Series 2007A (\$91,685) and Series 2007C (\$32,840) Bonds were repaid from proceeds of the Series 2010 Bonds. The remaining outstanding Series 2007A and Series 2007C Bonds were redeemed in 2011.

In 2011 during the letter of credit restructuring, the existing 2007B Bonds were repaid through a remarketing of Sub-Series 2007B-1, 2007B-2 and 2007B-3 (collectively, the Sub-Series 2007B Bonds), created per the mandatory tender and letter of credit substitution provisions. As discussed above, the payment of principal and interest on the Sub-Series 2007B Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit.

The variable rate of interest on the Series 2007 Bonds is determined weekly in the same manner as described above for the Series 2008 Bonds. In no event shall the variable rate on the bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the State of Tennessee. The Alliance has the option, upon written approval of the holder of the letters of credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate. Upon such conversion, the bonds become subject to mandatory tender for purchase.

The Sub-Series 2007 Bonds are subject to optional and mandatory tender in the same manner as described above for the Series 2008 Bonds. In addition, the Sub-Series 2007B Bonds are subject to a special mandatory tender with respect to its conversion from taxable debt to tax-exempt debt. As discussed in Note S, certain of the Sub-Series 2007B Bonds were redeemed subsequent to year end.

Series 2006 Bonds

During 2006, the Alliance issued \$173,030 Hospital First Mortgage Revenue Bonds (Series 2006A) and \$66,500 Hospital First Mortgage Variable Rate Revenue Bonds (Series 2006B). The proceeds from the sale of the Series 2006A Bonds were used to finance certain future and prior capital projects for the Alliance's hospital facilities and to refund certain existing indebtedness, specifically the Series 2001B Bonds (discussed below) and certain existing short and intermediate term loans and leases, as well as fund a debt service reserve fund. The Series 2006B Bond proceeds were substantially used to refund the remaining outstanding principal of the Series 2001B Bonds and establish a debt service reserve fund.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

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

Series 2001 Bonds

During 2001, the Alliance issued \$26,000 Hospital First Mortgage Revenue Bonds (Series 2001A) and \$60,175 Hospital First Mortgage Revenue Bonds (Series 2001B). The Series 2001A Bonds were subject to optional tender by Bond holders. Effective July 1, 2007, the Alliance entered into an agreement whereby the beneficial owners of the Series 2001A Bonds have irrevocably waived their rights to tender the Bonds under the provisions of the respective Bond Indenture. The waiver will continue in effect through the maturity of the 2001A Bonds. The Series 2001B Bonds were refunded and redeemed in 2006.

Series 2000 Bonds

The Hospital First Mortgage Revenue Refunding (Series 2000A Bonds) and First Mortgage Revenue Refunding Bonds (Series 2000B Bonds), were used to advance refund previously existing indebtedness as well as fund a required debt service reserve fund. The Hospital First Mortgage Revenue Bonds (Series 2000C Taxable Bonds) were intended to refinance certain mortgage indebtedness of BRMM, and to refund other previously existing indebtedness. The proceeds from the sale of the First Mortgage Bonds (Series 2000D Taxable Bonds) were used primarily to fund working capital for the Alliance.

The Series 2000A Bonds included at issue date \$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.

The advance refunding of previously issued debt requires funds to be placed in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments. 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, and the debt and escrowed securities are not considered liabilities or assets of the Alliance. Therefore, such debt has been derecognized.

Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2011 due to previous advance refundings of the Series 2000A Bonds, Series 2000B Bonds, Series 1998C Bonds, and Series 1991 Bonds, totaled approximately \$525,025.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

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

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.

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.

Other Bonds, Notes Payable and Financing Arrangements

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 NCH Series 2001 Hospital Refunding and Improvement Revenue Bonds are secured by revenues and a lien on certain real and personal property of NCH. The JMH Series 1998 Hospital Refunding and Improvement Revenue Bonds are secured by pledged gross receipts of JMH, as defined in the Master Trust indenture.

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, 2011 are as follows:

<i>Year Ending</i> <i>June 30,</i>		
2012	\$	28,162
2013		32,230
2014		28,706
2015		34,504
2016		33,585
Thereafter		912,560
		<hr/> 1,069,747
	Net discount	(662)
		<hr/> <hr/> \$ 1,069,085

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

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

The Alliance, NCH 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, NCH and JMH are in compliance with all such covenants at June 30, 2011.

In connection with the tax-exempt bonds, the Alliance is required every five years, and at maturity, to remit to the Internal Revenue Service amounts which are due related to positive arbitrage on the borrowed funds. The Alliance performs such computations when required and recognizes any liability at that time. Management does not believe there are any significant arbitrage liabilities at June 30, 2011 or 2010.

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 and \$1,000 annual aggregate retention. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

At June 30, 2011, 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, 2011 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Alliance 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, 2011 and 2010 was \$13,531 and \$12,601, respectively. The discount rate utilized was 5% at June 30, 2011 and 2010.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE G--SELF-INSURANCE PROGRAMS - Continued

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, including a catastrophic claims reserve based on historical claims in excess of \$75.

NOTE H--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates to net patient service revenue as presented in the accompanying Consolidated Statements of Operations is as follows for the years ended June 30:

	<u>2011</u>	<u>2010</u>
Inpatient service charges	\$ 1,983,340	\$ 1,848,590
Outpatient service charges	1,807,247	1,669,705
Gross patient service charges	3,790,587	3,518,295
Less:		
Estimated contractual adjustments and other discounts	2,647,514	2,417,082
Estimated uncollectible self-pay	110,387	111,565
Charity care	72,432	61,378
	<u>2,830,333</u>	<u>2,590,025</u>
Net patient service revenue	<u>\$ 960,254</u>	<u>\$ 928,270</u>

NOTE I--THIRD-PARTY REIMBURSEMENT

The Alliance renders services to patients under contractual arrangements with Medicare, Medicaid, TennCare, Blue Cross and various other commercial payors. 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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE I--THIRD-PARTY REIMBURSEMENT - Continued

also receives additional supplemental payments from the State of Tennessee. The amount recognized totaled \$11,480 and \$7,811 for the years ended June 30, 2011 and 2010, respectively. Such payments are not guaranteed in future periods.

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 based on Medicare cost reimbursement principles and settled through the filing of an annual Medicaid cost report.

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. 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. 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 2012, although the amount of any change cannot be estimated. The impact of final settlements of cost reports or changes in estimates decreased net patient service revenue by \$4,570 in 2011. The impact of final settlements of cost reports or changes in estimates were not significant in 2010.

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, 2011.

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 retirement plan (the Plan) which covers substantially all employees. The Plan is a defined contribution plan which consists mainly of employer-funded contributions. During

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE J--EMPLOYEE BENEFIT PLANS - Continued

2011 and 2010, the Alliance made contributions to the Plan under a stratified system, whereby the Alliance's contribution percentage is based on each employee's years of service. In addition, the Alliance sponsors a 403(b) plan which is funded solely by employees' contributions. The Alliance does not make any discretionary or matching contributions into the 403(b) plan. 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, 2011 and 2010 was \$12,682 and \$13,311, respectively.

NCH maintains a defined benefit pension plan and a post-retirement employee benefit plan. The accrued unfunded pension liability was \$1,313 and \$1,942, and the accrued unfunded post-retirement liability was \$3,761 and \$3,843 at June 30, 2011 and 2010, 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 date, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed \$929 and \$1,303 to the plan during 2011 and 2010, respectively. Other assets at June 30, 2011 and 2010 include \$7,888 and \$7,077, 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. The benefits for substantially all employees previously participating in the SEBP plan have been transferred into the 457(f) plan.

NOTE K--CONCENTRATIONS OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia which is considered a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. Net patient service revenue from Washington County, Tennessee operations were approximately 54% of total net patient service revenue for each of the years 2011 and 2010.

The mix of receivables from patients and third-party payors based on charges at established rates is as follows as of June 30:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE K--CONCENTRATIONS OF RISK - Continued

	<i>2011</i>	<i>2010</i>
Medicare	40%	42%
TennCare/Medicaid	12%	15%
Commercial	27%	25%
Other third-party payors	9%	10%
Patients	12%	8%
	<u>100%</u>	<u>100%</u>

Approximately 98% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2011 and 2010. Admitting physicians are primarily practitioners in the regional area.

Two of the Alliance's Virginia hospitals' employees are covered under collective bargaining agreements which extend through February 2, 2014.

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 and notes, 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. At June 30, 2011, the Alliance also had deposits in financial institutions significantly in excess of the Federal Deposit Insurance Corporation's limits.

NOTE L--INCOME TAXES

BRMM and its subsidiaries file a consolidated federal tax return and separate state tax returns. As of June 30, 2011 and 2010, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of \$34,822 and \$32,447, respectively, related to operating losses which expire through 2030. At June 30, 2011 and 2010, BRMM had state net operating loss carryforwards of \$65,979 and \$59,860, respectively, which expire through 2025. 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.

At June 30, 2011 and 2010, SWCH had federal and state net operating loss carryforwards of \$4,875 and \$4,376, respectively, which expire through 2030. CHC files separate federal and state tax returns. At June 30, 2011 and 2010, CHC had a net deferred tax liability of \$69 and \$58, respectively, due primarily to temporary timing differences related to depreciation. The net operating loss carryforwards may be off-set against future taxable income to the extent permitted by the Internal Revenue Code and tax codes of the Commonwealth of Virginia.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE L--INCOME TAXES - Continued

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--RELATED PARTY TRANSACTIONS

The Alliance enters into transactions with entities affiliated with certain members of the Board of Directors including transactions to construct Alliance facilities and provide professional services to the Alliance. Board members refrain from discussion and abstain from voting on transactions with entities with which they are related.

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES

Construction in Progress: Construction in progress at June 30, 2011 represents costs incurred related to various hospital and medical office building facility renovations and additions. 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 approximately \$98,721 at June 30, 2011. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

Physician Contracts: BRMM employs physicians to provide services to BRMM's physician practices through employment agreements which provide annual compensation, plus incentives based upon specified productivity levels. These contracts have various terms.

In addition, the Alliance has entered into contractual relationships with non-employed physicians to provide services in Upper East Tennessee and Southwest Virginia. These contracts guarantee certain base payments and allowable expenses and have terms of varying lengths. Upon completion of the respective guarantee period, amounts drawn and outstanding under each agreement are treated as a loan bearing interest at various rates and are subject to repayment over a specified period. The physician note may also be amortized by virtue of the physician's continued practice in the specified community during the repayment period. A net receivable of \$1,407 and \$1,818 related to these agreements is included in the accompanying Consolidated Balance Sheets at June 30, 2011 and 2010, respectively.

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 degree. 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 June 30, 2011 and 2010 includes \$7,250 and \$5,571, respectively, related to students in

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

school, graduates working at the Alliance and amounts due from others who are no longer in the scholarship program.

Promises to Give: The Alliance has recorded certain unconditional promises to give to unrelated organizations. At June 30, 2011, \$1,568 is due within one year, and an additional \$180 is due within five years and is included in other long-term liabilities.

Operating Leases and Maintenance Contracts: Total lease expense for the years ended June 30, 2011 and 2010 was \$9,362 and \$10,216, 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:

<u>Year Ending June 30,</u>	
2012	\$ 2,846
2013	2,631
2014	2,286
2015	2,121
2016	1,285
Thereafter	<u>9,914</u>
	<u>\$ 21,083</u>

Estimated future minimum payments under various noncancellable maintenance contracts with remaining terms in excess of one year at June 30, 2011 total in the aggregate \$1,422 through 2016.

Asset Retirement Obligation: The Alliance has identified asbestos in certain facilities and is required by law to dispose of it in a special manner if the facility undergoes major renovations or is demolished; otherwise, the Alliance is not required to remove the asbestos from the facility. The Alliance has complied with regulations by treating the asbestos so that it presents no known immediate or future safety concerns. An asset retirement obligation has been established to the extent that sufficient information exists upon which to estimate the liability.

Other: The Alliance is a party to various transactions and agreements in the normal course of business, which include purchase and re-purchase agreements, put arrangements and other commitments, which may bind the Alliance to undertake additional transactions or activities in the future. In addition, the Alliance has agreed to guarantee a portion of the outstanding indebtedness of a joint venture. Management estimates that the fair value of the guarantee of this debt is immaterial as of June 30, 2011.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

Healthcare Industry: Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

In March 2010, Congress adopted comprehensive health care insurance legislation, *Patient Care Protection and Affordable Care Act* and *Health Care and Education Reconciliation Act*. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens by 2019 through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

NOTE O--RENTAL INCOME UNDER OPERATING LEASES

The Alliance leases rental properties to third parties, most of whom are physician practices, for various terms, generally five years. The following is a schedule by year and in the aggregate of minimum future rental income due under noncancellable operating leases at June 30, 2011:

<u>Year Ending June 30,</u>	
2012	\$ 1,742
2013	1,219
2014	958
2015	796
2016	397
Total minimum future rentals	<u>\$ 5,112</u>

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2011 and 2010, 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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS - Continued

Investment in Joint Ventures: It is not practical to estimate the fair market value of the investments in joint ventures.

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 due to uncertainty of when these amounts may be paid. Other long-term liabilities are not discounted.

Long-Term Debt and Capital Leases: 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.

The Alliance's significant capital leases and vendor contracts were negotiated with various entities and are considered unique. It is not practicable to estimate the fair value of these obligations under current conditions. Other capital lease obligations are not significant.

The estimated fair value of the Alliance's financial instruments that have carrying values different from fair value is as follows at June 30:

	<i>2011</i>		<i>2010</i>	
	<i>Carrying Value</i>	<i>Estimated Fair Value</i>	<i>Carrying Value</i>	<i>Estimated Fair Value</i>
FINANCIAL LIABILITIES:				
Long-term debt	\$ 1,069,085	\$ 1,046,675	\$ 1,082,973	\$ 1,105,778

NOTE Q--FAIR VALUE MEASUREMENT

FASB ASC 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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE Q--FAIR VALUE MEASUREMENT - Continued

assets and liabilities in markets that are not active; or other inputs that are observable or can 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 assets and liabilities recorded at fair value on a recurring basis as of June 30, 2011 and 2010:

	<i>June 30, 2011</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>
Trading securities	\$ 333,610	\$ 164,953	\$ 135,939	\$ 32,718
Assets whose use is limited	117,170	117,170	-	-
Total assets	\$ 450,780	\$ 282,123	\$ 135,939	\$ 32,718
Fair value of derivative agreements - Note D	\$ (110,732)	\$ -	\$ -	\$ (110,732)
	<i>June 30, 2010</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>
Trading securities	\$ 209,644	\$ 164,510	\$ 16,526	\$ 28,608
Assets whose use is limited	177,180	177,180	-	-
Total assets	\$ 386,824	\$ 341,690	\$ 16,526	\$ 28,608
Fair value of derivative agreements - Note D	\$ (134,300)	\$ -	\$ -	\$ (134,300)

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 observable market-based inputs, including forward interest rate curves. The fair values of interest rate swap 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 based on observable

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE Q--FAIR VALUE MEASUREMENT - Continued

market forward interest rate curves 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, 2011 and 2010 resulted in a decrease in the fair value of the related liability of \$7,940 and \$10,085, 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.

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, 2011 and 2010:

	<i>Trading Securities</i>	<i>Derivatives, Net</i>
July 1, 2009	\$ 30,031	\$ (126,217)
Total unrealized/realized losses in the Performance Indicator, net	(1,546)	(8,607)
Purchases, issuance and settlements and other, net	1,446	524
Transfers in (out), net	(1,323)	-
June 30, 2010	28,608	(134,300)
Total unrealized/realized gains in the Performance Indicator, net	2,847	23,049
Purchases, issuance and settlements and other, net	1,263	519
June 30, 2011	\$ 32,718	\$ (110,732)

There were no changes in valuation techniques in 2011 or 2010. During 2011, as part of the transitional test of goodwill impairment, the Alliance recognized goodwill impairment of \$2,965 based primarily on the fair value of the reporting unit, utilizing the income approach. Remaining goodwill determined not to be impaired, for this specific reporting unit, is included in the Consolidated Balance Sheet at \$2,900. There were no significant assets or liabilities that were re-measured at fair value on a non-recurring basis during the fiscal year ended June 30, 2010.

NOTE R--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION

Direct expenses by functional classification are as follows for the years ended June 30:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE R--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION - Continued

	<u>2011</u>	<u>2010</u>
Healthcare services	\$ 817,397	\$ 795,725
Administrative and general	130,543	125,852
Other	9,233	8,625
	<u>\$ 957,173</u>	<u>\$ 930,202</u>

NOTE S--SUBSEQUENT EVENTS

Acquisition: Subsequent to June 30, 2011, the Alliance purchased the stock of a pharmacy provider for approximately \$6,700. The Alliance has not completed an allocation of the purchase price although it is anticipated significant intangible assets will be recognized upon such allocation.

Debt: In October 2011, the Alliance (along with BRMMC, NCH and SCCH) issued \$85,260 of Series 2011 Tax-exempt Hospital Revenue Bonds through The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the Tennessee Bonds) and \$110,580 through the Industrial Development Authority of Smyth, Virginia (the Virginia Bonds). Such bonds were issued on parity with the outstanding bond indebtedness of the Alliance as of June 30, 2011. The Bonds bear interest at a variable rate determined by a remarketing agent based upon a weekly rate period. Additionally, the Alliance issued \$15,960 of Series 2011 Taxable Bonds. NCH and SCCH were also admitted as members of the Alliance Obligated Group.

The proceeds from the Tennessee Bonds will be issued to finance certain capital acquisitions in the State of Tennessee and pay issuance costs related to these Bonds. The proceeds from the Virginia Bonds will be used to refinance \$11,200 of 2001 NCH Hospital Refunding and Improvement Revenue Bonds, finance capital acquisitions for NCH, JMH and SCCH and to pay issuance costs associated with these Bonds. The Series 2011 Taxable Bonds proceeds will be used to finance capital acquisitions of SCCH and BRMMC and pay issuance costs. The timely payment of the Tennessee and the Virginia Bonds is secured by a letter of credit which expires October 19, 2014. The Alliance also redeemed \$115,135 of the Series 2007B-1 Revenue Bonds and \$29,405 of the Series 2007B-3 Revenue Bonds.

Management further anticipates issuance of an additional \$25,000 of tax-exempt bonds for the benefit of JMH. JMH is not a member of the Mountain States Health Alliance Obligated Group.

Subsequent to June 30, 2011, JMH exercised their right to purchase a facility previously held under a capital lease for total consideration of \$16,051. \$2,093 was paid directly to the third party and the remaining \$13,958 was by assumption of a promissory note with payments through 2013. The promissory note bears interest at a variable rate of LIBOR plus 1.5%. Additionally, JMH assumed an interest rate swap in the notional amount of \$13,940. JMH pays a fixed rate of 7.46%

MOUNTAIN STATES HEALTH ALLIANCE

*Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE S--SUBSEQUENT EVENTS - Continued

and receives a variable rate of LIBOR plus 1.5%. The interest rate swap has a termination date of August 15, 2012.

Supplemental Schedules

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet
(Dollars in Thousands)

June 30, 2011

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities	Mountain States Properties	Eliminations	Total
ASSETS								
CURRENT ASSETS								
Cash and cash equivalents	\$ 450	\$ 85,976	\$ -	\$ 86,426	\$ 17,023	\$ 9,319	\$ -	\$ 112,768
Current portion of investments	-	7,629	-	7,629	94,775	13,771	-	116,175
Patient accounts receivable, less estimated allowances for uncollectible accounts	4,476	96,083	-	100,559	34,052	-	-	134,611
Other receivables, net	848	13,434	-	14,282	4,552	780	-	19,614
Inventories and prepaid expenses	553	18,783	-	19,336	9,477	152	-	28,965
TOTAL CURRENT ASSETS	6,327	221,905	-	228,232	159,879	24,022	-	412,133
INVESTMENTS, less amounts required to meet current obligations	19,193	337,367	-	356,560	190,937	33,879	-	581,376
EQUITY IN AFFILIATES	139,582	387,825	(155,611)	371,796	-	-	(371,795)	-
PROPERTY, PLANT AND EQUIPMENT, net	10,696	469,613	-	480,309	258,342	58,766	-	797,418
OTHER ASSETS								
Goodwill	3,281	143,276	-	146,557	2,109	-	-	148,666
Net deferred financing, acquisition costs and other charges, less current portion	168	27,991	-	28,159	568	1,117	-	29,844
Other assets	8,467	10,154	-	18,621	7,265	2,562	-	28,448
TOTAL OTHER ASSETS	11,916	181,421	-	193,337	9,942	3,679	-	206,958
	\$ 187,714	\$ 1,598,131	\$ (155,611)	\$ 1,630,234	\$ 619,100	\$ 120,346	\$ (371,795)	\$ 1,997,885

* Management Services Organization only

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet - Continued
(Dollars in Thousands)

June 30, 2011

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities	Mountain States Properties	Eliminations	Total
LIABILITIES AND NET ASSETS								
CURRENT LIABILITIES								
Accrued interest payable	\$ -	\$ 19,607	\$ -	\$ 19,607	\$ 440	\$ -	\$ -	\$ 20,047
Current portion of long-term debt and capital lease obligations	550	23,724	-	24,274	3,888	-	-	28,162
Current portion of estimated fair value of derivatives	-	92,044	-	92,044	-	10,565	-	102,609
Accounts payable and accrued expenses	3,463	66,494	-	69,957	27,645	1,217	-	98,819
Accrued salaries, compensated absences and amounts withheld	3,093	40,177	-	43,270	14,530	-	-	57,800
Payables to (receivables from) affiliates, net	11,094	(81,319)	-	(70,225)	94,632	(24,407)	-	-
Estimated amounts due to third-party payors, net	-	12,547	-	12,547	2,266	-	-	14,813
TOTAL CURRENT LIABILITIES	18,200	173,274	-	191,474	143,401	(12,625)	-	322,250
OTHER LIABILITIES								
Long-term debt and capital lease obligations, less current portion	4,923	979,774	-	984,697	56,226	-	-	1,040,923
Estimated fair value of derivatives, less current portion	-	7,783	-	7,783	-	340	-	8,123
Deferred revenue	-	19,167	-	19,167	100	-	-	19,267
Estimated professional liability self-insurance	2,285	4,494	-	6,779	2,913	-	-	9,692
Other long-term liabilities	6,695	2,402	-	9,097	5,255	-	-	14,352
TOTAL LIABILITIES	32,103	1,186,894	-	1,218,997	207,895	(12,285)	-	1,414,607
NET ASSETS								
UNRESTRICTED NET ASSETS								
Unrestricted net assets	155,478	400,395	(155,478)	400,395	228,554	132,631	(361,185)	400,395
Mountain States Health Alliance	-	-	-	-	171,984	-	-	171,984
Noncontrolling interests in subsidiaries	-	-	-	-	-	-	-	-
TOTAL UNRESTRICTED NET ASSETS	155,478	400,395	(155,478)	400,395	400,538	132,631	(361,185)	572,379
TEMPORARILY RESTRICTED NET ASSETS								
Temporarily restricted net assets	133	10,715	(133)	10,715	10,483	-	(10,483)	10,715
Mountain States Health Alliance	-	-	-	-	57	-	-	57
Noncontrolling interests in subsidiaries	-	-	-	-	-	-	-	-
TOTAL TEMPORARILY RESTRICTED NET ASSETS	133	10,715	(133)	10,715	10,540	-	(10,483)	10,772
Permanently restricted net assets	-	127	-	127	127	-	(127)	127
TOTAL NET ASSETS	155,611	411,237	(155,611)	411,237	411,205	132,631	(371,795)	583,278
\$	187,714	\$ 1,598,131	\$ (155,611)	\$ 1,630,234	\$ 619,100	\$ 120,346	\$ (371,795)	\$ 1,997,885

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

**Consolidating Statement of Operations
(Dollars in Thousands)**

Year Ended June 30, 2011

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities	Mountain States Properties	Eliminations	Total
Revenue, gains and support:								
Net patient service revenue	\$ 35,353	\$ 683,224	\$ (1,702)	\$ 716,875	\$ 243,487	\$ -	\$ (108)	\$ 960,254
Other operating revenue	26,855	3,657	(20,748)	9,764	39,423	7,807	(41,123)	15,871
Equity in net gain (loss) of affiliates	974	(3,283)	2,051	(238)	-	-	258	-
TOTAL REVENUE, GAINS AND SUPPORT	63,182	683,598	(20,399)	726,381	282,910	7,807	(40,973)	976,125
Expenses:								
Salaries and wages	17,287	235,564	-	252,851	92,108	150	(2,901)	342,208
Physician salaries and wages	32,631	1,010	-	33,641	55,417	-	(29,809)	59,249
Contract labor	866	3,234	-	4,100	2,123	-	(259)	5,964
Employee benefits	4,874	45,591	(1,743)	48,722	20,414	35	(2,032)	67,139
Fees	3,544	81,194	(20,612)	64,126	22,251	713	(1,171)	85,919
Supplies	1,745	129,126	-	130,871	38,594	2	(105)	169,562
Utilities	455	11,386	-	11,841	4,452	1,007	-	17,300
Other	4,778	38,479	(95)	43,162	28,206	3,230	(4,951)	69,647
Depreciation	1,476	59,635	-	61,111	23,666	2,722	-	87,499
Amortization	23	2,188	-	2,211	348	-	-	2,559
Estimated provision for bad debts	353	4,097	-	4,450	1,724	-	-	6,174
Interest and taxes	(1,228)	42,204	-	40,976	3,248	1,374	(1,445)	44,153
TOTAL EXPENSES	66,804	653,708	(22,450)	698,062	292,551	9,233	(42,673)	957,173
OPERATING INCOME (LOSS)	(3,622)	29,890	2,051	28,319	(9,641)	(1,426)	1,700	18,952
Nonoperating gains (losses):								
Interest and dividend income	662	9,810	-	10,472	6,552	645	(1,445)	16,224
Net realized gains on the sale of securities	73	1,449	-	1,522	435	-	-	1,957
Net unrealized gains on securities	1,311	13,664	-	14,975	7,949	(756)	-	22,168
Derivative related income	-	3,512	-	3,512	-	1,560	-	5,072
Change in estimated fair value of derivatives	-	23,137	-	23,137	(88)	-	-	23,049
Other nonoperating gains (losses)	(475)	1,245	-	770	(3,430)	4	3	(2,653)
Net assets released from restrictions used for operations	-	562	-	562	1,331	-	-	1,893
NET NONOPERATING GAINS	1,571	53,379	-	54,950	12,837	1,365	(1,442)	67,710
EXCESS (DEFICIT) OF REVENUE, GAINS AND	\$ (2,051)	\$ 83,269	\$ 2,051	\$ 83,269	\$ 3,196	\$ (61)	\$ 258	\$ 86,662
SUPPORT OVER EXPENSES AND LOSSES								

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Changes in Net Assets (Dollars in Thousands)

Year Ended June 30, 2011

	Blue Ridge Medical Management *		Other Obligated Group Members		Eliminations	Total Obligated Group		Other Entities		Total	
	Medical Management *	Obligated Group Members	Obligated Group	Other Members		Health Alliance	Noncontrolling Interests	Other Entities	Mountain States Properties	Eliminations	Total
UNRESTRICTED NET ASSETS:											
Excess of Revenue, Gains and Support over Expenses and Losses	\$ (2,051)	\$ 83,269	\$ 2,051	\$ -	\$ -	\$ 83,269	\$ (197)	\$ 3,393	\$ 3,196	\$ (61)	\$ 86,662
Pension and other defined benefit plan adjustments	-	620	-	-	-	620	620	617	1,237	-	1,237
Cumulative effect of a change in accounting principle	(2,965)	(2,965)	2,965	-	-	(2,965)	-	-	-	-	(2,965)
Net assets released from restrictions used for the purchase of property, plant and equipment	-	1,946	-	-	-	1,946	1,946	(270)	1,946	-	1,946
Distributions to noncontrolling interests	-	-	-	-	-	-	(182)	(115)	(297)	-	(270)
Repurchases of noncontrolling interests and other	(43)	40	43	-	40	-	(182)	(115)	(297)	-	(75)
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	(5,059)	82,910	5,059	-	82,910	2,187	3,625	5,812	(2,126)	(61)	86,535
TEMPORARILY RESTRICTED NET ASSETS:											
Restricted grants and contributions	-	3,612	-	-	-	3,612	2,990	58	3,048	-	3,670
Net assets released from restrictions	-	(3,787)	-	-	-	(3,787)	(3,225)	(52)	(3,277)	-	(3,839)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	-	(175)	-	-	(175)	(175)	(235)	6	(229)	-	(169)
INCREASE (DECREASE) IN TOTAL NET ASSETS	(5,059)	82,735	5,059	-	82,735	1,952	3,631	5,833	(61)	(61)	86,366
NET ASSETS, BEGINNING OF YEAR	160,670	328,502	(160,670)	-	328,502	237,212	168,410	405,622	132,692	(369,904)	496,912
NET ASSETS, END OF YEAR	\$ 155,611	\$ 411,237	\$ (155,611)	\$ -	\$ 411,237	\$ 239,164	\$ 172,041	\$ 411,205	\$ 132,631	\$ (371,795)	\$ 585,278

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Note to Supplemental Schedules

Year Ended June 30, 2011

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. In accordance with Article Six, Section 6.6 of the Amended and Restated Master Trust Indenture between Mountain States Health Alliance and the Bank of New York Trust Company, NA as Master Trustee, those members pledged 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 and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group (Obligated Group).

The supplemental consolidating schedules include the accounts of the members of the Obligated Group after elimination of all significant intergroup accounts and transactions. Certain other subsidiaries of the Alliance, Mountain States Properties, Inc. (MSP) and all other affiliates (Other Entities), 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.

SUMMARY OF THE FINANCING DOCUMENTS

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SUMMARY OF THE FINANCING DOCUMENTS

Brief descriptions of the Master Indenture, the Bond Indenture and the Loan Agreement are included in this Appendix C to the Official Statement. Such descriptions do not purport to be comprehensive or definitive. All references herein to the Master Indenture, the Bond Indenture and the Loan Agreement are qualified in their entirety by reference to each such document, copies of which are available for review at the offices of the Mountain States Health Alliance, Legal Department, 400 North State of Franklin Road, Johnson City, Tennessee. All references to the Bonds are qualified in their entirety by reference to the definitive forms thereof and the information with respect thereto included in the Master Indenture or the Bond Indenture.

DEFINITIONS OF CERTAIN TERMS

The following are definitions of certain terms used in the Master Indenture, the Bond Indenture, the Loan Agreement and this Official Statement.

“Act” means, in the case of the Series 2012A Bonds, Sections 48-101-301 to 48-101-318, Tennessee Code Annotated, as from time to time amended.

“Additional Bonds” means the bonds authorized to be issued by the Issuer under the Bond Indenture in addition to the initial series of Bonds issued thereunder.

“Additional Indebtedness” shall mean any Indebtedness (including all Obligations, other than the Initial Obligation) incurred by any Obligated Issuer, subsequent to its becoming an Obligated Issuer.

“Additional Obligations” means any Obligations issued under the Master Indenture after the issuance of the initial obligation thereunder.

“Affiliate” of any specified Person shall mean any other Person directly or indirectly controlling or controlled by or under direct or indirect common control with such specified Person. For purposes of this definition, (i) “control” when used with respect to any specified Person means the power to direct the management and policies of such Person, directly or indirectly, whether through the power to appoint and remove its directors, the ownership of voting securities, by contract, membership or otherwise; and (ii) the terms “controlling” and “controlled” have meanings correlative to the foregoing.

“Balloon Indebtedness” shall mean: (a) Long-Term Indebtedness as to which, when issued, 25% or more of the debt service thereon is due in a single year, or (b) Long-Term Indebtedness as to which, when issued, 25% or more of the original principal amount thereof may, at the option of the holder or registered owner thereof, be redeemed or repurchased at one time, which portion of the principal is not required by the documents pursuant to which such Indebtedness is issued to be amortized by redemption prior to such date, or (c) any Guaranty of Long-Term Indebtedness that is Balloon Indebtedness.

“Bankruptcy Law” shall mean the United States Bankruptcy Code, 11 U.S.C. §§ 101, *et seq.*, or any similar statute.

“Bond Indenture” means the Bond Trust Indenture dated as of September 1, 2012, between the Issuer and the Bond Trustee, as amended and supplemented.

“Bond Index” means the “Bond Buyer Revenue Bond Index” as published from time to time in The Bond Buyer, or, if such index shall no longer be published, a comparable index designated by the Bond Insurer during the period that any Related Bonds are outstanding that are insured by the Bond Insurer and thereafter by the Obligated Group Agent.

“Bond Insurer” means MBIA Insurance Corporation and its successor or successors. The Bonds offered pursuant to this Official Statement are not insured.

“Bond Trustee” means The Bank of New York Mellon Trust Company, N.A. or any successor trustee under the Bond Indenture.

“Bondholder,” “holder” or “owner of the Bonds” means the registered owner of any Related Bond.

“Book Value,” when used in connection with Property of any member of the Obligated Group, shall mean the cost of such Property, net of accumulated depreciation, calculated in conformity with generally accepted accounting principles, and when used in connection with Property of the Obligated Group, means the aggregate of the values so determined with respect to such Property of all members of the Obligated Group determined in such a manner that no portion of such value of Property of any member of the Obligated Group is included more than once.

“Capitalization” shall mean the principal amount of all outstanding Long-Term Indebtedness of the Obligated Group, plus the equity accounts of the Obligated Group (i.e., unrestricted fund balances, including any shareholder equity or partnership equity).

“Cash to Debt Ratio” means the ratio of Unrestricted Liquid Funds to Long Term Indebtedness.

“Chattel Paper” shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

“Code” shall mean the Internal Revenue Code of 1986, as amended from time to time, and any successor thereto.

“Collateral” shall mean (i) all Receivables, (ii) all Inventory, (iii) all Equipment, (iv) all General Intangibles, (v) all Contracts and all Contract rights, (vi) all amounts from time to time held in any checking, savings, deposit or other account of any Obligated Issuer, (vii) all Government Approvals, provided, that any Government Approval which by its terms or by the operation of law would become void, voidable, terminable or revocable if mortgaged, pledged or signed under the Master Indenture or if a security interest therein were granted under the Master Indenture or expressly accepted and excluded from the security interest by the Master Indenture granted to the extent necessary so as to avoid such voidness, voidability, terminability or revocability, (viii) all Fixtures, including but not limited to those now or hereafter attached to, placed on or incorporated in the Land, (ix) all Revenues, (x) without limiting the generality of the foregoing, all other personal property, goods, Instruments, Chattel Paper, Documents, credits, claims, demands and assets of any Obligated Issuer, whether now existing or hereafter acquired from time to time, and (xi) any and all additions and accessions to any of the foregoing, all improvements thereto, all substitutions and replacements therefor and all products and Proceeds thereof.

“Commitment Indebtedness” means the obligation of any Person to repay amounts disbursed pursuant to a Credit Facility to pay when due such Person’s obligations under Indebtedness incurred in accordance with the provisions of the Master Indenture.

“Completion Indebtedness” shall mean any Long-Term Indebtedness (i) incurred by any Person for the purpose of financing the completion of constructing or equipping Facilities with respect to which Long-Term Indebtedness was theretofore incurred in accordance with the provisions hereof, and (ii) with a principal amount not in excess of the amount required (a) to provide a completed and equipped Facility of substantially the type and scope contemplated at the time such prior Long-Term Indebtedness was incurred, (b) to provide for capitalized interest during the period of construction, (c) to capitalize a reserve with respect to such Completion Indebtedness and (d) to pay the costs and expenses of issuing such Completion Indebtedness.

“Construction Index” shall mean the health care component of the implicit price deflator for the gross national product as most recently reported prior to the date in question by the United States Department of Commerce or its successor agency, or, if such index is no longer published, such other index which is certified to be comparable and appropriate by the Obligated Group Agent in an Officer’s Certificate delivered to the Master Trustee.

“Consultant” shall mean a Person who or which is appointed by the Obligated Group Agent for the purpose of passing on questions relating to the financial affairs, management or operations of one or more members of the Obligated Group or the entire Obligated Group and, in the good faith opinion of the Obligated Group Agent, has a favorable reputation for skill and experience in performing similar services in respect of entities engaged in reasonably comparable endeavors. If any Consultant’s report or opinion is required to be given with respect to matters partly within and partly without the expertise of such Consultant, such Consultant may rely upon the report or opinion of another Consultant, which other Consultant shall be reasonably satisfactory to the relying Consultant and the Obligated Group Agent.

“Contract Rights” shall mean all rights under any Contract to make determinations, to exercise any election (including, but not limited to, election of remedies) or option or to give or receive any notice, consent, waiver or approval together with full power and authority with respect to any Contract to demand, receive, enforce, collect or receipt for any of the foregoing rights or any property the subject of any of the Contracts, to enforce or execute any checks, or other instruments or orders, to file any claims and to take any action which, in the reasonable opinion of a secured party, may be necessary or advisable in connection with any of the foregoing.

“Contracts” shall mean all contracts to which any Obligated Issuer now is, or hereafter will be, bound, or a party, beneficiary or assignee, including, without limitation, all instruments, agreements and documents executed and delivered with respect to such contracts, and all revenues, rentals, Proceeds and other sums of money due and to become due from any of the foregoing, as the same may be modified, supplemented or amended from time to time in accordance with their terms.

“Corporation” or **“Alliance”** means Mountain States Health Alliance, a Tennessee not-for-profit corporation, and its successors and assigns and any surviving, resulting or transferee corporation.

“Counsel” shall mean a lawyer duly admitted to practice law before the highest court of any state in the United States of America or the District of Columbia, or any law firm, who or which, as the case may be, is not unsatisfactory to any recipient of the opinion required to be rendered by such Counsel.

“Credit Facility” means any letter of credit, line of credit, insurance policy, guaranty or other agreement constituting a credit enhancement or liquidity facility which is issued by a bank, trust company, savings and loan association or other institutional lender, insurance company or surety company for the benefit of the holder of any Indebtedness in order to provide a source of funds for, the payment of all or any portion of an Obligated Issuer’s payment obligations under such Indebtedness.

“Days Cash on Hand Ratio” as of the end of any Fiscal Year means the product obtained by multiplying 365 times (i) the Unrestricted Liquid Funds of the Obligated Group as of the last day of such Fiscal Year, divided by (ii) the total operating expenses of the Obligated Group for such Fiscal Year, excluding depreciation and amortization expense and bad debt expense, as shown on the financial statements of the Obligated Group for such Fiscal Year.

“Debt Service Requirement” of any Person shall mean, for any period of time, the amounts payable or the payments required to be made by such Person in respect of principal and interest on outstanding Long-Term Indebtedness during such period (calculated in such a manner that no portion of Long-Term Indebtedness is included more than once), taking into account (for purposes of calculating any projected debt service requirements) (i) that any Indebtedness represented by a Guaranty shall be deemed payable on the dates and in the amounts contemplated in the Master Indenture (concerning the assumptions to be used in including debt service requirements of the guaranteed obligations), (ii) that any payments to be made in respect of Balloon Indebtedness and Variable Rate Indebtedness shall be calculated in accordance with the provisions of Section 4.4 of the Master Indenture, (iii) that, with respect to Indebtedness refunded or refinanced during such period, only an amount of principal and interest equal to the principal and interest not payable from the proceeds of Indebtedness shall be taken into account during such period, (iv) any amounts payable from funds available under an Escrow Deposit (other than amounts so payable solely by reason of the obligor’s failure to make payments from other sources) shall be excluded from the determination of the Debt Service Requirement, and (v) that with respect to any Indebtedness which is the subject of a Hedge Agreement, any Regular Scheduled Qualified Swap Payments under such Hedge Agreement (provided, however, that if the Regular Scheduled Qualified Swap Payments are variable rate payments, interest shall be

calculated as if the indebtedness was Variable Rate Indebtedness) payable or receivable with respect to such Indebtedness shall be taken into account in determining the interest payable with respect to such Indebtedness.*

“Defeasance Investments” shall mean (a) U.S. Treasury Certificates, Notes and Bonds (including State and Local Government Series-- “SLGS”); (b) Direct obligations of the Treasury which have been stripped by the Treasury itself, “CATS” and “TIGRS” and similar securities; (c) Resolution Funding Corp. (REFCORP) -- only the interest component of REFCORP strips which have been stripped by request to the Federal Reserve Bank of New York in book entry form are acceptable; (d) Pre-refunded municipal bonds rated “Aaa” by Moody’s or “AAA” by S&P. If however, the issue is rated by only S&P (i.e., there is no Moody’s rating), then the pre-refunded bonds must have been pre-refunded with cash, direct U.S. or U.S. guaranteed obligations, or AAA rated pre-refunded municipals to satisfy this condition; (e) Obligations issued by the following agencies which are backed by the full faith and credit of the U.S.; 1. U.S. Export-Import Bank (Eximbank): Direct obligations or fully guaranteed certificates of beneficial ownership; 2. Farmers Home Administration (FHA): Certificates of beneficial ownership; 3. Federal Financing Bank; General Services Administration: Participation certificates; U.S. Maritime Administration: Guaranteed Title XI financing; U.S. Department of Housing and Urban Development (HUD): Project Notes, Local Authority Bonds, New Community debentures - U.S. government guaranteed debentures, U.S. Public Housing Notes and Bonds - U.S. government guaranteed public housing notes and bonds; and (f) the following securities: (1) securities rated “Aaa” by Moody’s or “AAA” (at the time such securities are used to defease Bonds pursuant to Article XI hereof) by S&P; (2) collateralized GIC’s with providers rated “Aaa” by Moody’s and “AAA” by S&P (at the time such securities are used to defease Bonds pursuant to Article XI hereof; and (3) obligations of Federal Home Loan Mortgage Corporation and Federal National Mortgage Association.

“Discounted Indebtedness” means Indebtedness sold to the original purchaser thereof (other than any underwriter or other similar intermediary) at a discount from the par amount of such Indebtedness.

“Document” shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

“Equipment” shall mean any “equipment,” as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction, now or hereafter owned or leased by any Obligated Issuer and, in any event, shall include, but shall not be limited to, all equipment used in connection with the facilities constructed from time to time on the Land, all machinery, tools, office equipment, furniture, furnishings, fixtures, vehicles, motor vehicles, and any manuals, instructions, blueprints, computer software and similar items which relate to the above, and any and all additions, substitutions and replacements of any of the foregoing, wherever located, together with all improvements thereon and all attachments, components, parts, equipment and accessories installed thereon or affixed thereto.

“Escrow Deposit” shall mean a segregated escrow fund or other similar fund, account or deposit in trust of cash in an amount (or Defeasance Investments the principal of and interest on which will be in an amount), and

*By their purchase of the Bonds, the initial holders thereof will consent to an amendment of this definition as described in “SECURITY AND SOURCES OF PAYMENT FOR THE BONDS -- Amendment of the Master Indenture” in the front part of this Official Statement. The proposed amended definition is as follows:

“Debt Service Requirement” of any Person shall mean, for any period of time, the amounts payable or the payments required to be made by such Person in respect of principal and interest on Outstanding Long-Term Indebtedness during such period (calculated in such a manner that no portion of the Long-Term Indebtedness is included more than once), taking into account (for purposes of calculating any projected debt service requirements) (i) that any Indebtedness represented by a Guaranty shall be deemed payable on the dates and in the amounts contemplated in Section 4.3 (concerning the assumptions to be used in including debt service requirements of the guaranteed obligations), (ii) that any payments to be made in respect of Balloon Indebtedness and Variable Rate Indebtedness shall be calculated in accordance with the provisions of Section 4.4, (iii) that, with respect to Indebtedness refunded or refinanced during such period, only an amount of principal and interest equal to the principal and interest not payable from the proceeds of Indebtedness shall be taken into account during such period, (iv) any amounts payable from funds available under an Escrow Deposit (other than amounts to payable solely by reason of the obligor’s failure to make payments from other sources), shall be excluded from the determination of the Debt Service Requirement, and (v) that with respect to any Indebtedness which is the subject of a Hedge Agreement, the rate payable under such Hedge Agreement, rather than the actual interest payable on such Indebtedness, shall be taken into account in determining the interest payable with respect to such Indebtedness.

under terms, sufficient to pay all or a portion of the principal of, and premium, if any, and interest on, the indebtedness secured by such escrow fund or other similar fund, account or deposit as the same shall become due or payable upon redemption.

“Facilities” shall mean all land, leasehold interests and buildings and all fixtures and equipment of a Person.

“Fair Value Net Worth” of a person as of any date shall mean:

(i) the fair value or fair saleable value (as the case may be, determined in accordance, with applicable federal and state laws affecting creditors rights and governing determinations of insolvency of debtors) of such person’s assets (including such person’s rights to contribution and subrogation under Sections 2.3(d) and (f) of the Master Indenture or in respect of any other guarantee) as of such date, minus

(ii) the amount of all liabilities of such person (determined in accordance with such laws) as of such date, excluding (x) such person’s Cross Guarantee and (y) any liabilities subordinated in right of payment to such Cross Guarantee, minus

(iii) \$1.00.

“Financial Advisor” shall mean an investment banking or financial advisory firm, commercial bank or any other qualified Person who or which is appointed by the Obligated Group Agent for the purpose of passing on questions relating to the availability and terms of specified types of Indebtedness for any member of the Obligated Group and is actively engaged in and, in the good faith opinion of the Obligated Group Agent, has a favorable reputation for skill and experience in underwriting or providing financial advisory services in respect of similar types of indebtedness incurred by entities engaged in reasonably comparable endeavors.

“Fiscal Year” shall mean a period of twelve consecutive months ending on June 30 or on such other date as may be specified in an Officer’s Certificate of the Obligated Group Agent executed and delivered to the Master Trustee.

“Fixtures” shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction and in any event shall include all goods now or hereafter attached to, placed on, or incorporated in the Land.

“General Intangibles” shall mean “general intangibles” as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction, now or hereafter owned by any Obligated Group Issuer and shall include, but not be limited to, all trademarks, trademark applications, trademark registrations, tradenames, fictitious business names, business names, company names, business identifiers, prints, labels, trade styles and service marks (whether or not registered), including logos and/or designs, copyrights, patents, patent applications, goodwill of any Obligated Issuer’s business symbolized by any of the foregoing, trade secrets, license rights, license agreements, permits, franchises, and any rights to tax refunds to which any Obligated Issuer is now or hereafter may be entitled.

“Governing Body” shall mean, when used with respect to any Person, its board of directors, board of trustees, or other board, committee or group of individuals in which the powers of a board of directors or board of trustees is vested generally or for the specific matters under consideration.

“Government Issuer” shall mean any federal, state or municipal corporation or political subdivision thereof or any instrumentality of any of the foregoing empowered to issue obligations on behalf thereof.

“Government Obligations” shall mean direct obligations of, or obligations the principal of and interest on which are unconditionally guaranteed by, the United States of America, including evidences of a direct ownership interest in future interest or principal payments on obligations issued or guaranteed by the United States of America,

which obligations are held in a custody account by a custodian pursuant to the terms of a the terms of a custody agreement.

“Governmental Approvals” shall mean any authorization, consent, approval, license, ruling, permit, certification, exemption, filing or registration by or with any governmental authority.

“Gross Receipts” shall mean all Revenues, operating revenues and non-operating revenues, receipts, rentals and income of, or received by, any Obligated Issuer, under generally accepted accounting principles, and all rights to receive the same, whether in the form of accounts receivable, Receivables, accounts, Documents, Investment Property, Contract Rights, Chattel Paper, Instruments, General Intangibles or other rights and all Proceeds thereof, including insurance proceeds and condemnation awards payable or paid in respect of the Facilities, whether now existing or hereafter coming into existence and whether now owned or hereafter acquired, and the proceeds thereof including, without limitation, revenues derived from the ownership, operation or leasing of the Facilities; provided, however, that there shall be excluded from Gross Receipts (i) all gifts, grants, bequests, donations or contributions (collectively, “gifts”), which gifts may not be pledged or applied to the payment of principal or interest on the Obligations as a result of restrictions or designations imposed by the donor or maker of the gift in question at the time of the making thereof and income therefrom if such income may not be pledged or applied to the payment of principal or interest on the Obligations as a result of a restriction or designation described in this clause (i), and (ii) any proceeds of any additional indebtedness incurred or assumed by the Obligated Issuer pursuant to the terms of the Master Indenture, to the extent required by the terms of the documentation evidencing such additional indebtedness.

“Guaranty” shall mean any obligation of a Obligated Group member guaranteeing any obligation of any other Person other than a Obligated Group member, whether or not issued under the Master Indenture as an Indenture Guaranty, which obligation would, if such other Person were a member of the Obligated Group, constitute Indebtedness under the Master Indenture.

“Hedge Agreement” means (a) any contract known as or referred to or which performs the function of an interest rate swap agreement, currency swap agreement, forward payment conversion agreement or futures contract; (b) any contract providing for payments based on levels of, or changes or differences in, interest rates, currency exchange rates, or stock or other indices; (c) any contract to exchange cash flows or payments or series of payments; (d) any type of contract called, or designed to perform the function of, interest rate floors, collars, or caps, options, puts, or calls, to hedge or minimize any type of financial risk, including, without limitation, payments, currency, rate or other financial risk; and (e) any other type of contract or arrangement that the Obligated Group Agent determines is to be used, to manage or reduce the cost of an Indebtedness, to convert any element of any Indebtedness from one form to another, to maximize or increase investment return, to minimize investment return risk, or to protect against any type of financial risk or uncertainty.

“Historical Debt Service Coverage Ratio” shall mean, for any period of time, the ratio determined by dividing Total Income Available For Debt Service for such period by the Debt Service Requirement of the Obligated Group for such period.

“Historical Maximum Annual Debt Service Coverage Ratio” shall mean, for any period of time, the ratio determined by dividing Total Income Available for Debt Service for such period by the Maximum Annual Debt Service of the Obligated Group.

“Historical Pro Forma Debt Service Coverage Ratio” shall mean for any period of time, the ratio determined by dividing Total Income Available for Debt Service for such period by the Maximum Annual Debt Service of the Obligated Group for all Long Term Indebtedness then outstanding and the Long-Term Indebtedness then proposed to be issued.

“Holder” shall mean, as the context requires, the registered owner of any Note, the beneficiary of any Indenture Guaranty in whose name an Indenture Guaranty is issued or the holder or beneficiary of any other type of Obligation. In the case of an Obligation issued to a trustee or other fiduciary acting on behalf of the holders of any bonds, notes or other similar obligations which are secured by such Obligation, including any registered securities depository then in the business of holding (for the benefit of beneficial owners whose interests may be evidenced by

book-entry registration) substantial amounts of obligations of types comprising the Obligations, the term Holder shall mean the trustee or other fiduciary or, if so provided in the Related Financing Documents, the holders of the Related Bonds in proportion to their respective interests therein, including any registered securities depository then in the business of holding (for the benefit of beneficial owners whose interests may be evidenced by book-entry registration) substantial amounts of obligations of types comprising the Obligations. For purposes of determining the Holders of the two largest principal amounts of Uninsured Obligations, any Holder of Related Bonds relating to Uninsured Obligations shall be deemed to be the owner of a proportionate amount of the Uninsured Obligations, and any such Uninsured Obligations owned by affiliated entities shall be treated as owned by one Holder.

“Income Available For Debt Service” of a Person shall mean, with respect to any period of time, the excess of revenues over expenses, or, in the case of for-profit entities, net income before tax, as determined in accordance with generally accepted accounting principles, to which shall be added, in either case, (i) depreciation, (ii) amortization, (iii) interest expense on Long-Term Indebtedness, and, (iv) to the extent not already included, contributions and donations and from which shall be excluded any extraordinary items, any impairment losses, any gain or loss resulting from either the extinguishment of indebtedness or the sale, exchange or other disposition of assets not made in the ordinary course of business, provided, however, that (a) no determination of Income Available for Debt Service will take into account any gains or losses resulting from the periodic valuation of investments or Hedge Agreements that do not involve the sale, transfer or other disposition of any such investment or Hedge Agreement or the termination of any Hedge Agreement and (b) a Person may include in its net income such Person’s share of the net income of any Person controlled by such Person or in whom such Person has a legal interest.

“Indebtedness” of a Person means (i) all Notes and Guaranties, (ii) all liabilities (exclusive of reserves such as those established for deferred taxes or litigation) recorded on the audited financial statements of such Person as of the end of the most recent Fiscal Year for which financial statements reported upon by an Accountant are available, and (iii) all other obligations for borrowed money; provided that Indebtedness shall not include (1) Subordinated Indebtedness, (2) Hedge Agreements, (3) any other Indebtedness of any member of the Obligated Group to any other member of the Obligated Group, (4) rentals payable under leases which are not properly capitalized under generally accepted accounting principles or (5) any Guaranty by any member of the Obligated Group of Indebtedness of any other member of the Obligated Group.

“Indenture Guaranty” shall mean any Guaranty issued under the Master Indenture by an Obligated Issuer. **“Independent Counsel”** means an attorney duly admitted to practice law before the highest court of any state and, without limitation, may include independent legal counsel for any Related Issuer, any Obligated Issuer, the Master Trustee or any Related Bond Trustee.

“Instrument” shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

“Inventory” shall mean all of the inventory of any Obligated Issuer of every type or description, including all inventory as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction, now owned or hereafter acquired and wherever located, whether raw, in process or finished, all materials usable in processing the same and all documents of title covering any inventory, including but not limited to work in process, materials used or consumed in such Obligated Issuer’s business, now owned or hereafter acquired or manufactured by such Obligated Issuer and held for sale in the ordinary course of its business; all present and future substitutions therefor, parts and accessories thereof and all additions thereto; and all proceeds thereof and products of such inventory in any form whatsoever.

“Investment Property” shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

“Investment Securities” shall mean and include the following:

- (a) Government Obligations;

(b) debt obligations issued by any of the following agencies or such other like governmental or government-sponsored agencies which may be hereafter created: Bank for Cooperatives; Federal Intermediate Credit Banks; Federal Financing Bank; Federal Home Loan Bank System; Federal National Mortgage Association; Export-Import Bank of the United States; Farmers Home Administration; Small Business Administration; Government National Mortgage Association; or Resolution Funding Corporation;

(c) long-term debt obligations of any state or political subdivision thereof or any agency or instrumentality of such a state or political subdivision or of any corporation, provided that such obligations are rated by the Rating Agency in any of the three highest rating categories (without, reference to sub-categories) assigned by the Rating Agency;

(d) rights to receive the principal of or the interest on obligations of states, political subdivisions, agencies or instrumentalities meeting the requirements set forth in subsection (c) above, whether through (i) direct ownership as evidenced by physical possession of such obligations or unmatured interest coupons or by registration as to ownership on the books of the issuer or its duly authorized paying agent or transfer agent, or (ii) purchase of certificates or other instruments evidencing an undivided ownership interest in payments of the principal of or interest on such obligations;

(e) negotiable and non-negotiable certificates of deposit, time deposits or other similar banking arrangements which are issued by banks, trust companies or savings and loan associations, provided that, unless issued by a Qualified Financial Corporation, any such certificate, deposit or other arrangement shall be continuously secured as to principal in the manner and to the extent provided in the last paragraph of this definition;

(f) repurchase agreements for Investment Securities described in subparagraph (a) or (b) above with a Qualified Financial Corporation or with dealers in government bonds which report to, trade with and are recognized as primary dealers by a Federal Reserve Bank or are members of the Securities Investors Protection Corporation, provided that the repurchase price payable under any such agreement shall be continuously secured in the manner and to the extent provided in the last paragraph of this definition;

(g) investment agreements with Qualified Financial Corporations;

(h) commercial paper rated in the highest rating category (without reference to sub-categories) by the Rating Agency;

(i) shares or certificates in any short-term investment fund which short-term investment fund invests solely in obligations described in subparagraph (a), (b), (c) or (h) above; or

(j) debt obligations of any foreign government or political subdivision thereof or any agency or instrumentality of such foreign government or political subdivision provided that such obligations are rated by the Rating Agency (without reference to subcategories) in the highest rating category assigned by the Rating Agency.

Any security required to be maintained for Investment Securities in the form of certificates of deposit, time deposits, other similar banking arrangements and repurchase agreements described in subsections (e) and (f) above shall be subject to the following:

(i) the collateral shall be in the form of obligations described in subsections (a) or (b) above, except that the security for certificates of deposit, time deposits or other similar banking arrangements may include other marketable securities which are eligible as security for trust funds under applicable regulations of the Comptroller of the Currency of the United States of America or under applicable state laws and regulations.

(ii) the collateral shall have an aggregate market value, calculated not less frequently than monthly, at least equal to the principal amount (less any portion insured by the Federal Deposit Insurance Corporation or any comparable insurance corporation chartered by the United States of America) or the repurchase price secured thereby, as the case may be. The instruments governing the issuance of and security for the

Investment Securities shall designate the Person responsible for making the foregoing calculations; provided that the Master Trustee shall make such calculations if they are not made by the Person so designated.

“Issuer” shall mean, in the case of the Series 2012A Bonds, The Health and Educational Facilities Board of the City of Johnson City, Tennessee, its successors and assigns.

“Land” shall mean the land subject to the Master Deed of Trust.

“Lien” shall mean any mortgage or pledge of, security interest in or lien or encumbrance on any Property of any member of the Obligated Group in favor of, or which secures any Indebtedness or any other obligation of any member of the Obligated Group to any Person other than another member of the Obligated Group, but specifically excluding subordination arrangements among creditors.

“Loan Agreement” means the Loan Agreement dated as of September 1, 2012, between the Issuer and the Corporation.

“Long-Term Indebtedness” shall mean (i) all Indebtedness which, at the time of incurrence or issuance, has a final maturity or term greater than one year or which is renewable at the option of the obligor thereof for a term greater than one year from the date of original incurrence or issuance; and (ii) Short-Term Indebtedness which is incurred as interim financing and which is intended to be repaid out of the proceeds of other Long-Term Indebtedness, provided that any one of the applicable conditions described in Section 4.2 of the Master Indenture are met with respect to such Short-Term Indebtedness on the date of incurrence, assuming for purposes of compliance therewith that such Short-Term Indebtedness is Long Term Indebtedness characterized as Balloon Indebtedness for purposes of meeting any of the applicable conditions in Section 4.2 of the Master Indenture; provided, that, Long-Term Indebtedness shall not include (a) Non-Recourse Indebtedness or Subordinated Indebtedness; (b) current obligations payable out of current revenues, including current payments for the funding of pension plans and contributions to self insurance programs; (c) obligations under contracts for supplies, services or pensions, allocated to the current operating expenses of future years in which the supplies are to be furnished, the services rendered or the pensions paid; and (d) rentals payable under leases which are not properly capitalized under generally accepted accounting principles.

“Master Deed of Trust” shall mean the Deed of Trust and Security Agreement dated as of February 1, 2000 from the Corporation to an individual, as trustee, granting a deed of trust lien on and a security interest in the Land and the other collateral described therein for the benefit of the Master Trustee, to secure the payment and performance of outstanding Obligations.

“Master Indenture” means the Amended and Master Trust Indenture dated as of February 1, 2000 between the Corporation and the Master Trustee, as it may from time to time be amended or supplemented in accordance with the terms thereof.

“Master Trustee” means The Bank of New York Mellon Trust Company, N.A., or any successor trustee under the Master Indenture.

“Maximum Annual Debt Service” of the Obligated Group shall mean the highest annual Debt Service Requirement of the Obligated Group for the current or any succeeding Fiscal Year during the remaining term of all outstanding Obligations.

“Maximum Guaranty Liability” of a Person as of any date shall mean the greater of either (i) or (ii) below:

- (i) the greater of (A) or (B) as of such date:
 - (A) the outstanding amount of all Obligations issued by such Person or

(B) the fair market value of all property acquired, in whole or part, with the proceeds of such Obligations by such Person.

(ii) The greatest of the Fair Value Net Worth of such Person as of (1) the latest fiscal year-end of such Person, (2) each fiscal quarter-end of such Person thereafter occurring on or prior to the date of the determination of Maximum Guaranty Liability, (3) the date on which enforcement of the pertinent Cross Guarantee is sought, and (4) the date on which a case under the U.S. Bankruptcy Code is commenced with respect to any Obligated Issuer.

“Net Operating Revenues” of a Person means, with respect to any period of time, operating revenues less estimated contractual allowances, free care, discounts and bad debt expense, all determined, except as is specifically provided in the Master Indenture, in accordance with generally accepted accounting principles.

“Net Property, Plant and Equipment” means the Value of all Property, Plant and Equipment less accumulated depreciation.

“Non-Recourse Indebtedness” shall mean any Indebtedness secured by a Lien on Property of any Obligated Issuer, liability for which is effectively limited to the Property subject to such Lien, with no recourse, directly or indirectly, to any other Property of any Obligated Issuer.

“Note” shall mean any note issued under the Master Indenture by an Obligated Issuer to evidence Long-Term Indebtedness or Short-Term Indebtedness incurred pursuant to the terms of the Master Indenture.

“Obligated Group” shall mean all Obligated Issuers.

“Obligated Group Agent” shall mean the Corporation and any successor Obligated Group Agent appointed pursuant to the Master Indenture.

“Obligated Issuer” shall mean (i) the Corporation, Blue Ridge Medical Management Corporation, Norton Community Hospital, Smyth County Community Hospital and each other Person which becomes an Obligated Issuer in accordance with the provisions of the Master Indenture, whether or not such Person has issued any obligations thereunder, and which has not withdrawn from the Obligated Group, and (ii) when used in respect of any particular Obligation or other Indebtedness, shall mean the obligor thereunder.

“Obligations” shall mean all Notes and Indenture Guaranties issued under the Master Indenture, any lease, contractual agreement to pay money or other obligations of any Obligated Group Member issued under the Master Indenture and any additional forms of Obligations created pursuant to the Master Indenture.

“Officer’s Certificate” shall mean a certificate signed, in the case of a corporation, by the Chairman, Vice Chairman, President or Chief Financial Officer or, in the case of a certificate delivered by any other Person, the chief executive or chief financial officer of such Person, in either case whose authority to execute such certificate shall be evidenced to the satisfaction of the Master Trustee. When an Officer’s Certificate is required under the Master Indenture to set forth matters relating to one or more Obligated Issuers, such Officer’s Certificate may be given in reliance upon another certificate, or other certificates, and supporting materials, if any, provided by any duly authorized officer of the applicable Obligated Issuer.

“Opinion of Bond Counsel” shall mean an opinion in writing signed by an attorney or firm of attorneys experienced in the field of municipal bonds whose opinions are generally accepted by purchasers of municipal bonds.

“Paying Agent” means the bank or banks, if any, designated pursuant to a Related Bond Indenture to receive and disburse the principal of and interest on any Related Bonds or designated pursuant to the Master Indenture to receive and disburse the principal of and interest on any Obligations.

“Permitted Investments” shall mean the following:

- A. Direct obligations of the United States of America (including obligations issued or held in book-entry form on the books of the Department of the Treasury, and CATS and TIGRS) or obligations the principal of and interest on which are unconditionally guaranteed by the United States of America.
- B. Bonds, debentures, notes or other evidence of indebtedness issued or guaranteed by any of the following federal agencies and provided such obligations are backed by the full faith and credit of the United States of America (stripped securities are only permitted if they have been stripped by the agency itself):
 - 1. U.S. Export-Import Bank (Eximbank)
Direct obligations or fully guaranteed certificates of beneficial ownership
 - 2. Farmers Home Administration (FmHA)
Certificates of beneficial ownership
 - 3. Federal Financing Bank
 - 4. Federal Housing Administration Debentures (FHA)
 - 5. General Services Administration
Participation certificates
 - 6. Government National Mortgage Association (GNMA or “Ginnie Mae”)
GNMA - guaranteed mortgage-backed bonds
GNMA - guaranteed pass-through obligations
(not acceptable for certain cash-flow sensitive issues)
 - 7. U.S. Maritime Administration
Guaranteed Title XI financing
 - 8. U.S. Department of Housing and Urban Development (HUD) Project Notes
Local Authority Bonds
New Communities Debentures- U.S. government guaranteed debentures
U.S. Public Housing Notes and Bonds- U.S. government guaranteed public housing notes and bonds
- C. Bonds, debentures, notes or other evidence of indebtedness issued or guaranteed by any of the following non-full faith and credit U.S. government agencies (stripped securities are only permitted if they have been stripped by the agency itself):
 - 1. Federal Home Loan Bank System
Senior debt obligations
 - 2. Federal Home Loan Mortgage Corporation (FHLMC or “Freddie Mac”)
Participation Certificates
Senior debt obligations
 - 3. Federal National Mortgage Association (FNMA or “Fannie Mae”)
Mortgage-backed securities and senior debt obligations
 - 4. Student Loan Marketing Association (SLMA or “Sallie Mae”)
Senior debt obligations

5. Resolution Funding Corp. (REFCORP) obligations
 6. Farm Credit System
Consolidated systemwide bonds and notes
- D. Money market funds registered under the Federal Investment Company Act of 1940, whose shares are registered under the Federal Securities Act of 1933, and having a rating by S&P of AAAm-G; AAA-m; or AA-m and if rated by Moody's rated Aaa, Aa1 or Aa2.
 - E. Certificates of deposit secured at all times by collateral described in (A) and/or (B) above. Such certificates must be issued by commercial banks, savings and loan associations or mutual savings banks. The collateral must be held by a third party and the bondholders must have a perfected first security interest in the collateral.
 - F. Certificates of deposit, savings accounts, deposit accounts or money market deposits which are fully insured by FDIC, including BIF and SAIF.
 - G. Commercial paper rated, at the time of purchase, "Prime- 1" by Moody's and "A-1" or better by S&P.
 - H. Bonds or notes issued by any state or municipality which are rated by Moody's and S&P in one of the two highest rating categories assigned by such agencies.
 - I. Federal funds or bankers acceptances with a maximum term of one year of any bank which has an unsecured, uninsured and unguaranteed obligation rating of "Prime - I" or "A3" or better by Moody's and "A-1" or "A" or better by S&P.
 - J. Repurchase agreements ("repos") which provide for the transfer of securities from a dealer bank or securities firm (seller/borrower) to the Bond Trustee, and the transfer of cash from the Bond Trustee to the dealer bank or securities firm with an agreement that the dealer bank or securities firm will repay the cash plus a yield to the Bond Trustee in exchange for the securities at a specified date.
 1. Repos must be between the Bond Trustee and a dealer bank or securities firm as follows:
 - a. Primary dealers on the Federal Reserve reporting dealer list which are rated A or better by Standard & Poor's Corporation and Moody's Investor Services, or
 - b. Banks rated "A" or above by Standard & Poor's Corporation and Moody's Investor Services.
 2. The written repo contract must include the following:
 - a. Securities which are acceptable for transfer are:
 - (1) Direct U.S. governments, or
 - (2) Federal agencies backed by the full faith and credit of the U.S. government (and FNMA & FHLMC)
 - b. The collateral must be delivered to the Bond Trustee (if the Bond Trustee is not supplying the collateral) or third party acting as agent for the Bond Trustee (if the Bond Trustee is supplying the collateral) before/simultaneous with payment (perfection by possession of certificated securities).

c. Term and Valuation of Collateral

- (1) The value of collateral must be equal to 104% of the amount of cash transferred by the municipal entity to the dealer bank or security firm under the repo plus accrued interest. If the value of securities held as collateral slips below 104% of the value of the cash transferred by the Bond Trustee, then additional cash and/or acceptable securities must be transferred. If, however, the securities used as collateral are FNMA or FHLMC, then the value of collateral must equal 105%.
- (2) If the term of the repo is more than 30 days, the Bond Trustee must value the collateral no less frequently than monthly and must liquidate collateral if any deficiency in the required value of the collateral set forth above is not restored within two business days of such valuation.

K. Guaranteed investment contracts or similar agreements providing for a specified rate of return over a specified time period with entities rated in one (1) of the two (2) highest rating categories of Standard & Poor's Corporation and Moody's Investor Services.

"Permitted Liens" shall mean the Master Indenture, all Related Financing Documents and, as of any particular time:

(i) Any lien from any member of the Obligated Group to any other member of the Obligated Group;

(ii) Any judgment lien or notice of pending action against any member of the Obligated Group so long as (1) such judgment or pending action is being contested and execution thereon has been stayed or the period for responsive pleading or appeal has not lapsed, or (2) in the absence of such contest, neither the pledge and security interest of this Indenture nor any Property of any member of the Obligated Group will be materially impaired or subject to material loss or forfeiture;

(iii) (A) Rights reserved to or vested in any municipality or public authority by the terms of any right, power, franchise, grant, license, permit or provision of law affecting any Property, to (1) terminate such right, power, franchise, grant, license or permit, provided that the exercise of such right would not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof, or (2) purchase, condemn, appropriate or recapture, or designate a purchaser of, such Property; (B) any liens (or deposits to obtain the release of such liens) on any Property for taxes, assessments, levies, fees, water and sewer charges, and other governmental and similar charges and any liens of mechanics, materialmen, laborers, suppliers or vendors for work or services performed or materials furnished in connection with such Property, which are not due and payable or which are not delinquent or which, or the amount or validity of which, are being contested and execution thereon is stayed; (C) easements, rights-of-way, servitudes, restrictions and other minor defects, encumbrances, and irregularities in the title to any Property which do not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof; (D) rights reserved to or vested in any municipality or public authority to control or regulate any Property or to use such Property in any manner, which rights do not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof; and (E) to the extent that it affects title to any Property, the Master Indenture;

(iv) Any lease which relates to Property of the Obligated Group which is of a type that is customarily the subject of such leases, including but not limited to any leasehold interest required under any Related Financing Documents, leases with respect to office space for physicians and educational institutions, food service facilities, gift shops and radiology or other hospital-based specialty services, pharmacy and similar departments and statutory landlord's liens with respect to such leases;

(v) Any Lien securing Indebtedness provided such Lien also secures all Obligations (other than Obligations representing Subordinated Indebtedness or Non-Recourse indebtedness) on a parity basis;

(vi) Any Lien arising by reason of good faith deposits in connection with leases of real estate, bids or contracts (other than contracts for the payment of money), deposits by any member of the Obligated Group to secure public or statutory obligations, or to secure, or in lieu of, surety, stay or appeal bonds, and deposits as security for the payment of taxes or assessments or other similar charges;

(vii) Any Lien arising by reason of deposits with, or the giving of any form of security to, any governmental agency or any body created or approved by law or government regulation for any purpose at any time as required by law or governmental regulation as a condition to the transaction of any business or the exercise of any privilege or license, or to enable any member of the Obligated Group to maintain self insurance or to participate in any funds established to cover any insurance risks or in connection with workers compensation, unemployment insurance, pension or profit sharing plans or other similar social security plans, or to share in the privileges or benefits required for companies participating in such arrangements;

(viii) Any Lien arising by reason of an Escrow Deposit;

(ix) (A) Any Lien in favor of a trustee or the holder of a Note on the proceeds of Indebtedness or cash or investments deposited with such trustee and acquired with such proceeds prior to the application of such proceeds or cash or investments and (B) Liens in favor of a trustee, including the Master Trustee, to secure obligations to compensate, reimburse or indemnify such trustees;

(x) Any Lien on moneys deposited by patients or others with any member of the Obligated Group as security for or as prepayment for the cost of patient care;

(xi) Any Lien on Property received by any member of the Obligated Group through gifts, grants or bequests, such Lien being due to restrictions on such gifts, grants or bequests of property or the income thereon;

(xii) Statutory rights of the United States of America by reason of federal fund made available under 42 U.S.C. §§ 291 *et seq.* and similar rights under other federal and state statutes;

(xiii) Liens existing at the time of a Consolidation or Merger permitted under the Master Indenture, on the date of acquisition of any Property or at the time a Person becomes an Obligated Issuer; provided that no such Lien (or the amount of indebtedness secured thereby) may be increased, extended, renewed or modified to apply to any Property of any member of the Obligated Group not subject to such Lien on such date, unless such Lien as so extended, renewed or modified shall be offered as security for all Obligations hereunder;

(xiv) Any Lien described in Exhibit A to the Master Indenture, provided that no such Lien (or the amount of indebtedness secured thereby) may be increased, extended, renewed or modified to apply to any Property of any member of the Obligated Group not subject to such Lien on such date, unless such Lien as so extended, renewed or modified otherwise qualifies as a Permitted Lien under the Master Indenture;

(xv) A security interest in any funds or accounts established pursuant to the provisions of any Related Financing Documents;

(xvi) Liens in the form of purchase money security interests in Property financed with the proceeds of Indebtedness secured thereby;

(xvii) Liens securing any Indebtedness permitted under the Master Indenture, provided that the Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect

that not more than 20% of the Value of all Net Property, Plant and Equipment of the Obligated Group would be subject to a Lien (excluding any purchase money security interest permitted under subsection (xvi) above and the Lien created under the Master Deed of Trust for the purpose of making such calculation);

(xviii) Liens on accounts receivable arising as a result of sale of such accounts receivable with recourse, provided that such liens shall be limited to 25% of net accounts receivable outstanding;

(xix) Options granted by any member of the Obligated Group to others to purchase real property or other assets of such member; provided, however, that the sale pursuant to such option would be permitted under the conditions described in the Master Indenture; and

(xx) Liens on any Property that is not encumbered by the Master Deed of Trust so long as the aggregate amount secured by such Liens does not exceed \$5,000,000.

“Person” shall mean an individual, a corporation, a partnership, an association, a joint stock company, a joint venture, a trust, an unincorporated organization, a governmental unit or an agency, political subdivision or instrumentality thereof or any other group or organization of individuals.

“principal” when used to refer to the amount of the Obligations, shall mean (i) the principal amount of any Obligation that constitutes Indebtedness; (ii) with respect to an Indenture Guaranty, the principal amount guaranteed; (iii) with respect to a Hedge Agreement, five percent (5%) of the notional amount of such Hedge Agreement as in effect from time to time; (iv) with respect to a Credit Facility, the amount disbursed by the issuer of the Credit Facility and not reimbursed on the date the principal amount is determined; (v) with respect to Discounted Indebtedness, the accreted value of such Discounted Indebtedness at the time the determination is made computed on the basis of a constant yield to maturity; and (vi) with respect to any other type of Obligations, the amount specified in the Supplemental Indenture creating such Obligation.

“Proceeds” shall mean “proceeds” as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction or under other relevant law and, in any event, shall include, but shall not be limited to, (i) any and all proceeds of any insurance, indemnity, warranty or guaranty payable to any Obligated Issuer from time to time, and claims for insurance, indemnity, warranty or guaranty effected or held for the benefit of the Corporation, with respect to any of the Collateral, (ii) any and all payments (in any form whatsoever) made or due and payable to the any Obligated Issuer from time to time in connection with any requisition, confiscation, condemnation, seizure or forfeiture of all or any part of the Collateral by any Government Authority (or any person acting under color of Government Authority) and (iii) any and all other amounts from time to time paid or payable under or in connection with any of the Collateral.

“Project” means the project financed with the proceeds of the Bonds.

“Projected Debt Service Coverage Ratio” shall mean for any future period of time, the ratio determined by dividing projected Total Income Available for Debt Service for such period by Maximum Annual Debt Service of the Obligated Group.

“Property” means any and all rights, titles and interests in and to any and all assets of a person, including all real or personal property, all tangible or intangible property, and all cash, wherever such assets are situated.

“Property, Plant and Equipment” shall mean all Property which is classified as property, plant and equipment under generally accepted accounting principles.

“Qualified Financial Corporation” shall mean a bank, trust company, national banking association, insurance company or other financial services company whose unsecured long-term debt obligations (in the case of a bank, trust company, national banking association or other financial services company) or whose claims paying abilities (in the case of an insurance company) are rated in any of the three highest rating categories (without reference to sub-categories) by the Rating Agency. For purposes hereof, the term “financial services company”

shall include any investment banking firm or any affiliate or division thereof which may be legally authorized to enter into the transactions described in the Master Indenture pertaining, applicable or limited to a Qualified Financial Corporation.

“Rating Agency” shall, mean severally or collectively, if applicable (i) Standard & Poor’s Ratings Group and any successor thereto, if it has assigned a rating to any Obligation issued and outstanding under the Master Indenture or any Related Bonds issued and outstanding pursuant to any Related Financing Documents, (ii) Moody’s Investors Service, Inc. and any successor thereto, if it has assigned a rating to any Obligation issued and outstanding under the Master Indenture or any Related bonds issued and outstanding pursuant to any Related Financing Documents, and (iii) Fitch’s IBCA Inc. and any successor thereto, if it has assigned a rating to any Obligation issued and outstanding pursuant to any Related Financing Documents. If any such Rating Agency shall no longer perform the functions of a securities rating service for whatever reason, the term “Rating Agency” shall thereafter be deemed to refer to the others, but if both of the others shall no longer perform the functions of a securities rating service for whatever reason, term “Rating Agency” shall thereafter be deemed to refer to any other nationally recognized rating service or services as shall be designated in writing by the Obligated Group Agent to the Master Trustee; provided that such designee shall not be unsatisfactory to the Master Trustee.

“Receivables” shall mean any “Account” as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction and in any event shall include, but not be limited to, all of any Obligated Issuer’s rights to payment for goods (including, without limitation, steam and electricity) sold or leased, or for services performed, by such Obligated Issuer, whether now in existence or arising from time to time hereafter, including, without limitation, rights evidenced by an account, note, contract, security agreement, chattel paper, or other evidence of indebtedness or security, together with (i) all security pledged, assigned, hypothecated or granted to or held by any Obligated Issuer to secure the foregoing, (ii) all of such Obligated Issuer’s right, title and interest in and to any goods (including, without limitation, steam and electricity), the sale of which gave rise thereto, (iii) all guarantees, endorsements and indemnifications on, or of, any of the foregoing, (iv) all powers of attorney for the execution of any evidence of indebtedness or security or other writing in connection therewith, (v) all books, correspondence, credit files, records, ledger cards, invoices, and other papers relating thereto, including without limitation all similar information stored on a magnetic medium or other similar storage device and other papers and documents in the possession or under the control of any Obligated Issuer or any computer bureau from time to time acting for such Obligated Issuer, (vi) all evidences of the filing of financing statements and other statements and the registration of other instruments in connection therewith and amendments thereto, notices to other creditors or secured parties, and certificates from filing or other registration officers, (vii) all credit information, reports and memoranda relating thereto, and (viii) all other writings related in any way to the foregoing.

“Regularly Scheduled Qualified Swap Payments” means the regularly scheduled payments under the terms of a Hedge Agreement which are due or receivable absent any termination, default or dispute in connection with such Hedge Agreement.

“Related Bond Indenture” shall mean any indenture, bond resolution or other comparable instrument pursuant to which a series of Related Bonds is issued.

“Related Bond Issuer” shall mean the Government Issuer of any issue of Related Bonds.

“Related Bond Trustee” shall mean the trustee and its successors in the trust created under any Related Bond Indenture, and if there is no such trustee, shall mean the Related Bond Issuer.

“Related Bonds” shall mean the revenue bonds, notes, other evidences of indebtedness or any other obligations issued by a Government Issuer, pursuant to a single Related Bond Indenture, the proceeds of which are loaned or otherwise made available to an Obligated Issuer in consideration of the execution, authentication and delivery of a Note to or for the order of such Government Issuer.

“Related Financing Documents” shall mean:

(a) in the case of any Note, (i) all documents, including any Related Bond Indenture, pursuant to which the proceeds of the Note are made available to an Obligated Issuer, the payment obligations evidenced by the Note are created and any security for the Note (if permitted under this Indenture) is granted, and (ii) all documents creating any additional payment or other obligations on the part of an Obligated Issuer which are executed in favor of the Holder in consideration of the Note proceeds being loaned or otherwise made available to the Obligated Issuer;

(b) in the case of any Indenture Guaranty, all documents creating the indebtedness being guaranteed pursuant to the Indenture Guaranty and providing for the loan or other disposition of the proceeds of the indebtedness and all documents pursuant to which any security for the Indenture Guaranty (if permitted under the Master Indenture) is granted; and

(c) in the case of Indebtedness other than Notes and Indenture Guaranties, all documents relating thereto which are of the same nature and for the same purpose as the documents described in clauses (a) and (b) above.

“Revenues” means all revenues, income, receipts and other money received or accrued by or on behalf of any Obligated Issuer from any source whatsoever, including, without limitation, proceeds derived from (i) insurance except where otherwise provided herein, (ii) all accounts and assignable general intangibles now owned or hereafter acquired by any Obligated Issuer, and all proceeds therefrom whether cash or noncash, all as defined in Article 9 of the Uniform Commercial Code, as enacted by the State of Tennessee, (iii) the sale of goods, inventory and other tangible and intangible property, (iv) agreements respecting Medicare, Medicaid and Blue Cross or similar or successor programs, and (v) all gifts, grants, bequests, contributions and donations made to any Obligated Issuer, including the income and profits therefrom.

“Short-Term Indebtedness” shall mean all Indebtedness other than Long-Term indebtedness.

“State” shall mean the State of Tennessee.

“Subordinated Indebtedness” shall mean any promissory note, guaranty, lease, contractual agreement to pay money or other obligation of any Obligated Issuer which is expressly made subordinate and junior in right of payment of principal of, redemption premium, if any, and interest on, (i) all Obligations issued pursuant to the Master Indenture, and (ii) all other obligations of the Obligated Group under the Master Indenture, on terms and conditions which substantially require that (1) no payment on account of principal of, redemption premium, if any, or interest on such Subordinated Indebtedness shall be made, nor shall any property or assets be applied to the purchase or other acquisition or retirement of such Subordinated Indebtedness, unless full payment of all amounts when due and payable upon maturity of Obligations issued under the Master Indenture have been made or duly provided for in accordance with the terms of such Obligations; (2) no payment on account of principal of, redemption premium, if any, or interest on such Subordinated Indebtedness shall be made, nor shall any property or assets be applied to the purchase or other acquisition or retirement of such Subordinated Indebtedness if, at the time of such payment or application, or immediately after giving effect thereto, (i) there shall exist a default in the payment of the principal of, redemption premium, if any, or interest on any Obligations (whether at maturity or upon mandatory redemption), or (ii) there shall have occurred an Event of Default with respect to any Obligations, as defined therein and in this Indenture, and such Event of Default shall not have been cured or waived or shall not have ceased to exist; and (3) in the event that any Subordinated Indebtedness is declared or otherwise becomes due and payable because of the occurrence of an event of default with respect thereto, (x) the Holders at such time shall be entitled to receive payment in full thereon before the holders of the Subordinated Indebtedness shall be entitled to receive any payment on account of such Subordinated Indebtedness as a result of such event of default, and (y) no holder of Subordinated Indebtedness, or a trustee acting on such holder’s behalf, shall be entitled to exercise any control over proceedings to enforce the terms and conditions of the Master Indenture.

“Tax Agreement” means the Tax Exemption Certificate and Agreement by and among the Issuer, the Corporation and the Bond Trustee, including all appendices, certificates and attachments thereto, executed on the date of issuance and delivery of the Bonds, as it may be amended from time to time.

“Tax-Exempt Organization” shall mean a Person organized under the laws of the United States of America or any state thereof which is an organization described in Section 501(c)(3) of the Code, which is exempt from federal income taxes under Section 501(a) of the Code, and which is not a “private foundation” within the meaning of Section 509(a) of the Code, or corresponding provisions of federal income tax laws from time to time in effect.

“Thirty-Fourth Supplemental Indenture” means the Thirty-Fourth Supplemental Indenture, dated as of September 1, 2012, between the Alliance and the Master Trustee.

“Total Income Available for Debt Service” shall mean, as to any period, (a) the aggregate of Income Available for Debt Service of each member of the Obligated Group for such period, determined in such a manner that no portion of Income Available for Debt Service of any member of the Obligated Group is included more than once.

“Total Net Operating Revenues” shall mean, as to any period, the aggregate of Net Operating Revenues of each member of the Obligated Group for such period, determined in such a manner that no portion of Net Operating Revenues of any member of the Obligated Group is included more than once.

“Unrestricted Liquid Funds” as of any date means the aggregate of the unrestricted and unencumbered/unpledged cash and unrestricted and unencumbered/unpledged liquid securities (valued at fair market value) of the Obligated Group as of such date (including board-designated funds) from which there shall be subtracted each of the following: (i) the value of all self-insured professional and general liability insurance obligations of the Obligated Group determined by an independent actuary as of such date, (ii) any funds held by the lender or trustee with respect to any Long Term Indebtedness (including any debt service reserve fund, any debt service or bond fund or any construction or project fund), (iii) any proceeds drawn from a line of credit, liquidity facility or other similar facility, and (iv) any grantor or donor restricted funds.

“Value,” when used in connection with any Property, shall mean either (a) Book Value, or (b) at the election of the Obligated Group Agent evidenced by an Officer’s Certificate delivered to the Master Trustee, the aggregate fair market value of such Property, as reflected in the most recent written report of an appraiser selected by the Obligated Group Agent and, in the case of real property, who or which is a member of the American Institute of Real Estate Appraisers (MAI), delivered to the Master Trustee (which report shall be dated not more than three years prior to the date as of which value is to be calculated) (i) increased or decreased by the cost of any Property acquired, or the fair market value of any Property disposed of, since the date of such report and (ii) increased or decreased by a percentage equal to the aggregate percentage increase or decrease in the Construction Index from the date of such report to the date as of which value is to be calculated.

“Variable Rate Indebtedness” shall mean any portion of Indebtedness the interest rate on which fluctuates subsequent to the time of incurrence.

“Written Request” means with reference to a Related Issuer, a request in writing signed by the Chairman, Vice-Chairman, Executive Director, Associate Executive Director, Mayor, Clerk, President, Vice President, Secretary or Assistant Secretary of the Related Issuer and with reference to any Obligated Issuer means a request in writing signed by the President or a Vice President of such Obligated Issuer or any other officers designated in a certificate delivered to the Bond Trustee by the Related Issuer or such Obligated Issuer, as the case may be.

SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE

Each Obligation will be issued pursuant to the Master Indenture and will entitle each holder thereof to the protection of the covenants, restrictions and other obligations imposed upon the Corporation and each Obligated Issuer by the Master Indenture and the security provided for therein.

Accounting Principles

Where the character or amount of any asset or liability or item of income or expense is required to be determined or any consolidation, combination or other accounting computation is required to be made for the purposes of the Master Indenture or any agreement, document or certificate executed and delivered in connection with or pursuant to the Master Indenture, such determination or computation shall be done in accordance with generally accepted accounting principles in effect on (i) the date of the delivery of the Master Indenture, or (ii) at the election of the Obligated Group Agent, as specified in an Officer's Certificate delivered to the Master Trustee, the date such determination or computation is made for any purpose of the Master Indenture, such accounting principles, to the extent applicable, consistently applied; provided that intercompany balances and liabilities among the Obligated Issuers shall be disregarded and that the requirements set forth in this paragraph shall prevail, if inconsistent with generally accepted accounting principles. In the event that the fiscal year of any Obligated Issuer ends on a date other than the last day of a Fiscal Year, the character or amount of any asset or liability or item of income or expense of such Obligated Issuer for its fiscal year ending within any Fiscal Year under consideration shall be deemed to be the character or amount of the appropriate asset or liability or item of income or expense for such Fiscal Year. For purposes of calculating Total Income Available for Debt Service and Total Net Operating Revenues for any period, if any Obligated Issuer shall have become a member of the Obligated Group during such period, such calculations shall be made assuming that such Obligated Issuer became a member of the Obligated Group at the beginning of such period.

Master Indenture Obligations

Each Obligated Issuer is permitted to issue one or more series of Obligations under the Master Indenture on which all Obligated Issuers will be jointly and severally liable. The terms of each Obligation shall be set forth in a Supplemental Indenture.

The principal of, premium, if any, and interest on the Obligations shall be payable in any currency of the United States of America which is legal tender for the payment of public and private debts. Such payment shall be made at the principal corporate trust office of the Master Trustee or, if an Obligated Issuer so elects, by check, draft or wire transfer to such Holder. In the case of all payments made directly to a Holder, the Obligated Issuer shall give notice of such payment to the Master Trustee concurrently with the making thereof.

Each Obligated Issuer, jointly and severally, unconditionally guarantees to the Holders of the Obligations and to the Master Trustee the due and punctual payment of the principal of, and interest on, the Obligations and all other amounts due and payable under the Master Indenture; provided, however, that the maximum aggregate liability of each Obligated Issuer, as of any date, shall be its Maximum Guaranty Liability as of such date.

Each Obligated Issuer shall be subrogated to all rights of the Holders of the Obligations and the Master Trustee against the other Obligated Issuers in respect of any amounts paid pursuant to the Master Indenture.

If any Person ceases to be an Obligated Issuer, such Person shall cease to be a "Cross Guarantor" under the Master Indenture, and its Obligations as such shall be terminated and released; provided, however, that the foregoing provision is inapplicable (i) if such Person ceases to be an Obligated Issuer as a result of a transaction which is prohibited by the terms of the Master Indenture or (ii) if, at the time such Person would otherwise have been released under the provisions of this paragraph, there has occurred and is continuing a default in the payment of principal, or interest, on any Obligation.

If an Obligated Issuer is called upon to make a payment under its Cross Guarantee, each of the Obligated Issuers shall contribute to such paying Obligated Issuer their pro rata share, determined pursuant to the Master Indenture, of the amount of such payment.

All Obligations shall be executed for and on behalf of an Obligated Group Member by the officer as specified in the Master Indenture or such other officer designated in writing. A resolution of the Governing Body of the Obligated Group Agent shall also be joined thereto. Further, each Obligation shall be manually authenticated, in the form provided in the Master Indenture, by an authorized signer of the Master Trustee, without which authentication no Obligation shall be valid or entitled to the benefits of the Master Indenture.

The Master Trustee shall maintain at its principal corporate trust office a registration book relating to Obligations of the Obligated Group. These registration books shall contain (i) the names and addresses of Holders of Obligations, and (ii) any other information which may be necessary for the proper discharge of the Master Trustee's duties under the Master Indenture. The Supplemental Indenture, providing for the issuance thereof, shall govern the transfer or exchange of any Obligation.

If any Obligation is mutilated, lost, stolen or destroyed, the Holder thereof shall be entitled to the issuance of a substitute Obligation only as follows:

- (i) In the case of a lost, stolen or destroyed Obligation, the Holder shall: provide notice of the loss to the Obligated Group Agent, or to the Master Trustee; request the issuance of a substitute Obligation before the Obligated Group Agent receives notice of the transfer of the original Obligation to a bona fide purchaser for value without notice; provide indemnity to the Master Trustee against any and all claims arising out of, or otherwise related to, the issuance of substitute Obligations; and shall surrender any Obligation which have not been lost, stolen or destroyed and provide evidence of the ownership of the affected Obligation and the loss, theft or destruction thereof;
- (ii) In the case of a mutilated Obligation the Holder shall: surrender the Obligation to the Master Trustee for cancellation; and provide indemnity to the Master Trustee against any and all claims arising out of, or otherwise related to, the issuance of substitute Obligations.

Every substituted Obligation shall constitute an additional contractual obligation of the Obligated Group, whether or not the Obligation alleged to have been destroyed, lost or stolen shall be at any time enforceable by anyone, and shall be entitled to all the benefits of the Master Indenture equally and proportionately with any and all other Obligations, unless the Obligation alleged to have been destroyed, lost or stolen shall be at any time enforceable by a bona fide purchaser for value without notice.

The preceding provisions regarding substitute Obligations are exclusive with respect to the replacement or payment of mutilated, destroyed, lost or stolen Obligations and shall preclude any and all other rights or remedies, notwithstanding any law or statute existing or later enacted to the contrary.

The Master Trustee shall establish and maintain a revenue or similar debt service fund for the purpose of accumulating and paying amounts due on outstanding Obligations (i) if the applicable Supplemental Indenture provides for the making of deposits directly with the Master Trustee in respect of an Obligation, or (ii) upon the occurrence of an Event of Default under the Master Indenture and the exercise of any remedies by the Master Trustee for the benefit of all Holders of outstanding Obligations. All money held in any fund established under the Master Indenture, in the case of (i) above, shall, upon written request and direction of the Obligated Group Agent, be invested in Investment Securities, and any money realized by the Master Trustee in the case of (ii) above, shall be invested by the Master Trustee, without need of any further authorization or direction, only in Government Obligations with maturities not in excess of ninety days, unless the Master Trustee is otherwise directed by Holder. The Master Trustee shall not be liable or responsible for any loss resulting from any such investment.

Any Obligated Issuer and the Master Trustee may enter into a Supplemental Indenture to create an Obligation issued under the Master Indenture. The Supplemental Indenture shall (i) with respect to Obligations

created thereby, set forth the date thereof, and the date or dates on which principal of, premium, if any, and interest on such Obligations shall be payable, and (ii) provide for the form of such Obligations and shall contain such other terms and provisions as shall not be inconsistent with the provisions of the Master Indenture.

Simultaneously with or prior to the execution, authentication and delivery of the Obligations pursuant to the Master Indenture:

(a) All requirements and conditions to the issuance of such Obligations, if any, set forth in the Master Indenture and the Supplemental Indenture shall have been complied with and satisfied;

(b) The applicable Obligated Issuer or the Obligated Group Agent shall have delivered to the Master Trustee such opinions, certificates, proceedings, instruments and other documents as the Master Trustee or the Related Bond Issuer, if any, may reasonably request;

(c) The requirements of the Master Indenture with respect to the incurrence of Additional Indebtedness shall have been satisfied if such Obligations constitute Indebtedness;

(d) Each Supplemental Indenture shall specify the purpose or purposes for which such Obligations are being issued, which may be any purpose within the corporate power of the applicable Obligated Issuer; and

(e) The Obligated Group Agent shall have delivered to the Master Trustee an opinion of counsel, regarding the Securities Act of 1933 and the Trust Indenture Act of 1939, as required pursuant to the Master Indenture.

Security For Obligations

As security for the payment and performance of all outstanding Obligations, the Obligated Issuers shall grant the Master Trustee a security interest in (i) all money and Investment Securities which may at any time be held by the Master Trustee in any fund or account which may be established by the Master Trustee under the Master Indenture in connection with the administration of the trusts created thereby, (ii) all Gross Receipts, (iii) all Receivables, (iv) all Inventory, (v) all Equipment, (vi) all General Intangibles, (vii) all Contracts and all Contract Rights, (viii) all amounts from time to time held in any checking, savings, deposit or other account of any Obligated Issuer, (ix) all Government Approvals, provided, that any Government Approval which by its terms or by the operation of law would become void, voidable, terminable or revocable if mortgaged, pledged or signed under the Master Indenture or if a security interest therein were granted thereunder or expressly accepted and excluded from the security interest hereby granted to the extent necessary so as to avoid such voidness, voidability, terminability or revocability, (x) all Fixtures, including but not limited to those now or hereafter attached to, placed on or incorporated in the Land, (xi) all Revenues, (xii) without limiting the generality of the foregoing, all other personal property, goods, Instruments, Investment Property, Chattel Paper, Documents, credits, claims, demands and assets of any Obligated Issuer, whether now existing or hereafter acquired from time to time, and (xiii) any and all additions and accessions to any of the foregoing, all improvements thereto, all substitutions and replacements therefor and all products and Proceeds thereof (all of the above collectively, the "Collateral"), to have and to hold in trust for the benefit of the Holders from time to time of all Obligations issued and outstanding under the Master Indenture, without preference or priority of any one Obligation over any other Obligation except as otherwise expressly provided therein. The security interest granted to the Master Trustee pursuant to the Master Indenture extends to all Collateral of the kind which is subject to such security interest which any Obligated Issuer may acquire at any time during the continuation of the Master Indenture, whether such Collateral is in transit or in such Obligated Issuer, the Issuer's or any other Person's constructive, actual or exclusive occupancy or possession.

To further secure the payment of and performance under all outstanding Obligations, the Corporation has, on even date herewith, executed and delivered to the Master Trustee the Master Deed of Trust.

If (i) in any Fiscal Year beginning with the Fiscal Year ending June 30, 2006, the Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group is less than 1.50 to 1, (ii) the Obligated Group is not in compliance with the liquidity covenant described under the caption "Liquidity Covenant" herein, or (iii) an Event of

Default has occurred and is continuing, the Obligated Group Agent shall cause a special trust fund (the “Revenue Fund”) to be created with one or more banking institutions and each Obligated Issuer shall on a daily basis deposit all of its Gross Receipts therein.

The Obligated Group Agent shall cause each banking institution with which the Revenue Fund has been established to enter into a written depository agreement, which shall be satisfactory in form and substance to the Master Trustee and shall be in substantially the form of such agreement heretofore delivered to the Master Trustee (or with such changes therein as shall have been approved by the Holders of not less than 75% in aggregate principal amount of Obligations then outstanding) pursuant to which such banking institution shall agree to hold any and all Gross Receipts from time to time on deposit with such banking institution as assets of a trust for the Holders of the Obligations and to transfer such Gross Receipts to the Master Trustee upon receipt from the Master Trustee of a notice stating that delivery of such Gross Receipts is required pursuant to the Master Indenture. Prior to its receipt of a request from the Master Trustee, any Obligated Group member may transfer or expend all or any part of its Gross Receipts free of any security interest, subject, however, to the provisions of the Master Indenture. Deposits of Gross Receipts shall be made into the Revenue Fund on a daily basis, insofar as practicable, for the benefit of the Master Trustee and the Holders of the Obligations. Upon the request of the Obligated Group Agent, the Master Trustee will provide to such agent a written certifications as to whether there is currently outstanding a request from the Master Trustee.

Each Obligated Issuer agrees that except as may be otherwise provided in the Master Indenture, it will not pledge or grant a security interest in any of the Gross Receipts.

Each Obligated Issuer agrees that, if an Event of Default shall have occurred and be continuing, it will, upon request of the Master Trustee, deliver or direct to be delivered to the Master Trustee all Gross Receipts until such Event of Default has been cured, such Gross Receipts to be applied in accordance with the Master Indenture.

The Master Trustee shall establish and maintain a revenue or similar debt service fund hereunder for the purpose of accumulating and paying amounts due on outstanding Obligations (i) if the applicable Supplemental Indenture specifically provides for the making of deposits directly with the Master Trustee in respect of an Obligation, or (ii) upon the occurrence of an Event of Default and the exercise of any remedies by the Master Trustee for the benefit of all Holders of outstanding Obligations; provided, however, if neither (i) nor (ii) are at the time applicable but deposits to the Revenue Fund are then required under subsection (a) above, the Obligated Group Agent may deposit the Gross Receipts with one or more banking institutions (other than the Master Trustee) and such revenues shall, upon the request and direction of the Obligated Group Agent, be invested in Investment Securities. In the case of (i) above, deposits to any such fund and payments therefrom shall be made in accordance with the terms and provisions of the applicable Supplemental Indenture for the making of deposits into and payments from such fund. In the case of (ii) above, any moneys realized by the Master Trustee upon the exercise of any such remedies shall be applied in accordance with the provisions of the Master Indenture. All money held at any time in any fund in the case of (i) above, shall, upon written request and direction of the Obligated Group Agent, be invested in Investment Securities and any money realized by the Master Trustee in the case of (ii) above, shall be invested by the Master Trustee, without need of any further authorization or direction, only in Government Obligations having maturities not in excess of 90 days, unless the Master Trustee is otherwise directed by Holders in the manner provided in the Master Indenture.

Persons Becoming Obligated Issuers; Withdrawal from Obligated Group

The Master Indenture permits Persons other than the Corporation to become members of the Obligated Group subject to the satisfaction of certain conditions. The conditions include the following:

First, such Person shall execute and deliver to the Master Trustee an appropriate instrument, satisfactory to the Obligated Group Agent, containing (i) the agreement of such Person to become an Obligated Issuer under the Master Indenture and thereby to become subject to compliance with all provisions of the Master Indenture pertaining to an Obligated Issuer, including the performance and observance of all covenants and obligations of an Obligated Issuer under the Master Indenture; (ii) the agreement of such Person to consult with each other member of the Obligated Group prior to incurring any Obligations; and (iii) such other restrictions on the ability of such Person to incur Obligations as shall be imposed by the Obligated Group. Such Person shall execute and deliver to the

Master Trustee such security agreements, financing statements and other documents as are necessary to grant to the Master Trustee a perfected lien in all Collateral in which such Person has an interest.

Second, each instrument executed and delivered to the Master Trustee in accordance with the preceding paragraph shall be accompanied by an Officer's Certificate from the Obligated Group Agent to the effect that the Obligated Group Agent consents to such Person becoming an Obligated Issuer and an opinion of Counsel to the effect that (a) the conditions contained in the Master Indenture relating to such Person's membership in the Obligated Group have been satisfied; (b) under then existing law, such Person becoming an Obligated Issuer will not subject any Obligation to the registration provisions of the Securities Act of 1933, as amended, or that such Obligation has been so registered if so required, or the qualification of the Master Indenture pursuant to the Trust Indenture Act of 1939, as amended, or that the Master Indenture has been so qualified if qualification is required; and (c) each such instrument has been duly authorized, executed and delivered by such Person and constitutes a legal, valid and binding agreement, enforceable in accordance with its terms, except as limited by then-existing laws relating to bankruptcy and insolvency and other standards and customary legal exceptions.

If all amounts due or to become due on any outstanding Related Bond which bears interest that is not includable in gross income under the Code has not been paid to the holder thereof (or provision for such payment has not been made in such manner as to have resulted in the defeasance of the Related Financing Documents), the Master Trustee shall receive an Opinion of Bond Counsel to the effect that under then existing law such Person becoming an Obligated Issuer would not adversely affect the validity of such Related Bond or cause the interest payable on such Related Bond to become includable in gross income under the Code.

As a further condition to a Person becoming a member of the Obligated Group, the Master Trustee shall receive an Officer's Certificate from the Obligated Group Agent to the effect that (A) no Event of Default then exists under the Master Indenture, nor to such officer's knowledge, does there then exist any event which, with the passage of time or giving of notice or both, would or might become an Event of Default under the Master Indenture; (B) either (1) if one dollar of Additional Indebtedness were incurred immediately following such Person's admission, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to subsection (a)(i) or (ii) under the heading "Additional Long-Term Indebtedness" (assuming, for purposes of such certificate, that the Income Available for Debt Service and Indebtedness of such Person were Income Available for Debt Service and Indebtedness of an Obligated Issuer), or (2) such Person becoming a member of the Obligated Group will cure any Event of Default then in existence under the Master Indenture, or (3) by reason of such membership, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years following such entry into the Obligated Group will be greater than the projected Debt Service Coverage Ratio for such Fiscal Years had such entry into the Obligated Group not occurred; (C) immediately after such person's admission, the combined fund balance and net worth, as the case may be, of the Obligated Group is not less than 90% of such combined fund balance and net worth immediately prior to such admission; and (D) the Historical Pro Forma Debt Service Coverage Ratio of the Obligated Group (taking into account the admission of such Person) for each of the two most recent Fiscal Years for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available was not less than 1.30 to 1.

As a further condition to a Person becoming a member of the Obligated Group, the Master Trustee shall receive a Consultant's report to the effect that the Projected Debt Service Coverage Ratio of the Obligated Group (taking into account the admission of such Person) for each of the two Fiscal Years following the admission of such Person is not less than 1.3:1.

The Corporation shall not withdraw from the Obligated Group. No other Obligated Issuer may withdraw from the Obligated Group unless:

- (i) If the Obligated Issuer is other than the Obligated Group Agent, the Obligated Group Agent consents to the withdrawal;
- (ii) If all amounts due on any outstanding Related Bond which bears interest that is not includable in gross income under the Code have not been paid to the holder thereof (or provision for such payments has not been made in such manner as to have resulted in the defeasance of the Related Financing Documents), the Master Trustee shall have received an Opinion of Bond Counsel, in

form and substance satisfactory to the Master Trustee, to the effect that under then existing law such Person's withdrawal from the Obligated Group would not adversely affect the validity of such Related Bond or cause the interest payable on such Related Bond to become includable in gross income under the Code;

- (iii) The Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that either (1) after giving effect to such withdrawal, if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to subsection (a)(i) or (ii) under the heading "Additional Long-Term Indebtedness," or (2) such Person's withdrawal from the Obligated Group will cure any Event of Default then in existence under the Master Indenture, or (3) by reason of such withdrawal, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years immediately following withdrawal of such Obligated Issuer from the Obligated Group will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such withdrawal not occurred;
- (iv) The Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that, immediately after the withdrawal of such Person from the Obligated Group, no Event of Default then exists under the Master Indenture, nor to such officer's knowledge, does there then exist any event which, with the passage of time or giving of notice or both, would or might become an Event of Default; and
- (v) The Master Trustee shall have received a Consultant's report to the effect that the Projected Debt Service Coverage Ratio of the Obligated Group (taking into account the withdrawal of such Person) for each of the two Fiscal Years following the withdrawal of such Person is not less than 1.3:1;
- (vi) The Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that the Historical Pro Forma Debt Service Coverage Ratio of the Obligated Group (taking into account the withdrawal of such Obligated Issuer) for each of the two most recent Fiscal Years for which consolidated or combined financial statements reported upon an independent certified public Accountant are available was not less than 1.30 to 1; and
- (vii) The Obligated Group Agent shall have received an opinion of Counsel to the effect that following such Person's withdrawal from the Obligated Group no member of the Obligated Group will have any liability for the payment of any indebtedness of such Person.

Upon compliance with the above conditions, the Master Trustee shall execute any documents reasonably requested by the withdrawing Obligated Issuer to evidence the termination of such Issuer's obligations under the Master Indenture, under any Supplemental Indenture and under all Obligations.

Short-Term Indebtedness

Each Obligated Issuer agrees that it will not incur, nor permit any of its Restricted Affiliates to incur, any Additional Indebtedness constituting Short-Term Indebtedness unless immediately after the incurrence of such Short-Term Indebtedness:

- (a) (i) the principal amount of all Short-Term Indebtedness of the Obligated Group then outstanding does not exceed 20% of the Total Net Operating Revenues for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available, or
- (ii) any such Short-Term Indebtedness could be incurred under the tests set forth in the Master Indenture (relating to Long-Term Indebtedness) treating such Short-Term Indebtedness as Long-Term Indebtedness, and

(b) For a period of not fewer than 15 consecutive days within each Fiscal Year, the Obligated Group shall reduce the aggregate principal amount of all outstanding Short-Term Indebtedness described in (a)(i) above to less than 5% of the Total Net Operating Revenues for the immediately preceding Fiscal Year.

Additional Long-Term Indebtedness

Each Obligated Issuer agrees that it will not incur nor permit any of its Restricted Affiliates to incur, any Additional Indebtedness constituting Long-Term Indebtedness unless such Long-Term Indebtedness consists of one or more of the following:

(a) Long-Term Indebtedness of any member of the Obligated Group, if prior to the incurring thereof, there is delivered to the Master Trustee:

(i) an Officer's Certificate of the Obligated Group Agent demonstrating that the Historical Pro Forma Debt Service Coverage Ratio for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available was not less than 1.35; or

(ii) (A) an Officer's Certificate of the Obligated Group Agent demonstrating that the Historical Maximum Annual Debt Service Coverage Ratio for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available was not less than 1.25, and (B) a Consultant's report (or, in lieu thereof, an Officer's Certificate of the Obligated Group Agent if the Projected Debt Service Coverage Ratio described in this subsection (B) is 1.75 or greater) to the effect that the Projected Debt Service Coverage Ratio, taking the proposed Additional Indebtedness into account, (x) in the case of Additional Indebtedness (other than a Guaranty) to finance capital improvements, for each of the two Fiscal Years succeeding the date on which such capital improvements are expected to be in operation, or (y) in the case of Long-Term Indebtedness not financing capital improvements or in the case of a Guaranty, for each of the two Fiscal Years succeeding the date on which the Indebtedness or Guaranty is incurred, is not less than 1.40.

The requirements of (a)(ii)(A) and (B) will be deemed satisfied if (i) a Consultant's report filed with the Master Trustee states that applicable laws or regulations have prevented or will prevent the achievement of such debt service coverage ratios, (ii) the Obligated Group has generated Total Income Available for Debt Service in an amount which, in the opinion of such Consultant, the Obligated Group could reasonably have generated given such laws and regulations during the period affected thereby.

(b) Completion Indebtedness of any member of the Obligated Group without limit if there is delivered to the Master Trustee: (i) an Officer's Certificate of the applicable member of the Obligated Group stating that at the time the original Long-Term Indebtedness for the Facilities to be completed was incurred, such Obligated Group member had reason to believe that the proceeds of such Long-Term Indebtedness, together with other moneys then expected to be available, would provide sufficient moneys for the completion of such Facilities; (ii) a statement of an Architect or an expert setting forth the amount estimated to be needed to complete the Facilities, and (iii) an Officer's Certificate of such member of the Obligated Group stating that the proceeds of such Completion Indebtedness to be applied to the completion of the Facilities, together with a reasonable estimate of investment income to be earned on such proceeds and the amount of moneys, if any, committed to such completion by such Obligated Group member or through enumerated bank loans (including letters or lines of credit) or through federal or state grants, will be in an amount not less than the amount set forth in the statement of an architect or other expert referred to in (ii).

(c) Commitment Indebtedness of any member of the Obligated Group or any Guaranty of any Commitment Indebtedness of any member of the Obligated Group without limit.

(d) Long-Term Indebtedness of any member of the Obligated Group incurred for the purpose of refunding, repurchasing or refinancing (whether in advance or otherwise) any outstanding Long-Term Indebtedness;

provided, however, that additional Long-Term Indebtedness permitted under this paragraph (d) shall not result in an increase in Maximum Annual Debt Service in excess of 10%.

(e) The conversion without limit of Long-Term Indebtedness of any member of the Obligated Group that is convertible from one interest or payment made to another interest or payment (e.g., weekly to monthly or to a fixed rate) from one mode to another pursuant to the terms of the documentation authorizing such Long-Term Indebtedness.

(f) Subordinated Indebtedness without limit of any member of the Obligated Group or Non-Recourse Indebtedness without limit of any member of the Obligated Group; provided, however, that in the case of Subordinated Indebtedness, the Obligated Group Agent shall have furnished the Master Trustee with a certificate showing that prior to the issuance of such Subordinated Indebtedness, the debt to capitalization ratio of the Obligated Group does not exceed 60%.

(g) Indebtedness incurred in connection with a sale of not more than 25% of accounts receivable with recourse by any member of the Obligated Group consisting of an obligation to repurchase all or a portion of such accounts receivable upon certain conditions, provided that the principal amount of such Indebtedness permitted shall not exceed the aggregate sales price of such accounts receivable received by such Obligated Group member.

(h) Long-Term Indebtedness of any member of the Obligated Group, the principal amount of which at the time incurred, together with the aggregate principal amount of all other Long-Term Indebtedness and Short-Term Indebtedness of the Obligated Group then outstanding, does not exceed 25% of the Total Net Operating Revenues for the most recent Fiscal year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available.

Guaranties

Each Obligated Issuer agrees that it will not enter into, or become liable in respect of, or permit any Restricted Affiliate to enter into, or become liable in respect of, any Guaranty dated after the date of the Master Indenture unless the principal amount of the indebtedness being guaranteed could then be incurred as Indebtedness described under the heading "Additional Long-Term Indebtedness," taking into account the assumptions as to calculating the aggregate annual principal and interest payments on, and the principal amount of, the indebtedness being guaranteed, contained in the immediately succeeding paragraph.

In the case of Guaranties of indebtedness that would, if such indebtedness were incurred by a member of the Obligated Group, constitute Long-Term Indebtedness, the aggregate annual principal and interest payments on, and the principal amount of, the Guaranty shall be deemed to be equal to 20% of the principal and interest payments which would be payable on the indebtedness being guaranteed as if such indebtedness were Long-Term Indebtedness of the Guarantor. If at any time the Guaranty becomes due and payable, or if any payment has been made under the Guaranty during the two immediately preceding Fiscal Years, the aggregate annual principal and interest payments on, and the principal amount of, the Guaranty shall, for purposes of this paragraph, be deemed to equal 100% of the principal and interest payable on, and the principal amount of, the indebtedness being guaranteed for the Fiscal Year for which such determination is being made.

Debt Service on Balloon Indebtedness and Variable Rate Indebtedness

For purposes of the covenants and computations required or permitted pursuant to the Master Indenture, it shall be assumed that (A) the interest rate on Variable Rate Indebtedness is equal to the higher of (a) the current rate on the Variable Rate Indebtedness or (b) that rate that is the average of the rate of interest which was in effect on the last day of each of the twelve preceding full calendar months immediately preceding the month in which such calculation is made, provided that if the Variable Rate Indebtedness has not been outstanding for at least twelve full calendar months, the assumed rate of interest for such Variable Rate Indebtedness shall be the rate of interest borne on the date such Variable Rate Indebtedness was issued, and (B) the principal of Balloon Indebtedness is amortized:

(i) from the date of calculation thereof over a term equal to twenty (20) years, with level annual debt service payments at an assumed interest rate equal to the Bond Index (provided if the Balloon Indebtedness is also Variable Rate Indebtedness, the assumed interest rate may, at the option of the Obligated Group Agent, be the assumed interest rate applicable to Variable Rate Indebtedness); or

(ii) during the term to the maturity thereof by deposits made to a sinking fund therefor pursuant to the terms of such Balloon Indebtedness or in accordance with a sinking fund schedule established by resolution of the Governing Body of the applicable Obligated Issuer adopted at or subsequent to the time of incurrence of such Balloon Indebtedness, as certified in an Officer's Certificate, provided that, at the time of such calculation, all deposits required to have been made prior to such date shall have been made; or

(iii) the principal of Balloon Indebtedness is due and payable on the specified due date or due dates thereof; or

(iv) with respect to Balloon Indebtedness for which there exists a Credit Facility, the principal of such Balloon Indebtedness is due and payable in the amounts and at the times specified in the Credit Facility.

Insurance

Each Obligated Issuer will maintain, or cause to be maintained, insurance covering such risks and in such amounts as, in its reasonable judgment, is adequate to protect it and its Property and operations, including (to the extent that such Obligated Issuer is a health care institution) professional liability or medical malpractice insurance, one year's business interruption insurance (if commercially available) and extended coverage property insurance in an amount sufficient to avoid co-insurance. The Master Trustee shall be named as an additional insured on all such insurance policies. The Obligated Group Agent shall retain an Insurance Consultant who will prepare and file with the Master Trustee a report showing the adequacy of such insurance once every two years (such report to be filed as soon as practicable but in no event later than five months after the end of the applicable second Fiscal Year). Each Obligated Issuer will follow any recommendations of the Insurance Consultant to the extent feasible in the opinion of the Obligated Group Agent.

In lieu of maintaining the insurance policies required above, the Obligated Group, or any member thereof, may self-insure any of the required coverages (or a portion thereof), provided that the Obligated Group may not self-insure any required coverage with respect to Property, Plant and Equipment and provided further that the Master Trustee receives a report (as soon as practicable but in no event later than five months after the end of each Fiscal Year) of an Insurance Consultant to the effect that such self-insurance is consistent with proper management and insurance practices. If any member of the Obligated Group elects to self-insure in lieu of maintaining medical liability and malpractice insurance, a report of an Insurance Consultant shall be filed with the Master Trustee annually stating that such Insurance Consultant has reviewed the self-insurance program and that the self-insured Obligated Group Member has available the estimated amount required for the payment of claims and associated claims expenses with respect to such Fiscal Year.

In the event of damage to or destruction of all or any part of the Facilities of the Obligated Group with a Value in excess of five percent (5%) of the Value of all Property of the Obligated Group, the affected Obligated Group member or the Obligated Group Agent shall exercise its best efforts to recover any applicable insurance. Such proceeds shall be paid to the Obligated Group Agent for the payment or reimbursement of reasonable expenses of obtaining the recovery. The Obligated Group Agent shall then give notice to the Master Trustee of such expenses and of the amount of the remaining proceeds (herein called the "Net Proceeds").

Subject to the provisions of any Related Financing Document pertaining to a Permitted Lien, the affected Obligated Group member shall apply the Net Proceeds for any lawful corporate purpose as such Obligated Group member determines, if the Obligated Group Agent shall first have delivered to the Master Trustee an Officer's Certificate stating that the Projected Debt Service Coverage Ratio for each of the next two full succeeding Fiscal Years immediately following the date of such certificate(s), taking into account such damage or destruction and the proposed use of the Net Proceeds is at least 1.10. If the Obligated Group Agent is unable to deliver the foregoing

Officer's Certificate, the affected Obligated Group member shall apply the Net Proceeds or so much thereof as may be needed to the repair, replacement, restoration or reconstruction of the affected Facilities or, at the option of the applicable Obligated Group member, to any other capital project of equivalent value and utility, to the acquisition of any Property or to the repayment in whole or in part of any outstanding Obligations in such order of maturity or maturities or proportions as the Obligated Group Agent shall determine.

Any Net Proceeds remaining after compliance by the affected Obligated Group member and the Obligated Group Agent with the immediately preceding paragraph shall be transferred by the Obligated Group Agent to the Master Trustee and applied to the redemption of the outstanding Obligations that directly finance the damaged or condemned facilities and are secured thereby, second to other direct outstanding Obligations of the affected Member of the Obligated Group, and third to the redemption of other outstanding Obligations in such order of maturity or maturities or proportions as the Obligated Group Agent shall determine.

In the event of a taking by eminent domain of all or any part of the Facilities of the Obligated Group with a Value in excess of five percent (5%) of the Value of all Property of the Obligated Group, the affected Obligated Group member or the Obligated Group Agent shall exercise its best efforts to recover any applicable proceeds. Such proceeds shall be paid to the Obligated Group Agent. The Obligated Group Agent shall make appropriate deductions from such proceeds and give notice to the Master Trustee of such deductions and of the amount of the remaining proceeds (also, "Net Proceeds"). The Net Proceeds shall be applied in the same manner as insurance proceeds are applied pursuant to the two immediately preceding paragraphs.

Certain Covenants of the Obligated Issuers

Each Obligated Issuer covenants, among other things, to maintain its corporate or other separate legal existence and to be qualified to do business where such qualification is necessary, to maintain and keep its Facilities in good repair, to conduct its affairs in compliance with all applicable laws and regulations, to pay all lawful taxes and governmental charges and assessments levied or assessed upon or against it or its Property (except that each Obligated Issuer may withhold such payments where the validity of such taxes and assessments is being contested in good faith), to comply with any covenants and provisions of any Liens upon its property or securing any of its Indebtedness, to procure and maintain all necessary licenses and permits, to maintain accreditation of its health care Facilities and its status as a provider of health care services eligible for reimbursement under government programs (provided, however, that it need not comply with the requirements pertaining to licenses, permits, accreditation and its status as a provider if and to the extent its Governing Body shall have determined in good faith, evidenced by an Officer's Certificate that such compliance is not in its best interests and that lack of such compliance would not materially impair its ability to pay its indebtedness when due).

In addition, each Obligated Issuer covenants not to merge with or consolidate with any other Person not a member of the Obligated Group or sell or convey all or substantially all of its assets to any Person not a member of the Obligated Group unless: (a) the successor corporation (if other than the Obligated Issuer) shall be a Person organized and existing under the laws of the United States of America or a state thereof and such Person shall become an Obligated Issuer and shall expressly assume the due and punctual payment of the principal of, premium, if any, and interest on all outstanding Obligations according to their tenor, and the due and punctual performance and observance of all of the covenants and conditions of the Master Indenture by a Supplemental Indenture satisfactory to the Master Trustee, executed and delivered to the Master Trustee by such Person; (b) if all amounts due or to become due on any outstanding Related Bonds which bear interest that is not includable in gross income under the Code have not been fully paid to the holders thereof (or provision for such payment has not been made in such manner as will result in the defeasance of the Related Financing Documents), the Master Trustee shall have received an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law the consummation of such merger, consolidation, sale or conveyance, whether or not contemplated on the date of the delivery of any such Related Bonds, would not cause the interest payable on such Related Bonds to become includable in gross income under the Code or adversely affect the validity of such Related Bonds; and (c) there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent to the effect that immediately following such transaction, (A) no Event of Default then exists nor, to such officer's knowledge, does there exist any event which, with the passage of time or the giving of notice or both, would or might become an Event of Default under the Master Indenture, and (B) either (1) if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the tests providing for the incurrence of Long-Term

Indebtedness described in subsection (a)(i) or (ii) under the heading Additional Long-Term Indebtedness (assuming for purposes of such Certificate that the Income Available for Debt Service and Indebtedness of such person were Income Available for Debt Service and Indebtedness of an Obligated Issuer), or (2) such transaction will cure any Event of Default then in existence under the Master Indenture, or (3) by reason of such transaction, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years following such release will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such transaction not occurred, and (C) the combined fund balance and net worth, as the case may be, of the Obligated Group will not be less than 90% of such combined fund balance and net worth immediately prior to such transaction.

In case of any such consolidation, merger, sale or conveyance and upon any such assumption by the successor corporation, such successor corporation shall succeed to and be substituted for its predecessor.

In case of any such consolidation, merger, sale or conveyance, such changes in phraseology and form (but not in substance) may be made in Obligations thereafter to be issued as may be appropriate.

Permitted Encumbrances

No Obligated Issuer will create or suffer to be created or to exist (or permit any Restricted Affiliate to create or suffer to be created or to exist) any Lien upon any of their Property including, without limitation, all proceeds thereof, whether cash or non-cash, now owned or after acquired by any of them, other than Permitted Liens.

Disposition of Property

Each Obligated Issuer agrees that neither it will sell, lease or otherwise dispose of any Property, except for sales, leases or other dispositions of Property:

(a) To another member of the Obligated Group;

(b) To any Person if prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate stating that, in the judgment of the officer executing such certificate, such Property has become, or within the next succeeding 24 calendar months is reasonably expected to become, inadequate, obsolete, worn out, unsuitable, unprofitable, undesirable or unnecessary and sale, lease, removal or other disposition thereof will not impair the structural soundness, efficiency or economic value of the remaining Property;

(c) To any Person provided that prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent certifying (1) that Property transferred pursuant to this section in the then-current Fiscal Year by all Obligated Issuers does not exceed 5% of the Value of all Property of the Obligated Group for the immediately preceding Fiscal Year and (2) that Property transferred pursuant to this section in the then-current Fiscal Year and in each of the immediately preceding three Fiscal Years by all Obligated Issuers does not in the aggregate exceed 15% of the Value of all Property of the Obligated Group for the immediately preceding Fiscal Year;

(d) To any Person provided that prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent, to the effect that immediately after the transfer in question, either (1) if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to subsection (a)(i) or (ii) above contained under the heading Additional Long-Term Indebtedness or (2) such disposition will increase the Projected Debt Service Coverage Ratio in the Fiscal Year immediately following such disposition over what such ratio would have been in such Fiscal Year had such disposition not occurred;

(e) As part of a merger, consolidation, sale or conveyance permitted under the heading "Certain Covenants of the Obligated Issuers";

(f) In the ordinary course of business;

- (g) To any Person in connection with an operating lease of Property to such Person;
- (h) Upon fair and reasonable terms no less favorable than would be obtained in a comparable arm's-length transaction;
- (i) To any Person if the transfer involves any Property received as restricted gifts, grants, bequests or other similar sums or the income thereon, to the extent that such sums may not be pledged or applied to the payment of any Debt Service Requirement or operating expenses generally as a result of restrictions or designations imposed by the donor or maker of the gift, grant, bequest or other sums in question; or
- (j) To any Person so long as such Property is not encumbered by the Master Deed of Trust and the amount of Property transferred pursuant to this subsection U) in any Fiscal Year shall not exceed \$5,000,000.

To the extent that any Property of the Corporation that is permitted to be sold, leased or otherwise disposed of under the foregoing is encumbered by the Master Deed of Trust or the Master Indenture, upon receipt of an Officer's Certificate directing the Master Trustee to execute a release and/or termination statement with respect to such property to be sold, the Master Trustee shall execute and deliver to the Corporation a release and/or termination statement with respect to such property; provided, however, that no real property encumbered by the Master Deed of Trust shall be sold, leased or otherwise disposed of unless (1) such sale, lease or disposition is permitted under one of the provisions above and the Value of the Property being sold, leased or otherwise disposed of does not exceed \$2,500,000 or (2) such Property is sold for fair market value (as determined by an appraisal delivered to the Master Trustee), provided that if such sales is of real property having an aggregate Book Value in excess of \$15,000,000, the Corporation shall deliver to the Master Trustee an Officer's Certificate of the Obligated Group Agent to the effect that immediately after the transaction in question the Obligated Group (i) will have a Days Cash on Hand Ratio equal to or greater than 50 (110 as long as any Related Bonds remain outstanding that are insured by the Bond Insurer or any amounts are owed by any member of the Obligated Group to the Bond Insurer unless waived by the Bond Insurer) and (ii) will be in compliance with the provisions of the Master Indenture relating to rates and charges. In the event that any Property is released from the Master Deed of Trust pursuant to clause (2) of the immediately preceding sentence, the consideration received by the Corporation from the sale of such Property shall be applied to acquisition, construction or equipping of facilities for use by the Obligated Group or to the option redemption or defeasance of outstanding Related Bonds. Notwithstanding the foregoing, if outstanding Related Bonds are insured by the Bond Insurer at the time of any sale, the Corporation may not sell any Property pursuant to clause (2) of this paragraph unless the Corporation encumbers additional real property pursuant to the Master Deed of Trust with a Value not less than the Value of the Property being released that is approved in writing by the Bond Insurer or the Bond Insurer otherwise consents to such sale.

Filing of Financial Statements, Certificate of No Default, Other Information

The Obligated Group Agent covenants that it will:

(a) As soon as practicable but in no event later than four months after the end of each Fiscal Year, file, or cause to be filed, with the Master Trustee and, if such Persons are then providing a rating with respect to Obligations or any Related Bonds, with each Rating Agency, (i) a combined or consolidated revenue and expense statement of the Corporation, and each other Obligated Issuer, for such Fiscal Year and (ii) a combined or consolidated balance sheet of the Corporation and each other Obligated Issuer as of the end of such Fiscal Year, each accompanied by the required report of an Accountant.

(b) As soon as practicable but in no event later than four months after the end of each Fiscal Year, file with the Master Trustee, an Officer's Certificate of the Obligated Group Agent stating the Historical Debt Service Coverage Ratio and the Historical Maximum Annual Debt Service Coverage Ratio for such Fiscal year, stating that all insurance required by the Master Indenture has been obtained and is in full force and effect, and stating whether or not to the best knowledge of the signers, any Obligated Issuer is in default in the performance of any covenant contained in the Master Indenture, and, if so, specifying each such default of which the signers may have knowledge, and an Officer's Certificate stating the Historical Debt Service Coverage Ratio and the Historical Maximum Annual Debt Service Coverage Ratio for such fiscal year, provided, if either such ratio is less than 1.75 to

1.00, such Officer's Certificate shall be accompanied by a certificate of the accountant whose report accompanies the financial statements referred to in (a) above stating such ratios.

(c) If an Event of Default shall have occurred and be continuing, (i) file with the Master Trustee such other financial statements and information concerning its operations and financial affairs (or of any consolidated group of companies of which it is a member) as the Master Trustee may from time to time reasonably request, excluding specifically donor records, patient records and personnel records and (ii) provide access to its Facilities for the purpose of inspection by the Master Trustee during regular business hours or at such other times as the Master Trustee may reasonably request.

(d) Within 10 days after its receipt thereof, file with the Master Trustee a copy of each report which any provision of the Master Indenture requires to be prepared by a Consultant or an insurance consultant.

(e) As soon as practicable, but in no event later than 45 days after the end of each fiscal quarter, file, or cause to be filed, with the Master Trustee (i) a combined or consolidated revenue and expense statement of the Corporation and each other Obligated Issuer for such quarter, and (ii) a combined consolidated balance sheet presented on the basis described above as of the end of such quarter.

(f) Cause the information described in subsections (a), (b) and (e) above, including the calculations described in subsections (b) and (e) above, in each case any holder of \$1,000,000 or more in aggregate principal amount of Related Bonds who has requested such of the Corporation in writing (it being understood that such request may be a standing request).

Rates and Charges

Each Obligated Issuer covenants and agrees to operate, and to cause each of its Restricted Affiliates to operate on a revenue producing basis and to charge, and to cause each of its Restricted Affiliates to charge, such fees and rates for its Facilities and services and to exercise, and to cause each of its Restricted Affiliates to exercise, such skill and diligence as to provide income from its Property together with other available funds sufficient to pay promptly all payments of principal and interest on its Indebtedness, all expenses of operation, maintenance and repair of its Property and all other payments required to be made by it under the Master Indenture to the extent permitted by law, and to use its best efforts to maintain in each Fiscal Year beginning with the Fiscal Year ending June 30, 2001 a ratio of Total Income Available For Debt Service to Maximum Annual Debt Service at least equal to 1.30. Each Obligated Issuer further covenants and agrees that it will from time to time as often as necessary and to the extent permitted by law, revise its rates, fees and charges in such manner as may be necessary or proper to comply with the provisions of this Section.

If in any Fiscal Year beginning with the Fiscal Year ending June 30, 2001 the Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group is less than 1.30, the Master Trustee shall require the Obligated Group, at the expense of the Obligated Group, to retain a Consultant to make recommendations with respect to the rates, fees and charges of the Obligated Group and its methods of operation and other factors affecting its financial condition in order to increase such Historical Maximum Annual Debt Service Coverage Ratio to at least 1.30.

A copy of the Consultant's report and recommendations, if any, and any written responses from management of the Corporation, shall be filed with each Obligated Issuer, the Master Trustee, each Related Bond Trustee and each Related Issuer and, upon written request to the Corporation, any holder of at least \$1,000,000 in aggregate principal amount of Related Bonds. Each Obligated Issuer shall follow each recommendation of the Consultant applicable to it to the extent feasible (as determined by the Governing Body of such Obligated Issuer) and permitted by law. This Section shall not be construed to prohibit any Obligated Issuer from serving indigent patients to the extent required for such Obligated Issuer to continue its qualification as a Tax-Exempt Organization or from serving any other class or classes of patients without charge or at reduced rates so long as such service does not prevent the Obligated Group from satisfying the other requirements of this Section. So long as the Obligated Group shall retain a Consultant and shall follow such Consultant's recommendations to the extent permitted by law, this Section shall be deemed to have been complied with even if such ratio for any subsequent Fiscal Year is below 1:30:1; provided, however, that in no event shall the Historical Maximum Annual Debt Service Coverage Ratio for any year be less than 1:00:1.

Notwithstanding the provisions of the immediately preceding paragraph, if by the end of the second Fiscal Year after the Fiscal Year (beginning with the Fiscal Year ending June 30, 2001) for which the Obligated Group failed to achieve a Historical Maximum Annual Debt Service Coverage Ratio of at least 1.3:1 the Obligated Group has not achieved a Historical Maximum Annual Debt Service Coverage Ratio of at least 1.3:1, the Obligated Group shall be deemed to be in violation of the provisions of the Master Indenture.

The selection of any Consultant retained pursuant to this section and the scope of such Consultant's activities and recommendations shall be subject to the approval of the Bond Insurer and ratification by each of the Holders of the two largest principal amounts of Uninsured Obligations; provided that the ratification by such Holders shall not be unreasonably withheld.

Liquidity Covenant

The Obligated Group shall maintain Unrestricted Liquid Funds as of the last day of each Fiscal Year to produce a Days Cash on Hand Ratio equal to or greater than 75.

Accreditation

The Corporation shall not fail to maintain any accreditation status currently held by the Corporation with respect to its hospital facilities unless it provides the Master Trustee with a Consultant's opinion to the effect that failure to maintain any such accreditation will not adversely affect the Corporation's hospital facilities. Notwithstanding the foregoing, this Section shall not be construed to require the Corporation to continue to operate any hospital facility or to maintain any accreditation for any hospital facility that is closed.

Hedge Agreements*

The members of the Obligated Group may not enter into a Hedge Agreement without the prior written consent of the Bond Insurer (so long as any outstanding Related Bonds are insured by the Bond Insurer) unless the following conditions are met:

(a) The Hedge Agreement must be entered into as a hedge against (i) swaps currently outstanding (as in basis swaps or reverse swaps), or (ii) debt then outstanding or to be issued, or (iii) as a means of achieving forward transactions, or (iv) against assets held at the time of the execution of the Hedge Agreement;

(b) The Hedge Agreement does not contain any element of leverage or multiplier component in excess of 1.0x unless there is a matching hedge arrangement which effectively offsets the exposure from any such element or component;

* By their purchase of the Series 2012A Bonds, the initial holders thereof will consent to an amendment of this section. The amended section will read as follows:

Hedge Agreements. The members of the Obligated Group may not enter into a Hedge Agreement unless the following conditions are met:

(a) The Hedge Agreement must be entered into as a hedge against (i) swaps currently outstanding (as in basis swaps or reverse swaps), or (b) debt then outstanding or to be issued, or (iii) as a means of achieving forward transactions, or (iv) against assets held at the time of the execution of the Hedge Agreement;

(b) The Hedge Agreement does not contain any element of leverage or multiplier component in excess of 1.0x unless there is a matching hedge arrangement which effectively offsets the exposure from any such element or component;

(c) The uninsured payment due upon termination of any Hedge Agreement shall be subordinate in right of payment to all Obligations under the Master Indenture issued with respect to the Insured Bonds.

(d) The Obligated Group shall not be in default under the Days Cash on Hand Ratio contained in Section 13.1(b)(iv) of this Master Indenture.

(e) Notwithstanding the foregoing (a) through (d), the Corporation may assume the Hedge Agreements listed on Exhibit C attached to the Sixteenth Supplemental Master Trust Indenture that have been entered into by Mountain States Properties, Inc., an affiliate of the Corporation.

(c) If an amount equal to the Maximum Adverse Termination Payment (as defined below) of all of the Hedge Agreements of the Obligated Group, then in effect and those to be executed, determined as noted in (i) and (ii) below, at the time the new Hedge Agreement is to be entered into were excluded from unrestricted cash and investments, the Days Cash on Hand Ratio would still be satisfied:

(i) The Obligated Group Agent shall calculate the Maximum Adverse Termination Amount in three steps. First, the Obligated Group Agent will determine the actual mark-to-market value of all existing Hedge Agreements of the Obligated Group using standard mark-to-market methodology. Second, the Obligated Group Agent will calculate the Adverse Termination Amount (as defined below) of the contemplated derivative based on (ii) below. Third, the Adverse Termination Amount of the contemplated Hedge Agreement will be added to the actual mark-to-market value of all existing Hedge Agreements.

(ii) The methodology for calculating the Adverse Termination Amount for the contemplated Hedge Agreement depends on the type of swap it is. If the contemplated swap is a floating-to-fixed interest rate swap, a fixed-to-floating interest rates swap, or an option to enter into or cancel either of those structures, the Obligated Group Agent will calculate the present value of a 150 basis point loss using standard mark-to-market methodology and will assume taxable and tax-exempt rates both shift 150 basis points on the date of the calculation. This will result in the Adverse Termination Amount for the new swap. If the contemplated swap is a basis swap, a fixed spread basis swap, a constant maturity swap, a spread swap, or a similar structure (with or without an option), the Obligated Group Agent will calculate a 50 basis point loss by multiplying the absolute present value of one basis point in the then current market by -50 (negative fifty) to reflect an adverse change in ratios, spreads, rates, and other market conditions. This will result in the Adverse Termination Amount for the new swap.

(d) The Obligated Group's counterparty (or its guarantor) shall be rated at least "A+" or "A1" by a Rating Agent at the time the Hedge Agreement is entered into and a Credit Support Annex shall, or is required to, be executed to provide for collateral on a schedule that incorporates a zero threshold amount if any rating is below BBB+/Baa1;

(e) Termination payments are payable only if and to the extent that after such payment the Obligated Group: (a) would still be in compliance with its Days Cash on Hand Ratio, assuming such payment had been excluded from unrestricted cash and investments in making such liquidity calculation and (b) would not be in default;

(f) Collateral for the payments due under the Hedge Agreement can be posted only to the extent that after such posting the Obligated Group would still be in compliance with the Days Cash on Hand Ratio assuming such posting had been excluded from unrestricted cash and investments in making such liquidity calculation;

(g) The uninsured payment due upon termination of any Hedge Agreement shall be subordinate in right of payment to all Obligations under the Master Indenture issued with respect to the Insured Bonds; and

(h) The term "Adverse Termination Amount" shall mean the amount if positive that would be required to be paid by a member of the Obligated Group that is the party to a Hedge Agreement upon the termination of the Hedge Agreement calculated in the manner provided in subsection (c)(ii) above, and the term "Maximum Adverse Termination Amount" shall be determined in accordance with subsection (c)(i) above.

Projected Debt Service Coverage Ratio

Anything in the Master Indenture to the contrary notwithstanding, in each instance in the Master Indenture in which the Projected Debt Service Coverage Ratio is to be evidenced by an Officer's Certificate, such Projected Debt Service Coverage Ratio must also be evidenced by a Consultant's report unless the Projected Debt Service Coverage Ratio in such Officer's Certificate is greater than 1.75:1.00.

Defaults and Remedies

The following events are “Events of Default” under the Master Indenture:

(a) failure of any Obligated Issuer to make any payment of principal, redemption price or interest when due under the terms of any Obligations and such failure continues to exist as of the end of any applicable grace period; or

(b) failure of any Obligated Issuer to observe or perform any covenant or agreement contained in the Master Indenture or any Related Financing Documents for any Obligations for a period of 30 days after written notice of such failure, requiring the same to be remedied, has been given by the Master Trustee to each of the Obligated Issuers, the giving of which notice shall be at the discretion of the Master Trustee unless the Master Trustee is requested in writing to do so by the holders of at least 25% in aggregate principal amount of all outstanding Obligations, in which event such notice shall be given; provided, however, that if such observance or performance requires work to be done, actions to be taken, or conditions to be remedied, which by their nature cannot reasonably be done, taken or remedied, within such 30-day period, no Event of Default shall be deemed to have occurred or to exist if, and so long as, the defaulting Obligated Issuer shall commence such observance or performance within such 30-day period and shall diligently and continuously prosecute the same to completion; or

(c) (i) default of any Obligated Issuer in the payment of any Indebtedness (other than Obligations issued and outstanding under the Master Indenture), the principal amount of which in the aggregate exceeds 5% of the Book Value of all Property of the Obligated Group for the immediately preceding Fiscal Year, whether such Indebtedness now exists or shall be created after the date of the Master Indenture and any grace period with respect thereto shall have expired, or (ii) any event of default as defined in any Related Financing Documents under which any such Indebtedness may be issued, secured or evidenced shall occur, which default in payment or event of default results in such Indebtedness becoming or being declared due and payable unless within the time allowed for service of a responsive pleading in any proceeding to enforce payment of the Indebtedness under the laws governing such proceeding (i) the Obligated Issuers commence proceedings to contest the existence or payment of such Indebtedness, and (ii) in the absence of such contest, neither the pledge and security interest created under the Master Indenture nor any Property of the Obligated Group will be materially impaired or subject to material loss or forfeiture; or

(d) bankruptcy, dissolution, liquidation or reorganization in bankruptcy of any Obligated Issuer or other similar events; or

(e) if the Hospital Maximum Annual Debt Service Coverage Ratio of the Obligated Group for any Fiscal Year is less than 1.0 to 1; or

(f) a breach of the Alliance’s covenant to file audited financial statements as described above under “Filing of Financial Statements, Certificate of No Default, Other Information” under paragraph (a) above thereof shall have occurred and be continuing; or

(g) a breach of the Alliance’s “Liquidity Covenant” as described above shall have occurred and be continuing.

Upon the occurrence of an Event of Default, the Master Trustee may, by notice in writing to the Obligated Issuers, declare the principal of all (but not less than all) outstanding Obligations to be immediately due and payable provided that the Master Trustee shall be required to make such a declaration (i) if an Event of Default has occurred under subsection (a) above, or (ii) if the Master Trustee is requested to make such a declaration by the Holders of not less than 25% in aggregate principal amount of all outstanding Obligations. If all Events of Default other than nonpayment of amounts that have become due as a result of such declaration are remedied, the Holders of 25% in aggregate principal amount of all Obligations may waive all Events of Default and rescind and annul such declaration of acceleration.

Any acceleration of the principal shall be subject to the condition that if, at any time after the principal of all outstanding Obligations shall have been accelerated, and before any judgment or decree for the payment of the moneys due shall have been obtained or entered: (i) one or more Obligated Issuers shall deposit with the Master Trustee an aggregate sum sufficient to pay (A) all matured installments of interest upon all outstanding Notes and the principal and premium, if any, of all outstanding Notes due otherwise than by acceleration (with interest on overdue installments of interest, to the extent permitted by law and on such principal and premium, if any, at the respective rates borne by such Notes to the date of such deposit) and any other amounts required to be paid pursuant to such Notes, (B) all amounts due under each Indenture Guaranty other than by reason of acceleration, (C) all sums due under any Obligations other than Notes and Indenture Guaranties, other than by reason of acceleration, and (D) the expenses and fees of the Master Trustee; and (ii) any and all Events of Default under the Master Indenture, other than the nonpayment of principal of and accrued interest on outstanding Obligations that have become due by acceleration, shall have been remedied, then and in every such case, the Master Trustee shall, if requested by the Holders of twenty- five percent in aggregate principal amount of all Obligations then outstanding, waive all Events of Default and rescind and annul such declaration and its consequences, but no such waiver or rescission and annulment shall extend to or effect any subsequent Event of Default.

The Master Trustee may, at any time that an Event of Default exists, (i) by written notice to the banking institutions in which any Gross Receipts are deposited pursuant to the requirements of the Master Indenture, direct that such funds be immediately transferred to the Master Trustee, and upon receipt of such funds the same shall be held in trust by the Master Trustee and disbursed as provided in the Master Indenture, and (ii) by written notice to the Obligated Issuers direct that all subsequent deposits of Gross Receipts be made with the Master Trustee.

Upon the occurrence of an Event of Default, as described in the Master Indenture, and upon demand of the Master Trustee, each Obligated Issuer will pay to the Master Trustee, for the benefit of the Holders of all outstanding Obligations, (a) the amount then due and payable on all Obligations for principal or interest, or both, and such other amounts as may be required to be paid on all such Obligations, with interest on the overdue principal and installments of interest (to the extent permitted by law) at the respective rates of interest borne by such Obligations or as is provided in the applicable Supplemental Indenture, and (b) such further amounts sufficient to cover the cost and expenses of collection, including a reasonable compensation to the Master Trustee, its agents, attorneys and counsel, and any expenses incurred by the Master Trustee other than as a result of its gross negligence or bad faith.

The Master Trustee may institute any actions or proceedings at law or in equity for the collection of the sums due and may collect such sums in the manner provided by law out of the Property of the Obligated Issuer wherever situated.

In case there shall be pending proceedings for the bankruptcy or for the reorganization of any Obligated Issuer, or in case a receiver or trustee shall have been appointed for its Property, the Master Trustee shall be entitled and empowered, by intervention in such proceedings or otherwise, to file and prove a claim or claims for the whole amount of principal, premium, if any, interest and any other amounts owing and unpaid in respect of Obligations, and, in case of any judicial proceedings, to file such proofs of claim and other papers as may be necessary or advisable in order to have the claims of the Master Trustee and of the Holders of the Obligations allowed in such judicial proceedings relative to such member of the Obligated Group, its creditors or its Property, and to collect and receive any moneys or other Property payable or deliverable on any such claim and to distribute the same after the deduction of its charges and expenses.

All rights of action and rights to assert claims under any Obligation may be enforced by the Master Trustee without the possession of such Obligation. In any proceedings brought by the Master Trustee (and also any proceedings involving the interpretation of any provision of the Master Indenture to which the Master Trustee shall be a party) the Master Trustee shall be held to represent all the Holders of Obligations, and it shall not be necessary to make any Holders of Obligations parties to such proceedings.

Application of Moneys Collected

Any amounts collected by the Master Trustee in connection with the exercise of any rights and remedies following an Event of Default and, except as otherwise provided in the Master Indenture, all money and Investment

Securities on deposit in any funds which the Master Trustee may establish under the Master Indenture from time to time shall be applied for the equal and ratable benefit of the Holders of Obligations in the following order at the date or dates fixed by the Master Trustee for the distribution of such moneys, upon presentment of such Obligations, and stamping thereon the payment, if only partially paid, and upon surrender thereof if fully paid:

(a) to the payment of costs and expenses of collection, including fees of Counsel and reasonable compensation to the Master Trustee; and, thereafter,

(b) whether or not the principal of all outstanding Obligations shall have become or have been declared due and payable to Holders of the outstanding Obligations for amounts due and unpaid on the Obligations, ratably, without preference or priority of any kind, according to the amounts due and payable on the Obligations; provided that for the purpose of determining the unpaid amount of any Obligation, there shall be deducted the amount, if any, which has been realized by the Holder by exercise of its rights as a secured party with respect to any Liens permitted pursuant to the Master Indenture or is on deposit in any fund established pursuant to any Related Financing Documents for such Obligations (other than amounts consisting of payments of principal and interest previously made and credited against the payments due under such Obligations) as of the date of payment by the Master Trustee pursuant to this subsection (b), all as certified to the Master Trustee by the Holder; and

(c) to the payment of the remainder, if any, to the Obligated Group Agent, its successors or assigns, or to whomsoever may be lawfully entitled to receive the same, or as a court of competent jurisdiction may direct.

Actions by Holders

(a) No Holder of an Obligation shall have any right by virtue of or by availing of any provision of the Master Indenture to institute any suit, action or proceeding in equity or at law upon or under or with respect to the Master Indenture or for the appointment of a receiver or trustee, or any other remedy, unless the Holders of not less than 25% in aggregate principal amount of Obligations then outstanding shall have made written request upon the Master Trustee to institute such action, suit or proceeding in its own name as Master Trustee and shall have offered to the Master Trustee such reasonable indemnity as it may require against the costs, expenses and liabilities which may be incurred therein or thereby, and the Master Trustee, for 30 days after its receipt of such notice, request and offer of indemnity, shall have neglected or refused to institute any such action, suit or proceeding and no direction inconsistent with such written request shall have been given to the Master Trustee; it being understood and intended, and being expressly covenanted by the Holder of an Obligation and the Master Trustee, that no one or more Holders of Obligations shall have any right in any manner whatever by virtue of or by availing of any provision of the Master Indenture to affect, disturb or prejudice the rights of any other Holder of an Obligation or to obtain or seek to obtain priority over or preference to any other such Holder, or to enforce any right under the Master Indenture, except in the manner therein provided and for the equal, ratable and common benefit of all Holders of Obligations. For the protection and enforcement of these provisions, each and every Holder of an Obligation and the Master Trustee shall be entitled to such relief as can be given either at law or in equity.

(b) The Holder of an Obligation instituting a suit, action or proceeding in compliance with the provisions outlined herein and more fully set forth in the Master Indenture shall be entitled to such suit, action or proceeding to such amounts as shall be sufficient to cover the costs and expenses of collection, including to the extent permitted by applicable law, a reasonable compensation to its Counsel.

(c) Notwithstanding any other provision of the Master Indenture, the right of a Holder of an Obligation to receive payment of the principal of and interest on any Obligation and any other amounts payable thereunder, on or after the respective due dates expressed in such Obligation, or to institute suit for the enforcement of any such payment on or after such respective dates, shall not be impaired or affected without the consent of such Holder, provided that any moneys collected through the exercise of rights and remedies of any Holder against any Obligated Issuer pursuant to the Related Financing Documents for an Obligation (other than rights and remedies relating to Liens permitted pursuant to the Master Indenture or to funds and accounts established under such Related Financing Documents) shall be paid over to the Master Trustee or, with the consent of the Holder, collected directly by the Master Trustee.

Direction of Proceedings by Holders

The Holders of 75% in aggregate principal amount of Obligations then outstanding shall have the right to direct the time, method, and place of conducting any proceeding for any remedy available to the Master Trustee, or exercising any trust or power conferred on the Master Trustee; provided, however, that, subject to its right to be indemnified in the Master Indenture, the Master Trustee shall have the right to decline to follow any such direction if the Master Trustee, being advised by Counsel, determines that the action so directed may not lawfully be taken, or if the Master Trustee in good faith shall, by a responsible officer or officers of the Master Trustee, determine that the proceedings so directed would be illegal or involve it in personal liability, and provided further that nothing in the Master Indenture shall impair the right of the Master Trustee in its direction to take any action deemed proper by the Master Trustee and which is not inconsistent with such direction by the Holders.

Delay or Omission of Master Trustee

No delay or omission of the Master Trustee, or of any Holder of an Obligation, to exercise any right or power accruing upon an Event of Default shall impair any such right or power, or be construed as a waiver of any Event of Default or an acquiescence therein, nor shall the action of the Master Trustee or of the Holders of Obligations in case of any Event of Default, or in case of any Event of Default and subsequent waiver of such Event of Default, affect or impair the rights of the Master Trustee or of such Holders in respect of any subsequent Event of Default or any right resulting therefrom.

Remedies Cumulative

No remedy under the Master Indenture is intended to be exclusive of any other remedy, but each and every other such remedy shall be cumulative, and shall be in addition to the remedies pursuant to the Master Indenture; and the employment of any remedy under the Master Indenture or otherwise, shall not prevent the concurrent employment of any such other appropriate remedy or remedies. In the pursuit of any such remedies, the Master Trustee shall have and be vested with the rights of a secured creditor under the Tennessee Uniform Commercial Code (or similar laws of other jurisdictions as applicable) with respect to moneys collected by the Master Trustee pursuant to any provision of the Master Indenture, and shall have the power to foreclose any Lien which may be granted to it as Master Trustee under the Master Indenture, all to the extent permitted by law.

Notice of Default

The Master Trustee shall, within 10 days after the occurrence of an Event of Default known to the Trustee, mail to all Holders of Obligations, as the names and addresses of such Holders appear upon the books maintained by the Master Trustee, and, as long as the Initial Obligation remains outstanding, to the Bond Insurer, notice of such Event of Default under the Master Indenture known to the Master Trustee, unless such Event of Default shall have been cured before the giving of such notice; provided that, except above under "Defaults and Remedies," the Master Trustee shall be protected in withholding such notice if and so long as the Master Trustee in good faith determines that the withholding of such notice is in the interest of the Holders of the Obligations. For purposes of the Master Indenture, matters shall not be considered to be known to the Master Trustee unless an officer of its corporate trust department located at its principal corporate trust office has actual knowledge thereof.

Concerning the Master Trustee

Prior to the occurrence of an Event of Default and after the curing or waiving of all Events of Default which may have occurred, the Master Trustee undertakes to perform only those duties specifically set forth in the Master Indenture. In case an Event of Default has occurred, the Master Trustee shall exercise the rights and powers vested in it by the Master Indenture, and use the same degree of care and skill as a prudent man under the circumstances in the conduct of its own affairs.

No provision of the Master Indenture shall be construed to relieve the Master Trustee from liability for its own grossly negligent action, its own grossly negligent failure to act, or its own willful misconduct; provided, however, that:

(a) the Master Trustee shall not be liable for any error of judgment made in good faith by a responsible officer or officers of the Master Trustee, unless it is provided that the Master Trustee was grossly negligent in ascertaining the pertinent facts; and

(b) the Master Trustee shall not be liable with respect to any action taken or admitted to be taken by it in good faith in accordance with the direction of the Holders of the majority in aggregate principal amount of Obligations then outstanding relating to the time, method and place of conducting any proceeding for any remedy available to the Master Trustee, or exercising any trust or power conferred upon the Master Trustee, under the Master Indenture.

Except as otherwise provided in the immediately preceding paragraph:

(a) The Master Trustee may rely and shall be protected in acting or refraining from acting upon various papers or documents believed by it to be genuine and to have been signed or presented by the proper party or parties.

(b) An Officer's Certificate (unless otherwise specifically prescribed) shall be sufficient evidence of any request, direction, order or demand of any Obligated Issuer mentioned under the Master Indenture. Any resolution of the Governing Body of an Obligated Issuer may be evidenced to the Master Trustee by copy thereof, certified by the Secretary or an Assistant Secretary of such Obligated Issuer.

(c) The Master Trustee may consult with Counsel, and the advice of such counsel shall be full and complete authorization and protection. The Master Trustee shall be relieved of liability to the Holders of the Obligations and to the Obligated Issuers in respect of any action taken, suffered or omitted by it under the Master Indenture in good faith and in accordance with Counsel's advice.

(d) Prior to the occurrence of an Event of Default under the Master Indenture and after the curing of all Events of Default, the Master Trustee is not bound to make any investigation into facts or matters stated in various papers or documents, unless requested in writing to do so by the Holders of a majority in aggregate principal amount of Obligations then outstanding. As a condition to proceeding with the requested investigation, the Master Trustee, in accordance with the terms of the Master Indenture, may require indemnity against various costs, expenses or liabilities.

(e) The Master Trustee may execute any of the trusts or powers under the Master Indenture or perform any duties under the Master Indenture either directly or by or through agents or attorneys.

(f) The Master Trustee shall be under no responsibility for the approval by it in good faith by an expert or other skilled person for any of the purposes expressed in the Master Indenture.

The recitals contained in the Master Indenture and in the Obligations (other than the Certificate of Authentication on such Obligations) shall be taken as the statements of the Obligated Issuer, and the Master Trustee assumes no responsibility for the correctness thereof. Further, the Master Trustee makes no representations as to the validity or sufficiency of the Master Indenture or the liens and security created thereunder or of the Obligations. The Master Trustee shall not be accountable for the use or application of: any of the Notes or the proceeds of such Obligations, any moneys paid over by the Master Trustee, or any moneys received by any paying agent other than the Master Trustee.

The Master Trustee, in its individual or any other capacity, may become the owner or pledgee of Obligations with the same rights it would have if it were not the Master Trustee under the Master Indenture. Further, the Master Indenture shall not prohibit the Master Trustee from serving as Trustee under any Related Financing Documents or for maintaining a banking relationship with any Obligated Issuer; provided that if the

Master Trustee determines that there is a conflict with its duties under the Master Indenture, it shall eliminate the conflict or resign as Master Trustee.

Each Obligated Issuer shall pay, and shall be jointly and severally liable to pay, to the Master Trustee reasonable compensation, reimbursement for all reasonable expenses, disbursement and advances. Each Obligated Issuer shall indemnify, defend and shall be jointly and severally liable to indemnify, the Master Trustee and its officers, directors, employees and agents for, and to hold them harmless against, any loss, liability or expense incurred without gross negligence or willful misconduct on the part of the Master Trustee and arising out of or in connection with the acceptance or administration of such trusts, including the costs and expenses of defending itself against any claim of liability in the premises. The Obligated Issuers' joint and several obligations described in this paragraph shall survive the satisfaction and discharge of the Master Indenture and the resignation, removal and succession of the Master Trustee. Subject only to the rights of any Holder, the Master Trustee shall have an express first and prior lien on any moneys or Investment Securities on the deposit in any funds as security for the payment of all such obligations.

Subject to the first paragraph under this section entitled "Concerning the Master Trustee," any matter may be conclusively proved and established by an Officer's Certificate delivered to the Master Trustee. In the absence of bad faith on the part of the Master Trustee, any such Officer's Certificate shall be full ratification of any action taken, suffered or omitted by the Master Trustee under the provisions of the Master Indenture upon the faith thereof, and the Master Trustee shall not be obligated to make any investigation into the facts stated therein.

The Master Trustee may resign at any time without cause by giving notice as required under the Master Indenture. Further, the Master Trustee may be removed (a) with cause at the direction of the Holders of not less than 66-2/3% in aggregate principal amount of Obligations then outstanding, delivered to the Obligated Group and the Master Trustee, or (b) for any reason at the direction of the Obligation Group Agent if no Event of Default then exists under the Master Indenture. The Master Trustee shall promptly give notice of any removal pursuant to the previous sentence in writing to each Holder of an Obligation then outstanding. In the case of the resignation and removal of the Master Trustee, a successor Master Trustee may be appointed by the Obligated Group unless an Event of Default exists under the Master Indenture. If an Event of Default exists under the Master Indenture, or if the Obligated Group otherwise fails to appoint a successor in accordance with the terms of the Master Indenture, a successor may be appointed at the direction of the Holders of not less than 66-2/3% in aggregate principal amount of Obligations then outstanding.

Any successor Master Trustee, however appointed, in accordance with the terms of the Master Indenture, shall accept such appointment, and, without further act, shall become vested with all the estates, properties, rights, powers and duties of its predecessor under the Master Indenture as if originally named the Master Trustee. The successor Master Trustee may, however, request that its predecessor execute and deliver an instrument transferring the above and assigning, transferring, delivering and paying over to such successor Master Trustee all moneys or other property then held by the predecessor under the Master Indenture.

Any successor Master Trustee, however appointed, shall be a bank or trust company having together with its Affiliates a combined capital and surplus on a consolidated basis of at least \$50,000,000.

Any corporation into which the Master Trustee may be merged or converted or with which it may be consolidated, or any corporation resulting from any merger, conversion or consolidation to which the Master Trustee shall be a party, or any corporation to which substantially all the business of the Master Trustee may be transferred, shall, subject to the immediately preceding paragraph, be the Master Trustee under the Master Indenture without further act.

Subject to the terms and conditions as set forth in the Master Indenture, the Master Trustee shall have the power to appoint one or more Persons not unsatisfactory to the Obligated Group Agent to act as Co-Master Trustee.

Modifications and Amendments

Each Obligated Issuer, when authorized by a resolution of its Governing Body, and the Master Trustee may, without the consent of the holders of the Obligations then outstanding, enter into a Supplemental Indenture to the Master Indenture to (a) provide for the issuance of any Obligations under the Master Indenture, (b) evidence the addition of an Obligated Issuer or the succession of another corporation to any Obligated Issuer, (c) add additional covenants for the protection of the holders of Obligations, (d) cure any ambiguity or defective provision of the Master Indenture or any Supplemental Indenture in such manner as is not inconsistent with and does not impair the security of the Master Indenture or adversely affect the holders of Obligations of any series of Obligations issued under the Master Indenture, (e) qualify the Master Indenture under the Trust Indenture Act of 1939 or under any similar federal statute hereafter enacted, (f) provide for the establishment of additional funds and accounts, (g) permit the issuance of additional forms of Obligations provided such Obligations are equally and ratably secured with all other Obligations issued under the Master Indenture (except as provided herein), and (h) reflect a change in applicable law.

With the consent of the Holders of not less than a majority* in aggregate principal amount of Obligations then outstanding, each Obligated Issuer, when authorized by its Governing Body, and the Master Trustee, may from time to time and at any time enter into a Supplemental Indenture for the purpose of adding any provisions to or changing in any manner or eliminating any of the provisions of the Master Indenture or of any Supplemental Indenture or of modifying in any manner the rights of the Holders of Obligations; provided, however, that (i) without the consent of the Holders of all Obligations whose Obligations are proposed to be modified, no such supplemental indenture shall effect a change in the times, amounts or currency of payment of the principal of, premium, if any, or interest on any Obligation or a reduction in the principal amount or redemption price of any Obligation or the rate of interest thereon or permit the preference or priority of any Obligation over any other Obligation; (ii) without the consent of the Holders of all Obligations then outstanding, no such supplemental indenture shall reduce the aforesaid percentage or affected class of Obligations, the Holders of which are required to consent to any such Supplemental Indenture; (iii) without the consent of the Holders of all Obligations then outstanding, no such supplemental indenture shall effect a change in the conditions for withdrawal as a Member of the Obligated Group; (iv) without the consent of the Holders of all Obligations then outstanding, no such supplemental indenture shall effect a change in the provisions permitting the Holders of 25% in aggregate principal amount of all outstanding Obligations to direct acceleration upon the occurrence of an Event of Default; and (v) without the consent of the Holders of all Obligations then outstanding, any provision of the Master Indenture which specifies a percentage of Holders required to take any action hereunder.

Effect of Supplemental Indenture

Upon the execution of any Supplemental Indenture, the Master Indenture shall be modified and amended in accordance therewith, and the respective rights, limitation of rights, obligations, duties, and immunities under the Master Indenture of the Master Trustee, each Obligated Issuer and the Holders of Obligations issued under the Master Indenture shall thereafter be determined, exercised and enforced under the Master Indenture subject in all respects to such modifications and amendments, and all the terms and conditions of any such Supplemental Indenture shall be deemed to be part of the terms and conditions of the Master Indenture.

Satisfaction and Discharge of Indenture

If the Master Trustee receives: (a) an amount which is (i) in the form of (A) cash, or (B) Government Obligations, and (ii) in a principal amount sufficient, together with the interest thereon and any funds on deposit under the Master Indenture and available for such purpose, to provide for the payment of the principal of and

* By purchasing the Bonds, the initial holders thereof, as well as the holders of certain Obligations previously issued under the Master Indenture, have consented to an amendment providing for majority approval. However, with respect to the change to the definition of "Debt Service Requirement" (see "SECURITY AND SOURCES OF PAYMENT FOR THE BONDS - Amendment of the Master Indenture" in the front part of this Official Statement) and any future amendments to the Master Indenture requiring consent under this paragraph, the consent of the holders of 75% in the aggregate principal amount of Obligations outstanding will be required until receipt of the consent of the percentage of bondholders and credit enhancers required under the terms of the Master Indenture.

premium, if any, and interest on all outstanding Obligations to and including the maturity date or prior redemption or prepayment date thereof; (b) irrevocable instructions to redeem all Obligations to be redeemed prior to maturity and to notify the Holders of each such redemption; and (c) an amount sufficient to pay or provide for the payment of all other sums payable under the Master Indenture by the Obligated Issuers or any thereof, then the Master Indenture shall cease to be of further effect, and the Master Trustee, on demand of the Obligated Group Agent, shall execute all such instruments acknowledging satisfaction of and discharging the Master Indenture as requested by the Obligated Group Agent.

Similarly, the Obligated Issuer of any particular Obligation may provide for the payment thereof at or prior to maturity, and the Obligation so provided for shall thereupon cease to be outstanding under the Master Indenture.

In lieu of the foregoing, the Obligated Issuer of any particular Obligation may deliver to the Holder thereof the amount required under the Related Financing Documents to provide for the payment of the principal, premium, if any, and interest due or to become due in respect of such Obligation and such Obligation shall, upon surrender to the Master Trustee for cancellation, no longer be deemed outstanding under the Master Indenture.

SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURE

Funds; Disposition of Revenues

Revenue Fund. The Issuer shall establish with the Bond Trustee under the Bond Indenture and maintain so long as any of the Bonds are outstanding thereunder a separate account to be known as the “Revenue Fund-- Mountain States Health Alliance” (hereinafter called the “Revenue Fund”). All payments upon the Obligations pledged under such Bond Indenture and all transfers from the Rebate Fund shall, when received by the Bond Trustee, be deposited in the Revenue Fund and shall be held therein until disbursed as provided in the Bond Indenture. Beginning at the times indicated below, the Bond Trustee will make transfers each month from the Revenue Fund to the Interest Fund and then to the Bond Sinking Fund. If any payment is due and payable on a date which is not a business day, such payment shall be due and payable on the first business day immediately following such payment.

Interest Fund. The Issuer shall establish with the Bond Trustee and maintain so long as any of the Bonds are outstanding a separate account to be known as the “Interest Fund-- Mountain States Health Alliance” (hereinafter called the “Interest Fund”). A deposit to the credit of the Interest Fund is to be made in an amount equal to the accrued interest on each series of Bonds from the date of such series to the date of delivery thereof.

On or before the 14th day of each February and August, commencing with February 14, 2013, the Bond Trustee shall deposit in the Interest Fund from moneys in the Revenue Fund an amount which will be not less than the interest to become due on the next succeeding semi-annual interest payment date of the Bonds; provided, however, that such deposit shall be reduced to the extent that there is a sufficient amount already on deposit in the Interest Fund for that purpose. Moneys on deposit in the Interest Fund, other than income thereon which is to be transferred to other funds created under the Bond Indenture, must be used to pay interest on the bonds as it becomes due.

Bond Sinking Fund. The Issuer shall establish with the Bond Trustee and maintain so long as any of the Bonds are outstanding a separate account to be known as the “Bond Sinking Fund-- Mountain States Health Alliance” (hereinafter called the “Bond Sinking Fund”). On or before the 14th day of each August, commencing August 14, 2013, the Bond Trustee shall deposit in the Bond Sinking Fund from the moneys in the Revenue Fund an amount which is not less than the principal of the Bonds next to become due by maturity or mandatory Bond Sinking Fund redemption. No such deposit need be made, however, to the extent that there is a sufficient amount already on deposit and available for such purpose in the Bond Sinking Fund to be applied to such maturity or mandatory Bond Sinking Fund redemption payment.

Moneys on deposit in the Bond Sinking Fund, other than income earned thereon which is to be transferred to other funds created under the Bond Indenture, shall be applied by the Bond Trustee to pay principal on the Bonds as it becomes due and to redeem the Bonds in accordance with the mandatory Bond Sinking Fund redemption schedule provided for in the Bond Indenture. In lieu of such mandatory Bond Sinking Fund redemption, the Bond Trustee may, at the request of the Corporation, purchase for cancellation an equal principal amount of Bonds of the series and maturity to be redeemed in the open market at prices not exceeding the principal amount of such Bonds being purchased plus accrued interest, with the principal portion of such purchase price to be paid from the Bond Sinking Fund and with the interest portion of such purchase price to be paid from the Interest Fund. In addition, the amount of Bonds to be redeemed on any date pursuant to the mandatory Bond Sinking Fund redemption schedules shall be reduced by the principal amount of Bonds of the series and maturity required to be redeemed which are acquired by the Corporation or any other Obligated Issuer and delivered to the Bond Trustee for cancellation.

Optional Redemption Fund. The Issuer shall establish with the Bond Trustee and maintain so long as any of the Bonds are outstanding a separate account to be known as the “Optional Redemption Fund-- Mountain States Health Alliance” (hereinafter called the “Optional Redemption Fund”). In the event of (i) prepayment by or on behalf of the Corporation or any other Obligated Issuer of amounts payable on the Obligations pledged under the Bond Indenture, including prepayment with condemnation or insurance proceeds or proceeds of sale consummated under threat of condemnation, or (ii) deposit with the Bond Trustee by the Corporation or the Issuer of moneys from any other source for redeeming Bonds or purchasing Bonds for cancellation, except as otherwise provided in the Bond Indenture, such moneys shall be deposited in the Optional Redemption Fund. Moneys on deposit in the

Optional Redemption Fund shall be used first to make up any deficiencies existing in the Interest Fund and the Bond Sinking Fund (in the order listed) and second for the redemption of Bonds in accordance with the provisions of the Bond Indenture.

Expense Fund. The Issuer shall establish with the Bond Trustee and separate account to be known as the “Expense Fund-- Mountain States Health Alliance” (hereinafter called the “Expense Fund”). Amounts on deposit in the Expense Fund shall be used for the payment of expenses for recording, trustee’s and depository’s fees and expenses, accounting and legal fees, financing costs (including costs of acquiring investments for the funds and escrows), and other fees and expenses incurred or to be incurred by or on behalf of the Issuer or the Corporation in connection with or incident to the issuance and sale of the Bonds. At such time as the Bond Trustee is notified that all such fees and expenses have been paid, the Bond Trustee shall transfer any moneys remaining in the Expense Fund as provided in the Bond Indenture.

Project Fund. The Issuer shall establish with the Bond Trustee a separate account to be known as the “Project Fund -- Mountain States Health Alliance” (hereinafter called the “Project Fund”). Any moneys received by the Bond Trustee from any source for the Project shall be deposited into the Project Fund unless otherwise specifically excepted under the Bond Indenture. Except to the extent required to be transferred to the Rebate Fund in accordance with the Tax Agreement, moneys in the Project Fund shall be held in trust by the Bond Trustee, and shall be applied from time to time by the Bond Trustee in order to pay (or reimburse the Corporation for) the costs of the Project and other costs related to the Project and permitted under the Act, in each case after receipt by the Bond Trustee of a written request of the Corporation as specified in the Bond Indenture.

If, after receipt by the Bond Trustee of a completion certificate with respect to the Project required pursuant to the Bond Indenture, there shall remain any moneys in the Project Fund, the Corporation may (i) elect to retain all or a portion of such money in the Project Fund until approximately three years from the issue date of the Bonds as set forth in the Bond Indenture, or withdraw such moneys for payment of the cost of one or more “projects” (as such term is defined in the Act) but only if the Corporation complies with the requirements of the Tax Agreement relating to changes in or amendments to the Project, or (ii) deposit such moneys in the Revenue Fund to the extent necessary to make the transfers therefrom within one year from the date of deposit to the Interest Fund and the Bond Sinking Fund and then to the Optional Redemption Fund.

Investment of Funds

(a) Upon a Written Request of the Corporation filed with the Bond Trustee, moneys in the Revenue Fund, Project Fund, Interest Fund, Bond Sinking Fund, Expense Fund and Optional Redemption Fund shall be invested only in Permitted Investments. Such investments shall be made so as to mature on or prior to the date or dates that moneys therefrom are anticipated to be required. The Bond Trustee, when authorized by the Corporation, may trade with itself in the purchase and sale of securities for such investment; provided, however, that in no case shall any investment be otherwise than in accordance with the investment limitations contained in the Bond Indenture and in the Tax Agreement. The Bond Trustee shall not be liable or responsible for any loss resulting from any such investments.

(b) Until completion of the Project, if the Corporation so elects prior to the receipt of such investment income, investment income from the fund specified in subsection (a) above in excess of the requirements of such funds, shall be deposited into the Project Fund.

(c) Except as provided in subsection (b) above, all income in excess of the requirement of the Funds specified in subsection (a) derived from the investment of moneys on deposit in any such Fund will be deposited in the following Funds, in the order listed:

(i) The Interest Fund and Bond Sinking Fund (in that order) to the extent of the amounts required to be deposited in each on the next required payment date for the Bonds; and

(ii) The balance, if any, in the Optional Redemption Fund.

The Bond Trustee is permitted to transfer moneys in any of the trust funds established under the Bond Indenture to the Rebate Fund in order to comply with the provisions of the Tax Agreement.

Additional Bonds

In addition to providing for the issuance of the Bonds initially being issued thereunder, the Bond Indenture provides for the issuance by the Issuer of Additional Bonds for any one or more of the following purposes:

- (1) to refund any series of outstanding Bonds or portion thereof;
- (2) to advance refund any series of outstanding Bonds or portion thereof by depositing with the Bond Trustee, in trust for the sole benefit of such series of Bonds or portion thereof, cash or Defeasance Investments in a principal amount which, alone or, in the case of Defeasance Investments, together with the income or increment to accrue thereon, without consideration of any reinvestment thereof, will be, in the opinion of a certified public accountant acceptable to the Bond Trustee and the Issuer, sufficient to pay or redeem (when redeemable) and discharge the indebtedness on all Bonds of such series or portion thereof to be refunded at or before their respective maturity dates;
- (3) to obtain funds to loan to the Corporation in order to complete any "project" (as defined in the Act) financed or refinanced, in whole or in part, with the proceeds of any Bonds issued under the Bond Indenture; and
- (4) to obtain funds for any other purpose permitted under the Act.

The principal amount of such Additional Bonds may include an amount sufficient to pay the costs and expenses of issuance as well as such capitalized amounts as are permitted by Act. Such Additional Bonds shall be issued on a parity with the thereunder (except that any series of Bonds or portion thereof may be advance refunded through the deposit in escrow for the benefit of such Bonds of cash or Defeasance Investments) notwithstanding the fact that no additional security (except for the required pledge of an Additional Obligation issued pursuant to the Master Indenture) is made subject to the lien of the Bond Indenture; provided, however, that the Bond Trustee and the Bond are authorized to accept additional security upon the issuance of any Additional Bonds.

Prior to the delivery of any Additional Bonds, there shall be filed with the Bond Trustee, among other things, all of the following:

- (a) A written statement by the Corporation approving (i) the issuance and delivery of such Additional Bonds and the issuance of Additional Obligations to the Issuer (which Additional Obligations shall be pledged under the Bond Indenture) in a principal amount equal to such Additional Bonds and with payments of principal and interest thereon sufficient to cover payments of principal and interest to be made on such Additional Bonds to the same extent as if such Additional Bonds were included in the issuance of the existing Bonds, and (ii) any other matters to be approved by the Corporation pursuant to the Loan Agreement, the Master Indenture and the Bond Indenture.
- (b) A copy of the Issuer resolution theretofore adopted and approved authorizing the execution and delivery of such supplements to the Bond Indenture and to the Loan Agreement as may be necessary and authorizing the issuance of such Additional Bonds.
- (c) A copy of the Corporation resolutions theretofore adopted and approved authorizing the execution and delivery of the additional Obligations and a supplement to the Loan Agreement and the Master Indenture and further approving such supplemental bond indenture and the issuance and sale of such Additional Bonds.
- (d) The original executed additional Obligations referred to in paragraph (a) above made payable to the Issuer and duly issued pursuant to the Master Indenture and original executed counterparts of the supplements to the Bond Indenture, the Loan Agreement and the Master Indenture.

(e) A request and authorization to the Bond Trustee on behalf of the Issuer to authenticate and deliver such Additional Bonds (specifically stating the principal amount to be issued and delivered to the purchasers therein identified) upon payment to the Bond Trustee, but for the account of the Issuer, of a sum specified in such request and authorization plus accrued interest, if any, thereon to the date of delivery. The Bond Trustee shall out of such proceeds deposit to the Interest Fund under the Bond Indenture the amounts, if any, set forth in the supplemental indenture with respect to such Additional Bonds, and deposit to the credit of an expense fund the amount set forth in said supplemental indenture. If the proceeds received by the Bond Trustee are from the issuance of Additional Bonds for the purpose of acquiring or constructing additional health facilities, then the supplemental indenture shall provide that, after making the deposits set forth above, the balance of such proceeds shall be deposited in an acquisition or construction fund maintained under the Bond Indenture having such terms and provisions as are acceptable to the Issuer and shall be paid out against such showings as are acceptable to the Issuer.

(f) Copies of the materials required to be delivered to the Master Trustee in connection with the issuance of the Additional Obligations referred to in paragraph (a) above.

(g) Appropriate supplements to the Bond Indenture and the Loan Agreement providing, among other things, for the pledge of the Additional Obligations referred to in paragraph (a) above under the Bond Indenture.

(h) Such other closing documents and opinions of counsel as the Issuer and the Bond Trustee may reasonably specify.

Arbitrage

The Issuer and the Bond Trustee, to the extent of its discretion described under “Investment of Funds,” covenant and agree that they will not take any action or fail to take any action with respect to the investment of the proceeds of the Bonds or any Additional Bonds issued under the Bond Indenture or with respect to the payments derived from the Obligations pledged under such Bond Indenture or from the Loan Agreement or any other moneys regardless of source or where held which may, notwithstanding compliance with the other provisions of the Bond Indenture, Loan Agreement, and Tax Agreement, cause the Bonds to constitute “arbitrage bonds” within the meaning of such term as used in Section 148 of the Code. The Issuer further covenants and agrees that it will comply with and take all actions required by the Tax Agreement.

Supplemental Bond Indentures

Subject to the limitations set forth in the next paragraph, the Issuer and the Bond Trustee may, without the consent of, or notice to, any of the bondholders, enter into an indenture or indentures supplemental to the Bond Indenture to (a) cure any ambiguity or formal defect or omission in the Bond Indenture; (b) grant to or confer upon the bond Trustee for the benefit of the Bondholders any additional rights, remedies, powers or authority that may lawfully be granted to or conferred upon the Bondholders and the Bond Trustee, or either of them; (c) assign and pledge under the Bond Indenture additional revenues, properties or collateral; (d) evidence the appointment of a separate trustee or the succession of a new trustee under the Bond Indenture; (e) permit the qualification of the Bond Indenture under the Trust Indenture Act of 1939, as then amended, or any similar federal statute hereafter in effect or to permit the qualification of the Bonds for sale under the securities laws of any state of the United States; (f) permit the issuance of coupon Bonds of any series under the Master Indenture and permit the exchange of bonds from registered form to coupon form and vice versa; (g) provide for the refunding or advance refunding of any Bonds; (h) permit the issuance of any series of Additional Bonds; (i) permit continued compliance with the Tax Agreement or any similar agreement entered into in connection with the issuance of any series of Additional Bonds; and (j) to make any other change that, in the judgment of the Bond Trustee, does not materially adversely affect the rights of any Bondholders. The Issuer and the Bond Trustee may not enter into a bond indenture or indentures supplemental to the Bond Indenture pursuant to (f) above unless they shall have received an opinion of nationally recognized municipal bond counsel to the effect that the issuance of coupon Bonds will not adversely affect the validity of such Bonds or any exclusion from federal income taxation of interest paid on any Bonds to which such Bond would otherwise be entitled.

In addition to supplemental indentures for the purposes set forth in the previous paragraph, and subject to the terms and provisions described in this paragraph, and not otherwise, the holders of not less than a majority in the

aggregate principal amount of the Bond which are outstanding under the Bond Indenture at the time of the execution of such supplemental indenture or, in the case less than all of the several series of Bonds outstanding are affected thereby, the holders of not less than a majority in aggregate principal amount of all Bonds of each series so affected which are outstanding at the time of such execution shall have the right, from time to time, anything contained in the Bond Indenture to the contrary notwithstanding, to consent to and approve the execution by indenture as shall be deemed necessary and desirable by the board for the purpose of modifying, altering, amending, adding to or rescinding, in any particular, any of the terms or provisions contained in the Bond Indenture or in any supplemental indenture; except that no such supplemental indenture shall permit: (a) an extension of the stated maturity or reduction in the principal amount of, or reduction in the rate or extension of the time of paying interest on, or reduction of any premium payable on the redemption of any Bonds without the consent of the holders of such Bonds; (b) a reduction in the amount or extension of the time of any payment required to be made to or from the Interest Fund or the Bond Sinking Fund or any interest or sinking fund applicable to any Additional Bonds; (c) the creation of any lien prior to or on a parity with the lien of the Bond Indenture without the consent of the holders of all the Bonds at the time outstanding; (d) a reduction in the aforesaid aggregate principal amount of Bonds the holders of which are required to consent to any such supplemental indenture, without the consent of the holders of all the Bonds at the time outstanding which would be affected by the action to be taken; or (e) a modification of the rights, duties or immunities of the Bond Trustee, without the written consent of the Bond Trustee.

So long as the Obligated Issuers are not in default under the Master Indenture or the Corporation is not in default under the Loan Agreement, any supplemental indenture which adversely affect the rights of any member under the Master Indenture or the Corporation under the Loan Agreement shall not become effective unless and until the Corporation shall have consented in writing to the execution and delivery of such supplemental indenture.

Defeasance

The Issuer may pay or provide for the payment of the entire indebtedness on all Bonds outstanding (including, for these purposes, Bonds held by any Member of the Obligated Group) in any one or more of the following ways:

(a) by paying or causing to be paid the principal of (including redemption premium, if any) and interest on all Bonds outstanding, as and when the same become due and payable;

(b) by depositing with the Bond Trustee, in trust, at or before maturity, moneys in an amount sufficient to pay or redeem (when redeemable) all Bonds outstanding (including the payment of premium, if any, and interest payable on such Bonds to the maturity or redemption date thereof), provided that such moneys, if invested, shall be invested in Defeasance Investments increment to accrue thereon, sufficient to pay or redeem (when redeemable) and discharge the indebtedness on all Bonds outstanding at or before their respective maturity dates, it being understood that the investment income on such Defeasance Investments may be used for any other purpose under the Act;

(c) by delivering to the Bond Trustee, for cancellation, all Bonds outstanding; or

(d) by depositing with the Bond Trustee, in trust, Defeasance Investments in such amounts as the Bond Trustee shall determine will, together with the income or increment to accrue thereon, without consideration of any reinvestment thereof, be fully sufficient to pay or redeem (when redeemable) and discharge the indebtedness on all bonds at or before their respective maturity dates.

Upon the deposit with the Bond Trustee, in trust, of money or Defeasance Investments in the necessary amount to pay or redeem all outstanding Bonds and compliance with the other payment provisions of the Bond Indenture, including delivery to the Bond Trustee of a certificate of an independent certified public accounting firm satisfactory to the Bond Trustee that the cash or Defeasance Investments held by the bond Trustee pursuant to the provisions described above are sufficient for the purposes set forth above, the Bond Indenture may be discharged in accordance with the provisions thereof but the liability of the Issuer upon the Bonds shall continue provided that the holders thereof shall thereafter be entitled to payment only out of the moneys or the Defeasance Investments deposited with the Bond Trustee as indicated above.

If the Issuer shall pay or provide for the payment of the entire indebtedness on all Bonds of a particular series, or any portion of a particular series, in any one or more of the ways described in the first paragraph of this section, such Bonds shall cease to be entitled to any lien, benefit or security under the Bond Indenture. The liability of the Issuer in respect of such Bonds, if any, shall continue but the holders thereof shall thereafter be entitled to payment (to the exclusion of all other Bondholders) only out of the moneys or Defeasance Investments deposited with the Bond Trustee.

The foregoing notwithstanding, none of the Bonds may be so refunded nor may the Bond Indenture be discharged thereby if under any circumstances interest on such refunded Bonds is thereby made subject to federal income taxation to which such interest would not otherwise be subject. As a condition precedent to the advance refunding of any Bonds, the Bond Indenture requires the Bond Trustee to receive an opinion of Bond Counsel, which opinion may be based upon a ruling or rulings of the Internal Revenue Service, to the effect that interest on the Bonds being refunded will not, by reason of such refunding, be subject to federal income taxation to which such interest would not otherwise be subject.

Defaults and Remedies

Events of default are set forth in the Bond Indenture. Such events of default include, among other things: (i) failure to pay interest on any of the Bonds when the same shall become due and payable; (ii) failure to pay the principal of or the premium, if any, payable on any of the bonds when the same shall become due and payable, either at maturity, by proceedings for redemption, upon acceleration, through failure to make any payment to any Fund under the Bond Indenture or otherwise; (iii) certain events of bankruptcy, insolvency and the like relating to the Issuer; (iv) the Issuer shall for any reason be rendered incapable of fulfilling its obligations under the Bond Indenture; (v) any event of default as defined in the Loan Agreement or in the Master Indenture shall occur and be continuing from and after the date the Issuer is entitled under the Loan Agreement to request that the Master Trustee declare the Obligations pledged under the Bond Indenture immediately due and payable or the date on which the Master Trustee is entitled under the Master Indenture to declare any Obligation immediately due and payable; (vi) default by the Issuer in the due and punctual performance of any of the other covenants conditions, agreements and provisions be performed on the part of the Issuer and continuance of such default for the period of 30 days after written notice specifying such default and requiring the same to be remedied shall have been given to the Issuer, the Obligated Group Agent and the Corporation by the Bond Trustee (which notice may be given by the Bond Trustee in its discretion and shall be given by the Bond Trustee at the request of the owners of Bonds whose Bond Obligation is not less than 10% in aggregate principal amount of Bonds then outstanding); (vii) the Issuer, the Corporation or the Bond Trustee shall default in the performance of any covenant, condition, agreement or provision of the Tax Agreement, and such default shall continue for the period of 30 days after written notice specifying such default and requiring the same to be remedied shall have been given to the party in default, the Corporation and the Obligated Group Agent by the other party; and (viii) certain other events listed in the Bond Indenture.

Upon the happening of any event of default (other than the events of default described in (i) and (ii) above) and the continuance of the same for the period, if any, specified under the Bond Indenture, the Bond Trustee may, without any action on the part of the Bondholders, and upon the happening and continuance of any event of default described in (i) and (ii) or upon the happening and continuance of any other event of default and the written request of the owners of Bonds of not less than twenty-five percent (25%) in aggregate principal amount of all Bonds then outstanding under the Bond Indenture (exclusive of Bonds then owed by the Issuer of any Member), and upon being indemnified to its satisfaction, the Bond Trustee shall, by notice in writing delivered to the Issuer, declare the entire principal amount of the Bonds then outstanding and the interest accrued thereon, immediately due and payable, and such entire principal and interest shall thereupon become and be immediately due and payable, subject, however, to the provisions of the Bond Indenture with respect to waivers of events of default.

Direction of Proceedings

The owners of a majority in aggregate principal amount of all Bonds then outstanding shall have the right at any time, by an instrument or instruments in writing executed and delivered to the Bond Trustee, to direct the method and place of conducting all proceedings to be taken in connection with the enforcement of the terms and conditions of the Bond Indenture, including the enforcement of the rights of the Issuer under the Loan Agreement or

the appointment of a receiver or any other proceedings under the Bond Indenture; provided, that such direction shall not be otherwise than in accordance with the provisions of law and of the Bond Indenture.

Waivers of Events and Default

The Bond Trustee may in its discretion waive any event of default under the Bond Indenture and its consequences and rescind any declaration of maturity of principal, and shall do so upon written request of the owners of (1) at least a majority in aggregate principal amount of the Bonds outstanding in respect of which default in the payment of principal and/or interest exists, or (2) at least a majority in aggregate principal amount of all the Bonds outstanding in the case of any other event of default. The foregoing notwithstanding, in no event shall there be waived (a) any event of default in the payment of the principal of any outstanding Bond when due whether by mandatory redemption through the Bond Sinking Fund or at the dates of maturity specified therein, or (b) any default in the payment, other than an acceleration of the Bonds, when due of the interest on any such Bonds, unless prior to such waiver or rescission all arrears of interest, with interest (to the extent permitted by law) at the rate borne by the Bonds in respect of which such default shall have occurred on overdue installments of interest or all arrears of payments of principal when due, as they case may be, and all expenses of the Bond Trustee and any Paying Agent in connection with such default shall have been paid or provided for. In case of any such waiver or rescission or in case any proceeding taken by the Bond Trustee on account of any such default shall have been discontinued or abandoned or determined adversely, then and in every such case the Issuer, by the Bond Trustee and the Bondholders shall, subject to any determination in such proceedings, be restored to their former positions and rights under the Bond Indenture respectively, but no such waiver or rescission shall extend to any subsequent or other default, or impair any right consequent thereon.

SUMMARY OF CERTAIN PROVISIONS OF THE LOAN AGREEMENT

The following is a summary of certain provisions of the Loan Agreement between the Corporation and the Issuer, to which reference is made for a full and complete statement of its provisions.

Loan of Bond Proceeds

The Issuer will lend the proceeds from the sale of the Bonds to the Corporation. The Obligations will be delivered to the Issuer to evidence such loan and the obligation of the Corporation to repay the same. Each Obligation will be issued in a principal amount equal to the aggregate principal amount of the corresponding series of Bonds, and will provide for payment of principal, premium, if any, and interest thereon, sufficient to permit the Issuer to make payments of principal, premium, if any, and interest on the corresponding series of Bonds.

Representations

The Corporation represents that it is a not for profit corporation duly incorporated under the laws of the State of Tennessee, is in good standing and duly authorized to conduct its business in the State, has full power to execute and deliver the Loan Agreement, the Master Indenture, the Tax Agreement and each Obligation. The Corporation also warrants that each Obligation is in the hands of the holder thereof will be the legal and valid joint and several obligation of the Corporation and each other Obligated Issuer. In addition, the Corporation will represent that no litigation, proceedings or investigation are pending or, to the knowledge of the Corporation, threatened against the Corporation except (i) litigation, proceedings or investigations involving claims for hospital professional or general patient liability for which the probably ultimate recovers and the estimated costs and expenses of defense, in the opinion of Independent Counsel, will be entirely within applicable insurance policy limits (subject to applicable deductibles) or are not in excess of the total available assets held under applicable self-insurance programs or (ii) litigation, proceedings or investigations involving other types of claims which if adversely determined will not, in the opinion of Independent Counsel, have a material adverse effect on the operations or condition, financial or otherwise, of the Corporation.

Assignment of Rights under the Loan Agreement and the Obligations

The Corporation agrees that the Loan Agreement, the Obligation and any Additional Obligations delivered to the Issuer to evidence loans made by the Issuer pursuant to the Loan Agreement from the proceeds of Additional Bonds and payments to be made thereunder and thereon (excluding fees and expenses payable to the Issuer and the Issuer's right of indemnification in certain circumstances) shall be assigned and pledge to secure payment of the Bonds, and all of the rights, interest, powers, privileges and benefits accruing to or vested in the Issuer thereunder may be protected and enforced in conformity with the Bond Indenture and may be assigned by the Issuer to the Bond Trustee as additional security for the Bonds, other than the right of the Issuer to receive payment of its fees and expenses, its right to indemnification and its right to execute and deliver supplements and amendments to the Loan Agreement.

Payments in Respect of Obligation and Under the Loan Agreement

Under the terms of the Loan Agreement, the Corporation covenants and agrees to pay the Bond Trustee such amounts at such times as shall provide for payment of interest, premium, if any, and principal, whether upon a regularly schedule interest payment date, maturity, mandatory redemption or acceleration, on each series of Bonds outstanding under the Bond Indenture. The Loan Agreement also requires that the Corporation pay certain other charges which may be incurred for such items as the Bond Trustee's fees, the Issuer's fees and expenses, taxes and assessments, if any, and costs incurred in connection with or incident to the issuance and sale of the Bonds which exceed the amount on deposit in the Expense Fund. All payments due on each Obligation, on any Additional Obligations issued in connection with the issuance of Additional Bonds and under the Loan Agreement, shall be paid directly to the Bond Trustee's and applied in the manner provided in the Bond Indenture.

Corporation's Obligations are Unconditional

The obligations of the Corporation to pay the principal, premium, if any, and interest on the Obligations pledged under the Bond Indenture, to pay the other sums provided for in the Loan Agreement and to perform and observe its other agreements under the Loan Agreement shall be absolute and unconditional, and the Corporation shall not be entitled to any abatement or diminution thereof nor to any termination of the Loan Agreement for any reason whatsoever.

Completion of the Project; Completion Certificate. The Corporation agrees to cause the Project to be completed in accordance with the Loan Agreement and the Tax Agreement with reasonable dispatch. The Corporation shall provide (from its own funds if required) all moneys necessary to complete the Project.

The Corporation will deliver to the Bond Trustee, within 90 days after completion of the Project, the Completion Certificate in the form provided in the Bond Indenture and the Loan Agreement.

Changes in or Amendments to the Project. The Corporation may make, authorize or permit such changes in or amendments to the Project as it reasonably determines to be necessary or advisable. However, no such change shall be made to the Project if it would (i) cause the average maturity of the applicable series of Bonds to be more than 120% of the average reasonably expected economic life of the Project, (ii) result in the Facilities being used for any purpose prohibited by the Loan Agreement, (iii) violate or conflict with the terms of the approvals or findings of non-reviewability concerning the Project by the Tennessee Health Facilities Commission, or (iv) add material construction projects which were part of the Project contemplated in the Tax Agreement.

Certain Covenants of the Corporation Relating to the Use and Operation of Certain of its Property

The Corporation agrees that it will use its health care Facilities primarily as and for hospitals and related activities and only in the furtherance of the lawful corporate purposes of the Corporation.

The Corporation agrees that it will not permit any of the Property for which the Corporation or the Issuer is or has been reimbursed, in whole or in part, whether directly or indirectly, from the proceeds of the Bonds, to be used (i) by any Person in an Unrelated Trade of Business of the Corporation or by any person who is not a Tax-Exempt Organization, in either case in such manner or to such extent as would result in the loss of tax exemption of interest on the Bonds or any other such tax-exempt Additional Bonds otherwise afforded under Section 103(a) of the Code, (ii) primarily for sectarian instruction or study or as a place of devotional activities or religious worship or as a facility used primarily in connection with any part of the program of a school or department of divinity for any religious denomination or the training of ministers, priests, rabbis or other similar person in the field of religion, or (iii) in a manner which is prohibited by the Establishment of Religion Clause of the First Amendment to the Constitution of the United States of America and the decision of the United States Supreme Court interpreting the same or by any comparable provisions of the Constitution of the State and the decisions of the Supreme Court of the State interpreting the same.

Transfer of Assets by Corporation

The Corporation covenants and agrees that it will not sell, lease or otherwise dispose of any of its Property except as provided by the provision of the Master Indenture summarized under "Summary of Certain Provisions of the Master Indenture--Sale, Lease, or Other Disposition of Property" above. The provisions of the Master Indenture notwithstanding, the Corporation agrees that it will not sell, lease or otherwise dispose (including without limitation any involuntary disposition) of in excess of 2%, in the aggregate of the Property financed or refinanced with the proceeds of the Bonds (which percentage shall be reduced to the extent Property financed or refinanced with the proceeds of the Bonds is used in an Unrelated Trade of Business of the Corporation) unless: (a) prior to such sale, lease or other disposition there is delivered to the Bond Trustee and the Issuer an Officer's Certificate of the Corporation stating that, in the judgment of such officer, such Property has become inadequate, obsolete or worn out and that Any amounts received by the Corporation upon such disposition shall be applied by the Corporation to acquire additional property constituting a "project" under the Act; or (b) prior to such sale, lease or other disposition the Corporation delivers to the Bond Trustee and the Issuer a written Opinion of Bond Counsel (which counsel and

opinion is acceptable to the Bond Trustee and the Issuer) to the effect that any such disposition will not adversely affect the validity of the Bonds or the exclusion from federal income taxation of the interest paid on the Bonds or any other such tax-exempt Bonds under Section 103(a) of the Code. The Corporation agrees to apply the proceeds of any disposition described in (a) above as provided in such clause and agrees that any Property acquired with such proceeds shall be deemed to be Property financed with the proceeds of the Bonds for purpose of applying the provisions of the Loan Agreement. The amount of Property disposed of will be calculated in accordance with the provisions of the Master Indenture.

Indemnification of the Issuer

The Corporation agrees to pay, protect, indemnify and save the Issuer and the Bond Trustee harmless from and against any and all liability, losses, damages, costs and expenses (including those arising or resulting from any injury to or death of any person or damage to property) arising from or in any manner directly or indirectly growing out of or connected with, among other things, the use and occupancy of any of the Corporation's Property, any repairs, construction, alterations, renovation, relocation, remodeling and equipping thereof or thereto or the condition of any of the Corporation's Property including adjoining sidewalks, streets or alleys and any equipment or facilities at any time located on such Property or used in connection therewith, but which are not the result of the negligence of the Issuer or the Bond Trustee.

Maintenance of Corporate Existence; Bonds to Remain Tax-Exempt

The Corporation agrees to at all times maintain its existence as a Tennessee not-for-profit corporation and it will neither take any action nor suffer any action to be taken by others which will alter, change or destroy its status as a nonprofit corporation or its status as a Tax-Exempt Organization except as permitted by the Master Indenture. The Corporation covenants and agrees that, as long as any Bond remain outstanding, it or any successor thereto into which it is merged or consolidated under the terms of the Master Indenture will remain a Member of the Obligated Group. The Corporation further covenants that it will not make any distribution except as authorized by applicable law and as otherwise permitted under the terms of the Loan Agreement. The Corporation further agrees that it will not act or fail to act in any other manner which would adversely affect the tax exemption for federal income tax purpose of the interest earned by the owners of the Bonds or any other such tax-exempt Additional Bonds to which such Bonds would otherwise be entitled.

Accreditation and Licensure

The Corporation warrants that its hospitals are now accredited by the Joint Commission on Accreditation of Healthcare Organization or other applicable accreditation body and that its health care Facilities have all state and local licenses required for the operation thereof. The Corporation agrees to obtain and maintain all such licenses required for its operations and the operation of its health care Facility and to use its best efforts to obtain and maintain such accreditation, so long as it is in the best interests of the Corporation and the Bondholders, as determined by the Corporation.

Government Grants

The Corporation covenants to comply with all of the terms and provisions of any governmental grants it receives, including those made by the State and the federal government and the laws and regulations under which they are made.

Supplements and Amendments to the Loan Agreement

Under the terms of the Bond Indenture, the Issuer, the Corporation and the Bond Trustee may, without the consent of or notice to the holders of the Bonds, consent to any amendment, change or modification of the Loan Agreement as may be required (i) by the provisions of the Loan Agreement or the Bond Indenture, (ii) for the purpose of curing any ambiguity or formal defect or omission, (iii) in connection with the issuance of Additional Bonds, (iv) in connection with any other change therein which, in the judgment of the Bond Trustee, does not materially adversely affect the rights of the Bond Trustee or the owners of the Bonds, or (v) for the purpose of

complying with the provisions of the Tax Agreement. Except for the amendments, changes or modifications referred to in the preceding sentence, neither the Issuer nor the Bond Trustee shall consent to any other amendment, change or modification of the Loan Agreement without the written approval or consent of the owners of not less than a majority in aggregate principal amount of all Bonds at the time outstanding or in case less than all of the several series of Bonds then outstanding are affected thereby, the owners of not less than a majority in aggregate principal amount of all Bonds of each series so affected then outstanding at the time of execution of any such amendment, change or modification; provided that if such amendment, change or modification will, by its terms, not take effect so long as any Bonds of a specified series remain outstanding, the consent of the holders of such Bonds shall not be required.

Defaults and Remedies

Events of default under the Loan Agreement include: (i) failure of the Corporation to make any payment of principal, interest or premium, on any Obligation pledged under the Bond Indenture or any other payment required by the Loan Agreement when due and payable, (ii) payment of principal, interest or premium on any Bond is not made when due and payable, (iii) failure of the Corporation to perform and comply with any of the covenants and conditions under the Loan Agreement or the Tax Agreement and failure to remedy such default within 30 days after notice thereof from the Bond Trustee; provided that, if such default cannot with due diligence and dispatch be wholly cured within 30 days but can be wholly cured, the failure of the Corporation to remedy such default within such 30-day period shall not constitute a default under the Loan Agreement if the Corporation shall immediately upon receipt of such notice commence with due diligence and dispatch the curing of such default and, having so commenced the curing of such default, shall thereafter prosecute and complete the same with due diligence and dispatch, (iv) any event of default shall occur under the Master Indenture which would permit the acceleration of any Obligation, (v) certain events of bankruptcy, insolvency and the like relating to the Corporation, and (vi) certain other defaults described in the Loan Agreement.

Whenever any event of default shall have occurred and be continuing under the Loan Agreement, the Issuer may (i) request that the Master Trustee declare the unpaid principal balance of the outstanding Obligations (if not then due and payable) immediately due and payable subject to the provisions of the Master Indenture regarding waiver of events of default, and (ii) pursue any available remedy to collect the payments then due and thereafter to become due on the Obligations pledged under the Bond Indenture or to enforce performance and observance of any obligation, agreement or covenant of the Corporation under the Loan Agreement, the Obligations or the Master Indenture.

APPENDIX D

PROPOSED FORM OF OPINION OF BOND COUNSEL

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[Form of Opinion of Bond Counsel]
[Subject to Review]

September 18, 2012

The Health and Educational Facilities Board
of the City of Johnson City, Tennessee
Johnson City, Tennessee

The Bank of New York Mellon Trust Company, N.A.,
Bond Trustee and Master Trustee
St. Louis, Missouri

Merrill Lynch, Pierce, Fenner & Smith Incorporated
New York, New York

**Re: The Health and Educational Facilities Board of the City of Johnson City, Tennessee
\$55,000,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2012A**

Ladies and Gentlemen:

We have acted as bond counsel in connection with the issuance by The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the "Issuer") of its \$55,000,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2012A (the "Bonds"). We have examined the law and such certified proceedings and other papers as we deem necessary to render this opinion. Reference is made to the forms of the Bonds for additional information concerning their details, payment and redemption provisions and the proceedings pursuant to which they were issued.

The Bonds are issued pursuant to a Bond Trust Indenture dated as of September 1, 2012 (the "Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Bond Trustee"). The proceeds from the sale of the Bonds will be loaned by the Issuer to Mountain States Health Alliance, a not-for-profit corporation incorporated under the laws of the State of Tennessee (the "Alliance"), under a Loan Agreement dated as of September 1, 2012 (the "Loan Agreement"), between the Issuer and the Alliance, which loan will be evidenced by the \$55,000,000 Mountain States Health Alliance Note, Series 2012A (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) (the "Series 2012A Obligation") issued pursuant to an Amended and Restated Master Trust Indenture dated as of February 1, 2000, as heretofore amended and as amended by a Thirty-Fourth Supplemental Master Trust Indenture dated as of September 1, 2012 (collectively, the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"). Under the Loan Agreement and the Series 2012A Obligation, the Alliance has agreed to make payments to be used to pay when due the principal of and premium, if any, and interest on the Bonds, and such payments and other revenues under the Loan Agreement and the Series 2012A Obligation (collectively, the "Revenues") and the rights of the Issuer under the Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) are pledged and assigned by the Issuer as security for the Bonds. The Bonds are payable solely from the Revenues.

Reference is made to an opinion of even date of Anderson & Fugate, counsel to the Alliance, with respect, among other matters, to the corporate status, good standing and qualification to do business of the Alliance, the corporate power of the Alliance to enter into and perform the Loan Agreement, the Series 2012A Obligation and the Master Indenture and the authorization, execution and delivery of the Loan Agreement, the Series 2012A Obligation and the Master Indenture by the Alliance and with respect to the Loan Agreement, the Series 2012A Obligation and the Master Indenture being binding and enforceable upon the Alliance.

As to questions of fact material to our opinion, we have relied upon representations of the Issuer and the Alliance contained in the Bond Indenture and the Loan Agreement, the certified proceedings and other certifications of public officials furnished to us, and certifications furnished to us by or on behalf of the Alliance (including certifications as to the use of bond proceeds and other bond issues which are material to paragraph 4 below), without undertaking to verify the same by independent investigation.

Based upon the foregoing, we are of the opinion that, under existing law:

1. The Issuer is duly created and validly existing as a public, nonprofit corporation, organized and existing under the laws of the State of Tennessee with the corporate power to enter into and perform the Bond Indenture and issue the Bonds.

2. The Bond Indenture has been duly authorized, executed and delivered by the Issuer and is a valid and binding obligation of the Issuer enforceable against the Issuer. The Bond Indenture creates a valid lien on the Revenues and on the rights of the Issuer under the Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) for the benefit of the Bonds.

3. The Bonds have been duly authorized, executed and delivered by the Issuer and are valid and binding special obligations of the Issuer, payable solely from the Revenues.

4. Interest on the Bonds (a) will not be included in gross income for federal income tax purposes, and (b) will not be an item of tax preference for purposes of the federal alternative minimum income tax imposed on individuals and corporations; such interest, however, is taken into account in determining adjusted current earnings for purposes of computing the alternative minimum tax on corporations (as defined for federal income tax purposes). The foregoing opinion is given in reliance upon certifications by representatives of the Issuer and the Alliance as to certain facts relevant to both the opinion and the requirements of the Internal Revenue Code of 1986, as amended (the "Code"). The Issuer and/or the Alliance have covenanted to comply with the provisions of the Code regarding, among other matters, the use, expenditure and investment of the proceeds of the Bonds and the timely payment of arbitrage profits with respect to the Bonds to the United States. Failure by the Issuer or the Alliance to comply with such covenants could cause interest on the Bonds to be included in gross income for federal income tax purposes retroactively to their date of issue. We express no opinion regarding other federal tax consequences arising with respect to the Bonds.

5. The Bonds and the income therefrom shall be exempt from all state, county and municipal taxation in Tennessee except (a) inheritance, gift and estate taxes, (b) excise taxes on all or a portion of the interest on any of the Bonds during the period such Bonds are held or beneficially owned by any organization or entity, other than a sole proprietorship or general partnership, and (c) Tennessee franchise taxes by reason of the inclusion of the book value of the Bonds in the Tennessee franchise tax base of any organization or entity, other than a sole proprietorship or general partnership.

It is to be understood that the rights of the holders of the Bonds and the enforceability of the Bonds and the Bond Indenture may be subject to bankruptcy, insolvency, reorganization, moratorium and other laws affecting creditors' rights heretofore and hereafter enacted to the extent constitutionally applicable and that their enforcement may also be subject to the exercise of judicial discretion in appropriate cases.

Our services as bond counsel have been limited to rendering the foregoing opinion based on our review of such proceedings and documents as we deem necessary to approve the validity of the Bonds and the excludability of the interest on the Bonds from gross income for federal income tax purposes. We have not made any investigation concerning the financial resources of the Alliance and, therefore, we express no opinion as to the business or financial resources of the Alliance, its ability to provide for the payment of the Bonds or the accuracy or completeness of any information that may have been relied on by anyone in making the decision to purchase the Bonds.

Very truly yours,

APPENDIX E

PROPOSED FORM OF CONTINUING DISCLOSURE AGREEMENT

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CONTINUING DISCLOSURE AGREEMENT

This Continuing Disclosure Agreement (the “Agreement”) is executed by the Mountain States Health Alliance, a Tennessee nonprofit corporation (the “Alliance”), in connection with (i) the issuance by the Health and Educational Facilities Board of the City of Johnson City, Tennessee of its \$55,000,000 Hospital Revenue Bonds (Mountain States Health Alliance) Series 2012A (the “Series 2012A Bonds”), and its \$_____ Hospital Revenue Bonds (Mountain States Health Alliance) Series 2012B (the “Series 2012B Bonds”), and (ii) the issuance by the Industrial Development Authority of Wise County of its \$_____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2012C (the “Series 2012C Bonds” and, together with the Series 2012A Bonds and the Series 2012B Bonds, the “Bonds”).

1. Purpose of the Agreement

This Agreement is being executed and delivered by the Alliance for the benefit of the Beneficial Owners of the Bonds and in order to assist the Underwriter in complying with the Rule (as hereinafter defined).

2. Definitions

Except as otherwise indicated, any capitalized terms used, but not defined herein shall have the meaning assigned to them in the bond indenture pursuant to which the Bonds were issued. The following capitalized terms when used in this Agreement will have the following meanings:

“Annual Disclosure” means the annual financial information, audited financial statements prepared in accordance with generally accepted accounting principles and the operating data, all to be provided by the Alliance with respect to itself and any future Obligated Issuer pursuant to the Rule and this Agreement, as provided in Section 4 hereof.

“Beneficial Owner” means any person who (a) has the power, directly or indirectly, to vote or consent with respect to, or to dispose of ownership of, any Bonds (including persons holding Bonds through nominees, depositories or other intermediaries) or (b) is treated as the owner of any Bonds for federal income tax purposes.

“Fixed Rate Official Statement” means the Official Statement dated August 24, 2012, pursuant to which the Series 2012A Bonds were sold.

“Listed Events” means any of the events listed below under “Reporting of Significant Events.”

“MSRB” means the Municipal Securities Rulemaking Board, or any successor thereto. Currently, the MSRB’s address is: MSRB, 1900 Duke Street, Suite 600, Alexandria, Virginia 22314, Attn: Disclosure.

“Official Statements” means the Fixed Rate Official Statement and the Variable Rate Official Statement.

“Quarterly Disclosure” means the provision of the Quarterly Financial Information and any other financial information as provided in Section 5, hereof.

“Quarterly Financial Information” means (i) the Alliance’s quarterly financial results in the form of its unaudited quarterly statement of excess of revenue over expenses and its unaudited quarterly balance sheet, each on a consolidated basis for the combined Obligated Group (as defined in the bond documents pursuant to which the Bonds are issued) and (ii) two calculations of the Historical Maximum Annual Debt Service Coverage Ratio (one utilizing a *pro forma* Total Income Available for Debt Service based upon the results of such quarter and the other utilizing Total Income Available for Debt Service over the rolling twelve month period ended with the end of such quarter).

“Rule” means Rule 15c2-12(b)(5) adopted by the Securities and Exchange Commission under the Securities Exchange Act of 1934, as previously amended and as the same may be amended from time to time.

“Underwriter” means Merrill Lynch, Pierce, Fenner & Smith Incorporated.

“Variable Rate Official Statement” means the Official Statement dated _____, 2012, pursuant to which the Series 2012B Bonds and the Series 2012C Bonds were sold.

3. Provision of Annual Disclosure and Quarterly Disclosure

Not later than four months after the end of each fiscal year, the Alliance will file its Annual Disclosure with the MSRB. The Annual Disclosure may be submitted as a single document or as separate documents comprising a package, and may cross-reference other information as provided below.

Not later than 45 days after the end of each quarter of the Alliance’s fiscal year the Alliance shall file its Quarterly Financial Information with the MSRB.

If the Annual Disclosure is not filed as provided in the preceding paragraph, the Alliance will send a notice to that effect to the MSRB.

4. Content of Annual Disclosure

The Alliance and any future Obligated Issuer shall provide and incorporate the following information in its Annual Disclosure:

(a) The audited financial statements of the Alliance and any future Obligated Issuer whose operations are not reflected in the audited financial statements of the Alliance; and

(b) To the extent not included in the audited financial statements of the Alliance, the Alliance annually will make available the following financial and operating data:

(i) The patient origin analysis from all service areas as a percent of the discharges in Alliance-owned facilities for the prior 12 month period, as set forth under the caption “SERVICE AREA, MARKET SHARE AND COMPETITION – Patient Origin -- Alliance Facilities Patient Origin by Fiscal Year” in Appendix A of the Official Statements.

(ii) The percentage of gross patient revenues received by the Alliance from each program (i.e., Medicare, TennCare/Medicaid, Managed Care, Commercial and Other, and Private Pay) for the most recently concluded fiscal year, as set forth under the caption “SOURCES OF REVENUE – Gross Patient Revenues by Source of Payment (Payor Mix)” in Appendix A of the Official Statements.

(iii) The historic patient utilization for the Alliance and aggregate utilization for all divisions for the prior 12 month period ending June 30, as set forth in the table under the caption “HISTORICAL UTILIZATION INFORMATION” in Appendix A of the Official Statements.

Any or all of the items listed above may be incorporated by reference from other documents, including official statements of debt issues with respect to which the Alliance is an “obligated person” (as defined by the Rule), which have been filed in accordance with the Rule and the other rules of the Securities and Exchange Commission. If the document incorporated by reference is a final official statement, it must have been filed with and be available from the MSRB. The Alliance must clearly identify each such other document so incorporated by reference.

5. Content of Quarterly Disclosure

The Alliance’s Quarterly Disclosure will contain its Quarterly Financial Information.

6. Reporting of Significant Events

The following are Listed Events:

- (a) principal and interest payment delinquencies;
- (b) non-payment related defaults, if material;
- (c) unscheduled draws on debt service reserves reflecting financial difficulties;
- (d) unscheduled draws on any credit enhancement reflecting financial difficulties;
- (e) substitution of credit or liquidity providers, or their failure to perform;
- (f) adverse tax opinions; the issuance by the IRS of proposed or final determinations of taxability, Notices of Proposed Issue (IRS Form 5701-TEB) or other material notices or determinations with respect to the tax status of the Bonds, or other material events affecting the tax status of the Bonds;
- (g) modifications of rights of the holders of the Bonds, if material;
- (h) bond calls, if material, and tender offers;
- (i) defeasance of all or any portion of the Bonds;
- (j) release, substitution, or sale of property securing repayment of the Bonds, if material;
- (k) rating changes;
- (l) bankruptcy, insolvency, receivership or similar event of the Issuer;
- (m) the consummation of a merger, consolidation, or acquisition involving the Issuer or the sale of all or substantially all of the assets of the Issuer, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; and
- (n) appointment of a successor or additional trustee or the change of name of a trustee, if material.

If the Alliance obtains knowledge of the occurrence of a Listed Event, the Alliance shall, in a timely manner not in excess of ten business days after the occurrence of the event, file a notice of such occurrence with the MSRB. Notice of Listed Events described in subsections (h) and (i) will be disseminated automatically, but will not be given any earlier than the notice (if any) of the underlying event is given to the Beneficial Owners of affected Bonds pursuant to the governing bond documents. The content of any notice of the occurrence of a Listed Event will be determined by the Alliance in accordance with the requirements of the Rule.

7. Filing Method

Any filing required hereunder shall be made by transmitting such disclosure, notice or other information in electronic format to the MSRB through the MSRB's Electronic Municipal Market Access (EMMA) system pursuant to procedures promulgated by the MSRB.

8. Termination of Reporting Obligation

The Alliance's obligations under this Agreement will terminate upon the defeasance (within the meaning of the Rule), prior redemption or payment in full of all of the Bonds. The Alliance will notify the MSRB that the Alliance's obligations under this Agreement have terminated. If the Alliance's obligations are assumed in full by some other entity, such person will be responsible for compliance with this Agreement in the same manner as if it were the Alliance and the Alliance will have no further responsibility hereunder.

9. Dissemination Agent

The Alliance may, from time to time, appoint a dissemination agent to assist it in carrying out its obligations under this Agreement, and the Alliance may, from time to time, discharge the dissemination agent, with or without appointing a successor dissemination agent. If at any time there is not a designated dissemination agent, the Alliance will be the dissemination agent.

10. Amendment

This Agreement may not be amended unless independent counsel experienced in securities law matters has rendered an opinion to the Alliance to the effect that the amendment does not violate the provisions of the Rule.

In the event that this Agreement is amended or any provision of this Agreement is waived, the notice of a Listed Event pursuant to subsection (6) under the heading "Reporting of Significant Events" will explain, in narrative form, the reasons for the amendment or waiver and the impact of the change in the type of operating data or financial information being provided in the Annual Disclosure. If an amendment or waiver is made in this Agreement which allows for a change in the accounting principles to be used in preparing financial statements, the Annual Disclosure for the year in which allows for a change in the accounting principles to be used in preparing financial statements, the Annual Disclosure for the year in which the change is made will present a comparison between the financial statements or information prepared on the basis of the new accounting principles and those prepared on the basis of the former accounting principles. The comparison will include a qualitative discussion of the differences in the accounting principles and impact of the change in the accounting principles on the presentation of the financial information. A notice of the change in the accounting principles will be deemed to be material and will be filed with the MSRB.

11. Additional Information

Any registered owner of \$1,000,000 or more in principal amount of Bonds shall receive, upon written request, any of the Annual Financial Information, Audited Financial Information or Quarterly Financial Information directly from the Alliance, by sending such request to Mountain States Health Alliance, 400 North State of Franklin Road, Johnson City, Tennessee 37604, Attn: Chief Financial Officer.

Nothing in this Agreement will be deemed to prevent the Alliance from disseminating any other information, using the means of dissemination set forth in this Agreement or any other means of communication, or including any other information in any Annual Disclosure or notice of occurrence of a Listed Event, in addition to that which is required by this Agreement. If the Alliance chooses to include any information in any Annual Disclosure or notice of occurrence of a Listed Event, in addition to that which is specifically required by this Agreement, the Alliance will have no obligation under this Agreement to update such information or include it any future Annual Disclosure or notice of occurrence of a Listed Event.

12. Default

In the event of a failure of the Alliance to comply with any provision of this Agreement, the Underwriter or any Beneficial Owner may take such actions as may be necessary and appropriate, including seeking specific performance by court order, to cause the Alliance to comply with its obligations under this Agreement. A default under this Agreement will not be deemed an Event of Default under the bond documents, and the sole remedy under this Agreement in the event of any failure of any party to comply with this Agreement will be an action to compel performance.

Acting by and through its duly authorized officer, the Alliance has caused this Continuing Disclosure Agreement to be executed under seal as of the 1st day of September, 2012.

MOUNTAIN STATES HEALTH ALLIANCE

By: _____
Its: Senior Vice President and
Chief Financial Officer

BOOK-ENTRY ONLY SYSTEM

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BOOK-ENTRY ONLY SYSTEM

The description which follows of the procedures and recordkeeping with respect to beneficial ownership interests in the Bonds, payments of principal of and premium, if any, and interest on the Bonds to The Depository Trust Company, New York, New York, its nominee, Participants or Beneficial Owners (each as hereinafter defined), confirmation and transfer of beneficial ownership interests in the Bonds and other bond-related transactions by and between DTC, Participants and Beneficial Owners is based solely on information furnished by DTC.

DTC will act as securities depository for the Bonds. The Bonds will be issued as fully-registered securities registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered Bond certificate will be issued for each maturity of the Bonds, each in the aggregate principal amount of such maturity, and will be deposited with DTC.

DTC, the world's largest depository, is a limited-purpose trust company organized under the New York Banking Law, a "banking organization" within the meaning of the New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.5 million issues of U.S. and non-U.S. equity, corporate and municipal debt issues, and money market instruments (from over 100 countries) that DTC's participants (the "Direct Participants") deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("Indirect Participants"). DTC has a Standard & Poor's rating of AA+. The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com.

Purchases of the Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Bonds on DTC's records. The ownership interest of each actual purchaser of each Bond (the "Beneficial Owner") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners, however, are expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Bonds are to be accomplished by entries made on the books of Direct or Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their ownership interests in the Bonds, except in the event that use of the book-entry system for the Bonds is discontinued.

To facilitate subsequent transfers, all Bonds deposited by Direct Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of the Bonds with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such Bonds are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holding on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time.

Redemption notices shall be sent to DTC. If less than all of the Bonds are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such issue to be redeemed.

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to the Bonds unless authorized by a Direct Participant in accordance with DTC's Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to each of the respective Issuer or the Alliance, as applicable, as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts the Bonds are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Redemption proceeds, distributions, and dividend payments on the Bonds will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding detail information from the Alliance or the Bond Trustee on a payment date in accordance with their respective holdings shown on DTC's records. Payments by Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Participant and not of DTC, the Bond Trustee, the Issuer or the Alliance, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of redemption proceeds, distributions, and dividend payments to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Alliance or the Bond Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

DTC may discontinue providing its services as securities depository with respect to the Bonds at any time by giving reasonable notice to the respective Issuer or the Alliance. Under such circumstances, in the event that a successor securities depository is not obtained, Bond certificates will be printed and delivered.

The Issuer or the Alliance may decide to discontinue the use of the system of book-entry transfers through DTC (or a successor securities depository). In that event, Bond certificates will be printed and delivered.

The information in this section concerning DTC and DTC's book-entry system has been obtained from sources that the respective Issuer believes to be reliable, but the Issuer takes no responsibility for the accuracy thereof.

Neither the Issuer nor the Registrar has any responsibility or obligation to the Direct or Indirect Participants or the Beneficial Owners with respect to (a) the accuracy of any records maintained by DTC or any Direct or Indirect Participant; (b) the payment by any Direct or Indirect Participant of any amount due to any Beneficial Owner in respect of the principal of and interest on the Bonds; (c) the delivery or timeliness of delivery by any Direct or Indirect Participant of any notice to any Beneficial Owner that is required or permitted under the terms of the Bond Resolution to be given to Bondholders; or (d) any other action taken by DTC, or its nominee, Cede & Co., as Bondholder, including the effectiveness of any action taken pursuant to an Omnibus Proxy.

So long as Cede & Co. is the registered owner of the Bonds, as nominee of DTC, references in this Official Statement to the Owners of the Bonds shall mean Cede & Co. and shall not mean the Beneficial Owners, and Cede & Co. will be treated as the only holder of Bonds for all purposes under the Bond Resolution.

The Issuer may enter into amendments to the agreement with DTC or successor agreements with a successor securities depository, relating to the book-entry system to be maintained with respect to the Bonds without the consent of Beneficial Owners or Bondholders.

Exhibit 11.4

Attachment C

Mountain States Bonds Official Statement for 2013 Bonds

In the opinion of Bass, Berry & Sims PLC, Bond Counsel, under existing law and subject to conditions described in "TAX MATTERS," interest on the Series 2013A Bonds (a) will not be included in gross income for federal income tax purposes, and (b) will not be an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations; such interest, however, is taken into account in determining the adjusted current earnings for purposes of the alternative minimum tax on corporations. Interest on the Series 2013A Bonds and the Series 2013B Bonds will be exempt from all state, county and municipal taxation in Tennessee except inheritance, transfer, estate taxes and except that interest may not be exempt from Tennessee franchise and excise taxes. A holder may be subject to other federal tax consequences as described in "TAX MATTERS."

\$115,915,000

**THE HEALTH AND EDUCATIONAL FACILITIES BOARD OF
THE CITY OF JOHNSON CITY, TENNESSEE**

\$16,235,000

**Hospital Revenue Bonds
(Mountain States Health Alliance),
Series 2013A**

\$99,680,000

**Taxable Hospital Refunding Revenue Bonds
(Mountain States Health Alliance),
Series 2013B**

Dated: Date of Delivery

Maturity: As shown on inside cover page

This Official Statement contains information relating to the offering of two series of bonds (each, a "Series") for the benefit of Mountain States Health Alliance (the "Alliance"), a Tennessee non-profit corporation, with all such bonds secured on a parity basis with each other and certain previously issued bonds and bonds that may be issued in the future.

At the request of the Alliance, The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the "Issuer"), is issuing its \$16,235,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2013A (the "Series 2013A Bonds"), and its \$99,680,000 Taxable Hospital Refunding Revenue Bonds (Mountain States Health Alliance), Series 2013B (the "Series 2013B Bonds"). The Series 2013A Bonds and the Series 2013B Bonds (together, the "Series 2013 Bonds") are being issued under separate Bond Trust Indentures between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Bond Trustee"). The Series 2013 Bonds are limited obligations of the Issuer, payable from payments to be made by the Alliance to the Bond Trustee pursuant to separate Loan Agreements between the Issuer and the Alliance, and pursuant to the Series 2013 Obligations, hereinafter defined. The Series 2013 Obligations are promissory notes of the Alliance issued under and secured by the Amended and Restated Master Trust Indenture dated as of February 1, 2000, as amended (the "Master Indenture"), between the Obligated Issuers (as defined herein) and The Bank of New York Mellon Trust Company, N.A., as master trustee, which provides the security for the Series 2013 Obligations.

The Series 2013 Bonds will be issued in denominations of \$100,000 or any integral multiples of \$5,000 in excess thereof and will bear interest at variable rates as described herein from their date of issuance until maturity or any earlier Conversion Date to the Fixed Rate (as defined herein). Interest on the Series 2013 Bonds will be payable on each Interest Payment Date as described herein, commencing September 3, 2013. Each Series of Series 2013 Bonds will be subject to redemption prior to maturity, including optional redemption, mandatory sinking fund redemption and extraordinary optional redemption as described herein. The Series 2013 Bonds will be subject to mandatory tender for purchase prior to maturity under the circumstances described herein.

The timely payment of the principal of and interest on the Series 2013 Bonds and the purchase price of tendered Series 2013 Bonds of each Series will be secured by separate irrevocable, transferable direct-pay letters of credit (each, a "Letter of Credit") issued by



(the "Bank"). Each Letter of Credit will entitle the Bond Trustee to draw thereunder amounts equal to the principal amounts of the applicable Series 2013 Bonds outstanding and up to 37 days' interest thereon calculated at a rate of 12% per annum. Each Letter of Credit will expire on July 30, 2018, unless renewed, and each may be replaced by a Substitute Letter of Credit as described herein.

Payment of each Series of Series 2013 Bonds will be secured by a separate Letter of Credit. The Letter of Credit related to one Series of Series 2013 Bonds does not secure payments of principal or purchase price of or interest on the other Series of Series 2013 Bonds.

The Series 2013 Bonds, when issued, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York ("DTC"). DTC will act as securities depository for the Series 2013 Bonds. Purchasers will not receive certificates representing their ownership interest in the Series 2013 Bonds purchased. Interest on the Series 2013 Bonds will accrue from the date of issuance and be payable by the Bond Trustee from funds available to it under the Bond Indentures to DTC for the account of DTC Participants, who are responsible for crediting the accounts of the beneficial owners.

The Series 2013 Bonds will be limited obligations of the Issuer, payable solely from the sources described in this Official Statement and will not constitute or create any debt, liability or obligation of the State of Tennessee or any political subdivision or agency thereof or a pledge of the faith and credit of the State of Tennessee or any political subdivision or agency thereof. Neither the faith and credit nor taxing power of any state or any political subdivision or agency thereof will be pledged to the payment of the Series 2013 Bonds.

This cover page contains certain information for quick reference only. It is not a summary of this issue. Investors must read the entire Official Statement to obtain information necessary to make an informed investment decision. For a description of certain risk factors relating to the Series 2013 Bonds, see "CERTAIN RISK FACTORS."

The Series 2013 Bonds are offered when, as and if issued, subject to the approving opinion of Bass, Berry & Sims PLC, Nashville and Knoxville, Tennessee, as Bond Counsel, and certain other conditions. In connection with the issuance of the Series 2013 Bonds, certain legal matters will be passed upon by Anderson & Fugate, Johnson City, Tennessee, as counsel to the Alliance; Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Issuer; Thompson Coburn LLP, St. Louis, Missouri, as counsel to the Bank; and Hunton & Williams LLP, as Underwriter's Counsel. The Public Advisory Corporation serves as financial advisor to the Alliance. It is expected that the Series 2013 Bonds will be issued and available for delivery to DTC in New York, New York, on or about July 30, 2013.

BofA Merrill Lynch

**INFORMATION REGARDING MATURITIES, INITIAL RATE PERIODS
AND REMARKETING AGENTS**

The Health and Educational Facilities Board of the City of Johnson City, Tennessee

\$16,235,000
Hospital Revenue Bonds
(Mountain States Health Alliance),
Series 2013A
Initial Rate Period: Weekly
Due: August 15, 2043
CUSIP: 478271 JY6*
Remarketing Agent: U.S. Bancorp Investments, Inc.

\$99,680,000
Taxable Hospital Refunding Revenue Bonds
(Mountain States Health Alliance),
Series 2013B
Initial Rate Period: Weekly
Due: August 15, 2043
CUSIP: 478271 KA6*
Remarketing Agent: BofA Merrill Lynch

* CUSIP numbers have been assigned by an organization not affiliated with the Issuer or the Alliance and are included solely for the convenience of the holders of the Series 2013 Bonds. The Issuer and the Alliance are not responsible for the selection or use of these CUSIP numbers, nor is any representation made as to their correctness on the Series 2013 Bonds or as indicated above.

No dealer, salesperson, or other person has been authorized to give any information or to make any representation, other than the information contained in this Official Statement, in connection with the offering of the Series 2013 Bonds and, if given or made, such information or representation must not be relied upon as having been authorized by the Issuer, the Alliance, or the Underwriter. The information in this Official Statement is subject to change without notice, and neither the delivery of this Official Statement nor any sale hereunder shall, under any circumstances, create any implication that there has been no change in the affairs of the Issuer, the Alliance, or others since the date hereof. This Official Statement does not constitute an offer or solicitation in any jurisdiction in which such offer or solicitation is not authorized, or in which any person making such offer or solicitation is not qualified to do so, or to any person to whom it is unlawful to make such offer or solicitation. The information set forth herein has been obtained from the Issuer, the Alliance and other sources that are believed to be reliable, but it is not guaranteed as to accuracy or completeness by the Underwriter.

THE PRICES AT WHICH THE SERIES 2013 BONDS ARE OFFERED TO THE PUBLIC BY THE UNDERWRITER MAY VARY FROM THE INITIAL PUBLIC OFFERING PRICES APPEARING ON THE FOREGOING PAGE. IN ADDITION, THE UNDERWRITER MAY ALLOW CONCESSIONS OR DISCOUNTS TO DEALERS AND OTHERS FROM THE PRICES AT WHICH THE SERIES 2013 BONDS ARE OFFERED TO THE PUBLIC. IN CONNECTION WITH THE OFFERING OF THE SERIES 2013 BONDS, THE UNDERWRITER MAY EFFECT TRANSACTIONS THAT STABILIZE OR MAINTAIN THE MARKET PRICE OF THE SERIES 2013 BONDS AT A LEVEL ABOVE THAT WHICH MIGHT OTHERWISE PREVAIL IN THE OPEN MARKET. SUCH STABILIZING, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME.

THE SERIES 2013 BONDS WILL NOT BE REGISTERED BY THE ISSUER OR THE ALLIANCE UNDER THE SECURITIES ACT OF 1933, AS AMENDED, OR ANY STATE SECURITIES LAW AND WILL NOT BE LISTED ON ANY STOCK OR OTHER SECURITIES EXCHANGE. NEITHER THE SECURITIES AND EXCHANGE COMMISSION NOR ANY OTHER FEDERAL, STATE, MUNICIPAL, OR OTHER GOVERNMENTAL ENTITY OR AGENCY SHALL HAVE PASSED UPON THE ACCURACY OR ADEQUACY OF THIS OFFICIAL STATEMENT.

IN MAKING ANY INVESTMENT DECISION, INVESTORS MUST RELY ON THEIR OWN EXAMINATION OF THE TERMS OF THE OFFERING, INCLUDING THE MERITS AND RISKS INVOLVED. THESE SECURITIES HAVE NOT BEEN RECOMMENDED BY ANY FEDERAL OR STATE SECURITIES COMMISSION OR REGULATORY AUTHORITY. FURTHERMORE, THE FOREGOING AUTHORITIES HAVE NOT CONFIRMED THE ACCURACY OR DETERMINED THE ADEQUACY OF THIS OFFICIAL STATEMENT. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

THIS OFFICIAL STATEMENT CONTAINS FORWARD-LOOKING STATEMENTS THAT ARE SUBJECT TO A NUMBER OF RISKS AND UNCERTAINTIES, INCLUDING THOSE DESCRIBED IN "CERTAIN RISK FACTORS," MANY OF WHICH ARE BEYOND THE ISSUER'S AND THE ALLIANCE'S CONTROL. FORWARD-LOOKING STATEMENTS ARE TYPICALLY IDENTIFIED BY WORDS SUCH AS "BELIEVE," "EXPECT," "ANTICIPATE," "INTEND," "ESTIMATE," AND SIMILAR EXPRESSIONS. ACTUAL RESULTS COULD DIFFER MATERIALLY FROM THOSE CONTEMPLATED BY THESE FORWARD-LOOKING STATEMENTS AS A RESULT OF FACTORS ("CAUTIONARY STATEMENTS") SUCH AS THOSE DESCRIBED IN "CERTAIN RISK FACTORS" HEREIN. IN LIGHT OF THESE RISKS AND UNCERTAINTIES, THERE CAN BE NO ASSURANCE THAT THE RESULTS AND EVENTS CONTEMPLATED BY THE FORWARD-LOOKING INFORMATION CONTAINED IN THIS OFFICIAL STATEMENT WILL IN FACT TRANSPIRE. YOU ARE CAUTIONED NOT TO PLACE UNDUE RELIANCE ON THESE FORWARD-LOOKING STATEMENTS. NEITHER THE ISSUER NOR THE ALLIANCE UNDERTAKE ANY OBLIGATION TO UPDATE OR REVISE ANY FORWARD-LOOKING STATEMENTS. ALL SUBSEQUENT WRITTEN OR ORAL FORWARD-LOOKING STATEMENTS ATTRIBUTABLE TO THE ISSUER AND THE ALLIANCE OR PERSONS ACTING ON THEIR BEHALF ARE EXPRESSLY QUALIFIED IN THEIR ENTIRETY BY THE CAUTIONARY STATEMENTS.

Other than with respect to information concerning the Bank and the Letters of Credit contained under the headings "THE LETTERS OF CREDIT - Terms of the Letters of Credit" and "THE BANK" and in Appendix F, none of the information in this Official Statement has been supplied or verified by the Bank, and the Bank does not make any warranty, express or implied, as to (i) the accuracy or completeness of such information, (ii) the validity of the Bonds, or (iii) the tax status of interest on the Bonds.

MATTERS RELATED TO THE REMARKETING AGENTS

The Remarketing Agent is Paid by the Alliance. The Remarketing Agent's responsibilities include determining the interest rate from time to time and remarketing Series 2013 Bonds that are optionally or mandatorily tendered by the owners thereof, all as further described in this Official Statement. The Remarketing Agent is appointed by the Alliance and is paid by the Alliance for its services. As a result, the interests of the Remarketing Agent may differ from those of existing holders and potential purchasers of Series 2013 Bonds.

The Remarketing Agent Routinely Purchases Series 2013 Bonds for its Own Account. The Remarketing Agent is permitted, but not obligated, to purchase tendered Series 2013 Bonds for its own account. The Remarketing Agent, in its sole discretion, routinely acquires tendered Series 2013 Bonds for its own inventory in order to achieve a successful remarketing of the Series 2013 Bonds (i.e., because there otherwise are not enough buyers to purchase the Series 2013 Bonds) or for other reasons. However, the Remarketing Agent is not obligated to purchase Series 2013 Bonds, and may cease doing so at any time without notice. The Remarketing Agent also may make a market in the Series 2013 Bonds by routinely purchasing and selling Series 2013 Bonds other than in connection with an optional or mandatory tender and remarketing. Such purchases and sales may be at or below par. However, the Remarketing Agent is not required to make a market in the Series 2013 Bonds. The Remarketing Agent also may sell any Series 2013 Bonds it has purchased to one or more affiliated investment vehicles for collective ownership or enter into derivative arrangements with affiliates or others in order to reduce its exposure to the Series 2013 Bonds. The purchase of Series 2013 Bonds by the Remarketing Agent may create the appearance that there is greater third party demand for the Series 2013 Bonds in the market than is actually the case. The practices described above also may reduce the supply of Series 2013 Bonds that may be tendered in a remarketing.

Series 2013 Bonds May Be Offered at Different Prices on any Date. The Remarketing Agent is required to determine on the Adjustment Date (as defined herein) the applicable rate of interest that, in its judgment, is the lowest rate that would permit the sale of the Series 2013 Bonds at par plus accrued interest, if any, on the Adjustment Date. The interest rate will reflect, among other factors, the level of market demand for the Series 2013 Bonds (including whether the Remarketing Agent is willing to purchase Series 2013 Bonds for its own account). There may or may not be Series 2013 Bonds tendered and remarketed on an Adjustment Date, the Remarketing Agent may or may not be able to remarket any Series 2013 Bonds tendered for purchase on such date at par and the Remarketing Agent may sell Series 2013 Bonds at varying prices to different investors on such date or any other date. The Remarketing Agent is not obligated to advise purchasers in a remarketing if it does not have third party buyers for all of the Series 2013 Bonds at the remarketing price. In the event the Remarketing Agent owns any Series 2013 Bonds for its own account, the Remarketing Agent may, in its sole discretion in a secondary market transaction outside the tender process, offer the Series 2013 Bonds on any date, including the Adjustment Date, at a discount to par to some investors.

The Ability To Sell the Series 2013 Bonds other than through Tender Process May Be Limited. While the Remarketing Agent may buy and sell Series 2013 Bonds, it is not obligated to do so and may cease doing so at any time without notice. Thus, investors who purchase the Series 2013 Bonds, whether in a remarketing or otherwise, should not assume that they will be able to sell their Series 2013 Bonds other than by tendering the Series 2013 Bonds in accordance with the tender process. The Letters of Credit are not available to purchase Series 2013 Bonds other than those tendered in accordance with a sale of Series 2013 Bonds by the bondholder to the Remarketing Agent. The Letters of Credit will only be drawn when such Series 2013 Bonds have been properly tendered in accordance with the terms of the transaction.

Remarketing Agent May Be Removed, Resign or Cease Remarketing the Series 2013 Bonds Without a Successor Being Named. Under certain circumstances the Remarketing Agent may be removed or have the ability to resign or cease its remarketing efforts, without a successor having been named, subject to the terms of the Remarketing Agreement.

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\$115,915,000

**THE HEALTH AND EDUCATIONAL FACILITIES BOARD OF
THE CITY OF JOHNSON CITY, TENNESSEE**

\$16,235,000
Hospital Revenue Bonds
(Mountain States Health Alliance),
Series 2013A

\$99,680,000
Taxable Hospital Refunding Revenue Bonds
(Mountain States Health Alliance),
Series 2013B

OFFICIAL STATEMENT

INTRODUCTION

This Official Statement, including its cover page and appendices, provides information in connection with the issuance and sale of two series of bonds for the benefit of Mountain States Health Alliance (the "Alliance"), a Tennessee non-profit corporation, with all such bonds secured on a parity basis with each other and certain previously issued bonds and bonds that may be issued in the future. See below "Sources of Payment and Security for the Series 2013 Bonds."

The Series 2013 Bonds

At the request of the Alliance, The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the "Issuer") will issue its \$16,235,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2013A (the "Series 2013A Bonds"), and its \$99,680,000 Taxable Hospital Refunding Revenue Bonds, Series 2013B (the "Series 2013B Bonds" and, together with the Series 2013A Bonds, the "Series 2013 Bonds").

Capitalized terms used herein and not otherwise defined have the meanings given thereto (1) in the Amended and Restated Master Trust Indenture dated as of February 1, 2000, as amended (the "Master Indenture"), between the Obligated Issuers (as defined below) and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"), and (2) in separate Bond Trust Indentures, each dated as of July 1, 2013 (the "2013A Bond Indenture" and the "2013B Bond Indenture" and together, the "Bond Indentures"), and each between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Bond Trustee").

The Alliance

The Alliance is a Tennessee nonprofit corporation that is an "exempt organization" under Section 501(c)(3) of the Internal Revenue Code of 1986 (the "Code"). The Alliance provides an integrated, comprehensive continuum of care to people in portions of Tennessee, Virginia, Kentucky and North Carolina. The Alliance currently operates 13 hospital facilities containing a total of 1,623 licensed beds, and serves a population of more than 1,000,000 in 29 counties and two independent cities in the States of Tennessee, Virginia, Kentucky and North Carolina. Its integrated health care delivery system also includes 23 primary/preventive care centers and 12 outpatient care sites. **For additional information regarding the Alliance, see Appendix A.**

The Obligated Issuers

The Alliance, Blue Ridge Medical Management Corporation ("Blue Ridge"), Norton Community Hospital ("Norton") and Smyth County Community Hospital ("Smyth") are each an Obligated Issuer as such term is defined in the Master Indenture. Only the Obligated Issuers are obligated to make payments on the Series 2013 Bonds. See in Appendix A "HISTORY AND OVERVIEW - Operations of Subsidiary and Other Affiliates" and "CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS."

The Bank

The timely payment of the principal of and interest on each Series of the Series 2013 Bonds and the purchase price thereof will be secured by separate irrevocable transferable direct-pay letters of credit issued by U.S. Bank National Association. The Letter of Credit related to one Series of Series 2013 Bonds does not secure

payments of principal or purchase price of or interest on the other Series of Series 2013 Bonds. See “THE BANK” and Appendix F.

The Remarketing Agents

U.S. Bancorp Investments, Inc. will serve as the Remarketing Agent for the Series 2013A Bonds. Merrill Lynch, Pierce, Fenner and Smith Incorporated will serve as the Remarketing Agent for the Series 2013B Bonds.

Plan of Finance

The proceeds of the Series 2013 Bonds are being loaned to the Alliance pursuant to separate Loan Agreements each dated as of July 1, 2013 (respectively, the “2013A Loan Agreement” and the “2013B Loan Agreement” and together, the “Loan Agreements”), between the Issuer and the Alliance. The proceeds of the Series 2013A Bonds will be used by the Alliance (1) to finance or refinance capital improvements and equipment acquisitions at facilities owned by the Alliance and its affiliates and (2) to pay certain expenses incurred in connection with the issuance of the Series 2013A Bonds. The proceeds of the Series 2013B Bonds will be used by the Alliance (1) to refund \$97,915,000 principal amount of the Issuer’s Hospital Revenue Bonds (Mountain States Health Alliance), Series 2007B-2, and (2) to pay certain expenses incurred in connection with the issuance of the Series 2013B Bonds. See “PLAN OF FINANCE.”

Book-Entry Registration

The Series 2013 Bonds initially will be issued in the form of one registered bond in the aggregate principal amount of each maturity of each Series and will be registered in the name of Cede & Co., as nominee for The Depository Trust Company, New York, New York (“DTC”). DTC will maintain a book-entry system for recording ownership interest in the Series 2013 Bonds. Purchasers will not receive certificates representing their ownership interest in the Series 2013 Bonds purchased. Principal of, any redemption price for, and interest on the Series 2013 Bonds will be payable by the Bond Trustee from funds available to it under the Bond Indentures to DTC for the account of DTC Participants (as defined herein), who are responsible for crediting the accounts of the beneficial owners. See Appendix G - “BOOK-ENTRY ONLY SYSTEM.”

Sources of Payment and Security for the Series 2013 Bonds

The Series 2013 Bonds shall not constitute a debt or obligation of the State of Tennessee or any political subdivision or agency thereof or a pledge of the faith and credit of any state or any political subdivision or agency of any state, including the Issuer. The Series 2013 Bonds are special, limited obligations of the Issuer, each payable exclusively from the respective Trust Estates as described in “THE SERIES 2013 BONDS - General” and “SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2013 BONDS - Trust Estate.”

To evidence the Alliance’s repayment obligations in connection with the Series 2013 Bonds, the Alliance will issue under the Master Indenture (1) its \$16,235,000 Mountain States Health Alliance Note (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) Series 2013A (the “Series 2013A Obligation”), and (2) its \$99,680,000 Mountain States Health Alliance Note (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) Series 2013B (the “Series 2013B Obligation” and, together with the Series 2013A Obligation, the “Series 2013 Obligations”).

In the Master Indenture, the Alliance and the other Obligated Issuers have covenanted, and any future Obligated Issuer would be required to covenant, to operate its facilities in such a manner and to charge such fees and rates as will be sufficient to provide funds (together with other available amounts) to pay debt service on its outstanding indebtedness, to pay certain other expenses and indebtedness of the Alliance and all future Obligated Issuers, and to maintain a coverage ratio of Income Available for Debt Service to Maximum Annual Debt Service equal to at least 1.30:1. For a description of such covenants, including exceptions thereto, see “SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2013 BONDS” and Appendix C - “SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE.”

Certain existing bonds of the Issuer and other conduit issuers, as well as bonds of the Alliance, previously have been issued and are secured by Obligations issued by the Alliance and the other Obligated Issuers under the Master Indenture (“Master Obligations”) and therefore are secured on a parity with the Series 2013 Bonds. The reimbursement obligations of the Alliance with respect to the Letters of Credit also will be secured on a parity basis under the Master Indenture. The Alliance and any future Obligated Issuer have the right, subject to specified conditions, to incur additional indebtedness secured on a parity basis with the Series 2013 Obligations and therefore on a parity basis with the Series 2013 Bonds. See also “PLAN OF FINANCE” for a description of bonds expected to be issued and secured on a parity basis.

No Debt Service Reserve Fund

The Series 2013 Bonds are not secured by any Debt Service Reserve Fund.

Tax Matters

In the opinion of Bass, Berry & Sims PLC, Bond Counsel, under existing law and subject to conditions described under “TAX MATTERS,” interest on the Series 2013A Bonds (a) will not be included in gross income for federal income tax purposes and (b) will not be an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations; however, such interest on the Series 2013A Bonds is taken into account in determining a corporation’s alternative minimum income tax. Holders of Series 2013A Bonds may be subject to other federal tax consequences, as described herein under “TAX MATTERS.”

Interest on the Series 2013B Bonds will be included in gross income for federal income tax purposes.

In the opinion of Bond Counsel, interest on the Series 2013 Bonds will be exempt from all state, county, and municipal taxation in the State of Tennessee except inheritance, gift, and estate taxes and except that interest may not be exempt from Tennessee franchise and excise taxes.

Continuing Disclosure

To permit compliance with Rule 15c2-12 promulgated under the Securities Exchange Act of 1934 (“Rule 15c2-12”), the Alliance will execute a Continuing Disclosure Agreement in connection with the issuance of the Series 2013 Bonds in which it will agree for the benefit of the holders of the Series 2013 Bonds to provide certain annual financial information and operating data and certain quarterly financial data as to the Alliance and any future Obligated Issuer under the Master Indenture, and to provide notice of certain enumerated events, if material. See “CONTINUING DISCLOSURE AGREEMENT” for a more complete description of the Continuing Disclosure Agreement and the Alliance’s performance under previous continuing disclosure agreements.

Professionals Involved in the Offering

Bass, Berry & Sims PLC will act as Bond Counsel in connection with the issuance of the Series 2013 Bonds. In connection with the issuance of the Series 2013 Bonds, certain legal matters will be passed upon by Anderson & Fugate, Johnson City, Tennessee, as counsel to the Alliance; Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Issuer; Thompson Coburn LLP, St. Louis, Missouri, as counsel to the Bank; and Hunton & Williams LLP, as Underwriter’s Counsel. The Alliance’s consolidated financial statements for the fiscal years ended June 30, 2012 and 2011, included in Appendix B hereto, have been audited by Pershing Yoakley & Associates, P.C.

Relationships of the Parties

The Alliance has entered into interest rate exchange agreements, or swap agreements, with Bank of America, which is an affiliate of Bank of America Merrill Lynch, underwriter for the Series 2013 Bonds.

Acceleration

Subject to certain conditions, the Series 2013 Bonds are subject to acceleration of the maturity date upon the happening of an Event of Default under the Bond Indentures. See “SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURES” in Appendix C.

Bondholders’ Risks

Payment of the Series 2013 Bonds is dependent in part on the ability of the Alliance and the other Obligated Issuers to make payments under the Loan Agreements and the Master Indenture. The Alliance’s ability to make such payments may be adversely affected by many factors. There may also be legal and practical limitations on the enforcement of remedies and amounts that may be realized upon enforcement of remedies available to the Bond Trustee and owners of the Series 2013 Bonds. See “SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2013 BONDS” and “CERTAIN RISK FACTORS” herein and “SOURCES OF REVENUE” in Appendix A.

Legal Document Summaries and Definitions

Certain provisions of the Master Indenture, the Bond Indentures and the Loan Agreements are summarized in Appendix C hereto. Other definitions of certain terms used in this Official Statement are also set forth in Appendix C hereto.

Other Information

This Official Statement speaks only as of its date, and the information contained herein is subject to change.

The quotations from, and summaries and explanations of, the statutes, regulations and documents referenced herein do not purport to be complete and reference is made to those statutes, regulations and documents for full and complete statements of their provisions. Copies, in reasonable quantity, of such documents may be obtained during the offering period, upon request to the Alliance and upon payment to the Alliance of a charge for copying, mailing and handling, at 400 North State of Franklin Road, Johnson City, TN 37604-6094, Attn: Legal Department.

Purchasers of the Series 2013 Bonds should note the use of forward-looking information and the covenants related thereto.

Any statements in this Official Statement involving matters of opinion, whether or not expressly so stated, are intended as such and not as representations of fact. This Official Statement is not to be construed as a contract or agreement between either the Issuer or the Alliance and the purchasers or holders of any of the Series 2013 Bonds.

This introduction is not a summary of this Official Statement. It is only a summary description of and guide to, and is qualified by, more complete and detailed information contained in the entire Official Statement, including the cover page and appendices hereto, and the documents summarized or described herein. A full review should be made of the entire Official Statement. The offering of Series 2013 Bonds to potential investors is made only by means of the entire Official Statement.

THE ISSUER

The Issuer is a public nonprofit corporation organized under the laws of the State of Tennessee. The Issuer was incorporated on May 3, 1973, by the Board of Commissioners of the City of Johnson City, Tennessee, pursuant to the laws now codified under Tennessee Code Annotated Section 48-101-301, *et seq.* (the “Tennessee Act”). The Tennessee Act authorizes the Issuer, among other things, to issue its bonds, to acquire, improve, maintain, extend, equip and furnish hospital facilities either within or without the corporate limits of the City of Johnson City, and in

certain other jurisdictions in Tennessee, to mortgage its projects, to pledge the revenues and receipt therefrom, and to sell, exchange, donate and convey any or all of its properties. The Issuer has no taxing power.

THE ALLIANCE

The Alliance is a Tennessee nonprofit corporation recognized by the Internal Revenue Service as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986 (the “Code”). Today, the Alliance directly and through related entities provides an integrated, comprehensive continuum of care to people in 29 counties and two independent cities in Tennessee, Virginia, Kentucky and North Carolina. The Alliance was initially incorporated as Memorial Hospital on April 12, 1945, as a non-sectarian, general welfare, not-for-profit corporation. In connection with the relocation of its operations, it changed its name to Johnson City Medical Center Hospital, Inc. in 1983. In 1998, Johnson City Medical Center Hospital, Inc. assumed operating responsibility for five hospitals and related assets acquired from Columbia/HCA. In recognition of its expanded facilities and scope of services resulting from the 1998 acquisition, Johnson City Medical Center Hospital, Inc. changed its name to Mountain States Health Alliance.

The Alliance currently owns or controls the following facilities:

<u>Facility</u>	<u>Location</u>
Johnson City Medical Center	Johnson City, TN
James H. & Cecile Quillen Rehabilitation Hospital	Johnson City, TN
Woodridge Hospital	Johnson City, TN
Franklin Woods Community Hospital	Johnson City, TN
Indian Path Medical Center	Kingsport, TN
Sycamore Shoals Hospital	Elizabethton, TN
Johnson County Community Hospital	Mountain City, TN
Smyth County Community Hospital ⁽¹⁾	Marion, VA
Norton Community Hospital ⁽²⁾	Norton, VA
Dickenson Community Hospital ⁽²⁾	Clintwood, VA
Russell County Medical Center	Lebanon, VA
Johnston Memorial Hospital ⁽²⁾	Abingdon, VA

⁽¹⁾ 80% membership interest held by the Alliance.

⁽²⁾ 50.1% membership interest held by the Alliance.

The Alliance now has a total of 1,623 licensed beds serving a population of more than 1,000,000. In addition to its hospitals, the Alliance’s integrated health care delivery system includes 23 primary/preventive care centers and 12 outpatient care sites. The Alliance’s medical facilities provide a full spectrum of general and specialty medical services, including rehabilitative services for individuals with brain injuries, strokes and spinal cord injuries, in-patient psychiatric services and centers for health focusing on cardiovascular health, pulmonary medicine, women’s health and cancer therapy, among other services. The Alliance also serves as a clinical training facility for medical students, residents, and nursing students from the East Tennessee State University’s James H. Quillen College of Medicine and the School of Public and Allied Health. **For additional information regarding the Alliance, see Appendix A.**

The Alliance, Blue Ridge, Norton and Smyth are each an Obligated Issuer as such term is used in the Master Indenture. Blue Ridge is a wholly-owned, for-profit subsidiary of the Alliance. Norton is a Virginia non-stock corporation in which the Alliance owns a 50.1% interest. Smyth is a Virginia non-stock corporation in which the Alliance owns an 80% interest. See Appendix A - “HISTORY AND OVERVIEW - Operations of Subsidiary and Other Affiliates.”

The Alliance also operates the hospital facilities in Dickenson County and Washington County, Virginia, through ownership of a majority interest in the membership of the corporations owning such facilities. None of such corporations are an Obligated Issuer or otherwise are responsible for repayment of amounts due from the Alliance

with respect to the Series 2013 Bonds, and none of the assets of such corporations are pledged as security for the Alliance's payment obligations.

Only the Obligated Issuers are obligated to pay the Series 2013 Bonds. The audited and unaudited financial statements of the Alliance included as Appendices B and C reflect the assets, liabilities, revenues and expenses of related organizations that are not Obligated Issuers. See Appendix A – "CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS."

THE SERIES 2013 BONDS

Set forth below is a summary of certain provisions of the Series 2013 Bonds. General information describing the Series 2013 Bonds appears elsewhere in this Official Statement. That information should be read in conjunction with this summary, which is qualified in its entirety by reference to the Bond Indentures, and the forms of the Series 2013 Bonds. See "SUMMARY OF THE FINANCING DOCUMENTS" in Appendix C hereto.

General

The Series 2013 Bonds shall be initially issued as fully registered bonds without coupons in denominations of \$100,000 or any integral multiple of \$5,000 in excess thereof. The Series 2013 Bonds will mature, subject to prior redemption as described herein, on August 15, in the years noted below, and will bear interest payable on the first Business Day of each month, commencing September 3, 2013, so long as the Series 2013 Bonds bear interest at the Weekly Rate, as defined below. In the event the interest on either Series of Series 2013 Bonds is converted to the Medium-Term Rate or the Fixed Rate, as defined below, interest will be payable semiannually on February 15 and August 15 of each year (each such date referred to herein as an "Interest Payment Date"). The Weekly Rate for Series 2013 Bonds of different Series may be different rates at any time.

The Series 2013 Bonds will mature on August 15, 2043.

Interest on the Series 2013 Bonds shall be computed from the Interest Payment Date to which interest on the Series 2013 Bonds has been paid or duly provided for next preceding the date of authentication thereof, unless (a) such date of authentication shall be prior to the first Interest Payment Date, in which case interest shall be computed from the Closing Date, or (b) such date of authentication shall be an Interest Payment Date to which interest on the Series 2013 Bonds has been paid or duly provided for, in which case interest shall be computed from such Interest Payment Date, or (c) such date of authentication shall be after any Record Date and before the next succeeding Interest Payment Date, in which case interest shall be computed from the next succeeding Interest Payment Date.

The principal and premium, if any, of the Series 2013 Bonds, and the purchase price for any Series 2013 Bonds shall be payable at the office of the Bond Trustee in East Syracuse, New York, upon surrender of the Series 2013 Bonds at such office. Interest on the Series 2013 Bonds (other than Defaulted Interest) shall be payable by check drawn upon the Bond Trustee and paid to the Persons in whose names the Series 2013 Bonds are registered on the Bond Register as of the close of business on the Record Date next preceding the relevant Interest Payment Date, provided that during Weekly Rate Periods, on written request to the Bond Trustee by any Person who is the registered owner of Series 2013 Bonds of a Series in a principal amount of \$1,000,000 or more received by the Bond Trustee on or before 15 days prior to such Record Date (which instructions shall remain in effect until revoked by subsequent written instructions), interest on such Series 2013 Bonds shall be payable by wire transfer of immediately available funds to an account at a bank located in the continental United States specified by the person in whose name such Series 2013 Bonds are registered. Any interest on any Series 2013 Bond which is payable but which is not punctually paid or duly provided for ("Defaulted Interest") shall cease being payable to the person in whose name such Series 2013 Bond is registered on the Record Date and instead shall be payable to the person in whose name such Series 2013 Bond is registered at close of business on a Special Record Date selected by the Bond Trustee and which shall be at least 10 days but not more than 30 days before the date selected by the Bond Trustee for payment of such Defaulted Interest. The Bond Trustee shall give Notice by Mail of the Special Record Date and date for payment of Defaulted Interest at least 10 days before the Special Record Date.

THE SERIES 2013 BONDS ARE, AND ARE TO BE, EQUALLY AND RATABLY SECURED, TO THE EXTENT PROVIDED IN THE APPLICABLE BOND INDENTURE, SOLELY BY A PLEDGE OF THE REVENUES AND OTHER FUNDS PLEDGED UNDER SUCH BOND INDENTURE. THE SERIES 2013 BONDS, TOGETHER WITH PREMIUM, IF ANY, AND THE INTEREST THEREON, ARE SPECIAL AND LIMITED OBLIGATIONS OF THE ISSUER. THE SERIES 2013 BONDS AND THE INTEREST THEREON SHALL NOT BE DEEMED TO CONSTITUTE A DEBT OR A PLEDGE OF THE FAITH AND CREDIT OF THE STATE OF TENNESSEE OR ANY POLITICAL SUBDIVISION THEREOF, INCLUDING THE CITY OF JOHNSON CITY, TENNESSEE. THE CITY OF JOHNSON CITY, TENNESSEE, SHALL NOT IN ANY EVENT BE LIABLE FOR THE PAYMENT OF THE PRINCIPAL OF, PREMIUM, IF ANY, OR INTEREST ON THE SERIES 2013 BONDS, OR FOR THE PERFORMANCE OF ANY PLEDGE, MORTGAGE, OBLIGATION OR AGREEMENT OF ANY KIND WHATSOEVER THEREIN OR INDEBTEDNESS BY THE ISSUER, AND NEITHER THE SERIES 2013 BONDS NOR ANY OF THE ISSUER AGREEMENTS OR OBLIGATIONS DESCRIBED IN THE SERIES 2013 BONDS OR OTHERWISE SHALL BE CONSTRUED TO CONSTITUTE AN INDEBTEDNESS OF THE CITY OF JOHNSON CITY, TENNESSEE, WITHIN THE MEANING OF ANY CONSTITUTIONAL OR STATUTORY PROVISIONS WHATSOEVER. THE ISSUER HAS NO TAXING AUTHORITY.

Interest Rate on the Series 2013 Bonds

The Remarketing Agent shall determine the interest rate on the Series 2013 Bonds of a Series for each Weekly Rate Period, as defined in the next sentence. "Weekly Rate Periods" shall mean any period from and commencing on any Wednesday (or in certain circumstances on a Proposed Conversion Date) and ending on the earliest of (a) the next succeeding Tuesday (including such Tuesday), (b) the Conversion Date to the Fixed Rate, (c) the Interest Payment Date on which a Medium-Term Rate Period begins or (d) maturity of the Series 2013 Bonds of that Series. The interest rate on the Series 2013 Bonds of a series shall be determined by the Remarketing Agent for each Weekly Rate Period as the rate equal to the lowest rate which, having due regard for general financial conditions and such other special conditions as in the judgment of the Remarketing Agent may have a bearing on the rate, would produce as nearly as possible a par bid for the Series 2013 Bonds of a series (without regard to accrued interest) in the secondary market on the first day of such Weekly Rate Period. The rate for any Weekly Rate Period shall be determined prior to 10:00 a.m., New York City time on the first day for any Weekly Rate Period. The first day of any Weekly Rate Period is referred to herein as an "Adjustment Date." On the Adjustment Date, the Remarketing Agent shall notify the Bond Trustee no later than 10:00 a.m., New York City time of the rate applicable for such Weekly Rate Period. Any time after 10:00 a.m., New York City time on the Adjustment Date, any Bondholder may contact the Remarketing Agent to obtain such rate.

In the event the Remarketing Agent fails to determine the rate for any Weekly Rate Period, the rate of interest borne by the Series 2013 Bonds for such Weekly Rate Period shall be the SIFMA Municipal Swap Index.

In no event shall the interest rate borne by the Series 2013 Bonds during any Weekly Rate Period exceed the lesser of 12% per annum and the maximum contract rate of interest permitted by the laws of the State of Tennessee. During the Weekly Rate Periods, interest on the Series 2013 Bonds will be computed on the basis of a 365- or 366-day year, as the case may be, and the actual days elapsed.

The determination of any interest rate in accordance with the provisions of the Bond Indentures shall be conclusive and shall be binding upon the Bond Trustee, the Issuer, the Alliance, the Bank, the Remarketing Agent and the Bondholders.

Effective on any Interest Payment Date while the Weekly Rate Periods are in effect, the Alliance shall have the option, with the written approval of the Bank, the Issuer and the Remarketing Agent, to change the Rate Periods for a Series of the Series 2013 Bonds from the Weekly Rate Periods then in effect to the Medium-Term Rate Periods or to a Fixed Rate Period. Upon such event, the Bond Trustee shall notify the holders of the Series 2013 Bonds of such conversion, and the Series 2013 Bonds shall be subject to mandatory tender for purchase as described herein. The date on which the interest rate on the Series 2013 Bonds is converted to a Fixed Rate is referred to herein as the "Conversion Date."

Registration and Transfer of Series 2013 Bonds

The Bond Indentures contain the following provisions with respect to registration of transfer and exchange of Series 2013 Bonds. Such provisions do not apply while the Series 2013 Bonds are held by DTC. See Appendix G - "BOOK-ENTRY ONLY SYSTEM."

Any holder of a Series 2013 Bond, in person or by his duly authorized attorney, may register the transfer of his Series 2013 Bond on the Bond Register, upon surrender thereof at the office of the Bond Trustee in East Syracuse, New York, together with a written instrument of transfer (in such form as shall be reasonably satisfactory to the Bond Trustee) executed by the holder or his duly authorized attorney; and upon surrender for registration of transfer of any Series 2013 Bond, the Issuer shall execute and the Bond Trustee shall authenticate and deliver in the name of the designated transferee or transferees a new Series 2013 Bond or Bonds of the same Stated Maturity, aggregate principal amount and tenor as the Series 2013 Bond surrendered and of any Authorized Denomination.

Series 2013 Bonds may be exchanged at the office of the Bond Trustee in East Syracuse, New York, for an equal aggregate principal amount of Series 2013 Bonds of the same Series, Stated Maturity, interest rate, aggregate principal amount and tenor as the Series 2013 Bonds being exchanged and of any Authorized Denomination. The Issuer shall execute and the Bond Trustee shall authenticate and deliver Series 2013 Bonds which the Bondholder making the exchange is entitled to receive, bearing numbers not contemporaneously then outstanding.

Such registrations of transfers or exchanges of Series 2013 Bonds shall be without charge to the holders of such Series 2013 Bonds, but any taxes or other governmental charges required to be paid with respect to the same shall be paid by the Holder of the Series 2013 Bond requesting such registration of transfer or exchange as a condition precedent to the exercise of such privilege. The Bond Trustee shall not be required (a) to transfer or exchange any Series 2013 Bond during the period from a Record Date to an Interest Payment Date or from the Business Day prior to a Special Record Date to the date for payment of Defaulted Interest, or (b) to make any exchange or registration of transfer of any Series 2013 Bonds called for redemption in whole or in part.

The person in whose name any Series 2013 Bond shall be registered shall be deemed and regarded as the absolute owner thereof for all purposes, and payment of, or on account of, either principal or interest shall be made only to or upon the order of such person or his duly authorized attorney, but such registration may be changed as hereinabove described. All such payments shall be valid and effectual to satisfy and discharge the liability upon such Series 2013 Bond to the extent of the sum or sums so paid.

Redemption

The Series 2013 Bonds may not be called for redemption during the Weekly Rate Periods except as described below. This Official Statement does not describe any redemption provisions for Series 2013 Bonds during the Medium-Term Rate Period or after the Conversion Date. The Letters of Credit do not secure the payment of any premium due to the optional redemption of Series 2013 Bonds by the Alliance.

Optional Redemption. While the Weekly Rate Periods are in effect, the Series 2013 Bonds of each Series are subject to optional redemption upon the direction of the Alliance, in whole or in part on any Business Day, at the direction of the Alliance, with the prior written consent of the Bank if proceeds drawn under any Letter of Credit will be used for redemption of Series 2013 Bonds, at a redemption price equal to the principal amount thereof plus accrued interest to the redemption date.

Extraordinary Optional Redemption. The Series 2013 Bonds are callable for redemption prior to maturity in the event of damage to or destruction of the Property of any member of the Obligated Group (as defined in the Master Indenture) or any part thereof or condemnation of the Facilities or any part thereof, if the Net Proceeds of insurance or condemnation received in connection therewith to the extent such Net Proceeds are not applied either to any lawful purposes of the Obligated Group or to the repair, replacement, restoration or reconstruction of the affected Facilities pursuant to the Master Indenture, but only to the extent of the funds provided for in the Master Indenture. If thus called for redemption, Series 2013 Bonds shall be subject to redemption by the Issuer or the Alliance, as applicable, at any time, in whole or in part, and if in part, the Alliance may decide the amount of each Series of Series 2013 Bonds to be redeemed. Such redemption shall be at the principal amount thereof plus accrued

interest to the redemption date, and without premium, from the proceeds of such insurance or condemnation award or such sale but not in excess of the amount of such proceeds applied to such purpose. If no direction is given by the Alliance, the Bond Trustee will redeem Series 2013 Bonds of each Series then outstanding pro rata based on the then outstanding principal amount of each Series.

Mandatory Sinking Fund Redemption. Subject to the credit described following the tables below, the Series 2013 Bonds of each Series are subject to Mandatory Sinking Fund Redemption prior to maturity on August 15 in the years and in the principal amounts specified below for each Series of Series 2013 Bonds, at a redemption price equal to 100% of the principal amount thereof plus accrued interest:

<u>Series 2013A Bonds</u>		<u>Series 2013B Bonds</u>	
<u>August 15,</u>	<u>Principal Amount</u>	<u>August 15,</u>	<u>Principal Amount</u>
		2039	\$16,715,000
2040	\$ 1,260,000	2040	15,990,000
2041	1,650,000	2041	16,070,000
2042	1,300,000	2042	17,590,000
2043	12,025,000	2043	33,315,000

At its option, to be exercised on or before the forty-fifth (45th) day next preceding any such redemption date, the Alliance may (i) deliver to the Bond Trustee for cancellation bonds of the applicable Series of Series 2013 Bonds to be redeemed, in any aggregate principal amount desired, and/or (ii) receive a credit in respect of its redemption obligation under this mandatory redemption provision for any bonds of the applicable Series of Series 2013 Bonds of the maturity to be redeemed which prior to said date have been purchased or redeemed (otherwise than through the operation of this mandatory sinking fund redemption provision) and canceled by the Bond Trustee and not theretofore applied as a credit against any redemption obligation under this mandatory sinking fund provision. Each Series 2013 Bond so delivered or previously purchased or redeemed shall be credited by the Bond Trustee at 100% of the principal amount thereof on the obligation of the Issuer or the Alliance, as applicable, on such payment date and any excess shall be credited on future redemption obligations in such order as the Alliance directs, and the principal amount of Series 2013 Bonds of the applicable Series to be redeemed by operation of the mandatory sinking fund provision shall be accordingly reduced. The Alliance shall on or before the forty-fifth (45th) day next preceding each payment date furnish the Bond Trustee with its certificate indicating whether or not and to what extent the provisions of clauses (i) and (ii) of this paragraph are to be availed of with respect to such payment and confirm that funds for the balance of the next succeeding prescribed payment will be paid on or before the next succeeding payment date.

Notice of Redemption. The Bond Trustee shall cause notice of the call for any such redemption identifying the Series 2013 Bonds to be redeemed to be sent not less than 30 nor more than 60 days prior to the redemption date (a) by first-class mail postage prepaid, to the holder of each such Series 2013 Bond to be redeemed at his address as it appears on the registration books of the Bond Trustee, (b) by first-class mail, to at least two organizations registered with the Securities and Exchange Commission as securities depositories, (c) to at least one information service of national recognition which disseminates redemption information with respect to municipal securities, and (d) if a Letter of Credit is in effect, to the Bank. Failure to give any notice described in (a), or any defect therein, shall not affect the validity of any proceedings for the redemption of any Series 2013 Bonds with respect to which no such failure has occurred and failure to give any notice described in (b) or (c), or any defect therein, shall not affect the validity of any proceedings for the redemption of any Series 2013 Bonds with respect to which the notice specified in (a) is correctly given. Any notice mailed as described above shall conclusively be presumed to have been given whether or not actually received by any Holder. All Series 2013 Bonds called for redemption shall cease to bear interest on the specified redemption date, provided funds for their redemption are on deposit at the place of payment on the date fixed for redemption. Notwithstanding the foregoing, if the depository is DTC, the Bond Trustee shall send redemption notices in accordance with DTC procedures.

Partial Redemption of Series 2013 Bonds. If less than all the Series 2013 Bonds of a Series are to be redeemed, the particular Series 2013 Bonds of a Series or portions thereof to be redeemed shall be selected by the Bond Trustee by lot or in such other manner as the Bond Trustee shall deem appropriate, which shall be deemed to

include pro rata redemption of Series 2013 Bonds of a Series, and which may provide for the selection for redemption of portions (equal to Authorized Denominations) of the principal of Series 2013 Bonds of a Series; provided that (a) if at the time of selection of any Series 2013 Bonds for redemption any Series 2013 Bonds of a Series are Pledged Bonds or Borrower Bonds, such Pledged Bonds or Borrower Bonds shall be selected for redemption prior to any other Series 2013 Bonds of such Series, and (b) if at the time of selection, the Bond Trustee has received notice of tender of any Series 2013 Bonds for which the Optional Tender Date will be on or after the redemption date, the Bond Trustee (after redeeming all Series 2013 Bonds to which clause (a) applies) shall select such Tendered Bonds for redemption prior to any Series 2013 Bonds of such Series, other than Pledged Bonds or Borrower Bonds.

Any Series 2013 Bond which is to be redeemed only in part shall be surrendered to the Bond Trustee (a) for payment of the redemption price (including accrued interest thereon to the redemption date) of the portion thereof called for redemption and (b) for exchange for Series 2013 Bonds in any Authorized Denomination or denominations in aggregate principal amount equal to the unredeemed portion of such Series 2013 Bond, without charge therefor.

Notwithstanding the foregoing, in the event that the depository for the Series 2013 Bonds is DTC, the Bond Trustee will follow the procedure for redemption, and selection of Series 2013 Bonds for redemption, prescribed by DTC.

Purchase of Series 2013 Bonds in Lieu of Redemption. In lieu of redeeming Series 2013 Bonds, the Bond Trustee may, at the request of the Alliance, use Eligible Moneys otherwise available under the Bond Indenture for redemption of Series 2013 Bonds to purchase Series 2013 Bonds identified by the Alliance in the open market for cancellation at a price specified by the Alliance not exceeding the redemption price then applicable under the Bond Indenture. In the case of any extraordinary redemption or any purchase and cancellation of the Series 2013 Bonds, the Alliance shall receive credit against its required deposits to the Bond Sinking Fund with respect to Series 2013 Bonds of the Series and maturity redeemed or purchased in such order as the Alliance elects prior to such extraordinary redemption or purchase and cancellation or, if no election is made, in the inverse order thereof.

Tender and Purchase of Series 2013 Bonds

Purchase of Series 2013 Bonds at Option of Holder. While the Weekly Rate Periods are in effect, the Bond Trustee, from funds available to it under the Bond Indentures, as Tender Agent and acting on behalf of the Alliance and for the benefit of the Bondholders, shall purchase any Series 2013 Bond (other than Pledged Bonds and Borrower Bonds), in whole or in part in Authorized Denominations upon the demand of the holder thereof at a purchase price equal to the principal amount thereof plus accrued interest, if any, to the date of purchase, for the account of the Alliance, but only upon (a) delivery to the Bond Trustee and the Remarketing Agent at their respective principal offices (St. Louis, Missouri for the Bond Trustee) of a written notice, or at the option of the Bond Trustee or the Remarketing Agent (with respect to their respective notices), telephonic notice confirmed in writing, from the Holder of such Series 2013 Bond (an "Optional Tender Notice") which shall state (1) the principal amount or portions of such Series 2013 Bond being tendered, the number of the Series 2013 Bond being tendered and the name of the Holder thereof and (2) the date such Series 2013 Bond or portion thereof shall be purchased pursuant to the Bond Indenture (the "Optional Tender Date"), which date shall be a Business Day not sooner than 3:00 p.m., New York City time on the Business Day that is five Business Days after the date of receipt of such Optional Tender Notice by the Remarketing Agent and the Bond Trustee and (b) delivery of such Series 2013 Bond (with all necessary endorsements) to the Bond Trustee, at its office in East Syracuse, New York, at or prior to 10:00 a.m., New York City time, on the first Business Day prior to the date of purchase specified in the aforesaid notice; provided, however, that payment of the purchase price of such Series 2013 Bonds shall be made only if the Series 2013 Bonds so delivered to the Bond Trustee, as Tender Agent, shall conform in all respects to the description thereof in the aforesaid notice. Payment of such purchase price shall be made by check unless the Bondholder's Optional Tender Notice contains instructions to the Bond Trustee to wire such purchase price to a particular account. If the date that a Series 2013 Bond is to be purchased is after a Record Date but before the next succeeding Interest Payment Date, the owner of such Series 2013 Bond shall also be required to deliver to the Bond Trustee a due bill instructing that the interest due on the next succeeding Interest Payment Date be paid to the person who purchases such Series 2013 Bond on the purchase date.

On the Optional Tender Date, the Bond Trustee, as Tender Agent, shall purchase the Series 2013 Bond or portion thereof identified in such Optional Tender Notice from the Holder thereof for the account of the Alliance, at a purchase price equal to the principal amount or portion thereof being tendered plus accrued interest, but only from funds provided by the Alliance, including moneys drawn under the Letter of Credit.

Any Series 2013 Bonds which are not tendered on an Optional Tender Date pursuant to an Optional Tender Notice (the "Untendered Bonds"), for which there has been irrevocably deposited in trust with the Bond Trustee an amount sufficient to pay the purchase price thereof, shall be deemed to have been tendered for purchase and purchased as described herein. Holders of Untendered Bonds shall not be entitled to any payment (including any interest to accrue subsequent to the Optional Tender Date) other than the purchase price for such Untendered Bonds, and the Holders of such Untendered Bonds shall no longer be entitled to the benefits of the Bond Indenture, except for the purpose of payment of the purchase price thereof. Replacement Bonds shall be issued in place of such Untendered Bonds and after the issuance of such Replacement Bonds, such Untendered Bonds shall be deemed to have been purchased and shall no longer be Outstanding under the Bond Indenture.

Mandatory Purchase Upon Conversion Date. The Series 2013 Bonds are required to be tendered for purchase on each Conversion Date or any Proposed Conversion Date. Upon receipt of notice from the Alliance establishing the Proposed Conversion Date and certain other documentation required by the Bond Indenture, the Bond Trustee shall give Notice by Mail to the Bondholders at least 30 days before the Proposed Conversion Date that the Proposed Conversion Date is a Mandatory Tender Date. Such notice shall state (a) that the interest rate on the Series 2013 Bonds will be converted to a Fixed Rate; (b) the Conversion Date; (c) the date by which (1) the Preliminary Fixed Rate that is required to be determined pursuant to the Bond Indenture is to be determined and (2) the Bondholders may contact the Bond Trustee (and the name and telephone number of the person whom the Bondholders may contact) to obtain the Preliminary Fixed Rate; (d) the date by which (1) the Remarketing Agent is required to determine the Fixed Rate, (2) the Bondholders may contact the Bond Trustee (and the name and telephone number of the person whom the Bondholders may contact) to obtain the Fixed Rate, and (3) the Bond Trustee will notify upon request the Bondholders of the Fixed Rate; (e) that subsequent to the conversion to a Fixed Rate (1) any ratings of the Rating Agency or Agencies then rating the Series 2013 Bonds may be withdrawn or changed (if such is the case) and (2) the Bondholders will no longer have the right to tender their Series 2013 Bonds to the Bond Trustee for purchase under the Bond Indenture; (f) the last date on which the Bondholders' right to tender Series 2013 Bonds may be exercised; (g) that the Series 2013 Bonds will not be entitled to the benefit of the Letter of Credit or a Substitute Letter of Credit after the Conversion Date, if such is the case; (h) that there will be a failure of conversion (1) if the Fixed Rate is less than the Preliminary Fixed Rate, (2) if the Opinion of Bond Counsel required in connection with such a conversion is withdrawn prior to the Conversion Date, (3) if the Remarketing Agent fails to determine the Preliminary Fixed Rate or Fixed Rate or (4) if the Alliance revokes its request to convert the interest rate on the Series 2013 Bonds to a Fixed Rate; (i) that such failure of conversion shall result in the Series 2013 Bonds bearing interest at a Weekly Rate; (j) the Termination Date of the Letter of Credit; and (k) that, on the Proposed Conversion Date, the Bondholder shall have no further rights under such Series 2013 Bond or Bonds except to receive the principal of the Series 2013 Bond or Bonds upon presentation and surrender of such Series 2013 Bond or Bonds to the Bond Trustee.

On the Proposed Conversion Date, whether or not a Failed Conversion as described below has occurred, the Bond Trustee shall purchase all outstanding Series 2013 Bonds (except Pledged Bonds and Borrower Bonds) from the Holders thereof, who shall also have delivered such Series 2013 Bonds to the Bond Trustee, all as above described.

If (i) the Fixed Rate as determined by the Remarketing Agent is less than the Preliminary Fixed Rate, (ii) the Remarketing Agent fails to determine the Preliminary Fixed Rate or Fixed Rate, (iii) the Opinion of Bond Counsel required with respect to the conversion to the Fixed Rate is withdrawn prior to the Conversion Date or, (iv) the Alliance revokes its request to convert the interest rate on the Series 2013 Bonds to a Fixed Rate, then a failed conversion shall be deemed to have occurred (a "Failed Conversion"). In the event of a Failed Conversion, the interest rate on the Series 2013 Bonds will be the Weekly Rate, and the Weekly Rate Periods shall be in effect. If the Weekly Rate Periods were not in effect prior to the Proposed Conversion Date, the Proposed Conversion Date shall be deemed to be an Adjustment Date for a Weekly Rate Period beginning on such date.

Mandatory Purchase Upon Conversion to Medium-Term Rate Periods. The Series 2013 Bonds are required to be tendered for purchase on the first day of each period at which the Series 2013 Bonds bear interest at the Medium-Term Rate, each such date being an Adjustment Date for the Medium-Term Rate Periods. The Bond Trustee shall give Notice by Mail to the Bondholders, the Remarketing Agent, the Issuer and the Bank at least 30 days before each Adjustment Date for the Medium-Term Rate Periods that such date is a Mandatory Tender Date. Such notice shall state (a) the Mandatory Tender Date; (b) the date on which the Remarketing Agent is required to determine the length of the Medium-Term Rate Period that begins on such Date; (c) the date by which the Remarketing Agent is required to determine the interest rate for such Medium-Term Rate Period; (d) that the Bondholders may contact the Bond Trustee (and the name and telephone number of the person whom the Bondholders may contact) to obtain the length of the Medium-Term Rate Period and the interest rate for such Medium-Term Rate Period on or after the date of its determination; (e) the Interest Payment Date and Record Date for such Medium-Term Rate Period; (f) that during the Medium-Term Rate Period, the Bondholders will no longer have the right to tender their Series 2013 Bonds to the Bond Trustee for purchase under the Bond Indenture and the last day on which the Bondholders' right to tender Series 2013 Bonds may be exercised; (g) the rating of the Series 2013 Bonds by each Rating Agency, if the Series 2013 Bonds are to be rated, after the Mandatory Tender Date; and (h) that, on such Mandatory Tender Date, the Bondholder shall have no further rights under such Series 2013 Bond or Bonds except to receive the principal of the Series 2013 Bond or Bonds upon presentation and surrender of such Series 2013 Bond or Bonds to the Bond Trustee.

Mandatory Purchase Upon Substitution Tender Date. The Series 2013 Bonds of a Series are required to be tendered for purchase on the fifth Business Day prior to the effective date of any Substitute Letter of Credit (the "Substitution Tender Date") for such Series. The Bond Trustee shall give Notice by Mail to the Bondholders, the Remarketing Agent, the Issuer, the Alliance and the Bank at least 30 days before the Substitution Tender Date that such date will be a Mandatory Tender Date. Such notice shall state: (i) the Substitution Tender Date; (ii) the identity of the bank that is issuing the Substitute Letter of Credit; and (iii) that, on such Mandatory Tender Date, interest shall cease to accrue with respect to such Bondholder's Series 2013 Bond or Bonds on such date and the Bondholder shall have no further rights under such Series 2013 Bond or Bonds except to receive the principal of the Series 2013 Bond or Bonds upon presentation and surrender of such Series 2013 Bond or Bonds to the Bond Trustee.

Mandatory Purchase on Termination of Letter of Credit. The Series 2013 Bonds of each Series are subject to mandatory tender for purchase in whole on the second Business Day prior to the Termination Date of the Letter of Credit securing such Series.

No Purchase After Event of Default. Anything in the Bond Indentures to the contrary notwithstanding, there shall be no purchases of Series 2013 Bonds pursuant to such Bond Indenture if there shall have occurred and be continuing an Event of Default of which the Bond Trustee has knowledge that immediately requires the acceleration of the Series 2013 Bonds under such Bond Indenture.

Defeasance

If the Issuer deposits with the Bond Trustee funds, evidenced by moneys or Defeasance Investments (as defined in Appendix C) the principal of and interest on which, when due, will be sufficient to pay the principal or redemption price of any Series of Series 2013 Bonds, by call for redemption or otherwise, together with interest accrued to the due date or the redemption date, as appropriate, in accordance with the terms of the Bond Indentures, such Series of Series 2013 Bonds shall no longer be deemed to be Outstanding under the applicable Bond Indenture. Interest on such Series of Series 2013 Bonds, as appropriate, will cease to accrue on the due date or the redemption date, as appropriate, and from and after the date of such deposit of funds with the Bond Trustee the holders of such Series of Series 2013 Bonds will be restricted to the funds so deposited as provided in the Bond Indentures.

PLAN OF FINANCE

Application of Proceeds

The proceeds of the Series 2013A Bonds will be loaned by the Issuer to the Alliance pursuant to the 2013A Loan Agreement and used by the Alliance (1) to finance or refinance certain capital improvements and equipment acquisitions at facilities owned by the Alliance and its affiliates and (2) to pay certain expenses incurred in connection with the issuance of the Series 2013A Bonds. The proceeds of the Series 2013B Bonds will be loaned by the Issuer to the Alliance pursuant to the 2013B Loan Agreement and used by the Alliance (1) to refund \$97,915,000 principal amount of the Issuer's Hospital Revenue Bonds (Mountain States Health Alliance), Series 2007B-2 (the "Series 2007B-2 Bonds"), and (2) to pay certain expenses incurred in connection with the issuance of the Series 2013B Bonds.

The Alliance expects that, contemporaneously with the issuance of the Series 2013 Bonds and the refunding of the Series 2007B-2 Bonds, the Alliance will cause the refunding of (1) the Issuer's Hospital Revenue Bonds, Series 2008A, and Hospital Revenue Bonds, Series 2012B, (2) the Industrial Development Authority of Russell County's Hospital Revenue Bonds, Series 2008B, (3) the Industrial Development Authority of Smyth County's Hospital Revenue Bonds, Series 2011C, and Hospital Revenue Bonds, Series 2011D, and (4) the Industrial Development Authority of Wise County's Hospital Revenue Bonds, Series 2012C, through private placements with financial institutions, as reflected in the table in "Current and Pro Forma Long-Term Debt," below.

Estimated Sources and Uses of Funds

The sources and uses of the proceeds of the Series 2013 Bonds are set forth below.

<u>Sources of Funds</u>	<u>2013A</u>	<u>2013B</u>
Principal Amount	<u>\$16,235,000</u>	<u>\$99,680,000</u>
TOTAL	<u>\$16,235,000</u>	<u>\$99,680,000</u>
<u>Uses of Funds</u>		
Project Costs	\$15,945,000	-
Refund Series 2007B-2 Bonds	-	\$97,915,000
Costs of Issuance	<u>290,000</u>	<u>1,765,000</u>
TOTAL	<u>\$16,235,000</u>	<u>\$99,680,000</u>

Current and Pro Forma Long-Term Debt

The left column of the following table reflects the total outstanding debt of the Alliance under the Master Indenture as of July 1, 2013, prior to the issuance of the Series 2013 Bonds. The right column of the following table shows the outstanding debt of the Alliance under the Master Indenture as of July 1, 2013, but adjusted to show the effect of the issuance of the Series 2013 Bonds. The table below and the information in the immediately following section do not include the indebtedness of certain entities controlled by the Alliance that are not Obligated Issuers.

Outstanding Long-Term Debt (at July 1, 2013)		Pro Forma Long-Term Debt (at July 1, 2013)	
Description	Principal Amount	Description	Principal Amount
Debt:		Debt:	
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Refunding Bonds, Series 2000A	\$35,100,246 ⁽¹⁾	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Refunding Bonds, Series 2000A	\$35,100,246 ⁽¹⁾
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2000C	30,750,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2000C	30,750,000
Mountain States Health Alliance Taxable Note, Series 2000D	13,245,000	Mountain States Health Alliance Taxable Note, Series 2000D	13,245,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2001A	20,400,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2001A	20,400,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2006A	167,730,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2006A	167,730,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-1	19,515,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-1	19,515,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-2	97,915,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2009A	5,415,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2008A	13,245,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2009B	5,400,000
Industrial Development Authority of Russell County Hospital Revenue Bonds, Series 2008B	50,970,000	Industrial Development Authority of Washington County, Virginia, Hospital Revenue Bonds, Series 2009C	111,265,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2009A	5,415,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2010A	154,240,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2009B	5,400,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2010B	25,230,000
Industrial Development Authority of Washington County, Virginia, Hospital Revenue Bonds, Series 2009C	111,265,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011A	56,945,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2010A	154,240,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011B	19,985,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2010B	25,230,000	Mountain States Health Alliance Taxable Bonds, Series 2011E ¹	6,445,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011A	56,945,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2012A	55,000,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011B	19,985,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2013A	16,235,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011C	48,220,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2013B	99,680,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011D	60,655,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2013C	13,350,000
Mountain States Health Alliance Taxable Bonds, Series 2011E	15,945,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2013D	61,180,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2012A	55,000,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2013E	9,880,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2012B	28,095,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2013F	51,430,000
Industrial Development Authority of Wise County Hospital Revenue Bonds, Series 2012C	9,785,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2013G	28,310,000
		Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2013H	48,600,000
Total Long-Term Debt	\$1,045,050,246	Total Long-Term Debt	\$1,055,330,246
Less: 2000 Reserve Fund	\$7,000,000	Less: 2000 Reserve Fund	\$7,000,000
NET TOTAL LONG-TERM DEBT	\$1,038,050,246	NET TOTAL LONG-TERM DEBT	\$1,048,330,246

¹ The Alliance expects to pay off its Taxable Bonds, Series 2011E, by December 31, 2013.

Estimated Annual Debt Service Requirements

The following table reflects the estimated outstanding debt service obligations of the Alliance on all long term indebtedness secured under the Master Indenture following the issuance of the Series 2013 Bonds. The estimated annual debt service with respect to outstanding indebtedness assumes a 3.0% interest rate on all variable rate bonds, and does not take into account any interest rate hedges that may exist or may be executed in the future.

Year Ending June 30	<u>Annual Debt Service Requirements</u>										Estimated Annual Debt Service on Other Outstanding Indebtedness	Estimated Total Annual Long-Term Debt Service Requirements
	<u>2013A</u> Principal	<u>2013B</u> Principal	<u>2013C</u> Principal	<u>2013D</u> Principal	<u>2013E</u> Principal	<u>2013F</u> Principal	<u>2013G</u> Principal	<u>2013H</u> Principal	<u>2013A-H</u> Interest			
2014	-	-	-	-	-	-	-	-	\$ 5,340,806	\$ 20,897,931	\$ 26,238,738	
2015	-	-	-	-	-	\$ 250,000	-	\$ 630,000	9,846,750	58,267,769	68,994,519	
2016	-	-	-	-	-	250,000	-	470,000	9,822,750	58,448,188	68,990,938	
2017	-	-	-	-	-	260,000	-	540,000	9,799,950	58,394,294	68,994,244	
2018	-	-	-	\$ 95,000	-	1,120,000	-	1,430,000	9,748,275	56,240,800	68,634,075	
2019	-	-	-	2,900,000	\$ 370,000	1,595,000	-	1,510,000	9,612,975	52,645,063	68,633,038	
2020	-	-	\$ 25,000	3,345,000	370,000	2,165,000	-	6,170,000	9,336,225	47,222,266	68,633,491	
2021	-	-	25,000	3,855,000	370,000	2,590,000	-	5,895,000	8,964,075	46,933,231	68,632,306	
2022	-	-	30,000	3,730,000	370,000	2,745,000	-	3,065,000	8,623,950	50,068,309	68,632,259	
2023	-	-	30,000	3,955,000	370,000	3,645,000	-	3,115,000	8,308,125	49,209,241	68,632,366	
2024	-	-	-	4,305,000	370,000	4,005,000	-	3,245,000	7,962,525	48,746,334	68,633,859	
2025	-	-	-	6,420,000	370,000	2,880,000	-	2,890,000	7,595,250	48,474,250	68,629,500	
2026	-	-	-	7,395,000	370,000	2,875,000	-	3,170,000	7,199,700	47,621,306	68,631,006	
2027	-	-	-	955,000	370,000	2,060,000	-	-	6,941,775	58,303,506	68,630,281	
2028	-	-	-	995,000	-	2,525,000	-	-	6,838,200	58,272,669	68,630,869	
2029	-	-	-	2,025,000	-	1,990,000	-	-	6,725,175	57,891,444	68,631,619	
2030	-	-	-	3,685,000	-	-	-	-	6,609,675	57,468,169	67,762,844	
2031	-	-	-	3,920,000	-	-	-	490,000	6,488,250	56,867,031	67,765,281	
2032	-	-	-	13,600,000	-	-	\$ 1,450,000	9,610,000	6,052,200	37,054,644	67,766,844	
2033	-	-	-	-	-	-	2,970,000	6,370,000	5,542,200	52,881,838	67,764,038	
2034	-	-	-	-	-	-	10,330,000	-	5,247,150	52,188,094	67,765,244	
2035	-	-	-	-	-	-	-	-	5,092,200	65,065,925	70,158,125	
2036	-	-	-	-	-	-	-	-	5,092,200	64,959,275	70,051,475	
2037	-	-	-	-	-	-	-	-	5,092,200	64,829,500	69,921,700	
2038	-	-	-	-	-	-	-	-	5,092,200	60,813,413	65,905,613	
2039	-	-	13,240,000	-	-	-	-	-	4,893,600	43,813,306	61,946,906	
2040	-	\$16,715,000	-	-	1,330,000	6,015,000	2,495,000	-	4,296,675	15,166,625	46,018,300	
2041	\$ 1,260,000	15,990,000	-	-	1,375,000	6,140,000	2,595,000	-	3,487,950	15,168,500	46,016,450	
2042	1,650,000	16,070,000	-	-	1,740,000	5,955,000	2,780,000	-	2,654,625	15,166,875	46,016,500	
2043	1,300,000	17,590,000	-	-	2,105,000	2,365,000	5,690,000	-	1,795,950	15,170,000	46,015,950	
2044	12,025,000	33,315,000	-	-	-	-	-	-	680,100	-	46,020,100	
	\$16,235,000	\$99,680,000	\$13,350,000	\$61,180,000	\$9,880,000	\$51,430,000	\$28,310,000	\$48,600,000	\$200,783,681	\$1,434,249,794	\$1,963,698,475	

SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2013 BONDS

Special, Limited Obligations of the Issuer

The Series 2013 Bonds will be issued under and secured by the Bond Indentures and are payable from moneys received by the Bond Trustee from the Alliance, as further described in “Trust Estate” below.

Trust Estate

The Series 2013 Bonds of each Series are payable from the respective Trust Estates under the Bond Indentures, which consist of (i) payments or prepayments to be made on the Series 2013 Obligations, and any additional obligations of the Alliance to the Issuer to the extent such additional obligations may be pledged under the Bond Indentures in the future; (ii) other payments under the Loan Agreements (other than fees and expenses payable to the Issuer and the Issuer’s rights to notices and indemnification in certain circumstances); (iii) all moneys and investments held under the applicable Bond Indenture as security for the Series 2013 Bonds (excluding funds held in the Rebate Fund established under the applicable Bond Indenture); and (iv) in certain circumstances, proceeds from certain insurance and condemnation awards.

Pursuant to the Series 2013 Obligations, the Alliance is required to make payments to the applicable Bond Trustee for deposit into the Debt Service Fund established under the applicable Bond Indenture, at the times and in amounts sufficient to pay the principal of and interest on the Series 2013 Bonds.

Payment of principal and interest on the Series 2013 Bonds will not be secured by any encumbrance, mortgage or other pledge of any property of the Issuer. **The Series 2013 Bonds will not constitute a debt or indebtedness of any state or any political subdivision or agency thereof, including the Issuer, within the meaning of any constitutional or statutory provision or limitation. The Issuer does not have taxing power.**

Master Indenture Covenants

In the Master Indenture, the Alliance has made certain covenants, on behalf of itself and the Obligated Group (as defined in the Master Indenture), regarding maintenance of fees and rates, and any future Obligated Issuer would be required to make similar covenants upon joining the Obligated Group. These covenants provide, among other matters, that each Obligated Issuer (including the Alliance) will continue to impose such fees as are included within the Gross Revenues, operate on a revenue producing basis, and charge such fees and rates for its facilities and services and exercise such skill and diligence as to provide income from its property together with other available funds sufficient to pay promptly all payments of principal and interest on its indebtedness secured by the Master Indenture, all expenses of operation, maintenance, and repair of its property subject to the Master Indenture, and all other payments required to be made by it under the Master Indenture to the extent permitted by law. Each Obligated Issuer (including the Alliance) also covenants to use its best efforts to maintain in each Fiscal Year a ratio of total Income Available for Debt Service to Maximum Annual Debt Service for all Obligated Issuers at least equal to 1.30 to 1. Each Obligated Issuer (including the Alliance) further covenants that it will from time to time as often as necessary and to the extent permitted by law, revise its rates, fees and charges in such manner as may be necessary or proper to comply with the provisions of the Master Indenture described in this paragraph. See Appendix C - “SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE - Rates and Charges.”

The Master Indenture defines “Income Available for Debt Service” of the Alliance or other Obligated Issuer to mean, with respect to any period of time, the excess of revenues over expenses, or, in the case of for-profit entities, net income after tax, as determined in accordance with generally accepted accounting principles, to which shall be added, in either case, (i) depreciation, (ii) amortization, (iii) interest expense on Long-Term Indebtedness (as defined in the Master Indenture) and (iv) to the extent not already included, contributions and donations and from which shall be excluded any extraordinary items, any impairment losses, any gain or loss resulting from either the extinguishment of indebtedness or the sale, exchange or other disposition of assets not made in the ordinary course of business, provided, however, that (a) no determination of Income Available for Debt Service will take into account any gains or losses resulting from the periodic valuation of investments or Hedge Agreements that do not

involve the sale, transfer or other disposition of any such investment or Hedge Agreement or the termination of any Hedge Agreement and (b) a person may include in its net income such person's share of the net income of any person controlled by such person or in whom such person has a legal interest. The Master Indenture contains provisions relating to the calculation of Maximum Annual Debt Service that provides for reallocation of amounts due on balloon indebtedness and assumptions as to the interest rates on variable rate indebtedness and payment of guaranties. For financial information of the Alliance, see Appendix A and the Alliance's audited consolidated financial statements for the fiscal years ended June 30, 2012 and June 30, 2011, included as Appendix B. For a more complete description of the covenants under the Master Indenture, see "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE - Rates and Charges" in Appendix C.

Only Obligated Issuers are obligated to make payments on the Series 2013 Bonds and to abide by the covenants under the Master Indenture. The audited and unaudited financial statements included as Appendices B and C reflect the assets and operations of entities that are not Obligated Issuers. See Appendix A – "CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS."

Amendment of Master Indenture

By purchasing the Series 2013 Bonds, the initial holders thereof will consent to an amendment to the definition of "Debt Service Requirement" in the Master Indenture and an amendment to the requirements applicable to interest rate swaps. Such amendments will not become effective immediately and will become effective only upon receipt of the consent of the required percentage of bondholders and credit enhancers under the terms of the Master Indenture.

Both the existing definition and the proposed definition are set forth in Appendix C, "SUMMARY OF THE FINANCING DOCUMENTS – DEFINITIONS OF CERTAIN TERMS." The definition of "Debt Service Requirement" is utilized in calculations under both the additional debt test and the rate covenant under the Master Indenture, and such amendment may in certain circumstances increase or decrease the amount of the Debt Service Requirement in any required calculation. See "Additional Long-Term Indebtedness" and "Rates and Charges" in "SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE" in Appendix C.

Both the existing requirements and the proposed new requirements for interest rate swaps are set forth in Appendix C.

Pledged Assets; Mortgage

Currently, the Series 2013 Bonds are secured by the applicable Trust Estate, including the assignment of the applicable Series 2013 Obligation. As security for its Master Obligations, the Alliance has granted to the Master Trustee a security interest in its Pledged Assets, subject to Permitted Liens. The Pledged Assets consist of: Receivables, Inventory, Equipment, General Intangibles, Contracts and Contract Rights, Government Approvals, Fixtures and other personal property, goods, instruments, chattel paper, documents, credits, claims, demands and assets. For a definition of these terms see Appendix C - "SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS." Financing statements will be filed in the appropriate records of the Office of the Tennessee Secretary of State to perfect the security interest in Pledged Assets and Equipment to the extent possible by such filing. Continuation statements meeting the requirements of the Uniform Commercial Code of Tennessee (the "UCC") must be filed every five years to continue the perfection of such security interest. The security interest in the Pledged Assets and Equipment is subject to Permitted Liens that exist prior to or may be created subsequent to the time the security interest granted by the Master Indenture attaches.

The security interest in any item of inventory will be inferior to the interest of a buyer in the ordinary course of business and will be inferior to a purchase money security interest, as defined in the UCC, perfected in connection with the sale to an Obligated Issuer of such item. The lien on certain other Pledged Assets may not be enforceable against third parties unless such other Pledged Assets are transferred to the Master Trustee (which transfer Obligated Issuers are not required by the Master Indenture to make prior to an Event of Default thereunder and which transfer may be set aside if it occurs within 90 days of the filing of a petition in bankruptcy) and is subject

to exception under the UCC. The federal government may in the future proscribe or restrict the assignment of rights arising out of Medicare, Medicaid or other federal programs.

As a condition to becoming a Member of the Obligated Group, an entity must grant to the Master Trustee a security interest in its Pledged Assets.

Pursuant to the Master Indenture, the Obligated Issuers agree that they will not create or suffer to be created or exist any Lien other than Permitted Liens, as defined under “SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS” in Appendix C, upon any of their facilities now owned or hereafter acquired.

The Series 2013 Obligations also are secured by a mortgage on the Johnson City Medical Center located in Johnson City, Tennessee, and the Sycamore Shoals Hospital facility in Elizabethton, Tennessee (together, the “Mortgaged Property”). Such mortgage secures all Master Obligations issued under the Master Indenture.

Subject to certain conditions, in case of the failure of the Obligated Issuers to make any payment on the Master Obligations when due or upon any other event of default under the Master Indenture, the Master Trustee may, after such notice as is required by the Master Indenture and the applicable security instruments, take possession of Mortgaged Property or, upon such public notice as required by Tennessee statute, sell the Mortgaged Property, and apply the proceeds to payment of principal of and interest on the Master Obligations (and thereby on the Series 2013 Bonds) on a parity basis with any other Master Obligation.

Additional Indebtedness

The Alliance has certain debt outstanding under the Master Indenture. The Master Indenture permits the Alliance and any other members of the Obligated Group to incur Additional Indebtedness (including Guaranties), all upon the terms and subject to the conditions specified therein. Such Additional Indebtedness may, but need not, be evidenced or secured by a Master Obligation. Additional Indebtedness may be issued to the Issuer or to persons other than the Issuer.

The reimbursement obligations of the Alliance with respect to the Letters of Credit will also be secured under the Master Indenture.

Except as noted above, under the Master Indenture, the Alliance and each other Obligated Issuer agrees that it will not incur other Additional Indebtedness unless it can demonstrate that certain coverage ratios have been and will be met between debt service obligations and Income Available for Debt Service. Under the Master Indenture, Additional Indebtedness may be Long-Term Indebtedness or Short-Term Indebtedness. The Master Indenture allows any future Obligated Issuer to incur Additional Indebtedness under the Master Indenture as a Master Obligation constituting the joint and several obligation of the Alliance and all other Obligated Issuers and subject to cross-guarantees of all Obligated Issuers, including the Alliance. Except to the extent entitled to the benefits of additional security as permitted by the Master Indenture and except for Subordinated Indebtedness, all Master Obligations will be equally and ratably secured by the Master Indenture. See Appendix C - “SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE.”

Subject to certain conditions set forth in the Master Indenture, Additional Indebtedness incurred by any Member of the Obligated Group may be secured by security which does not extend to any other Indebtedness. Such security may include Liens on the Property (including health care facilities) of the Members of the Obligated Group, letters or lines of credit or insurance, and could also consist of Liens on cash or securities deposited or held in any depreciation reserve, debt service or interest reserve, debt service or similar fund established pursuant to the terms of any Supplemental Master Indenture, Related Bond Indenture or Related Loan Document. The Master Indenture provides that Supplemental Master Indentures pursuant to which one or more series of Master Obligations entitled to additional security are issued may provide for such amendments to provisions of the Master Indenture, including the provisions thereof relating to the exercise of remedies upon the occurrence of an event of default, as are necessary to provide for such security and to permit realization upon such security solely for the benefit of the Master Obligation secured thereby.

Defeasance

If the interest on, and the principal or redemption price (as the case may be) of a Series of the Series 2013 Bonds have been paid, or the required amount of money and/or Defeasance Investment (see “SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS” in Appendix C) have been deposited with the applicable Bond Trustee to provide sufficient amounts to pay the principal of, and premium, if any, and interest due and to become due on such Series of Series 2013 Bonds on or prior to the redemption date or maturity date thereof, such Series of Series 2013 Bonds shall no longer be deemed outstanding under the applicable Bond Indenture and will no longer be secured thereby. If all Series 2013 Bonds of a Series have been so provided for, the applicable Bond Trustee shall cancel and discharge the applicable Bond Indenture. See “SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURES - Defeasance” in Appendix C.

Bankruptcy

The lien on the Pledged Assets and Equipment given for the benefit of holders of Master Obligations (and thereby the Series 2013 Bonds) are generally superior to the claims of other creditors (subject to the limitations set forth above). However, bankruptcy and similar proceedings and usual equity principles may affect the enforcement of rights to such security. If such security is inadequate for payment in full of the Bonds, bankruptcy proceedings and usual equity principles may also limit any attempt by the Master Trustee to seek payment from other property of the Alliance or future Obligated Issuers. In particular, federal bankruptcy law permits adoption of a reorganization plan even though it has not been accepted by the holders of a majority in aggregate principal amount of the Bonds if the holders are provided with the benefit of their original lien or the “indubitable equivalent.” In addition, if the bankruptcy court concludes that the holders have “adequate protection,” it may (1) substitute other security for the security subject to the lien of the holders and (2) subordinate the lien of the holders to claims by entities or persons supplying post-petition financing to the Alliance after bankruptcy. Furthermore, the reasonable and necessary costs and expenses of preserving or disposing of the Pledged Assets and Equipment in a bankruptcy may, in certain circumstances, reduce the value of the lien on the Pledged Assets and Equipment to the extent such costs and expenses benefit the Master Trustee (and holders). In the event of the bankruptcy of the Alliance, the amount realized by the holders might depend on the bankruptcy court’s interpretation of “indubitable equivalent” and “adequate protection” under the then existing circumstances, which may result in a reduction in the security for or proceeds available to the holders.

THE LETTERS OF CREDIT

Terms of the Letters of Credit

The timely payment of the principal of and interest on the Series 2013 Bonds and the purchase price of each Series of the Series 2013 Bonds will be secured by a corresponding irrevocable transferable direct-pay letter of credit (each, a “Letter of Credit”) issued by the Bank in a stated amount equal to the aggregate principal amount of the respective Series 2013 Bonds outstanding at any time plus 37 days’ interest thereon, calculated at the rate of 12% per annum (the “Maximum Rate”). Each Letter of Credit will be issued pursuant to a Reimbursement Agreement dated as of July 1, 2013 (each a “Reimbursement Agreement” and, together, the “Reimbursement Agreements”), among the Alliance, on its own behalf and as Obligated Group agent on behalf of each of the other Obligated Issuers, and the Bank and any syndicate lenders. The obligations on the part of the Alliance to reimburse the Bank for draws made under each respective Letter of Credit, and to pay to the Bank all other amounts due under the Reimbursement Agreement, will be evidenced by Obligations (as defined in the Master Indenture) issued and secured under the Master Indenture.

Each Letter of Credit will expire on July 30, 2018, unless otherwise terminated or extended. Each Letter of Credit shall expire earlier than such expiration date upon the first to occur of (a) the Business Day following a Conversion Date; (b) the date of receipt by the Bank of notice from the Bond Trustee that a Substitute Letter of Credit, as described below, has been issued in substitution for the Letter of Credit; (c) the date on which the Bank honors the final drawing or drawings available; and (d) the date on which the Bond Trustee certifies that no Series 2013 Bonds of the Series are outstanding. At the request of the Alliance, and with the consent of the Bank and any syndicate lenders, the term of the respective Letter of Credit may be extended by one year. Such consent shall be at

the sole discretion of the Bank and any syndicate lenders, subject to earlier termination or extension at the option of the Bank. Pursuant to the Bond Indentures and subject to certain conditions described herein, prior to the expiration of a Letter of Credit or any other Letter of Credit, the Alliance may deliver to the Bond Trustee a substitute Letter of Credit. Each Letter of Credit and any substitute Letter of Credit are herein referred to as a "Letter of Credit;" the Bank and the issuer of any other Letter of Credit are herein referred to as a "Letter of Credit Provider."

In the case of a drawing to pay the principal or the purchase price of the Series 2013 Bonds of a Series, the stated amount of the Letter of Credit will be reduced by the principal amount of such drawing plus a corresponding amount of the interest portion of the Letter of Credit. In the case of a drawing to pay principal of the Series 2013 Bonds of a Series, the stated amount of the Letter of Credit will be reduced to the extent of any such drawing thereunder. Reductions in the Letter of Credit resulting from a drawing to pay the purchase price of Series 2013 Bonds of a Series shall be reinstated upon receipt by the Bond Trustee of remarketing proceeds or other funds sufficient to reimburse the Bank for such drawing. Drawings to pay interest on the Series 2013 Bonds on an Interest Payment Date shall be automatically reinstated in an amount equal to the amount of such drawing following the honoring of such drawing.

Trustee Draws on Letters of Credit

The Bond Indentures provide that, while any Letter of Credit is in effect, the Bond Trustee shall draw moneys under such Letter of Credit in the following circumstances:

(i) on or before 4:00 p.m., New York City time, on the Business Day prior to any date any payment referred to in this paragraph is required to be made under the Bond Indenture, the Bond Trustee shall, without making any prior demand or claim upon the Alliance, make a drawing under and in accordance with the Letter of Credit so as to receive moneys thereunder on the next Business Day in an amount which will be sufficient for the payment in full of (i) accrued interest on the Series 2013 Bonds on any Interest Payment Date, (ii) the principal of and accrued interest on the Series 2013 Bonds upon the Stated Maturity of the Series 2013 Bonds, and (iii) the principal of and accrued interest on the Series 2013 Bonds upon the redemption of the Series 2013 Bonds.

(ii) on or before 11:30 a.m., New York City time, on the Business Day any payment referred to in this paragraph is required to be made under the Bond Indenture, the Bond Trustee shall, without making any prior demand or claim upon the Alliance, make a drawing under and in accordance with the Letter of Credit so as to receive moneys thereunder on such Business Day in an amount which will be sufficient, together with any proceeds of the remarketing of the Series 2013 Bonds by the Remarketing Agent then in the Bond Purchase Fund and available for application to the Series 2013 Bonds, for the payment in full of the purchase price (including, if applicable, accrued interest due in connection with a purchase on a Mandatory Tender Date or an Optional Tender Date, as the case may be) of all Series 2013 Bonds to be purchased under the terms of the Bond Indenture.

(iii) on or before 4:00 p.m., New York City time, on the Business Day prior to the payment date of the Series 2013 Bonds upon acceleration of the Series 2013 Bonds after an event of default under the Bond Indenture, the Bond Trustee shall, without making any prior demand or claim upon the Alliance, make a drawing under and in accordance with the Letter of Credit so as to receive moneys thereunder in an amount which will be sufficient for the payment in full of the principal of and interest due on the Series 2013 Bonds on such payment date.

The Alliance has agreed pursuant to the Reimbursement Agreements to reimburse the Bank for amounts paid under and otherwise owing with respect to the Letters of Credit.

Extensions of Letter of Credit and Substitute Letter of Credit

Pursuant to the Loan Agreement for each Series of Series 2013 Bonds, the Alliance is required to maintain with the Bond Trustee during the Weekly Rate Periods a Letter of Credit in an amount at least equal to the aggregate principal amount of Series 2013 Bonds then Outstanding plus 37 days' interest thereon. Prior to the expiration of a

Letter of Credit, the Alliance shall deliver to the Bond Trustee a Substitute Letter of Credit or cause an extension of such Letter of Credit. The extension of a Letter of Credit may be effected by the Bank's allowance of the Letter of Credit to renew automatically, delivery of an amendment to the Letter of Credit or by the delivery of a new Letter of Credit in the same form as the expiring Letter of Credit with an extended expiration date. The Alliance also may deliver a Substitute Letter of Credit to the Bond Trustee at any time prior to the Conversion Date in the manner described below.

The Series 2013 Bonds shall be subject to mandatory tender for purchase on any Substitution Tender Date. A Substitute Letter of Credit must be an irrevocable letter of credit, having a term of at least one year, issued by a commercial bank organized or doing business in the United States, the terms of which shall in all material respects be the same as the initial Letter of Credit. Pursuant to the Bond Indenture, the Bond Trustee shall accept a Substitute Letter of Credit and surrender the previously held Letter of Credit if the Bond Trustee receives (a) the Substitute Letter of Credit, (b) an Opinion of Counsel to the effect that the Substitute Letter of Credit has been duly authorized, executed and delivered by the issuer thereof and is a valid and binding obligation of the issuer thereof and (c) in the case of the Series 2013A Bonds, an Opinion of Bond Counsel that the delivery of such Substitute Letter of Credit will not adversely affect the exclusion from gross income of interest on such Series 2013A Bonds for federal income tax purposes. Upon the date the Bond Trustee is permitted to draw under such Substitute Letter of Credit, the Bond Trustee shall promptly surrender the previously held Letter of Credit to the issuer thereof for cancellation. At least 40 days prior to the effective date of such substitution, the Alliance is required to give the Bond Trustee notice of such proposed substitution, and at least 30 days prior to the effective date of such substitution the Bond Trustee will mail notice of such proposed substitution to the holders of all Series 2013 Bonds, advising them of the identity of the Bank giving the Substitute Letter of Credit.

THE BANK

For certain information on U.S. Bank National Association, the provider of the Letters of Credit, see Appendix F. Such information has been provided by the Bank and has not been reviewed by the Issuer or the Alliance.

INTEREST RATE SWAPS

The Alliance has various interest rate swaps and related derivatives currently in place, as described in Appendix A. Some of the existing arrangements have been entered into with affiliates of the Underwriter. The Alliance may in the future enter into swap agreements with respect to some or all of its obligations issued under the Master Indenture. See "MANAGEMENT'S DISCUSSION OF FINANCIAL PERFORMANCE – Interest Rate Swaps and Derivatives" in Appendix A.

CERTAIN RISK FACTORS

The purchase of the Series 2013 Bonds involves certain risks, a number of which are discussed throughout this Official Statement. Each prospective purchaser of the Series 2013 Bonds should make an independent evaluation of all of the information presented in this Official Statement in order to make an informed investment decision. Certain specific risks are described below.

General

The ability of the Obligated Issuers to make payments on the Series 2013 Bonds is dependent upon the ability of the Obligated Issuers to generate revenue sufficient to cover collective operating expenses and debt service on the Series 2013 Bonds and other indebtedness of the Obligated Issuers. Health care providers, especially hospitals, face increasing economic pressures from both governmental health care programs and private purchasers of health care such as insurance companies and health maintenance organizations (collectively, "third-party payors"). The dependence of hospitals on governmental programs requires hospitals to accept both limitations on payments and regulations and other restrictions and requirements triggered by participation in such programs. Many governmental and private third-party payors have required healthcare providers to accept "capitated" or other fixed payments, which have the effect of shifting significant economic risk to healthcare providers.

Health care, especially at the hospital level, is a highly regulated industry with complicated and frequently changing regulations arising both from payment programs and governmental police power generally. Health care providers are increasingly subject to audits, investigations and litigation that may threaten access to governmental reimbursement programs, require substantial payments, generate adverse publicity, create significant legal and other transaction costs and result in significant civil and criminal penalties. See below “Health Care Revenues.” In addition, because the Alliance and a number of its affiliates are tax-exempt charitable organizations under the Internal Revenue Code (“Exempt Organizations”), they are subject to increasing regulation and restrictions that may have adverse effects on their economic performance or threaten their tax-exempt status and the economic benefits derived from it. In particular, such regulations and restrictions may require the facilities of the Alliance or such affiliates to provide health care services for which they do not receive payment. In addition, Congress is likely to consider imposing additional regulations and restrictions on Exempt Organizations.

Future economic and other conditions, including inflation, demand for health care services, the ability of the Alliance and other members of the Obligated Group to provide the services required or requested by patients, physicians’ confidence in the Alliance, economic developments in the applicable service areas, employee relations and unionization, competition, the level of rates or charges, increased costs, availability of professional liability insurance, casualty losses, third-party reimbursement and changes in governmental regulation may adversely affect revenues and, consequently, the ability of the Alliance and other members of the Obligated Group to generate revenues sufficient for the payment of the principal of and interest on the Series 2013 Obligations.

Certain more specific factors that could affect the Series 2013 Bonds and the future financial condition of the Alliance and any future members of the Obligated Group are described below. This discussion of risk factors is not intended to be exhaustive.

Discretion of the Board and Management

The Master Indenture does not significantly restrict the ability of the Alliance to enter into transactions that could materially affect the business, organizational structure and control of the Alliance and any future members of the Obligated Group. Such transactions could include, for example, such things as divestitures of Affiliates, substantial new joint ventures, and mergers, consolidations or other forms of affiliations in which control of the Alliance and any future members of the Obligated Group could be materially changed. As a substantial health system, the Alliance regularly considers and analyzes opportunities for such undertakings. The ability of the Alliance to generate revenues sufficient to pay debt service on the Series 2013 Obligations is dependent in large measure on the decisions of the Board of Directors and management of the Alliance with respect to such opportunities.

Voting Control Under Master Indenture

Certain amendments and waivers to the provisions of the Master Indenture may be made with the consent of the owners of 75% of the aggregate principal amount of the Master Obligations then outstanding. Certain other amendments may be made with the consent of the owners of two-thirds (2/3) in aggregate principal amount of Master Obligations related to bonds that are not the beneficiaries of certain municipal bond insurance policies and the consent of the provider of certain municipal bond insurance policies. Such amendments may adversely affect the security of the holders of the Series 2013 Bonds.

For a discussion of what actions may be taken with the consent or direction of a majority percent or more of the holders of outstanding Master Obligations under the Master Indenture, see the discussion under “SUMMARY OF THE FINANCING DOCUMENTS” in Appendix C.

Matters Relating to Enforceability of the Master Indenture

The practical realization of any rights upon any default under the Loan Agreements or under the Master Indenture may depend upon the exercise of various remedies specified in such instruments, as restricted by federal and state laws. The federal bankruptcy laws may adversely affect the ability of the Bond Trustees, the Master Trustee and the owners of the Series 2013 Bonds to enforce their claims granted by the Bond Indentures, the Loan

Agreements or the Master Indenture. The obligation of the Alliance on the Series 2013 Obligations and other Master Obligations will be limited to the same extent as the obligations of debtors typically are affected by bankruptcy, reorganization, insolvency, fraudulent conveyance, moratorium or other similar laws affecting the enforcement of creditors' rights and by the availability of equitable remedies.

The remedies available to the Bond Trustees, the Master Trustee, the Issuer or the owners of the Series 2013 Bonds upon an event of default under the Master Indenture, the Bond Indentures, the Loan Agreements or the Series 2013 Obligations are in many respects dependent upon judicial actions, which are often subject to discretion and delay. Under existing constitutional and statutory law and judicial decisions, including, specifically, Title 11 of the United States Code (the "Bankruptcy Code"), the remedies provided in the Master Indenture, the Bond Indentures, the Loan Agreements and the Series 2013 Obligations and other Master Obligations may not be readily available or may be limited.

There is no clear precedent in the law as to whether transfers from an Affiliate in order to pay debt service on the Master Obligations issued for the benefit of another Affiliate may be voided by a trustee in bankruptcy in the event of a bankruptcy of the transferring Affiliate or by third-party creditors in an action brought pursuant to state fraudulent conveyances statutes. Under the United States Bankruptcy Code, a trustee in bankruptcy and, under state fraudulent conveyances statutes, a creditor of a related guarantor, may avoid any obligation incurred by a related guarantor, if, among other bases therefor, (i) the guarantor has not received fair consideration or reasonably equivalent value in exchange for the guaranty and (ii) the guaranty renders the guarantor insolvent, as defined in the United States Bankruptcy Code or state fraudulent conveyances statutes, or the guarantor is undercapitalized.

Limited Value at Foreclosure

The Mortgaged Property was constructed for the provision of hospital care. The number of entities that could be expected to purchase or lease the Mortgaged Property are limited, and thus, the ability of the Master Trustee to realize funds from the sale or rental of the Mortgaged Property upon an event of default may be limited.

Bond Ratings

There is no assurance that the ratings assigned to the Series 2013 Bonds will not be lowered or withdrawn at any time, the effect of which could adversely affect the market price for and marketability of the Series 2013 Bonds. See "RATINGS."

Market for the Series 2013 Bonds

The relative buying and selling interest of market participants in securities such as the Series 2013 Bonds, and in the market for such securities as a whole, will vary over time, and such variations may be affected by, among other things, news relating to the Alliance and the other Obligated Issuers, the attractiveness of alternative investments, the perceived risk of owning the security (whether related to credit, liquidity or any other risk), the tax treatment accorded the instruments, the accounting treatment accorded such securities, reactions to regulatory actions or press reports, financial reporting cycles and marketing sentiment generally. Shifts of demand in response to any one or simultaneous particular events cannot be predicted and may be short-lived or exist for longer periods. See below "Matters Affecting Tax Exemption."

Health Care Revenues

There are a number of factors that could adversely affect both revenues and expenses of the Alliance. Some, but not all such factors, are discussed briefly below. Governmental payment provisions, regulations and other restrictions change frequently and may be altered or expanded while the Series 2013 Bonds are outstanding.

Dependence on Governmental and Other Third-Party Payors. The Alliance receives a substantial portion of its revenues from Medicare, Medicaid, including TennCare, TRICARE² and other third-party health care programs. See Appendix A - “SOURCES OF REVENUE.”

The governmental payment programs, such as Medicare, Medicaid and TRICARE, depend on funding by federal and state governments. The increasing cost of health care services and the strain on operating budgets of governmental entities have imposed significant limitations on reimbursement for services provided to beneficiaries of these programs. These challenges are expected to continue in the future. Both governmental payment programs and private third-party payors (i.e., insurance and managed care programs) have increasingly imposed limitations on the coverage of services and payment rates for services. These limitations often require hospitals to provide certain services below cost. Many of the private programs reimburse health care providers based on a percentage of payment rates from governmental programs for similar services. Thus, reductions or limitations in reimbursement under governmental programs can also result in reductions or limitations under private programs. Receipt of revenues from these programs also subjects the Alliance to extensive regulation and risks of enforcement as described below.

TennCare. In 1994, the State of Tennessee, with the approval of the federal government, withdrew from the Medicaid program and began providing services to Medicaid eligible and uninsurable or uninsured persons through TennCare, a managed care plan administered through third party insurers, rather than the traditional Medicaid program. Similar to traditional Medicaid programs, TennCare is funded with a combination of federal and State of Tennessee funds. The program generally does not pay providers amounts that are adequate to cover the cost of care provided. The Alliance is a significant provider of health care services to TennCare enrollees and, as a result, has incurred substantial losses serving TennCare beneficiaries. Approximately 8.4% of the Alliance’s gross patient service charges for the fiscal year ended June 30, 2012, was derived from patients covered by TennCare. Tennessee Governor Bill Haslam announced in March 2013 that he will not pursue expanding TennCare as allowed by the Healthcare Reform Act. However, if the State of Tennessee decides otherwise in the future to expand the program, the percentage of the Alliance’s gross patient service charges derived from patients covered by TennCare may increase.

Virginia Medicaid Program. The hospitals of the Alliance located in Virginia receive a substantial portion of their revenues under the federal Medicare Program. Reimbursement under this program is controlled by extensive regulations and procedures. Under the current Medicare payment system, payment for inpatient hospital services is tied to predetermined amounts based on national averages of costs for categories of treatments and conditions known as diagnosis related groups (“DRGs”). DRG reimbursement may provide a hospital less than its actual costs in providing services. The Medicare Program reimburses health care providers for outpatient hospital services through a similar prospective payment system based on ambulatory payment classifications (“APCs”) of clinically-related and resource-similar items and services. Reimbursement for outpatient services under the APC system and for other services provided by the hospitals of the Alliance may not reflect the actual costs incurred in providing such services or items.

Medicare reimbursement in recent years has been subject to changes that have adversely affected hospitals and other health care providers, and the Alliance cannot predict how future limitations, cutbacks or modifications by Congress or regulatory agencies to such reimbursement may affect the financial condition of the Alliance.

Regulation. The operation of hospitals and other health care providers is extensively regulated by the federal and state governments. These regulations affect virtually every aspect of hospital operations, including (1) imposing procedures that increase costs (including complicated billing and other record-keeping procedures), (2) requiring the provision of services for free or below cost, (3) limiting the ability to make decisions based on economic best interest and (4) restricting the ability to pursue advantageous business opportunities with physicians and other health care providers.

Significant restrictions include (1) the Physician’s Self-Referral (“Stark”) and “Anti-Kickback” laws, and similar state laws, which severely restrict financial relationships with and referrals by physicians and other entities; (2) the Emergency Medical Treatment and Active Labor Act (“EMTALA”), imposing operating requirements upon

² TRICARE is the successor to CHAMPUS and provides health benefits for military personnel and retirees and their dependents.

physicians, hospitals and other facilities that provide emergency medical services; (3) the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the Health Information Technology for Economic and Clinical Health Act (“HITECH”), enacted as part of the American Recovery and Reinvestment Act of 2009, with both affecting the privacy and security of personal health information; (4) the federal False Claims Act, similar state false claim laws and other laws and regulations related to the billing for, coverage of and receipt of payment for services; (5) state corporate practice of medicine and fee splitting laws ; (6) licensure, certificate of need and accreditation requirements; and (7) numerous federal conditions of participation requirements for the Medicare and Medicaid programs. Compliance with HIPAA, HITECH and related regulations has imposed substantial financial burdens on the Alliance and related entities in such areas as electronic billing and other electronic transactions and in implementing procedures and altering facilities to promote privacy of patient records.

Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate violations of existing laws and regulations, including criminal fines, civil monetary penalties, repayment of erroneously paid claims, prison terms and exclusion from the Medicare, Medicaid, TennCare and/or other governmental payment programs. Because of the complexity of the regulations and the increased enforcement, there are numerous circumstances where alleged violations may trigger investigations, audits and inquiries that could result in expensive and prolonged enforcement actions against the Alliance. Enforcement actions may be initiated and prosecuted by one or more government entities and/or private individuals, and in some circumstances more than one of the available penalties may be imposed for each violation. Exclusion from participation in Medicare, Medicaid, TennCare or other governmental health care programs likely would result in a loss of substantial revenues.

National Healthcare Reform

Comprehensive health care reform legislation was enacted by the federal government in March 2010 through the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the “Healthcare Reform Act”). The Healthcare Reform Act fundamentally changes the health care system and the manner in which services are provided and paid for generally, including substantial increases in health care insurance for persons not currently covered, new requirements on employers who provide health benefits to their employees, reimbursement reductions and methodology changes, and the imposition of further restrictions and requirements adversely affecting tax-exempt hospitals such as the Alliance and its related entities.

Implementation of the Healthcare Reform Act is uncertain as to timing and scope and is likely to have a variety of effects on both the operations and financial performance of hospitals. In particular, extension of health insurance to those not currently insured and the costs associated therewith may result in (1) inadequate reimbursement to cover costs under such new coverage, (2) offsetting reductions in reimbursements for the provision of services under Medicare, Medicaid and other federally funded programs and (3) increased costs of compliance generally. In addition, the Healthcare Reform Act is likely to have significant indirect effects on the Alliance and related hospitals as a result of the Healthcare Reform Act’s effects on other healthcare industry participants, including pharmaceutical and medical device companies, health insurers, and others with which the Alliance and related hospitals do business.

The Healthcare Reform Act imposes substantial and costly additional requirements on nonprofit hospitals. Failure of any hospital with 501(c)(3) status to comply with such requirements may result in significant penalties including, but not limited to, the loss of tax-exempt status. See below “Matters Affecting Tax Exemption – Tax Exemption for Non-profit Corporations.”

There have been, and will likely continue to be, legislative efforts in Congress to delay, repeal, amend or defund the Healthcare Reform Act or otherwise block its implementation; President Obama has announced delays to implementing the employer mandate and certain other provisions of the Act; and the Healthcare Reform Act is subject to lawsuits challenging its constitutionality and may be subject to additional lawsuits. Further, there are no implementing regulations or detailed interpretive guidance for many of the law’s provisions. Thus it is impossible to predict the extent to which the Healthcare Reform Act will be implemented or the effects it will have to the extent it is implemented.

Competition

The Alliance faces competition not only from other area hospitals (see in Appendix A -“SERVICE AREA, MARKET SHARE AND COMPETITION”), but also from other forms of health care providers, including health maintenance organizations, preferred provider organizations, specialty hospitals, home health agencies, surgical centers, rehabilitation and therapy centers, physician group practices and other alternative delivery systems and non-hospital providers of medical services. Increasing costs of health care services are likely to stimulate additional forms of competition. Many new forms of health care providers may not be subject to the restrictions imposed on the Alliance by its participation in governmental health care programs and as part of a tax-exempt organization. The application of federal and state antitrust laws to health care is still evolving, and enforcement and other developments in this area could adversely affect the Alliance’s competitive position.

Other Economic Developments

Other economic developments that could adversely affect operations at the Alliance include (1) unexpected increases in costs of labor and equipment (including new technologies) that cannot be recovered through charges; (2) increased costs of maintaining malpractice and general liability insurance; and (3) availability of, or the cost of, required specialty employees, including nurses and other health care professionals.

Matters Affecting Tax Exemption

Tax Exemption for Non-profit Corporations. Loss of tax-exempt status by the Alliance or related entities could result in loss of tax exemption for interest on the Series 2013A Bonds and of other tax-exempt debt issued for the benefit of the Alliance, and defaults in covenants regarding the Series 2013A Bonds and other tax-exempt debt would likely be triggered. Such an event would have material adverse consequences on the financial condition of the Alliance. See “TAX MATTERS.”

The maintenance by the Alliance of its tax-exempt status and that of its related entities depends, in part, upon its maintenance of status as an organization described in Section 501(c)(3) of the Code (an “Exempt Organization”). The maintenance of such status is contingent upon compliance with provisions of the Code and related regulations and administrative interpretations regarding the organization and operation of tax-exempt entities, including its operation for charitable and educational purposes and its avoidance of transactions that may cause its assets to inure to the benefit of private individuals.

The Internal Revenue Service (the “IRS”) has announced that it intends to closely scrutinize transactions between Exempt Organizations and for-profit entities and has issued audit guidelines for tax-exempt hospitals. In March 1998, the IRS issued a revenue ruling that places restrictions upon the participation of Exempt Organizations (including hospitals) in joint venture arrangements with for-profit entities. Although specific activities of hospitals, such as medical office building leases and compensation arrangements and other contracts with physicians, have been the subject of interpretations by the IRS in the form of Private Letter Rulings, many activities have not been addressed in any official opinion, interpretation or policy of the IRS. Because the Alliance conducts large-scale and diverse operations involving private parties, there can be no assurances that certain of its transactions would not be challenged by the IRS.

The IRS has taken the position that hospitals that violate the federal Anti-kickback Law may also be subject to revocation of their tax-exempt status. As a result, tax-exempt hospitals, such as those of the Alliance, which have and will continue to have, extensive transactions with physicians are subject to an increased degree of scrutiny and perhaps enforcement by the IRS.

Furthermore, the Healthcare Reform Act imposed additional operational requirements on tax-exempt hospitals under new Internal Revenue Code Section 501(r) (“Section 501(r”). Each tax-exempt hospital must (1) conduct a community health needs assessment (“CHNA”) every three years; (2) have a written financial assistance policy that meets several specific requirements; (3) limit amounts charged for emergency or other medically necessary care provided to individuals eligible for financial assistance; and (4) refrain from engaging in “extraordinary” collection actions before the hospital has made reasonable efforts to determine whether an

individual is eligible for financial assistance. Compliance with the CHNA requirement in particular is expected to impose substantial burdens on tax-exempt hospitals.

The penalty for failure to comply with Section 501(r) is loss of tax-exempt status at the entity level, if the organization operates one hospital, or loss of exemption at the facility level, if the organization operates more than one hospital. In addition, failure to satisfy the CHNA requirement also will result in the imposition of a \$50,000 penalty excise tax on each noncompliant hospital. The Alliance believes that it is currently in compliance with Section 501(r).

Periodically, Congress considers options and recommendations in the area of taxation of unrelated business income of Exempt Organizations. The scope and effect of legislation, if any, that may be adopted at the federal and state levels with respect to unrelated business income cannot be predicted at this time. However, any such legislation could have the effect of subjecting a portion of the income of the Alliance to federal or state income taxes.

In addition to the foregoing proposals with respect to income by Exempt Organizations, various state and local governmental bodies have challenged the tax-exempt status of such institutions and have sought to remove the exemption of property from real estate taxes of part or all of the property of various nonprofit institutions on the grounds that a portion of such property was not being used to further the charitable purposes of the institutions or that the institutions did not provide sufficient care to indigent persons so as to warrant exemption from taxation as a charitable institution. Several of these disputes have been determined in favor of the taxing authorities or have resulted in settlements.

It is not possible to predict the scope or effect of future legislative or regulatory actions with respect to taxation of Exempt Organizations. There can be no assurance that future changes in the laws and regulations of federal, state or local governments, or the interpretation of such laws by courts or other governmental entities, will not materially adversely affect the operations and financial condition of the Alliance by requiring any of its entities to pay income or local property taxes.

Tax-Exempt Status of the Series 2013A Bonds. Any failure by the Alliance or related entities to remain qualified as tax-exempt under Section 501(c)(3) of the Code could affect the amount of funds that would be available to pay debt service on the Series 2013 Bonds. If the Alliance or the Issuer fails to comply continuously with certain covenants contained in the 2013A Bond Indenture and the 2013A Loan Agreement after delivery of the Series 2013A Bonds, interest on the Series 2013A Bonds could become taxable from the date of delivery of the Series 2013A Bonds regardless of the date on which the event causing such taxability occurs. See “TAX MATTERS.”

In recent years, the IRS has undertaken an extensive audit program that involves review of both the general tax-exempt status of non-profit hospitals and the tax-exempt status of bonds issued for their benefit.

Legislative Proposals. Current and future legislative proposals, if enacted into law, could cause interest on the Series 2013A Bonds to be subject, directly or indirectly, to federal income taxation or otherwise prevent owners thereof from realizing the full current benefit of the tax-exempt status of such interest.

Other Risk Factors Generally Affecting Health Care Facilities

In the future, the following factors, among others, may adversely affect the operations of the Alliance to an extent that cannot be determined at this time:

1. Health care systems are major employers, combining a complex mix of professional, quasi-professional, technical, clerical, housekeeping, maintenance, dietary and other types of workers in a single operation. As with all large employers, the Alliance bears a wide variety of risks in connection with its employees. These risks include strikes and other related work actions, contract disputes, discrimination claims, personal tort actions, work-related injuries, exposure to hazardous materials, interpersonal torts (such as between employees, between physicians or management and employees, or between employees and patients), and other risks that may flow from the relationships between employer and employee or between physicians, patients and employees. Many

of these risks are not covered by insurance, and certain of them cannot be anticipated or prevented in advance. The Alliance is subject to all of the risks listed above. Such risks, alone or in combination, could have material adverse consequences to the financial condition or operations of the Alliance.

2. Competition from other health care systems and other competitive facilities now or hereafter located in the respective service areas of the Alliance's facilities may adversely affect revenues. Development of health maintenance and other alternative health delivery programs could result in decreased usage of inpatient hospital facilities and other facilities operated by the Alliance.

3. Cost and availability of any insurance, such as malpractice, fire, automobile, and general comprehensive liability, that hospitals and other health care facilities of similar size and type as the facilities generally carry may adversely affect revenues, as would any losses that exceed amounts covered.

4. The occurrences of natural disasters may damage some or all of the facilities, interrupt utility service to some or all of the facilities, significantly increase the demand on some or all of the facilities or otherwise impair the operation of some or all of the facilities or the generation of revenues from some or all of the facilities.

5. Scientific and technological advances, new procedures, drugs and appliances, preventive medicine, occupational health and safety and outpatient health care delivery may reduce utilization and revenues of the facilities. Technological advances in recent years have accelerated the trend toward the use by hospitals of sophisticated and costly equipment and services for diagnosis and treatment. The acquisition and operation of certain equipment or services may continue to be a significant factor in hospital utilization, but the ability of the Alliance to offer such equipment or services may be subject to the availability of equipment or specialists, governmental approval or the ability to finance such acquisitions or operations.

6. Reduced demand for the services of the Alliance that might result from decreases in population in the services areas of facilities operated by the Alliance.

7. Increased unemployment or other adverse economic conditions in the service areas of the Alliance that would increase the proportion of patients who are unable to pay fully for the cost of their care.

8. Any increase in the quantity or cost of indigent care provided that is mandated by law or required due to increase needs of the community in order to maintain the charitable status of the Alliance.

9. Regulatory actions that might limit the ability of the Alliance to undertake capital improvements to their respective facilities or to develop new institutional health services.

LITIGATION

There is no action, suit, or proceeding pending or, to the knowledge of the Issuer, threatened restraining or enjoining the execution or delivery of the Series 2013 Bonds, or in any way contesting or affecting the validity of the Series 2013 Bonds, the Bond Indentures, the Master Indenture, or any proceedings of the Issuer or the Alliance, as applicable, taken with respect thereto. No securities of the Issuer have been in default as to principal or interest payments or in any other material respect, and no agreements or legal proceedings of the Issuer relating to its securities have been declared invalid or unenforceable since the formation of the Issuer. The Issuer will provide a certificate to this effect at the time of delivery of the Series 2013 Bonds.

There is no action, suit, or proceeding pending or threatened restraining or enjoining the execution or delivery of the Series 2013 Obligations, or in any way contesting or affecting the validity of the Series 2013 Obligations, the Master Indenture, the Loan Agreements or any proceedings of the Alliance taken with respect thereto. No securities of the Alliance have been in default as to principal or interest payments or in any other material respect, and no agreements or legal proceedings of the Alliance relating to its securities have been declared invalid or unenforceable since the original formation of the corporation now called Mountain States Health Alliance. The Alliance will provide a certificate to this effect at the time of delivery of the Series 2013 Bonds.

For other litigation matters involving the Alliance, see "HISTORY AND OVERVIEW - Insurance; Litigation" in Appendix A hereto.

LEGAL MATTERS

Legal matters relating to the authorization and issuance of the Series 2013 Bonds are subject to the approving opinion of Bass, Berry & Sims PLC of Nashville and Knoxville, Tennessee, as Bond Counsel, which will be delivered with the Series 2013 Bonds. Certain legal matters relating to the Series 2013 Bonds will also be passed upon by Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Issuer; and by Anderson & Fugate, Johnson City, Tennessee, as counsel to the Alliance. Certain legal matters will be passed upon by Thompson Coburn LLP, St. Louis, Missouri, as counsel to the Bank. Certain legal matters will be passed upon by Hunton & Williams LLP, as counsel to the Underwriter.

TAX MATTERS

Tennessee State Tax Exemption

Under existing law, the Series 2013 Bonds and the income therefrom are exempt from all present state, county and municipal taxes in Tennessee except (a) inheritance, transfer and estate taxes, (b) Tennessee excise taxes on interest on the Series 2013 Bonds during the period the Series 2013 Bonds are held or beneficially owned by any organization or entity, other than a sole proprietorship or general partnership doing business in the State, and (c) Tennessee franchise taxes by reason of the inclusion of the book value of the Series 2013 Bonds in the Tennessee franchise tax base of any organization or entity, other than a sole proprietorship or general partnership, doing business in the State.

Series 2013A Bonds

General. Bass, Berry & Sims PLC, Nashville, Tennessee, is Bond Counsel for the Series 2013A Bonds. Bond Counsel is of the opinion that, under existing law, relying on certain statements by the Issuer and the Alliance and assuming compliance by the Issuer and the Alliance with certain covenants, interest on the Series 2013A Bonds is:

- excluded from a bondholder's federal gross income under the Internal Revenue Code of 1986,
- not a preference item for a bondholder under the federal alternative minimum tax;
- included in the adjusted current earnings of certain corporations for purposes of the federal corporate alternative minimum tax.

The Internal Revenue Code of 1986, as amended (the "Code") imposes requirements on the Series 2013A Bonds that the Issuer and the Alliance must continue to meet after the Series 2013A Bonds are issued. These requirements generally involve the way that Series 2013A Bond proceeds must be invested and ultimately used. If the Issuer and the Alliance do not meet these requirements, it is possible that a bondholder may have to include interest on the Series 2013A Bonds in its federal gross income on a retroactive basis to the date of issue. The Issuer and the Alliance have covenanted to do everything necessary to meet these requirements of the Code.

A bondholder who is a particular kind of taxpayer may also have additional tax consequences from owning the Series 2013A Bonds. This is possible if a bondholder is:

- an S corporation,
- a United States branch of a foreign corporation,
- a financial institution,
- a property and casualty or a life insurance company,
- an individual receiving Social Security or railroad retirement benefits,
- an individual claiming the earned income credit, or
- a borrower of money to purchase or carry the Series 2013A Bonds.

If a bondholder is in any of these categories, it should consult its tax advisor.

Bond Counsel is not responsible for updating its opinion in the future. It is possible that future events or changes in applicable law could change the tax treatment of the interest on the Series 2013A Bonds or affect the market price of the Series 2013A Bonds.

Bond Counsel expresses no opinion on the effect of any action taken or not taken in reliance upon an opinion of other counsel on the federal income tax treatment of interest on the Series 2013A Bonds, or under state, local or foreign tax law.

Original Issue Discount. A Series 2013A Bond will have “original issue discount” if the price paid by the original purchaser of such Series 2013A Bond is less than the principal amount of such Series 2013A Bond. Bond Counsel’s opinion is that any original issue discount on the Series 2013A Bond as it accrues is excluded from a bondholder’s federal gross income under the Internal Revenue Code. The tax accounting treatment of original issue discount is complex. It accrues on an actuarial basis and as it accrues a bondholder’s tax basis in the Series 2013A Bonds will be increased. If a bondholder owns one of the Series 2013A Bonds, it should consult its tax advisor regarding the tax treatment of original issue discount.

Bond Premium. If a bondholder purchases a Series 2013A Bond for a price that is more than the principal amount, generally the excess is “bond premium” on that Series 2013A Bond. The tax accounting treatment of bond premium is complex. It is amortized over time and as it is amortized a bondholder’s tax basis in that Series 2013A Bond will be reduced. The holder of a Series 2013A Bond that is callable before its stated maturity date may be required to amortize the premium over a shorter period, resulting in a lower yield on such Series 2013A Bond. A bondholder in certain circumstances may realize a taxable gain upon the sale of a Series 2013A Bond with bond premium, even though the Series 2013A Bond is sold for an amount less than or equal to the owner’s original cost. If a bondholder owns any Series 2013A Bonds with bond premium, it should consult its tax advisor regarding the tax accounting treatment of bond premium.

Series 2013B Bonds

Disclaimer. Any discussion of the tax issues relating to the Series 2013B Bonds in this Official Statement was written to support the promotion or marketing of the Series 2013B Bonds. Such discussion was not intended or written to be used, and it cannot be used, by any person for the purpose of avoiding any tax penalties that may be imposed on such person. Each investor should seek advice with respect to the Series 2013B Bonds based on its particular circumstances from an independent tax advisor.

General. The following is a summary of certain anticipated United States federal income tax consequences of the purchase, ownership and disposition of the Series 2013B Bonds. The summary is based upon the provisions of the Code, the regulations promulgated thereunder and the judicial and administrative rulings and decisions now in effect, all of which are subject to change. The summary generally addresses Series 2013B Bonds held as capital assets and does not purport to address all aspects of federal income taxation that may affect particular investors in light of their individual circumstances or certain types of investors subject to special treatment under the federal income tax laws, including but not limited to financial institutions, insurance companies, dealers in securities or currencies, those holding such bonds as hedge against currency risks or as a position in a “straddle” for tax purposes, or those whose functional currency is not the United States dollar. Potential purchasers of the Series 2013B Bonds should consult their own tax advisors in determining the federal, state or local consequences to them of the purchase, ownership and disposition of the Series 2013B Bonds.

Interest on the Series 2013B Bonds is not excluded from gross income for federal income tax purposes. Purchasers other than those who purchase Series 2013B Bonds in the initial offering at their stated principal amounts will be subject to federal income tax accounting rules affecting the timing and/or characterization of payments received with respect to such Series 2013B Bonds. In general, interest paid on the Series 2013B Bonds, accrual of original issue discount and market discount, if any, will be treated as ordinary income to an owner of Series 2013B Bonds and, after adjustment for the foregoing, principal payments will be treated as a return of capital.

Original Issue Discount. The following summary is a general discussion of certain federal income tax consequences of the purchase, ownership and disposition of Series 2013B Bonds issued with original issue discount (“Discount Taxable Bonds”). A Series 2013B Bond will be treated as having original issue discount if the excess of

its “stated redemption price at maturity” (defined below) over its issue price (defined as the initial offering price at which a substantial amount of the Series 2013B Bonds of the same maturity have first been sold to the public, excluding bond houses and brokers) equals or exceeds one quarter of one percent of such Series 2013B Bond’s stated redemption price at maturity multiplied by the number of complete years to its maturity.

A Discount Taxable Bond’s “stated redemption price at maturity” is the total of all payments provided by the Discount Taxable Bond that are not payments of “qualified stated interest.” Generally, the term “qualified stated interest” includes stated interest that is unconditionally payable in cash or property (other than debt instruments of the issuer) at least annually at a single fixed rate.

In general, the amount of original issue discount includable in income by the initial holder of a Discount Taxable Bond is the sum of the “daily portions” of original issue discount with respect to such Discount Taxable Bond for each day during the taxable year in which such holder held such Discount Taxable Bond. The daily portion of original issue discount on any Discount Taxable Bond is determined by allocating to each day in any “accrual period” a ratable portion of the original issue discount allocable to that accrual period.

An accrual period may be of any length, and may vary in length over the term of a Discount Taxable Bond, provided that each accrual period is not longer than one year and each scheduled payment of principal or interest occurs at the end of an accrual period. The amount of original issue discount allocable to each accrual period is equal to the difference between (i) the product of the Discount Taxable Bond’s adjusted issue price at the beginning of such accrual period and its yield to maturity (determined on the basis of compounding at the close of each accrual period and appropriately adjusted to take into account the length of the particular accrual period) and (ii) the amount of any qualified stated interest payments allocable to such accrual period. The “adjusted issue price” of a Discount Taxable Bond at the beginning of any accrual period is the sum of the issue price of the Discount Taxable Bond plus the amount of original issue discount allocable to all prior accrual periods minus the amount of any prior payments on the Discount Taxable Bond that were not qualified stated interest payments. Under these rules, holders will have to include in income increasingly greater amounts of original issue discount in successive accrual periods.

Holders utilizing the accrual method of accounting may generally, upon election, include all interest (including stated interest, acquisition discount, original issue discount, de minimis original issue discount, market discount, de minimis market discount, and unstated interest, as adjusted by any amortizable bond premium or acquisition premium) on the Discount Taxable Bond by using the constant yield method applicable to original issue discount, subject to certain limitations and exceptions.

Market Discount. Any owner who purchases a Series 2013B Bond at a price which includes market discount in excess of a prescribed de minimis amount (*i.e.*, at a purchase price that is less than its adjusted issue price in the hands of an original owner) will be required to recharacterize all or a portion of the gain as ordinary income upon receipt of each scheduled or unscheduled principal payment or upon other disposition. In particular, such owner will generally be required either (a) to allocate each such principal payment to accrued market discount not previously included in income and to recognize ordinary income to that extent and to treat any gain upon sale or other disposition of such a Series 2013B Bond as ordinary income to the extent of any remaining accrued market discount (under this caption) or (b) to elect to include such market discount in income currently as it accrues on all market discount instruments acquired by such owner on or after the first day of the taxable year to which such election applies.

The Code authorizes the Treasury Department to issue regulations providing for the method for accruing market discount on debt instruments the principal of which is payable in more than one installment. Until such time as regulations are issued by the Treasury Department, certain rules described in the legislative history of the Tax Reform Act of 1986 will apply. Under those rules, market discount will be included in income either (a) on a constant interest basis or (b) in proportion to the accrual of stated interest.

An owner who acquires a Series 2013B Bond at a market discount also may be required to defer, until the maturity date of such Series 2013B Bond or the earlier disposition in a taxable transaction, the deduction of a portion of the amount of interest that the owner paid or accrued during the taxable year on indebtedness incurred or maintained to purchase or carry a Series 2013B Bond in excess of the aggregate amount of interest (including original issue discount) includable in such owner’s gross income for the taxable year with respect to such Series

2013B Bond. The amount of such net interest expense deferred in a taxable year may not exceed the amount of market discount accrued on the Series 2013B Bonds for the days during the taxable year on which the owner held the Series 2013B Bond and, in general, would be deductible when such market discount is includable in income. The amount of any remaining deferred deduction is to be taken into account in the taxable year in which the Series 2013B Bond matures or is disposed of in a taxable transaction. In the case of a disposition in which gain or loss is not recognized in whole or in part, any remaining deferred deduction will be allowed to the extent gain is recognized on the disposition. This deferral does not apply if the bondowner elects to include such market discount in income currently as described above.

Bond Premium. A purchaser who purchases a Series 2013B Bond at a cost greater than its then principal amount (or, in the case of Series 2013B Bond issued with original issue premium, at a price in excess of its adjusted issue price) will have amortizable bond premium. If the holder elects to amortize the premium under Section 171 of the Code (which election will apply to all bonds held by the holder on the first day of the taxable year to which the election applies, and to all bonds thereafter acquired by the holder), such a purchaser must amortize the premium using constant yield principles based on the purchaser's yield to maturity. Amortizable bond premium is generally treated as an offset to interest income, and a reduction in basis is required for amortizable bond premium that is applied to reduce interest payments. Purchasers of any Series 2013B Bonds who acquire such Series 2013B Bonds at a premium (or with acquisition premium) should consult with their own tax advisors with respect to the determination and treatment of such premium for federal income tax purposes and with respect to state and local tax consequences of owning such Series 2013B Bonds.

Sale or Redemption of Series 2013B Bonds. A bondowner's tax basis for a Series 2013B Bond is the price such owner pays for the Series 2013B Bond plus the amount of any original issue discount and market discount previously included in income, reduced on account of any payments received (other than "qualified stated interest" payments) and any amortized bond premium. Gain or loss recognized on a sale, exchange or redemption of a Series 2013B Bond, measured by the difference between the amount realized and the basis of the Series 2013B Bond as so adjusted, will generally give rise to capital gain or loss if the Series 2013B Bond is held as a capital asset (except as discussed above under "Market Discount"). The legal defeasance of Series 2013B Bonds may result in a deemed sale or exchange of such Series 2013B Bonds under certain circumstances; owners of such Series 2013B Bonds should consult their tax advisors as to the federal income tax consequences of such an event.

Backup Withholding. A bondowner may, under certain circumstances, be subject to "backup withholding" (currently the rate of this withholding obligation is 28%, but the rate may change in the future) with respect to interest or original issue discount on the Series 2013B Bonds. This withholding generally applies if the owner of a Series 2013B Bond (a) fails to furnish the Registration Agent or other payor with its taxpayer identification number; (b) furnishes the Registration Agent or other payor an incorrect taxpayer identification number; (c) fails to report properly interest, dividends or other "reportable payments" as defined in the Code; or (d) under certain circumstances, fails to provide the Registration Agent or other payor with certified statement, signed under penalty of perjury, that the taxpayer identification number provided is its correct number and that holder is not subject to backup withholding. Backup withholding will not apply, however, with respect to certain payments made to bondowners, including payments to certain exempt recipients (such as certain exempt organizations) and to certain Nonresidents. Owners of the Series 2013B Bonds should consult their tax advisors as to their qualification for exemption from backup withholding and the procedure for obtaining the exemption.

Backup withholding is not an additional tax. Any amount paid as backup withholding would be credited against the bondholder's U.S. federal income tax liability, provided that the requisite information is timely provided to the Internal Revenue Service. The amount of "reportable payments" for each calendar year and the amount of tax withheld, if any, with respect to payments on the Series 2013B Bonds will be reported to the bondowners and to the Internal Revenue Service.

Nonresident Borrowers. Under the Code, interest and original issue discount income with respect to Series 2013B Bonds held by nonresident alien individuals, foreign corporations or other non-United States persons ("Nonresidents") generally will not be subject to the United States withholding tax (or backup withholding) if the Alliance (or other who would otherwise be required to withhold tax from such payments) is provided with an appropriate statement that the beneficial owner of the Series 2013B Bond is a Nonresident. Notwithstanding the foregoing, if any such payments are effectively connected with a United States trade or business conducted by a

Nonresident bondowner, they will be subject to regular United States income tax, but will ordinarily be exempt from United States withholding tax.

Changes In Federal And State Tax Law

From time to time, there are Presidential proposals, proposals of various federal committees, and legislative proposals in the Congress and in the states that, if enacted, could alter or amend the federal and state tax matters referred to herein or adversely affect the marketability or market value of the Series 2013 Bonds or otherwise prevent holders of the Series 2013A Bonds from realizing the full benefit of the tax exemption of interest on the Series 2013A Bonds. Further, such proposals may impact the marketability or market value of the Series 2013 Bonds simply by being proposed. It cannot be predicted whether or in what form any such proposal might be enacted or whether if enacted it would apply to bonds issued prior to enactment. In addition, regulatory actions are from time to time announced or proposed and litigation is threatened or commenced which, if implemented or concluded in a particular manner, could adversely affect the market value, marketability or tax status of the Series 2013 Bonds. It cannot be predicted whether any such regulatory action will be implemented, how any particular litigation or judicial action will be resolved, or whether the Series 2013 Bonds would be impacted thereby. Purchasers of the Series 2013 Bonds should consult their tax advisors regarding any pending or proposed legislation, regulatory initiatives or litigation.

The opinions expressed by Bond Counsel are based upon existing legislation and regulations as interpreted by relevant judicial and regulatory authorities as of the date of issuance and delivery of the Series 2013 Bonds, and Bond Counsel has expressed no opinion as of any date subsequent thereto or with respect to any proposed or pending legislation, regulatory initiatives or litigation.

Prospective purchasers of the Series 2013 Bonds should consult their own tax advisors regarding the foregoing matters.

Copies of the proposed forms of Bond Counsel opinions for the Series 2013A Bonds and the Series 2013B Bonds are set forth in **Appendix D** attached hereto.

RATINGS

Fitch Ratings (“Fitch”) has assigned ratings of AA-/F1+ to the Series 2013 Bonds.

Standard & Poor’s Rating Services, a division of The McGraw Hill Companies, Inc. (“S&P”) is expected to assign ratings of AA-/A1+ to the Series 2013 Bonds.

Each such rating is based on the availability of the Letters of Credit and reflects only the views of the rating agency assigning such rating and an explanation of the significance of such rating should be obtained from the applicable rating agency itself. Certain materials and information relating to the Series 2013 Bonds, the Bank and the Alliance that may not be described in this Official Statement were furnished to the rating agencies in connection with the issuance of the ratings. Generally, rating agencies base their ratings on such materials and information and on their own investigations, studies and assumptions. There is no assurance that any rating will remain in effect for any given period of time or that any rating will not be lowered or withdrawn entirely if, in the judgment of the rating agency, circumstances so warrant.

No information is provided regarding the ratings of other outstanding bonds issued for the benefit of the Alliance and related entities.

UNDERWRITING

Merrill Lynch, Pierce, Fenner & Smith Incorporated (“Merrill Lynch” or the “Underwriter”) has agreed to purchase (1) the Series 2013A Bonds at a price of \$16,179,801, representing the par amount of the Series 2013A Bonds less an Underwriter’s discount of \$55,199 (0.34% of the principal amount thereof); and (2) the Series 2013B Bonds at a price of \$99,341,088, representing the par amount of the Series 2013B Bonds less an Underwriter’s

discount of \$338,912 (0.34% of the principal amount thereof). Merrill Lynch is committed to take and pay for all of the Series 2013 Bonds if any are taken.

The prices at which the Series 2013 Bonds are offered to the public (and the yields resulting therefrom) may vary from the initial public offering prices. In addition, the Underwriter may allow commissions or discounts to dealers and others from the initial offering prices appearing on the cover page of this Official Statement. From time to time, the Underwriter may enter into other transactions with the Alliance, including interest rate swaps and options, for which it receives other compensation.

The Underwriter and its affiliates are full service financial institutions engaged in various activities, which may include securities trading, commercial and investment banking, financial advisory, investment management, principal investment, hedging, financing and brokerage services. The Underwriter and its affiliates may, from time to time, perform various financial advisory and investment banking services for the Alliance, for which they received or will receive customary fees and expenses. In the ordinary course of their various business activities, the Underwriter and its affiliates may make or hold a broad array of investments and actively trade debt and equity securities (or related derivative securities, which may include credit default swaps) and financial instruments (including bank loans) for their own account and for the accounts of their customers and may at any time hold long and short positions in such securities and instruments. Such investment and securities activities may involve securities and instruments of the Alliance. The Underwriter and its affiliates also may communicate independent investment recommendations, market color or trading ideas and/or publish or express independent research views in respect of such assets, securities or instruments and may at any time hold, or recommend to clients that they should acquire, long and/or short positions in such assets, securities and instruments.

INDEPENDENT AUDITORS

The consolidated financial statements of the Alliance as of and for the years ended June 30, 2012 and 2011, included in Appendix B to this Official Statement, have been audited by Pershing Yoakley & Associates, P.C. See also “CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS” in Appendix A.

CONTINUING DISCLOSURE AGREEMENT

The Agreement

To permit compliance by the Underwriter with the continuing disclosure requirements of Rule 15c2-12 (the “Rule”) promulgated by the Securities and Exchange Commission, the Alliance will execute a Continuing Disclosure Agreement (the “Continuing Disclosure Agreement”) at closing pursuant to which the Alliance will agree to provide certain quarterly and annual financial information and notices regarding certain enumerated events required by the Rule. Such information will be filed through the Electronic Municipal Market Access System (“EMMA”) maintained by the Municipal Securities Rulemaking Board and may be accessed through the Internet at emma.mrsb.org. The proposed form of the Continuing Disclosure Agreement is set forth in Appendix E. It requires the Alliance to provide **only limited information at specific times, and the information provided may not be all the information necessary to value the Series 2013 Bonds at any particular time.** The Alliance may from time to time disclose certain information and data in addition to that required by the Continuing Disclosure Agreement. If the Alliance chooses to provide any additional information, the Alliance shall have no obligation to continue to update such information or to include it in any future disclosure filing.

Failure by the Alliance to comply with the Continuing Disclosure Agreement is not an Event of Default under the Loan Agreements. The Continuing Disclosure Agreement provides that the only remedy for its violation is a lawsuit seeking specific performance.

Prior Undertakings

In connection with the issuance of previous bonds, the Alliance has entered into continuing disclosure undertakings similar to the Continuing Disclosure Agreement. Prior to July 1, 2009, the Alliance's filings under such undertakings were made through the then existing national recognized municipal securities information repositories. Since then filings have been made through EMMA.

The Alliance failed to make certain filings previously scheduled under previous continuing disclosure undertakings. In November, 2008, the Alliance submitted Annual Financial Information for the fiscal years ended June 30, 2000, through June 30, 2008, and Quarterly Financial Information for the quarters ended March 31, 2000, through June 30, 2008. Such filings were not timely under the Alliance's existing continuing disclosure undertakings. The Alliance has made timely filings of the Quarterly Financial Information for the quarters ended September 30, 2008, through March 31, 2013. The Alliance believes it has now made all filings required under all of its continuing disclosure undertakings.

RELATIONSHIPS OF PARTIES

As noted above, the Alliance or its affiliates have entered into interest rate swaps and other financial transactions with affiliates of the Underwriter.

From time to time, Bond Counsel and Hunton & Williams LLP have represented the Alliance in other matters, and may do so in the future. Bond Counsel also has represented the Underwriter in unrelated transactions. Anderson & Fugate, counsel to the Alliance, receives a substantial portion of its annual legal fee income from the Alliance. The Alliance typically engages in bidding to select the contractors for its capital projects. Whether or not such projects are bid, from time to time the contractor selected may be one in which members of the board of directors of the Issuer or the Alliance have an interest.

MISCELLANEOUS

This Official Statement and its distribution and use by the Underwriter have been duly authorized and approved by the Issuer and by the Alliance. This Official Statement has been executed and delivered by the Chairman of the Issuer on behalf of the Issuer and by the Senior Vice President and Chief Financial Officer of the Alliance on behalf of the Alliance.

So far as any statements made in this Official Statement involve matters of opinion, forecasts or estimates, whether or not expressly stated, they are set forth as such and not as representations of fact.

The Appendices are an integral part of this Official Statement and must be read together with all other parts of this Official Statement.

**THE HEALTH AND EDUCATIONAL FACILITIES
BOARD OF THE CITY OF JOHNSON CITY,
TENNESSEE**

By /s/ W. Hanes Lancaster
Chairman

MOUNTAIN STATES HEALTH ALLIANCE

By /s/ Marvin H. Eichorn
Senior Vice President and Chief Financial Officer

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APPENDIX A

MOUNTAIN STATES HEALTH ALLIANCE

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HISTORY AND OVERVIEW

Background

Mountain States Health Alliance (the “Alliance”), a Tennessee not-for-profit corporation headquartered in Johnson City, Tennessee, was originally incorporated as Memorial Hospital on April 12, 1945. In January 1951, the corporation acquired Appalachian Hospital and Training School, an 82-bed acute care facility in Johnson City, and simultaneously opened a 120-bed acute care facility in Johnson City. By 1977, its facilities had expanded to include 369 acute care beds and a 52-bed nursing home. In September 1980, the facilities were relocated and began operating as the Johnson City Medical Center (“JCMC”). In 1983, the corporation changed its name to the Johnson City Medical Center Hospital, Inc. The corporation has been determined to be an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended.

In 1998, the Alliance purchased the assets and assumed certain liabilities of five hospitals from Columbia/HCA (the “1998 Acquisition”) located in Johnson City, Kingsport, and Elizabethton, Tennessee. In 1999, the corporation changed its name to Mountain States Health Alliance. On May 1, 2005, the Alliance purchased the assets of Woodridge Hospital, an acute inpatient psychiatric facility in Johnson City. On November 1, 2006, the Alliance purchased an 80% membership interest in Smyth County Community Hospital, which owns a general acute care facility and a 109-bed long-term care facility in Southwest Virginia. On October 31, 2007, the Alliance purchased a 50.1% membership interest in Norton Community Hospital, which owns and operates both Norton Community Hospital and Dickenson County Community Hospital in Southwest Virginia. On January 31, 2008, the Alliance acquired the assets and liabilities of Russell County Medical Center in Lebanon, Virginia. On April 1, 2009, the Alliance acquired a 50.1% interest in Johnston Memorial Hospital, which owns a 116-bed facility in Abingdon, Virginia. Listed below are facilities currently owned or controlled by the Alliance:

<u>Facility</u>	<u>Location</u>	<u>Licensed Beds (excludes nursery)</u>
Johnson City Medical Center (“JCMC”)*	Johnson City, TN	514
James H. & Cecile Quillen Rehabilitation Hospital (“Quillen”)*	Johnson City, TN	60
Woodridge Hospital (“Woodridge”)*	Johnson City, TN	84
Franklin Woods Community Hospital (“Franklin Woods”)	Johnson City, TN	80
Indian Path Medical Center (“Indian Path”)	Kingsport, TN	261
Sycamore Shoals Hospital (“Sycamore Shoals”)	Elizabethton, TN	121
Johnson County Community Hospital (“Johnson County Community”)	Mountain City, TN	2
Smyth County Community Hospital (“Smyth County Community”) ⁽¹⁾	Marion, VA	153
Norton Community Hospital (“Norton Community”) ⁽²⁾	Norton, VA	129
Dickenson Community Hospital (“Dickenson Community”) ⁽²⁾	Clintwood, VA	25
Russell County Medical Center (“Russell”)	Lebanon, VA	78
Johnston Memorial Hospital (“Johnston Memorial”) ⁽²⁾	Abingdon, VA	<u>116</u>
		1,623

*JCMC, Quillen and Woodridge are operated under a single 658-bed hospital license.

⁽¹⁾ 80% membership interest held by the Alliance.

⁽²⁾ 50.1% membership interest held by the Alliance.

In addition to the above-described hospital facilities, the Alliance owns directly or through wholly-owned subsidiaries, medical office buildings, physician practices, undeveloped land and outpatient surgery centers. The Alliance is a majority shareholder of Integrated Solutions Health Network, LLC (“ISHN”).

Operations of the Alliance

The facilities of the Alliance are naturally divided geographically into two groupings: (i) the “Tennessee Facilities,” which include JCMC, Quillen, Woodridge, and Franklin Woods, all in Washington County; Indian Path, in Sullivan County; Sycamore Shoals, in Carter County; and Johnson County Community, in Johnson County; and (ii) the “Virginia Facilities,” which include Smyth County Community, in Smyth County; Norton Community, in the City of Norton; Dickenson Community, in Dickenson County; Russell, in Russell County; and Johnston Memorial,

in Washington County. All of the Tennessee hospital facilities and Russell are owned by the Alliance. Smyth County Community is owned by Smyth County Community Hospital; Norton Community is owned by Norton Community Hospital; and Johnston Memorial is owned by Johnston Memorial Hospital.

Johnson City Medical Center is a 514 licensed bed, general acute care facility located on a 75-acre site on State of Franklin Road, a major regional thoroughfare in Johnson City. JCMC provides a wide array of acute care services on an inpatient and outpatient basis, including a complete range of cardiovascular, neurology, oncology, skilled nursing, and rehabilitation services. JCMC also operates a 69 licensed bed children's hospital with the region's only pediatric-specific emergency department. JCMC is designated as a Level III Perinatal Center and a Level I trauma center. JCMC earned international recognition as a Magnet Hospital by the American Nurses Credentialing Center. On or adjacent to JCMC's main campus are seven physician office buildings providing office space for approximately 75 physicians.

The James H. & Cecile C. Quillen Rehabilitation Hospital (formerly Northeast Tennessee Rehabilitation Hospital) is a 60 licensed bed rehabilitation and skilled nursing hospital in Johnson City, operated under the JCMC license. This facility provides a complete array of skilled nursing services as well as rehabilitative services for individuals with brain injury, stroke, or spinal cord injury, amputation and other orthopedic and neurological diagnosis. These rehabilitative services include respiratory, occupational, physical, and speech therapy. The facility also provides pediatric outpatient rehab services. The facility was constructed in 1991.

Woodridge Hospital is an 84 licensed bed, acute-care facility located in Johnson City, offering psychiatric and substance abuse services. This facility was purchased in May 2005 and is operated under the JCMC license.

Franklin Woods Community Hospital is an 80 licensed bed facility offering a full array of primary care and some specialty services. Franklin Woods opened in July 2010 (replacing Johnson City Specialty and North Side hospitals) and was the first "green" hospital in the state.

Indian Path Medical Center is a 261 licensed bed facility in Kingsport. This facility provides a complete range of medical/surgical, acute care, psychiatric and skilled nursing services on an inpatient basis and a full complement of outpatient services. The facility is located on an 80 acre campus that also includes nine medical office buildings. Indian Path Medical Center was constructed in 1974.

Sycamore Shoals Hospital is a 121 licensed bed general acute care hospital in Elizabethton, Tennessee (Carter County). The facility provides inpatient, geropsychiatric, and outpatient services for acute care and medical/surgical patients. Sycamore Shoals was founded in 1955 as Carter County Memorial Hospital. It was moved to a newly constructed facility in 1986. A medical office building constructed in 2010 is also located on the main campus.

Johnson County Community Hospital is a facility located in Mountain City with two licensed beds and critical access designation. Johnson County offers inpatient care, emergency care, and outpatient services.

Smyth County Community Hospital is a 153 licensed bed, Medicare Dependent, skilled and long term care hospital in Marion, Virginia, owned by Smyth County Community Hospital (the "Smyth County Corporation"), a Virginia non-stock corporation in which the Alliance controls an 80% interest. The current facility was built in 2012, and provides a full range of acute inpatient and outpatient care, including OB/GYN, general surgery, urology, ENT, orthopedics, cardiology, oncology, and skilled nursing services. The new facility meets LEED standards and is certified as a "green" facility. Nursing home services provided by Francis Marion Manor, a 109 licensed bed long term care facility, are included as part of Smyth County Community's bed complement. Smyth County Corporation is a member of the Obligated Group.

Norton Community Hospital, located in the City of Norton, Virginia, is a 129 licensed bed, acute-care facility, which has served Southwest Virginia and Southeastern Kentucky since 1949. Norton Community is owned and operated by Norton Community Hospital (the "Norton Corporation"), a Virginia non-stock corporation in which the Alliance controls a 50.1% interest. The largest healthcare facility in the coalfield region, Norton Community provides a wide array of services through highly trained physicians and support staff. Norton Community is a

member of the Virginia Hospital and Healthcare Association and is accredited by the American Osteopathic Association. Norton Community was the first AOA accredited teaching facility in the state of Virginia. The Norton Corporation is a member of the Obligated Group.

Dickenson Community Hospital, located in Clintwood, Virginia, opened in November 2003. It is a 25 licensed bed critical access hospital owned and operated by the Norton Corporation. A recent expansion included a 5,700 square foot physician office building on the hospital campus. Dickenson Community offers laboratory, imaging, inpatient acute care and a wide array of therapy services. Dickenson Community is not a member of the Obligated Group.

Russell County Medical Center is a 78-bed Medicare Dependent Hospital located in Lebanon, Virginia, which includes a 20-bed inpatient psychiatric unit. Russell offers cardiac, home health, hospice, surgical and behavioral healthcare services. Russell is wholly owned by the Alliance, which is an Obligated Issuer.

Johnston Memorial Hospital is a 116 licensed bed, general acute care hospital in Abingdon, Virginia, which can trace its history back to a 12 bed facility started in 1905. Johnston Memorial provides a wide array of healthcare services in a newly constructed facility that opened in 2011. Johnston Memorial is owned and operated by Johnston Memorial Hospital, Inc. (the "Johnston Corporation"), in which the Alliance owns a 50.1% interest. The Johnston Corporation is not a member of the Obligated Group and the Obligated Issuers are not required to pay debt service on the JMH Bonds.

Future Facilities

On March 28, 2013, the Alliance executed an agreement to acquire Unicoi County Memorial Hospital, a 48-bed acute care hospital located in Erwin, Tennessee. The hospital has approximately 250 employees and offers emergency, surgical, and home health services. Nursing home services are provided in a 46 licensed bed long term care facility. The Alliance will fund the acquisition from cash flow. After consideration of the revenues and expenses expected from operations of the facility, management of the Alliance does not expect this acquisition to have a material effect on the Alliance. The Tennessee attorney general's office has delayed its decision on whether to approve the acquisition pending, among other things, certain local approvals.

Operations of Subsidiary and Other Affiliates

The Alliance directly owns and operates the hospital facilities listed above that are located in Tennessee, and directly owns and operates Russell in Lebanon, Virginia. It has controlling membership interests in the corporations that own Smyth County Community, Norton Community, Dickinson Community and Johnston Memorial. Additionally, the Alliance owns or otherwise controls a number of for-profit and not-for-profit affiliates that provide complementary health care services and help support the health care needs of the region. The principal affiliates are Mountain States Foundation, Inc., Mountain States Health Alliance Auxiliary, Integrated Solutions Health Network ("ISHN"), and Blue Ridge Medical Management Corporation ("Blue Ridge").

ISHN is a Tennessee for-profit limited liability company established in 2009 and 99.6% owned by the Alliance. ISHN administers a provider-sponsored health care delivery network. ISHN has two lines of business: (1) Anew Care Collaborative - an accountable care organization (the "ACO") and (2) CrestPoint Health ("CrestPoint"). The ACO has created a network of participating physicians, hospitals and other health care providers, and participates, pursuant to a contract with the Centers for Medicare and Medicaid Services, in the Medicare Shared Savings Program established pursuant to Section 3022 of the Patient Protection and Affordable Care Act and its implementing regulations. The ACO may enter into shared savings or other contracts with other third party payors. CrestPoint provides third party administrator services to the Alliance for its self-insured employee health plan. In the fall of 2012, CrestPoint began offering a regionally-based Medicare advantage plan.

Blue Ridge is a Tennessee for-profit stock corporation, and the Alliance owns 100% of its stock. Blue Ridge in turn owns all of the stock or other ownership interest in the following entities (collectively, the "Blue Ridge Affiliates"): Mountain States Physician Group, Inc., Mountain States Properties, Inc., Mediserve Medical Equipment of Kingsport, Inc., HealthPlus, and Synergy Health Group LLC. While Blue Ridge is an Obligated

Issuer under the Master Indenture, none of the Blue Ridge Affiliates is an Obligated Issuer. Blue Ridge provides, directly or through the Blue Ridge Affiliates, management services for clinics in 13 counties at 97 locations (50 specialty care, 37 primary care, and 10 urgent care and occupational medicine clinics). At the 97 locations, Blue Ridge provides management services to a total of 196 practicing physicians, 78 nurse practitioners and physician assistants and five nurse anesthetists. Blue Ridge has various levels of ownership in five surgery centers and owns and/or manages a total of 29 medical office buildings, seven of which are held in condominium-ownership form.

Obligated Issuers

The Obligated Issuers under the Amended and Restated Master Trust Indenture dated as of February 1, 2000, as amended (the “Master Indenture”), with The Bank of New York Mellon Trust Company, N.A., as master trustee, are the Alliance, Smyth County Community Hospital, Norton Community Hospital and Blue Ridge Medical Management Corporation.

Inpatient Bed Complement

The following table shows the Alliance’s licensed bed capacity by service line as of May 31, 2013:

<u>Service</u>	<u>Licensed Beds</u>	<u>Distribution</u>
Medical/Surgical	996	61%
OB/GYN	86	6
Critical Care	125	8
Neonatal	51	3
Psychiatry	136	8
Rehabilitation	51	3
Skilled Nursing / Nursing Home	<u>178</u>	<u>11</u>
Total	1,623	100%

Source: The Alliance.

Educational Programs

Pursuant to an agreement with the Division of Health Sciences at East Tennessee State University (“ETSU”), the Alliance provides JCMC as a site for clinical and other training of medical students and residents from ETSU’s James H. Quillen College of Medicine (“QCM”), nursing students at the associate, baccalaureate and master’s level from the School of Nursing and students from the School of Public and Allied Health. Woodridge provides sites for clinical training for QCM psychiatric residents. Approved medical residencies are offered by ETSU in Family Medicine, Internal Medicine/Psychiatry, OB/GYN, Pathology, Pediatrics, Cardiology, Infectious Disease, Pulmonary/Critical Care, Sleep and General Surgery. Approved fellowships are offered by ETSU in Gastroenterology and Medical Oncology. JCMC is also a clinical site for various health professional and allied health programs located in Tennessee, Kentucky, Virginia and North Carolina.

QCM, which is located adjacent to JCMC, has made a commitment to promote medical educational programs in Johnson City, Tennessee. With QCM’s location adjacent to JCMC and the Veteran Affairs Medical Center at Mountain Home, a large portion of QCM’s clinical training occurs at JCMC. An ETSU facility housing clinical training programs is located across the street from JCMC. QCM’s presence promotes the presence of substantial numbers of physicians in private practice. Additionally, the concentration of medical specialists, researchers, and medical educators in Johnson City make the Alliance competitively stronger in patient care opportunities in the region and also provides a good source of nurses for Alliance facilities.

Licenses and Accreditation

The Tennessee Facilities are licensed by the State of Tennessee Department of Health and Environment; the Virginia Facilities are licensed by the Virginia Department of Health. All facilities are accredited by The Joint Commission (“TJC”). Norton and Quillen are accredited by the Commission of Accreditation of Rehabilitation

Facilities. The Alliance facilities are accredited by the College of American Pathologists. JCMC is also accredited by the American College of Surgeons Commission on Cancer and is designated as a Regional Perinatal Center by the Tennessee Department of Health and Environment.

Employees

As of April 30, 2013, the Alliance employed a staff of 9,044 persons (equal to approximately 7,478 full-time equivalent employees), including 3,634 registered/licensed practical nurses. The Alliance's employees are covered for a variety of employee benefits, including qualified pension plans, health and dental insurance, life insurance and vacation, holiday and sick time benefits. Certain employees at Norton Community and Dickenson Community are represented by a union. The Alliance has never experienced a strike or other work stoppage by its employees. The Alliance considers its employee relations to be excellent.

Pension Plans

The Alliance has qualified defined contribution pension plans covering substantially all of its employees. Contributions to the defined contribution pension plans are current. The Norton Corporation has a defined benefit plan that was amended to freeze participation and all benefit accruals effective December 31, 2006. The Norton Corporation's defined benefit plan has met the ERISA minimum funding requirements.

Insurance; Litigation

The Alliance is substantially self-insured and has established self-insurance reserves to provide for professional and general liability claims and related expenses in amounts based upon an annual actuarial valuation. The self-insurance program currently has the following limits: \$10,000,000 per claim; with an annual aggregate of \$15,000,000. The Alliance has never had a claim to exceed the self-insurance limits. The Alliance maintains a \$25,000,000 excess/umbrella policy, which attaches over the self-insurance fund's \$10,000,000 per claim, \$15,000,000 annual aggregate retention.

Additionally, the Alliance is self-insured for employee health and worker's compensation claims for the Tennessee Facilities. For the Virginia Facilities, the Alliance is self-insured for employee health. The Alliance maintains a large deductible policy for worker's compensation claims with limits of \$750,000 per employee per accident, \$2,500,000 aggregate, \$5,000,000 all covered bodily injury aggregate maximum for the policy period. The Alliance recognizes expense each year based upon actual claims paid and an estimate of claims incurred, but not yet paid. The Alliance has established a reserve for reported and unreported worker's compensation claims based upon an annual actuarial valuation.

The Alliance and related entities are defendants in litigation relating to medical malpractice, worker's compensation and other claims arising in the ordinary course of business. Based on an evaluation of pending and threatened actions, management of the Alliance does not believe that any existing litigation, individually or collectively, would materially and adversely affect the financial resources of the Alliance or the business or continuous operation of the Alliance. Furthermore, the Alliance has accrued amounts in its self-insurance reserves at levels that it believes are sufficient to provide for payments reasonably projected to be due in connection with pending and potential claims and liabilities of the Alliance.

MEDICAL SERVICES

The Alliance provides a wide range of general and specialty medical services for the residents of Northeast Tennessee and Southwest Virginia and the surrounding states of Kentucky and North Carolina. The majority of tertiary care provided by the Alliance is concentrated at Johnson City Medical Center. Some highlights of the medical services and programs offered by the Alliance are described below.

Surgical Services. The Alliance has approximately 60 operating rooms located in eight facilities. The Alliance's surgical facilities are equipped with state-of-the-art technologies to meet the health care needs of the region. The Alliance provides services in all major surgical specialties including orthopedics, vascular,

cardiothoracic, neurological, general, gynecological, laparoscopic, laser, urological, oncological, pediatric, plastic, ear, nose and throat, and dental.

Cardiovascular Services. The Alliance offers comprehensive regional cardiac services and highly advanced equipment for the detection, treatment, care and rehabilitation of those with heart problems. Advanced services include a wide range of non-invasive tests, cardiac catheterization, angioplasty and open-heart surgery. JCMC is known throughout the region for its medical expertise in cardiac care and has been recognized as the region's top hospital for cardiovascular services by US News and World Report for three consecutive years, most recently in 2012. Indian Path provides a full complement of cardiovascular services including interventional cardiology. Johnston Memorial's services include diagnostic cardiac catheterization.

Pulmonary Medicine. Respiratory therapy services are provided at each of the Alliance's facilities. The Center for Pulmonary Medicine at JCMC diagnoses and manages disorders of the respiratory and the pulmonary vascular systems, including emphysema and black-lung disease. A state-of-the-art metabolic laboratory assesses heart and respiratory problems. Pulmonary outreach services are provided at JCMC. Black Lung diagnostic services are provided at Norton Community Hospital.

Comprehensive Wound Care is provided at JCMC, Norton Community, and Johnston Memorial. JCMC is the home to three hyperbaric oxygen chambers and Norton Community and Johnston Memorial each have one chamber.

Women's Services. The Alliance provides specially designed women's services equipped to meet the unique health needs of women. Locations for obstetric and newborn care include The Family Birth Centers at JCMC, Franklin Woods, Indian Path, Norton Community, and Johnston Memorial. Gynecologic care is provided at each of the preceding facilities as well as Smyth County Community and Sycamore Shoals. The complement of women's services includes: routine and high-risk obstetrical care, gynecological surgery, breast disease diagnosis and treatment, fertility services, laser and microscopic surgery, plastic surgery, wellness/fitness programs, and educational sessions covering a wide spectrum of women's concerns. The Family Birth Center at JCMC includes the region's only State-designated Perinatal Center for pregnancy and newborn medical complications and a transport team to bring critically ill infants to the Niswonger Children's Hospital at JCMC.

Children's Services. The Niswonger Children's Hospital at JCMC is the only children's hospital in northeast Tennessee. More than 20 pediatric subspecialties provide specialty care through this 69 licensed bed "hospital within a hospital" and pediatric emergency department. Niswonger has met stringent criteria to become a member of the Children's Hospital Association linking providers and staff with more than 202 of the nation's leading pediatric facilities. Also located on the campus of JCMC is the region's only *Ronald McDonald House*, with the mission of meeting the support needs of pediatric patients and family members. In addition, in October 1999, the Alliance entered into a clinical affiliation with St. Jude's Children's Research Hospital to provide pediatric cancer and other catastrophic disease treatment services. On December 7, 2012, Niswonger Children's Hospital entered into a clinical affiliation with Cincinnati Children's Hospital.

Diabetes Services. The Alliance provides diabetes management programs with specialized healthcare providers able to address the needs of the diabetic patient. The diabetes services emphasizes the importance of patient education and support with both patient and family involvement in the treatment process and provides education in all aspects of diabetes management.

Rehabilitation Services. The James H. and Cecile C. Quillen Rehabilitation Hospital provides a complete range of physical rehabilitative services for the region, including specialized rehabilitative services for individuals with brain injuries, strokes and spinal cord injuries. The Alliance also provides outpatient physical, occupational, and speech therapies at eight locations for individuals with physical disabilities.

Cancer Services. The Alliance provides comprehensive cancer treatment services throughout the system with four tertiary care facilities in Johnson City, Kingsport, Abingdon, and Marion. The Regional Cancer Center at JCMC serves as a referral center and education host for students, and is the only facility within several hours travel time with specialized infrastructure capable of supporting the treatment of complex cases such as pediatric cancers and acute leukemia. The St. Jude's Children's Research Hospital, Tri-Cities Affiliate, is located on JCMC's

campus. It is a collaborative effort between the Alliance, East Tennessee State University, and St. Jude's Children's Research Hospital in Memphis to provide pediatric oncology services in the region. Regional Cancer Centers at Indian Path, Johnston Memorial, and Smyth County Community provide surgical and chemotherapy treatments to patients from Northeast Tennessee and Southwest Virginia. Outpatient radiation services are provided at Regional Cancer Centers at Indian Path and Johnston Memorial. The program emphasizes the use of market-leading facility design, multi-specialty team-based care, highly trained and certified sub-specialty staff and an emphasis on patient-centered care.

Behavioral Health Services. Respond/Crisis Line provides information, assessment, and referral assistance to patients in need of psychiatric services. Services are provided at three locations. Woodridge provides inpatient care for children, adolescents, adults, and geriatric populations and outpatient services, including Intensive Outpatient Program for adults. Sycamore Shoals provides inpatient Geropsych services. Russell provides inpatient acute psychiatry and outpatient services for adults.

In addition to the services described above, the Alliance offers many other services throughout the region including emergency departments and urgent care centers, skilled nursing facilities, and the medical air transport service called *WINGS Air Rescue*.

In May 2013, the Alliance announced a clinical, strategic affiliation with Vanderbilt University Medical Center ("VUMC") in Nashville. The two organizations will collaborate clinically, with particular emphasis on cardiovascular and oncology services. As part of the affiliation agreement, VUMC and the Alliance will work together in the area of physician recruitment to facilitate access to specialists and subspecialists to serve the Northeast Tennessee/Southwest Virginia area and to develop consultative relationships among these specialists. VUMC and the Alliance will share best practices in the areas of evidence-based care models to enhance the care of patients. VUMC and the Alliance will collaborate on clinical trials that have the potential to benefit patients while making significant advances in medical research.

Medical Staff

As of May 31, 2013, there were 1,018 physicians and dentists on the Alliance's active, courtesy and consulting medical staffs. Of the 1,018 physicians on staff, 946 are board certified in their specialty. The average age of the medical staff is 49.95 years.

Medical staff appointment is available to licensed physicians, dentists, podiatrists and certain other professionals who are licensed to practice in the State of Tennessee or Virginia, as applicable, and who meet other specific requirements of the medical staff by-laws. Appointments and re-appointments are made by the Alliance Board of Directors upon the recommendations of the various medical staffs and the Alliance's administrative staff. Associate staff members are persons who have applied for active staff membership, but have been on the staff for less than two years.

The Alliance conducts a recruitment program to support the recruiting efforts of the affiliated medical staff. Recruiting assistance is provided to both private and university affiliated physicians as requested, and includes contracting and interaction with recruiting firms, receipt and screening of candidates' curriculum vitae, candidate site visit, and relocation and initial practice management assistance to the new physicians.

GOVERNANCE AND MANAGEMENT

Board of Directors

The management of the Alliance's affairs is vested in a Board of Directors consisting of not less than 9 and not more than 14 members, including the President/CEO, who serves as an ex-officio member. No more than twenty-five percent of the directors of the Board of Directors may consist of physicians. Except for the ex-officio member, directors serve for staggered three-year terms. Directors may be reappointed twice for a total of nine years on the Board before rotating off for at least one year before being reappointed. Standing committees of the Board of Directors include Executive, Finance, Governance and Corporate Audit and Compliance. Special committees may

be appointed by the Chairman of the Board for specific assignments. Current officers and members of the Board of Directors and their occupations and dates of expiration of their terms are set forth below:

<u>Name and Office Held</u>	<u>Business Affiliation</u>	<u>Term Expiration</u>
Clem Wilkes, Jr., Chairperson	Financial Advisor, Raymond James Financial Services	2014
Joanne Gilmer, Vice Chairperson	Retired, General Shale Brick	2016
Michael Christian, Treasurer	Retired, Banker	2015
Barbara Allen, Secretary	Small Business Owner, Stowaway Storage	2015
Bob Feathers, Past-Chair	President, Workspace Interiors, Inc.	2015
Sandra Brooks, M.D.	Pathologist, Watauga Pathology Associates	2015
Jeff Farrow, M.D.	Pulmonologist, Johnson City Medical Center	2015
Tom Fowlkes	General Counsel, The United Company	2015
Linda Garceau	Dean, College of Business & Technology, East Tennessee State University	2015
David May, M.D.	Anesthesiologist, Sycamore Shoals Anesthesia Assoc.	2016
Gary Peacock	Retired, Royal Mouldings Ltd.	2014
Rick Storey	Banker, Citizens Bank	2016

Further, five community-based boards serve as advisory boards for the Alliance’s Board of Directors. The community-based boards represent the communities serviced by the following facilities: (1) Sycamore Shoals, (2) Johnson County Community, (3) Russell, (4) Indian Path and (5) Franklin Woods and JCMC. Four governing boards serve the Alliance’s joint-ventured facilities and include: (1) Dickenson Community, (2) Johnston Memorial, (3) Norton Community, and (4) Smyth County Community. One other governing board oversees the operations of Blue Ridge Medical Management Corporation. The bylaws of the community boards are rooted in the Alliance’s bylaws and the remaining boards are distinguished through separate bylaws. The bylaws of each of the community boards provide that their boards consist of no fewer than nine and no more than 18 persons. No more than thirty-five percent of the directors of each Community Board may consist of physicians. Terms vary for the remaining boards, but are predominately staggered for three-year terms.

Management of the Corporation

The President and Chief Executive Officer, selected by the Board of Directors, manages the Alliance’s administrative staff and has the authority and responsibility of system-wide direction of the Alliance’s facilities, subject to policies adopted by the Board of Directors or any of its committees to which it has delegated power for such action. The principal members of the administrative staff of the Alliance are described below.

Dennis Vonderfecht (62) – President and Chief Executive Officer. Mr. Vonderfecht has served as President and CEO since January 1990. Prior to joining the Alliance, he was employed by Research Health Services System in Kansas City, Missouri, where he held the position of Regional Vice President. Mr. Vonderfecht worked for Humana, Inc. for approximately eight years in capacities such as: Administrative Specialist at Humana Hospital, Greensboro, North Carolina; Associate Administrator at Gibson General Hospital, Trenton, Tennessee; Associate Executive Director for Humana Hospital, Brandon, Florida; Associate Executive Director, Humana Hospital, Greensboro, North Carolina; Project Manager for Parkway Medical Center, Cary, North Carolina; and as Executive Director, Humana Hospital, Newnan, Georgia. Mr. Vonderfecht’s undergraduate study was at Colorado State University and the University of Nebraska, where he was awarded a B.S. degree in Business Administration. He obtained two master’s degrees from the University of Missouri: one in Business Administration and the other in

Hospital Administration. He also holds an honorary doctorate from Milligan College. He presently serves on the Boards of Directors of Premier, Inc., ETSU Foundation, Tennessee Hospital Association, Tennessee Business Roundtable, Tennessee Valley Corridor Inc., and the Tennessee Center for Performance Excellence. Mr. Vonderfecht currently serves as Chairman of the Board for the Tennessee Center for Performance Excellence and has previously served as Chairman of the Tennessee Hospital Association Board of Directors and Chairman of the Board of Hospital Alliance of Tennessee. Mr. Vonderfecht is a Fellow in the American College of Healthcare Executives. He has been the recipient of the Distinguished Service Award and the Meritorious Service Award from the Tennessee Hospital Association and was awarded the American College of Healthcare Executives Regent's Award. He has also been recognized with the Health Care Heroes Award, as well as the Cup of Kindness Award through the Tri-Cities Business Journal. In addition, Mr. Vonderfecht was presented with a "Leaders in Christian Service" award by Milligan College and has received recognition as an "Honorary Alumni" by East Tennessee State University. Mr. Vonderfecht has announced his intention to retire as of December 31, 2013. A search committee of the Board of Directors has been formed to find replacement candidates.

Marvin Eichorn (57) - Senior Vice President and Chief Financial Officer. Mr. Eichorn has served the Alliance since August 1998, when he joined as Senior Vice President/Regional Operations. He was named Chief Financial Officer in January 1999. As Senior Vice President/Chief Financial Officer, he is responsible for all of the financial operations and services of the Alliance as well as managed care and physician operation activities for the Alliance. Prior to joining the Alliance, he was employed by Covenant Health/Fort Sanders Health System in Knoxville, Tennessee in various positions over a 14 year period including Executive Vice President/Non-Hospital Operations and Executive Vice President/Chief Financial Officer. Mr. Eichorn is a Certified Public Accountant and is a member of various health care and finance organizations. His educational background includes a bachelor's degree in finance from the University of West Florida and a master's degree in business administration from Milligan College. In 2000, Mr. Eichorn received the Meritorious Service Award for an Executive Staff member from the Tennessee Hospital Association. He also serves on the board or key committees of various national and regional healthcare related organizations.

Candace Jennings (59) - Senior Vice President for Tennessee Operations. Ms. Jennings joined the Alliance in 2007 as Vice President and Chief Operating Officer for Washington County, Tennessee operations. Her current responsibilities include the strategy development and operation of the Alliance's eight Tennessee hospitals, including a critical access hospital (Johnson County Community Hospital), a children's hospital (Niswonger Children's Hospital) and a new, LEED certified hospital, Franklin Woods Community Hospital which opened in July 2010. Prior to joining Mountain States Health Alliance, she was Chief Nursing Officer for St. John's Hospital in Springfield, Illinois. As a consultant with Ernst and Young, she led organizations through transformational change specializing in organizational resizing and patient focused care. She has served as a health care leader for over 20 years in tertiary teaching hospitals in Alabama, Texas, Illinois and Tennessee. Her educational background includes bachelors and master's degrees in Nursing and a master's in Health Services Administration from the University of Alabama at Birmingham (UAB). Ms. Jennings has been a Fellow in ACHE since 2001.

Ann Fleming (65) - Senior Vice President of Regional Operations as well as the Cardiovascular, Oncology, Medicine Strategic Service Units and Outpatient Services. Since joining the Alliance in March 2007, Ms. Fleming has served as an examiner for the Tennessee Center for Performance Excellence and currently serves as a Board Member for the Senate Productivity and Quality Award and as a Board Member for the Virginia Hospital and Healthcare Association. Prior to joining the Alliance, Ms. Fleming served as the VP of Clinical Service Lines, Merrillville Hospital Administrator and as the Chief Nursing Officer at The Methodist Hospitals Inc., Gary and Merrillville, Indiana. As part of her work there, she launched the Cardiovascular, Oncology, Rehabilitation/Ortho/Neuro, Women's and Children Service Lines. Ms. Fleming also served as Rehabilitation Consultant at Porter Memorial Hospital, Valparaiso, Indiana, and served as an operating room nurse with the 475th MASH during Operation Desert Storm in Saudi Arabia and Iraq. She received a bachelor's degree in Nursing from the University of Kentucky and a master's degree in Public Administration from Kentucky State University. Ms. Fleming is a member of the American College of Health Care Executives, the Association of Nursing Executives and the Medical Group Management Association. She received the Army Commendation Medal in 1991. Ms. Fleming is a Registered Nurse and currently is licensed in Tennessee, Kentucky, Virginia and Indiana.

Morris Seligman (57) - Senior Vice President and Chief Medical Officer. Dr. Seligman joined the Alliance in January 2010, and has responsibility on a system-wide basis for Medical Staff Services, Graduate

Medical Education, Continuing Medical Education, Patient Resource Management (case management), Clinical Research, Accreditation, Infection Prevention, Patient Safety, Quality, Information Systems, Telecommunications, and Clinical Informatics. Prior to joining the Alliance, Dr. Seligman was employed by Trinity Regional Health System Quad Cities-Senior Affiliate of Iowa Health System, Illinois and Iowa, where he served as the Chief Medical Officer and Vice President for Physician Services. Dr. Seligman is a diplomat of the American Board of Quality Assurance Utilization Review Physicians, a Fellow of the American Institute of Healthcare Quality certified in Healthcare Quality Management (CHCQM), a Fellow of the American College of Physicians (FACP), a Fellow of the American College of Healthcare Executives (FACHE), and a Certified Physician Executive (CPE). Dr. Seligman also has a two year degree in Engineering Sciences. Dr. Seligman is a board certified internist by training and has practiced Internal Medicine, Emergency Medicine and Occupational Medicine. Dr. Seligman received his MD from the University of Missouri-Columbia and his BSBA/MBA from Washington University. Dr. Seligman also earned his CPA Certificate and previously worked at Arthur Andersen & Co.

SERVICE AREA, MARKET SHARE AND COMPETITION

Patient Origin

The Alliance operates hospital facilities located in the Counties of Washington, Sullivan, Carter, and Johnson in the northeastern region of Tennessee. In the southwestern region of Virginia, the Alliance operates facilities in the Counties of Smyth, Wise, Dickenson, Russell and Washington, and in the City of Norton. The core service area for the Alliance (the “Core Service Area”) consists of Washington, Sullivan, Carter, Johnson, Greene, Hawkins, and Unicoi Counties in Tennessee and Smyth, Russell, Wise (including the City of Norton), Dickenson, Scott, and Washington Counties (including Bristol City) in Virginia. Approximately 93.2% of the Alliance’s discharges originated from the Core Service Area for the fiscal year ended June 30, 2012. The patient origin analysis from all service areas (*i.e.*, both the Core Service Area and the Non-Core Service Area, as defined below) as a percent of the Alliance’s discharges for fiscal years 2009, 2010, 2011 and 2012 is presented in the following table:

Alliance Facilities Patient Origin By Fiscal Year (June 30)

	<u>2009</u>		<u>2010</u>		<u>2011</u>		<u>2012</u>	
	<u>Discharges</u>	<u>Percent</u>	<u>Discharges</u>	<u>Percent</u>	<u>Discharges</u>	<u>Percent</u>	<u>Discharges</u>	<u>Percent</u>
<u>Core Counties</u>								
Washington, TN	16,692	26.6%	16,351	26.8%	16,920	27.4%	16,724	26.8%
Sullivan, TN	8,044	12.8	7,795	12.8	7,732	12.5	7,971	12.8
Carter, TN	6,489	10.3	6,486	10.6	6,762	10.9	6,738	10.8
Wise, VA ¹	4,601	7.3	4,414	7.2	4,224	6.8	4,286	6.9
Greene, TN	2,757	4.4	2,672	4.4	2,547	4.1	2,450	3.9
Smyth, VA	3,825	6.1	3,673	6.0	3,707	6.0	3,582	5.7
Unicoi, TN	2,157	3.4	1,904	3.1	2,094	3.4	2,092	3.4
Johnson, TN	1,927	3.1	1,972	3.2	1,914	3.1	2,052	3.3
Hawkins, TN	1,675	2.7	1,546	2.5	1,539	2.5	1,520	2.4
Russell, VA	3,435	5.5	3,378	5.5	3,134	5.1	3,183	5.1
Dickenson, VA	1,330	2.1	1,456	2.4	1,479	2.4	1,407	2.3
Scott, VA	982	1.6	925	1.5	943	1.5	963	1.6
Washington, VA ⁽²⁾	4,574	7.3	4,248	7.0	4,595	7.4	5,109	8.2
Core Subtotal	58,488	93.2%	56,820	93.2%	57,590	93.2%	58,077	93.2%
Non-Core Subtotal	3,133	5.0%	3,030	5.0%	2,874	4.6%	3,216	5.2%
Other Areas Subtotal	1,104	1.8%	1,070	1.8%	1,360	2.2%	1,024	1.6%
Total	62,725	100.0%	60,920	100.0%	61,824	100.0%	62,317	100.0%

Source: The Alliance – Fiscal year data excludes normal newborns. Acquired facilities have been included from date of acquisition forward.

⁽¹⁾ Includes City of Norton, Virginia, data.

⁽²⁾ Includes City of Bristol, Virginia, data.

The Alliance has a strong extended market encompassing numerous counties in northeastern Tennessee, western North Carolina, southwestern Virginia, and southeastern Kentucky (the “Non-Core Service Area” and, together with the Core Service Area, the “Service Area”), as shown in the map in “Service Areas and Facility Locations” below. As the table above shows, approximately 5.2% of discharges for the fiscal year ended June 30, 2012, were from the Non-Core Service Area, and approximately 1.6% of discharges were from beyond the Service Area. With the addition of Smyth County Community, Norton Community, Dickenson Community, Russell, and Johnston Memorial, the percentage of discharges from Virginia has increased. The Alliance is also a referral center for numerous advanced services such as high-risk obstetrics, perinatology, neonatology, cardiology, oncology and medical surgeries (including laparoscopies), and therefore serves many patients from outside the Service Area.

Service Area Facilities

The principal competitor of the Alliance in the Core Service Area is Wellmont Health System (“Wellmont”), which operates eight hospitals within the Alliance’s Core Service Area: Holston Valley Medical Center, in Kingsport, Tennessee; Bristol Regional Medical Center, in Bristol, Tennessee; Hawkins County Memorial Hospital, in Rogersville, Tennessee; Lonesome Pine Hospital, in Big Stone Gap, Virginia; Mountain View Regional Medical Center, in Norton, Virginia; Hancock County Hospital, in Sneedville, Tennessee; Takoma Regional Hospital, in Greeneville, Tennessee; and Lee Regional Medical Center, in Pennington Gap, Virginia. Certain operating statistics for the facilities of the Alliance and Wellmont located within Tennessee are set forth below:

**Core Service Area - Tennessee Hospitals
Facility Information and Selected Utilization Data – Fiscal 2011**

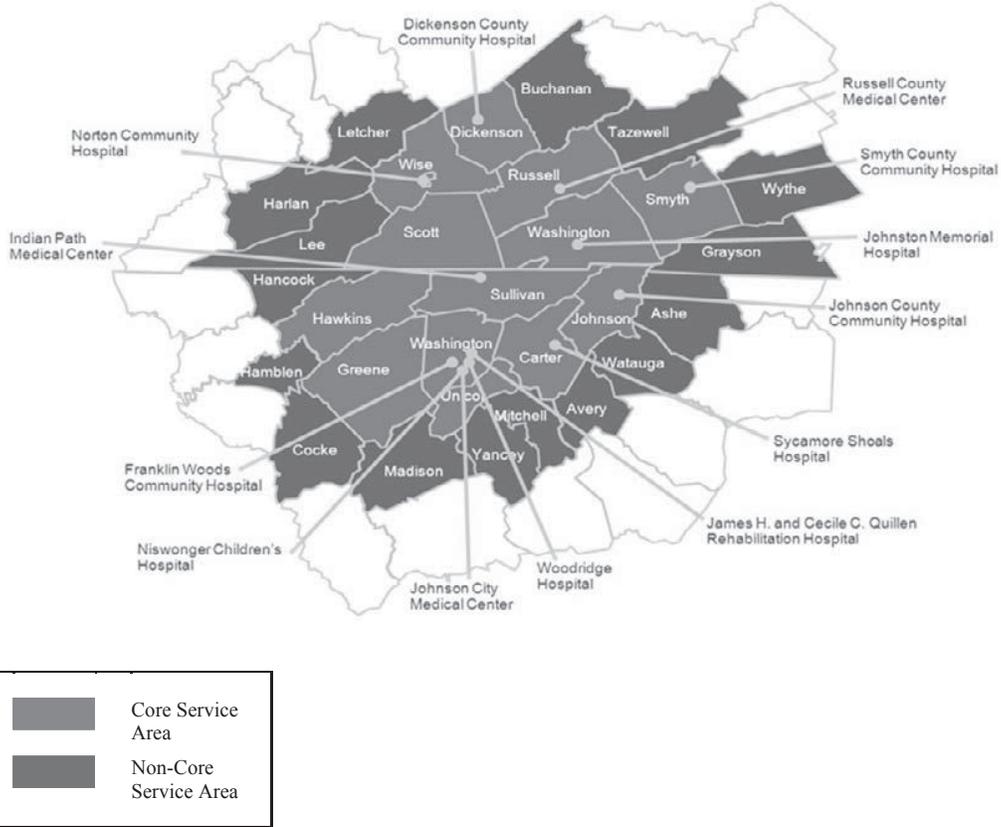
	County in Tennessee	Licensed Beds	Staffed Beds	Total Discharges	Total Patient Days	Average Daily Census
<u>Mountain States Health Alliance</u>						
Johnson City Medical Center	Washington	514	514	26,111	133,256	365
Quillen Rehabilitation Hospital	Washington	60	60	654	8,453	23
Woodridge Hospital	Washington	84	84	3,412	19,827	54
Franklin Woods Community Hospital	Washington	80	80	4,431	24,785	68
Indian Path Medical Center	Sullivan	261	189	6,823	29,534	81
Sycamore Shoals Hospital	Carter	121	79	3,640	15,299	42
Johnson County Community Hospital	Johnson	2	2	20	43	0
MSHA Subtotal		1,122	1,008	45,091	231,197	633
<u>Wellmont Health System</u>						
Holston Valley Medical Center	Sullivan	505	339	19,931	91,756	251
Bristol Regional Medical Center	Sullivan	312	261	15,293	66,214	181
Hawkins County Memorial Hospital	Hawkins	50	46	1,603	5,153	14
Hancock County Hospital	Hancock	10	10	245	808	2
Takoma Regional Hospital	Greene	100	100	2,494	11,508	32
Wellmont Subtotal		977	756	39,566	175,439	480
<u>Other Core Service Area Facilities</u>						
Laughlin Memorial Hospital	Greene	140	140	3,813	16,131	44
Healthsouth Rehabilitation Hospital	Sullivan	50	50	947	14,500	40
Unicoi County Memorial Hospital	Unicoi	48	15	1,214	4,568	13
Other Core Service Area Facilities		238	205	5,974	35,199	97
Core Service Area Total		2,337	1,969	90,631	441,835	1,210

Source: 2011 Tennessee Joint Annual Reports.

Service Areas and Facility Locations

The Alliance’s Core and Non-Core Service Areas are depicted in the map set forth below:

**Mountain States Health Alliance
Service Area**



Market Share

Market share represents the proportion of service area residents discharged from each of the service area hospitals. Market share by hospital for the defined service area was calculated using data published by the Tennessee Hospital Association, the Virginia Hospital and Healthcare Association and the North Carolina Hospital Association. Hospital specific discharges are divided by service area specific discharges to estimate market share for each of the service area hospitals.

The Alliance maintains the largest market share of its core service area, capturing over 52.6% of the market for the calendar year ended 2011. Wellmont’s facilities had a market share for the same period of approximately 37.0%. The following tables present calendar years 2007, 2008, 2009, 2010 and 2011, Core Service Area and total Service Area market share information for facilities currently owned or controlled by the Alliance and Wellmont.

Core Service Area Market Share Summary

System	Hospital Name	Calendar 2007		Calendar 2008		Calendar 2009		Calendar 2010		Calendar 2011	
		Discharges	% of Total								
<u>MSHA</u>	Johnson City Medical Center	24,427	24.3%	25,095	24.9%	25,168	25.9%	25,048	25.8%	23,996	24.7%
	Indian Path Medical Center	5,340	5.3	5,867	5.8	5,526	5.7	6,035	6.2	5,970	6.1
	Sycamore Shoals Hospital	4,031	4.0	3,724	3.7	3,206	3.3	3,225	3.3	3,556	3.7
	Franklin Woods Community Hospital	3,106	3.1	2,655	2.6	2,384	2.5	2,683	2.8	3,920	4.0
	Johnson County Community Hospital	40	0.0	44	0.0	31	0.0	24	0.0	26	0.0
	Smyth County Community Hospital	2,139	2.1	2,113	2.1	2,164	2.2	1,958	2.0	1,664	1.7
	Norton Community Hospital	4,793	4.8	4,139	4.1	3,980	4.1	3,636	3.8	3,696	3.8
	Dickenson Community Hospital	757	0.8	366	0.4	7	0.0	2	0.0	1	0.0
	Russell County Medical Center	2,270	2.3	2,242	2.2	2,298	2.4	2,099	2.2	1,993	2.0
	Johnston Memorial Hospital	4,979	4.9	5,656	5.6	5,496	5.6	5,534	5.7	6,400	6.6
MSHA Total		51,882	51.5%	51,901	51.4%	50,260	51.7%	50,244	51.8%	51,222	52.6%
<u>Wellmont</u>	Wellmont Holston Valley Medical Center	16,556	16.4	16,057	15.9	16,260	16.7	16,724	17.3	16,308	16.8
	Wellmont Bristol Regional Medical Center	12,288	12.2	12,676	12.6	12,455	12.8	12,831	13.2	12,827	13.2
	Wellmont Lonesome Pine Hospital	2,745	2.7	2,656	2.6	2,181	2.2	2,005	2.1	1,785	1.8
	Wellmont Hawkins County Memorial Hospital	1,699	1.7	1,778	1.8	1,639	1.7	1,521	1.6	1,419	1.5
	Wellmont Hancock County Hospital	11	0.0	9	0.0	10	0.0	10	0.0	9	0.0
	Takoma Regional Hospital	2,227	2.2	2,320	2.3	2,093	2.2	1,827	1.9	1,939	2.0
	Lee Regional Medical Center	136	0.1	151	0.1	153	0.2	146	0.2	127	0.1
	Mountain View Regional Medical Center	1,880	1.9	2,058	2.0	1,597	1.6	1,601	1.7	1,605	1.6
Wellmont Total		37,542	37.3%	37,705	37.4%	36,388	37.4%	36,665	37.8%	36,019	37.0%
<u>All Other</u>		11,271	11.2%	11,272	11.2%	10,628	10.9%	10,022	10.3%	10,076	10.4%
Grand Total		100,695	100.0%	100,878	100.0%	97,276	100.0%	96,931	100.0%	97,317	100.0%

Source: Tennessee Hospital Association, the Virginia Hospital and Healthcare Association, and the North Carolina Hospital Association.

Notes:

Information based on calendar year and excludes normal newborns, psych, substance abuse, and rehab.

Acquired facilities are fully included retrospectively.

JCMC, Quillen, and Woodridge are reported together as "Johnson City Medical Center" because they operate under a single license.

Franklin Woods reflects historical values for North Side Hospital and Johnson City Specialty Hospital prior to June 2010.

Total Service Area Market Share Summary

System	Hospital Name	Calendar 2007		Calendar 2008		Calendar 2009		Calendar 2010		Calendar 2011	
		Discharges	% of Total								
<u>MSHA</u>	Johnson City Medical Center	25,677	17.2%	26,404	17.6%	26,472	18.2%	26,259	18.3%	25,213	17.6%
	Indian Path Medical Center	5,547	3.7	6,091	4.1	5,711	3.9	6,242	4.4	6,162	4.3
	Sycamore Shoals Hospital	4,048	2.7	3,736	2.5	3,214	2.2	3,239	2.3	3,576	2.5
	Franklin Woods Community Hospital	3,133	2.1	2,686	1.8	2,398	1.7	2,714	1.9	3,941	2.8
	Johnson County Community Hospital	40	0.0	46	0.0	31	0.0	24	0.0	26	0.0
	Smyth County Community Hospital	2,417	1.6	2,348	1.6	2,399	1.7	2,197	1.5	1,855	1.3
	Norton Community Hospital	5,085	3.4	4,337	2.9	4,174	2.9	3,807	2.7	3,887	2.7
	Dickenson Community Hospital	765	0.5	369	0.2	7	0.0	2	0.0	1	0.0
	Russell County Medical Center	2,563	1.7	2,478	1.7	2,587	1.8	2,368	1.7	2,237	1.6
	Johnston Memorial Hospital	<u>5,342</u>	<u>3.6</u>	<u>6,094</u>	<u>4.1</u>	<u>5,978</u>	<u>4.1</u>	<u>5,928</u>	<u>4.1</u>	<u>6,820</u>	<u>4.8</u>
MSHA Total		54,617	36.5	54,589	36.4	52,971	36.5	52,780	36.8	53,718	37.6
<u>Wellmont</u>	Wellmont Holston Valley Medical Center	18,504	12.4	17,984	12.0	18,155	12.5	18,723	13.1	18,453	12.9
	Wellmont Bristol Regional Medical Center	13,160	8.8	13,831	9.2	13,696	9.4	14,102	9.8	14,180	9.9
	Wellmont Lonesome Pine Hospital	3,377	2.3	3,266	2.2	2,681	1.8	2,421	1.7	2,215	1.6
	Wellmont Hawkins County Memorial Hospital	1,808	1.2	1,866	1.2	1,704	1.2	1,597	1.1	1,487	1.0
	Wellmont Hancock County Hospital	375	0.3	360	0.2	303	0.2	243	0.2	202	0.1
	Takoma Regional Hospital	2,358	1.6	2,441	1.6	2,219	1.5	1,935	1.3	2,056	1.4
	Lee Regional Medical Center	2,768	1.9	2,509	1.7	2,370	1.6	2,398	1.7	2,172	1.5
	Mountain View Regional Medical Center	<u>1,977</u>	<u>1.3</u>	<u>2,132</u>	<u>1.4</u>	<u>1,652</u>	<u>1.1</u>	<u>1,661</u>	<u>1.2</u>	<u>1,661</u>	<u>1.2</u>
Wellmont Total		44,327	29.6%	44,389	29.6%	42,780	29.5%	43,080	30.0%	42,426	29.6%
<u>All Other</u>		<u>50,651</u>	<u>33.9%</u>	<u>51,003</u>	<u>34.0%</u>	<u>49,314</u>	<u>34.0%</u>	<u>47,553</u>	<u>33.2%</u>	<u>46,974</u>	<u>32.8%</u>
Grand Total		149,595	100.0%	149,981	100.0%	145,065	100.0%	143,413	100.0%	143,118	100.0%

Source: Tennessee Hospital Association, the Virginia Hospital and Healthcare Association, and the North Carolina Hospital Association.

Notes:

Information based on calendar year and excludes normal newborns, psych, substance abuse, and rehab.

Acquired facilities are fully included retrospectively. JCMC, Quillen, and Woodridge are reported together as "Johnson City Medical Center" because they operate under a single license.

Franklin Woods reflects historical values for North Side Hospital and Johnson City Specialty Hospital prior to June 2010.

Demographic and Socio-Economic Characteristics of the Service Area

The following table provides information on major employers in the region:

Major Employers in the PSA/SSA

<u>Rank</u>	<u>Employer</u>	<u>Headquarters</u>	<u>Estimated Employees</u>	<u>Industry</u>
1	K-VA-T Food Stores	Abingdon, VA	13,033	Retail Supermarkets
2	Mountain States Health Alliance	Johnson City, TN	9,130	Health Care
3	Eastman Chemical Company	Kingsport, TN	6,675	Manufacturing
4	Wellmont Health System	Kingsport, TN	4,849	Health Care
5	East Tennessee State University	Johnson City, TN	2,280	Higher Education
6	James H. Quillen VA Medical Center	Mountain Home, TN	2,000	Govt Health Care Facility
7	Citi Cards	Gray, TN	1,700	Retail/Call Center
8	Sullivan County Dept. of Education	Blountville, TN	1,646	Education
9	Advanced Call Center Technologies	Jonesborough, TN	1,358	Call Center
10	Hawkins County Schools	Rogersville, TN	1,300	Education
11	Washington County Dept. of Education	Jonesborough, TN	1,200	Education
12	A.O. Smith Water Products Company	Johnson City, TN	1,081	Manufacturing
13	Kingsport City Schools	Kingsport, TN	1,050	Education
14	Frontier Health	Gray, TN	1,007	Health Care
15	DTR Tennessee, Inc.	Midway, TN	1,000	Manufacturing

Source: The Business Journal of Tri-Cities/Virginia, Book of Lists, 2012.

SOURCES OF REVENUE

Patient service payments are made to the Alliance by commercial insurance carriers, the federal government under the Medicare program, the State of Tennessee under the TennCare program and surrounding states under their Medicaid programs. The table below shows the percentage of gross patient revenues received by the Alliance from each program and from private pay.

Gross Patient Revenues by Source of Payment (Payor Mix)

	<u>Audited</u>				<u>FY13</u>
	<u>Fiscal Years Ended June 30</u>				<u>As of March 31</u>
	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>
Medicare	42.0%	43.4%	43.7%	44.1%	44.3%
TennCare/Medicaid	15.0	14.2	13.7	14.1	14.1
Managed Care/ Commercial and Other	35.7	34.2	34.2	33.3	32.4
Private Pay	7.3	8.2	8.4	8.5	9.2
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Source: The Alliance.

Medicaid and Medicare

Approximately 44% and 14% of the gross patient service charges of the Alliance for the fiscal year ended June 30, 2012, were derived from the Medicare and TennCare/Medicaid programs, respectively. Medicare provides certain health care benefits to beneficiaries who generally are 65 years of age and older, are long term disabled, or qualify for the end stage renal disease (“ESRD”) program. Medicare Part A covers, among other things, inpatient

hospital services, skilled nursing care, hospice and some home health care. Medicare Part B covers, among other things, physician services, outpatient hospital services and some supplies. TennCare/Medicaid is designed to pay providers for care given to the medically indigent and others who receive federal aid.

TennCare/Medicaid

The State of Tennessee transferred a portion of its Medicaid program to a managed care program (“TennCare”) under a Section 1115 Waiver effective January 1, 1994. The long term care and ESRD Medicaid programs were not transferred to TennCare. The TennCare program also covers a number of uninsured non-Medicaid beneficiaries.

Medicare

Medicare pays acute care hospitals for most services provided to inpatients under a payment system known as the Prospective Payment System (“PPS”). Separate PPS payments are made for inpatient operating costs and inpatient capital costs.

Inpatient Operating Costs. Under PPS, acute care hospitals are reimbursed for inpatient operating costs on a per-discharge basis at fixed rates established for identified Diagnosis Related Groups (“DRGs”). DRG classification is based on the diagnosis at discharge and major procedures and other factors for each particular Medicare patient. The amount to be paid for each DRG is established prospectively by the Centers for Medicare and Medicaid Services (“CMS”), an agency of the United States Department of Health and Human Services (“HHS”), and is not related to a hospital’s actual costs. For certain Medicare beneficiaries who have unusually costly hospital stays (referred to as “outliers”), CMS will provide additional payments above those specified for the DRG.

The prospective payment rate is updated annually based upon the hospital “market basket” index, which generally measures changes in the cost of providing health care services. Future adjustments are subject to change by Congress. There is no assurance that these or any future increases in the prospective payment rates will keep pace with the increases in the cost of providing hospital services.

CMS reviews and publishes changes in the DRG classification system at least annually. This process is intended to ensure that each DRG is clinically coherent and represents an acceptable range of resource consumption. There is no assurance that the Alliance will be paid amounts which will reflect adequately changes in the cost of providing health care or in the cost of health care technology being made available to patients.

Costs of Medical Education. Medicare pays for certain direct and indirect costs associated with medical education. Payment for the indirect costs of medical education will be made as an adjustment to the federal rate for capital-related costs during the transition to PPS for inpatient capital-related costs. The indirect medical education adjustment for capital-related costs is based in part on the ratio of a hospital’s number of full-time equivalent (“FTE”) residents to its average daily census. Medicare also adjusts the inpatient operating PPS payment for indirect costs of medical education. This adjustment is based in part on the ratio of FTE residents to beds. Payment for direct medical education is based on a per resident rate adjusted by inflation and the number of current-year reimbursable resident positions.

Disproportionate Share. Section 402 of the Medicare Prescription Drug, Improvement, and Modernization Act (“MMA”) provides for payments to hospitals serving a large number of low-income patients, which qualifies them for a Medicare Disproportionate Share (“DSH”) payment adjustment. Payment is based on the SSI% plus Medicaid Eligible Patient Days to Total Patient Days. There is no assurance in the future that the Alliance will be paid amounts to adequately offset the additional costs of providing services to low income patients to Acute and Rehabilitation services. A rule recently proposed by CMS indicates that the DSH will be based on 25% of the current calculation (SSI% + Medicaid Eligible Patient Days to Total) and 75% (88.8% of the uncompensated care pool x Medicaid Eligible Days + SSI Days).

Costs of Outpatient Services. Ambulatory payment classifications (“APCs”) form the basis for outpatient PPS. Services in each APC are similar clinically and with respect to the resources necessary to provide the services.

Generally, the primary classification variable under the APC system is the procedure performed rather than the patient's diagnosis, as is the case with the DRG system. Each APC is assigned a payment rate based on median (or, if the Secretary of HHS so chooses, mean) hospital costs for procedures performed, weighted by procedure volume. Beneficiary coinsurance amounts are established for each APC based on 20 percent of the national median of charges for APC services. The APC payment and beneficiary's coinsurance amounts for outpatient services will be adjusted to reflect geographic wage variations and other factors determined to be necessary by the Secretary of HHS. Annual payment updates are based on the hospital market basket index. As with inpatient hospital services, there is no assurance that future increases in the prospective payment rates will reflect adequately the changes in the costs of providing outpatient services.

Costs of Inpatient Rehabilitation Facilities (IRF). Under IRF PPS, Federal rates are adjusted to reflect patient case mix, resource intensity associated with the patients clinical condition, and facility characteristics. Cases are grouped into case-mix groups (CMGs) and are further classified into four tiers driven by conditions that are secondary to the principal diagnosis. Rates are paid to reflect all costs of furnishing IRF services for routine, ancillary, and capital. There is no assurance that the Alliance will be paid amounts that will sufficiently match all costs associated with care.

Costs of Psychiatric Facilities (IPF). Under the IPF PPS, services are reimbursed under Federal Per Diem rates to include Operating and Capital costs. Payment is based on geographic factors, patient characteristics (DRG, age, length of stay and presence of specified comorbidities), facility characteristics, services received in a qualified Emergency Department and Electroconvulsive Therapy.

Costs of Skilled Nursing Facilities. Medicare reimbursements for skilled nursing facility ("SNF") stays are also based on a prospective payment system that requires "bundling" of virtually all SNF services, similar to the current practice for hospital inpatient services. A SNF therefore is responsible for providing or arranging to provide all Medicare services (subject to certain exceptions) needed by a SNF patient, and could potentially receive less than it costs the SNF to provide or arrange to provide those services. Accordingly, there can be no assurance that the aggregate amount of payments under SNF PPS will be sufficient to cover all of the Alliance's actual costs of providing SNF services to Medicare beneficiaries.

Physician Services. Physicians are reimbursed under Medicare based on their professional services according to the lesser of the actual charge or the amount determined from a resource-based relative value scale (RBRVS) fee schedule. The fee schedule is subject to update by the Secretary of HHS and Congress on an annual basis.

Electronic Health Records (EHR) Costs. The American Recovery Act of 2009 provides for incentive payments for Medicare and Medicaid eligible professionals and hospitals to purchase and implement meaningful use certified EHR technology. Payments provide an incentive for the "meaningful use" of certified EHR technology and to achieve health care and efficiency goals. The incentive payment will be paid out over a period of five years, which offsets the costs of purchase and implementation of the products. There is no indication that future rule-making will extend payments beyond the five years.

Audits, Exclusions, Fines and Enforcement Action. Hospitals participating in Medicare are subject to audits and retroactive audit adjustments by a Medicare Audit Contractor under the Medicare program. From an audit, a Medicare Audit Contractor may conclude, for example, that a patient has been discharged under an incorrect DRG, that services may not have been provided under the direct supervision of a physician (to the extent so required), that a patient should not have been characterized as an inpatient, that certain services provided prior to an admission as an inpatient should not have been billed as outpatient services or that certain required procedures or processes were not satisfied. As a consequence, payments may be retroactively disallowed. Under certain circumstances, payments made may be determined to have been made as a consequence of improper claims subject to the federal False Claims Act or other federal statutes, subjecting the hospital to civil or criminal sanctions. Generally, the Alliance maintains limited reserves for anticipated or proposed audit adjustments which are likely to be contested. Nevertheless, such adjustments may exceed such reserves and may be substantial. Medicare regulations also provide for withholding Medicare payment in certain circumstances, and such withholdings could have a substantial adverse effect on the financial condition of the Alliance.

Management of the Alliance is not aware of any situation in which reserves are inadequate or a material amount of Medicare payments is being withheld. The Alliance utilizes internal and external resources to review and audit practice compliance with policies, procedures, applicable laws and regulations. Whenever such reviews identify practice deviation from policies, procedures, applicable rules and regulations, management is obligated to refund any overpayments as part of the Alliance’s continuous improvement processes. Currently, management is unaware of any deviations that may have a material adverse effect on the results of the operations or financial condition of the Alliance.

Commercial Managed Care and Other

The Alliance contracts with certain private third party payors. Contractual agreements with these payors include reimbursement arrangements such as discounted charges, per diem amounts and capitated payments. The Alliance actively manages these contracts and negotiates terms that are in the best interest of the Alliance and its patients. While not participating in all commercial contracts, the Alliance participates in the vast majority of contracts covering the population of its primary service area.

Additionally, the Alliance treats patients with no insurance coverage. Those meeting certain income requirements are treated at no cost to the patient. Those not qualifying for this classification are classified as “self-pay” and reimburse the Alliance privately for the services rendered.

HISTORICAL UTILIZATION INFORMATION

The table below provides historic system-wide patient utilization data for the Alliance for the fiscal years ended June 30, 2009 through June 30, 2012 and the nine months ended March 31, 2013. The number reflects the inclusion of the following facilities as of the following dates: Russell – January 31, 2008, and Johnston Memorial – April 1, 2009.

	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	As of March 31,	
					<u>2012</u>	<u>2013</u>
Occupancy Rate (licensed)	45%	46%	47%	48%	49%	50%
Patient Days	283,555	291,986	288,167	292,910	221,237	211,695
Admissions	57,127	60,102	61,035	61,154	46,165	44,080
Average Daily Census	777	800	789	800	804	773
Avg Length of Stay (days)	5.0	4.9	4.7	4.8	4.8	4.8
Outpatient Visits	1,511,699	1,604,036	1,546,325	1,590,307	1,227,951	1,243,180
ER Visits	219,983	250,942	242,677	246,821	183,660	189,064
Surgical Cases	38,812	39,313	38,521	36,971	28,109	27,309
Births	4,371	4,684	4,511	4,505	3,367	3,347
Newborn Days	8,569	9,112	9,287	9,116	6,910	6,561
Licensed Beds	1,841	1,789	1,749	1,623	1,623	1,623

Source: The Alliance.

CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS

The following Condensed Summary of Revenue and Expenses (the “Condensed Summary”) for each of the five Fiscal Years ended June 30, 2008 through June 30, 2012, is derived from the Alliance’s audited financial statements for those Fiscal Years. The annual financial statements were audited by Pershing Yoakley & Associates, P.C. The financial information for the nine month period ended March 31, 2013, is unaudited and reflects, in the opinion of the Alliance, all adjustments necessary to summarize fairly the results for such period on a basis consistent with that used in preparing the annual financial statements for the years ended June 30, 2008 through June 30, 2012. The financial statements include the assets and liabilities and reflect the revenue and expenses of the Alliance and all consolidated entities, including those that are not Obligated Issuers.

The Condensed Summary as well as the audited financial statements included in Appendix B and the unaudited financial statements included as Appendix C are for all entities consolidated with the Alliance for

accounting purposes (the “Consolidated Entities”) and therefore reflect the assets, liabilities, revenues and expenses of entities that are not Obligated Issuers (see “THE ALLIANCE” in the front half of this Official Statement). For the fiscal year ended June 30, 2012, the Obligated Issuers accounted for approximately 91% of the total assets and 82% of the total revenue of the Consolidated Entities.

The following Condensed Summary of Consolidated Revenue and Expenses should be read in conjunction with the audited financial statements and notes contained in Appendix B hereto.

Condensed Summary of Revenue and Expenses

	Audited Fiscal Years Ended June 30					(Unaudited) Nine Months Ended March 31, <u>2012</u>	(Unaudited) Nine Months Ended March 31, <u>2013</u>
	(In Thousands)					(In Thousands)	(In Thousands)
	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	Audited <u>2012</u> ⁽⁸⁾	<u>2013</u>	
Revenues:							
Net patient service revenue	\$726,542	\$822,898	\$928,270	\$945,875	\$952,133	\$713,597	\$706,849
Other revenue	16,098	17,046	16,009	24,868	39,407	20,991	36,530
Total Revenue, Gains and Support	<u>742,640</u>	<u>839,944</u>	<u>944,279</u>	<u>970,743</u>	<u>991,540</u>	<u>734,588</u>	<u>743,379</u>
Expenses:							
Operating expenses	633,842	719,193	806,379	815,687	862,007	644,858	651,556
Depreciation and Amortization	60,048	68,523	81,559	90,058	75,305	55,858	58,210
Interest and Taxes	44,581	45,225	42,264	44,153	45,903	35,446	32,404
Total Expenses	<u>738,471</u>	<u>832,941</u>	<u>930,202</u>	<u>949,898</u>	<u>983,215</u>	<u>736,162</u>	<u>742,170</u>
Operating Income (loss)	4,169	7,003	14,077	20,845	8,325	(1,574)	1,209
Net non-operating gains (losses) ⁽¹⁾	(74,343) ⁽²⁾	(89,683) ⁽³⁾	30,598 ⁽⁴⁾	65,817 ⁽⁵⁾	19,651 ⁽⁶⁾	19,534 ⁽⁷⁾	44,780 ⁽⁸⁾
Excess of Revenue, Gains and Support Over Expenses and Losses	<u>\$ (70,174)</u>	<u>\$ (82,680)</u>	<u>\$ 44,675</u>	<u>\$ 86,662</u>	<u>\$ 27,976</u>	<u>\$ 17,960</u>	<u>\$ 45,988</u>

Source: The Alliance.

⁽¹⁾ Net non-operating gains and losses include the change in fair value of derivatives and realized and unrealized gains and losses on investments.

⁽²⁾ Includes \$20.6 million of unrealized losses on derivatives, and \$57.7 million loss on early extinguishment of debt and \$33.4 million of unrealized losses on investments.

⁽³⁾ Includes \$42.1 million of unrealized losses on derivatives and \$62.6 million of unrealized losses on investments.

⁽⁴⁾ Includes \$8.6 million of unrealized losses on derivatives, and \$15.0 million of unrealized gains on investments.

⁽⁵⁾ Includes \$23.0 million of unrealized gains on derivatives and \$22.2 million of unrealized gains on investments.

⁽⁶⁾ Includes \$6.2 million of unrealized losses on derivatives and \$2.9 million of unrealized losses on investments.

⁽⁷⁾ Includes \$2.022 million of unrealized losses on derivatives and \$2.757 million of unrealized gains on investments.

⁽⁸⁾ Includes \$11.4 million of unrealized gains on derivatives and \$15.0 million of unrealized gains on investments.

⁽⁹⁾ In Fiscal 2012, the Alliance early adopted Financial Accounting Standards Board Update 2011-07, which requires reclassification of bad debt expense from an operating expense to a deduction from patient service revenue. For 2012, bad debt of \$7.057 million is classified as a deduction from net revenue and \$6.174 million for 2011, for all years prior to 2011, bad debt is classified as an operating expense. In Fiscal 2012, revenue of \$5.611 million related to durable medical equipment and retail pharmacy is included in other revenue and \$8.205 million for 2011. Prior to 2011, this revenue was included in net patient service revenues.

TRENDS IN UNRESTRICTED LIQUIDITY AND LEVERAGE

The following table provides information on unrestricted liquidity and leverage for the fiscal years ended June 30, 2008 through June 30, 2012, and the nine months ended March 31, 2013.

	Fiscal 2008	Fiscal 2009	Fiscal 2010	Fiscal 2011	Fiscal 2012	Unaudited Nine months ended March 31, 2013
Total Unrestricted Cash (\$ in Thousands)	\$466,478	\$515,066	\$551,608	\$592,537	\$531,151	\$575,966
Total Days' Cash on Hand	246	249	240	252	214	231
Unrestricted Net Assets (\$ in Thousands)	\$349,081	\$272,049	\$317,433	\$400,395	\$436,388	\$480,238
Net Long Term Debt to Capitalization⁽¹⁾	68.0% ⁽²⁾	74.7%	71.2%	67.5%	65.4%	67.6%

⁽¹⁾ For purposes of calculating the ratio, Net Long-Term Debt is determined net of debt service reserve funds and moneys held in principal and interest funds.

⁽²⁾ The increase in Net Long Term Debt to Capitalization in Fiscal Year 2008 was due in part to the \$57.7 million loss on early extinguishment of debt. The Net Long Term Debt to Capitalization, excluding the loss on early extinguishment of debt, was 65.1%.

MANAGEMENT'S DISCUSSION OF FINANCIAL PERFORMANCE

Overview

The Alliance has maintained a positive operating income for each of the last six fiscal years, reflecting rises in net patient service revenues that have generally kept pace with increases in expenses. However, non-operating losses from derivatives and other investments resulted in deficits of revenue, gains, and support over expenses for Fiscal 2008 and 2009. The losses from derivatives are discussed further below. The losses from other investments resulted from losses in market value reflecting primarily the general market decline in the value of securities in the Alliance's investment portfolio. Beginning in Fiscal 2007, operating income or losses for recent acquisitions is included (Fiscal 2008: Norton/Dickenson – 8 months and Russell – 5 months, Fiscal 2009: Johnston Memorial – 3 months).

Fiscal 2011

Operating Income for Fiscal 2011 was \$20.845 million compared with \$14.077 million for the same period in Fiscal 2010. The Operating Margin for Fiscal 2011 was 1.9%, compared with 1.5% for the same period in Fiscal 2010. Moreover, net non-operating gains of \$65.817 million, reflecting primarily \$20.600 million of income realized from investments, \$22.168 million of unrealized income from investments, and \$23.049 million in gains derived from interest rate swaps and derivatives, produced an \$86.662 million excess of revenue, gains and support over expenses.

Fiscal 2012

Operating Income for Fiscal 2012 was \$8.325 million compared with \$20.845 million for the same period in Fiscal 2011. The Operating Margin for Fiscal 2012 was 0.8%, compared with 1.9% for the same period in Fiscal 2011. Net non-operating gains of \$19.651 million, reflecting primarily \$28.733 million of income realized from investments, \$2.884 million of unrealized losses from investments, and \$6.198 million in losses derived from interest rate swaps and derivatives, produced a \$27.976 million excess of revenue, gains and support over expenses. The decrease in operating margin was due to a decline in surgical admissions and an increase in operating expenses. The increase in operating expenses was mainly due to increases in physician salaries and fees.

Nine Months Ended March 31, 2013

For the first nine months of fiscal year 2013, the Alliance had total revenue of \$743.4 million, compared to \$734.6 million for the first nine months of fiscal year 2012. Operating expenses for the first nine months of this fiscal year were \$742.2 million, compared to \$736.2 million for the first nine months of last fiscal year, resulting in an operating gain of \$1.2 million, compared to a loss of \$1.6 million for the same period in the prior year. Non-operating gains were \$44.8 million for the first nine months of the current fiscal year, including \$11.4 million of unrealized gains on derivatives, compared to non-operating gains of \$19.5 million for the first nine months of fiscal year 2012, resulting in an Excess of Revenue, Gains and Support over Expenses and Losses of \$46.0 million, compared to \$18.0 million for the same nine month period of fiscal year 2012.

Interest Rate Swaps and Derivatives

The Alliance has utilized several forms of derivative financial instruments, including interest rate swaps, constant maturity swaps and total return swaps, in order to lower the cost of debt and reduce interest rate risk.

As of April 30, 2013 the Alliance had a total of approximately \$591,500,000 (notional amount) of total return swaps, basis swaps, and constant maturity basis swaps with Bank of America, which swaps have been implemented as part of a carefully managed program. Through this program, the Alliance has realized approximately \$49,500,000 of savings since 2001. In January and May of 2011, the Alliance “locked in” approximately \$16,000,000 of future cash payments through April 2014 on \$438,000,000 (notional amount) of the constant maturity basis swaps. In January 2011, the Alliance converted two fixed payor swaps, totaling \$132,000,000 (notional amount), to basis swaps. As of April 30, 2013, the market value of all these swaps was negative \$1,660,000 with no collateral currently posted to Bank of America.

The Alliance also has a \$5,600,000 (notional amount) interest rate swap with First Tennessee Bank. As of April 30, 2013 the market value of this swap was negative \$92,000. Additionally, the Alliance previously had \$106,000,000 (notional amount) of total return and fixed payor swaps with Lehman Brothers Special Financing, Inc. (“Lehman”). As of September 30, 2012, the Alliance had posted \$13,800,000 of collateral under the Lehman swap agreements. In the fall of 2008, Lehman notified the Alliance that these transactions were going to be terminated as of January 1, 2009. The termination did not occur, due to a dispute between counterparties regarding the amount of the cost of the termination. In October 2012, both parties reached an agreement to fully settle the liability in which the Alliance paid the counterparty from the funds held as collateral and the remaining collateral was returned to the Alliance.

Additional Indebtedness

Other than the surgical services improvements currently underway at JCMC, the Alliance has no significant capital expenditures planned or in process for the near future. Funding for the surgical services project is expected to come from cash flow and the proceeds of a previous bond issue. The estimated date of completion for the surgical improvements is October 28, 2013. Other capital improvements are expected to be funded from cash flow.

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APPENDIX B

**AUDITED CONSOLIDATED FINANCIAL STATEMENTS
FOR FISCAL YEARS ENDED JUNE 30, 2012 AND 2011**

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MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Schedules)

Years Ended June 30, 2012 and 2011



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MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Schedules)

Years Ended June 30, 2012 and 2011

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited the accompanying consolidated balance sheets of Mountain States Health Alliance and subsidiaries (the Alliance) as of June 30, 2012 and 2011 and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Alliance's management. 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 of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing 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 over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe our audits provide a reasonable basis for our 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 subsidiaries as of June 30, 2012 and 2011 and the results of their operations, changes in net assets and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplemental information as listed in the accompanying index 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 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 financial statements as a whole.

Knoxville, Tennessee
October 26, 2012

Pershing Yoakley & Associates PC

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets
(Dollars in Thousands)

	<i>June 30,</i>	
	2012	2011
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 65,107	\$ 112,768
Current portion of investments - Note C	36,557	116,175
Patient accounts receivable, less estimated allowances for uncollectible accounts of \$52,911 in 2012 and \$53,366 in 2011	150,690	134,611
Other receivables, net	23,008	19,614
Inventories and prepaid expenses	28,810	28,965
TOTAL CURRENT ASSETS	304,172	412,133
INVESTMENTS, less amounts required to meet current obligations	560,697	581,376
PROPERTY, PLANT AND EQUIPMENT, net	865,456	797,418
OTHER ASSETS		
Goodwill	154,391	148,666
Net deferred financing, acquisition costs and other charges	28,187	29,844
Other assets	28,144	28,448
TOTAL OTHER ASSETS	210,722	206,958

\$ 1,941,047	\$	1,997,885
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	<i>June 30,</i>	
	2012	2011
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	\$ 18,525	\$ 20,047
Current portion of long-term debt and capital lease obligations	32,477	28,162
Current portion of estimated fair value of derivatives - Note D	10,395	102,609
Accounts payable and accrued expenses	108,870	98,819
Accrued salaries, compensated absences and amounts withheld	55,589	57,800
Estimated amounts due to third-party payors, net	18,060	14,813
TOTAL CURRENT LIABILITIES	243,916	322,250
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	1,048,098	1,040,923
Estimated fair value of derivatives, less current portion	8,986	8,123
Deferred revenue	3,134	19,267
Estimated professional liability self-insurance	9,344	9,692
Other long-term liabilities	16,822	14,352
TOTAL LIABILITIES	1,330,300	1,414,607
COMMITMENTS AND CONTINGENCIES - Notes D, F, G, and N		
NET ASSETS		
Unrestricted net assets		
Mountain States Health Alliance	436,388	400,395
Noncontrolling interests in subsidiaries	162,959	171,984
TOTAL UNRESTRICTED NET ASSETS	599,347	572,379
Temporarily restricted net assets		
Mountain States Health Alliance	11,223	10,715
Noncontrolling interests in subsidiaries	50	57
TOTAL TEMPORARILY RESTRICTED NET ASSETS	11,273	10,772
Permanently restricted net assets	127	127
TOTAL NET ASSETS	610,747	583,278
	\$ 1,941,047	\$ 1,997,885

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	2012	2011
Revenue, gains and support:		
Patient service revenue, net of contractual allowances and discounts	\$ 1,075,050	\$ 1,062,123
Provision for bad debts	(122,917)	(116,248)
Net patient service revenue	<u>952,133</u>	<u>945,875</u>
Other operating revenue	39,407	24,868
TOTAL REVENUE, GAINS AND SUPPORT	991,540	970,743
Expenses:		
Salaries and wages	358,607	342,208
Physician salaries and wages	65,706	59,249
Contract labor	6,375	5,964
Employee benefits	69,600	67,139
Fees	97,959	85,919
Supplies	170,186	168,261
Utilities	17,289	17,300
Other	76,285	69,647
Depreciation	73,060	87,499
Amortization	2,245	2,559
Interest and taxes	45,903	44,153
TOTAL EXPENSES	983,215	949,898
OPERATING INCOME	8,325	20,845
Nonoperating gains (losses):		
Interest and dividend income	15,213	16,224
Net realized gains (losses) on the sale of securities	(2,595)	1,957
Change in net unrealized gains on securities	(2,884)	22,168
Derivative related income	7,515	5,072
Loss on early extinguishment of debt - Note F	(2,636)	-
Change in estimated fair value of derivatives	(6,198)	23,049
Other nonoperating gains (losses)	11,236	(2,653)
NET NONOPERATING GAINS	19,651	65,817
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	\$ 27,976	\$ 86,662

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

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

Year Ended June 30, 2012

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
UNRESTRICTED NET ASSETS:			
Excess (Deficit) of Revenue, Gains and Support over Expenses and Losses	\$ 31,702	\$ (3,726)	\$ 27,976
Pension and other defined benefit plan adjustments	(1,119)	(1,115)	(2,234)
Net assets released from restrictions used for the purchase of property, plant and equipment	1,550	-	1,550
Distributions to noncontrolling interests	-	(324)	(324)
Repurchases of noncontrolling interests	3,860	(3,860)	-
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	35,993	(9,025)	26,968
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	3,860	39	3,899
Net assets released from restrictions	(3,352)	(46)	(3,398)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	508	(7)	501
INCREASE (DECREASE) IN TOTAL NET ASSETS	36,501	(9,032)	27,469
NET ASSETS, BEGINNING OF YEAR	411,237	172,041	583,278
NET ASSETS, END OF YEAR	\$ 447,738	\$ 163,009	\$ 610,747

MOUNTAIN STATES HEALTH ALLIANCE

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

Year Ended June 30, 2011

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	\$ 83,269	\$ 3,393	\$ 86,662
Pension and other defined benefit plan adjustments	620	617	1,237
Cumulative effect of a change in accounting principle - Note B	(2,965)	-	(2,965)
Net assets released from restrictions used for the purchase of property, plant and equipment	1,946	-	1,946
Distributions to noncontrolling interests	-	(270)	(270)
Repurchases of noncontrolling interests and other	40	(115)	(75)
INCREASE IN UNRESTRICTED NET ASSETS	82,910	3,625	86,535
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	3,612	58	3,670
Net assets released from restrictions	(3,787)	(52)	(3,839)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	(175)	6	(169)
INCREASE IN TOTAL NET ASSETS	82,735	3,631	86,366
NET ASSETS, BEGINNING OF YEAR	328,502	168,410	496,912
NET ASSETS, END OF YEAR	\$ 411,237	\$ 172,041	\$ 583,278

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2012</i>	<i>2011</i>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase in net assets	\$ 27,469	\$ 86,366
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	75,777	90,472
Loss on early extinguishment of debt	2,636	-
Cumulative effect of a change in accounting principle	-	2,965
Change in estimated fair value of derivatives	6,198	(23,049)
Equity in net income of joint ventures, net	(979)	(898)
Loss (gain) on disposal of assets	446	(367)
Amounts received on interest rate swap settlements	(7,515)	(5,072)
Gain on escrow restructuring - Note F	(5,337)	-
Income recognized through forward sale agreements	(864)	(864)
Gain on termination of swaption and forward sale agreements - Note D	(7,766)	-
Capital Appreciation Bond accretion and other	3,159	2,738
Restricted contributions	(3,899)	(3,670)
Pension and other defined benefit plan adjustments	2,234	(1,237)
Increase (decrease) in cash due to change in:		
Patient accounts receivable	(16,079)	(9,031)
Other receivables, net	(3,501)	(2,802)
Inventories and prepaid expenses	155	(643)
Trading securities	21,646	(123,966)
Other assets	(2,733)	(3,632)
Accrued interest payable	(1,522)	4,008
Accounts payable and accrued expenses	4,131	2,741
Accrued salaries, compensated absences and amounts withheld	(2,211)	11,361
Estimated amounts due to third-party payors, net	3,247	4,658
Other long-term liabilities	236	2,961
Estimated professional liability self-insurance	(348)	151
Total adjustments	<u>67,111</u>	<u>(53,176)</u>
NET CASH PROVIDED BY OPERATING ACTIVITIES	94,580	33,190
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property, plant and equipment	(132,890)	(172,786)
Additions to goodwill	(5,725)	(279)
Net decrease in assets limited as to use	85,947	81,383
Purchases of held-to-maturity securities	(9,516)	(41,060)
Net distribution from joint ventures and unconsolidated affiliates	882	1,057
Proceeds from sale of property, plant and equipment	<u>1,881</u>	<u>812</u>
NET CASH USED IN INVESTING ACTIVITIES	(59,421)	(130,873)

	<i>Year Ended June 30,</i>	
	<i>2012</i>	<i>2011</i>
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt and capital lease obligations, including deposits to escrow	(71,997)	(37,735)
Payment of acquisition and financing costs	(2,742)	(1,716)
Proceeds from issuance of long-term debt and other financing arrangements	67,451	5,954
Payment on termination of swaption	(93,353)	-
Gain on escrow restructuring	5,337	-
Net amounts received on interest rate swap settlements	7,515	5,072
Restricted contributions received	4,969	4,350
NET CASH USED IN FINANCING ACTIVITIES	<u>(82,820)</u>	<u>(24,075)</u>
NET DECREASE IN CASH AND CASH EQUIVALENTS		
	(47,661)	(121,758)
CASH AND CASH EQUIVALENTS, beginning of year	112,768	234,526
CASH AND CASH EQUIVALENTS, end of year	<u>\$ 65,107</u>	<u>\$ 112,768</u>

SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:

Cash paid for interest	<u>\$ 41,168</u>	<u>\$ 39,507</u>
Cash paid for federal and state income taxes	<u>\$ 336</u>	<u>\$ 739</u>
Construction related payables in accounts payable and accrued expenses	<u>\$ 6,821</u>	<u>\$ 11,384</u>
Property acquired through capital lease arrangement	<u>\$ 13,959</u>	<u>\$ 15,951</u>
Payable on termination of forward sale agreements in accounts payable and accrued expenses	<u>\$ 13,429</u>	<u>\$ -</u>
Land held for expansion placed in use	<u>\$ 1,610</u>	<u>\$ 4,904</u>

During the year ended June 30, 2012, the Alliance refinanced previously issued debt of \$174,547.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements (Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE A--ORGANIZATION AND OPERATIONS

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The initial funds for the establishment of the Alliance in 1945 were provided by individuals and various institutions. Membership of the Alliance consists of individuals and institutions who have contributed at least \$100 to the capital fund of the Alliance and are entitled to vote at the annual election of the Board of Directors.

The primary operations of the Alliance consist of ten acute and specialty care hospitals, as follows:

- Johnson City Medical Center (JCMC) - licensed for 658 beds
- Indian Path Medical Center (IPMC) - licensed for 261 beds
- Smyth County Community Hospital (SCCH) - licensed for 153 beds
- Norton Community Hospital (NCH) - licensed for 129 beds
- Sycamore Shoals Hospital (SSH) - licensed for 121 beds
- Johnston Memorial Hospital (JMH) - licensed for 116 beds
- Franklin Woods Community Hospital (FWCH) - licensed for 80 beds
- Russell County Medical Center (RCMC) - licensed for 78 beds
- Dickenson Community Hospital (DCH) - licensed for 25 beds
- Johnson County Community Hospital (JCCH) - licensed for 2 beds

The Alliance has a 50.1% interest in JMH. JMH is also the sole member of Abingdon Physician Partners (APP), a non-taxable corporation that owns and manages physician practices.

The Alliance has a 50.1% interest in NCH. NCH is also the sole member or shareholder of DCH and Norton Community Physician Services, LLC (NCPS), a taxable corporation that consists of physician practices and a pharmacy and; Community Home Care (CHC), a taxable corporation that provides home medical equipment.

The Alliance has an 80% interest in SCCH. SCCH is the sole shareholder of Southwest Community Health Services, Inc. (SWCH), a taxable entity that operates a pharmacy and provides other health services.

The activities and accounts of JMH, NCH and SCCH are included in the accompanying consolidated financial statements.

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices and provides other healthcare services to patients in Tennessee and Virginia. BRMM also operates as a medical office real estate developer by

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE A--ORGANIZATION AND OPERATIONS - Continued

owning, selling and leasing real estate to physician practices and other entities. BRMM is either the sole shareholder, a significant shareholder, or member of the following organizations:

Mountain States Physician Group, Inc. (MSPG): A company that contracts with physicians to provide services to BRMM physician practices.

Mountain States Properties, Inc. (MSPI): An entity that owns and manages certain real estate (primarily medical office buildings) and provides rehabilitation and fitness services. In addition, MSPI is counter-party to an interest rate swap.

Mediserve Medical Equipment of Kingsport, Inc. (Mediserve): A company that provides durable medical equipment services.

Kingsport Ambulatory Surgery Center (KASC) (d.b.a. Kingsport Day Surgery): A joint venture operating as an outpatient surgery center which performs procedures primarily in otolaryngology, orthopedics, ophthalmology, and general surgery. BRMM has a 43% ownership of KASC and maintains control over KASC through a management agreement. The accounts and activities of KASC are included in the accompanying consolidated financial statements.

Piney Flats Urgent Care (PFUC): A for-profit entity that provides urgent care patient services. BRMM has a 75% ownership of PFUC. The accounts and activities of PFUC are included in the accompanying consolidated financial statements.

Wilson Pharmacy, Inc. (Wilson): In August 2012, BRMM acquired Wilson, a Company that owns and operates retail pharmacies. BRMM purchased 100% of the total issued and outstanding capital stock of Wilson for \$8,114 and recognized goodwill of \$5,725.

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc. (MSF), a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance. The Alliance is also the beneficiary of the Mountain States Health Alliance Auxiliary (Auxiliary), a not-for-profit organization formed to coordinate volunteer activities of the Alliance. The activities and accounts of MSF and the Auxiliary are included in the accompanying consolidated financial statements.

The Alliance is a majority shareholder of Integrated Solutions Health Network, LLC (ISHN). The primary function of ISHN is to establish, operate and administer a provider-sponsored health care delivery network. The accounts and activities of ISHN are included in the accompanying consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation: The accompanying consolidated financial statements include the accounts of the Alliance and its subsidiaries after elimination of all significant intercompany accounts and transactions. The Alliance classifies those activities directly associated with its mission of providing healthcare services, as well as other activities deemed significant to its operations, as operating activities.

Noncontrolling Interests in Subsidiaries: The Alliance's accompanying consolidated financial statements include all assets, liabilities, revenues, expenses, and changes in net assets, including amounts attributable to the noncontrolling interest. Noncontrolling interests represent the portion of equity (net assets) into a subsidiary not attributable, directly or indirectly, to the Alliance. For the years ending June 30, 2012 and 2011, the Alliance attributed an Excess (Deficit) of Revenue, Gains and Support over Expenses and Losses of (\$3,726) and \$3,393, respectively, to the noncontrolling interests in JMH, NCH, SCCH, KASC, PFUC and ISHN based on the noncontrolling interests' respective ownership percentage.

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 on the Consolidated Balance Sheets.

Investments: Investments as reported in the Consolidated Balance Sheets include trading securities, held-to-maturity securities and assets limited as to use (Note C). The Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958-320, *Investments – Debt and Equity Securities*, allows not-for-profit organizations to report in a manner similar to business entities by identifying securities as available-for-sale or held-to-maturity and to exclude the unrealized gains and losses on those securities from the Performance Indicator (as defined below). Investments which the Alliance has the positive intent and ability to hold to maturity are considered as held-to-maturity. Substantially all other investments are considered as trading securities. Management annually evaluates the held-to-maturity investment portfolio and recognizes any "other-than-temporary" losses as deductions from the Performance Indicator. Management's evaluation considers the amount of decline in fair value, as well as the time period of any such decline.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Management does not believe any investment classified as held-to-maturity is other-than-temporarily impaired at June 30, 2012.

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 pursuant to FASB ASC 825, *Financial Instruments*. Guaranteed investment contracts are reported at contract value.

Realized gains and losses on trading securities and assets limited as to use are computed using the specific identification method for cost determination. Interest and dividend income is reported net of related investment fees.

Investments in joint ventures are reported under the equity method of accounting, which approximates the Alliance's equity in the underlying net book value, unless the ownership structure requires consolidation. Other assets include investments in joint ventures of \$2,153 and \$2,367 at June 30, 2012 and 2011, respectively.

Inventories: Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

the carrying amount of the asset, a write-down to estimated fair value is recorded. The Alliance did not recognize any impairment losses during 2012 and 2011.

Other assets include property held for resale and property held for expansion of \$2,620 and \$4,230, respectively, at June 30, 2012 and 2011. During 2012, property held for expansion totaling approximately \$1,610 was transferred to property, plant and equipment in conjunction with the construction of a replacement facility for SCCH. During 2011, property held for expansion totaling approximately \$4,904 was transferred to property, plant and equipment in conjunction with the construction of FWCH. Property held for resale and property held for expansion primarily represent 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 2012 and 2011.

Goodwill: Goodwill represents the difference between the acquisition cost of assets and the estimated fair value of net tangible and any separately identified intangible assets. Effective July 1, 2010, the Alliance adopted ASC 350, *Intangibles – Goodwill and Other*, which requires goodwill to be evaluated for impairment at least annually. Upon adoption of ASC 350, the Alliance was required to perform a transitional impairment test. As a result of this testing, management determined that as of July 1, 2010 approximately \$2,965 of goodwill associated with one of its reporting units was impaired, and such impairment has been reflected as the Cumulative Effect of a Change in Accounting Principle in the 2011 Consolidated Statement of Changes in Net Assets.

In September 2011, the FASB issued Accounting Standards Update (ASU) 2011-08 which allows entities to use a qualitative approach to determine whether the fair value of a reporting unit is more likely than not impaired. The Alliance early adopted the provisions of this ASU and, based upon this qualitative analysis, management does not believe it is more likely than not that goodwill associated with any of its reporting units is impaired as of June 30, 2012. The reporting unit for evaluation of substantially all such goodwill is the Alliance's aggregate acute-care operations.

Deferred Financing, Acquisition Costs and Other Charges: Other assets, including deferred financing, acquisition costs and other charges, total \$28,187 and \$29,844 at June 30, 2012 and 2011, respectively. Deferred financing costs are amortized over the life of the respective bond issue principally using the average bonds outstanding method. Other intangible assets include licenses and similar assets and are being amortized over the intangible's estimated useful life under the straight-line method.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Prior to 2009, the Alliance routinely financed interest rate swap and other derivative transaction issuance costs through modification of future settlement terms. As such, the unamortized issuance costs of these derivatives are included as deferred financing costs in the accompanying Consolidated Balance Sheets and are being amortized over the term of the respective derivative instrument. The unpaid issuance costs are included as a part of the estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. Subsequent to 2009, interest rate swap and derivative transaction issuance costs were expensed as incurred.

Derivative Financial Instruments: As further described in Note D, the Alliance is a party to interest rate swap and other derivative agreements. 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. Changes in the estimated fair value of these derivatives are included in the Consolidated Statements of Operations as part of nonoperating gains (losses). Net settlements and other related income of derivatives are also reflected as a part of the Performance Indicator (described below).

These fair values are based on the estimated amount the Alliance would receive, or be required to pay, to enter into equivalent agreements at the valuation date and include an estimated credit value adjustment. The fair value of various derivatives are netted on the Consolidated Balance Sheets based on management's evaluation of the settlement provisions in the master contract. Gross positions of these derivatives are disclosed in Note D. Due to the nature of these financial instruments, such estimates of fair value are subject to significant change in the near term.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims (Note G) 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 payors. 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 payors emphasize revenue recognition only when collections are reasonably assured.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

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. 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 his or her 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. The estimated direct and indirect cost of providing these services totaled approximately \$24,709 and \$18,158 in 2012 and 2011, respectively. Such costs are determined using a ratio of cost to charges analysis with indirect cost allocated under a reasonable and systematic approach.

In addition to the charity care services described above, 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 (Deficit) 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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

caption *Excess (Deficit) 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, pension and related adjustments, and distributions to, or contributions from, owners 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. Taxable entities account for income taxes in accordance with FASB ASC 740, *Income Taxes* (Note L). The Alliance has no significant uncertain tax positions at June 30, 2012 and 2011.

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 Consolidated Statements of 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 nonoperating gains (losses) in the Consolidated Statements of Operations. Permanently restricted net assets have been restricted by donors to be maintained by the Alliance in perpetuity.

Fair Value Measurement: The Alliance had previously adopted FASB ASC 820, *Fair Value Measurements and Disclosures*, which defines fair value, establishes a framework for measuring fair value under generally accepted accounting principles and expands disclosures about fair value measurements.

Subsequent Events: The Alliance evaluated all events or transactions that occurred after June 30, 2012, through October 26, 2012, 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, 2012 consolidated financial statements, other than as discussed in Notes D and S.

New Accounting Pronouncements: In July 2011, the FASB issued ASU 2011-07, *Healthcare Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and Allowance for Doubtful Accounts for Certain Healthcare Entities*, which requires certain healthcare entities reclassify the provision for bad debts associated with providing patient care from an operating expense to a deduction from net patient service revenue in the Consolidated

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Statements of Operations. Additionally, ASU 2011-07 requires enhanced disclosures about an entity's policies for recognizing revenue and assessing bad debts and qualitative and quantitative information about changes in the allowance for doubtful accounts. The Alliance retroactively adopted ASU 2011-07 in fiscal year 2012. The adoption of ASU 2011-07 did not have a material impact on the 2012 or 2011 consolidated financial statements.

In August 2010, the FASB issued ASU 2010-24, *Health Care Entities – Presentation of Insurance Claims and Related Insurance Recoveries* (ASU 2010-24). The amendments in ASU 2010-24 clarify that a healthcare entity may not net insurance recoveries against related claim liabilities. In addition, the amount of the claim liability must be determined without consideration of insurance recoveries. The Alliance adopted ASU 2010-24 prospectively during 2012. The adoption of ASU 2010-24 did not have a material impact on the consolidated financial statements.

In August 2010, the FASB issued ASU 2010-23, *Health Care Entities – Measuring Charity Care for Disclosure*. ASU 2010-23 is intended to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care. ASU 2010-23 requires that cost, identified as the direct and indirect costs of providing the charity care, be used as the measurement basis for disclosure purposes. ASU 2010-23 also requires disclosure of the method used to identify or determine such costs. The Alliance adopted ASU 2010-23 in 2012. The adoption of ASU 2010-23 did not have a material impact on the consolidated financial statements.

Reclassifications: Certain 2011 amounts have been reclassified to conform with the 2012 presentation in the accompanying consolidated financial statements.

NOTE C--INVESTMENTS

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

	<u>2012</u>		<u>2011</u>
Designated or restricted:			
Under safekeeping agreements and other	\$ 24,026	\$	28,349
Under guarantee agreements	-		92,720
By Board for capital improvements	4		4

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE C--INVESTMENTS - Continued

	<u>2012</u>	<u>2011</u>
Under bond indenture agreements:		
For debt service and interest payments	77,602	67,874
For capital acquisitions	29,578	28,835
	<u>131,210</u>	<u>217,782</u>
Less: amount required to meet current obligations	<u>(36,557)</u>	<u>(116,175)</u>
	<u>\$ 94,653</u>	<u>\$ 101,607</u>

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

	<u>2012</u>	<u>2011</u>
Cash, cash equivalents and money market funds	\$ 80,304	\$ 115,579
U.S. Government securities	8,582	1,795
U.S. Agency securities	40,398	7,688
Municipal obligations	1,926	-
Guaranteed investment contract	-	92,720
	<u>\$ 131,210</u>	<u>\$ 217,782</u>

Trading securities consist of the following at June 30:

	<u>2012</u>	<u>2011</u>
Cash, cash equivalents and money market funds	\$ 5,186	\$ 29,159
U.S. Government securities	10,697	9,409
U.S. Agency securities	26,165	31,551
Corporate and foreign bonds	52,581	32,895
Municipal obligations	961	451
Preferred and asset backed securities	11,183	8,945
U.S. equity securities	28,344	21,774
Mutual funds	141,968	166,708
Other	34,880	32,718
	<u>\$ 311,965</u>	<u>\$ 333,610</u>

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE C--INVESTMENTS - Continued

	<u>2012</u>	<u>2011</u>
Cash, cash equivalents and money market funds	\$ 298	\$ 753
Corporate and foreign bonds	138,232	135,745
Municipal obligations	15,549	9,661
	<u>\$ 154,079</u>	<u>\$ 146,159</u>

Held-to-maturity securities had gross unrealized gains and losses of \$11,432 and \$33, respectively, at June 30, 2012 and \$6,838 and \$276, respectively at June 30, 2011. At June 30, 2012, the Alliance held no securities within the held-to-maturity portfolio which had been at an unrealized loss position for over one year. At June 30, 2011, the Alliance held nine securities within the held-to-maturity portfolio with a fair value and unrealized loss of \$549 and \$44, respectively, which had been at an unrealized loss position for over one year. At June 30, 2012, the contractual maturities of held-to-maturity securities were \$11,225 due in one year or less, \$67,532 due from one to five years and \$75,322 due after five years. At June 30, 2011, the contractual maturities of held-to-maturity securities were \$13,816 due in one year or less, \$55,563 due from one to five years and \$76,780 due after five years.

At June 30, 2012 and 2011, the Alliance held investments in certain limited partnerships and hedge funds of \$34,880 and \$32,718, respectively, that have a wide range of investment strategies with various levels of risk. These funds are included within trading securities and do not have readily determinable fair values. The funds are reported at estimated fair market value pursuant to FASB ASC 825, *Financial Instruments*.

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is a party to a number of derivative transactions. These derivatives have not been designated as hedges and are valued at estimated fair value in the accompanying Consolidated Balance Sheets. Management's primary objective in holding such derivatives is to introduce a variable rate component into its fixed rate debt structure. Under the terms of these agreements, changes in the interest rate environment could have a significant effect on the Alliance.

These derivative agreements require that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. Such investments are included as assets limited as to use. As of June 30, 2012, management believes the Alliance was fully collateralized with respect to the derivative agreements and management does not believe such collateral is exposed to third-party credit risk.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE D--DERIVATIVE TRANSACTIONS - Continued

Interest Rate Swaps: The Alliance is a party to six interest rate swap agreements with Bank of America, Merrill Lynch as the counterparty. The terms of five of these agreements were modified without settlement during 2011. No gain or loss was realized as a result of the modifications although such modifications did impact the estimated fair value of the interest rate swaps. A liability, representing the estimated net fair value of these swaps, of \$8,765 and \$8,123 was recognized by the Alliance as of June 30, 2012 and 2011, respectively.

The following is a summary of five of these interest rate swap agreements at June 30, 2012:

<i>Swap</i>	<i>Notional Amount</i>	<i>Term</i>	<i>Payments by:</i>		<i>Estimated Fair Value</i>
			<i>Counterparty</i>	<i>Alliance</i>	
A	\$ 170,000	4/2008-4/2026	1.265% through April 2013; 1.07% through April 2014; then 71.10% of USD-ISDA Swap Rate	0.00% through April 2014, then USD-SIFMA	\$ 3,500
B	95,000	4/2008-4/2026	1.265% through April 2013; 1.08% through April 2014; then 71.18% of USD-ISDA Swap Rate	0.00% through April 2014, then USD-SIFMA	1,983
C	173,030	4/2008-4/2034	1.315% through April 2013; 1.12% through April 2014; then 72.35% of USD-ISDA Swap Rate	0.00% through April 2014, then USD-SIFMA	(513)
D	82,055	12/2007-7/2033	3.493% through July 2012; then 0% USD-LIBOR-BBA through July 2012, then 67% USD- LIBOR-BBA	4.41% through July 2012; then .312% USD-SIFMA	(9,520)
E	50,000	2/2008-7/2038	67.00% of USD-LIBOR-BBA plus .145%	USD-SIFMA	(3,895)

Deferred financing and acquisition costs, net of amortization, include \$6,135 and \$6,480 at June 30, 2012 and 2011, respectively, related to these swaps.

In addition to the interest rate swaps described above, the Alliance and Bank of America, Merrill Lynch are also parties to a total return swap. The notional amount of the total return swap is equal to the outstanding 2001A Hospital Revenue and Improvement Bonds which was \$22,300 at June 30, 2012. The estimated fair value of the total return swap was \$(320) and \$(340) at June 30, 2012 and 2011, respectively. The terms of the swap were modified without settlement during 2012. No gain or loss was realized as a result of the modifications although such modifications did impact the swap's estimated fair value. The payment terms, as amended consist of the following:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE D--DERIVATIVE TRANSACTIONS - Continued

- Beginning July 1, 2012, the Alliance will pay a variable rate of USD-SIFMA plus basis points ranging from 65 to 400, depending on the Alliance's bond rating as set forth by Standard and Poor's Ratings Service and Moody's Investors Service. The Alliance will receive a fixed rate of 4.50% and settlements will be made semi-annually through July 1, 2015.
- A "total return provision" under which the Alliance will pay (or receive) an amount equal to the product of the outstanding 2001A Reference Bonds multiplied by the difference between the outstanding 2001A Reference Bonds and the 2001A Reference Bonds' market price at termination, as defined in the agreement.

In addition to the six interest rate swaps discussed above, the Alliance is also a party to an interest rate swap with Regions Bank (the Regions swap) and an interest rate swap with First Tennessee Bank National Association (the FTB swap). The Regions swap was entered into in July 2011 and terminates in August 2012. The FTB swap was entered into in June 2010 and terminates in July 2015. The notional amounts of the Regions swap and FTB swap were \$13,727 and \$5,524, respectively, at June 30, 2012. A liability, representing the estimated net fair value of these swaps, of \$221 was recognized by the Alliance as of June 30, 2012. The estimated fair value of the FTB swap was not significant at June 30, 2011.

The Alliance was previously a party to a total return swap with Lehman Brothers as the counterparty. Lehman Brothers filed for bankruptcy in September 2008. The Alliance subsequently received notification from Lehman Brothers Special Financing, Inc. indicating the intent of the counterparty to terminate this agreement effective January 1, 2009. The Alliance and Lehman Brothers Special Financing, Inc. were unable to reach a settlement agreement at the time the swap was terminated.

An estimated liability related to the agreement of \$10,395 and \$10,565 was recognized by the Alliance at June 30, 2012 and 2011. In addition, a third party holds investments with a fair market value of approximately \$13,809 and \$13,381, respectively, at June 30, 2012 and 2011 as collateral. The collateral and estimated liability related to this agreement are classified as current in the accompanying Consolidated Balance Sheets.

At June 30, 2012, the parties were undergoing alternate dispute resolution, including non-binding arbitration. Subsequent to year end, the parties reached a tentative settlement agreement. In full settlement of the liability, the Alliance will pay the counterparty \$7,375 from the funds held as collateral and the remaining collateral will be returned to the Alliance.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE D--DERIVATIVE TRANSACTIONS - Continued

Interest Rate Swap Option: In June 2004, the Alliance entered into an agreement with Bear Stearns (acquired by JP Morgan) whereby Bear Stearns purchased from the Alliance an option to enter into an interest rate swap agreement (swaption) with the Alliance beginning July 1, 2011, which is an optional redemption date related to the Alliance's early extinguished 2000A and 2000B Bonds (Note F). The purpose of this agreement was to effectively sell the call features related to the early extinguished Series 2000A and 2000B Bonds. As consideration under this agreement, the Alliance received a total of \$42,500 in upfront payments as the swaption premium. Such amounts were initially recorded as estimated fair value of derivatives in the Consolidated Balance Sheets.

During 2012, the counterparty expressed their intent to exercise the swaption on January 1, 2012 and the Alliance exercised its right to terminate the swaption at its fair market value. The swaption was terminated on October 13, 2011. To effectuate the termination, the Alliance transferred \$93,353 of a Guaranteed Investment Contract (GIC), described below, to the third party as a termination payment. A gain of \$3,058 was recognized on the termination, which is included within other nonoperating gains (losses) in the accompanying 2012 Consolidated Statement of Operations.

A liability of \$92,044, representing the estimated fair value of the swaption at June 30, 2011, respectively, is included in estimated fair value of derivatives in the accompanying 2011 Consolidated Balance Sheet. The change in estimated fair value of derivatives in the accompanying Consolidated Statements of Operations for 2012 and 2011 includes an unrealized loss of \$4,676 and \$2,394, respectively, related to this derivative, prior to termination.

Forward Sale Agreements: In June 2004, the Alliance entered into two related forward sale agreements with the counterparty to the swaption agreements and the Master Trustee of the Series 2000 Bonds. The forward sale agreements originally related to the Debt Service Reserve Fund and to the Debt Service Fund, respectively, (collectively, the "Funds"), as established under provisions of the Master Trust Indenture related to the issuance of the Series 2000 Bonds. In consideration of the future earnings on the Funds, the counterparty paid the Master Trustee a total of \$30,000 during 2005, to be held on behalf of the Alliance. As the original intent of these Funds was to secure debt service payments under the above referenced Bonds, the agreement requires these funds to be held under a guaranty agreement as further described below.

In June 2006, one of these agreements was amended to also relate to the Series 2000C, 2000D, 2006A and 2006B Bonds, and to remove the Series 2000A Bonds from consideration under the agreement. In connection with the issuance of the Series 2007 Bonds and the derecognition of a portion of the Series 2000A Bonds, all of the outstanding Series 2000B Bonds, and all of the outstanding 2006B Bonds (Note F), one of these agreements as it relates to the Series 2000A and 2000B Bonds was partially terminated. As such, during 2008 the Alliance reduced its liability with respect to the portion related to the Series 2000A and 2000B Bonds, and paid the counterparty

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE D--DERIVATIVE TRANSACTIONS - Continued

\$6,186 under the terms of the agreement. The agreement was amended in fiscal year 2011 to include the Series 2010A Bonds and to remove the Series 2000B and 2006B Bonds.

Amounts were being recognized as investment income over the life of the agreements. A liability of \$19,001 representing the unamortized payments from the counterparty at June 30, 2011 is included as part of deferred revenue in the accompanying 2011 Consolidated Balance Sheet.

In June 2012, the Alliance and the counterparty terminated the two forward sale agreements. To effectuate the termination, the Alliance agreed to pay \$13,429 to the counterparty. At June 30, 2012, the termination payable was included in accounts payable and accrued expenses in the accompanying 2012 Consolidated Balance Sheet. The Alliance recognized a gain of \$4,708 on the termination of these agreements, which is included within other nonoperating gains (losses) in the accompanying 2012 Consolidated Statement of Operations.

Pursuant to these agreements, the counterparty required that the Alliance's obligations under the swaption and forward sale agreements be collateralized under a guarantee agreement in favor of the counterparty. Due to various requirements of the Master Trust Indenture, the Alliance had previously transferred to MSF a total of \$42,500 that was in turn deposited with the counterparty as collateral in a GIC. Amounts received under the forward sale agreements were also deposited into the GIC. All GIC deposits earn interest compounded at 4.14% for the first year, and at 3.5% thereafter through July 1, 2011. The GIC deposits as of June 30, 2011 totaled \$92,720. The GIC was substantially utilized on October 13, 2011 to terminate the swaption discussed above and, as such, is included in the current portion of assets whose use is limited in the 2011 Consolidated Balance Sheet.

NOTE E--PROPERTY, PLANT AND EQUIPMENT

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

	<u>2012</u>	<u>2011</u>
Land	\$ 69,356	\$ 63,749
Buildings and leasehold improvements	661,146	454,852
Property and improvements held for leasing	74,914	80,568
Equipment	571,774	532,767
Buildings and equipment held under capital lease	20,540	42,720
	<u>1,397,730</u>	<u>1,174,656</u>

MOUNTAIN STATES HEALTH ALLIANCE

*Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE E--PROPERTY, PLANT AND EQUIPMENT - Continued

	<u>2012</u>	<u>2011</u>
Less: Allowances for depreciation and amortization	(626,552)	(586,471)
	771,178	588,185
Construction in progress (Note N)	94,278	209,233
	<u>\$ 865,456</u>	<u>\$ 797,418</u>

Accumulated depreciation and amortization on property and improvements held for leasing purposes is \$22,951 and \$23,348 at June 30, 2012 and 2011, respectively. Net interest capitalized was \$3,110 and \$10,640 for the years ended June 30, 2012 and 2011, respectively.

During 2012, the Alliance executed an Amendment and Mutual Release Agreement with a vendor whereby the Alliance waived its right to take any action with respect to prior contracts in exchange for professional services in future periods, primarily related to accelerated deployment of information systems. The Alliance recognized approximately \$3,200 in 2012 as additions to property, plant and equipment with an offsetting gain related to the agreed-upon value of such professional services. The Alliance anticipates recognition of additional amounts in future periods as such services are provided.

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

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

<i>Description</i>	<i>Maturities</i>	<i>Rates</i>	<i>Outstanding Balance</i>	
			<i>2012</i>	<i>2011</i>
2011A Hospital Revenue Bonds	\$65,260 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 0.19% at June 30, 2012	\$ 65,260	\$ -
2011B Hospital Revenue Bonds	\$20,000 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 0.19% at June 30, 2012	20,000	-
2011C Hospital Revenue Bonds	\$49,875 uninsured term bonds, due July 1, 2031, subject to early redemption or tender	Variable, 0.16% at June 30, 2012	49,875	-
2011D Hospital Revenue Bonds	\$60,705 uninsured term bonds, due July 1, 2031, subject to early redemption or tender	Variable, 0.19% at June 30, 2012	60,705	-
2011E Taxable Bonds	\$15,960 uninsured term bonds, due July 1, 2026, subject to early redemption or tender	Variable, 0.24% at June 30, 2012	15,960	-
2011 Hospital Facility Revenue Refunding and Improvement Bonds (JMHS)	\$24,870 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 1.2% at June 30, 2012	24,870	-
2010A Hospital Revenue Bonds, net of unamortized premium of \$1,017 and \$1,056 at June 30, 2012 and 2011, respectively	\$32,515 uninsured serially, through 2020 \$14,985 uninsured term bonds, due July 1, 2025 \$19,385 uninsured term bonds, due July 1, 2030 \$39,570 uninsured term bonds, due July 1, 2038 \$55,480 uninsured term bonds, due July 1, 2038	3.00% to 5.00% 5.38% 5.63% 6.50% 6.00%	162,952	169,137

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2012 and 2011

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

Description	Maturities	Rates	Outstanding Balance	
			2012	2011
2010B Hospital Revenue Bonds, net of unamortized premium of \$669 and \$711 at June 30, 2012 and 2011, respectively	\$23,855 uninsured serially, through 2020 \$4,355 uninsured term bonds, due July 1, 2023 \$4,250 uninsured term bonds, due July 1, 2028	2.50% to 5.00% 5.00% 5.50%	33,129	36,646
2009A Hospital Revenue Bonds, net of unamortized discount of \$117 and \$121 at June 30, 2012 and 2011, respectively	\$725 uninsured term bonds, due July 1, 2019 \$1,730 uninsured term bonds, due July 1, 2029 \$3,105 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	5,443	5,439
2009B Hospital Revenue Bonds	\$5,535 uninsured term bonds, due July 1, 2038	8.00%	5,535	5,535
2009C Hospital Revenue Bonds, net of unamortized discount of \$2,334 and \$2,421 at June 30, 2012 and 2011, respectively	\$21,100 uninsured term bonds, due July 1, 2019 \$20,000 uninsured term bonds, due July 1, 2029 \$74,855 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	113,621	113,534
2008A Hospital Revenue Bonds	\$13,245 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.19% at June 30, 2012	13,245	13,245
2008B Hospital Revenue Bonds	\$52,930 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.19% at June 30, 2012	52,930	53,853
2007B Taxable Hospital Revenue Bonds, bifurcated into sub-series B-1, B-2 and B-3 during 2011	\$156,760 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 0.20% to 0.23% at June 30, 2012	156,760	307,900
2006A Hospital First Mortgage Revenue Bonds, net of unamortized premium of \$141 and \$147 at June 30, 2012 and 2011, respectively	\$5,940 uninsured serially, through 2019 \$7,375 uninsured term bonds, due July 1, 2026 \$20,505 uninsured term bonds, due July 1, 2031 \$135,175 uninsured term bonds, due July 1, 2036	5.00% 5.25% 5.50% 5.50%	169,136	169,782
2001A Hospital First Mortgage Revenue Bonds, re-issued in 2012	\$22,300 term bonds, due July 1, 2026, subject to early redemption or tender	4.50% as re-issued	22,300	23,100
2001 Hospital Refunding and Improvement Revenue Bonds (NCH), net of unamortized discount of \$34 June 30, 2011	Redeemed in 2012	N/A	-	11,876
2000A Hospital First Mortgage Revenue Refunding Bonds	\$32,431 insured Capital Appreciation Bonds, interest and principal due July 1, 2026 through 2030	6.63%	32,431	30,358
2000C Hospital First Mortgage Revenue Bonds	\$33,230 insured term bonds, due July 1, 2026	8.50%	33,230	34,325
2000D First Mortgage Taxable Bonds	\$14,315 insured term bonds, due July 1, 2026	8.50%	14,315	14,790
1998 Hospital Refunding and Improvement Revenue Bonds (JMH)	Redeemed in 2012	N/A	-	14,115
Capitalized lease obligation	Lease paid-off in 2012	N/A	-	13,656
\$7,500 promissory note	Note paid-off in 2012	N/A	-	5,473
Capitalized lease obligations secured by equipment	Various monthly payments of monthly principal and interest	Various	1,645	2,518
\$1,065 note payable	Note paid-off in 2012	N/A	-	572
\$6,332 promissory note	Promissory note paid-off in 2012	N/A	-	5,945
\$3,955 note payable	Note paid-off in 2012	N/A	-	3,743
Notes payable under Master Financing Agreement	Notes paid-off in 2012	N/A	-	14,011
\$1,885 line of credit	Line of credit paid-off in 2012	N/A	-	1,873
\$1,593 note payable, secured by equipment	Various annual principal payments through July 2014	Unspecified	1,343	1,593
Capitalized lease obligation secured by medical office building (JMH)	Maturing through 2026 - Note 8	9.72%	15,498	15,952
Master installment payment agreement	Various quarterly payments through May 2014	Unspecified	4,438	112

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

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

<i>Description</i>	<i>Maturities</i>	<i>Rates</i>	<i>Outstanding Balance</i>	
			<i>2012</i>	<i>2011</i>
Master installment payment agreement, secured by equipment	Various quarterly payments through May 2014	Unspecified	3,032	-
\$1,870 note payable, secured by land	Monthly principal payments of \$10 through maturity in July 2015	Unspecified	1,870	-
\$1,052 in promissory notes secured by assets of Emmaus Community Healthcare, LLC	Various monthly principal and interest payments through 2019	3.00% - 3.75%	1,052	-
			1,080,575	1,069,085
	Less current portion		(32,477)	(28,162)
			\$ 1,048,098	\$ 1,040,923

Series 2011 Bonds: In October 2011, the Alliance issued \$65,260 (Series 2011A) and \$20,000 (Series 2011B) variable rate tax-exempt Hospital Revenue Bonds through The Health and Educational Facilities Board of the City of Johnson City, Tennessee, \$49,875 (Series 2011C) and \$60,705 (Series 2011D) variable rate tax-exempt Hospital Revenue Bonds through the Industrial Development Authority of Smyth, Virginia and \$15,960 (Series 2011E) variable rate Taxable Bonds (collectively, the Series 2011 Bonds). The Series 2011 Bonds bear interest at a variable rate determined by a remarketing agent based upon a weekly rate period. The proceeds from the Series 2011A and Series 2011B Bonds were used to finance certain capital acquisitions in the State of Tennessee and pay issuance costs related to these Bonds. The proceeds from the Series 2011C and 2011D Bonds were used to refinance the 2001 NCH Hospital Refunding and Improvement Revenue Bonds, finance capital acquisitions for NCH, JMH and SCCH and to pay issuance costs associated with these Bonds. The Series 2011E Bond proceeds were used to refinance certain capital acquisitions of SCCH and BRMMC and pay issuance costs. The timely payment of the Series 2011 Bonds is secured by a letter of credit which expires October 19, 2014.

In November 2011, JMH issued \$24,870 (JMH Series 2011) variable rate tax-exempt Hospital Facility Revenue Refunding and Improvement Bonds through the Industrial Development Authority of Smyth County. The JMH Series 2011 Bonds bear interest at a variable rate determined by a remarketing agent based upon a weekly rate period. The proceeds from the JMH Series 2011 Bonds were used to refinance the 1998 Hospital Refunding and Improvement Revenue Bonds, refinance existing indebtedness incurred to finance capital acquisitions and to pay issuance costs associated with the Bonds.

Series 2010 Bonds: In April 2010, the Alliance issued \$168,080 (Series 2010A) and \$35,935 (Series 2010B) fixed rate Hospital Refunding Revenue Bonds (collectively, the Series 2010 Bonds). Proceeds of the Series 2010A and the Series 2010B Bonds were used to refinance outstanding indebtedness, specifically related to the Alliance's facilities in Tennessee and in Virginia, respectively, fund debt service reserve funds and pay costs of issuance.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

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

Series 2009 Bonds: In March 2009, the Alliance issued \$5,560 (Series 2009A), \$5,535 (Series 2009B) and \$115,955 (Series 2009C) fixed rate Hospital Revenue Bonds (collectively, the Series 2009 Bonds). The proceeds of Series 2009 Bonds were used to refinance a portion of the outstanding Series 2006C Taxable Notes, which were originally issued to finance a capital commitment to SCCH and purchase certain leased assets, finance the acquisition of a majority ownership in JMHI, fund a debt service reserve fund and pay costs of issuance. The portion of the 2006C taxable notes which were not refinanced with the Series 2009 Bonds were repaid with cash on hand.

Series 2008 Bonds: In February 2008, the Alliance issued \$72,770 (Series 2008A) and \$54,230 (Series 2008B) variable rate Hospital Revenue Bonds (collectively, the Series 2008 Bonds). The proceeds of Series 2008 Bonds were primarily used to finance certain future capital projects for the Alliance's hospital facilities and for the repayment of previously issued 2008 Taxable Notes used for the acquisition of RCMC. The payment of principal and interest on the Series 2008 Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit. A portion (\$59,525) of the Series 2008A Bonds were repaid from proceeds of the Series 2010 Bonds.

Series 2007 Bonds: In December 2007, the Alliance issued \$104,355 (Series 2007A), \$327,170 (Series 2007B taxable) and \$36,575 (Series 2007C) variable rate Hospital Revenue Bonds (collectively, the Series 2007 Bonds). The proceeds of Series 2007 Bonds were primarily used to early extinguish a portion of the outstanding Series 2000A Bonds, all of the outstanding 2000B Bonds, all of the outstanding Series 1994 Bonds, and all of the outstanding Series 2006B Bonds; to finance the acquisition of a majority ownership in NCH, and to finance certain capital improvements and equipment acquisitions for the Alliance's hospital facilities. A portion of the outstanding Series 2007A (\$91,685) and Series 2007C (\$32,840) Bonds were repaid from proceeds of the Series 2010 Bonds.

During 2011, the remaining outstanding Series 2007A and Series 2007C Bonds were redeemed and the existing 2007B Bonds were repaid through a remarketing of Sub-Series 2007B-1, 2007B-2 and 2007B-3 (collectively, the Sub-Series 2007B Bonds), created per the mandatory tender and letter of credit substitution provisions. The payment of principal and interest on the Sub-Series 2007B Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit.

During 2012, the Alliance redeemed \$115,135 of the Series 2007B-1 Bonds and \$29,405 of the Series 2007B-3 Bonds.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

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

Series 2006 Bonds: During 2006, the Alliance issued \$173,030 Hospital First Mortgage Revenue Bonds (Series 2006A) and \$66,500 Hospital First Mortgage Variable Rate Revenue Bonds (Series 2006B). The proceeds from the sale of the Series 2006A Bonds were used to finance certain future and prior capital projects for the Alliance's hospital facilities and to refund certain existing indebtedness, specifically the Series 2001B Bonds (discussed below) and certain existing short and intermediate term loans and leases, as well as fund a debt service reserve fund. The Series 2006B Bond proceeds were substantially used to refund the remaining outstanding principal of the Series 2001B Bonds and establish a debt service reserve fund.

Series 2001 Bonds: During 2001, the Alliance issued \$26,000 Hospital First Mortgage Revenue Bonds (Series 2001A) and \$60,175 Hospital First Mortgage Revenue Bonds (Series 2001B). The Series 2001A Bonds were subject to optional tender by Bond holders. The Series 2001B Bonds were refunded and redeemed in 2006. The Alliance redeemed the 2001A Bonds and released a new Series 2001A to Bank of America Merrill Lynch during 2012.

Series 2000 Bonds: The Hospital First Mortgage Revenue Refunding (Series 2000A Bonds) and First Mortgage Revenue Refunding Bonds (Series 2000B Bonds), were used to advance refund previously existing indebtedness as well as fund a required debt service reserve fund. The Hospital First Mortgage Revenue Bonds (Series 2000C Taxable Bonds) were used to refinance certain mortgage indebtedness of BRMM, and to refund other previously existing indebtedness. The proceeds from the sale of the First Mortgage Bonds (Series 2000D Taxable Bonds) were used primarily to fund working capital for the Alliance.

The Series 2000A Bonds included at issue date \$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.

Derecognized Bonds: The advance refunding of previously issued debt requires funds to be placed in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments. 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, and the debt and escrowed securities are not considered liabilities or assets of the Alliance. Therefore, such debt has been derecognized.

Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2012 due to previous advance refundings of the Series 2000A Bonds, Series 2000B Bonds, Series 1998C Bonds, and Series 1991 Bonds, totaled approximately \$483,625.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

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

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.

During 2012, the Alliance instructed the trustee of the 1998C Bonds to liquidate certain investments held in the related irrevocable trust account and to redeem a portion of the 1998C Bonds with the proceeds from the liquidation. The fair value of the liquidated assets exceeded the payment necessary to redeem the 1998C Bonds and the excess was paid to the Alliance. As a result of this transaction, the Alliance recognized a gain of \$5,337, net of fees, which is included in other nonoperating gains (losses) in the accompanying 2012 Consolidated Statement of Operations.

Variable Rate Issuances: The variable rate of interest on the Series 2011, Series 2008 and Series 2007 Bonds is determined weekly by the Remarketing Agent, as the rate equal to the lowest rate which, in regard to general financial conditions and other special conditions bearing on the rate, would produce as nearly as possible a par bid for the Bonds in the secondary market. In no event shall the variable rate on the Bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the applicable State of issue. The Alliance has the option, upon written approval of the holder of the letters of credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate.

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.

Other Bonds, Notes Payable and Financing Arrangements: 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 JMH Series 2011 Hospital Refunding and Improvement Revenue Bonds are secured by pledged revenues of JMH, as defined in the Credit Agreement.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

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

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, 2012 are as follows:

<u>Year Ending June 30,</u>	
2013	\$ 32,477
2014	33,414
2015	29,932
2016	31,315
2017	31,006
Thereafter	<u>923,055</u>
	1,081,199
Net discount	<u>(624)</u>
	<u>\$ 1,080,575</u>

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, 2012.

In connection with the tax-exempt bonds, the Alliance is required every five years, and at maturity, to remit to the Internal Revenue Service amounts which are due related to positive arbitrage on the borrowed funds. The Alliance performs such computations when required and recognizes any liability at that time. Management does not believe there are any significant arbitrage liabilities at June 30, 2012 or 2011.

During 2012, the Alliance recognized a \$2,636 loss on early extinguishment of debt representing the write off of previously deferred and unamortized financing costs generally related to the refinanced or otherwise redeemed portion of the Series 2007B Bonds, Series 1998 JMH Bonds and the Series 2001 NCH Bonds.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

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 and \$1,000 annual aggregate retention. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

At June 30, 2012, 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, 2012 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Alliance 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, 2012 and 2011 was \$12,896 and \$13,531, respectively. The discount rate utilized was 5% at June 30, 2012 and 2011.

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, including a catastrophic claims reserve based on historical claims in excess of \$75.

NOTE H--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates to net patient service revenue as presented in the accompanying Consolidated Statements of Operations is as follows for the years ended June 30:

	<u>2012</u>		<u>2011</u>
Inpatient service charges	\$ 2,095,036	\$	1,983,340
Outpatient service charges	1,982,154		1,791,858
Gross patient service charges	4,077,190		3,775,198

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE H—NET PATIENT SERVICE REVENUE - Continued

	<u>2012</u>	<u>2011</u>
Less:		
Estimated contractual adjustments and other discounts	2,899,678	2,640,909
Charity care	102,462	72,166
Provision for bad debts	122,917	116,248
	<u>3,125,057</u>	<u>2,829,323</u>
Net patient service revenue	<u>\$ 952,133</u>	<u>\$ 945,875</u>

Net patient service revenue by major payor source for the years ended June 30, 2012 and 2011, net of contractual allowances and self-pay discounts (before the provision for bad debts), is as follows:

	<u>2012</u>	<u>2011</u>
Third-party payors	\$ 968,101	\$ 957,828
Self-pay	106,949	104,295
Patient service revenue	<u>\$ 1,075,050</u>	<u>\$ 1,062,123</u>

Deductibles and copayments under third-party payment programs, which are included within the third-party payor amounts above, are the patient's responsibility and the Alliance considers these amounts in its determination of the provision for bad debts based on prior collection experience. Accounts receivable are also reduced by an allowance for doubtful accounts. In evaluating the collectibility of accounts receivable, the Alliance analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Alliance analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary, for expected uncollectible deductibles and copayments or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely. For receivables associated with self-pay patients, which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill, the Alliance records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between discounted rates and the amounts actually collected after all reasonable collection efforts have been exhausted is charged against the allowance for doubtful accounts.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE H--NET PATIENT SERVICE REVENUE - Continued

The Alliance's allowance for doubtful accounts totaled \$52,911 and \$53,366 at June 30, 2012 and 2011, respectively. The allowance for doubtful accounts decreased from 28% of patient accounts receivable, net of contractual allowances, at June 30, 2011 to 26% of patient accounts receivable, net of contractual allowances, as of June 30, 2012. Write-offs, net of recoveries, for the years ending June 30, 2012 and 2011 were \$123,373 and \$108,823, respectively, and relate primarily to self-pay patients. Write-offs of third-party payor accounts were not significant in the years ending June 30, 2012 and 2011. The Alliance has not experienced significant changes in write-off trends and has not changed its charity care policy for the year ended June 30, 2012. 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, Blue Cross and various other commercial payors. 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. The amount recognized totaled \$11,300 and \$11,480 for the years ended June 30, 2012 and 2011, respectively. In addition, during 2012 the Alliance recognized \$4,894 from TennCare related to the implementation and meaningful use of electronic medical records as provided by the Health Information Technology for Economics and Clinical Health (HITECH) Act. Such payments are included within other operating revenue in the accompanying 2012 Consolidated Statement of Operations and are not guaranteed in future periods.

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 based on Medicare cost reimbursement principles and settled through the filing of an annual Medicaid cost report.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE I--THIRD-PARTY REIMBURSEMENT - Continued

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. 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. 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 2013, although the amount of any change cannot be estimated. The impact of final settlements of cost reports or changes in estimates decreased net patient service revenue by \$1,556 and \$4,570 in 2012 and 2011, respectively.

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, 2012.

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 retirement plan (the Plan) which covers substantially all employees. The Plan is a defined contribution plan which consists mainly of employer-funded contributions. During 2012 and 2011, the Alliance made 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, 2012 and 2011 was \$15,072 and \$12,682, respectively.

NCH maintains a defined benefit pension plan and a post-retirement employee benefit plan. The accrued unfunded pension liability was \$2,560 and \$1,313, and the accrued unfunded post-retirement liability was \$4,554 and \$3,761 at June 30, 2012 and 2011, respectively.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE J--EMPLOYEE BENEFIT PLANS - Continued

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 date, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed \$1,734 and \$929 to the plan during 2012 and 2011, respectively. Other assets at June 30, 2012 and 2011 include \$9,675 and \$7,888, 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.

NOTE K--CONCENTRATIONS OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia which is considered a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. Net patient service revenue from Washington County, Tennessee operations were approximately 53% and 53% of total net patient service revenue for 2012 and 2011, respectively.

The mix of receivables from patients and third-party payors based on charges at established rates is as follows as of June 30:

	<i>2012</i>	<i>2011</i>
Medicare	36%	40%
TennCare/Medicaid	14%	12%
Commercial	26%	27%
Other third-party payors	13%	9%
Patients	11%	12%
	<u>100%</u>	<u>100%</u>

Approximately 96% and 96% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2012 and 2011, respectively. Admitting physicians are primarily practitioners in the regional area.

Two of the Alliance's Virginia hospitals' employees are covered under collective bargaining agreements which extend through February 2014 and January 2015, respectively.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE K--CONCENTRATIONS OF RISK - Continued

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. At June 30, 2012, the Alliance also had deposits in financial institutions significantly in excess of the Federal Deposit Insurance Corporation's limits.

NOTE L--INCOME TAXES

BRMM and its subsidiaries file a consolidated federal tax return and separate state tax returns. As of June 30, 2012 and 2011, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of \$38,888 and \$34,822, respectively, related to operating loss carryforwards which expire through 2031. At June 30, 2012 and 2011, BRMM had state net operating loss carryforwards of \$69,999 and \$65,979, respectively, which expire through 2026. 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.

At June 30, 2012 and 2011, SWCH had federal and state net operating loss carryforwards of \$5,614 and \$4,875, respectively, which expire through 2031. The net operating loss carryforwards may be off-set against future taxable income to the extent permitted by the Internal Revenue Code and tax codes of the Commonwealth of Virginia.

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--RELATED PARTY TRANSACTIONS

The Alliance enters into transactions with entities affiliated with certain members of the Board of Directors including transactions to construct Alliance facilities and provide professional services to the Alliance. Board members refrain from discussion and abstain from voting on transactions with entities with which they are related.

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES

Construction in Progress: Construction in progress at June 30, 2012 represents costs incurred related to various hospital and medical office building facility renovations and additions. The Alliance has outstanding contracts and other commitments related to the completion of these

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

projects, and the cost to complete these projects is estimated to be approximately \$100,312 at June 30, 2012. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

Physician Contracts: BRMM employs physicians to provide services to BRMM's physician practices through employment agreements which provide annual compensation, plus incentives based upon specified productivity levels. These contracts have various terms.

In addition, the Alliance has entered into contractual relationships with non-employed physicians to provide services in Upper East Tennessee and Southwest Virginia. These contracts guarantee certain base payments and allowable expenses and have terms of varying lengths. Amounts drawn and outstanding under each agreement are treated as a loan bearing interest at various rates and are subject to repayment over a specified period. The physician notes may also be amortized by virtue of the physician's continued practice in the specified community during the repayment period. A net receivable of \$1,436 and \$1,407 related to these agreements is included in the accompanying Consolidated Balance Sheets at June 30, 2012 and 2011, respectively.

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 degree. 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, 2012 and 2011 include \$8,005 and \$7,250, 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 allowance.

Promises to Give: The Alliance has recorded certain unconditional promises to give to unrelated organizations. At June 30, 2012, \$1,354 is due within one year, and an additional \$100 is due within five years and is included in other long-term liabilities.

Operating Leases and Maintenance Contracts: Total lease expense for the years ended June 30, 2012 and 2011 was \$8,823 and \$9,362, 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:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

<u>Year Ending June 30,</u>	
2013	\$ 4,661
2014	4,476
2015	4,253
2016	3,997
2017	2,332
Thereafter	8,008
	<hr/> <u>\$ 27,727</u>

Asset Retirement Obligation: The Alliance has identified asbestos in certain facilities and is required by law to dispose of it in a special manner if the facility undergoes major renovations or is demolished; otherwise, the Alliance is not required to remove the asbestos from the facility. The Alliance has complied with regulations by treating the asbestos so that it presents no known immediate or future safety concerns. An asset retirement obligation has been established to the extent that sufficient information exists upon which to estimate the liability.

Other: The Alliance is a party to various transactions and agreements in the normal course of business, which include purchase and re-purchase agreements, put arrangements and other commitments, which may bind the Alliance to undertake additional transactions or activities in the future. In addition, the Alliance has agreed to guarantee a portion of the outstanding indebtedness of a joint venture. Management estimates that the fair value of the guarantee of this debt is immaterial as of June 30, 2012.

Healthcare Industry: Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

In March 2010, Congress adopted comprehensive health care insurance legislation, *Patient Care Protection and Affordable Care Act* and *Health Care and Education Reconciliation Act*. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens by 2019 through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE O--RENTAL INCOME UNDER OPERATING LEASES

The Alliance leases rental properties to third parties, most of whom are physician practices, for various terms, generally five years. The following is a schedule by year and in the aggregate of minimum future rental income due under noncancellable operating leases at June 30, 2012:

<u>Year Ending June 30,</u>		
2013	\$	1,574
2014		1,454
2015		1,339
2016		762
2017		405
Thereafter		116
Total minimum future rentals	\$	<u>5,650</u>

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2012 and 2011, 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.

Investment in Joint Ventures: It is not practical to estimate the fair market value of the investments in joint ventures.

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 due to uncertainty of when these amounts may be paid. Other long-term liabilities are not discounted.

Long-Term Debt and Capital Leases: 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.

The Alliance's significant capital leases and vendor contracts were negotiated with various entities and are considered unique. It is not practicable to estimate the fair value of these obligations under current conditions. Other capital lease obligations are not significant.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS - Continued

The estimated fair value of the Alliance's financial instruments that have carrying values different from fair value is as follows at June 30:

	<i>2012</i>		<i>2011</i>	
	<i>Carrying Value</i>	<i>Estimated Fair Value</i>	<i>Carrying Value</i>	<i>Estimated Fair Value</i>
FINANCIAL LIABILITIES:				
Long-term debt	\$ 1,080,575	\$ 1,150,201	\$ 1,069,085	\$ 1,046,675

NOTE Q--FAIR VALUE MEASUREMENT

FASB ASC 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 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 assets and liabilities recorded at fair value on a recurring basis as of June 30, 2012 and 2011:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE Q--FAIR VALUE MEASUREMENT - Continued

	Total	Level 1	Level 2	Level 3
June 30, 2012				
Cash, cash equivalents and money market funds	\$ 85,017	\$ 85,017	\$ -	\$ -
U.S. Government securities	15,693	15,693	-	-
U.S. Agency securities	62,437	62,437	-	-
Corporate and foreign bonds	52,581	-	52,581	-
Municipal obligations	961	-	961	-
Preferred and asset backed securities	11,183	-	11,183	-
U.S. equity securities	28,344	28,344	-	-
Mutual funds	141,968	97,600	44,368	-
Other	34,880	-	-	34,880
Total assets	\$ 433,064	\$ 289,091	\$ 109,093	\$ 34,880
Fair value of derivative agreements - Note D	\$ (19,381)	\$ -	\$ -	\$ (19,381)
June 30, 2011				
Cash, cash equivalents and money market funds	\$ 142,031	\$ 142,031	\$ -	\$ -
U.S. Government securities	11,204	11,204	-	-
U.S. Agency securities	34,054	34,054	-	-
Corporate and foreign bonds	32,895	-	32,895	-
Municipal obligations	451	-	451	-
Preferred and asset backed securities	8,945	-	8,945	-
U.S. equity securities	21,774	21,774	-	-
Mutual funds	166,708	73,060	93,648	-
Other	32,718	-	-	32,718
Total assets	\$ 450,780	\$ 282,123	\$ 135,939	\$ 32,718
Fair value of derivative agreements - Note D	\$ (110,732)	\$ -	\$ -	\$ (110,732)

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, 2012 and 2011 resulted in a decrease in the fair value of the related liability of \$5,726 and \$7,940, respectively.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE Q--FAIR VALUE MEASUREMENT - Continued

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.

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, 2012 and 2011:

	<i>Trading Securities</i>	<i>Derivatives, Net</i>
July 1, 2010	\$ 28,608	\$ (134,300)
Total unrealized/realized gains in the Performance Indicator, net	2,847	23,049
Net investment income	1,263	519
June 30, 2011	32,718	(110,732)
Total unrealized/realized gains in the Performance Indicator, net	1,466	(6,198)
Net investment income	1,221	515
Purchases	5,107	-
Settlements	-	97,034
Distributions	(5,632)	-
June 30, 2012	\$ 34,880	\$ (19,381)

There were no changes in valuation techniques in 2012 or 2011. During 2011, as part of the transitional test of goodwill impairment, the Alliance recognized goodwill impairment of \$2,965 based primarily on the fair value of the reporting unit, utilizing the income approach. Remaining goodwill determined not to be impaired, for this specific reporting unit, is included in the Consolidated Balance Sheets at \$2,900.

NOTE R--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 enterprise, other indicators contained in these consolidated financial statements are considered important in evaluating how well management has discharged their stewardship responsibilities.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE S--SUBSEQUENT EVENTS

In September 2012, the Alliance issued \$55,000 (Series 2012A) fixed rate and \$28,095 (Series 2012B) variable rate tax-exempt Hospital Revenue Bonds through The Health and Educational Facilities Board of the City of Johnson City, Tennessee, and \$9,785 (Series 2012C) variable rate tax-exempt Hospital Revenue Bonds through the Industrial Development Authority of Wise, Virginia (collectively, the Series 2012 Bonds). The proceeds from the Series 2012A Bonds will be used to finance a surgery center project at JCMC and pay issuance costs related to these Bonds. The proceeds from the Series 2012B and 2012C Bonds will be used to finance or refinance capital improvements and equipment acquisitions and to pay issuance costs associated with these Bonds. The timely payment of the Series 2012B and Series 2012C Bonds is secured by irrevocable transferable direct-pay letters of credit.

In July 2012, the Trustee of the previously derecognized 1998C Bonds liquidated certain investments held in the related irrevocable trust account and redeemed a portion of the 1998C Bonds with the proceeds from the liquidation. The fair value of the liquidated assets exceeded the payment necessary to redeem the 1998C Bonds and the excess was paid to the Alliance. As a result of this transaction, the Alliance recognized a gain of \$13,847, net of fees.

Subsequent to June 30, 2012, JMH exercised their purchase option related to a medical office building previously held under a capital lease. The purchase price was \$17,529 which was financed through a taxable private placement bond issuance.

Supplemental Schedules

MOUNTAIN STATES HEALTH ALLIANCE

**Consolidating Balance Sheet
(Dollars in Thousands)**

June 30, 2012

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities	Mountain States Properties	Eliminations	Total
ASSETS								
CURRENT ASSETS								
Cash and cash equivalents	\$ 1,482	\$ 36,881	\$ -	\$ 38,363	\$ 22,006	\$ 4,738	\$ -	\$ 65,107
Current portion of investments	-	22,745	-	22,745	3	13,809	-	36,557
Patient accounts receivable, less estimated allowances for uncollectible accounts	5,051	116,629	-	121,680	29,010	-	-	150,690
Other receivables, net	1,624	18,852	-	20,476	3,120	412	(1,000)	23,008
Inventories and prepaid expenses	832	20,951	-	21,783	6,924	103	-	28,810
TOTAL CURRENT ASSETS	8,989	216,058	-	225,047	61,063	19,062	(1,000)	304,172
INVESTMENTS, less amounts required to meet current obligations	19,348	395,778	-	415,126	100,811	44,760	-	560,697
EQUITY IN AFFILIATES	143,050	318,231	(157,099)	304,182	-	-	(304,182)	-
PROPERTY, PLANT AND EQUIPMENT, net	13,539	598,415	-	611,974	199,990	53,492	-	865,456
OTHER ASSETS								
Goodwill	9,007	143,276	-	152,283	2,108	-	-	154,391
Net deferred financing, acquisition costs and other charges	302	26,776	-	27,078	602	507	-	28,187
Other assets	8,887	12,145	-	21,032	4,550	2,562	-	28,144
TOTAL OTHER ASSETS	18,196	182,197	-	200,393	7,260	3,069	-	210,722
	\$ 203,142	\$ 1,710,679	\$ (157,099)	\$ 1,756,722	\$ 369,124	\$ 120,383	\$ (305,182)	\$ 1,941,047

* Management Services Organization only

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

**Consolidating Balance Sheet - Continued
(Dollars in Thousands)**

June 30, 2012

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities	Mountain States Properties	Eliminations	Total
LIABILITIES AND NET ASSETS								
CURRENT LIABILITIES								
Accrued interest payable	\$ 46	\$ 18,455	\$ -	\$ 18,501	\$ 24	\$ -	\$ -	\$ 18,525
Current portion of long-term debt and capital lease obligations	-	29,824	-	29,824	2,653	-	-	32,477
Current portion of estimated fair value of derivatives	-	-	-	-	-	10,395	-	10,395
Accounts payable and accrued expenses	4,191	94,352	-	98,543	9,297	1,030	-	108,870
Accrued salaries, compensated absences and amounts withheld	3,704	40,121	-	43,825	11,764	-	-	55,589
Payables to (receivables from) affiliates, net	15,321	3,118	-	18,439	8,365	(26,804)	-	-
Estimated amounts due to third-party payors, net	-	16,607	-	16,607	1,453	-	-	18,060
TOTAL CURRENT LIABILITIES	23,262	202,477	-	225,739	33,556	(15,379)	-	243,916
OTHER LIABILITIES								
Long-term debt and capital lease obligations, less current portion	13,676	994,014	-	1,007,690	41,408	-	(1,000)	1,048,098
Estimated fair value of derivatives, less current portion	-	8,534	-	8,534	133	319	-	8,986
Deferred revenue	-	2,929	-	2,929	205	-	-	3,134
Estimated professional liability self-insurance	2,268	5,975	-	8,243	1,101	-	-	9,344
Other long-term liabilities	6,837	9,839	-	16,676	146	-	-	16,822
TOTAL LIABILITIES	46,043	1,223,768	-	1,269,811	76,549	(15,060)	(1,000)	1,330,300
NET ASSETS								
Unrestricted net assets								
Mountain States Health Alliance	157,099	436,388	(157,099)	436,388	164,117	135,443	(299,560)	436,388
Noncontrolling interests in subsidiaries	-	39,123	-	39,123	117,377	-	6,459	162,959
TOTAL UNRESTRICTED NET ASSETS	157,099	475,511	(157,099)	475,511	281,494	135,443	(293,101)	599,347
Temporarily restricted net assets								
Mountain States Health Alliance	-	11,223	-	11,223	10,955	-	(10,955)	11,223
Noncontrolling interests in subsidiaries	-	50	-	50	(1)	-	1	50
TOTAL TEMPORARILY RESTRICTED NET ASSETS	-	11,273	-	11,273	10,954	-	(10,954)	11,273
Permanently restricted net assets								
Mountain States Health Alliance	157,099	486,911	(157,099)	486,911	299,575	135,443	(304,182)	610,747
Noncontrolling interests in subsidiaries	203,142	1,710,679	(157,099)	1,756,722	369,124	120,383	(305,182)	1,941,047
TOTAL NET ASSETS	\$ 203,142	\$ 1,710,679	\$ (157,099)	\$ 1,756,722	\$ 369,124	\$ 120,383	\$ (305,182)	\$ 1,941,047

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

**Consolidating Statement of Operations
(Dollars in Thousands)**

Year Ended June 30, 2012

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities	Mountain States Properties	Eliminations	Total
Revenue, gains and support:								
Patient service revenue, net of contractual allowances and discounts	\$ 50,213	\$ 824,899	\$ (2,165)	\$ 872,947	\$ 202,108	\$ -	\$ (5)	\$ 1,075,050
Provision for bad debts	(4,597)	(95,444)	-	(99,837)	(23,080)	-	-	(122,917)
Net patient service revenue	45,816	729,459	(2,165)	773,110	179,028	-	(5)	952,133
Other operating revenue	39,451	15,163	(29,595)	25,019	67,543	8,398	(61,553)	39,407
Equity in net gain (loss) of affiliates	3,332	(17,848)	(1,488)	(16,004)	-	-	16,004	-
TOTAL REVENUE, GAINS AND SUPPORT	88,599	726,774	(33,248)	782,125	246,571	8,398	(45,554)	991,540
Expenses:								
Salaries and wages	21,613	268,799	-	290,412	72,358	451	(4,614)	358,607
Physician salaries and wages	43,468	1,162	-	44,630	62,704	-	(41,628)	65,706
Contract labor	777	3,864	-	4,641	2,382	9	(657)	6,375
Employee benefits	7,416	51,007	(2,236)	56,187	17,510	85	(4,182)	69,600
Fees	4,025	100,938	(29,034)	75,929	25,946	517	(4,433)	97,959
Supplies	2,454	135,733	-	138,187	32,124	40	(165)	170,186
Utilities	626	12,222	-	12,848	3,476	965	-	17,289
Other	7,538	47,568	(490)	54,616	23,471	4,077	(5,879)	76,285
Depreciation	1,395	49,959	-	51,354	19,458	2,248	-	73,060
Amortization	50	2,161	-	2,191	54	-	-	2,245
Interest and taxes	(1,169)	42,976	-	41,807	3,018	1,112	(34)	45,903
TOTAL EXPENSES	88,173	716,389	(31,760)	772,802	262,501	9,504	(61,592)	983,215
OPERATING INCOME (LOSS)	426	10,385	(1,488)	9,323	(15,930)	(1,106)	16,038	8,325
Nonoperating gains (losses):								
Interest and dividend income	673	10,841	-	11,514	2,401	1,332	(34)	15,213
Net realized gains (losses) on the sale of securities	21	611	-	632	(3,227)	-	-	(2,595)
Change in net unrealized gains on securities	(455)	(3,758)	-	(4,213)	133	1,196	-	(2,884)
Derivative related income	-	6,051	-	6,051	-	1,464	-	7,515
Loss on early extinguishment of debt	-	(2,553)	-	(2,553)	(83)	-	-	(2,636)
Change in estimated fair value of derivatives	-	(6,086)	-	(6,086)	(133)	21	-	(6,198)
Other nonoperating gains (losses)	823	12,485	-	13,308	(1,977)	(95)	-	11,236
NET NONOPERATING GAINS	1,062	17,591	-	18,653	(2,886)	3,918	(34)	19,651
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	\$ 1,488	\$ 27,976	\$ (1,488)	\$ 27,976	\$ (18,816)	\$ 2,812	\$ 16,004	\$ 27,976

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

**Consolidating Statement of Changes in Net Assets
(Dollars in Thousands)**

Year Ended June 30, 2012

	Blue Ridge Medical Management *		Other Obligated Group Members		Total Obligated Group		Other Entities		Total	
	Mountain States Health Alliance	Noncontrolling Interests	Mountain States Properties	Eliminations						
UNRESTRICTED NET ASSETS:										
Excess (deficit) of revenue, gains and support over expenses and losses	\$ 1,488	\$ -	\$ 31,702	\$ (3,726)	\$ 27,976	\$ (1,488)	\$ (12,729)	\$ (6,087)	\$ (18,816)	\$ 16,004
Periton and other defined benefit plan adjustments	-	-	(1,119)	(1,115)	(2,234)	-	(9)	(9)	(18)	18
Net assets released from restrictions used for the purchase of property, plant and equipment	-	-	1,550	-	1,550	-	1,550	-	1,550	(1,550)
Distributions to noncontrolling interests	-	-	-	(324)	(324)	-	-	(324)	(324)	324
Repurchases of noncontrolling interests	-	-	3,860	(3,860)	-	-	-	-	-	-
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	1,488	-	35,993	(9,025)	26,968	(1,488)	(11,188)	(6,420)	(17,608)	14,796
TEMPORARILY RESTRICTED NET ASSETS:										
Restricted grants and contributions	-	-	3,860	39	3,899	-	3,036	12	3,048	(3,048)
Net assets released from restrictions	-	-	(3,352)	(46)	(3,398)	-	(3,255)	(22)	(3,277)	3,277
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	-	-	508	(7)	501	-	(219)	(10)	(229)	229
INCREASE (DECREASE) IN TOTAL NET ASSETS	1,488	-	36,501	(9,032)	27,469	(1,488)	(11,407)	(6,430)	(17,837)	15,025
NET ASSETS, BEGINNING OF YEAR	155,611	-	411,237	-	411,237	(155,611)	239,164	172,041	411,205	(371,795)
ADDITION OF OBLIGATED MEMBERS	-	-	-	54,025	54,025	-	(52,599)	(54,054)	(106,613)	52,588
NET ASSET TRANSFER	-	-	-	(5,820)	(5,820)	-	-	5,820	-	-
NET ASSETS, END OF YEAR	\$ 157,099	\$ -	\$ 447,738	\$ 39,173	\$ 486,911	\$ (157,099)	\$ 175,198	\$ 117,377	\$ 295,575	\$ (304,182)
										\$ 610,747

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Note to Supplemental Schedules

Year Ended June 30, 2012

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. In accordance with Article Six, Section 6.6 of 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, those members pledged in 2011 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 and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group (Obligated Group). In 2012, NCH and SCCH (hospitals only) were admitted into the Obligated Group. These entities' operations since admission (including noncontrolling interests) are included as part of the Obligated Group results for 2012 in the accompanying consolidated statements of operations and changes in net assets.

The supplemental consolidating schedules include the accounts of the members of the Obligated Group after elimination of all significant intergroup accounts and transactions. Certain other subsidiaries of the Alliance, Mountain States Properties, Inc. (MSP) and all other affiliates (Other Entities), 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.

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SUMMARY OF THE FINANCING DOCUMENTS

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SUMMARY OF THE FINANCING DOCUMENTS

Brief descriptions of the Master Indenture, each Bond Indenture and each Loan Agreement are included in this Appendix C to the Official Statement. Such descriptions do not purport to be comprehensive or definitive. All references herein to the Master Indenture, the Bond Indenture and the Loan Agreement are qualified in their entirety by reference to each such document, copies of which are available for review at the offices of the Mountain States Health Alliance, Legal Department, 400 North State of Franklin Road, Johnson City, Tennessee. All references to the Bonds of any Series are qualified in their entirety by reference to the definitive forms thereof and the information with respect thereto included in the Master Indenture or the Bond Indenture.

USE OF CERTAIN TERMS

The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the “Issuer”) is issuing its Hospital Revenue Bonds (Mountain States Health Alliance) Series 2013A (the “Series 2013A Bonds”) pursuant to a Bond Trust Indenture (the “Series 2013A Bond Indenture”) dated as of July 1, 2013, between the Issuer and The Bank of New York Mellon Trust Company, N.A. (the “Bond Trustee”) and lending the proceeds thereof to the Mountain States Health Alliance (the “Alliance”) pursuant to a Loan Agreement (the “Series 2013A Loan Agreement”) dated as of July 1, 2013, between the Alliance and the Issuer. U.S. Bank National Association (the “Bank”) is issuing its Letter of Credit (the “Series 2013A Original Letter of Credit”) as security for the Series 2013A Bonds.

The Issuer is issuing its Taxable Hospital Refunding Revenue Bonds (Mountain States Health Alliance) Series 2013B (the “Series 2013B Bonds”) pursuant to a Bond Trust Indenture (the “Series 2013B Bond Indenture”) dated as of July 1, 2013, between the Issuer and the Bond Trustee and lending the proceeds thereof to the Alliance pursuant to a Loan Agreement (the “Series 2013B Loan Agreement”) dated as of July 1, 2013, between the Alliance and the Issuer. The Bank is issuing its Letter of Credit (the “Series 2013B Original Letter of Credit”) as security for the Series 2013B Bonds.

As used in this Appendix, the terms “Loan Agreement,” “Bond Indenture,” and “Original Letter of Credit” shall refer individually, not collectively, to the Series 2013A Loan Agreement, the Series 2013B Loan Agreement, the Series 2013A Bond Indenture, the Series 2013B Bond Indenture, the Series 2013A Original Letter of Credit and the Series 2013B Original Letter of Credit. For avoidance of doubt, the terms, security, funds and payments under the Series 2013A Loan Agreement, the Series 2013A Bond Indenture and the Series 2013A Original Letter of Credit relate only to the Series 2013A Bonds. Similarly, the terms, security, funds and payments under the Series 2013B Loan Agreement, the Series 2013B Bond Indenture and the Series 2013B Original Letter of Credit relate only to the Series 2013B Bonds.

DEFINITIONS OF CERTAIN TERMS

The following are definitions of certain terms used in the Master Indenture, the Bond Indenture, the Loan Agreement and this Official Statement.

“Accountant” shall mean an independent, certified public accountant, or a firm of independent, certified public accountants, selected by the Borrower.

“Act of Bankruptcy” means any of the following events:

(a) The Alliance or the Issuer shall (1) apply for or consent to the appointment of, or the taking of possession by, a receiver, custodian, trustee, liquidator or the like of the Alliance or the Issuer or of all or a substantial part of the property of any of them, (2) commence a voluntary case under the Federal Bankruptcy Code (as now or hereafter in effect) or (3) file a petition seeking to take advantage of any other law relating to bankruptcy, insolvency, reorganization, winding-up or composition or adjustment of debts; or

(b) A proceeding or case shall be commenced, without the application or consent of the Alliance or the Issuer, as the case may be, in any court of competent jurisdiction, seeking (1) the liquidation, reorganization, dissolution, winding-up, or the composition or adjustment of debts, of the Alliance or the Issuer, (2) the appointment of a trustee, receiver, custodian, liquidator or the like of the Alliance or the Issuer or of all or any substantial part of the assets of either the Alliance or the Issuer, or (3) similar relief in respect of the Alliance or the Issuer under any law relating to bankruptcy, insolvency, reorganization, winding-up or composition or adjustment of debts, and such proceeding or case shall continue undismissed, or an order, judgment or decree approving or ordering any of the foregoing shall be entered and continue unstayed and in effect for a period of 60 days from the commencement of such proceeding or case.

“Additional Indebtedness” means any Indebtedness (including all Obligations, other than the Initial Obligation) incurred by any Obligated Issuer, subsequent to its becoming an Obligated Issuer.

“Adjustment Date” means the first day of each Weekly Rate Period and each Medium-Term Rate Period.

“Affiliate” of any specified person means any other person directly or indirectly controlling or controlled by or under direct or indirect common control with such specified person. For purposes of this definition, (i) “control” when used with respect to any specified person means the power to direct the management and policies of such person, directly or indirectly, whether through ownership of voting securities, by contract, or otherwise; and (ii) the terms “controlling” and “controlled” have meanings correlative to the foregoing.

“Authorized Denominations” means prior to the Conversion Date, \$100,000 or any integral multiple of \$5,000 in excess thereof, provided that, with the written consent of the Issuer, “Authorized Denominations” shall mean after the Conversion Date, \$5,000 or any integral multiple thereof.

“Balloon Indebtedness” means: (a) Long-Term Indebtedness as to which, when issued, 25% or more of the debt service thereon is due in a single year, or (b) Long-Term Indebtedness as to which, when issued, 25% or more of the original principal amount thereof may, at the option of the holder or registered owner thereof, be redeemed or repurchased at one time, which portion of the principal is not required by the documents pursuant to which such Indebtedness is issued to be amortized by redemption prior to such date, or (c) any Guaranty of Long-Term Indebtedness that is Balloon Indebtedness.

“Bank” means U.S. Bank National Association, a national banking association, in its capacity as issuer of the Original Letter of Credit, its successors in such capacity and their assigns, until the Termination Date of the Original Letter of Credit and the payment in full to the Bank of all amounts owed to it under the Reimbursement Agreement and other related documents; provided, however, that upon the effective date of a Substitute Letter of Credit, “Bank” means the issuer of such Substitute Letter of Credit, its successors in such capacity and their assigns until the Termination Date of such Substitute Letter of Credit and the payment in full to such Bank of all amounts owed to it under the Reimbursement Agreement, if any, relating to such Substitute Letter of Credit.

“Bonds” means individually the Series 2013A Bonds and the Series 2013B Bonds.

“Bond Indenture” means individually the Series 2013A Bond Indenture and the Series 2013B Bond Indenture.

“Bond Index” means the “Bond Buyer Revenue Bond Index” as published from time to time in The Bond Buyer, or, if such index shall no longer be published, a comparable index designated by the Bond Insurer during the period that any Related Bonds are outstanding that are insured by the Bond Insurer and thereafter by the Obligated Group Agent.

“Bond Insurer” means MBIA Insurance Corporation and its successor or successors, as insurer of certain Related Bonds.

“Bond Trustee” means The Bank of New York Mellon Trust Company, N.A. or any successor trustee under the Bond Indenture.

“Bondholder”, “Owner”, “owner”, “Holder” or “holder” or any similar term, when used with reference to any of the Bonds, means (i) in the event that the book-entry system of evidence and transfer of ownership of the Bonds is employed pursuant to the Bond Indenture, Cede & Co., as nominee for DTC, or its nominee, and (ii) in all other cases, the registered owner or owners of any Bond as shown on the registration books maintained by the Bond Trustee.

“Book Value,” when used in connection with Property of any member of the Obligated Group, means the cost of such Property, net of accumulated depreciation, calculated in conformity with generally accepted accounting principles, and when used in connection with Property of the Obligated Group, means the aggregate of the values so determined with respect to such Property of all members of the Obligated Group determined in such a manner that no portion of such value of Property of any member of the Obligated Group is included more than once.

“Borrower Bond” means any Bond registered in the name of the Alliance; provided, however, that in no event shall a Pledged Bond be deemed to be a Borrower Bond.

“Business Day” means any day other than a Saturday, Sunday or other day on which the New York Stock Exchange or banks are authorized or obligated by law or executive order to close in New York, New York, or any city in which the principal corporate trust office of the Bond Trustee is located or the office of the Bank at which demands for a draw on, or a borrowing or payment under, the Letter of Credit will be made, which for purposes of the Original Letter of Credit is St. Louis, Missouri.

“Cash to Debt Ratio” means the ratio of Unrestricted Liquid Funds to Long Term Indebtedness.

“Chattel Paper” shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

“Code” means the Internal Revenue Code of 1986, as amended, as it applies to the Bonds, including applicable regulations and revenue rulings thereunder. Reference herein to sections of the Code are to the sections thereof as they exist on the date of execution of the Bond Indenture, but include any successor provisions thereof.

“Collateral” means (i) all Receivables, (ii) all Inventory, (iii) all Equipment, (iv) all General Intangibles, (v) all Contracts and all Contract rights, (vi) all amounts from time to time held in any checking, savings, deposit or other account of any Obligated Issuer, (vii) all Government Approvals, provided, that any Government Approval which by its terms or by the operation of law would become void, voidable, terminable or revocable if mortgaged, pledged or signed under the Master Indenture or if a security interest therein were granted under the Master Indenture or expressly accepted and excluded from the security interest by the Master Indenture granted to the extent necessary so as to avoid such voidness, voidability, terminability or revocability, (viii) all Fixtures, including but not limited to those now or hereafter attached to, placed on or incorporated in the Land, (ix) all Revenues, (x) without limiting the generality of the foregoing, all other personal property, goods, Instruments, Chattel Paper, Documents, credits, claims, demands and assets of any Obligated Issuer, whether now existing or hereafter acquired from time to time, and (xi) any and all additions and accessions to any of the foregoing, all improvements thereto, all substitutions and replacements therefor and all products and Proceeds thereof.

“Commitment Indebtedness” means the obligation of any person to repay amounts disbursed pursuant to a Credit Facility to pay when due such person’s obligations under Indebtedness incurred in accordance with the provisions of the Master Indenture.

“Completion Indebtedness” means any Long-Term Indebtedness (i) incurred by any person for the purpose of financing the completion of constructing or equipping Facilities with respect to which Long-Term Indebtedness was theretofore incurred in accordance with the provisions hereof, and (ii) with a principal amount not in excess of the amount required (a) to provide a completed and equipped Facility of substantially the type and scope contemplated at the time such prior Long-Term Indebtedness was incurred, (b) to provide for capitalized interest during the period of construction, (c) to capitalize a reserve with respect to such Completion Indebtedness and (d) to pay the costs and expenses of issuing such Completion Indebtedness.

“Construction Index” means the health care component of the implicit price deflator for the gross national product as most recently reported prior to the date in question by the United States Department of Commerce or its successor agency, or, if such index is no longer published, such other index which is certified to be comparable and appropriate by the Obligated Group Agent in an Officer’s Certificate delivered to the Master Trustee.

“Contract Rights” means all rights under any Contract to make determinations, to exercise any election (including, but not limited to, election of remedies) or option or to give or receive any notice, consent, waiver or approval together with full power and authority with respect to any Contract to demand, receive, enforce, collect or receipt for any of the foregoing rights or any property the subject of any of the Contracts, to enforce or execute any checks, or other instruments or orders, to file any claims and to take any action which, in the reasonable opinion of a secured party, may be necessary or advisable in connection with any of the foregoing.

“Contracts” means all contracts to which any Obligated Issuer now is, or hereafter will be, bound, or a party, beneficiary or assignee, including, without limitation, all instruments, agreements and documents executed and delivered with respect to such contracts, and all revenues, rentals, Proceeds and other sums of money due and to become due from any of the foregoing, as the same may be modified, supplemented or amended from time to time in accordance with their terms.

“Consultant” means a person who or which is appointed by the Obligated Group Agent for the purpose of passing on questions relating to the financial affairs, management or operations of one or more members of the Obligated Group or the entire Obligated Group and, in the good faith opinion of the Obligated Group Agent, has a favorable reputation for skill and experience in performing similar services in respect of entities engaged in reasonably comparable endeavors. If any Consultant’s report or opinion is required to be given with respect to matters partly within and partly without the expertise of such Consultant, such Consultant may rely upon the report or opinion of another Consultant, which other Consultant shall be reasonably satisfactory to the relying Consultant and the Obligated Group Agent.

“Conversion Date” means the Interest Payment Date on which the Bonds begin to bear interest at the Fixed Rate.

“Corporation” or “Alliance” means Mountain States Health Alliance, a Tennessee not-for-profit corporation, and its successors and assigns and any surviving, resulting or transferee corporation.

“Counsel” means an attorney, or firm thereof, admitted to practice law before the highest court of any state in the United States of America or the District of Columbia.

“Credit Facility” means any letter of credit, line of credit, insurance policy, guaranty or other agreement constituting a credit enhancement or liquidity facility which is issued by a bank, trust company, savings and loan association or other institutional lender, insurance company or surety company for the benefit of the holder of any Indebtedness in order to provide a source of funds for, the payment of all or any portion of an Obligated Issuer’s payment obligations under such Indebtedness.

“Days’ Cash-on-Hand Ratio,” as of the end of any Fiscal Year, means the product obtained by multiplying 365 times (i) the Unrestricted Liquid Funds of the Obligated Group as of the last day of such Fiscal Year, divided by (ii) the total operating expenses of the Obligated Group for such Fiscal Year, excluding depreciation and amortization expense and bad debt expense, as shown on the financial statements of the Obligated Group for such Fiscal Year.

“Debt Service Requirement” of any person means, for any period of time, the amounts payable or the payments required to be made by such person in respect of principal and interest on outstanding Long-Term Indebtedness during such period (calculated in such a manner that no portion of Long-Term Indebtedness is included more than once), taking into account (for purposes of calculating any projected debt service requirements) (i) that any Indebtedness represented by a Guaranty shall be deemed payable on the dates and in the amounts contemplated in the Master Indenture (concerning the assumptions to be used in including debt service requirements of the guaranteed obligations), (ii) that any payments to be made in respect of Balloon Indebtedness and Variable

Rate Indebtedness shall be calculated in accordance with the provisions of the Master Indenture, (iii) that, with respect to Indebtedness refunded or refinanced during such period, only an amount of principal and interest equal to the principal and interest not payable from the proceeds of Indebtedness shall be taken into account during such period, (iv) any amounts payable from funds available under an Escrow Deposit (other than amounts so payable solely by reason of the obligor's failure to make payments from other sources), shall be excluded from the determination of the Debt Service Requirement, and (v) that with respect to any Indebtedness which is the subject of a Hedge Agreement, any Regular Scheduled Qualified Swap Payments under such Hedge Agreement (provided, however, that if the Regular Scheduled Qualified Swap Payments are variable rate payments, interest shall be calculated as if the indebtedness was Variable Rate Indebtedness) payable or receivable with respect to such Indebtedness shall be taken into account in determining the interest payable with respect to such Indebtedness.^{1*}

“Default” means any event which with the giving of notice or lapse of time, or both, would constitute an Event of Default.

“Defeasance Investments” means non-redeemable direct obligations of the United States of America or obligations for which the full faith and credit of the United States of America are pledged for the timely payment of principal and interest, including evidences of a direct ownership interest in future interest or principal payments on such obligations, which obligations are held in a custody account by a custodian pursuant to the terms of a custody agreement.

“Discounted Indebtedness” means Indebtedness sold to the original purchaser thereof (other than any underwriter or other similar intermediary) at a discount from the par amount of such Indebtedness.

“Document” shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

“Eligible Moneys” means (a) proceeds of Bonds not sold to the Alliance or the Issuer or an affiliate of the Alliance or the Issuer, (b) moneys irrevocably drawn under the Letter of Credit, (c) moneys deposited with the Bond Trustee by the Alliance for the benefit of the Bondholders for 123 days during which no Act of Bankruptcy has occurred as evidenced by a certificate of the Alliance or Issuer, (d) moneys with respect to which the Alliance delivers to the Bond Trustee an Opinion of Counsel with nationally recognized expertise in bankruptcy acceptable to the Bond Trustee and Moody's that such payments will not constitute a voidable transfer or preference under and pursuant to Sections 362a, 541 or 547 of the Federal Bankruptcy Code and (e) investment income on the foregoing types of money.

“Equipment” means any “equipment,” as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction, now or hereafter owned or leased by any Obligated Issuer and, in any event, shall include, but shall not be limited to, all equipment used in connection with the facilities constructed from time to time on the Land, all machinery, tools, office equipment, furniture, furnishings, fixtures, vehicles, motor vehicles, and any manuals, instructions, blueprints, computer software and similar items which relate to the above, and any and all additions, substitutions and replacements of any of the foregoing, wherever located, together with all improvements thereon and all attachments, components, parts, equipment and accessories installed thereon or affixed thereto.

^{1*} By their purchase of the Bonds, the initial holders thereof will consent to an amendment of this definition as described in “SECURITY AND SOURCES OF PAYMENT FOR THE BONDS – Amendment of the Master Indenture” in the front part of this Official Statement. The proposed amended definition is as follows:

¹“Debt Service Requirement” of any Person shall mean, for any period of time, the amounts payable or the payments required to be made by such Person in respect of principal and interest on Outstanding Long-Term Indebtedness during such period (calculated in such a manner that no portion of the Long-Term Indebtedness is included more than once), taking into account (for purposes of calculating any projected debt service requirements) (i) that any Indebtedness represented by a Guaranty shall be deemed payable on the dates and in the amounts contemplated in Section 4.3 (concerning the assumptions to be used in including debt service requirements of the guaranteed obligations), (ii) that any payments to be made in respect of Balloon Indebtedness and Variable Rate Indebtedness shall be calculated in accordance with the provisions of Section 4.4, (iii) that, with respect to Indebtedness refunded or refinanced during such period, only an amount of principal and interest equal to the principal and interest not payable from the proceeds of Indebtedness shall be taken into account during such period, (iv) any amounts payable from funds available under an Escrow Deposit (other than amounts payable solely by reason of the obligor's failure to make payments from other sources), shall be excluded from the determination of the Debt Service Requirement, and (v) that with respect to any Indebtedness which is the subject of a Hedge Agreement, the rate payable under such Hedge Agreement, rather than the actual interest payable on such Indebtedness, shall be taken into account in determining the interest payable with respect to such Indebtedness.

“Escrow Deposit” means a segregated escrow fund or other similar fund, account or deposit in trust of cash in an amount (or Defeasance Investments the principal of and interest on which will be in an amount), and under terms, sufficient to pay all or a portion of the principal of, and premium, if any, and interest on, the indebtedness secured by such escrow fund or other similar fund, account or deposit as the same shall become due or payable upon redemption.

“Event of Default” shall, with respect to each Bond Indenture and each Loan Agreement, respectively, have the meanings described under this Appendix C in “SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURE - Events of Default” and “THE LOAN AGREEMENT- Events of Default And Remedies on Default.”

“Facilities” means all land, leasehold interests and buildings and all fixtures and equipment of a person.

“Fair Value Net Worth” of a person as of any date means:

(i) the fair value or fair saleable value (as the case may be, determined in accordance, with applicable federal and state laws affecting creditors rights and governing determinations of insolvency of debtors) of such person’s assets (including such person’s rights to contribution and subrogation under Sections 2.3(d) and (f) of the Master Indenture or in respect of any other guarantee) as of such date, minus

(ii) the amount of all liabilities of such person (determined in accordance with such laws) as of such date, excluding (x) such person’s Cross Guarantee and (y) any liabilities subordinated in right of payment to such Cross Guarantee, minus

(iii) \$1.00.

“Fiscal Year” means a period of twelve consecutive months ending on June 30 or on such other date as may be specified in an Officer’s Certificate of the Obligated Group Agent executed and delivered to the Master Trustee.

“Fitch” means Fitch Ratings, Inc., its successors and assigns; and if such corporation shall be dissolved or liquidated or shall no longer perform the function of a municipal securities rating agency, “Fitch” shall be deemed to refer to any other recognized municipal securities rating agency designated by the Alliance.

“Fixed Rate Period” means the period from and including the Conversion Date to and including the date next preceding the payment in full of the Bonds.

“Fixtures” shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction and in any event shall include all goods now or hereafter attached to, placed on, or incorporated in the Land.

“General Intangibles” means “general intangibles” as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction, now or hereafter owned by any Obligated Group Issuer and shall include, but not be limited to, all trademarks, trademark applications, trademark registrations, trade names, fictitious business names, business names, company names, business identifiers, prints, labels, trade styles and service marks (whether or not registered), including logos and/or designs, copyrights, patents, patent applications, goodwill of any Obligated Issuer’s business symbolized by any of the foregoing, trade secrets, license rights, license agreements, permits, franchises, and any rights to tax refunds to which any Obligated Issuer is now or hereafter may be entitled.

“Governing Body” means, when used with respect to any person, its board of directors, board of trustees, or other board, committee or group of individuals in which the powers of a board of directors or board of trustees is vested generally or for the specific matters under consideration.

“Government Issuer” means any federal, state or municipal corporation or political subdivision thereof or any instrumentality of any of the foregoing empowered to issue obligations on behalf thereof.

“Government Obligations” means (i) for purposes of the Master Indenture, direct obligations of, or obligations the principal of and interest on which are unconditionally guaranteed by, the United States of America, including evidences of a direct ownership interest in future interest or principal payments on obligations issued or guaranteed by the United States of America, which obligations are held in a custody account by a custodian pursuant to the terms of a the terms of a custody agreement, and (ii) for purposes of the Bond Indenture, means direct general obligations of, or obligations the prompt payment of the principal of and the interest on which are fully and unconditionally guaranteed by, the United States of America. In addition, investments having a maturity of seven days or less in a money market fund rated Aaa by Moody’s, investments of which fund are exclusively in Government Obligations, shall be considered investments in Government Obligations for purposes of the Bond Indenture.

“Gross Receipts” means all Revenues, operating revenues and non-operating revenues, receipts, rentals and income of, or received by, any Obligated Issuer, under generally accepted accounting principles, and all rights to receive the same, whether in the form of accounts receivable, Receivables, accounts, Documents, Investment Property, Contract Rights, Chattel Paper, Instruments, General Intangibles or other rights and all Proceeds thereof, including insurance proceeds and condemnation awards payable or paid in respect of the Facilities, whether now existing or hereafter coming into existence and whether now owned or hereafter acquired, and the proceeds thereof including, without limitation, revenues derived from the ownership, operation or leasing of the Facilities; provided, however, that there shall be excluded from Gross Receipts (i) all gifts, grants, bequests, donations or contributions (collectively, “gifts”), which gifts may not be pledged or applied to the payment of principal or interest on the Obligations as a result of restrictions or designations imposed by the donor or maker of the gift in question at the time of the making thereof and income therefrom if such income may not be pledged or applied to the payment of principal or interest on the Obligations as a result of a restriction or designation described in this clause (i), and (ii) any proceeds of any additional indebtedness incurred or assumed by the Obligated Issuer pursuant to the terms of the Master Indenture, to the extent required by the terms of the documentation evidencing such additional indebtedness.

“Guaranty” means any obligation of an Obligated Group member guaranteeing any obligation of any other person other than a Obligated Group member, whether or not issued under the Master Indenture as an Indenture Guaranty, which obligation would, if such other person were a member of the Obligated Group, constitute Indebtedness under the Master Indenture.

“Hedge Agreement” means (a) any contract known as or referred to or which performs the function of an interest rate swap agreement, currency swap agreement, forward payment conversion agreement or futures contract; (b) any contract providing for payments based on levels of, or changes or differences in, interest rates, currency exchange rates, or stock or other indices; (c) any contract to exchange cash flows or payments or series of payments; (d) any type of contract called, or designed to perform the function of, interest rate floors, collars, or caps, options, puts, or calls, to hedge or minimize any type of financial risk, including, without limitation, payment, currency, rate or other financial risk; and (e) any other type of contract or arrangement that the Obligated Group Agent determines is to be used, to manage or reduce the cost of an Indebtedness, to convert any element of any Indebtedness from one form to another, to maximize or increase investment return, to minimize investment return risk, or to protect against any type of financial risk or uncertainty.

“Historical Debt Service Coverage Ratio” means, for any period of time, the ratio determined by dividing Total Income Available For Debt Service for such period by the Debt Service Requirement of the Obligated Group for such period.

“Historical Maximum Annual Debt Service Coverage Ratio” means, for any period of time, the ratio determined by dividing Total Income Available for Debt Service for such period by the Maximum Annual Debt Service of the Obligated Group.

“Historical Pro Forma Debt Service Coverage Ratio” means for any period of time, the ratio determined by dividing Total Income Available for Debt Service for such period by the Maximum Annual Debt Service of the Obligated Group for all Long Term Indebtedness then outstanding and the Long-Term Indebtedness then proposed to be issued.

“Holder” means, as the context requires, the registered owner of any Note, the beneficiary of any Indenture Guaranty in whose name an Indenture Guaranty is issued or the holder or beneficiary of any other type of Obligation. In the case of an Obligation issued to a trustee or other fiduciary acting on behalf of the holders of any bonds, notes or other similar obligations which are secured by such Obligation, including any registered securities depository then in the business of holding (for the benefit of beneficial owners whose interests may be evidenced by book-entry registration) substantial amounts of obligations of types comprising the Obligations, the term Holder shall mean the trustee or other fiduciary or, if so provided in the Related Financing Documents, the holders of the Related Bonds in proportion to their respective interests therein, including any registered securities depository then in the business of holding (for the benefit of beneficial owners whose interests may be evidenced by book-entry registration) substantial amounts of obligations of types comprising the Obligations. For purposes of determining the Holders of the two largest principal amounts of Uninsured Obligations, any Holder of Related Bonds relating to Uninsured Obligations shall be deemed to be the owner of a proportionate amount of the Uninsured Obligations, and any such Uninsured Obligations owned by affiliated entities shall be treated as owned by one Holder.

“Immediate Notice” means notice (a) by tested telex, telecopier or telephone, or delivery by hand, (b) promptly followed by written notice by first class mail, postage prepaid, and (c) to such address or such telex, telecopier or telephone number as the person receiving such notice shall have previously furnished to the Bond Trustee in writing.

“Income Available For Debt Service” of a person means, with respect to any period of time, the excess of revenues over expenses, or, in the case of for-profit entities, net income before tax, as determined in accordance with generally accepted accounting principles, to which shall be added, in either case, (i) depreciation, (ii) amortization, (iii) interest expense on Long-Term Indebtedness, and, to the extent not already included, and (iv) to the extent not already included contributions and donations and from which shall be excluded any extraordinary items, any impairment losses, any gain or loss resulting from either the extinguishment of indebtedness or the sale, exchange or other disposition of assets not made in the ordinary course of business, provided, however, that (a) no determination of Income Available for Debt Service will take into account any gains or losses resulting from the periodic valuation of investments or Hedge Agreements that do not involve the sale, transfer or other disposition of any such investment or Hedge Agreement or the termination of any Hedge Agreement and (b) a person may include in its net income such person’s share of the net income of any person controlled by such person or in whom such person has a legal interest.

“Indebtedness” of a person means (i) all Notes and Guaranties, (ii) all liabilities (exclusive of reserves such as those established for deferred taxes or litigation) recorded on the audited financial statements of such person as of the end of the most recent Fiscal Year for which financial statements reported upon by an Accountant are available, and (iii) all other obligations for borrowed money; provided that Indebtedness shall not include (1) Subordinated Indebtedness, (2) Hedge Agreements, (3) any other Indebtedness of any member of the Obligated Group to any other member of the Obligated Group, (4) rentals payable under leases which are not properly capitalized under generally accepted accounting principles or (5) any Guaranty by any member of the Obligated Group of Indebtedness of any other member of the Obligated Group.

“Indenture Guaranty” means any Guaranty issued under the Master Indenture by an Obligated Issuer.

“Instrument” shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

“Interest Payment Date” means (a) during Weekly Rate Periods, the first Business Day of each calendar month and any Conversion Date, Proposed Conversion Date or the maturity of the Bonds, and (b) during any Medium-Term Rate Periods and any Fixed Rate Period, each Long-Term Interest Payment Date.

“Interest Rate Swap Obligations” means obligations of any person pursuant to any arrangement with any other person whereby, directly or indirectly, such person is entitled to receive from time-to-time periodic payments calculated by applying either a floating or a fixed rate of interest on a stated principal amount in exchange for periodic payments made by such other person calculated by applying a fixed or a floating rate of interest on the same amount.

“Inventory” means all of the inventory of any Obligated Issuer of every type or description, including all inventory as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction, now owned or hereafter acquired and wherever located, whether raw, in process or finished, all materials usable in processing the same and all documents of title covering any inventory, including but not limited to work in process, materials used or consumed in such Obligated Issuer’s business, now owned or hereafter acquired or manufactured by such Obligated Issuer and held for sale in the ordinary course of its business; all present and future substitutions therefor, parts and accessories thereof and all additions thereto; and all proceeds thereof and products of such inventory in any form whatsoever.

“Investment Property” shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

“Investment Securities” means, to the extent permitted by applicable law:

(i) Certificates or interest-bearing notes or obligations of the United States, or those for which the full faith and credit of the United States are pledged for the payment of principal and interest.

(ii) Investments in any of the following obligations, provided such obligations are backed by the full faith and credit of the United States: (a) the Export-Import Bank of the United States, (b) the Federal Housing Administration, (c) the Government National Mortgage Association (“GNMA”), (d) the Rural Economic Community Development Administration (formerly known as the Farmers Home Administration), (e) the Federal Financing Bank, (f) the Department of Housing and Urban Development, (g) the General Services Administration, (h) the U.S. Maritime Administration or (i) the Small Business Administration.

(iii) Investments in direct obligations in any of the following agencies, which obligations are not fully guaranteed by the full faith and credit of the United States: (a) senior obligations by the Federal Home Loan Bank System, (b) senior debt obligations and participation certificates (excluding stripped mortgage securities which are purchased at prices exceeding their principal amounts) issued by the Federal Home Loan Mortgage Corporation (“FHLMC”) or senior debt obligations and mortgage-backed securities (excluding stripped mortgage securities which are purchased at prices exceeding their principal amounts) of the Federal National Mortgage Association (“FNMA”), (c) obligations of the Resolution Funding Corporation (“REFCORP”), or (d) senior debt obligations of the Student Loan Marketing Association (“SLMA”) (excluding securities that do not have a fixed par value or whose terms do not promise a fixed dollar amount at maturity or call date).

(iv) Investments in (a) U.S. dollar denominated deposit accounts, federal funds, bankers acceptances, and certificates of deposit of any bank whose short-term debt obligations are rated A-1+ by S&P and P-1 by Moody’s and maturing no more than 360 calendar days after the date of purchase (holding company ratings are not considered as rating of the bank) or (b) certificates of deposit of any bank, which certificates are fully insured by the Federal Deposit Insurance Corporation (“FDIC”).

(v) Investments in money market funds rated “AAAm” or “AAAm-G” by S&P.

(vi) Commercial paper which is rated at the time of purchase in the single highest classification, “P-1” by Moody’s, Inc. and “A-1+” by S&P and which matures not more than 270 calendar days after the date of purchase.

(vii) Pre-refunded municipal obligations defined as follows: any bonds or other obligations rated “AAA” by S&P and “Aaa” by Moody’s (based on an irrevocable escrow account or fund) of any state of the United States of America or any agency, instrumentality or local governmental unit of any such state which are not callable at the option of the obligor prior to maturity or as to which irrevocable instructions have been given by the obligor to call on the date specified in the notice.

(viii) Municipal obligations rated “Aaa/AAA” or general obligations of states with a rating of “A1/A+” or higher by both Moody’s and S&P at the time of purchase.

(ix) Repurchase agreements with (a) any domestic bank, or domestic branch of a foreign bank, the long-term debt which is rated at least “A” by S&P and “A2” by Moody’s; or (b) any broker-dealer with “retail customers” or a related affiliate thereof, which broker-dealer has, or the parent company (which guarantees the provider) of which has, long-term debt rated at least “A” by S&P and “A2” by Moody’s, which broker-dealer falls under the jurisdiction of the Securities Investors Protection Corporation; or (c) any other entity rated at least “A” by S&P and “A2” by Moody’s; provided that:

(a) the repurchase agreement is collateralized with the obligations described in paragraphs (i) or (ii) above, or with obligations described in paragraph (iii)(a) and (b) above.

(b) the trustee will value the collateral securities no more than semi-annually and will liquidate the collateral securities if any deficiency in the required collateral percentage is not restored within two (2) business days.

(c) the market value of the collateral must be maintained at: 104% of the total principal of the repurchase agreement for obligations described in paragraphs (i) and (ii); 105% of the total principal of the repurchase agreement for obligations described in paragraph (iii)(a) and (b) above.

(d) the trustee or a third party acting solely as agent therefor or for the issuer (the “Holder of the Collateral”) has possession of the collateral or the collateral has been transferred to the Holder of the Collateral in accordance with applicable state and federal laws (other than by means of entries on the transferor’s books).

(e) the repurchase agreement shall state, and an opinion of counsel shall be rendered at the time such collateral is delivered, that the Holder of the Collateral has a perfected first priority security interest in the collateral, and substituted collateral and all proceeds thereof.

(f) the repurchase agreement shall provide that if during its term the provider’s rating by either Moody’s or S&P is withdrawn or suspended or falls below “A-“ by S&P or “A3” by Moody’s, as appropriate, the provider must, at the direction of the Issuer or the trustee, within 10 days of receipt of such direction, repurchase all collateral and terminate the agreement, with no penalty or premium to the issuer or trustee.

(x) Investment agreements with (a) a domestic or foreign bank or corporation (other than a life or property casualty insurance company), the long-term debt of which, or, in the case of a guaranteed corporation, the long-term debt is rated at least “AA” by S&P and “Aa2” by Moody’s at the time of purchase; or (b) a monoline municipal bond insurance company or a subsidiary thereof whose claims paying ability is rated at least “AA” by S&P and “Aa2” by Moody’s at the time of purchase; provided, that in all cases, by the terms of the investment agreement:

(a) interest payments are to be made to the Bond Trustee at least one business day prior to debt service payment dates on the Bonds and in such amounts as are necessary to pay debt service (or, if the investment agreement is for the construction fund, construction draws) on the Bonds;

(b) the invested funds are available for withdrawal, without penalty or premium, at any time upon not more than seven days’ prior notice (which notice may be amended or withdrawn at any time prior to the specified withdrawal date); provided that the investment agreement specifically requires the Issuer or the Bond Trustee to give notice in accordance with the terms of the investment agreement so as to receive funds thereunder with no penalty or premium paid;

(c) the investment agreement shall state that it is the unconditional and general obligation of, and is not subordinated to any other obligation of, the provider thereof;

(d) a fixed guaranteed rate of interest is to be paid on invested funds and all future deposits, if any, required to be made to restore the amount of such funds to the level specified under the Bond Indenture;

(e) the term of the investment agreement does not exceed seven years;

(f) the Issuer or the Bond Trustee receives the opinion of domestic counsel that such investment agreement is legal, valid, binding and enforceable upon the provider in accordance with its terms and of foreign counsel (if applicable);

(g) the Bond Indenture and investment agreement shall provide that if, during its term:

(1) the provider's rating by either S&P or Moody's falls below "AA " or "Aa3," respectively, the provider must, at the direction of the Issuer or the Bond Trustee, within 10 days of receipt of such direction, either (i) collateralize the investment agreement by delivering or transferring in accordance with applicable state and federal laws (other than by means of entries on the provider's books) to the Issuer, the Bond Trustee or a third party acting solely as agent therefor Permitted Collateral which are free and clear of any third-party liens or claims at the Collateral Levels set forth below; or (ii) repay the principal of and accrued but unpaid interest on the investment (the choice of (i) or (ii) above shall be that of the Issuer or Trustee, as appropriate); and

(2) the provider's rating by either Moody's or S&P is withdrawn or suspended or falls below "A-" or "A3" by S&P or Moody's, as appropriate, the provider must, at the direction of the Issuer or the Bond Trustee, within 10 days of receipt of such direction, repay the principal of and accrued but unpaid interest on the investment, in either case with no penalty or premium to the Issuer or Bond Trustee;

(h) The investment agreement shall state and an opinion of counsel shall be rendered that the Bond Trustee has a perfected first priority security interest in the Permitted Collateral, any substituted collateral and all proceeds thereof (in the case of bearer securities, this means the trustee is in possession); and

(i) the investment agreement must provide that if, during its term:

(1) the provider shall default in its payment obligations, the provider's obligations under the investment agreement shall, at the direction of the Issuer or the Bond Trustee, be accelerated and amounts invested and accrued but unpaid interest thereon shall be repaid to the Issuer or Bond Trustee, as appropriate;

(2) the provider shall become insolvent, not pay its debts as they become due, be declared or petition to be declared bankrupt, etc. ("event of insolvency"), the provider's obligations shall automatically be accelerated and amounts invested and accrued but unpaid interest thereon shall be repaid to the Issuer or Bond Trustee, as appropriate;

(3) the provider fails to perform any of its obligations under the investment agreement (other than obligations related to payment or rating) and such breach continues for ten (10) business days or more after written notice thereof is given by the Bond Trustee to the provider, it shall be an Event of Default; or

(4) a representation or warranty made by the provider proves to have been incorrect or misleading in any material respect when made, it shall be an Event of Default.

Permitted Collateral for Investment Agreements ("Permitted Collateral"):

- (A) U.S. direct Treasury obligations;
- (B) Senior debt and/or mortgage-backed obligations of GNMA, FNMA or FHLMC and other government-sponsored agencies backed by the full faith and credit of the U.S. government;
- (C) Collateral levels must be 104% of the total principal deposited under the investment agreement for U.S. direct Treasury obligations, GNMA obligations and full faith and credit U.S. government obligations and 105% of the total principal deposited under the investment agreement for FNMA and FHLMC;
- (D) The collateral must be held by a third party, segregated and marked to market at least weekly.

“Land” means the land subject to the Master Deed of Trust.

“Letter of Credit” means the Original Letter of Credit or, upon the effective date of any Substitute Letter of Credit, such Substitute Letter of Credit.

“Letter of Credit Period” means any period that a Letter of Credit is in effect with respect to the Bonds.

“Lien” means any mortgage or pledge of, security interest in or lien or encumbrance on any Property of any member of the Obligated Group in favor of, or which secures any Indebtedness or any other obligation of any member of the Obligated Group to any person other than another member of the Obligated Group, but specifically excluding subordination arrangements among creditors.

“Loan Agreement” means individually the Series 2013A Loan Agreement and the Series 2013B Loan Agreement.

“Long-Term Indebtedness” means (i) all Indebtedness which, at the time of incurrence or issuance, has a final maturity or term greater than one year or which is renewable at the option of the obligor thereof for a term greater than one year from the date of original incurrence or issuance; and (ii) Short-Term Indebtedness which is incurred as interim financing and which is intended to be repaid out of the proceeds of other Long-Term Indebtedness, provided that any one of the applicable conditions described in the Master Indenture are met with respect to such Short-Term Indebtedness on the date of incurrence, assuming for purposes of compliance therewith that such Short-Term Indebtedness is Long Term Indebtedness characterized as Balloon Indebtedness for purposes of meeting any of the applicable conditions in the Master Indenture; provided, that, Long-Term Indebtedness shall not include (a) Non-Recourse Indebtedness or Subordinated Indebtedness; (b) current obligations payable out of current revenues, including current payments for the funding of pension plans and contributions to self insurance programs; (c) obligations under contracts for supplies, services or pensions, allocated to the current operating expenses of future years in which the supplies are to be furnished, the services rendered or the pensions paid; and (d) rentals payable under leases which are not properly capitalized under generally accepted accounting principles.

“Long-Term Interest Payment Date” means the first January 1 or July 1 next succeeding the Medium-Term Adjustment Date or Conversion Date, as the case may be, and each January 1 or July 1 thereafter until the earlier of payment of the Bonds or the date that the Weekly Rate Periods begin.

“Long-Term Rate Period” means any Medium-Term Rate Period and the Fixed Rate Period.

“Master Deed of Trust” means the Deed of Trust and Security Agreement dated as of February 1, 2000 from the Alliance to an individual, as trustee, granting a deed of trust lien on and a security interest in the Land and the other collateral described therein for the benefit of the Master Trustee, to secure the payment and performance of outstanding Obligations.

“Master Indenture” means the Amended and Master Trust Indenture dated as of February 1, 2000 between the Alliance and the Master Trustee, as it may from time to time be amended or supplemented in accordance with the terms thereof.

“Master Trustee” means The Bank of New York Mellon Trust Company, N.A., or any successor trustee under the Master Indenture.

“Maximum Annual Debt Service” of the Obligated Group means the highest annual Debt Service Requirement of the Obligated Group for the current or any succeeding Fiscal Year during the remaining term of all outstanding Obligations.

“Maximum Guaranty Liability” of a person as of any date means the greater of either (i) or (ii) below:

(i) the greater of (A) or (B) as of such date:

(A) the outstanding amount of all Obligations issued by such person or

(B) the fair market value of all property acquired, in whole or part, with the proceeds of such Obligations by such person.

(ii) The greatest of the Fair Value Net Worth of such person as of (1) the latest fiscal year-end of such person, (2) each fiscal quarter-end of such person thereafter occurring on or prior to the date of the determination of Maximum Guaranty Liability, (3) the date on which enforcement of the pertinent Cross Guarantee is sought, and (4) the date on which a case under the U.S. Bankruptcy Code is commenced with respect to any Obligated Issuer.

“Medium-Term Rate Period” means any period of time from one year to five years as determined by the Remarketing Agent pursuant to the Bond Indenture.

“Moody’s” means Moody’s Investors Service, Inc., its successors and assigns; and if such corporation shall be dissolved or liquidated or shall no longer perform the function of a municipal securities rating agency, “Moody’s” shall be deemed to refer to any other recognized municipal securities rating agency designated by the Alliance.

“Net Operating Revenues” of a person means, with respect to any period of time, operating revenues less estimated contractual allowances, free care, discounts and bad debt expense, all determined, except as is specifically provided in the Master Indenture, in accordance with generally accepted accounting principles.

“Net Property, Plant and Equipment” means the Value of all Property, Plant and Equipment less accumulated depreciation.

“Non-Recourse Indebtedness” means any Indebtedness secured by a Lien on Property of any Obligated Issuer, liability for which is effectively limited to the Property subject to such Lien, with no recourse, directly or indirectly, to any other Property of any Obligated Issuer.

“Note” means any note issued under the Master Indenture by an Obligated Issuer to evidence Long-Term Indebtedness or Short-Term Indebtedness incurred pursuant to the terms of the Master Indenture.

“Notice by Mail” or “notice” of any action or condition “by Mail” means a written notice meeting the requirements of the Bond Indenture mailed by first-class mail, postage prepaid, to the Holders of specified Bonds at the addresses shown in the Bond Register. If, because of the temporary or permanent suspension of mail service or for any other reason, it is impossible or impracticable to mail any such notice in the manner described, then such notification in lieu thereof as shall be made with the approval of the Bond Trustee shall constitute a sufficient notice.

“Obligated Group” means all Obligated Issuers.

“Obligated Group Agent” means the Alliance and any successor Obligated Group Agent appointed pursuant to the Master Indenture.

“Obligated Issuer” means (i) the Alliance, Blue Ridge Medical Management Corporation, Norton Community Hospital, Smyth County Community Hospital and each other person which becomes an Obligated Issuer in accordance with the provisions of the Master Indenture, whether or not such person has issued any obligations thereunder, and which has not withdrawn from the Obligated Group pursuant to the Master Indenture, and (ii) when used in respect of any particular Obligation or other Indebtedness, means the obligor thereunder.

“Obligations” means all Notes and Indenture Guaranties issued under the Master Indenture, any lease, contractual agreement to pay money or other obligations of any Obligated Group Member issued thereunder and any additional forms of Obligations created pursuant to the Master Indenture.

“Officer’s Certificate” means a certificate signed, in the case of a corporation, by the Chairman, Vice Chairman, President or Chief Financial Officer or, in the case of a certificate delivered by any other person, the chief executive or chief financial officer of such person, in either case whose authority to execute such certificate shall be evidenced to the satisfaction of the Master Trustee. When an Officer’s Certificate is required under the Master Indenture to set forth matters relating to one or more Obligated Issuers, such Officer’s Certificate may be given in reliance upon another certificate, or other certificates, and supporting materials, if any, provided by any duly authorized officer of the applicable Obligated Issuer.

“Opinion of Bond Counsel” means an opinion in writing signed by an attorney or firm of attorneys experienced in the field of municipal bonds whose opinions are generally accepted by purchasers of municipal bonds.

“Opinion of Counsel” means a written opinion of Counsel, who may (except as otherwise expressly provided in the Loan Agreement or the Bond Indenture) be counsel for the Issuer or the Alliance or both, or other Counsel acceptable to the Bond Trustee.

“Original Letter of Credit” means individually the Series 2013A Original Letter of Credit and the Series 2013B Letter of Credit.

“Paying Agent” means the bank or banks, if any, designated pursuant to a Related Bond Indenture to receive and disburse the principal of and interest on any Related Bonds or designated pursuant to the Master Indenture to receive and disburse the principal of and interest on any Obligations.

“Permitted Liens” means the Master Indenture, all Related Financing Documents and, as of any particular time:

(i) Any lien from any member of the Obligated Group to any other member of the Obligated Group;

(ii) Any judgment lien or notice of pending action against any member of the Obligated Group so long as (1) such judgment or pending action is being contested and execution thereon has been stayed or the period for responsive pleading or appeal has not lapsed, or (2) in the absence of such contest, neither the pledge and security interest of this Indenture nor any Property of any member of the Obligated Group will be materially impaired or subject to material loss or forfeiture;

(iii) (A) Rights reserved to or vested in any municipality or public authority by the terms of any right, power, franchise, grant, license, permit or provision of law affecting any Property, to (1) terminate such right, power, franchise, grant, license or permit, provided that the exercise of such right would not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof, or (2) purchase, condemn, appropriate or recapture, or designate a purchaser of, such Property; (B) any liens (or deposits to obtain the release of such liens) on any Property for taxes, assessments, levies, fees, water and sewer charges, and other governmental and similar charges and any liens of mechanics, materialmen, laborers, suppliers or

vendors for work or services performed or materials furnished in connection with such Property, which are not due and payable or which are not delinquent or which, or the amount or validity of which, are being contested and execution thereon is stayed; (C) easements, rights-of-way, servitudes, restrictions and other minor defects, encumbrances, and irregularities in the title to any Property which do not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof; (D) rights reserved to or vested in any municipality or public authority to control or regulate any Property or to use such Property in any manner, which rights do not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof; and (E) to the extent that it affects title to any Property, the Master Indenture;

(iv) Any lease which relates to Property of the Obligated Group which is of a type that is customarily the subject of such leases, including but not limited to any leasehold interest required under any Related Financing Documents, leases with respect to office space for physicians and educational institutions, food service facilities, gift shops and radiology or other hospital-based specialty services, pharmacy and similar departments and statutory landlord's liens with respect to such leases;

(v) Any Lien securing Indebtedness provided such Lien also secures all Obligations (other than Obligations representing Subordinated Indebtedness or Non-Recourse indebtedness) on a parity basis;

(vi) Any Lien arising by reason of good faith deposits in connection with leases of real estate, bids or contracts (other than contracts for the payment of money), deposits by any member of the Obligated Group to secure public or statutory obligations, or to secure, or in lieu of, surety, stay or appeal bonds, and deposits as security for the payment of taxes or assessments or other similar charges;

(vii) Any Lien arising by reason of deposits with, or the giving of any form of security to, any governmental agency or any body created or approved by law or government regulation for any purpose at any time as required by law or governmental regulation as a condition to the transaction of any business or the exercise of any privilege or license, or to enable any member of the Obligated Group to maintain self insurance or to participate in any funds established to cover any insurance risks or in connection with workers compensation, unemployment insurance, pension or profit sharing plans or other similar social security plans, or to share in the privileges or benefits required for companies participating in such arrangements;

(viii) Any Lien arising by reason of an Escrow Deposit;

(ix) (A) Any Lien in favor of a trustee or the holder of a Note on the proceeds of Indebtedness or cash or investments deposited with such trustee and acquired with such proceeds prior to the application of such proceeds or cash or investments and (B) Liens in favor of a trustee, including the Master Trustee, to secure obligations to compensate, reimburse or indemnify such trustees;

(x) Any Lien on moneys deposited by patients or others with any member of the Obligated Group as security for or as prepayment for the cost of patient care;

(xi) Any Lien on Property received by any member of the Obligated Group through gifts, grants or bequests, such Lien being due to restrictions on such gifts, grants or bequests of property or the income thereon;

(xii) Statutory rights of the United States of America by reason of federal funds made available under 42 U.S.C. §§ 291 *et seq.* and similar rights under other federal and state statutes;

(xiii) Liens existing at the time of a Consolidation or Merger permitted under the Master Indenture, on the date of acquisition of any Property or at the time a person becomes an Obligated Issuer; provided that no such Lien (or the amount of indebtedness secured thereby) may be increased, extended, renewed or modified to apply to any Property of any member of the Obligated Group not subject to such Lien on such date, unless such Lien as so extended, renewed or modified shall be offered as security for all Obligations hereunder;

(xiv) Any Lien described in Exhibit A to the Master Indenture, provided that no such Lien (or the amount of indebtedness secured thereby) may be increased, extended, renewed or modified to apply to any Property of any member of the Obligated Group not subject to such Lien on such date, unless such Lien as so extended, renewed or modified otherwise qualifies as a Permitted Lien under the Master Indenture;

(xv) A security interest in any funds or accounts established pursuant to the provisions of any Related Financing Documents;

(xvi) Liens in the form of purchase money security interests in Property financed with the proceeds of Indebtedness secured thereby;

(xvii) Liens securing any Indebtedness permitted under the Master Indenture, provided that the Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that not more than 20% of the Value of all Net Property Plant and Equipment of the Obligated Group would be subject to a Lien (excluding any purchase money security interest permitted under subsection (xvi) above and the Lien created under the Master Deed of Trust for the purpose of making such calculation);

(xviii) Liens on accounts receivable arising as a result of sale of such accounts receivable with recourse, provided that such liens shall be limited to 25% of net accounts receivable outstanding; and

(xix) Options granted by any member of the Obligated Group to others to purchase real property or other assets of such member; provided, however, that the sale pursuant to such option would be permitted under the conditions described in the Master Indenture.

(xx) Liens on any Property that is not encumbered by the Master Deed of Trust so long as the aggregate amount secured by such Liens does not exceed \$5,000,000.

“Pledged Bonds” means any Bonds purchased with the proceeds of a drawing under and in accordance with the provisions of the Letter of Credit until such time as such Bonds are released from the security interest created by the Reimbursement Agreement in accordance with the provisions thereof.

“Proceeds” means “proceeds” as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction or under other relevant law and, in any event, shall include, but shall not be limited to, (i) any and all proceeds of any insurance, indemnity, warranty or guaranty payable to any Obligated Issuer from time to time, and claims for insurance, indemnity, warranty or guaranty effected or held for the benefit of the Corporation, with respect to any of the Collateral, (ii) any and all payments (in any form whatsoever) made or due and payable to the any Obligated Issuer from time to time in connection with any requisition, confiscation, condemnation, seizure or forfeiture of all or any part of the Collateral by any Government Authority (or any person acting under color of Government Authority) and (iii) any and all other amounts from time to time paid or payable under or in connection with any of the Collateral.

“Projected Debt Service Coverage Ratio” means for any future period of time, the ratio determined by dividing projected Total Income Available for Debt Service for such period by Maximum Annual Debt Service of the Obligated Group.

“Property” means any and all rights, titles and interests in and to any and all assets of a person, including all real or personal property, all tangible or intangible property, and all cash, wherever such assets are situated.

“Property, Plant and Equipment” means all Property which is classified as property, plant and equipment under generally accepted accounting principles.

“Rate Period” or “Rate Periods” means any of (a) the Weekly Rate Periods, (b) the Medium-Term Rate Periods or (c) the Fixed Rate Period.

“Rating Agency” means, severally or collectively, if applicable (i) Standard & Poor’s Ratings Group and any successor thereto, if it has assigned a rating to any Obligation issued and outstanding under the Master Indenture or any Related Bonds issued and outstanding pursuant to any Related Financing Documents, (ii) Moody’s Investors Service, Inc. and any successor thereto, if it has assigned a rating to any Obligation issued and outstanding under the Master Indenture or any Related bonds issued and outstanding pursuant to any Related Financing Documents, and (iii) Fitch’s IBCA Inc. and any successor thereto, if it has assigned a rating to any Obligation issued and outstanding pursuant to any Related Financing Documents. If any such Rating Agency shall no longer perform the functions of a securities rating service for whatever reason, the term “Rating Agency” shall thereafter be deemed to refer to the others, but if both of the others shall no longer perform the functions of a securities rating service for whatever reason, term “Rating Agency” shall thereafter be deemed to refer to any other nationally recognized rating service or services as shall be designated in writing by the Obligated Group Agent to the Master Trustee; provided that such designee shall not be unsatisfactory to the Master Trustee.

“Receivables” means any “Account” as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction and in any event shall include, but not be limited to, all of any Obligated Issuer’s rights to payment for goods (including, without limitation, steam and electricity) sold or leased, or for services performed, by such Obligated Issuer, whether now in existence or arising from time to time hereafter, including, without limitation, rights evidenced by an account, note, contract, security agreement, chattel paper, or other evidence of indebtedness or security, together with (i) all security pledged, assigned, hypothecated or granted to or held by any Obligated Issuer to secure the foregoing, (ii) all of such Obligated Issuer’s right, title and interest in and to any goods (including, without limitation, steam and electricity), the sale of which gave rise thereto, (iii) all guarantees, endorsements and indemnifications on, or of, any of the foregoing, (iv) all powers of attorney for the execution of any evidence of indebtedness or security or other writing in connection therewith, (v) all books, correspondence, credit files, records, ledger cards, invoices, and other papers relating thereto, including without limitation all similar information stored on a magnetic medium or other similar storage device and other papers and documents in the possession or under the control of any Obligated Issuer or any computer bureau from time to time acting for such Obligated Issuer, (vi) all evidences of the filing of financing statements and other statements and the registration of other instruments in connection therewith and amendments thereto, notices to other creditors or secured parties, and certificates from filing or other registration officers, (vii) all credit information, reports and memoranda relating thereto, and (viii) all other writings related in any way to the foregoing.

“Record Date” means (a) during Weekly Rate Periods, the Business Day preceding any Interest Payment Date, and (b) during any Medium-Term Rate Periods or Fixed Rate Periods, the first day of the month preceding any Interest Payment Date.

“Redemption Date” when used with respect to any Bond to be redeemed means the date on which it is to be redeemed pursuant hereto.

“Redemption Price” when used with respect to any Bond to be redeemed means the price at which it is to be redeemed pursuant thereto.

“Regularly Scheduled Qualified Swap Payments” means the regularly scheduled payments under the terms of an Hedge Agreement which are due or receivable absent any termination, default or dispute in connection with such Hedge Agreement.

“Reimbursement Agreement” means individually (i) the Reimbursement Agreement relating to the Series 2013A Bonds dated as of July 30 among the Obligated Group, the Bank and other Lenders Parties thereto, including any amendments or supplements thereto and (ii) the Reimbursement Agreement relating to the Series 2013B Bonds dated as of July 30 among the Obligated Group, the Bank and other Lenders Parties thereto, including any amendments or supplements thereto; and upon the effective date of any Substitute Letter of Credit, “Reimbursement Agreement” shall mean a similar agreement, if any, between the issuer of such Substitute Letter of Credit and the Alliance.

“Related Bond Indenture” means any indenture, bond resolution or other comparable instrument pursuant to which a series of Related Bonds is issued.

“Related Bond Issuer” means the Government Issuer of any issue of Related Bonds.

“Related Bond Trustee” means the trustee and its successors in the trust created under any Related Bond Indenture, and if there is no such trustee, shall mean the Related Bond Issuer.

“Related Bonds” means the revenue bonds, notes, other evidences of indebtedness or any other obligations issued by a Government Issuer, pursuant to a single Related Bond Indenture, the proceeds of which are loaned or otherwise made available to an Obligated Issuer in consideration of the execution, authentication and delivery of a Note to or for the order of such Government Issuer.

“Related Financing Documents” means:

(a) in the case of any Note, (i) all documents, including any Related Bond Indenture, pursuant to which the proceeds of the Note are made available to an Obligated Issuer, the payment obligations evidenced by the Note are created and any security for the Note (if permitted under this Indenture) is granted, and (ii) all documents creating any additional payment or other obligations on the part of an Obligated Issuer which are executed in favor of the Holder in consideration of the Note proceeds being loaned or otherwise made available to the Obligated Issuer;

(b) in the case of any Indenture Guaranty, all documents creating the indebtedness being guaranteed pursuant to the Indenture Guaranty and providing for the loan or other disposition of the proceeds of the indebtedness and all documents pursuant to which any security for the Indenture Guaranty (if permitted under the Master Indenture) is granted; and

(c) in the case of Indebtedness other than Notes and Indenture Guaranties, all documents relating thereto which are of the same nature and for the same purpose as the documents described in clauses (a) and (b) above.

“Revenues” means all revenues, income, receipts and other money received or accrued by or on behalf of any Obligated Issuer from any source whatsoever, including, without limitation, proceeds derived from (i) insurance except where otherwise provided herein, (ii) all accounts and assignable general intangibles now owned or hereafter acquired by any Obligated Issuer, and all proceeds therefrom whether cash or noncash, all as defined in Article 9 of the Uniform Commercial Code, as enacted by the State of Tennessee, (iii) the sale of goods, inventory and other tangible and intangible property, (iv) agreements respecting Medicare, Medicaid and Blue Cross or similar or successor programs, and (v) all gifts, grants, bequests, contributions and donations made to any Obligated Issuer, including the income and profits therefrom.

“S&P” means Standard & Poor’s Rating Group, a division of McGraw-Hill Financial Services Company, its successors and assigns; and if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a municipal securities rating agency, Standard & Poor’s Corporation shall be deemed to refer to any other nationally recognized municipal securities rating agency designated by the Alliance.

“Series 2013A Bond Indenture” means the Bond Trust Indenture dated as of July 1, 2013, between the Issuer and the Bond Trustee, as amended and supplemented, relating to the Series 2013A Bonds.

“Series 2013B Bond Indenture” means the Bond Trust Indenture dated as of July 1, 2013, between the Issuer and the Bond Trustee, as amended and supplemented, relating to the Series 2013B Bonds.

“Series 2013A Bonds” means the Issuer’s Hospital Revenue Bonds (Mountain States Health Alliance) Series 2013A Bonds.

“Series 2013B Bonds” means the Issuer’s Taxable Hospital Refunding Revenue Bonds (Mountain States Health Alliance) Series 2013B Bonds.

“Series 2013A Loan Agreement” means Loan Agreement dated as of July 1, 2013, between the Issuer and the Alliance, as amended and supplemented, relating to the Series 2013A Bonds.

“Series 2013B Loan Agreement” means Loan Agreement dated as of July 1, 2013, between the Issuer and the Alliance, as amended and supplemented, relating to the Series 2013B Bonds.

“Series 2013 Obligations” means the Mountain States Health Alliance Notes being issued by the Alliance under the Master Indenture in connection with the issuance of the Bonds.

“Series 2013A Original Letter of Credit” the Letter of Credit delivered by the Bank to the Bond Trustee on the date of original issuance of the Series 2013A Bonds in accordance with the Series 2013A Loan Agreement, and all amendments, extensions, modifications and supplements thereto.

“Series 2013B Original Letter of Credit” the Letter of Credit delivered by the Bank to the Bond Trustee on the date of original issuance of the Series 2013B Bonds in accordance with the Series 2013B Loan Agreement, and all amendments, extensions, modifications and supplements thereto.

“Short-Term Indebtedness” means all Indebtedness other than Long-Term indebtedness.

“Subordinated Indebtedness” means any promissory note, guaranty, lease, contractual agreement to pay money or other obligation of any Obligated Issuer which is expressly made subordinate and junior in right of payment of principal of, redemption premium, if any, and interest on, (i) all Obligations issued pursuant to the Master Indenture, and (ii) all other obligations of the Obligated Group under the Master Indenture, on terms and conditions which substantially require that (1) no payment on account of principal of, redemption premium, if any, or interest on such Subordinated Indebtedness shall be made, nor shall any property or assets be applied to the purchase or other acquisition or retirement of such Subordinated Indebtedness, unless full payment of all amounts when due and payable upon maturity of Obligations issued under the Master Indenture have been made or duly provided for in accordance with the terms of such Obligations; (2) no payment on account of principal of, redemption premium, if any, or interest on such Subordinated Indebtedness shall be made, nor shall any property or assets be applied to the purchase or other acquisition or retirement of such Subordinated Indebtedness if, at the time of such payment or application, or immediately after giving effect thereto, (i) there shall exist a default in the payment of the principal of, redemption premium, if any, or interest on any Obligations (whether at maturity or upon mandatory redemption), or (ii) there shall have occurred an Event of Default with respect to any Obligations, as defined therein and in this Indenture, and such Event of Default shall not have been cured or waived or shall not have ceased to exist; and (3) in the event that any Subordinated Indebtedness is declared or otherwise becomes due and payable because of the occurrence of an event of default with respect thereto, (x) the Holders at such time shall be entitled to receive payment in full thereon before the holders of the Subordinated Indebtedness shall be entitled to receive any payment on account of such Subordinated Indebtedness as a result of such event of default, and (y) no holder of Subordinated Indebtedness, or a trustee acting on such holder’s behalf, shall be entitled to exercise any control over proceedings to enforce the terms and conditions of the Master Indenture.

“Tax-Exempt Organization” means a person organized under the laws of the United States of America or any state thereof which is an organization described in Section 501(c)(3) of the Code, which is exempt from federal income taxes under Section 501(a) of the Code, and which is not a “private foundation” within the meaning of Section 509(a) of the Code, or corresponding provisions of federal income tax laws from time to time in effect.

“Termination Date” means the stated expiration date of the Letter of Credit or the immediately preceding Business Day if such date is not a Business Day but shall not include the expiration date of the Letter of Credit due to a conversion to the Fixed Rate.

“Total Income Available for Debt Service” means, as to any period, (a) the aggregate of Income Available for Debt Service of each member of the Obligated Group for such period, determined in such a manner that no portion of Income Available for Debt Service of any member of the Obligated Group is included more than once.

“Total Net Operating Revenues” means, as to any period, the aggregate of Net Operating Revenues of each member of the Obligated Group for such period, determined in such a manner that no portion of Net Operating Revenues of any member of the Obligated Group is included more than once.

“Unrestricted Liquid Funds” as of any date means the aggregate of the unrestricted and unencumbered/unpledged cash and unrestricted and unencumbered/unpledged liquid securities (valued at fair market value) of the Obligated Group as of such date (including board-designated funds) from which there shall be subtracted each of the following: (i) the value of all self-insured professional and general liability insurance obligations of the Obligated Group determined by an independent actuary as of such date, (ii) any funds held by the lender or trustee with respect to any Long Term Indebtedness (including any debt service reserve fund, any debt service or bond fund or any construction or project fund), (iii) any proceeds drawn from a line of credit, liquidity facility or other similar facility and (iv) any grantor or donor restricted funds.

“Value,” when used in connection with any Property, means either (a) Book Value, or (b) at the election of the Obligated Group Agent evidenced by an Officer’s Certificate delivered to the Master Trustee, the aggregate fair market value of such Property, as reflected in the most recent written report of an appraiser selected by the Obligated Group Agent and, in the case of real property, who or which is a member of the American Institute of Real Estate Appraisers (MAI), delivered to the Master Trustee (which report shall be dated not more than three years prior to the date as of which value is to be calculated) (i) increased or decreased by the cost of any Property acquired, or the fair market value of any Property disposed of, since the date of such report and (ii) increased or decreased by a percentage equal to the aggregate percentage increase or decrease in the Construction Index from the date of such report to the date as of which value is to be calculated.

“Variable Rate Indebtedness” means any portion of Indebtedness the interest rate on which fluctuates subsequent to the time of incurrence.

SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE

Each Obligation will be issued pursuant to the Master Indenture and will entitle each holder thereof to the protection of the covenants, restrictions and other obligations imposed upon the Corporation and each Obligated Issuer by the Master Indenture and the security provided for therein.

Accounting Principles

Where the character or amount of any asset or liability or item of income or expense is required to be determined or any consolidation, combination or other accounting computation is required to be made for the purposes of the Master Indenture or any agreement, document or certificate executed and delivered in connection with or pursuant to the Master Indenture, such determination or computation shall be done in accordance with generally accepted accounting principles in effect on (i) the date of the delivery of the Master Indenture, or (ii) at the election of the Obligated Group Agent, as specified in an Officer’s Certificate delivered to the Master Trustee, the date such determination or computation is made for any purpose of the Master Indenture, such accounting principles, to the extent applicable, consistently applied; provided that intercompany balances and liabilities among the Obligated Issuers shall be disregarded and that the requirements set forth in this paragraph shall prevail, if inconsistent with generally accepted accounting principles. In the event that the fiscal year of any Obligated Issuer ends on a date other than the last day of a Fiscal Year, the character or amount of any asset or liability or item of income or expense of such Obligated Issuer for its fiscal year ending within any Fiscal Year under consideration shall be deemed to be the character or amount of the appropriate asset or liability or item of income or expense for such Fiscal Year. For purposes of calculating Total Income Available for Debt Service and Total Net Operating Revenues for any period, if any Obligated Issuer shall have become a member of the Obligated Group during such period, such calculations shall be made assuming that such Obligated Issuer became a member of the Obligated Group at the beginning of such period.

Master Indenture Obligations

Each Obligated Issuer is permitted to issue one or more series of Obligations under the Master Indenture on which all Obligated Issuers will be jointly and severally liable. The terms of each Obligation shall be set forth in a Supplemental Indenture.

The principal of, premium, if any, and interest on the Obligations shall be payable in any currency of the United States of America which is legal tender for the payment of public and private debts. Such payment shall be made at the principal corporate trust office of the Master Trustee or, if an Obligated Issuer so elects, by check, draft or wire transfer to such Holder. In the case of all payments made directly to a Holder, the Obligated Issuer shall give notice of such payment to the Master Trustee concurrently with the making thereof.

Each Obligated Issuer, jointly and severally, unconditionally guarantees to the Holders of the Obligations and to the Master Trustee the due and punctual payment of the principal of, and interest on, the Obligations and all other amounts due and payable under the Master Indenture; provided, however, that the maximum aggregate liability of each Obligated Issuer, as of any date, shall be its Maximum Guaranty Liability as of such date.

Each Obligated Issuer shall be subrogated to all rights of the Holders of the Obligations and the Master Trustee against the other Obligated Issuers in respect of any amounts paid pursuant to the Master Indenture.

If any person ceases to be an Obligated Issuer, such person shall cease to be a “Cross Guarantor” under the Master Indenture, and its Obligations as such shall be terminated and released; provided, however, that the foregoing provision is inapplicable (i) if such person ceases to be an Obligated Issuer as a result of a transaction which is prohibited by the terms of the Master Indenture or (ii) if, at the time such person would otherwise have been released under the provisions of this paragraph, there has occurred and is continuing a default in the payment of principal, or interest, on any Obligation.

If an Obligated Issuer is called upon to make a payment under its Cross Guarantee, each of the Obligated Issuers shall contribute to such paying Obligated Issuer their pro rata share, determined pursuant to the Master Indenture, of the amount of such payment.

All Obligations shall be executed for and on behalf of an Obligated Group Member by the officer as specified in the Master Indenture or such other officer designated in writing. A resolution of the Governing Body of the Obligated Group Agent shall also be joined thereto. Further, each Obligation shall be manually authenticated, in the form provided in the Master Indenture, by an authorized signer of the Master Trustee, without which authentication no Obligation shall be valid or entitled to the benefits of the Master Indenture.

The Master Trustee shall maintain at its principal corporate trust office a registration book relating to Obligations of the Obligated Group. These registration books shall contain (i) the names and addresses of Holders of Obligations, and (ii) any other information which may be necessary for the proper discharge of the Master Trustee’s duties under the Master Indenture. The Supplemental Indenture, providing for the issuance thereof, shall govern the transfer or exchange of any Obligation.

If any Obligation is mutilated, lost, stolen or destroyed, the Holder thereof shall be entitled to the issuance of a substitute Obligation only as follows:

(i) In the case of a lost, stolen or destroyed Obligation, the Holder shall: provide notice of the loss to the Obligated Group Agent, or to the Master Trustee; request the issuance of a substitute Obligation before the Obligated Group Agent receives notice of the transfer of the original Obligation to a bona fide purchaser for value without notice; provide indemnity to the Master Trustee against any and all claims arising out of, or otherwise related to, the issuance of substitute Obligations; and shall surrender any Obligation which have not been lost, stolen or destroyed and provide evidence of the ownership of the affected Obligation and the loss, theft or destruction thereof;

(ii) In the case of a mutilated Obligation the Holder shall: surrender the Obligation to the Master Trustee for cancellation; and provide indemnity to the Master Trustee against any and all claims arising out of, or otherwise related to, the issuance of substitute Obligations.

Every substituted Obligation shall constitute an additional contractual obligation of the Obligated Group, whether or not the Obligation alleged to have been destroyed, lost or stolen shall be at any time enforceable by anyone, and shall be entitled to all the benefits of the Master Indenture equally and proportionately with any and all other Obligations, unless the Obligation alleged to have been destroyed, lost or stolen shall be at any time enforceable by a bona fide purchaser for value without notice.

The preceding provisions regarding substitute Obligations are exclusive with respect to the replacement or payment of mutilated, destroyed, lost or stolen Obligations and shall preclude any and all other rights or remedies, notwithstanding any law or statute existing or later enacted to the contrary.

The Master Trustee shall establish and maintain a revenue or similar debt service fund for the purpose of accumulating and paying amounts due on outstanding Obligations (i) if the applicable Supplemental Indenture provides for the making of deposits directly with the Master Trustee in respect of an Obligation, or (ii) upon the occurrence of an Event of Default under the Master Indenture and the exercise of any remedies by the Master Trustee for the benefit of all Holders of outstanding Obligations. All money held in any fund established under the Master Indenture, in the case of (i) above, shall, upon written request and direction of the Obligated Group Agent, be invested in Investment Securities, and any money realized by the Master Trustee in the case of (ii) above, shall be invested by the Master Trustee, without need of any further authorization or direction, only in Government Obligations with maturities not in excess of ninety days, unless the Master Trustee is otherwise directed by Holder. The Master Trustee shall not be liable or responsible for any loss resulting from any such investment.

Any Obligated Issuer and the Master Trustee may enter into a Supplemental Indenture to create an Obligation issued under the Master Indenture. The Supplemental Indenture shall (i) with respect to Obligations created thereby, set forth the date thereof, and the date or dates on which principal of, premium, if any, and interest on such Obligations shall be payable, and (ii) provide for the form of such Obligations and shall contain such other terms and provisions as shall not be inconsistent with the provisions of the Master Indenture.

Simultaneously with or prior to the execution, authentication and delivery of the Obligations pursuant to the Master Indenture:

(a) All requirements and conditions to the issuance of such Obligations, if any, set forth in the Master Indenture and the Supplemental Indenture shall have been complied with and satisfied;

(b) The applicable Obligated Issuer or the Obligated Group Agent shall have delivered to the Master Trustee such opinions, certificates, proceedings, instruments and other documents as the Master Trustee or the Related Bond Issuer, if any, may reasonably request;

(c) The requirements of the Master Indenture with respect to the incurrence of Additional Indebtedness shall have been satisfied if such Obligations constitute Indebtedness;

(d) Each Supplemental Indenture shall specify the purpose or purposes for which such Obligations are being issued, which may be any purpose within the corporate power of the applicable Obligated Issuer; and

(e) The Obligated Group Agent shall have delivered to the Master Trustee an opinion of counsel, regarding the Securities Act of 1933 and the Trust Indenture Act of 1939, as required pursuant to the Master Indenture.

Security For Obligations

As security for the payment and performance of all outstanding Obligations, the Obligated Issuers shall grant the Master Trustee a security interest in (i) all money and Investment Securities which may at any time be held

by the Master Trustee in any fund or account which may be established by the Master Trustee under the Master Indenture in connection with the administration of the trusts created thereby, (ii) all Gross Receipts, (iii) all Receivables, (iv) all Inventory, (v) all Equipment, (vi) all General Intangibles, (vii) all Contracts and all Contract Rights, (viii) all amounts from time to time held in any checking, savings, deposit or other account of any Obligated Issuer, (ix) all Government Approvals, provided, that any Government Approval which by its terms or by the operation of law would become void, voidable, terminable or revocable if mortgaged, pledged or signed under the Master Indenture or if a security interest therein were granted thereunder or expressly accepted and excluded from the security interest hereby granted to the extent necessary so as to avoid such voidness, voidability, terminability or revocability, (x) all Fixtures, including but not limited to those now or hereafter attached to, placed on or incorporated in the Land, (xi) all Revenues, (xii) without limiting the generality of the foregoing, all other personal property, goods, Instruments, Investment Property, Chattel Paper, Documents, credits, claims, demands and assets of any Obligated Issuer, whether now existing or hereafter acquired from time to time, and (xiii) any and all additions and accessions to any of the foregoing, all improvements thereto, all substitutions and replacements therefor and all products and Proceeds thereof (all of the above collectively, the "Collateral"), to have and to hold in trust for the benefit of the Holders from time to time of all Obligations issued and outstanding under the Master Indenture, without preference or priority of any one Obligation over any other Obligation except as otherwise expressly provided therein. The security interest granted to the Master Trustee pursuant to the Master Indenture extends to all Collateral of the kind which is subject to such security interest which any Obligated Issuer may acquire at any time during the continuation of the Master Indenture, whether such Collateral is in transit or in such Obligated Issuer, the Issuer's or any other person's constructive, actual or exclusive occupancy or possession.

To further secure the payment of and performance under all outstanding Obligations, the Corporation has, on even date herewith, executed and delivered to the Master Trustee the Master Deed of Trust.

If (i) in any Fiscal Year beginning with the Fiscal Year ending June 30, 2006, the Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group is less than 1.50 to 1, (ii) the Obligated Group is not in compliance with the liquidity covenant described under the caption "Liquidity Covenant" herein, or (iii) an Event of Default has occurred and is continuing, the Obligated Group Agent shall cause a special trust fund (the "Revenue Fund") to be created with one or more banking institutions and each Obligated Issuer shall on a daily basis deposit all of its Gross Receipts therein.

The Obligated Group Agent shall cause each banking institution with which the Revenue Fund has been established to enter into a written depository agreement, which shall be satisfactory in form and substance to the Master Trustee and shall be in substantially the form of such agreement heretofore delivered to the Master Trustee (or with such changes therein as shall have been approved by the Holders of not less than 75% in aggregate principal amount of Obligations then outstanding) pursuant to which such banking institution shall agree to hold any and all Gross Receipts from time to time on deposit with such banking institution as assets of a trust for the Holders of the Obligations and to transfer such Gross Receipts to the Master Trustee upon receipt from the Master Trustee of a notice stating that delivery of such Gross Receipts is required pursuant to the Master Indenture. Prior to its receipt of a request from the Master Trustee, any Obligated Group member may transfer or expend all or any part of its Gross Receipts free of any security interest, subject, however, to the provisions of the Master Indenture. Deposits of Gross Receipts shall be made into the Revenue Fund on a daily basis, insofar as practicable, for the benefit of the Master Trustee and the Holders of the Obligations. Upon the request of the Obligated Group Agent, the Master Trustee will provide to such agent a written certifications as to whether there is currently outstanding a request from the Master Trustee.

Each Obligated Issuer agrees that except as may be otherwise provided in the Master Indenture, it will not pledge or grant a security interest in any of the Gross Receipts.

Each Obligated Issuer agrees that, if an Event of Default shall have occurred and be continuing, it will, upon request of the Master Trustee, deliver or direct to be delivered to the Master Trustee all Gross Receipts until such Event of Default has been cured, such Gross Receipts to be applied in accordance with the Master Indenture.

The Master Trustee shall establish and maintain a revenue or similar debt service fund hereunder for the purpose of accumulating and paying amounts due on outstanding Obligations (i) if the applicable Supplemental Indenture specifically provides for the making of deposits directly with the Master Trustee in respect of an

Obligation, or (ii) upon the occurrence of an Event of Default and the exercise of any remedies by the Master Trustee for the benefit of all Holders of outstanding Obligations; provided, however, if neither (i) nor (ii) are at the time applicable but deposits to the Revenue Fund are then required under subsection (a) above, the Obligated Group Agent may deposit the Gross Receipts with one or more banking institutions (other than the Master Trustee) and such revenues shall, upon the request and direction of the Obligated Group Agent, be invested in Investment Securities. In the case of (i) above, deposits to any such fund and payments therefrom shall be made in accordance with the terms and provisions of the applicable Supplemental Indenture for the making of deposits into and payments from such fund. In the case of (ii) above, any moneys realized by the Master Trustee upon the exercise of any such remedies shall be applied in accordance with the provisions of the Master Indenture. All money held at any time in any fund in the case of (i) above, shall, upon written request and direction of the Obligated Group Agent, be invested in Investment Securities and any money realized by the Master Trustee in the case of (ii) above, shall be invested by the Master Trustee, without need of any further authorization or direction, only in Government Obligations having maturities not in excess of 90 days, unless the Master Trustee is otherwise directed by Holders in the manner provided in the Master Indenture.

Persons Becoming Obligated Issuers; Withdrawal from Obligated Group

The Master Indenture permits persons other than the Corporation to become members of the Obligated Group subject to the satisfaction of certain conditions. The conditions include the following:

First, such person shall execute and deliver to the Master Trustee an appropriate instrument, satisfactory to the Obligated Group Agent, containing (i) the agreement of such person to become an Obligated Issuer under the Master Indenture and thereby to become subject to compliance with all provisions of the Master Indenture pertaining to an Obligated Issuer, including the performance and observance of all covenants and obligations of an Obligated Issuer under the Master Indenture; (ii) the agreement of such person to consult with each other member of the Obligated Group prior to incurring any Obligations; and (iii) such other restrictions on the ability of such person to incur Obligations as shall be imposed by the Obligated Group. Such person shall execute and deliver to the Master Trustee such security agreements, financing statements and other documents as are necessary to grant to the Master Trustee a perfected lien in all Collateral in which such person has an interest.

Second, each instrument executed and delivered to the Master Trustee in accordance with the preceding paragraph shall be accompanied by an Officer's Certificate from the Obligated Group Agent to the effect that the Obligated Group Agent consents to such person becoming an Obligated Issuer and an opinion of Counsel to the effect that (a) the conditions contained in the Master Indenture relating to such person's membership in the Obligated Group have been satisfied; (b) under then existing law, such person becoming an Obligated Issuer will not subject any Obligation to the registration provisions of the Securities Act of 1933, as amended, or that such Obligation has been so registered if so required, or the qualification of the Master Indenture pursuant to the Trust Indenture Act of 1939, as amended, or that the Master Indenture has been so qualified if qualification is required; and (c) each such instrument has been duly authorized, executed and delivered by such person and constitutes a legal, valid and binding agreement, enforceable in accordance with its terms, except as limited by then-existing laws relating to bankruptcy and insolvency and other standards and customary legal exceptions.

If all amounts due or to become due on any outstanding Related Bond which bears interest that is not includable in gross income under the Code has not been paid to the holder thereof (or provision for such payment has not been made in such manner as to have resulted in the defeasance of the Related Financing Documents), the Master Trustee shall receive an Opinion of Bond Counsel to the effect that under then existing law such person becoming an Obligated Issuer would not adversely affect the validity of such Related Bond or cause the interest payable on such Related Bond to become includable in gross income under the Code.

As a further condition to a person becoming a member of the Obligated Group, the Master Trustee shall receive an Officer's Certificate from the Obligated Group Agent to the effect that (A) no Event of Default then exists under the Master Indenture, nor to such officer's knowledge, does there then exist any event which, with the passage of time or giving of notice or both, would or might become an Event of Default under the Master Indenture, and (B) either (1) if one dollar of Additional Indebtedness were incurred immediately following such person's admission, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to subsection (a)(i) or (ii) under the heading "Additional Long-Term Indebtedness" (assuming, for purposes

of such certificate, that the Income Available for Debt Service and Indebtedness of such person were Income Available for Debt Service and Indebtedness of an Obligated Issuer), or (2) such person becoming a member of the Obligated Group will cure any Event of Default then in existence under the Master Indenture, or (3) by reason of such membership, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years following such entry into the Obligated Group will be greater than the projected Debt Service Coverage Ratio for such Fiscal Years had such entry into the Obligated Group not occurred, and (C) immediately after such person's admission, the combined fund balance and net worth, as the case may be, of the Obligated Group is not less than 90% of such combined fund balance and net worth immediately prior to such admission, and (D) the Historical Pro Forma Debt Service Coverage Ratio of the Obligated Group (taking into account the admission of such person) for each of the two most recent Fiscal Years for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available was not less than 1.30:1.

As a further condition to a person becoming a member of the Obligated Group, the Master Trustee shall receive a Consultant's report to the effect that the Projected Debt Service Coverage Ratio of the Obligated Group (taking into account the admission of such person) for each of the two Fiscal Years following the admission of such person is not less than 1.30:1.

The Corporation shall not withdraw from the Obligated Group. No other Obligated Issuer may withdraw from the Obligated Group unless:

(i) If the Obligated Issuer is other than the Obligated Group Agent, the Obligated Group Agent consents to the withdrawal;

(ii) If all amounts due on any outstanding Related Bond which bears interest that is not includable in gross income under the Code have not been paid to the holder thereof (or provision for such payments has not been made in such manner as to have resulted in the defeasance of the Related Financing Documents), the Master Trustee shall have received an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law such person's withdrawal from the Obligated Group would not adversely affect the validity of such Related Bond or cause the interest payable on such Related Bond to become includable in gross income under the Code;

(iii) The Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that either (1) after giving effect to such withdrawal, if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to subsection (a)(i) or (ii) under the heading "Additional Long-Term Indebtedness," or (2) such person's withdrawal from the Obligated Group will cure any Event of Default then in existence under the Master Indenture, or (3) by reason of such withdrawal, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years immediately following withdrawal of such Obligated Issuer from the Obligated Group will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such withdrawal not occurred;

(iv) The Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that, immediately after the withdrawal of such person from the Obligated Group, no Event of Default then exists under the Master Indenture, nor to such officer's knowledge, does there then exist any event which, with the passage of time or giving of notice or both, would or might become an Event of Default; and

(v) The Master Trustee shall have received a Consultant's report to the effect that the Projected Debt Service Coverage Ratio of the Obligated Group (taking into account the withdrawal of such person) for each of the two Fiscal Years following the withdrawal of such person is not less than 1.3:1;

(vi) The Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that the Historical Pro Forma Debt Service Coverage Ratio of the Obligated Group (taking into account the withdrawal of such Obligated Issuer) for each of the two most recent Fiscal Years for which consolidated or combined financial statements reported upon an independent certified public Accountant are available was not less than 1.30 to 1; and

(vii) The Obligated Group Agent shall have received an opinion of Counsel to the effect that following such person's withdrawal from the Obligated Group no member of the Obligated Group will have any liability for the payment of any indebtedness of such person.

Upon compliance with the above conditions, the Master Trustee shall execute any documents reasonably requested by the withdrawing Obligated Issuer to evidence the termination of such Issuer's obligations under the Master Indenture, under any Supplemental Indenture and under all Obligations.

Short-Term Indebtedness

Each Obligated Issuer agrees that it will not incur, nor permit any of its Restricted Affiliates to incur, any Additional Indebtedness constituting Short-Term Indebtedness unless immediately after the incurrence of such Short-Term Indebtedness:

(a) (i) the principal amount of all Short-Term Indebtedness of the Obligated Group then outstanding does not exceed 20% of the Total Net Operating Revenues for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available, or

(ii) any such Short-Term Indebtedness could be incurred under the tests set forth in the Master Indenture (relating to Long-Term Indebtedness) treating such Short-Term Indebtedness as Long-Term Indebtedness, and

(b) For a period of not fewer than 15 consecutive days within each Fiscal Year, the Obligated Group shall reduce the aggregate principal amount of all outstanding Short-Term Indebtedness described in (a)(i) above to less than 5% of the Total Net Operating Revenues for the immediately preceding Fiscal Year.

Additional Long-Term Indebtedness

Each Obligated Issuer agrees that it will not incur nor permit any of its Restricted Affiliates to incur, any Additional Indebtedness constituting Long-Term Indebtedness unless such Long-Term Indebtedness consists of one or more of the following:

(a) Long-Term Indebtedness of any member of the Obligated Group, if prior to the incurrence thereof, there is delivered to the Master Trustee:

(i) an Officer's Certificate of the Obligated Group Agent demonstrating that the Historical Pro Forma Debt Service Coverage Ratio for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available, was not less than 1.35; or

(ii) (A) an Officer's Certificate of the Obligated Group Agent demonstrating that the Historical Maximum Annual Debt Service Coverage Ratio for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available, was not less than 1.25 and (B) a Consultant's report (or, in lieu thereof, an Officer's Certificate of the Obligated Group Agent if the Projected Debt Service Coverage Ratio described in this subsection (B) is 1.75 or greater) to the effect that the Projected Debt Service Coverage Ratio, taking the proposed Additional Indebtedness into account, (x) in the case of Additional Indebtedness (other than a Guaranty) to finance capital improvements, for each of the two Fiscal Years succeeding the date on which such capital improvements are expected to be in operation, or (y) in the case of Long-Term Indebtedness not financing capital improvements or in the case of a Guaranty, for each of the two Fiscal Years succeeding the date on which the Indebtedness or Guaranty is incurred, is not less than 1.40.

The requirements of (a)(ii)(A) and (B) will be deemed satisfied if (i) a Consultant's report filed with the Master Trustee states that applicable laws or regulations have prevented or will prevent the achievement of such debt service coverage ratios, (ii) the Obligated Group has generated Total Income Available for Debt Service in an amount which, in the opinion of such Consultant, the Obligated Group could reasonably have generated given such laws and regulations during the period affected thereby.

(b) Completion Indebtedness of any member of the Obligated Group without limit if there is delivered to the Master Trustee: (i) an Officer's Certificate of the applicable member of the Obligated Group stating that at the time the original Long-Term Indebtedness for the Facilities to be completed was incurred, such Obligated Group member had reason to believe that the proceeds of such Long-Term Indebtedness, together with other moneys then expected to be available, would provide sufficient moneys for the completion of such Facilities; (ii) a statement of an Architect or an expert setting forth the amount estimated to be needed to complete the Facilities, and (iii) an Officer's Certificate of such member of the Obligated Group stating that the proceeds of such Completion Indebtedness to be applied to the completion of the Facilities, together with a reasonable estimate of investment income to be earned on such proceeds and the amount of moneys, if any, committed to such completion by such Obligated Group member or through enumerated bank loans (including letters or lines of credit) or through federal or state grants, will be in an amount not less than the amount set forth in the statement of an architect or other expert referred to in (ii).

(c) Commitment Indebtedness of any member of the Obligated Group or any Guaranty of any Commitment Indebtedness of any member of the Obligated Group without limit.

(d) Long-Term Indebtedness of any member of the Obligated Group incurred for the purpose of refunding, repurchasing or refinancing (whether in advance or otherwise) any outstanding Long-Term Indebtedness; provided, however, that additional Long-Term Indebtedness permitted under this paragraph (d) shall not result in an increase in Maximum Annual Debt Service in excess of 10%.

(e) The conversion without limit of Long-Term Indebtedness of any member of the Obligated Group that is convertible from one interest or payment made to another interest or payment (e.g., weekly to monthly or to a fixed rate) from one mode to another pursuant to the terms of the documentation authorizing such Long-Term Indebtedness.

(f) Subordinated Indebtedness without limit of any member of the Obligated Group or Non-Recourse Indebtedness without limit of any member of the Obligated Group; provided, however, that in the case of Subordinated Indebtedness, the Obligated Group Agent shall have furnished the Master Trustee with a certificate showing that prior to the issuance of such Subordinated Indebtedness, the debt to capitalization ratio of the Obligated Group does not exceed 60%.

(g) Indebtedness incurred in connection with a sale of not more than 25% of accounts receivable with recourse by any member of the Obligated Group consisting of an obligation to repurchase all or a portion of such accounts receivable upon certain conditions, provided that the principal amount of such Indebtedness permitted shall not exceed the aggregate sales price of such accounts receivable received by such Obligated Group member.

(h) Long-Term Indebtedness of any member of the Obligated Group, the principal amount of which at the time incurred, together with the aggregate principal amount of all other Long-Term Indebtedness and Short-Term Indebtedness of the Obligated Group then outstanding, does not exceed 25% of the Total Net Operating Revenues for the most recent Fiscal year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available.

(i) Long-Term Indebtedness of any member of the Obligated Group if prior to the incurrence thereof an Officer's Certificate of the Obligated Group Agent is delivered to the Master Trustee certifying that, immediately following the incurrence of such Long-Term Indebtedness, the total outstanding Long-Term Indebtedness of the Obligated Group will not exceed 66-2/3% of the sum of the principal amount of all outstanding Long-Term Indebtedness of the Obligated Group, plus the equity accounts of the Obligated Group (i.e., unrestricted fund balances, including any shareholder equity or partnership equity).

Guaranties

Each Obligated Issuer agrees that it will not enter into, or become liable in respect of, or permit any Restricted Affiliate to enter into, or become liable in respect of, any Guaranty dated after the date of the Master Indenture unless the principal amount of the indebtedness being guaranteed could then be incurred as Indebtedness described under the heading "Additional Long-Term Indebtedness," taking into account the assumptions as to calculating the aggregate annual principal and interest payments on, and the principal amount of, the indebtedness being guaranteed, contained in the immediately succeeding paragraph.

In the case of Guaranties of indebtedness that would, if such indebtedness were incurred by a member of the Obligated Group, constitute Long-Term Indebtedness, the aggregate annual principal and interest payments on, and the principal amount of, the Guaranty shall be deemed to be equal to 20% of the principal and interest payments which would be payable on the indebtedness being guaranteed as if such indebtedness were Long-Term Indebtedness of the Guarantor. If at any time the Guaranty becomes due and payable, or if any payment has been made under the Guaranty during the two immediately preceding Fiscal Years, the aggregate annual principal and interest payments on, and the principal amount of, the Guaranty shall, for purposes of this paragraph, be deemed to equal 100% of the principal and interest payable on, and the principal amount of, the indebtedness being guaranteed for the Fiscal Year for which such determination is being made.

Debt Service on Balloon Indebtedness and Variable Rate Indebtedness

For purposes of the covenants and computations required or permitted pursuant to the Master Indenture, it shall be assumed that (A) the interest rate on Variable Rate Indebtedness is equal to the higher of (a) the current rate on the Variable Rate Indebtedness or (b) that rate that is the average of the rate of interest which was in effect on the last day of each of the twelve preceding full calendar months immediately preceding the month in which such calculation is made, provided that if the Variable Rate Indebtedness has not been outstanding for at least twelve full calendar months, the assumed rate of interest for such Variable Rate Indebtedness shall be the rate of interest borne on the date such Variable Rate Indebtedness was issued and (B) the principal of Balloon Indebtedness is amortized:

(i) from the date of calculation thereof over a term equal to twenty (20) years, with level annual debt service payments at an assumed interest rate equal to the Bond Index (provided if the Balloon Indebtedness is also Variable Rate Indebtedness, the assumed interest rate may, at the option of the Obligated Group Agent, be the assumed interest rate applicable to Variable Rate Indebtedness); or

(ii) during the term to the maturity thereof by deposits made to a sinking fund therefor pursuant to the terms of such Balloon Indebtedness or in accordance with a sinking fund schedule established by resolution of the Governing Body of the applicable Obligated Issuer adopted at or subsequent to the time of incurrence of such Balloon Indebtedness, as certified in an Officer's Certificate, provided that, at the time of such calculation, all deposits required to have been made prior to such date shall have been made; or

(iii) the principal of Balloon Indebtedness is due and payable on the specified due date or due dates thereof; or

(iv) with respect to Balloon Indebtedness for which there exists a Credit Facility, the principal of such Balloon Indebtedness is due and payable in the amounts and at the times specified in the Credit Facility or related documents.

Insurance

Each Obligated Issuer will maintain, or cause to be maintained, insurance covering such risks and in such amounts as, in its reasonable judgment, is adequate to protect it and its Property and operations, including (to the extent that such Obligated Issuer is a health care institution) professional liability or medical malpractice insurance, one year's business interruption insurance (if commercially available) and extended coverage property insurance in an amount sufficient to avoid co-insurance. The Master Trustee shall be named as an additional insured on all such insurance policies. The Obligated Group Agent shall retain an Insurance Consultant who will prepare and file with

the Master Trustee a report showing the adequacy of such insurance once every two years (such report to be filed as soon as practicable but in no event later than five months after the end of the applicable second Fiscal Year). Each Obligated Issuer will follow any recommendations of the Insurance Consultant to the extent feasible in the opinion of the Obligated Group Agent.

In lieu of maintaining the insurance policies required above, the Obligated Group, or any member thereof, may self-insure any of the required coverages (or a portion thereof), provided that the Obligated Group may not self-insure any required coverage with respect to Property, Plant and Equipment and provided further that the Master Trustee receives a report (as soon as practicable but in no event later than five months after the end of each Fiscal Year) of an Insurance Consultant to the effect that such self-insurance is consistent with proper management and insurance practices. If any member of the Obligated Group elects to self-insure in lieu of maintaining medical liability and malpractice insurance, a report of an Insurance Consultant shall be filed with the Master Trustee annually stating that such Insurance Consultant has reviewed the self-insurance program and that the self-insured Obligated Group Member has available the estimated amount required for the payment of claims and associated claims expenses with respect to such Fiscal Year.

In the event of damage to or destruction of all or any part of the Facilities of the Obligated Group with a Value in excess of five percent (5%) of the Value of all Property of the Obligated Group, the affected Obligated Group member or the Obligated Group Agent shall exercise its best efforts to recover any applicable insurance. Such proceeds shall be paid to the Obligated Group Agent for the payment or reimbursement of reasonable expenses of obtaining the recovery. The Obligated Group Agent shall then give notice to the Master Trustee of such expenses and of the amount of the remaining proceeds (herein called the "Net Proceeds").

Subject to the provisions of any Related Financing Document pertaining to a Permitted Lien, the affected Obligated Group member shall apply the Net Proceeds for any lawful corporate purpose as such Obligated Group member determines, if the Obligated Group Agent shall first have delivered to the Master Trustee an Officer's Certificate stating that the Projected Debt Service Coverage Ratio for each of the next two full succeeding Fiscal Years immediately following the date of such certificate(s), taking into account such damage or destruction and the proposed use of the Net Proceeds is at least 1.10. If the Obligated Group Agent is unable to deliver the foregoing Officer's Certificate, the affected Obligated Group member shall apply the Net Proceeds or so much thereof as may be needed to the repair, replacement, restoration or reconstruction of the affected Facilities or, at the option of the applicable Obligated Group member, to any other capital project of equivalent value and utility, to the acquisition of any Property or to the repayment in whole or in part of any outstanding Obligations in such order of maturity or maturities or proportions as the Obligated Group Agent shall determine.

Any Net Proceeds remaining after compliance by the affected Obligated Group member and the Obligated Group Agent with the immediately preceding paragraph shall be transferred by the Obligated Group Agent to the Master Trustee and applied to the redemption of the outstanding Obligations that directly finance the damaged or condemned facilities and are secured thereby, second to other direct outstanding Obligations of the affected Member of the Obligated Group, and third to the redemption of other outstanding Obligations in such order of maturity or maturities or proportions as the Obligated Group Agent shall determine.

In the event of a taking by eminent domain of all or any part of the Facilities of the Obligated Group with a Value in excess of five percent (5%) of the Value of all Property of the Obligated Group, the affected Obligated Group member or the Obligated Group Agent shall exercise its best efforts to recover any applicable proceeds. Such proceeds shall be paid to the Obligated Group Agent. The Obligated Group Agent shall make appropriate deductions from such proceeds and give notice to the Master Trustee of such deductions and of the amount of the remaining proceeds (also, "Net Proceeds"). The Net Proceeds shall be applied in the same manner as insurance proceeds are applied pursuant to the two immediately preceding paragraphs.

Certain Covenants of the Obligated Issuers

Each Obligated Issuer covenants, among other things, to maintain its corporate or other separate legal existence and to be qualified to do business where such qualification is necessary, to maintain and keep its Facilities in good repair, to conduct its affairs in compliance with all applicable laws and regulations, to pay all lawful taxes and governmental charges and assessments levied or assessed upon or against it or its Property (except that each

Obligated Issuer may withhold such payments where the validity of such taxes and assessments is being contested in good faith), to comply with any covenants and provisions of any Liens upon its property or securing any of its Indebtedness, to procure and maintain all necessary licenses and permits, to maintain accreditation of its health care Facilities and its status as a provider of health care services eligible for reimbursement under government programs (provided, however, that it need not comply with the requirements pertaining to licenses, permits, accreditation and its status as a provider if and to the extent its Governing Body shall have determined in good faith, evidenced by an Officer's Certificate that such compliance is not in its best interests and that lack of such compliance would not materially impair its ability to pay its indebtedness when due).

In addition, each Obligated Issuer covenants not to merge with or consolidate with any other person not a member of the Obligated Group or sell or convey all or substantially all of its assets to any person not a member of the Obligated Group unless: (a) the successor corporation (if other than the Obligated Issuer) shall be a person organized and existing under the laws of the United States of America or a state thereof and such person shall become an Obligated Issuer and shall expressly assume the due and punctual payment of the principal of, premium, if any, and interest on all outstanding Obligations according to their tenor, and the due and punctual performance and observance of all of the covenants and conditions of the Master Indenture by a Supplemental Indenture satisfactory to the Master Trustee, executed and delivered to the Master Trustee by such person; (b) if all amounts due or to become due on any outstanding Related Bonds which bear interest that is not includable in gross income under the Code have not been fully paid to the holders thereof (or provision for such payment has not been made in such manner as will result in the defeasance of the Related Financing Documents), the Master Trustee shall have received an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law the consummation of such merger, consolidation, sale or conveyance, whether or not contemplated on the date of the delivery of any such Related Bonds, would not cause the interest payable on such Related Bonds to become includable in gross income under the Code or adversely affect the validity of such Related Bonds; and (c) there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent to the effect that immediately following such transaction, (A) no Event of Default then exists nor, to such officer's knowledge, does there exist any event which, with the passage of time or the giving of notice or both, would or might become an Event of Default under the Master Indenture, and (B) either (1) if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the tests providing for the incurrence of Long-Term Indebtedness described in subsection (a)(i) or (ii) under the heading Additional Long-Term Indebtedness (assuming for purposes of such Certificate that the Income Available for Debt Service and Indebtedness of such person were Income Available for Debt Service and Indebtedness of an Obligated Issuer), or (2) such transaction will cure any Event of Default then in existence under the Master Indenture, or (3) by reason of such transaction, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years following such release will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such transaction not occurred, and (C) the combined fund balance and net worth, as the case may be, of the Obligated Group will not be less than 90% of such combined fund balance and net worth immediately prior to such transaction.

In case of any such consolidation, merger, sale or conveyance and upon any such assumption by the successor corporation, such successor corporation shall succeed to and be substituted for its predecessor.

In case of any such consolidation, merger, sale or conveyance, such changes in phraseology and form (but not in substance) may be made in Obligations thereafter to be issued as may be appropriate.

Permitted Encumbrances

No Obligated Issuer will create or suffer to be created or to exist (or permit any Restricted Affiliate to create or suffer to be created or to exist) any Lien upon any of their Property including, without limitation, all proceeds thereof, whether cash or non-cash, now owned or after acquired by any of them, other than Permitted Liens.

Disposition of Property

Each Obligated Issuer agrees that neither it will sell, lease or otherwise dispose of any Property, except for sales, leases or other dispositions of Property:

- (a) To another member of the Obligated Group;
- (b) To any person if prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate stating that, in the judgment of the officer executing such certificate, such Property has become, or within the next succeeding 24 calendar months is reasonably expected to become, inadequate, obsolete, worn out, unsuitable, unprofitable, undesirable or unnecessary and sale, lease, removal or other disposition thereof will not impair the structural soundness, efficiency or economic value of the remaining Property;
- (c) To any person provided that prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent certifying (1) that Property transferred pursuant to this section in the then-current Fiscal Year by all Obligated Issuers does not exceed 5% of the Value of all Property of the Obligated Group for the immediately preceding Fiscal Year and (2) that Property transferred pursuant to this section in the then-current Fiscal Year and in each of the immediately preceding three Fiscal Years by all Obligated Issuers does not in the aggregate exceed 15% of the Value of all Property of the Obligated Group for the immediately preceding Fiscal Year;
- (d) To any person provided that prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent, to the effect that immediately after the transfer in question, either (1) if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to subsection (a)(i) or (ii) above contained under the heading Additional Long-Term Indebtedness or (2) such disposition will increase the Projected Debt Service Coverage Ratio in the Fiscal Year immediately following such disposition over what such ratio would have been in such Fiscal Year had such disposition not occurred;
- (e) As part of a merger, consolidation, sale or conveyance permitted under the heading "Certain Covenants of the Obligated Issuers";
- (f) In the ordinary course of business;
- (g) To any person in connection with an operating lease of Property to such person;
- (h) Upon fair and reasonable terms no less favorable than would be obtained in a comparable arm's-length transaction;
- (i) To any person if the transfer involves any Property received as restricted gifts, grants, bequests or other similar sums or the income thereon, to the extent that such sums may not be pledged or applied to the payment of any Debt Service Requirement or operating expenses generally as a result of restrictions or designations imposed by the donor or maker of the gift, grant, bequest or other sums in question; or
- (j) To any person so long as such Property is not encumbered by the Master Deed of Trust and the amount of Property transferred pursuant to this subsection (j) in any Fiscal Year shall not exceed \$5,000,000.

To the extent that any Property of the Corporation that is permitted to be sold, leased or otherwise disposed of under the foregoing is encumbered by the Master Deed of Trust or the Master Indenture, upon receipt of an Officer's Certificate directing the Master Trustee to execute a release and/or termination statement with respect to such property to be sold, the Master Trustee shall execute and deliver to the Corporation a release and/or termination statement with respect to such property; provided, however, that no real property encumbered by the Master Deed of Trust shall be sold, leased or otherwise disposed of unless (1) such sale, lease or disposition is permitted under one of the provisions above and the Value of the Property being sold, leased or otherwise disposed of does not exceed \$2,500,000 or (2) such Property is sold for fair market value (as determined by an appraisal delivered to the Master Trustee), provided that if such sale is of real property having an aggregate Book Value in excess of \$15,000,000, the Corporation shall deliver to the Master Trustee an Officer's Certificate of the Obligated Group Agent to the effect that immediately after the transaction in question the Obligated Group (i) will have a Days Cash on Hand Ratio equal to or greater than 50 and (ii) will be in compliance with the provisions of the Master Indenture relating to rates and charges. In the event that any Property is released from the Master Deed of Trust pursuant to clause (2) of the

immediately preceding sentence, the consideration received by the Corporation from the sale of such Property shall be applied to acquisition, construction or equipping of facilities for use by the Obligated Group or to the optional redemption or defeasance of outstanding Related Bonds, provided, however, that if outstanding Related Bonds are insured by the Bond Insurer at the time of such sale, the Bond Insurer shall be entitled to approve the application of any such consideration that is not used to redeem or defease Related Bonds and may in connection with any such approval required the Obligated Group to encumber additional real property pursuant to the Master Deed of Trust with a Value not less than the Value of the Property being released.

Filing of Financial Statements, Certificate of No Default, Other Information

The Obligated Group Agent covenants that it will:

(a) As soon as practicable but in no event later than four months after the end of each Fiscal Year, file, or cause to be filed, with the Master Trustee and, if such persons are then providing a rating with respect to Obligations or any Related Bonds, with each Rating Agency, (i) a combined or consolidated revenue and expense statement of the Corporation, and each other Obligated Issuer, for such Fiscal Year and (ii) a combined or consolidated balance sheet of the Corporation and each other Obligated Issuer as of the end of such Fiscal Year, each accompanied by the required report of an Accountant.

(b) As soon as practicable but in no event later than four months after the end of each Fiscal Year, file with the Master Trustee, an Officer's Certificate of the Obligated Group Agent stating the Historical Debt Service Coverage Ratio and the Historical Maximum Annual Debt Service Coverage Ratio for such Fiscal year, stating that all insurance required by the Master Indenture has been obtained and is in full force and effect, and stating whether or not to the best knowledge of the signers, any Obligated Issuer is in default in the performance of any covenant contained in the Master Indenture, and, if so, specifying each such default of which the signers may have knowledge, and an Officer's Certificate stating the Historical Debt Service Coverage Ratio and the Historical Maximum Annual Debt Service Coverage Ratio for such fiscal year, provided, if either such ratio is less than 1.75 to 1.00, such Officer's Certificate shall be accompanied by a certificate of the accountant whose report accompanies the financial statements referred to in (a) above stating such ratios.

(c) If an Event of Default shall have occurred and be continuing, (i) file with the Master Trustee such other financial statements and information concerning its operations and financial affairs (or of any consolidated group of companies of which it is a member) as the Master Trustee may from time to time reasonably request, excluding specifically donor records, patient records and personnel records and (ii) provide access to its Facilities for the purpose of inspection by the Master Trustee during regular business hours or at such other times as the Master Trustee may reasonably request.

(d) Within 10 days after its receipt thereof, file with the Master Trustee a copy of each report which any provision of the Master Indenture requires to be prepared by a Consultant or an insurance consultant.

(e) As soon as practicable, but in no event later than 45 days after the end of each fiscal quarter, file, or cause to be filed, with the Master Trustee (i) a combined or consolidated revenue and expense statement of the Corporation and each other Obligated Issuer for such quarter, and (ii) a combined consolidated balance sheet presented on the basis described in (i) above as of the end of such quarter.

(f) Cause the information described in subsections (a), (b) and (e) above, including the calculations described in subsections (b) and (e) above, in each case any holder of \$1,000,000 or more in aggregate principal amount of Related Bonds who has requested such of the Corporation in writing (it being understood that such request may be a standing request).

Rates and Charges

Each Obligated Issuer covenants and agrees to operate, and to cause each of its Restricted Affiliates to operate on a revenue producing basis and to charge, and to cause each of its Restricted Affiliates to charge, such fees and rates for its Facilities and services and to exercise, and to cause each of its Restricted Affiliates to exercise, such

skill and diligence as to provide income from its Property together with other available funds sufficient to pay promptly all payments of principal and interest on its Indebtedness, all expenses of operation, maintenance and repair of its Property and all other payments required to be made by it under the Master Indenture to the extent permitted by law, and to use its best efforts to maintain in each Fiscal Year beginning with the Fiscal Year ending June 30, 2001 a ratio of Total Income Available For Debt Service to Maximum Annual Debt Service at least equal to 1.30. Each Obligated Issuer further covenants and agrees that it will from time to time as often as necessary and to the extent permitted by law, revise its rates, fees and charges in such manner as may be necessary or proper to comply with the provisions of this Section.

If in any Fiscal Year beginning with the Fiscal Year ending June 30, 2001 the Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group is less than 1.30, the Master Trustee shall require the Obligated Group, at the expense of the Obligated Group, to retain a Consultant to make recommendations with respect to the rates, fees and charges of the Obligated Group and its methods of operation and other factors affecting its financial condition in order to increase such Historical Maximum Annual Debt Service Coverage Ratio to at least 1.30.

A copy of the Consultant's report and recommendations, if any, and any written responses from management of the Corporation, shall be filed with each Obligated Issuer, the Master Trustee, each Related Bond Trustee and each Related Issuer and, upon written request to the Corporation, any holder of at least \$1,000,000 in aggregate principal amount of Related Bonds. Each Obligated Issuer shall follow each recommendation of the Consultant applicable to it to the extent feasible (as determined by the Governing Body of such Obligated Issuer) and permitted by law. This Section shall not be construed to prohibit any Obligated Issuer from serving indigent patients to the extent required for such Obligated Issuer to continue its qualification as a Tax-Exempt Organization or from serving any other class or classes of patients without charge or at reduced rates so long as such service does not prevent the Obligated Group from satisfying the other requirements of this Section. So long as the Obligated Group shall retain a Consultant and shall follow such Consultant's recommendations to the extent permitted by law, this Section shall be deemed to have been complied with even if such ratio for any subsequent Fiscal Year is below 1.30:1; provided, however, that in no event shall the Historical Maximum Annual Debt Service Coverage Ratio for any year be less than 1.00:1.

Notwithstanding the provisions of the immediately preceding paragraph, if by the end of the second Fiscal Year after the Fiscal Year (beginning with the Fiscal Year ending June 30, 2001) for which the Obligated Group failed to achieve a Historical Maximum Annual Debt Service Coverage Ratio of at least 1.30:1 the Obligated Group has not achieved a Historical Maximum Annual Debt Service Coverage Ratio of at least 1.30:1, the Obligated Group shall be deemed to be in violation of the provisions of the Master Indenture.

The selection of any Consultant retained pursuant to this section and the scope of such Consultant's activities and recommendations shall be subject to the approval of the Bond Insurer and ratification by each of the Holders of the two largest principal amounts of Uninsured Obligations; provided that the ratification by such Holders shall not be unreasonably withheld.

Liquidity Covenant

The Obligated Group shall maintain Unrestricted Liquid Funds as of the last day of each Fiscal Year to produce a Days Cash on Hand Ratio equal to or greater than 75 as of the last day of each Fiscal Year.

Accreditation

The Corporation shall not fail to maintain any accreditation status currently held by the Corporation with respect to its hospital facilities unless it provides the Master Trustee with a Consultant's opinion to the effect that failure to maintain any such accreditation will not adversely affect the Corporation's hospital facilities. Notwithstanding the foregoing, this Section shall not be construed to require the Corporation to continue to operate any hospital facility or to maintain any accreditation for any hospital facility that is closed.

Hedge Agreements^{2*}

The members of the Obligated Group may not enter into a Hedge Agreement without the prior written consent of the Bond Insurer (so long as any outstanding Related Bonds are insured by the Bond Insurer) unless the following conditions are met:

(a) The Hedge Agreement must be entered into as a hedge against (i) swaps currently outstanding (as in basis swaps or reverse swaps), or (ii) debt then outstanding or to be issued, or (iii) as a means of achieving forward transactions, or (iv) against assets held at the time of the execution of the Hedge Agreement;

(b) The Hedge Agreement does not contain any element of leverage or multiplier component in excess of 1.0x unless there is a matching hedge arrangement which effectively offsets the exposure from any such element or component;

(c) If an amount equal to the Maximum Adverse Termination Payment (as defined below) of all of the Hedge Agreements of the Obligated Group, then in effect and those to be executed, determined as noted in (i) and (ii) below, at the time the new Hedge Agreement is to be entered into were excluded from unrestricted cash and investments, the Days Cash on Hand Ratio would still be satisfied;

(i) The Obligated Group Agent shall calculate the Maximum Adverse Termination Amount in three steps. First, the Obligated Group Agent will determine the actual mark-to-market value of all existing Hedge Agreements of the Obligated Group using standard mark-to-market methodology. Second, the Obligated Group Agent will calculate the Adverse Termination Amount (as defined below) of the contemplated derivative based on (ii) below. Third, the Adverse Termination Amount of the contemplated Hedge Agreement will be added to the actual mark-to-market value of all existing Hedge Agreements.

(ii) The methodology for calculating the Adverse Termination Amount for the contemplated Hedge Agreement depends on the type of swap it is. If the contemplated swap is a floating-to-fixed interest rate swap, a fixed-to-floating interest rates swap, or an option to enter into or cancel either of those structures, the Obligated Group Agent will calculate the present value of a 150 basis point loss using standard mark-to-market methodology and will assume taxable and tax-exempt rates both shift 150 basis points on the day of the calculation. This will result in the Adverse Termination Amount for the new swap. If the contemplated swap is a basis swap, a fixed spread basis swap, a constant maturity swap, a spread swap, or a similar structure (with or without an option), the Obligated Group Agent will calculate a 50 basis point loss by multiplying the absolute present value of one basis point in the then current market by -50 (negative fifty), to reflect an adverse change in ratios, spreads, rates, and other market conditions. This will result in the Adverse Termination Amount for the new swap.

(d) The Obligated Group's counterparty (or its guarantor) shall be rated at least "A+" or "A1" by a Rating Agency at the time the Hedge Agreement is entered into and a Credit Support Annex shall, or is required to,

^{2*} By their purchase of the Series 2012A Bonds, the initial holders thereof will consent to an amendment of this section. The amended section will read as follows:

²**Hedge Agreements.** The members of the Obligated Group may not enter into a Hedge Agreement unless the following conditions are met:

²(a) The Hedge Agreement must be entered into as a hedge against (i) swaps currently outstanding (as in basis swaps or reverse swaps), or (b) debt then outstanding or to be issued, or (iii) as a means of achieving forward transactions, or (iv) against assets held at the time of the execution of the Hedge Agreement;

²(b) The Hedge Agreement does not contain any element of leverage or multiplier component in excess of 1.0x unless there is a matching hedge arrangement which effectively offsets the exposure from any such element or component;

²(c) The uninsured payment due upon termination of any Hedge Agreement shall be subordinate in right of payment to all Obligations under the Master Indenture issued with respect to the Insured Bonds.

²(d) The Obligated Group shall not be in default under the Days Cash on Hand Ratio contained in Section 13.1(b)(iv) of this Master Indenture.

²(e) Notwithstanding the foregoing (a) through (d), the Corporation may assume the Hedge Agreements listed on Exhibit C attached to the Sixteenth Supplemental Master Trust Indenture that have been entered into by Mountain States Properties, Inc., an affiliate of the Corporation.

be executed to provide for collateral on a schedule that incorporates a zero threshold amount if any rating is below BBB+/Baa1;

(e) Termination payments are payable only if and to the extent that after such payment the Obligated Group: (a) would still be in compliance with its Days Cash on Hand Ratio, assuming such payment had been excluded from unrestricted cash and investments in making such liquidity calculation and (b) would not be in default;

(f) Collateral for the payments due under the Hedge Agreement can be posted only to the extent that after such posting the Obligated Group would still be in compliance with the Days Cash on Hand Ratio assuming such posting had been excluded from unrestricted cash and investments in making such liquidity calculation; and

(g) The uninsured payment due upon termination of any Hedge Agreement shall be subordinate in right of payment to all Obligations under the Master Indenture issued with respect to the Insured Bonds.

(h) The term “Adverse Termination Amount” shall mean the amount if positive that would be required to be paid by a member of the Obligated Group that is the party to a Hedge Agreement upon the termination of the Hedge Agreement calculated in the manner provided in subsection (c)(ii) above, and the term “Maximum Adverse Termination Amount” shall be determined in accordance with subsection (c)(i) above.

Projected Debt Service Coverage Ratio

Anything in the Master Indenture to the contrary notwithstanding, in each instance in the Master Indenture in which the Projected Debt Service Coverage Ratio is to be evidenced by an Officer’s Certificate, such Projected Debt Service Coverage Ratio must also be evidenced by a Consultant’s report unless the Projected Debt Service Coverage Ratio in such Officer’s Certificate is greater than 1.75:1.00.

Defaults and Remedies

The following events are “Events of Default” under the Master Indenture:

(a) failure of any Obligated Issuer to make any payment of principal, redemption price or interest when due under the terms of any Obligations and such failure continues to exist as of the end of any applicable grace period; or

(b) failure of any Obligated Issuer to observe or perform any covenant or agreement contained in the Master Indenture or any Related Financing Documents for any Obligations for a period of 30 days after written notice of such failure, requiring the same to be remedied, has been given by the Master Trustee to each of the Obligated Issuers, the giving of which notice shall be at the discretion of the Master Trustee unless the Master Trustee is requested in writing to do so by the holders of at least 25% in aggregate principal amount of all outstanding Obligations, in which event such notice shall be given; provided, however, that if such observance or performance requires work to be done, actions to be taken, or conditions to be remedied, which by their nature cannot reasonably be done, taken or remedied, within such 30-day period, no Event of Default shall be deemed to have occurred or to exist if, and so long as, the defaulting Obligated Issuer shall commence such observance or performance within such 30-day period and shall diligently and continuously prosecute the same to completion; or

(c) (i) default of any Obligated Issuer in the payment of any Indebtedness (other than Obligations issued and outstanding under the Master Indenture), the principal amount of which in the aggregate exceeds 5% of the Book Value of all Property of the Obligated Group for the immediately preceding Fiscal Year, whether such Indebtedness now exists or shall be created after the date of the Master Indenture and any grace period with respect thereto shall have expired, or (ii) any event of default as defined in any Related Financing Documents under which any such Indebtedness may be issued, secured or evidenced shall occur, which default in payment or event of default results in such Indebtedness becoming or being declared due and payable unless within the time allowed for service of a responsive pleading in any proceeding to enforce payment of the Indebtedness under the laws governing such

proceeding (i) the Obligated Issuers commence proceedings to contest the existence or payment of such Indebtedness, and (ii) in the absence of such contest, neither the pledge and security interest created under the Master Indenture nor any Property of the Obligated Group will be materially impaired or subject to material loss or forfeiture; or

(d) bankruptcy, dissolution, liquidation or reorganization in bankruptcy of any Obligated Issuer or other similar events; or

(e) if the Hospital Maximum Annual Debt Service Coverage Ratio of the Obligated Group for any Fiscal Year is less than 1.0 to 1; or

(f) a breach of the Alliance's covenant to file audited financial statements as described above under "Filing of Financial Statements, Certificate of No Default, Other Information" under paragraph (a) thereof shall have occurred and be continuing; or

(g) a breach of the Alliance's "Liquidity Covenant" as described above shall have occurred and be continuing.

Upon the occurrence of an Event of Default, the Master Trustee may, by notice in writing to the Obligated Issuers, declare the principal of all (but not less than all) outstanding Obligations to be immediately due and payable provided that the Master Trustee shall be required to make such a declaration (i) if an Event of Default has occurred under subsection (a) above, or (ii) if the Master Trustee is requested to make such a declaration by the Holders of not less than 25% in aggregate principal amount of all outstanding Obligations. If all Events of Default other than nonpayment of amounts that have become due as a result of such declaration are remedied, the Holders of 25% in aggregate principal amount of all Obligations may waive all Events of Default and rescind and annual such declaration of acceleration.

Any acceleration of the principal shall be subject to the condition that if, at any time after the principal of all outstanding Obligations shall have been accelerated, and before any judgment or decree for the payment of the moneys due shall have been obtained or entered: (i) one or more Obligated Issuers shall deposit with the Master Trustee an aggregate sum sufficient to pay (A) all matured installments of interest upon all outstanding Notes and the principal and premium, if any, of all outstanding Notes due otherwise than by acceleration (with interest on overdue installments of interest, to the extent permitted by law and on such principal and premium, if any, at the respective rates borne by such Notes to the date of such deposit) and any other amounts required to be paid pursuant to such Notes, (B) all amounts due under each Indenture Guaranty other than by reason of acceleration, (C) all sums due under any Obligations other than Notes and Indenture Guaranties, other than by reason of acceleration, and (D) the expenses and fees of the Master Trustee; and (ii) any and all Events of Default under the Master Indenture, other than the nonpayment of principal of and accrued interest on outstanding Obligations that have become due by acceleration, shall have been remedied, then and in every such case, the Master Trustee shall, if requested by the Holders of twenty-five percent in aggregate principal amount of all Obligations then outstanding, waive all Events of Default and rescind and annul such declaration and its consequences, but no such waiver or rescission and annulment shall extend to or effect any subsequent Event of Default.

The Master Trustee may, at any time that an Event of Default exists, (i) by written notice to the banking institutions in which any Gross Receipts are deposited pursuant to the requirements of the Master Indenture, direct that such funds be immediately transferred to the Master Trustee, and upon receipt of such funds the same shall be held in trust by the Master Trustee and disbursed as provided in the Master Indenture, and (ii) by written notice to the Obligated Issuers direct that all subsequent deposits of Gross Receipts be made with the Master Trustee.

Upon the occurrence of an Event of Default, as described in the Master Indenture, and upon demand of the Master Trustee, each Obligated Issuer will pay to the Master Trustee, for the benefit of the Holders of all outstanding Obligations, (a) the amount then due and payable on all Obligations for principal or interest, or both, and such other amounts as may be required to be paid on all such Obligations, with interest on the overdue principal and installments of interest (to the extent permitted by law) at the respective rates of interest borne by such Obligations or as is provided in the applicable Supplemental Indenture, and (b) such further amounts sufficient to cover the cost and expenses of collection, including a reasonable compensation to the Master Trustee, its agents,

attorneys and counsel, and any expenses incurred by the Master Trustee other than as a result of its gross negligence or bad faith.

The Master Trustee may institute any actions or proceedings at law or in equity for the collection of the sums due and may collect such sums in the manner provided by law out of the Property of the Obligated Issuer wherever situated.

In case there shall be pending proceedings for the bankruptcy or for the reorganization of any Obligated Issuer, or in case a receiver or trustee shall have been appointed for its Property, the Master Trustee shall be entitled and empowered, by intervention in such proceedings or otherwise, to file and prove a claim or claims for the whole amount of principal, premium, if any, interest and any other amounts owing and unpaid in respect of Obligations, and, in case of any judicial proceedings, to file such proofs of claim and other papers as may be necessary or advisable in order to have the claims of the Master Trustee and of the Holders of the Obligations allowed in such judicial proceedings relative to such member of the Obligated Group, its creditors or its Property, and to collect and receive any moneys or other Property payable or deliverable on any such claim and to distribute the same after the deduction of its charges and expenses.

All rights of action and rights to assert claims under any Obligation may be enforced by the Master Trustee without the possession of such Obligation. In any proceedings brought by the Master Trustee (and also any proceedings involving the interpretation of any provision of the Master Indenture to which the Master Trustee shall be a party) the Master Trustee shall be held to represent all the Holders of Obligations, and it shall not be necessary to make any Holders of Obligations parties to such proceedings.

Application of Moneys Collected

Any amounts collected by the Master Trustee in connection with the exercise of any rights and remedies following an Event of Default and, except as otherwise provided in the Master Indenture, all money and Investment Securities on deposit in any funds which the Master Trustee may establish under the Master Indenture from time to time shall be applied for the equal and ratable benefit of the Holders of Obligations in the following order at the date or dates fixed by the Master Trustee for the distribution of such moneys, upon presentment of such Obligations, and stamping thereon the payment, if only partially paid, and upon surrender thereof if fully paid:

(a) to the payment of costs and expenses of collection, including fees of Counsel and reasonable compensation to the Master Trustee; and, thereafter,

(b) whether or not the principal of all outstanding Obligations shall have become or have been declared due and payable to Holders of the outstanding Obligations for amounts due and unpaid on the Obligations, ratably, without preference or priority of any kind, according to the amounts due and payable on the Obligations; provided that for the purpose of determining the unpaid amount of any Obligation, there shall be deducted the amount, if any, which has been realized by the Holder by exercise of its rights as a secured party with respect to any Liens permitted pursuant to the Master Indenture or is on deposit in any fund established pursuant to any Related Financing Documents for such Obligations (other than amounts consisting of payments of principal and interest previously made and credited against the payments due under such Obligations) as of the date of payment by the Master Trustee pursuant to this subsection (b), all as certified to the Master Trustee by the Holder; and

(c) to the payment of the remainder, if any, to the Obligated Group Agent, its successors or assigns, or to whomsoever may be lawfully entitled to receive the same, or as a court of competent jurisdiction may direct.

Actions by Holders

(a) No Holder of an Obligation shall have any right by virtue of or by availing of any provision of the Master Indenture to institute any suit, action or proceeding in equity or at law upon or under or with respect to the Master Indenture or for the appointment of a receiver or trustee, or any other remedy, unless the Holders of not less than 25% in aggregate principal amount of Obligations then outstanding shall have made written request upon the Master Trustee to institute such action, suit or proceeding in its own name as Master Trustee and shall have

offered to the Master Trustee such reasonable indemnity as it may require against the costs, expenses and liabilities which may be incurred therein or thereby, and the Master Trustee, for 30 days after its receipt of such notice, request and offer of indemnity, shall have neglected or refused to institute any such action, suit or proceeding and no direction inconsistent with such written request shall have been given to the Master Trustee; it being understood and intended, and being expressly covenanted by the Holder of an Obligation and the Master Trustee, that no one or more Holders of Obligations shall have any right in any manner whatever by virtue of or by availing of any provision of the Master Indenture to affect, disturb or prejudice the rights of any other Holder of an Obligation or to obtain or seek to obtain priority over or preference to any other such Holder, or to enforce any right under the Master Indenture, except in the manner therein provided and for the equal, ratable and common benefit of all Holders of Obligations. For the protection and enforcement of these provisions, each and every Holder of an Obligation and the Master Trustee shall be entitled to such relief as can be given either at law or in equity.

(b) The Holder of an Obligation instituting a suit, action or proceeding in compliance with the provisions outlined herein and more fully set forth in the Master Indenture shall be entitled to such suit, action or proceeding to such amounts as shall be sufficient to cover the costs and expenses of collection, including to the extent permitted by applicable law, a reasonable compensation to its Counsel.

(c) Notwithstanding any other provision of the Master Indenture, the right of a Holder of an Obligation to receive payment of the principal of and interest on any Obligation and any other amounts payable thereunder, on or after the respective due dates expressed in such Obligation, or to institute suit for the enforcement of any such payment on or after such respective dates, shall not be impaired or affected without the consent of such Holder, provided that any moneys collected through the exercise of rights and remedies of any Holder against any Obligated Issuer pursuant to the Related Financing Documents for an Obligation (other than rights and remedies relating to Liens permitted pursuant to the Master Indenture or to funds and accounts established under such Related Financing Documents) shall be paid over to the Master Trustee or, with the consent of the Holder, collected directly by the Master Trustee.

Direction of Proceedings by Holders

The Holders of 75% in aggregate principal amount of Obligations then outstanding shall have the right to direct the time, method, and place of conducting any proceeding for any remedy available to the Master Trustee, or exercising any trust or power conferred on the Master Trustee; provided, however, that, subject to its right to be indemnified in the Master Indenture, the Master Trustee shall have the right to decline to follow any such direction if the Master Trustee, being advised by Counsel, determines that the action so directed may not lawfully be taken, or if the Master Trustee in good faith shall, by a responsible officer or officers of the Master Trustee, determine that the proceedings so directed would be illegal or involve it in personal liability, and provided further that nothing in the Master Indenture shall impair the right of the Master Trustee in its direction to take any action deemed proper by the Master Trustee and which is not inconsistent with such direction by the Holders.

Delay or Omission of Master Trustee

No delay or omission of the Master Trustee, or of any Holder of an Obligation, to exercise any right or power accruing upon an Event of Default shall impair any such right or power, or be construed as a waiver of any Event of Default or an acquiescence therein, nor shall the action of the Master Trustee or of the Holders of Obligations in case of any Event of Default, or in case of any Event of Default and subsequent waiver of such Event of Default, affect or impair the rights of the Master Trustee or of such Holders in respect of any subsequent Event of Default or any right resulting therefrom.

Remedies Cumulative

No remedy under the Master Indenture is intended to be exclusive of any other remedy, but each and every other such remedy shall be cumulative, and shall be in addition to the remedies pursuant to the Master Indenture; and the employment of any remedy under the Master Indenture or otherwise, shall not prevent the concurrent employment of any such other appropriate remedy or remedies. In the pursuit of any such remedies, the Master Trustee shall have and be vested with the rights of a secured creditor under the Tennessee Uniform Commercial Code (or similar laws of other jurisdictions as applicable) with respect to moneys collected by the Master Trustee

pursuant to any provision of the Master Indenture, and shall have the power to foreclose any Lien which may be granted to it as Master Trustee under the Master Indenture, all to the extent permitted by law.

Notice of Default

The Master Trustee shall, within 10 days after the occurrence of an Event of Default known to the Trustee, mail to all Holders of Obligations, as the names and addresses of such Holders appear upon the books maintained by the Master Trustee, and, as long as the Initial Obligation remains outstanding, to the Bond Insurer, notice of such Event of Default under the Master Indenture known to the Master Trustee, unless such Event of Default shall have been cured before the giving of such notice; provided that, except above under “Defaults and Remedies,” the Master Trustee shall be protected in withholding such notice if and so long as the Master Trustee in good faith determines that the withholding of such notice is in the interest of the Holders of the Obligations. For purposes of the Master Indenture, matters shall not be considered to be known to the Master Trustee unless an officer of its corporate trust department located at its principal corporate trust office has actual knowledge thereof.

Concerning the Master Trustee

Prior to the occurrence of an Event of Default and after the curing or waiving of all Events of Default which may have occurred, the Master Trustee undertakes to perform only those duties specifically set forth in the Master Indenture. In case an Event of Default has occurred, the Master Trustee shall exercise the rights and powers vested in it by the Master Indenture, and use the same degree of care and skill as a prudent man under the circumstances in the conduct of its own affairs.

No provision of the Master Indenture shall be construed to relieve the Master Trustee from liability for its own grossly negligent action, its own grossly negligent failure to act, or its own willful misconduct; provided, however, that:

(i) the Master Trustee shall not be liable for any error of judgment made in good faith by a responsible officer or officers of the Master Trustee, unless it is provided that the Master Trustee was grossly negligent in ascertaining the pertinent facts; and

(ii) the Master Trustee shall not be liable with respect to any action taken or admitted to be taken by it in good faith in accordance with the direction of the Holders of the majority in aggregate principal amount of Obligations then outstanding relating to the time, method and place of conducting any proceeding for any remedy available to the Master Trustee, or exercising any trust or power conferred upon the Master Trustee, under the Master Indenture.

Except as otherwise provided in the immediately preceding paragraph:

(a) The Master Trustee may rely and shall be protected in acting or refraining from acting upon various papers or documents believed by it to be genuine and to have been signed or presented by the proper party or parties.

(b) An Officer’s Certificate (unless otherwise specifically prescribed) shall be sufficient evidence of any request, direction, order or demand of any Obligated Issuer mentioned under the Master Indenture. Any resolution of the Governing Body of an Obligated Issuer may be evidenced to the Master Trustee by copy thereof, certified by the Secretary or an Assistant Secretary of such Obligated Issuer.

(c) The Master Trustee may consult with Counsel, and the advice of such counsel shall be full and complete authorization and protection. The Master Trustee shall be relieved of liability to the Holders of the Obligations and to the Obligated Issuers in respect of any action taken, suffered or omitted by it under the Master Indenture in good faith and in accordance with Counsel’s advice.

(d) Prior to the occurrence of an Event of Default under the Master Indenture and after the curing of all Events of Default, the Master Trustee is not bound to make any investigation into facts or matters stated in

various papers or documents, unless requested in writing to do so by the Holders of a majority in aggregate principal amount of Obligations then outstanding. As a condition to proceeding with the requested investigation, the Master Trustee, in accordance with the terms of the Master Indenture, may require indemnity against various costs, expenses or liabilities.

(e) The Master Trustee may execute any of the trusts or powers under the Master Indenture or perform any duties under the Master Indenture either directly or by or through agents or attorneys.

(f) The Master Trustee shall be under no responsibility for the approval by it in good faith by an expert or other skilled person for any of the purposes expressed in the Master Indenture.

The recitals contained in the Master Indenture and in the Obligations (other than the Certificate of Authentication on such Obligations) shall be taken as the statements of the Obligated Issuer, and the Master Trustee assumes no responsibility for the correctness thereof. Further, the Master Trustee makes no representations as to the validity or sufficiency of the Master Indenture or the liens and security created thereunder or of the Obligations. The Master Trustee shall not be accountable for the use or application of: any of the Notes or the proceeds of such Obligations, any moneys paid over by the Master Trustee, or any moneys received by any paying agent other than the Master Trustee.

The Master Trustee, in its individual or any other capacity, may become the owner or pledgee of Obligations with the same rights it would have if it were not the Master Trustee under the Master Indenture. Further, the Master Indenture shall not prohibit the Master Trustee from serving as Trustee under any Related Financing Documents or for maintaining a banking relationship with any Obligated Issuer; provided that if the Master Trustee determines that there is a conflict with its duties under the Master Indenture, it shall eliminate the conflict or resign as Master Trustee.

Each Obligated Issuer shall pay, and shall be jointly and severally liable to pay, to the Master Trustee reasonable compensation, reimbursement for all reasonable expenses, disbursement and advances. Each Obligated Issuer shall indemnify, defend and shall be jointly and severally liable to indemnify, the Master Trustee and its officers, directors, employees and agents for, and to hold them harmless against, any loss, liability or expense incurred without gross negligence or willful misconduct on the part of the Master Trustee and arising out of or in connection with the acceptance or administration of such trusts, including the costs and expenses of defending itself against any claim of liability in the premises. The Obligated Issuers' joint and several obligations described in this paragraph shall survive the satisfaction and discharge of the Master Indenture and the resignation, removal and succession of the Master Trustee. Subject only to the rights of any Holder, the Master Trustee shall have an express first and prior lien on any moneys or Investment Securities on the deposit in any funds as security for the payment of all such obligations.

Subject to the first paragraph under this section entitled "Concerning the Master Trustee," any matter may be conclusively proved and established by an Officer's Certificate delivered to the Master Trustee. In the absence of bad faith on the part of the Master Trustee, any such Officer's Certificate shall be full ratification of any action taken, suffered or omitted by the Master Trustee under the provisions of the Master Indenture upon the faith thereof, and the Master Trustee shall not be obligated to make any investigation into the facts stated therein.

The Master Trustee may resign at any time without cause by giving notice as required under the Master Indenture. Further, the Master Trustee may be removed (a) with cause at the direction of the Holders of not less than 66-2/3% in aggregate principal amount of Obligations then outstanding, delivered to the Obligated Group and the Master Trustee, or (b) for any reason at the direction of the Obligation Group Agent if no Event of Default then exists under the Master Indenture. The Master Trustee shall promptly give notice of any removal pursuant to the previous sentence in writing to each Holder of an Obligation then outstanding. In the case of the resignation and removal of the Master Trustee, a successor Master Trustee may be appointed by the Obligated Group unless an Event of Default exists under the Master Indenture. If an Event of Default exists under the Master Indenture, or if the Obligated Group otherwise fails to appoint a successor in accordance with the terms of the Master Indenture, a successor may be appointed at the direction of the Holders of not less than 66-2/3% in aggregate principal amount of Obligations then outstanding.

Any successor Master Trustee, however appointed, in accordance with the terms of the Master Indenture, shall accept such appointment, and, without further act, shall become vested with all the estates, properties, rights, powers and duties of its predecessor under the Master Indenture as if originally named the Master Trustee. The successor Master Trustee may, however, request that its predecessor execute and deliver an instrument transferring the above and assigning, transferring, delivering and paying over to such successor Master Trustee all moneys or other property then held by the predecessor under the Master Indenture.

Any successor Master Trustee, however appointed, shall be a bank or trust company having together with its Affiliates a combined capital and surplus on a consolidated basis of at least \$50,000,000.

Any corporation into which the Master Trustee may be merged or converted or with which it may be consolidated, or any corporation resulting from any merger, conversion or consolidation to which the Master Trustee shall be a party, or any corporation to which substantially all the business of the Master Trustee may be transferred, shall, subject to the immediately preceding paragraph, be the Master Trustee under the Master Indenture without further act.

Subject to the terms and conditions as set forth in the Master Indenture, the Master Trustee shall have the power to appoint one or more persons not unsatisfactory to the Obligated Group Agent to act as Co-Master Trustee.

Modifications

Each Obligated Issuer, when authorized by a resolution of its Governing Body, and the Master Trustee may, without the consent of the holders of the Obligations then outstanding, enter into a Supplemental Indenture to the Master Indenture to (a) provide for the issuance of any Obligations under the Master Indenture, (b) evidence the addition of an Obligated Issuer or the succession of another corporation to any Obligated Issuer, (c) add additional covenants for the protection of the holders of Obligations, (d) cure any ambiguity or defective provision of the Master Indenture or any Supplemental Indenture in such manner as is not inconsistent with and does not impair the security of the Master Indenture or adversely affect the holders of Obligations of any series of Obligations issued under the Master Indenture, (e) qualify the Master Indenture under the Trust Indenture Act of 1939 or under any similar federal statute hereafter enacted, (f) provide for the establishment of additional funds and accounts, (g) permit the issuance of additional forms of Obligations provided such Obligations are equally and ratably secured with all other Obligations issued under the Master Indenture (except as provided herein), and (h) reflect a change in applicable law.

With the consent of the Holders of not less than a majority in aggregate principal amount of Obligations then outstanding, each Obligated Issuer, when authorized by its Governing Body, and the Master Trustee, may from time to time and at any time enter into a Supplemental Indenture for the purpose of adding any provisions to or changing in any manner or eliminating any of the provisions of the Master Indenture or of any Supplemental Indenture or of modifying in any manner the rights of the Holders of Obligations; provided, however, that (i) without the consent of the Holders of all Obligations whose Obligations are proposed to be modified, no such supplemental indenture shall effect a change in the times, amounts or currency of payment of the principal of, premium, if any, or interest on any Obligation or a reduction in the principal amount or redemption price of any Obligation or the rate of interest thereon or permit the preference or priority of any Obligation over any other Obligation; (ii) without the consent of the Holders of all Obligations then outstanding, no such supplemental indenture shall reduce the aforesaid percentage or affected class of Obligations, the Holders of which are required to consent to any such Supplemental Indenture; (iii) without the consent of the Holders of all Obligations then outstanding, no such supplemental indenture shall effect a change in the conditions for withdrawal as a Member of the Obligated Group; (iv) without the consent of the Holders of all Obligations then outstanding, no such supplemental indenture shall effect a change in the provisions permitting the Holders of 25% in aggregate principal amount of all outstanding Obligations to direct acceleration upon the occurrence of an Event of Default; and (v) without the consent of the Holders of all Obligations then outstanding, any provision hereof which specifies a percentage of Holders required to take any action hereunder.

Effect of Supplemental Indenture

Upon the execution of any Supplemental Indenture, the Master Indenture shall be modified and amended in accordance therewith, and the respective rights, limitation of rights, obligations, duties, and immunities under the Master Indenture of the Master Trustee, each Obligated Issuer and the Holders of Obligations issued under the Master Indenture shall thereafter be determined, exercised and enforced under the Master Indenture subject in all respects to such modifications and amendments, and all the terms and conditions of any such Supplemental Indenture shall be deemed to be part of the terms and conditions of the Master Indenture.

Satisfaction and Discharge of Indenture

If the Master Trustee receives: (a) an amount which is (i) in the form of (A) cash, or (B) Government Obligations, and (ii) in a principal amount sufficient, together with the interest thereon and any funds on deposit under the Master Indenture and available for such purpose, to provide for the payment of the principal of and premium, if any, and interest on all outstanding Obligations to and including the maturity date or prior redemption or prepayment date thereof; (b) irrevocable instructions to redeem all Obligations to be redeemed prior to maturity and to notify the Holders of each such redemption; and (c) an amount sufficient to pay or provide for the payment of all other sums payable under the Master Indenture by the Obligated Issuers or any thereof, then the Master Indenture shall cease to be of further effect, and the Master Trustee, on demand of the Obligated Group Agent, shall execute all such instruments acknowledging satisfaction of and discharging the Master Indenture as requested by the Obligated Group Agent.

Similarly, the Obligated Issuer of any particular Obligation may provide for the payment thereof at or prior to maturity, and the Obligation so provided for shall thereupon cease to be outstanding under the Master Indenture.

In lieu of the foregoing, the Obligated Issuer of any particular Obligation may deliver to the Holder thereof the amount required under the Related Financing Documents to provide for the payment of the principal, premium, if any, and interest due or to become due in respect of such Obligation and such Obligation shall, upon surrender to the Master Trustee for cancellation, no longer be deemed outstanding under the Master Indenture.

SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURE

Security and Pledge

The Bonds will be secured by the Issuer's grant and assignment under the Bond Indenture of (i) the Issuer's interest in the related Series 2013 Obligation and the Loan Agreement, including but not limited to all revenues and receipts derived by the Issuer therefrom but excluding certain rights of the Issuer to (a) receive attorney fees under the terms of the Loan Agreement, (b) certain indemnification from the Alliance, (c) receive notices under the Loan Agreement, (d) to make advances under the Loan Agreement and (e) to inspect the projects financed with the Bonds, and (ii) all monies and securities in funds held by the Bond Trustee under the Bond Indenture (other than certain funds to be used to make rebate payments to the United States to preserve the tax-exempt status of the Series 2013A Bonds).

During the occurrence and continuation of an Event of Default under the Bond Indenture, the Bond Trustee will have a claim prior to the Bondholders on the moneys derived from the exercise of remedies under the Bond Indenture for payment of its costs and expenses and the repayment of advances made by it to effect performance of certain covenants in the Bond Indenture. The Bond Trustee, however, shall not have any claim or lien upon or with respect to moneys drawn under the Letter of Credit or the proceeds from the remarketing of Bonds.

Provisions for the Bonds

The Bond Indenture provides for the issuance of the Bonds, their redemption and all other terms pertaining to the Bonds. The Bonds will only be authenticated by the Bond Trustee upon the delivery of certain documents, including the original executed Bond Indenture, the Loan Agreement and the Original Letter of Credit.

Mutilated, lost or destroyed Bonds may be replaced subject to certain conditions specified in the Bond Indenture.

General Covenants and Provisions

The Issuer covenants that it will promptly pay the principal and purchase price of premium, if any, and interest on the Bonds subject to the limited nature of such obligations. The Issuer agrees that the Bond Trustee may enforce all rights of the Issuer under the Loan Agreement whether or not the Issuer is in default under the Bond Indenture.

Creation of Funds

The Bond Indenture provides for the creation of certain trust funds into which the proceeds from the sale of the Bonds, payments made by the Alliance under the Loan Agreement and proceeds from drawings on the Letter of Credit are to be deposited. These trust funds are the Bond Fund, the Project Fund (in Series 2103A Bond Indenture only), the Bond Purchase Fund, and the Rebate Fund. Each of these funds is described below.

Bond Fund. Within the Bond Fund, the Bond Trustee is to create a General Account and a Letter of Credit Account. There is to be deposited in the General Account of the Bond Fund all payments made pursuant to the provisions of the Bond Indenture or the Loan Agreement for credit to the Bond Fund and all income derived from the investment of such amounts. The Bond Trustee will also establish a subaccount within the General Account in the Bond Fund for the purpose of holding all Eligible Moneys therein. Moneys held in the Eligible Money Subaccount of the Bond Fund shall not be commingled with any other funds or accounts. The Bond Trustee will credit to the Letter of Credit Account all moneys drawn by the Bond Trustee under the Letter of Credit to pay the principal of and interest on the Bonds. Moneys in the Letter of Credit Account shall not be commingled with any other funds or accounts. Moneys in the Bond Fund shall be used to pay principal, premium, if any, and interest on the Bonds and the redemption price of Bonds.

Project Fund. The moneys and Investment Securities in the Project Fund (in Series 2013A Bond Indenture only) shall be held in trust by the Bond Trustee, shall be applied to the payment of the costs of the projects being financed except to the extent required to be transferred to the Rebate Fund and, pending such application, shall be held as trust funds under the Bond Indenture in favor of holders of the outstanding bonds and for the further security of such holders until paid out or transferred as provided in the Bond Indenture.

Bond Purchase Fund. Within the Bond Purchase Fund, the Bond Trustee is to create a General Account and a Letter of Credit Account. There shall also be established a subaccount within the General Account for the purpose of holding Eligible Moneys therein. Moneys in the Bond Purchase Fund shall be used solely for the payment of the purchase price of the Bonds in the event of any purchase of Bonds at the option of the holder or on a Mandatory Tender Date. Payments received from the proceeds of the remarketing of the Bonds by the Remarketing Agent and all other moneys received by the Bond Trustee under the terms of the Bond Indenture or the Loan Agreement which are required to be deposited in the Bond Purchase Fund shall be credited to the General Account. All moneys drawn by the Bond Trustee under the Letter of Credit for the purchase of Bonds pursuant to the terms of the Bond Indenture shall be credited to the Letter of Credit Account. All moneys in the Bond Purchase Fund remaining on any Optional Tender Date or Mandatory Tender Date after payment of the purchase price of the Bonds purchased shall be paid to the Bank if the Bond Trustee receives prior notice from the Bank stating that certain specified amounts are due and payable to the Bank under the Reimbursement Agreement and any balance remaining after payment to the Bank shall be paid to the Alliance.

Rebate Fund. Any arbitrage profits to be rebated to the United States are to be held in the Rebate Fund. The Series 2013A Bond Indenture contains provisions regarding the responsibility of an independent rebate analyst to calculate the amount of such arbitrage profits.

Investment of Funds. Moneys (other than Eligible Moneys) held in the General Accounts of the Bond Fund and the Bond Purchase Fund (other than remarketing proceeds) and in the Project Fund (in Series 2013A Bond Indenture only) shall be invested by the Bond Trustee as directed by the Alliance in Investment Securities. Eligible Moneys held in the General Accounts of the Bond Fund and the Bond Purchase Fund (other than remarketing proceeds) shall be invested by the Bond Trustee as directed by the Alliance in Government Obligations. Remarketing proceeds shall not be invested. The Bond Trustee shall sell and reduce to cash a sufficient amount of such investments whenever the cash balance in any fund or account is insufficient for the purposes thereof. The Bond Trustee shall not be responsible for any losses on investments made in accordance with the Bond Indenture. The Bond Trustee may make any investments through its own bond department or trust investments department.

Events of Default

The Bond Indenture provides that any of the following events shall constitute an Event of Default:

- (a) default in the due and punctual payments of any interest on any Bond when the same shall become due and payable; or
- (b) default in the due and punctual payment of the principal of any Bond at its maturity or upon mandatory redemption; or
- (c) default in the due and punctual payment of the purchase price of Bonds required to be purchased pursuant to the Bond Indenture when payment of such amount has become due and payable; or
- (d) receipt by the Bond Trustee of a written notice from the Bank of an event of default under the Reimbursement Agreement and a demand by the Bank for acceleration of the Bonds; or
- (e) the occurrence of an “Event of Default” under the Loan Agreement.

Acceleration

Subject to the rights of the Bank to control remedies, upon the occurrence of any Event of Default described in paragraphs (a), (b), (c) or (f) above, the Bond Trustee may, and at the written request of the Bank or the holders of more than 50% in aggregate principal amount of the outstanding Bonds shall (within one Business Day of its receipt of such written request), and, upon the occurrence and continuance of an Event of Default described in paragraphs (d) or (e) above, the Bond Trustee shall, by notice in writing delivered to the Issuer, the Alliance and the Bank, declare the principal of all the Bonds immediately due and payable, whereupon the same shall become immediately due and payable, anything in the Bond Indenture or in the Bonds to the contrary notwithstanding. Upon any such acceleration, the Bonds and the interest thereon shall forthwith be paid in accordance with the Bond Indenture. Upon any declaration of acceleration under the Bond Indenture, the Bond Trustee shall immediately declare the payments required to be made by the Alliance under the Loan Agreement to be immediately due and payable in accordance with the Loan Agreement and, if during the Letter of Credit Period, shall draw on the Letter of Credit. Upon such a drawing on the Letter of Credit, the Bond Trustee shall immediately pay to the bondholders an amount equal to the principal of and accrued interest on the Bonds.

Other Remedies

Subject to the rights of the Bank to control remedies, upon the occurrence of an Event of Default under the Bond Indenture, the Bond Trustee shall have the power to proceed with any right or remedy available at law or in equity or by statute, as it may deem best, including any suit, action or special proceeding in equity or at law for the collection of amounts due and to become due under the Bond Indenture and under the Bonds or the performance of any covenant or agreement contained in the Bond Indenture or for the enforcement of any proper legal or equitable

remedy as the Bond Trustee shall deem most effectual to protect the rights aforesaid, insofar as such may be authorized by law. The rights specified in the Bond Indenture are to be cumulative to all other available rights, remedies or powers.

No delay or omission to exercise any right or remedy accruing upon any Event of Default under the Bond Indenture shall impair any such right or remedy or shall be construed to be a waiver of any such Event of Default or acquiescence therein; and every such right and remedy may be exercised from time to time and as often as may be deemed expedient.

No waiver of any Event of Default under the Bond Indenture, whether by the Bond Trustee or by the bondholders, shall extend to or shall affect any subsequent event of default or shall impair any rights or remedies consequent thereon.

Rights of Bondholders

Upon the occurrence of an Event of Default and if requested to do so by more than two-thirds (2/3) in aggregate principal amount of Bonds then outstanding and being indemnified as provided in the Bond Indenture, the Bond Trustee subject to the provisions of the Bond Indenture, shall be obligated to exercise such one or more of the rights and remedies conferred heretofore as the Bond Trustee, being advised by counsel, shall deem most expedient in the interests of the bondholders and the Bank.

Right of Bondholders to Direct Proceedings

Except in the case of a default under paragraphs (d) and (e) under "Events of Default" and subject to the rights of the Bank to control remedies, the holders of more than two-thirds (2/3) in principal amount of Bonds then outstanding shall have the right, at any time, by an instrument or instruments in writing executed and delivered to the Bond Trustee, to direct the time, method and place of conducting all proceedings to be taken in connection with the enforcement of the terms and conditions of the Bond Indenture, or for the appointment of a receiver or any other proceedings under the Bond Indenture.

Application of Moneys

All moneys drawn by the Bond Trustee under the Letter of Credit in connection with any Event of Default shall be deposited in the Letter of Credit Account in the Bond Fund and all other moneys or property received by the Bond Trustee pursuant to any right given or remedy or action taken under the provisions of the Bond Indenture shall, after payment of all fees and expenses of the Bond Trustee, including, without limitation, the costs and expenses of its counsel and agents and the proceedings resulting in the collection of such other moneys and of the related expenses, liabilities and advances incurred or made by the Bond Trustee, be deposited in the General Account in the Bond Fund, and all such moneys shall be paid to the Bond Trustee and applied by it as follows:

(a) Unless the principal of all the Bonds shall have become or shall have been declared due and payable, all such moneys shall be applied:

FIRST - to the payment to the persons entitled thereto of all installments of interest then due on the outstanding Bonds (other than Borrower Bonds and Pledged Bonds), in the order of the maturity of the installments of such interest and, if the amount available shall not be sufficient to pay in full any particular installment, then to the payment of such installment ratably, according to the amounts due on such installment, to the persons entitled thereto, without any discrimination or privilege;

SECOND - to the payment to the persons entitled thereto of the unpaid principal of any of the outstanding Bonds which shall have become due (other than Borrower Bonds and Pledged Bonds), in the order of their due dates, with interest on such Bonds at the rate last borne by the Bonds from the respective dates upon which they became due and, if the amount available shall not be sufficient to pay in full the principal which became due on such Bonds on any particular date, together with such

interest, then to the payment thereof ratably, according to the amount of principal due on such date, to the persons entitled thereto, without any discrimination or privilege;

THIRD - to the payment of any amounts owed with respect to Pledged Bonds or owed by the Alliance to the Bank under the Reimbursement Agreement or other related documents or by the Issuer to the Bank under this Bond Indenture in such order as the Bank directs; and

FOURTH - to the payment of the principal of and interest on the Borrower Bonds in the same order of priority as specified in the first and second clauses.

(b) If the principal of all the Bonds shall have become due or shall have been declared due and payable, all such moneys shall be applied FIRST, to the payment of the principal and the interest then due and unpaid on the outstanding Bonds (other than Borrower Bonds and Pledged Bonds), without preference or priority of principal over interest or of interest over principal, or of any installment of interest over any other installment of interest, or of any such Bond over any other such Bond, ratably, according to the amounts due respectively for principal and interest, to the persons entitled thereto without any discrimination or privilege, SECOND, to the payment of any amounts owed with respect to Pledged Bonds or owed by the Alliance to the Bank under the Reimbursement Agreement or other related documents or by the Issuer to the Bank under this Bond Indenture in such order as the Bank directs and THIRD to the payment of the principal of and interest on the Borrower Bonds in the same manner as other outstanding Bonds.

(c) If the principal of all the Bonds shall have been declared due and payable, and if such declaration shall thereafter have been rescinded and annulled under the provisions of this Bond Indenture, in the event that the principal of all the Bonds shall later become due or be declared due and payable, the moneys to be applied shall be applied in accordance with the provisions of paragraph (b) above.

Subject to the provisions regarding acceleration, whenever moneys are to be applied pursuant to the provisions of this Section, such moneys shall be applied at such times, and from time to time, as the Bond Trustee shall determine, having due regard to the amount of such moneys available for application and the likelihood of additional moneys becoming available for such application in the future. Whenever the Bond Trustee shall apply such funds, it shall fix the date (which shall be an Interest Payment Date unless it shall deem another date more suitable or unless the principal of all of the Bonds has been declared immediately due and payable, in which case application shall be made immediately) upon which such application is to be made and upon such date interest on the amounts of principal to be paid on such dates shall cease to accrue provided that such amount of principal is in fact paid on such date. The Bond Trustee shall give such notice to the Holders of the Bonds and the Bank as it may deem appropriate of the deposit with it of any such moneys and of the fixing of any such date, and shall not be required to make payment from such moneys to the Holder of any Bonds until such Bond shall be presented to the Bond Trustee.

Rights and Remedies of Bondholders

No Holder of any Bond shall have any right to institute any suit, action or proceeding in equity or at law for the enforcement hereof, for the execution of any trust hereof or for the appointment of a receiver or to enforce any other right or remedy under the Bond Indenture, except subject to the rights of the Bank to control remedies and unless (a) a Default has occurred of which the Bond Trustee has been notified as provided in the Bond Indenture or of which it is deemed to have notice, (b) such Default shall have become an Event of Default and the Holders of more than two-thirds (2/3) in aggregate principal amount of Bonds then outstanding shall have made written request to the Bond Trustee and shall have offered reasonable opportunity to the Bond Trustee either to proceed to exercise the powers granted in the Bond Indenture or to institute such action, suit or proceeding in its own name, and (c) such Bondholders have offered to the Bond Trustee indemnity as provided in the Bond Indenture and the Bond Trustee shall thereafter fail or refuse to exercise the powers granted in the Bond Indenture, or to institute such action, suit or proceeding in its own name. Such notification, request and offer of indemnity are at the option of the Bond Trustee conditions precedent to the execution of the powers and trusts hereof, and to any action or cause of action for the enforcement hereof, or for the appointment of a receiver or for any other right or remedy under the Bond Indenture. Nothing in the Bond Indenture shall, however, affect or impair the right of any Bondholder to enforce the payment of the principal and purchase price of, and interest on, any Bond at and after the date such payment is due, or the

obligation of the Issuer or the Bond Trustee to pay the principal and purchase price of, and interest on, each of the Bonds to the respective Holders thereof at the time, place, from the source and in the manner expressed in the Bonds.

Waivers of Events of Default

Subject to the rights of the Bank to control remedies, the Bond Trustee shall waive any Event of Default under the Bond Indenture and its consequences upon the written request of the holders of more than 50% in aggregate principal amount of all Bonds then outstanding, provided, however, that there shall not be waived

(a) any Event of Default pertaining to the payment of the principal or purchase price of any Bond at its maturity, Redemption Date, or Tender Date, or

(b) any Event of Default pertaining to the payment when due of the interest on any Bond unless prior to such waiver, all arrears of interest and all principal or purchase price payments in respect of which such Event of Default shall have occurred, with interest thereon (to the extent permitted by law) for the period from the occurrence of such Event of Default until paid in full at a rate per annum equal to the interest rate payable on the Bonds from time to time during such period in accordance with the terms of the Bonds, and all expenses of the Bond Trustee in connection with such Event of Default, shall have been paid or provided for, and in case of any such waiver, or in case any proceeding taken by the Bond Trustee on account of any such Event of Default shall have been discontinued or abandoned or determined adversely to the Bond Trustee, then and in every such case the Issuer, the Bond Trustee, the Bank and the Bondholders shall be restored to their former positions and rights under the Bond Indenture, respectively, but no such waiver shall extend to any subsequent or other Event of Default, or impair any right consequent thereon, or

(c) any Event of Default described in paragraphs (d) or (e) under “Events of Default.”

If a declaration of acceleration is made pursuant to the Bond Indenture, then and in every such case, the Bond Trustee shall upon the written request of more than two-thirds (2/3) in principal amount of all Bonds then outstanding rescind and annul such declaration, and the consequences thereof, provided that at the time such declaration is rescinded and annulled:

(1) no judgment or decree has been entered for the payment of any moneys due pursuant to the Bonds;

(2) all arrears of interest on all of the Bonds and all other sums payable under the Bonds (except as to principal of, and interest on, the Bonds which have become due and payable by reason of such declaration) shall have been duly paid;

(3) each and every Event of Default under the Bond Indenture shall have been waived pursuant to the preceding paragraph or otherwise made good or cured; and

(4) no drawing shall have been made under the Letter of Credit in connection with or as a result of such declaration of acceleration;

and, provided further, that no such rescission and annulment shall extend to or affect any subsequent Event of Default or impair any right consequent thereon. Notwithstanding the foregoing, neither the Bond Trustee nor the Bondholders shall have the right to waive an Event of Default described in paragraphs (d) or (e) under “Events of Default.”

Rights of Bank to Control Remedies and Other Proceedings

Subject to the next paragraph, the Bank shall be entitled to control and direct the enforcement of all remedies and rights granted to the Holders of the Bonds and to the Bond Trustee under the Bond Indenture and all proceedings related thereto, including, without limitation,

(a) the right of the Holders of more than two-thirds (2/3) in aggregate principal amount of outstanding Bonds to request the acceleration of the principal of the Bonds;

(b) the right of the Holders of more than two-thirds (2/3) in aggregate principal amount of outstanding Bonds to request the Bond Trustee to exercise certain remedies and direct the time, method and place of conducting all proceedings;

(c) the right to institute any suit, action or proceeding, pursuant to the Bond Indenture; and

(d) the right of the Holders of more than fifty percent (50%) in aggregate principal amount of outstanding Bonds to waive any Event of Default or to rescind a declaration of acceleration of the principal of the Bonds;

provided that notwithstanding anything in the Bond Indenture to the contrary, the Bank may not direct the Bond Trustee not to accelerate the principal amount of the Bonds and draw on the Letter of Credit upon an Event of Default specified in paragraphs (a), (b) or (c) under "Events of Default."

All rights and remedies given to the Bank in the Bond Indenture and the Loan Agreement are expressly conditioned upon the Bank not being in default in the performance of its obligations under the Letter of Credit, and the Bank shall have no rights or remedies under the Bond Indenture or under the Loan Agreement if it is in default in such performance.

The Bond Trustee

After any Event of Default, the Bond Trustee shall exercise the rights and powers vested in it by the Bond Indenture with the degree of care and skill in their exercise as a prudent man would exercise in the conduct of his own affairs. Otherwise, the Bond Trustee undertakes to perform such duties and only such duties as are specifically set forth in the Bond Indenture, and no implied agreements or obligations shall be read into the Bond Indenture against the Bond Trustee. The Bond Trustee may execute its trusts through its employees, agents or attorneys, and the Bond Trustee shall not be responsible for any misconduct or negligence on the part of any agent or attorney appointed with due care by it. In carrying out its duties, the Bond Trustee may rely on any document believed by it to be genuine and to have been signed by the proper person and in determining the existence or nonexistence of any fact or the validity of any instrument, the Bond Trustee may rely on certificates provided by the Issuer or the Alliance. The Bond Trustee shall not be liable with respect to any action it takes or omits to take in good faith in accordance with a request or direction received by it from the Bank or the holders of a majority of Bonds Outstanding pursuant to the Bond Indenture.

The Bond Trustee is not required to take notice of any Event of Default under the Bond Indenture except failure by the Issuer to make payments on the Bonds, an Act of Bankruptcy of which it is given notice or Events of Default described in paragraphs (d) or (e) under "Events of Default." Before taking any action under the Bond Indenture or the Loan Agreement other than making a draw on the Letter of Credit, the Bond Trustee may require that a satisfactory indemnity bond be furnished. The Bond Trustee is not responsible for the tax-exempt status of the Series 2013A Bonds. The Bond Trustee is entitled to the payment of its reasonable fees and expenses.

The Bond Trustee may resign by giving written notice to the Issuer, the Alliance, the Bank and the Bondholders, provided that such resignation will not take effect until a successor trustee is appointed. The Bond Trustee may be removed at the written request of the holders of more than two-thirds (2/3) in the principal amount of the outstanding Bonds or by the Alliance (provided no Default or Event of Default has occurred under the Bond Indenture). The holders of more than two-thirds (2/3) in the principal amount of the outstanding Bonds may appoint a successor trustee.

The Bond Trustee will serve as Paying Agent under the Bond Indenture. The Paying Agent may resign by giving written notice to the Issuer, the Trustee, the Alliance, the Bank and the Bondholders, provided that such resignation will not take effect until a successor paying agent is appointed. The Paying Agent may be removed at the written request of the holders of more than 50% in the principal amount of the outstanding Bonds or by the

Alliance (provided no Default or Event of Default has occurred under the Bond Indenture). The holders of more than 50% in the principal amount of the outstanding Bonds may appoint a successor paying agent.

The Remarketing Agent

The Remarketing Agent will set the interest rate on the Bonds, will remarket the Bonds upon purchase and will perform such other duties as are required under the Bond Indenture. The Remarketing Agent may resign by giving 30 days' notice to the Issuer, the Alliance, Bank and Bond Trustee provided that no such resignation shall take effect until a successor Remarketing Agent has been appointed and such successor Remarketing Agent has accepted such appointment. The Remarketing Agent may be removed from time to time by the Alliance.

Supplemental Bond Indentures

The Issuer and the Bond Trustee, without the consent of any of the bondholders may enter into an indenture or indentures supplemental to the Bond Indenture for any one or more of the following purposes: (a) to cure any ambiguity or formal defect or omission in the Bond Indenture or between the terms and provisions of the Bond Indenture and the terms and provisions of any other instrument or document executed in connection therewith or with the issuance of the Bonds; (b) to grant or confer upon the Bond Trustee for the benefit of the Bondholders any additional rights, remedies, power or authority; (c) to subject to the lien of the Bond Indenture additional payments, revenues or collateral; (d) to modify, amend or supplement the Bond Indenture or the bonds in such a manner as to permit qualification thereof under the Trust Indenture Act of 1939 or any federal or state securities law; (e) to evidence the appointment of a co-Bond Trustee or the succession of a new Bond Trustee; (f) to make any other supplement to the Bond Indenture which will not adversely affect the interest of the Bondholders; (g) to obtain or maintain a rating on the Bonds from S&P or Moody's as high as the debt rating of the Bank; (h) to modify or supplement the Bond Indenture in such manner as may be necessary, in the Opinion of Bond Counsel, to comply fully with all applicable rules, rulings, policies, procedures, regulations or other official statements promulgated or proposed by the Department of the Treasury or the Internal Revenue Service; or (i) as may be necessary in connection with the provision of a Substitute Letter of Credit meeting the requirements of the Bond Indenture.

Exclusive of supplemental indentures for the purposes described in the preceding paragraph and subject to the terms and provisions of the Bond Indenture, the holders of not less than two-thirds in aggregate principal amount of the bonds then outstanding shall have the right, from time to time, to consent to and approve the execution by the Issuer and the Bond Trustee of such other indenture or indentures supplemental to the Bond Indenture for the purpose of modifying, amending, adding to or rescinding, in any particular, any of the terms or provisions contained in the Bond Indenture; provided, however, that such modification or amendment shall not permit or be construed as permitting without the consent of the holders of all the Bonds outstanding (a) an extension of the maturity of the principal of, premium, if any, or interest on any of the Bonds, (b) a reduction in the principal amount of, premium, if any, or interest rate on, any Bond (c) a privilege or priority of any Bond or Bonds over any other Bond or Bonds, (d) a reduction in the aggregate principal amount of the bonds the holders of which are required to consent to any such supplemental indenture, (e) the creation of a lien ranking prior to or on a parity with the lien of the Bond Indenture on the property conveyed and mortgaged pursuant to the Bond Indenture or the deprivation of such lien or (f) the elimination of any mandatory redemption or mandatory purchase of Bonds, extension of the due date for the purchase of the Bonds or call for mandatory redemption or the reduction of the purchase price or Redemption Price for the Bonds.

Any supplemental indenture that affects the rights of the Alliance must be consented to by the Alliance. The Bond Trustee shall also not be required to enter into any supplemental indenture if such action might adversely affect its rights or liabilities. All supplemental indentures entered into during the Letter of Credit Period must be consented to by the Bank.

Amendments to the Loan Agreement

The Issuer may enter into, and the Bond Trustee may consent to, any amendment of or supplement to the Loan Agreement without notice to or consent of any Bondholder, if the amendment or supplement is required (a) by the provisions of the Loan Agreement or the Bond Indenture, (b) to cure any ambiguity, inconsistency or formal defect or omission in the Loan Agreement or between the terms and provisions of the Loan Agreement and the terms

and provisions of any other instrument or document executed in connection therewith or with the issuance of the Bonds, (c) to identify more precisely any collateral securing the Bonds, (d) to effect any amendment that does not adversely affect the interests of the Bondholders or (e) to obtain or maintain a rating on the Bonds from S&P or Moody's as high as the debt rating on the Bank.

If an amendment of or supplement to the Loan Agreement without the consent of the Bondholders is not permitted as described in the foregoing paragraph, the Issuer may enter into, and the Bond Trustee may consent to, such amendment or supplement with notice to the Bondholders and with the consent of the holders of at least a two-thirds in principal amount of the Bonds then outstanding. However, no amendment to the Loan Agreement is permitted that would decrease the Trust's unconditional obligation to make payments under the Loan Agreement or that would affect the Trust's obligations as to the use of the proceeds of the Bonds. All amendments to the Loan Agreement entered into during the Letter of Credit Period must be consented to by the Bank.

SUMMARY OF CERTAIN PROVISIONS OF THE LOAN AGREEMENT

Payments

The Alliance covenants to make all payments required by the Loan Agreement, as and when the same become due. Pursuant to the Loan Agreement, the Alliance agrees to make payments of principal, interest and purchase price identical to payments (including payments of principal upon redemption and acceleration) due by the Issuer under the Bonds. The obligations of the Alliance to make payments under the Loan Agreement shall be deemed satisfied to the extent of a corresponding payment made by the Bank to the Bond Trustee under the Letter of Credit. The Alliance also covenants to pay the reasonable fees and expenses of the Bond Trustee and the Issuer.

Special Representations and Covenants

Indemnification. The Alliance agrees that it will indemnify and save harmless the Issuer, City of Johnson, Tennessee, the Bond Trustee, the Remarketing Agent and the Bank from and against all liabilities, losses, expenses and damages arising generally from the operation of the projects financed with the Bonds or the failure of the Alliance to comply with its covenants or any term or condition contained in the Loan Agreement and any documents relating thereto.

Sale of Facilities. The Alliance may not sell, convey or lease the facilities financed or refinanced with the proceeds of the Bonds or any significant portion thereof unless the Alliance delivers to the Bond Trustee an Opinion of Bond Counsel that such sale, conveyance or lease will not adversely affect the exclusion from gross income of interest on the Bonds for federal income tax purposes. In connection with any such sale during the Letter of Credit Period, another party may assume the obligations of the Alliance under the Borrower Documents, and the Alliance may be released from liability therefrom with the written consent of the Bank.

Miscellaneous Covenants. The Alliance agrees to notify the Bank, the Issuer and the Bond Trustee if a petition in bankruptcy is filed against it.

Events of Default and Remedies on Default

The occurrence of any of the following events shall constitute an event of default under the Loan Agreement:

(a) If the Alliance shall fail to make any payment with respect to the principal and purchase price of or interest on the Bonds when the same becomes due and payable.

(b) If the Alliance shall fail to observe or perform any of its other covenants, conditions, or agreements under the Loan Agreement for a period of 30 days after notice (unless the Bank shall consent to an extension of such time), or in the case of any such default that cannot be cured within such 30-day period, if the

Alliance shall fail to take corrective action to cure such default and diligently pursue such action until such failure is cured.

(c) If the Alliance shall (1) fail to pay generally its debts as they become due, (2) commence a voluntary case under the Federal bankruptcy laws, as now or hereafter constituted, or any other applicable Federal or state bankruptcy, insolvency or other similar law, (3) consent or fail to object to the appointment of a receiver, liquidator, assignee, trustee, custodian, sequestrator or other similar official for the Alliance or any substantial part of its property, or to the taking possession by any such official of any substantial part of the property of the Alliance, (4) make any assignment for the benefit of creditors, or (5) take corporate action in contemplation or in furtherance of any of the foregoing.

(d) If there shall occur the commencement of a voluntary or involuntary case by or against the Alliance under the Federal bankruptcy laws, as now or hereinafter constituted, provided, however, that if an involuntary case in bankruptcy is commenced against the Alliance prior to the 120th day before payment of the Bonds (whether at maturity, by acceleration, demand for prepayment, call for redemption or otherwise), the filing of such petition shall not constitute an Event of Default if such petition is dismissed, subject to no further review, within 60 days thereafter.

(e) If any warranty, representation or other statement by or on behalf of the Alliance contained in the Loan Agreement or in any instrument furnished in connection with the issuance or sale of the Bonds shall prove to have been false or misleading in any material respect at the time it was made or delivered.

(f) If an Event of Default under the Bond Indenture shall occur and continue.

Upon an occurrence of an Event of Default, the Bond Trustee shall immediately notify the Bank and may:

(a) With the written consent of the Bank (provided such written consent shall not be required (1) if there is no Letter of Credit, or (2) if the Event of Default is due to the fact that there has been a default in the payment of the principal and purchase price or interest on the Bonds), declare all payments under the Loan Agreement and the Bonds to be immediately due and payable in an amount sufficient to pay all the principal of and premium, if any, and accrued interest on the Bonds, whereupon the same shall become immediately due and payable.

(b) Take whatever action at law or in equity may appear necessary or desirable to collect the amounts then due and thereafter to become due under the Loan Agreement or to enforce observance or performance of any covenant, condition or agreement of the Alliance.

Option to Prepay Obligations under Loan Agreement

The Alliance shall have the option to prepay its obligations under the Loan Agreement in whole or in part to the extent that the Bonds are redeemable under the provisions of the Bond Indenture. If the Alliance intends that such prepayment shall result in a redemption in whole or in part of the Bonds, the Alliance shall take such action as is required under the Bond Indenture to cause the Bonds to be redeemed. In the event the Alliance intends that such prepayment to cause the discharge of the lien of the Bond Indenture under the provisions thereof, the Alliance shall comply with such provisions.

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APPENDIX D

PROPOSED FORMS OF OPINIONS OF BOND COUNSEL

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[Opinion of Bass Berry Sims]

July 30, 2013

The Health and Educational Facilities Board
of the City of Johnson City, Tennessee
Johnson City, Tennessee

The Bank of New York Mellon Trust Company, N.A.,
Bond Trustee and Master Trustee
St. Louis, Missouri

U.S. Bank National Association
St. Louis, Missouri

Merrill Lynch, Pierce, Fenner & Smith Incorporated
New York, New York

Re: The Health and Educational Facilities Board of the City of Johnson City, Tennessee \$16,235,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2013A

Ladies and Gentlemen:

We have acted as bond counsel in connection with the issuance by The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the "Issuer") of its \$16,235,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2013A (the "Series 2013A Bonds"). We have examined the law and such certified proceedings and other papers as we deem necessary to render this opinion. Reference is made to the forms of the Series 2013A Bonds for additional information concerning their details, payment and redemption provisions and the proceedings pursuant to which they were issued.

The Series 2013A Bonds are issued pursuant to a Bond Trust Indenture dated as of July 1, 2013 (the "Series 2013A Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Series 2013A Bond Trustee"). The proceeds from the sale of the Series 2013A Bonds will be loaned by the Issuer to Mountain States Health Alliance, a not-for-profit corporation incorporated under the laws of the State of Tennessee (the "Alliance"), under a Loan Agreement dated as of July 1, 2013 (the "Series 2013A Loan Agreement"), between the Issuer and the Alliance, which loan will be evidenced by the \$16,235,000 Mountain States Health Alliance Note, Series 2013A (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) (the "Series 2013A Obligation") issued pursuant to an Amended and Restated Master Trust Indenture dated as of February 1, 2000, as heretofore amended and as amended by a Thirty-Ninth Supplemental Master Trust Indenture dated as of July 1, 2013 (collectively, the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"). Under the Series 2013A Loan Agreement and the Series 2013A Obligation, the Alliance has agreed to make payments to be used to pay when due the principal of and premium, if any, and interest on the Series 2013A Bonds, and such payments and other revenues under the Series 2013A Loan Agreement and the Series 2013A Obligation (collectively, the "2013A Revenues") and the rights of the Issuer under the Series 2013A Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) are pledged and assigned by the Issuer as security for the Series 2013A Bonds.

U.S. Bank National Association (the "Bank"), has issued an irrevocable letter of credit dated the date hereof (the "2013A Letter of Credit") to secure payment of the principal of and up to 37 days' accrued interest on the Series 2013A Bonds which expires, unless extended, on July 30, 2018.

The Series 2013A Bonds are payable solely from the 2013A Revenues and draws on the 2013A Letter of Credit.

Reference is made to an opinion of even date of Anderson & Fugate, counsel to the Alliance, with respect, among other matters, to the corporate status, good standing and qualification to do business of the Alliance, the corporate power of the Alliance to enter into and perform the Series 2013A Loan Agreement, the Series 2013A Obligation and the Master Indenture and the authorization, execution and delivery of the Series 2013A Loan Agreement, the Series 2013A Obligation and the Master Indenture by the Alliance and with respect to the Series 2013A Loan Agreement, the Series 2013A Obligation and the Master Indenture being binding and enforceable upon the Alliance.

As to questions of fact material to our opinion, we have relied upon representations of the Issuer and the Alliance contained in the Series 2013A Bond Indenture and the Series 2013A Loan Agreement, the certified proceedings and other certifications of public officials furnished to us, and certifications furnished to us by or on behalf of the Alliance (including certifications as to the use of bond proceeds and other bond issues which are material to paragraph 4 below), without undertaking to verify the same by independent investigation.

Based upon the foregoing, we are of the opinion that, under existing law:

1. The Issuer is duly created and validly existing as a public, nonprofit corporation, organized and existing under the laws of the State of Tennessee with the corporate power to enter into and perform the Bond Indenture and issue the Series 2013A Bonds.

2. The Series 2013A Bond Indenture has been duly authorized, executed and delivered by the Issuer and is a valid and binding obligation of the Series 2013A Issuer enforceable against the Issuer. The Series 2013A Bond Indenture creates a valid lien on the Revenues and on the rights of the Issuer under the Series 2013A Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) for the benefit of the Series 2013A Bonds.

3. The Series 2013A Bonds have been duly authorized, executed and delivered by the Issuer and are valid and binding special obligations of the Issuer, payable solely from the Series 2013A Revenues and draws on the Series 2013A Letter of Credit.

4. Interest on the Series 2013A Bonds (a) will not be included in gross income for federal income tax purposes and (b) will not be an item of tax preference for purposes of the federal alternative minimum income tax imposed on individuals and corporations; however, with respect to corporations (as defined for federal income tax purposes) such interest is taken into account in determining adjusted current earnings for purposes of computing the alternative minimum income tax on corporations. The foregoing opinion is given in reliance upon certifications by representatives of the Issuer and the Alliance as to certain facts relevant to both the opinion and the requirements of the Internal Revenue Code of 1986, as amended (the "Code"). The Issuer and/or the Alliance have covenanted to comply with the provisions of the Code regarding, among other matters, the use, expenditure and investment of the proceeds of the Series 2013A Bonds and the timely payment of arbitrage profits with respect to the Series 2013A Bonds to the United States. Failure by the Issuer or the Alliance to comply with such covenants could cause interest on the Series 2013A Bonds to be included in gross income for federal income tax purposes retroactively to their date of issue. We express no opinion regarding other federal tax consequences arising with respect to the Series 2013A Bonds.

5. The Series 2013A Bonds and the income therefrom shall be exempt from all state, county and municipal taxation in Tennessee except (a) inheritance, gift and estate taxes, (b) excise taxes on all or a portion of the interest on any of the Series 2013A Bonds during the period such Series 2013A Bonds are held or beneficially owned by any organization or entity, other than a sole proprietorship or general partnership, and (c) Tennessee franchise taxes by reason of the inclusion of the book value of the Series 2013A Bonds in the Tennessee franchise tax base of any organization or entity, other than a sole proprietorship or general partnership.

It is to be understood that the rights of the holders of the Series 2013A Bonds and the enforceability of the Series 2013A Bonds and the Series 2013A Bond Indenture may be subject to bankruptcy, insolvency, reorganization, moratorium and other laws affecting creditors' rights heretofore and hereafter enacted to the extent constitutionally applicable and that their enforcement may also be subject to the exercise of judicial discretion in appropriate cases.

Our services as bond counsel have been limited to rendering the foregoing opinion based on our review of such proceedings and documents as we deem necessary to approve the validity of the Series 2013A Bonds and the excludability of the interest on the Series 2013A Bonds from gross income for federal income tax purposes. We have not made any investigation concerning the financial resources of the Alliance and, therefore, we express no opinion as to the business or financial resources of the Alliance, its ability to provide for the payment of the Series 2013A Bonds or the accuracy or completeness of any information, including the Official Statement relating to the Series 2013A Bonds that may have been relied on by anyone in making the decision to purchase the Series 2013A Bonds.

Very truly yours,

[Opinion of Bass Berry Sims]

July 30, 2013

The Health and Educational Facilities Board
of the City of Johnson City, Tennessee
Johnson City, Tennessee

The Bank of New York Mellon Trust Company, N.A.,
Bond Trustee and Master Trustee
St. Louis, Missouri

U.S. Bank National Association
St. Louis, Missouri

Merrill Lynch, Pierce, Fenner & Smith Incorporated
New York, New York

Re: The Health and Educational Facilities Board of the City of Johnson City, Tennessee \$99,680,000 Taxable Hospital Refunding Revenue Bonds (Mountain States Health Alliance), Series 2013B

Ladies and Gentlemen:

We have acted as bond counsel in connection with the issuance by The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the "Issuer") of its \$99,680,000 Taxable Hospital Refunding Revenue Bonds (Mountain States Health Alliance), Series 2013B (the "Series 2013B Bonds"). We have examined the law and such certified proceedings and other papers as we deem necessary to render this opinion. Reference is made to the forms of the Series 2013B Bonds for additional information concerning their details, payment and redemption provisions and the proceedings pursuant to which they were issued.

The Series 2013B Bonds are issued pursuant to a Bond Trust Indenture dated as of July 1, 2013 (the "Series 2013B Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Series 2013B Bond Trustee"). The proceeds from the sale of the Series 2013B Bonds will be loaned by the Issuer to Mountain States Health Alliance, a not-for-profit corporation incorporated under the laws of the State of Tennessee (the "Alliance"), under a Loan Agreement dated as of July 1, 2013 (the "Series 2013B Loan Agreement"), between the Issuer and the Alliance, which loan will be evidenced by the \$99,680,000 Mountain States Health Alliance Note, Series 2013B (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) (the "Series 2013B Obligation") issued pursuant to an Amended and Restated Master Trust Indenture dated as of February 1, 2000, as heretofore amended and as amended by a Thirty-Ninth Supplemental Master Trust Indenture dated as of July 1, 2013 (collectively, the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"). Under the Series 2013B Loan Agreement and the Series 2013B Obligation, the Alliance has agreed to make payments to be used to pay when due the principal of and premium, if any, and interest on the Series 2013B Bonds, and such payments and other revenues under the Series 2013B Loan Agreement and the Series 2013B Obligation (collectively, the "2013B Revenues") and the rights of the Issuer under the Series 2013B Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) are pledged and assigned by the Issuer as security for the Series 2013B Bonds.

U.S. Bank National Association (the "Bank"), has issued an irrevocable letter of credit dated the date hereof (the "2013B Letter of Credit") to secure payment of the principal of and up to 37 days' accrued interest on the Series 2013B Bonds which expires, unless extended, on July 30, 2018.

The Series 2013B Bonds are payable solely from the 2013B Revenues and draws on the 2013B Letter of Credit.

Reference is made to an opinion of even date of Anderson & Fugate, counsel to the Alliance, with respect, among other matters, to the corporate status, good standing and qualification to do business of the Alliance, the corporate power of the Alliance to enter into and perform the Series 2013B Loan Agreement, the Series 2013B Obligation and the Master Indenture and the authorization, execution and delivery of the Series 2013B Loan Agreement, the Series 2013B Obligation and the Master Indenture by the Alliance and with respect to the Series 2013B Loan Agreement, the Series 2013B Obligation and the Master Indenture being binding and enforceable upon the Alliance.

As to questions of fact material to our opinion, we have relied upon representations of the Issuer and the Alliance contained in the Series 2013B Bond Indenture and the Series 2013B Loan Agreement, the certified proceedings and other certifications of public officials furnished to us, and certifications furnished to us by or on behalf of the Alliance (including certifications as to the use of bond proceeds and other bond issues which are material to paragraph 4 below), without undertaking to verify the same by independent investigation.

Based upon the foregoing, we are of the opinion that, under existing law:

1. The Issuer is duly created and validly existing as a public, nonprofit corporation, organized and existing under the laws of the State of Tennessee with the corporate power to enter into and perform the Bond Indenture and issue the Series 2013B Bonds.

2. The Series 2013B Bond Indenture has been duly authorized, executed and delivered by the Issuer and is a valid and binding obligation of the Series 2013B Issuer enforceable against the Issuer. The Series 2013B Bond Indenture creates a valid lien on the Revenues and on the rights of the Issuer under the Series 2013B Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) for the benefit of the Series 2013B Bonds.

3. The Series 2013B Bonds have been duly authorized, executed and delivered by the Issuer and are valid and binding special obligations of the Issuer, payable solely from the Series 2013B Revenues and draws on the Series 2013B Letter of Credit.

4. The Series 2013B Bonds and the income therefrom shall be exempt from all state, county and municipal taxation in Tennessee except (a) inheritance, gift and estate taxes, (b) excise taxes on all or a portion of the interest on any of the Series 2013B Bonds during the period such Series 2013B Bonds are held or beneficially owned by any organization or entity, other than a sole proprietorship or general partnership, and (c) Tennessee franchise taxes by reason of the inclusion of the book value of the Series 2013B Bonds in the Tennessee franchise tax base of any organization or entity, other than a sole proprietorship or general partnership.

It is to be understood that the rights of the holders of the Series 2013B Bonds and the enforceability of the Series 2013B Bonds and the Series 2013B Bond Indenture may be subject to bankruptcy, insolvency, reorganization, moratorium and other laws affecting creditors' rights heretofore and hereafter enacted to the extent constitutionally applicable and that their enforcement may also be subject to the exercise of judicial discretion in appropriate cases.

Our services as bond counsel have been limited to rendering the foregoing opinion based on our review of such proceedings and documents as we deem necessary to approve the validity of the Series 2013B Bonds. We have not made any investigation concerning the financial resources of the Alliance and, therefore, we express no opinion as to the business or financial resources of the Alliance, its ability to provide for the payment of the Series 2013B Bonds or the accuracy or completeness of any information, including the Official Statement relating to the Series 2013B Bonds that may have been relied on by anyone in making the decision to purchase the Series 2013B Bonds.

Very truly yours,

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APPENDIX E

PROPOSED FORM OF CONTINUING DISCLOSURE AGREEMENT

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CONTINUING DISCLOSURE AGREEMENT

This Continuing Disclosure Agreement (the “Agreement”) is executed by the Mountain States Health Alliance, a Tennessee nonprofit corporation (the “Alliance”), in connection with the issuance by the Health and Educational Facilities Board of the City of Johnson City, Tennessee, of its \$16,235,000 Hospital Revenue Bonds (Mountain States Health Alliance) Series 2013A (the “Series 2013A Bonds”) and its \$99,680,000 Taxable Hospital Refunding Revenue Bonds, Series 2013B (the “Series 2013B Bonds” and, together with the Series 2013A Bonds, the “Bonds”).

1. Purpose of the Agreement

This Agreement is being executed and delivered by the Alliance for the benefit of the Beneficial Owners of the Bonds and in order to assist the Underwriter in complying with the Rule (as hereinafter defined).

2. Definitions

Except as otherwise indicated, any capitalized terms used, but not defined herein shall have the meaning assigned to them in the bond indenture pursuant to which the Bonds were issued. The following capitalized terms when used in this Agreement will have the following meanings:

“Annual Disclosure” means the annual financial information, audited financial statements prepared in accordance with generally accepted accounting principles and the operating data, all to be provided by the Alliance with respect to itself and any future Obligated Issuer pursuant to the Rule and this Agreement, as provided in Section 4.

“Beneficial Owner” means any person who (a) has the power, directly or indirectly, to vote or consent with respect to, or to dispose of ownership of, any Bonds (including persons holding Bonds through nominees, depositories or other intermediaries) or (b) is treated as the owner of any Bonds for federal income tax purposes.

“Listed Events” means any of the events listed below under “Reporting of Significant Events.”

“MSRB” means the Municipal Securities Rulemaking Board, or any successor thereto. Currently, the MSRB’s address is: MSRB, 1900 Duke Street, Suite 600, Alexandria, Virginia 22314, Attn: Disclosure.

“Official Statement” means the Official Statement dated July 25, 2013, pursuant to which the Bonds were sold.

“Quarterly Disclosure” means the provision of the Quarterly Financial Information and any other financial information as provided in Section 5.

“Quarterly Financial Information” means (i) the Alliance’s quarterly financial results in the form of its unaudited quarterly statement of excess of revenue over expenses and its unaudited quarterly balance sheet, each on a consolidated basis for the combined Obligated Group (as defined in the bond documents pursuant to which the Bonds are issued) and (ii) two calculations of the Historical Maximum Annual Debt Service Coverage Ratio (one utilizing a *pro forma* Total Income Available for Debt Service based upon the results of such quarter and the other utilizing Total Income Available for Debt Service over the rolling twelve-month period ended with the end of such quarter).

“Rule” means Rule 15c2-12(b)(5) adopted by the Securities and Exchange Commission under the Securities Exchange Act of 1934, as previously amended and as the same may be amended from time to time.

“Underwriter” means Merrill Lynch, Pierce, Fenner & Smith Incorporated.

3. Provision of Annual Disclosure and Quarterly Disclosure

Not later than four months after the end of each fiscal year, the Alliance will file its Annual Disclosure with the MSRB. The Annual Disclosure may be submitted as a single document or as separate documents comprising a package, and may cross-reference other information as provided below.

Not later than 45 days after the end of each quarter of the Alliance's fiscal year the Alliance shall file its Quarterly Financial Information with the MSRB.

If the Annual Disclosure is not filed as provided in the preceding paragraph, the Alliance will send a notice to that effect to the MSRB.

4. Content of Annual Disclosure

The Alliance and any future Obligated Issuer shall provide and incorporate the following information in its Annual Disclosure:

(a) The audited financial statements of the Alliance and any future Obligated Issuer whose operations are not reflected in the audited financial statements of the Alliance; and

(b) To the extent not included in the audited financial statements of the Alliance, the Alliance annually will make available the following financial and operating data:

(i) The patient origin analysis from all service areas as a percent of the discharges in Alliance-owned facilities for the prior 12 month period, as set forth under the caption "SERVICE AREA, MARKET SHARE AND COMPETITION – Patient Origin – Alliance Facilities Patient Origin by Fiscal Year" in Appendix A of the Official Statements.

(ii) The percentage of gross patient revenues received by the Alliance from each program (i.e., Medicare, TennCare/Medicaid, Managed Care, Commercial and Other, and Private Pay) for the most recently concluded fiscal year, as set forth under the caption "SOURCES OF REVENUE – Gross Patient Revenues by Source of Payment (Payor Mix)" in Appendix A of the Official Statements.

(iii) The historic patient utilization for the Alliance and aggregate utilization for all divisions for the prior 12-month period ending June 30, as set forth in the table under the caption "HISTORICAL UTILIZATION INFORMATION" in Appendix A of the Official Statements.

Any or all of the items listed above may be incorporated by reference from other documents, including official statements of debt issues with respect to which the Alliance is an "obligated person" (as defined by the Rule), which have been filed in accordance with the Rule and the other rules of the Securities and Exchange Commission. If the document incorporated by reference is a final official statement, it must have been filed with and be available from the MSRB. The Alliance must clearly identify each such other document so incorporated by reference.

5. Content of Quarterly Disclosure

The Alliance's Quarterly Disclosure will contain its Quarterly Financial Information.

6. Reporting of Significant Events

The following are Listed Events:

- (a) principal and interest payment delinquencies;
- (b) non-payment related defaults, if material;
- (c) unscheduled draws on debt service reserves reflecting financial difficulties;

- (d) unscheduled draws on any credit enhancement reflecting financial difficulties;
- (e) substitution of credit or liquidity providers, or their failure to perform;
- (f) adverse tax opinions; the issuance by the IRS of proposed or final determinations of taxability, Notices of Proposed Issue (IRS Form 5701-TEB) or other material notices or determinations with respect to the tax status of the Bonds, or other material events affecting the tax status of the Bonds;
- (g) modifications of rights of the holders of the Bonds, if material;
- (h) bond calls, if material, and tender offers;
- (i) defeasance of all or any portion of the Bonds;
- (j) release, substitution, or sale of property securing repayment of the Bonds, if material;
- (k) rating changes;
- (l) bankruptcy, insolvency, receivership or similar event of the Alliance;
- (m) the consummation of a merger, consolidation, or acquisition involving the Alliance or the sale of all or substantially all of the assets of the Alliance, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; and
- (n) appointment of a successor or additional trustee or the change of name of a trustee, if material.

If the Alliance obtains knowledge of the occurrence of a Listed Event, the Alliance shall, in a timely manner not in excess of ten business days after the occurrence of the event, file a notice of such occurrence with the MSRB. Notice of Listed Events described in subsections (h) and (i) will be disseminated automatically, but will not be given any earlier than the notice (if any) of the underlying event is given to the Beneficial Owners of affected Bonds pursuant to the governing bond documents. The content of any notice of the occurrence of a Listed Event will be determined by the Alliance in accordance with the requirements of the Rule.

7. Filing Method

Any filing required hereunder shall be made by transmitting such disclosure, notice or other information in electronic format to the MSRB through the MSRB's Electronic Municipal Market Access (EMMA) system pursuant to procedures promulgated by the MSRB.

8. Termination of Reporting Obligation

The Alliance's obligations under this Agreement will terminate upon the defeasance (within the meaning of the Rule), prior redemption or payment in full of all of the Bonds. The Alliance will notify the MSRB that the Alliance's obligations under this Agreement have terminated. If the Alliance's obligations are assumed in full by some other entity, such person will be responsible for compliance with this Agreement in the same manner as if it were the Alliance and the Alliance will have no further responsibility hereunder.

9. Dissemination Agent

The Alliance may, from time to time, appoint a dissemination agent to assist it in carrying out its obligations under this Agreement, and the Alliance may, from time to time, discharge the dissemination agent, with or without appointing a successor dissemination agent. If at any time there is not a designated dissemination agent, the Alliance will be the dissemination agent.

10. Amendment

This Agreement may not be amended unless independent counsel experienced in securities law matters has rendered an opinion to the Alliance to the effect that the amendment does not violate the provisions of the Rule.

In the event that this Agreement is amended or any provision of this Agreement is waived, the notice of a Listed Event pursuant to subsection (6) under the heading "Reporting of Significant Events" will explain, in narrative form, the reasons for the amendment or waiver and the impact of the change in the type of operating data or financial information being provided in the Annual Disclosure. If an amendment or waiver is made in this

Agreement which allows for a change in the accounting principles to be used in preparing financial statements, the Annual Disclosure for the year in which allows for a change in the accounting principles to be used in preparing financial statements, the Annual Disclosure for the year in which the change is made will present a comparison between the financial statements or information prepared on the basis of the new accounting principles and those prepared on the basis of the former accounting principles. The comparison will include a qualitative discussion of the differences in the accounting principles and impact of the change in the accounting principles on the presentation of the financial information. A notice of the change in the accounting principles will be deemed to be material and will be filed with the MSRB.

11. Additional Information

Any registered owner of \$1,000,000 or more in principal amount of Bonds shall receive, upon written request, any of the Annual Financial Information, Audited Financial Information or Quarterly Financial Information directly from the Alliance, by sending such request to Mountain States Health Alliance, 400 North State of Franklin Road, Johnson City, Tennessee 37604, Attn: Chief Financial Officer.

Nothing in this Agreement will be deemed to prevent the Alliance from disseminating any other information, using the means of dissemination set forth in this Agreement or any other means of communication, or including any other information in any Annual Disclosure or notice of occurrence of a Listed Event, in addition to that which is required by this Agreement. If the Alliance chooses to include any information in any Annual Disclosure or notice of occurrence of a Listed Event, in addition to that which is specifically required by this Agreement, the Alliance will have no obligation under this Agreement to update such information or include it any future Annual Disclosure or notice of occurrence of a Listed Event.

12. Default

In the event of a failure of the Alliance to comply with any provision of this Agreement, the Underwriter or any Beneficial Owner may take such actions as may be necessary and appropriate, including seeking specific performance by court order, to cause the Alliance to comply with its obligations under this Agreement. A default under this Agreement will not be deemed an Event of Default under the bond documents, and the sole remedy under this Agreement in the event of any failure of any party to comply with this Agreement will be an action to compel performance.

Acting by and through its duly authorized officer, the Alliance has caused this Continuing Disclosure Agreement to be executed under seal as of the 30th day of July, 2013.

MOUNTAIN STATES HEALTH ALLIANCE

By: _____
Its: Senior Vice President and
Chief Financial Officer

APPENDIX F

THE BANK

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**CERTAIN INFORMATION CONCERNING
U.S. BANK NATIONAL ASSOCIATION**

The delivery of this Appendix to the Official Statement shall not create any implication that there has been no change in the affairs of U.S. Bank since the date hereof, or that the information contained or referred to in this Appendix F is correct as of any time subsequent to its date.

U.S. Bank National Association (“USBNA”) is a national banking association organized under the laws of the United States and is the largest subsidiary of U.S. Bancorp. At March 31, 2013, USBNA reported total assets of \$346 billion, total deposits of \$252 billion and total shareholders’ equity of \$40 billion. The foregoing financial information regarding USBNA has been derived from and is qualified in its entirety by the unaudited financial information contained in the Federal Financial Institutions Examination Council report Form 031, Consolidated Report of Condition and Income for a Bank with Domestic and Foreign Offices (“Call Report”), for the quarter ended March 31, 2013. The publicly available portions of the quarterly Call Reports with respect to USBNA are on file with, and available upon request from, the FDIC, 550 17th Street, NW, Washington, D.C. 20429 or by calling the FDIC at (877) 275-3342. The FDIC also maintains an Internet website at www.fdic.gov that contains reports and certain other information regarding depository institutions such as USBNA. Reports and other information about USBNA are available to the public at the offices of the Comptroller of the Currency at One Financial Place, Suite 2700, 440 South LaSalle Street, Chicago, IL 60605.

U.S. Bancorp is subject to the informational requirements of the Securities Exchange Act of 1934, as amended, and, in accordance therewith, files reports and other information with the Securities and Exchange Commission (the “SEC”). U.S. Bancorp is not guaranteeing the obligations of USBNA and is not otherwise liable for the obligations of USBNA.

Except for the contents of this section, USBNA and U.S. Bancorp assume no responsibility for the nature, contents, accuracy or completeness of the information set forth in this Official Statement.

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BOOK-ENTRY ONLY SYSTEM

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BOOK-ENTRY ONLY SYSTEM

The description which follows of the procedures and recordkeeping with respect to beneficial ownership interests in the Bonds, payments of principal of and premium, if any, and interest on the Bonds to The Depository Trust Company, New York, New York, its nominee, Participants or Beneficial Owners (each as hereinafter defined), confirmation and transfer of beneficial ownership interests in the Bonds and other bond-related transactions by and between DTC, Participants and Beneficial Owners is based solely on information furnished by DTC.

DTC will act as securities depository for the Bonds. The Bonds will be issued as fully-registered securities registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered Bond certificate will be issued for each Series of the Bonds, each in the aggregate principal amount of such issue, and will be deposited with DTC.

DTC, the world's largest depository, is a limited-purpose trust company organized under the New York Banking Law, a "banking organization" within the meaning of the New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.5 million issues of U.S. and non-U.S. equity, corporate and municipal debt issues, and money market instruments (from over 100 countries) that DTC's participants (the "Direct Participants") deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("Indirect Participants"). DTC has a Standard & Poor's rating of AA+. The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com.

Purchases of the Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Bonds on DTC's records. The ownership interest of each actual purchaser of each Bond (the "Beneficial Owner") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners, however, are expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Bonds are to be accomplished by entries made on the books of Direct or Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their ownership interests in the Bonds, except in the event that use of the book-entry system for the Bonds is discontinued.

To facilitate subsequent transfers, all Bonds deposited by Direct Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of the Bonds with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such Bonds are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holding on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time.

Redemption notices shall be sent to DTC. If less than all of the Bonds are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such issue to be redeemed.

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to the Bonds unless authorized by a Direct Participant in accordance with DTC's Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to the Issuer or the Alliance, as applicable, as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts the Bonds are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Redemption proceeds, distributions, and dividend payments on the Bonds will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding detail information from the Alliance or the Bond Trustee on a payment date in accordance with their respective holdings shown on DTC's records. Payments by Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Participant and not of DTC, the Bond Trustee, the Issuer or the Alliance, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of redemption proceeds, distributions, and dividend payments to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Alliance or the Bond Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

DTC may discontinue providing its services as securities depository with respect to the Bonds at any time by giving reasonable notice to the Issuer or the Alliance. Under such circumstances, in the event that a successor securities depository is not obtained, Bond certificates will be printed and delivered.

The Issuer or the Alliance may decide to discontinue the Issuer's use of the system of book-entry transfers through DTC (or a successor securities depository). In that event, Bond certificates will be printed and delivered.

The information in this section concerning DTC and DTC's book-entry system has been obtained from sources that the Issuer believes to be reliable, but the Issuer takes no responsibility for the accuracy thereof.

Neither the Issuer nor the Registrar has any responsibility or obligation to the Direct or Indirect Participants or the Beneficial Owners with respect to (a) the accuracy of any records maintained by DTC or any Direct or Indirect Participant; (b) the payment by any Direct or Indirect Participant of any amount due to any Beneficial Owner in respect of the principal of and interest on the Bonds; (c) the delivery or timeliness of delivery by any Direct or Indirect Participant of any notice to any Beneficial Owner that is required or permitted under the terms of the Bond Resolution to be given to Bondholders; or (d) any other action taken by DTC, or its nominee, Cede & Co., as Bondholder, including the effectiveness of any action taken pursuant to an Omnibus Proxy.

So long as Cede & Co. is the registered owner of the Bonds, as nominee of DTC, references in this Official Statement to the Owners of the Bonds shall mean Cede & Co. and shall not mean the Beneficial Owners, and Cede & Co. will be treated as the only holder of Bonds for all purposes under the Bond Resolution.

The Issuer may enter into amendments to the agreement with DTC or successor agreements with a successor securities depository, relating to the book-entry system to be maintained with respect to the Bonds without the consent of Beneficial Owners or Bondholders.



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Exhibit 11.4

Attachment D

The Mountain States Covenant Compliance Certificates are considered confidential information and will be subsequently filed.

Exhibit 11.4

Attachment E

The Mountain States Officer's Certificates accompanying Independent Auditor's Reports are considered confidential information and will be subsequently filed.

Exhibit 11.4

Attachment F

Mountain States Audited Financial Statements for 2009 to 2014

MOUNTAIN STATES HEALTH ALLIANCE

*Audited Consolidated Financial Statements
(and Supplemental Schedules)*

Years Ended June 30, 2010 and 2009

MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Schedules)

Years Ended June 30, 2010 and 2009

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CERTIFIED PUBLIC ACCOUNTANTS

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited the accompanying consolidated balance sheets of Mountain States Health Alliance and subsidiaries (the Alliance) as of June 30, 2010 and 2009 and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Alliance's management. 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 of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing 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 over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe our audits provide a reasonable basis for our 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 subsidiaries as of June 30, 2010 and 2009 and the results of their operations, changes in net assets and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The supplemental schedules, as listed in the accompanying index, are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Knoxville, Tennessee
October 25, 2010

Pershing Yoakley & Associates, P.C.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets
(Dollars in Thousands)

	<i>June 30,</i>	
	<i>2010</i>	<i>2009</i>
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 234,526	\$ 239,836
Current portion of investments	28,467	27,317
Patient accounts receivable, less estimated allowances for uncollectible accounts of \$45,941 in 2010 and \$42,587 in 2009	125,580	128,812
Other receivables, net	17,926	16,108
Inventories and prepaid expenses	29,163	27,135
TOTAL CURRENT ASSETS	435,662	439,208
INVESTMENTS, less amounts required to meet current obligations	586,756	597,440
PROPERTY, PLANT AND EQUIPMENT, net	695,598	590,569
OTHER ASSETS		
Goodwill, net of accumulated amortization of \$95,760 in 2010 and \$84,687 in 2009	151,352	162,620
Net deferred financing, acquisition costs and other charges, less current portion	30,819	31,473
Other assets	29,313	34,765
TOTAL OTHER ASSETS	211,484	228,858
	\$ 1,929,500	\$ 1,856,075

	<i>June 30,</i>	
	<i>2010</i>	<i>2009</i>
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	\$ 16,039	\$ 12,050
Current portion of long-term debt and capital lease obligations	28,131	31,306
Current portion of estimated fair value of derivatives	10,740	10,921
Accounts payable and accrued expenses	99,227	94,712
Accrued salaries, compensated absences and amounts withheld	47,280	49,569
Estimated amounts due to third-party payors, net	10,155	6,398
TOTAL CURRENT LIABILITIES	211,572	204,956
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	1,054,842	1,040,944
Estimated fair value of derivatives, less current portion	123,560	115,296
Deferred revenue	20,445	21,078
Estimated professional liability self-insurance	9,541	10,012
Other long-term liabilities	12,628	13,885
TOTAL LIABILITIES	1,432,588	1,406,171
MINORITY INTERESTS	168,410	165,500
COMMITMENTS AND CONTINGENCIES - Notes D, F, G, and N		
NET ASSETS		
Unrestricted net assets	317,434	272,049
Temporarily restricted net assets	10,941	12,178
Permanently restricted net assets	127	177
TOTAL NET ASSETS	328,502	284,404
	\$ 1,929,500	\$ 1,856,075

MOUNTAIN STATES HEALTH ALLIANCE

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

	<i>Year Ended June 30,</i>	
	<i>2010</i>	<i>2009</i>
CHANGES IN UNRESTRICTED NET ASSETS:		
Revenue, gains and support:		
Net patient service revenue	\$ 928,270	\$ 822,898
Other operating revenue	16,009	17,046
TOTAL REVENUE, GAINS AND SUPPORT	944,279	839,944
Expenses:		
Salaries and wages	325,663	296,073
Physician salaries and wages	54,489	38,240
Contract labor	6,546	16,899
Employee benefits	68,362	61,134
Fees	82,542	71,896
Supplies	175,469	156,418
Utilities	16,193	15,548
Other	67,640	57,974
Depreciation	68,436	56,373
Amortization	13,123	12,150
Estimated provision for bad debts	7,961	5,011
Interest and taxes	42,264	45,225
TOTAL EXPENSES	928,688	832,941
OPERATING INCOME	15,591	7,003
Nonoperating gains (losses):		
Interest and dividend income	17,298	19,105
Net realized gains (losses) on the sale of securities	2,385	(6,552)
Net unrealized gains (losses) on securities	15,018	(62,582)
Derivative related income	4,394	4,772
Loss on termination of derivatives - Note D	-	(2,785)
Loss on early extinguishment of debt - Note F	(3,029)	-
Change in estimated fair value of derivatives	(8,607)	(42,128)
Other nonoperating gains (losses)	512	(306)
Net assets released from restrictions used for operations	1,113	793
NET NONOPERATING GAINS (LOSSES)	29,084	(89,683)

	<i>Year Ended June 30,</i>	
	<i>2010</i>	<i>2009</i>
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES, BEFORE DISCONTINUED OPERATIONS AND MINORITY INTERESTS	44,675	(82,680)
Gain on sale of and deficit of revenue, gains and support over expenses and losses from discontinued operations	-	2,519
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES BEFORE MINORITY INTERESTS	44,675	(80,161)
Minority interest in consolidated subsidiaries' net (gain) loss	(3,162)	546
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	41,513	(79,615)
Other changes in unrestricted net assets:		
Pension and other defined benefit plan adjustments	1,589	(512)
Net assets released from restrictions used for the purchase of property, plant and equipment	2,283	3,095
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	45,385	(77,032)
CHANGES IN TEMPORARILY RESTRICTED NET ASSETS:		
Restricted grants and contributions	2,159	3,929
Net assets released from restrictions	(3,396)	(3,888)
(DECREASE) INCREASE IN TEMPORARILY RESTRICTED NET ASSETS	(1,237)	41
CHANGES IN PERMANENTLY RESTRICTED NET ASSETS:		
Net assets released from restrictions by donor	(50)	-
INCREASE (DECREASE) IN TOTAL NET ASSETS	44,098	(76,991)
NET ASSETS, BEGINNING OF YEAR	284,404	361,395
NET ASSETS, END OF YEAR	\$ 328,502	\$ 284,404

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2010</i>	<i>2009</i>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase (decrease) in net assets	\$ 44,098	\$ (76,991)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	81,982	68,967
Loss on early extinguishment of debt	3,029	-
Loss on termination of derivatives	-	3,245
Change in estimated fair value of derivatives	8,607	42,128
Equity in net income of joint ventures	(1,117)	(723)
Gain on sale of assets held for resale and disposal of assets	(548)	(568)
Amounts received on interest rate swap settlements	(4,394)	(4,772)
Minority interest in consolidated subsidiaries' net (gain) loss	3,162	(546)
Income recognized through forward sale agreements	(864)	(796)
Capital Appreciation Bond accretion and other	2,071	1,678
Restricted contributions	(2,159)	(3,929)
Pension and other defined benefit plan adjustments	598	512
Increase (decrease) in cash due to change in:		
Net patient accounts receivable	3,232	724
Other receivables, net	(1,246)	(4,107)
Inventories and prepaid expenses	(4,640)	1,843
Trading securities	(13,368)	183,450
Other assets	(1,159)	(4,144)
Accrued interest payable	3,989	1,900
Accounts payable and accrued expenses	(855)	8,551
Accrued salaries, compensated absences and amounts withheld	(2,289)	3,500
Estimated amounts due from/to third-party payors, net	3,757	6,492
Other long-term liabilities	(201)	(1,363)
Estimated professional liability self-insurance	(471)	(610)
Total adjustments	<u>77,116</u>	<u>301,432</u>
NET CASH PROVIDED BY OPERATING ACTIVITIES	121,214	224,441
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property, plant and equipment, property held for resale and property held for expansion, net	(172,240)	(119,741)
Additions to goodwill	-	(16,097)
Net decrease (increase) in assets limited as to use	50,362	(28,152)
Purchases of held-to-maturity securities	(28,175)	-
Net sale or distribution from joint ventures and unconsolidated affiliates	1,162	384

	<i>Year Ended June 30,</i>	
	<i>2010</i>	<i>2009</i>
Proceeds from sale of property, plant and equipment and property held for resale	9,565	2,056
NET CASH USED IN INVESTING ACTIVITIES	(139,326)	(161,550)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt and capital lease obligations, including deposits to escrow	(226,315)	(36,820)
Payment of acquisition and financing costs	(3,565)	(3,214)
Proceeds from issuance of long-term debt and other financing arrangements	235,158	135,780
Net amounts received on interest rate swap settlements	4,394	4,772
Restricted contributions received	3,382	5,767
Distribution to minority shareholders and other	(252)	(158)
NET CASH PROVIDED BY FINANCING ACTIVITIES	12,802	106,127
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	(5,310)	169,018
CASH AND CASH EQUIVALENTS, beginning of year	239,836	70,818
CASH AND CASH EQUIVALENTS, end of year	\$ 234,526	\$ 239,836

SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:

Cash paid for interest	\$ 38,666	\$ 45,218
Cash paid for federal and state income taxes	\$ 446	\$ 664
Construction related payables in accounts payable and accrued expenses	\$ 14,847	\$ 9,246
Increase in receivable from sale of property	\$ 1,483	\$ -
Decrease in land held for expansion related to property exchange transaction	\$ 3,432	\$ -

During the years ended June 30, 2010 and 2009, the Alliance refinanced previously issued debt of \$184,050 and \$9,445, respectively.

As discussed in Note A, the Alliance acquired a 50.1% interest in Johnston Memorial Hospital, Inc. (JMH) in fiscal year 2009. JMH is consolidated within the accompanying financial statements as of the acquisition date, April 1, 2009. The consolidated cash flows include JMH's cash flows since the acquisition date.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE A--ORGANIZATION AND OPERATIONS

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The initial funds for the establishment of the Alliance in 1945 were provided by individuals and various institutions. Membership of the Alliance consists of individuals and institutions who have contributed at least \$100 to the capital fund of the Alliance and are entitled to vote at the annual election of the Board of Directors.

The primary operations of the Alliance consist of eleven acute and specialty care hospitals, as follows:

- Johnson City Medical Center (JCMC) - licensed for 645 beds
- Indian Path Medical Center (IPMC) - licensed for 322 beds
- Smyth County Community Hospital (SCCH) - licensed for 279 beds
- Johnston Memorial Hospital (JMH) - licensed for 135 beds
- Norton Community Hospital (NCH) - licensed for 129 beds
- Sycamore Shoals Hospital (SSH) - licensed for 121 beds
- North Side Hospital (NSH) - licensed for 91 beds
- Russell County Medical Center (RCMC) - licensed for 78 beds
- Johnson City Specialty Hospital (JCSH) - licensed for 23 beds
- Dickenson Community Hospital (DCH) - licensed for 25 beds
- Johnson County Community Hospital (JCCH) - licensed for 2 beds

Effective April 1, 2009, the Alliance acquired an interest in Johnston Memorial Hospital, Inc. (JMH), a 135 bed general acute care hospital located in Abingdon, Virginia. JMH is also the sole member of Abingdon Physician Partners (APP), a non-taxable corporation that owns and manages physician practices. The Alliance acquired a 50.1% interest in JMH by providing \$132,000 to JMH (designated for capital). Johnston Memorial Healthcare Foundation, Inc. (JMHF), a hospital supporting organization, retained a 49.9% interest in JMH. The assets and liabilities of JMH at April 1, 2009 have been consolidated by the Alliance at their carrying value as of that date. The following is condensed, unaudited financial information related to JMH as of March 31, 2009:

Current Assets	\$	23,516
Other Assets		139,576
		<hr/>
Total	\$	163,092
		<hr/>
Liabilities	\$	47,440
Net Assets (initial membership interest of JMHF)		115,652
		<hr/>
	\$	163,092
		<hr/>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE A--ORGANIZATION AND OPERATIONS - Continued

The activities and accounts of JMH since April 1, 2009 are included in the accompanying consolidated financial statements.

The Alliance has a 50.1% interest in NCH. NCH is also the sole member or shareholder of DCH and Norton Community Physician Services, LLC (NCPS), a taxable corporation that consists of physician practices and a pharmacy and; Community Home Care (CHC), a taxable corporation that provides home medical equipment. The activities and accounts of NCH are included in the accompanying consolidated financial statements.

The Alliance also has an 80% interest in SCCH. SCCH is the sole shareholder of Southwest Community Health Services, Inc. (SWCH), a taxable entity that operates a pharmacy and provides other health services. The activities and accounts of SCCH are included in the accompanying consolidated financial statements.

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices and provides other healthcare services to patients in Tennessee and Virginia. BRMM also operates as a medical office real estate developer by owning, selling and leasing real estate to physician practices and other entities. BRMM is either the sole shareholder, a significant shareholder, or member of the following organizations:

Blue Ridge Physician Group, Inc. (BRPG): A company that contracts with physicians to provide services to BRMM physician practices.

Mountain States Properties, Inc. (MSPI): An entity that owns and manages certain real estate (primarily medical office buildings) and provides rehabilitation and fitness services. In addition, MSPI is a counter-party to various financing transactions, including interest rate swaps.

Mediserve Medical Equipment of Kingsport, Inc. (Mediserve): A company that provides durable medical equipment services.

Kingsport Ambulatory Surgery Center (KASC) (d.b.a. Kingsport Day Surgery): A joint venture operating as an outpatient surgery center which performs procedures primarily in otolaryngology, orthopedics, ophthalmology, and general surgery. BRMM has a 43% ownership of KASC at June 30, 2010 and 2009; however, BRMM maintains control over KASC. As such, the accounts and activities of KASC are included in the accompanying consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE A--ORGANIZATION AND OPERATIONS - Continued

Piney Flats Urgent Care (PFUC): A for-profit entity that provides urgent care patient services.

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc. (MSF), a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance. The Alliance is also the beneficiary of Mountain States Health Alliance Auxiliary (Auxiliary), a not-for-profit organization formed to coordinate volunteer activities of the Alliance. The activities and accounts of MSF and the Auxiliary are included in the accompanying consolidated financial statements.

Prior to 2010, the Alliance was a majority shareholder of PHP of Tri-Cities, LLC (PHPT). PHPT's primary purpose was to hold an equity interest in another organization engaged in and related to the financing and/or delivery of healthcare services. During 2009, PHPT's equity interest in this other entity was reacquired by that entity (PHP Companies, Inc. (PHP)). PHPT sold the interest to PHP for a net gain of \$2,519. The activities of PHPT and gain on sale are included in the accompanying 2009 consolidated financial statements as "discontinued operations". During 2009, PHPT was reorganized under the business name of Integrated Solutions Health Network, LLC (ISHN). Concurrent with the reorganization, the Alliance purchased the remaining ownership interest of Health Alliance PHO, Inc. (PHO), an entity in which the Alliance previously held a minority interest. The net assets of the PHO were merged into ISHN on June 30, 2009. The primary function of ISHN is to establish, operate and administer a provider-sponsored health care delivery network.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation: The accompanying consolidated financial statements include the accounts of the Alliance and its subsidiaries after elimination of all significant intercompany accounts and transactions. The Alliance classifies those activities directly associated with its mission of providing healthcare services, as well as other activities deemed significant to its operations, as operating activities.

A minority interest is recorded to recognize the ownership or membership interests of third parties with respect to JMH, NCH, SCCH, KASC, PFUC and ISHN.

In 2011, the Alliance will adopt recently issued accounting standards, which change the accounting for, and the financial statement presentation of, noncontrolling interests in a subsidiary within consolidated financial statements. This new standard requires that a noncontrolling interest in the equity of a subsidiary be accounted for and reported as equity, provides revised guidance on the treatment of net income and losses attributable to the noncontrolling interest and changes in ownership interests in a subsidiary and requires additional disclosures that identify and distinguish between the interests of the controlling and noncontrolling owners. Management of the

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Alliance is currently assessing the potential impact of the adoption of this new guidance on the consolidated financial statements.

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.

Accounting Standards Codification: In June 2009, the Financial Accounting Standards Board (FASB) issued Statement of Financial Accounting Standard (SFAS) No. 168, *The FASB Accounting Standards Codification and the Hierarchy of Generally Accepted Accounting Principles (GAAP) - a Replacement of FASB Statement No. 162*. This Statement modifies the GAAP hierarchy by establishing only two levels of GAAP, authoritative and nonauthoritative literature. Effective September 2009, the FASB Accounting Standards Codification (ASC), also known collectively as the "Codification," is considered the single source of authoritative U.S. accounting and reporting standards. FASB ASC 105-10, *Generally Accepted Accounting Principles*, became applicable during fiscal year 2010. All accounting references have been updated, and therefore SFAS references have been replaced with ASC references. The adoption of the ASC did not have an impact on the consolidated financial statements.

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 on the Consolidated Balance Sheets.

Investments: Investments as reported in the Consolidated Balance Sheets includes trading securities, held-to-maturity securities and assets limited as to use (Note C). FASB ASC 958-320, *Investments - Debt and Equity Securities*, allows not-for-profit organizations to report in a manner similar to business entities by identifying securities as available-for-sale or held-to-maturity and to exclude the unrealized gains and losses on those securities from the Performance Indicator (as defined below). Investments which the Alliance has the positive intent and ability to hold to maturity are considered as held-to-maturity. Substantially all other investments (including assets limited as to use) are considered as trading securities. Management annually evaluates the held-to-maturity investment portfolio and recognizes any "other-than-temporary" losses as deductions from the Performance Indicator. Management's 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, 2010.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

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 fair market value pursuant to FASB ASC 825, *Financial Instruments*. Guaranteed investment contracts are reported at contract value.

Realized gains and losses on trading securities and assets limited as to use are computed using the specific identification method for cost determination. Interest and dividend income is reported net of related investment fees.

Investments in joint ventures are reported under the equity method of accounting, which approximates the Alliance's equity in the underlying net book value, unless the ownership structure requires consolidation. Other assets include investments in joint ventures of \$2,418 and \$2,463 at June 30, 2010 and 2009, respectively.

Inventories: Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market.

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 equipment held under capital lease is shown as a part of depreciation expense and accumulated depreciation in the accompanying consolidated financial statements.

Interest costs incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The amount capitalized is net of investment earnings on assets limited as to use derived from borrowings designated for capital assets. Renewals and betterments are capitalized and depreciated over their useful life, whereas costs of maintenance and repairs are expensed as incurred.

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 2010 and 2009.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Property held for resale and property held for expansion primarily represent land contributed to, or purchased by, the Alliance plus costs incurred to develop the infrastructure of such land. Other assets include property held for resale and property held for expansion of \$9,135 and \$12,542, respectively, at June 30, 2010 and 2009. 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 2010 and 2009.

Goodwill: Goodwill represents the difference between the acquisition cost of assets and the estimated fair value of net tangible and any separately identified intangible assets. The Alliance amortizes goodwill associated with its not-for-profit subsidiaries under the straight-line method over various estimated useful lives. For goodwill acquired by its for-profit subsidiaries, the Alliance does not amortize the goodwill and annually performs impairment testing in accordance with FASB ASC 350, *Intangibles – Goodwill and Other*. At June 30, 2010, management does not believe any goodwill so tested to be impaired.

FASB ASC 350, *Intangibles - Goodwill and Other*, will require, among other things, that goodwill associated with not-for-profit entities be evaluated annually for impairment, including a transitional impairment test upon adoption, and that such goodwill no longer be amortized. The Alliance will be required to adopt this standard in 2011 and will perform such transitional testing as of July 1, 2010 prior to December 31, 2010. While the Alliance is evaluating the potential impact of the adoption of this standard, including the transitional impairment testing, it is currently not possible to determine the effects, if any, the adoption of this standard will have on the consolidated financial statements.

Deferred Financing, Acquisition Costs and Other Charges: Deferred financing costs are amortized over the life of the respective bond issue principally using the average bonds outstanding method. Other intangible assets include licenses and similar assets and are being amortized over the intangible's estimated useful life under the straight-line method.

Prior to 2009, the Alliance routinely financed interest rate swap and other derivative transaction issuance costs through modification of future settlement terms. As such, the unamortized issuance costs of these derivatives are included as deferred financing costs in the accompanying Consolidated Balance Sheets and are being amortized over the term of the respective derivative instrument. The unpaid issuance costs are included as a part of the estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. Beginning in 2009, interest rate swap and derivative transaction issuance costs are expensed as incurred, in accordance with FASB ASC 820, *Fair Value Measurements and Disclosures* (FASB ASC 820). No such costs were incurred in 2010 and 2009.

Derivative Financial Instruments: As further described in Note D, the Alliance is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

and have been presented at estimated fair market value in the accompanying Consolidated Balance Sheets. These fair values are based on the estimated amount the Alliance would receive, or be required to pay, to enter into equivalent agreements at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims (Note G) 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 payors. 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 payors 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, TennCare and other third-party payment programs. Current operations include a provision for bad debts in the Consolidated Statements of Operations and Changes in Net Assets estimated based upon the age of the patient accounts receivable, prior experience 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 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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

which no payment is anticipated and, as such, charges at established rates are not included in net patient service revenue.

In addition to the charity care services described above, the Alliance provides a number of other services to benefit the poor for which little or no payment is received. Medicare, 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 (Deficit) of Revenue, Gains and Support Over Expenses and Losses: The Consolidated Statements of Operations and Changes in Net Assets includes the caption *Excess (Deficit) 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 transfers of assets to and from affiliates and contributions of long-lived assets or amounts restricted to the purchase of long-lived assets, as well as pension and related adjustments.

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. Taxable entities account for income taxes in accordance with FASB ASC 740, *Income Taxes* (Note L). The Alliance has no significant uncertain tax positions at June 30, 2010 and 2009.

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 Statements of Operations and Changes in Net Assets as net assets released from restrictions. Permanently restricted net assets have been restricted by donors to be maintained by the Alliance in perpetuity.

Fair Value Measurement: In 2009, the Hospital adopted FASB ASC 820, *Fair Value Measurements and Disclosures*, which defines fair value, establishes a framework for measuring fair value under generally accepted accounting principles and expands disclosures about fair value measurements. There was no significant impact on the consolidated financial statements as a result of adopting this standard (Note Q).

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

In January 2010, the FASB issued ASU 2010-06, *Fair Value Measurements and Disclosures (Topic 820) - Improving Disclosures about Fair Value Measurements* (ASU 2010-06). ASU 2010-06 requires new disclosures regarding significant transfers in and out of Levels 1 and 2, as well as information about activity in Level 3 fair value measurements, including presenting information about purchases, sales, issuances and settlements on a gross versus a net basis in the Level 3 activity roll forward. In addition, ASU 2010-06 clarifies existing disclosures regarding input and valuation techniques, as well as the level of disaggregation for each class of assets and liabilities. The Alliance will adopt ASU 2010-06 in 2011, except for the disclosures related to purchases, sales, issuance and settlements, which will be effective for the Alliance beginning July 1, 2012. The adoption of ASU 2010-06 is not expected to have an impact on the Alliance's consolidated financial statements.

Subsequent Events: The Alliance evaluated all events or transactions that occurred after June 30, 2010, through October 25, 2010, the issuance date of the consolidated financial statements. During this period management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2010 consolidated financial statements, other than as discussed in Note D and in Note F.

Reclassifications: Certain 2009 amounts have been reclassified to conform with the 2010 presentation in the accompanying consolidated financial statements.

NOTE C--INVESTMENTS

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

	<u>2010</u>	<u>2009</u>
Designated or restricted:		
Under safekeeping agreements	\$ 52,050	\$ 40,604
Under guarantee agreements	89,486	86,364
By Board for capital improvements	2,776	-
Under bond indenture agreements:		
For debt service and interest payments	78,612	60,828
For capital acquisitions	76,241	161,731
	<u>299,165</u>	<u>349,527</u>
Less: amount required to meet current obligations	<u>(25,092)</u>	<u>(22,492)</u>
	<u>\$ 274,073</u>	<u>\$ 327,035</u>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE C--INVESTMENTS- Continued

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

	<u>2010</u>		<u>2009</u>
Cash, cash equivalents and money market funds	\$ 170,897	\$	173,859
U.S. Government securities	1,795		1,795
U.S. Agency securities	12,319		18,827
Guaranteed investment contracts	114,154		155,046
	<u>\$ 299,165</u>	\$	<u>349,527</u>

Trading securities consist of the following at June 30:

	<u>2010</u>		<u>2009</u>
Cash, cash equivalents and money market funds	\$ 4,799	\$	14,622
U.S. Government securities	3,137		-
U.S. Agency securities	13,760		16,013
Corporate and foreign bonds	15,063		10,014
Municipal obligations	1,461		3,101
U.S. equity securities	142,816		161,284
Other	28,608		30,031
	209,644		235,065
Less: amount classified as current	(3,375)		(4,825)
	<u>\$ 206,269</u>	\$	<u>230,240</u>

Held-to-Maturity securities consist of the following at June 30:

	<u>2010</u>		<u>2009</u>
Cash, cash equivalents and money market funds	\$ 1,131	\$	452
Corporate and foreign bonds	103,968		39,504
Municipal obligations	1,315		209
	<u>\$ 106,414</u>	\$	<u>40,165</u>

Held-to-maturity securities had gross unrealized gains and losses of \$5,525 and \$607, respectively, at June 30, 2010 and \$831 and \$110, respectively at June 30, 2009. At June 30, 2010, the Alliance held one security within the held-to-maturity portfolio with a fair value and unrealized loss of \$591

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE C--INVESTMENTS- Continued

and \$166, respectively, which had been at an unrealized loss position for over one year. At June 30, 2009, no securities held in the held-to-maturity portfolio had been in an unrealized loss position for over one year. At June 30, 2010, the contractual maturities of held-to-maturity securities were \$13,389 due in one year or less, \$48,447 due from one to five years and \$44,578 due after five years. At June 30, 2009, the contractual maturities of held-to-maturity securities were \$733 due in one year or less, \$21,190 due from one to five years and \$18,242 due after five years.

At June 30, 2010 and 2009, the Alliance held investments in certain limited partnerships and hedge funds of \$28,608 and \$30,031, respectively, that have a wide range of investment strategies with various levels of risk. These funds are included within trading securities and do not have readily determinable fair values. The funds are reported at fair market value pursuant to FASB ASC 825, *Financial Instruments*.

The Alliance has investments in several joint ventures and corporations which are accounted for under the equity method of accounting.

As a part of the acquisition of membership interests in JMH, SCCH and NCH, the Alliance has committed to invest \$132,000, \$48,100, and \$45,000, respectively. Cumulative amounts expended at June 30, 2010 under these commitments are approximately \$73,600.

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is a party to a number of derivative transactions. These derivatives have not been designated as hedges and, as such, are valued at estimated fair value in the accompanying Consolidated Balance Sheets. Management's primary objective in holding such derivatives is to introduce a variable rate component into its fixed rate debt structure. Under the terms of these agreements, changes in the interest rate environment could have a significant effect on the Alliance.

These derivative agreements require that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. Such investments are included as assets limited as to use. As of June 30, 2010, management believes the Alliance was fully collateralized with respect to the derivative agreements and management does not believe such collateral is exposed to third-party credit risk. Further, certain of the agreements contain requirements regarding maintenance of financial and liquidity ratios. Management has represented the Alliance is in compliance with all such covenants at June 30, 2010.

Interest Rate Swaps: The Alliance is a party to six interest rate swap agreements with Merrill Lynch as the counterparty. A liability, representing the estimated fair value of these swaps, of \$33,910 and \$37,274 was recognized by the Alliance as of June 30, 2010 and 2009, respectively.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE D--DERIVATIVE TRANSACTIONS - Continued

The following is a summary of five of these interest rate swap agreements at June 30, 2010:

<i>Swap</i>	<i>Notional Amount</i>	<i>Term</i>	<i>Payments by:</i>	
			<i>Counterparty</i>	<i>Alliance</i>
A	\$ 170,000	4/2008-4/2026	0.51% through April 2011, then 71.10% of USD-ISDA Swap Rate	0.00% through April 2011, then USD-SIFMA Municipal Swap Index
B	95,000	4/2008-4/2026	0.52% through April 2011, then 71.18% of USD-ISDA Swap Rate	0.00% through April 2011, then USD-SIFMA Municipal Swap Index
C	173,030	4/2008-4/2034	0.53% through April 2011, then 72.35% of USD-ISDA Swap Rate	0.00% through April 2011, then USD-SIFMA Municipal Swap Index
D	82,055	12/2007-7/2033	USD-LIBOR-BBA through June 2012, then 67.00% USD-LIBOR-BBA	4.411% through June 2012, then 3.805%
E	50,000	2/2008-7/2038	67.00% of USD-LIBOR-BBA less 0.07%	3.41%

Deferred financing and acquisition costs, net of amortization, include \$6,823 and \$7,167 at June 30, 2010 and 2009, respectively, related to these swaps.

In addition to the swaps described above, the Alliance and Merrill Lynch are also parties to a total return swap in the notional amount of \$23,900. No deferred financing and acquisition costs were recorded as a result of this transaction. The agreement consists of the following:

- An agreement that requires the Alliance to pay a variable rate of USD-SIFMA Municipal Swap Index through July 1, 2012 (or termination of the swap) on a notional amount equal to the outstanding 2001A Hospital Revenue and Improvement Bonds (the 2001A Reference Bonds). The Alliance receives a fixed rate of 6.25% on the outstanding 2001A Reference Bonds.
- A “total return provision” under which the Alliance will pay (or receive) an amount equal to the product of the outstanding 2001A Reference Bonds multiplied by the difference between the outstanding 2001A Reference Bonds and the 2001A Reference Bonds’ market price at termination, as defined in the agreement. In the event the swap does not terminate prior to July 1, 2012, there would be no settlement of this component as there would be no outstanding 2001A Reference Bonds.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE D--DERIVATIVE TRANSACTIONS - Continued

During 2009, the Alliance terminated an interest rate swap with a notional amount of \$318,315 to which Merrill Lynch was the counterparty. As a result of the termination, the Alliance wrote-off deferred financing and issuance costs of \$3,220 and recognized a gain on termination of \$3,054, which are included in loss on termination of derivatives in the accompanying 2009 Consolidated Statement of Operations and Changes in Net Assets.

The Alliance is party to a total return swap with Lehman Brothers as the counterparty. Lehman Brothers filed for bankruptcy in September 2008. The Alliance subsequently received notification from Lehman Brothers Special Financing, Inc. indicating the intent of the counterparty to terminate this agreement effective January 1, 2009. As of October 25, 2010, the Alliance and Lehman Brothers Special Financing, Inc. have been unable to reach a settlement agreement. In September 2010, the Alliance was issued a subpoena to furnish certain documentation related to the transaction. A protocol has been put into place by the bankruptcy court whereby the parties are to undergo alternate dispute resolution. If a settlement is not reached through the alternate dispute resolution process, the matter will be subject to non-binding arbitration. Legal counsel has advised management that the court ordered process may take several years.

The fair value of these swaps is undeterminable at January 1, 2009, as prior to the termination date Lehman Brothers liquidated the underlying referenced securities, making a valuation not commercially viable. An estimated liability of \$10,740 and \$10,921 was recognized by the Alliance as of June 30, 2010 and 2009, respectively. Management believes that the liability as recorded at June 30, 2010 is sufficient to cover any exposure arising from litigation in this matter. However, it is reasonably possible management's estimate may change in the near term, although the amount of any change cannot be estimated. Due to the termination of this agreement, the estimated liability is included as a current liability in the accompanying Consolidated Balance Sheets.

A third party holds collateral with a fair market value of approximately \$13,570 and \$13,252, respectively, at June 30, 2010 and 2009, with respect to these derivative agreements. Such collateral is included as current assets limited as to use. Additionally, during 2009 the Alliance wrote-off deferred financing and issuance costs related to these swaps of \$2,619 which is included in loss on termination of derivatives in the accompanying 2009 Consolidated Statement of Operations and Changes in Net Assets.

The arrangement consists of nine agreements each with three separate components (described below) with notional values of \$23,600, \$8,000, and \$8,750 each. The swaps generally consist of the following:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE D--DERIVATIVE TRANSACTIONS - Continued

- An arrangement that calls for the Alliance to pay a variable rate (SIFMA Municipal Swap Index) plus certain fixed payment amounts and receive a payment equal to the interest paid by the Alliance on a portion of its early extinguished, but still outstanding, 2000A and 2000B Hospital Mortgage Revenue Refunding Bonds (the Reference Bonds) (whose fixed rates range from 7.50% to 7.75%).
- An arrangement that requires the Alliance to pay a fixed rate of 4.211% through either July 1, 2025, 2029 or 2033 (or termination of the swap) on the outstanding Reference Bonds and receive a variable rate of 67% of USD-LIBOR-BBA on the outstanding Reference Bonds; and
- A “total return provision” under which the Alliance will pay (or receive) the difference between the outstanding Reference Bonds, multiplied by 132%, less the fair value of the Reference Bonds on the date of termination and any fixed interest payments made under the arrangements described above. In the event the swaps do not terminate prior to their stated termination dates (2025, 2029 or 2033), there would be no settlement of this component as there would be no outstanding Reference Bonds.

The swap also contains an agreement that consists of two separate components:

- An arrangement that requires the Alliance to pay a fixed rate of 2.98% through July 1, 2016 (or termination of the swap) on the outstanding, but previously defeased, 1991 Hospital Revenue and Improvement Bonds (the 1991 Reference Bonds) and receive a variable rate of 67% of USD-LIBOR-BBA on the outstanding 1991 Reference Bonds; and
- A “fixed payor provision” under which the Alliance will pay (or receive) the difference between the outstanding 1991 Reference Bonds multiplied by 100% and any fixed interest payments made as required under the agreement minus the outstanding 1991 Reference Bonds multiplied by the average market price at termination. In the event the swaps do not terminate prior to their stated termination date (2016), there would be no settlement of this component as there would be no outstanding 1991 Reference Bonds.

Interest Rate Swap Option: In June 2004, the Alliance entered into an agreement with Bear Stearns (acquired by JP Morgan) whereby Bear Stearns has purchased from the Alliance an option to enter into an interest rate swap agreement (swaption) with the Alliance on July 1, 2011, which is an optional redemption date related to the Alliance’s early extinguished 2000A and 2000B Bonds (Note F). The purpose of this agreement was to effectively sell the call features related to the early extinguished Series 2000A and 2000B Bonds. As consideration under this agreement, the Alliance

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE D--DERIVATIVE TRANSACTIONS - Continued

received a total of \$42,500 in upfront payments as the swaption premium. Such amounts were initially recorded as estimated fair value of derivatives in the Consolidated Balance Sheets. Beginning 30 calendar days prior to July 1, 2011 and terminating 30 calendar days prior to July 1, 2015, the counterparty has the periodic right to exercise the swaption.

The underlying interest rate swap transactions to which the swaption transaction relates have the following terms:

<i>Swap</i>	<i>Notional Amount</i>	<i>Term</i>	<i>Payments by:</i>	
			<i>Counterparty</i>	<i>Alliance</i>
2000A	Ranging from \$148,170 through July 1, 2018 to \$23,000 through July 2033	30 days following the exercise date through July 2033	64% of USD-LIBOR-BBA	Fixed amounts ranging from 7.13% upon execution to 7.50% through July 2033, based on notional amount
2000B	Ranging from \$76,240 through July 1, 2021 to \$8,800 through July 2033	30 days following the exercise date through July 2033	64% of USD-LIBOR-BBA	Fixed amounts ranging from 7.54% upon execution to 8.00% through July 2033, based on notional amount

Management anticipates the swaption will be settled by a payment of cash and not by the execution of an actual interest rate swap transaction, should the counterparty not elect to terminate.

The Alliance retains the right to terminate the swaption at any time prior to May 17, 2011 at its fair market value. A liability of \$89,650 and \$78,022, representing the estimated fair value of the swaption at June 30, 2010 and 2009, respectively, is included in estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. As a derivative financial instrument, this swaption is extremely sensitive to changes in long-term interest rates and other elements in the financial marketplace. As such, estimates of fair value are subject to significant changes in the near term.

Deferred financing and acquisition costs include \$434 and \$868 at June 30, 2010 and 2009, respectively, related to the costs of this transaction. The change in estimated fair value of derivatives in the accompanying Statement of Operations and Changes in Net Assets for 2010 and 2009 includes an unrealized loss of \$11,628 and \$9,195, respectively, related to this derivative.

Forward Sale Agreements: In June 2004, the Alliance entered into two related forward sale agreements with the counterparty to the swaption agreements and the Master Trustee of the Series 2000 Bonds. The forward sale agreements originally related to the Debt Service Reserve Fund and to the Debt Service Fund, respectively, (collectively, the "Funds"), as established under provisions

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE D--DERIVATIVE TRANSACTIONS - Continued

of the Master Trust Indenture related to the issuance of the Series 2000 Bonds. In consideration of the future earnings on the Funds, the counterparty paid the Master Trustee a total of \$30,000 during 2005, to be held on behalf of the Alliance. In June 2006, one of these agreements was amended to also relate to the Series 2000C, 2000D, 2006A and 2006B Bonds, and to remove the Series 2000A Bonds from consideration under the agreement. As the original intent of these Funds was to secure debt service payments under the above referenced Bonds, the agreement requires these funds to be held under a guaranty agreement as further described below.

In connection with the issuance of the Series 2007 Bonds and the derecognition of a portion of the Series 2000A Bonds, all of the outstanding Series 2000B Bonds, and all of the outstanding 2006B Bonds (Note F), one of these agreements as it relates to the Series 2000A and 2000B Bonds was partially terminated. As such, during 2008 the Alliance reduced its liability with respect to the portion related to the Series 2000A and 2000B Bonds, and paid the counterparty \$6,186 under the terms of the agreement. Management has represented that the other agreement will be amended in fiscal year 2011 to include the Series 2010A Bonds and to remove the Series 2000B and 2006B Bonds. As such, the Alliance has not reduced its liability for the portion related to the Series 2000B or 2006B Bonds under this agreement.

A liability of \$19,864 and \$20,728 representing the unamortized payments from the counterparty is included as part of deferred revenue in the accompanying Consolidated Balance Sheets as of June 30, 2010 and 2009, respectively. Amounts are being recognized as investment income over the life of the agreements.

Pursuant to these agreements, the counterparty required that the Alliance's obligations under the swaption and forward sale agreements be collateralized under a guarantee agreement in favor of the counterparty. Due to various requirements of the Master Trust Indenture, the Alliance transferred to MSF a total of \$42,500 that was in turn deposited with the counterparty as collateral in a Guaranteed Investment Contract (GIC). Amounts received under the forward sale agreements were also deposited into the GIC. All GIC deposits earn interest compounded at 4.14% for the first year, and at 3.5% thereafter through July 1, 2011. The GIC deposits as of June 30, 2010 and 2009 totaled \$89,486 and \$86,364, respectively.

In the event the counterparty does not exercise the swaption, the Alliance will realize the swaption premium, forward sale amounts, and earnings on the GIC when the swaption expires on July 1, 2015. In the event the Alliance settles with the counterparty, the Alliance would in effect lose the earnings on these funds.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE E--PROPERTY, PLANT AND EQUIPMENT

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

	<u>2010</u>	<u>2009</u>
Land	\$ 60,351	\$ 51,484
Buildings and leasehold improvements	404,790	407,063
Property and improvements held for leasing	84,421	96,457
Equipment	479,523	424,738
Equipment held under capital lease	22,679	25,032
	<u>1,051,764</u>	<u>1,004,774</u>
Less: Allowances for depreciation and amortization	(569,913)	(505,600)
	481,851	499,174
Construction in progress (Note N)	213,747	91,395
	<u>\$ 695,598</u>	<u>\$ 590,569</u>

Accumulated depreciation and amortization on property and improvements held for leasing purposes is \$21,543 and \$21,829 at June 30, 2010 and 2009, respectively. Net interest capitalized was \$11,117 and \$3,744 for the years ended June 30, 2010 and 2009, respectively.

The Alliance is constructing two new hospital facilities, including Franklin Woods Community Hospital (FWCH) in Washington County, Tennessee and a replacement facility for JMH and has plans to construct a replacement facility at SCCH which will commence in 2011. The Alliance is also performing various renovations on existing hospital facilities. These projects may have a significant impact on the remaining useful life of the existing hospital facilities. Where commitments to construct new facilities have been finalized, management has adjusted the estimated useful lives of existing hospital facilities.

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

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

<u>Description</u>	<u>Maturities</u>	<u>Rates</u>	<u>Outstanding Balance</u>	
			<u>2010</u>	<u>2009</u>
2010A Hospital Refunding Revenue Bonds, net of unamortized premium of \$1,096 at June 30, 2010	\$38,660 uninsured serially, through 2020 \$14,985 uninsured term bonds, due July 1, 2025 \$19,385 uninsured term bonds, due July 1, 2030 \$39,570 uninsured term bonds, due July 1, 2038 \$55,480 uninsured term bonds, due July 1, 2038	3.00% to 5.00% 5.38% 5.63% 6.50% 6.00%	\$ 169,176	\$ -
2010B Hospital Refunding Revenue Bonds, net of unamortized premium of \$753 at June 30, 2010	\$27,330 uninsured serially, through 2020 \$4,355 uninsured term bonds, due July 1, 2023 \$4,250 uninsured term bonds, due July 1, 2028	2.50% to 5.00% 5.00% 5.50%	36,688	-

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

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

Description	Maturities	Rates	Outstanding Balance	
			2010	2009
2009A Hospital Revenue Bonds, net of unamortized discount of \$126 and \$129 at June 30, 2010 and 2009, respectively	\$725 uninsured term bonds, due July 1, 2019 \$1,730 uninsured term bonds, due July 1, 2029 \$3,105 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	5,434	5,431
2009B Hospital Revenue Bonds	\$5,535 uninsured term bonds, due July 1, 2038	8.00%	5,535	5,535
2009C Hospital Revenue Bonds, net of unamortized discount of \$2,508 and \$2,595 at June 30, 2010 and 2009, respectively	\$21,100 uninsured term bonds, due July 1, 2019 \$20,000 uninsured term bonds, due July 1, 2029 \$74,855 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	113,447	113,360
2008A Hospital Revenue Bonds	\$13,245 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.91% at June 30, 2010	13,245	72,770
2008B Hospital Revenue Bonds	\$54,050 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.91% at June 30, 2010	54,050	54,230
2007A Hospital Revenue Bonds	\$4,305 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.91% at June 30, 2010	4,305	100,220
2007B Taxable Hospital Revenue Bonds	\$314,190 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 2.42% at June 30, 2010	314,190	320,170
2007C Hospital Revenue Bonds	\$1,900 uninsured term bonds, due July 1, 2032, subject to early redemption or tender	Variable, 0.91% at June 30, 2010	1,900	36,575
2006A Hospital First Mortgage Revenue Bonds, net of unamortized premium of \$153 and \$159 at June 30, 2010 and 2009, respectively	\$7,265 uninsured serially, through 2019 \$7,375 uninsured term bonds, due July 1, 2026 \$20,505 uninsured term bonds, due July 1, 2031 \$135,175 uninsured term bonds, due July 1, 2036	4.50% to 5.00% 5.25% 5.50% 5.50%	170,473	171,149
2001A Hospital First Mortgage Revenue Bonds	\$23,900 term bonds, due July 1, 2026, subject to early redemption or tender	6.85%	23,900	24,600
2001 Hospital Refunding and Improvement Revenue Bonds (NCH), net of unamortized discount of \$43 and \$38 at June 30, 2010 and 2009, respectively	\$675 insured term bonds, due December 1, 2010 \$1,465 insured term bonds, due December 1, 2012 \$1,635 insured term bonds, due December 1, 2014 \$8,815 insured term bonds, due December 1, 2022	5.13% 5.75% 6.00% 6.00%	12,547	13,183
2000A Hospital First Mortgage Revenue Refunding Bonds	\$28,417 insured Capital Appreciation Bonds, interest and principal due July 1, 2026 through 2030	6.63%	28,417	26,601
2000C Hospital First Mortgage Revenue Taxable Bonds	\$35,335 insured term bonds, due July 1, 2026	8.50%	35,335	36,270
2000D First Mortgage Taxable Bonds	\$15,225 insured term bonds, due July 1, 2026	8.50%	15,225	15,630
1998 Hospital Refunding and Improvement Revenue Bonds (JMH)	\$1,125 uninsured serially, through 2011 \$6,495 uninsured term bonds, due July 1, 2016 \$7,620 uninsured term bonds, due July 1, 2028	5.00% 5.25% 5.38%	15,240	16,310
Capitalized lease obligations secured by buildings and equipment	Maturing through 2027	3.18% to 13.01%	16,715	17,211
Note payable secured by assets of Kingsport Ambulatory Surgery Center	Monthly principal and interest payments maturing through June 2010	5.50%	-	334
Note payable secured by property	Monthly principal and interest payments of \$7 beginning March 2007 maturing February 2012. Note was paid-off in 2010	LIBOR + 1.25%	-	204
\$7,500 promissory note secured by assets of Mediserve Medical Equipment of Kingsport, Inc.	Monthly principal and interest payments of \$56 beginning February 2007 maturing December 2011; remaining principal of \$6,473 due January 2012	LIBOR + 1.10%	6,064	6,647
Capitalized lease obligations secured by equipment	Various monthly payments of monthly principal and interest	Various	1,325	1,526
\$7,482 promissory note secured by property and unsecured letter of credit	Monthly interest-only payments through maturity on December 31, 2010; paid off in 2010	\$32 interest per month	-	7,450
Master installment payment agreement	\$2,194 due August 1, 2010	Unspecified	2,194	3,140
\$1,409 unsecured promissory note	Monthly principal and interest payments of \$23 beginning July 2008 through September 2013; remaining principal and accrued interest due October 2014	LIBOR + 1.25%	920	1,202

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

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

Description	Maturities	Rates	Outstanding Balance	
			2010	2009
\$1,800 note payable secured by property	Monthly interest-only payments through maturity in July 2009	3.74%	-	1,800
\$10,221 note payable secured by property	Various annual principal and interest payments through April 2013	6.25%	7,836	10,221
\$5,000 line of credit secured by investments	Payable on demand	LIBOR + 1.25%	-	5,039
\$4,600 note payable secured by property	Monthly principal and interest payments of \$50 beginning February 2009 maturing December 2013; remaining principal due January 2014. Note was paid-off in 2010	5.47%	-	4,377
\$1,065 note payable secured by land	Monthly interest-only payments through April 2011; remaining principal and accrued interest due May 2011	5.50%	1,065	1,065
\$6,332 promissory note secured by substantially all assets of the Alliance	Monthly principal payments of \$35 plus accrued interest beginning July 2010 maturing June 2015; remaining principal due July 2015	LIBOR + 2.00%	6,332	-
\$3,955 note payable secured by property	Monthly principal and interest payments of \$27 beginning July 2010 maturing May 2015; remaining principal due June 2015	3.00%	3,955	-
Note payable under Master Financing Agreement, secured by Equipment	Monthly principal and interest payments of \$166 beginning July 2010 maturing June 2017	4.62%	11,900	-
Note payable under Master Financing Agreement, secured by Equipment	Monthly principal and interest payments of \$56 beginning July 2010 maturing June 2017	3.75%	4,100	-
\$4,926 convertible construction loan secured by property and assigned rents	Monthly interest-only payments through January 2011 followed by monthly principal and interest payments of \$25 maturing December 2014; remaining principal and accrued interest due January 2015	Prime (stated minimum and maximum interest rates of 3.75% and 6.75%, respectively)	1,195	-
\$1,885 line of credit secured by property	Monthly interest-only payments through March 2011 followed by monthly principal and interest payments of \$9 maturing February 2015; remaining principal and accrued interest due March 2015	Prime - 0.50% (stated minimum and maximum interest rates of 3.50% and 6.25%, respectively)	265	-
			1,082,973	1,072,250
	Less current portion		(28,131)	(31,306)
			<u>\$ 1,054,842</u>	<u>\$ 1,040,944</u>

Series 2010 Bonds: In April 2010, the Alliance issued \$168,080 (Series 2010A) and \$35,935 Series 2010B fixed rate Hospital Refunding Revenue Bonds (collectively, the Series 2010 Bonds). Proceeds of the Series 2010A and the Series 2010B Bonds were used to refinance outstanding indebtedness, specifically related to the Alliance's facilities in Tennessee and in Virginia, respectively, fund debt service reserve funds and pay costs of issuance. The Alliance recognized a \$3,029 loss on early extinguishment of debt representing the write off of previously deferred and unamortized financing costs related to the refinanced Series 2008A and the Series 2007A and 2007C debt issues discussed below.

Series 2009 Bonds

In March 2009, the Alliance issued \$5,560 (Series 2009A), \$5,535 (Series 2009B) and \$115,955 (Series 2009C) fixed rate Hospital Revenue Bonds (collectively, the Series 2009 Bonds). The proceeds of Series 2009 Bonds were used to refinance a portion of the outstanding Series 2006C

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

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

Taxable Notes, which were originally issued to finance a capital commitment to SCCH and purchase certain leased assets, finance the acquisition of a majority ownership in JMH, fund a debt service reserve fund and pay costs of issuance. The portion of the 2006C taxable notes which were not refinanced with the Series 2009 Bonds were repaid with cash on hand.

In connection with its acquisition of a majority ownership in JMH, the Alliance assumed the then outstanding long-term debt of JMH, totaling \$33,906, including the JMH Series 1998 Hospital Refunding and Improvement Revenue Bonds as further described in the table above.

Series 2008 Bonds

In February 2008, the Alliance issued \$72,770 (Series 2008A) and \$54,230 (Series 2008B) variable rate Hospital Revenue Bonds (collectively, the Series 2008 Bonds). The proceeds of Series 2008 Bonds were primarily used to finance certain future capital projects for the Alliance's hospital facilities and for the repayment of previously issued 2008 Taxable Notes used for the acquisition of RCMC. The payment of principal and interest on the Series 2008 Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit (the Letters of Credit). The Letters of Credit entitle the Master Trustee to draw amounts equal to the principal amounts of the Series 2008 Bonds outstanding and up to 35 days interest at a rate of 12%. The Letters of Credit expire on December 14, 2012 unless renewed or replaced. A portion (\$59,525) of the Series 2008A Bonds were repaid from proceeds of the Series 2010 Bonds.

The variable rate of interest on the Series 2008 Bonds is determined weekly by the Remarketing Agent (Merrill Lynch), as the rate equal to the lowest rate which, in regard to general financial conditions and other special conditions bearing on the rate, would produce as nearly as possible a par bid for the Series 2008 Bonds in the secondary market. In no event shall the variable rate on the Series 2008 Bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the State of Tennessee for the Series 2008A Bonds or the Commonwealth of Virginia for the Series 2008B Bonds. The Alliance has the option, upon written approval of the holder of the Letters of Credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate.

The Series 2008 Bonds are subject to optional and mandatory tender for purchase prior to maturity at the option of the holder, upon conversion to a fixed rate, upon conversion to a medium-term rate period, prior to the effective date of any substitute letter of credit, or upon the termination of the Letters of Credit. The optional and mandatory tender provisions generally call for the Master Trustee to purchase the outstanding Series 2008 Bonds at a purchase price equal to the principal amount thereof plus accrued interest upon a stated date as described in the tender notice delivered to the bond holders.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

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

Series 2007 Bonds

In December 2007, the Alliance issued \$104,355 (Series 2007A), \$327,170 (Series 2007B taxable) and \$36,575 (Series 2007C) variable rate Hospital Revenue Bonds (collectively, the Series 2007 Bonds). The proceeds of Series 2007 Bonds were primarily used to early extinguish a portion of the outstanding Series 2000A Bonds, all of the outstanding 2000B Bonds, all of the outstanding Series 1994 Bonds, and all of the outstanding Series 2006B Bonds; to finance the acquisition of a majority ownership in NCH, and to finance certain capital improvements and equipment acquisitions for the Alliance's hospital facilities. The payment of principal and interest on the Series 2007 Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit (the Letters of Credit). The Letters of Credit entitle the Master Trustee to draw amounts equal to the principal amounts of the Series 2007 Bonds outstanding and up to 35 days interest at a rate of 12%. The Letters of Credit expire on December 14, 2012 unless renewed or replaced. A portion of the outstanding Series 2007A (\$91,685) and Series 2007C (\$32,840) Bonds were repaid from proceeds of the Series 2010 Bonds.

The variable rate of interest on the Series 2007 Bonds is determined weekly in the same manner as described above for the Series 2008 Bonds. In no event shall the variable rate on the Series 2007 Bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the State of Tennessee for the Series 2007A and 2007B Bonds or the Commonwealth of Virginia for the 2007C Bonds. The Alliance has the option, upon written approval of the holder of the Letters of Credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate. Upon such conversion, the Series 2007 Bonds become subject to mandatory tender for purchase.

The Series 2007 Bonds are subject to optional and mandatory tender in the same manner as described above for the Series 2008 Bonds. In addition, the Series 2007B Bonds are subject to a special mandatory tender with respect to its conversion from taxable debt to tax-exempt debt.

Series 2006 Bonds

During 2006, the Alliance issued \$173,030 Hospital First Mortgage Revenue Bonds (Series 2006A) and \$66,500 Hospital First Mortgage Variable Rate Revenue Bonds (Series 2006B). The proceeds from the sale of the Series 2006A Bonds were used to finance certain future and prior capital projects for the Alliance's hospital facilities and to refund certain existing indebtedness, specifically the Series 2001B Bonds (discussed below) and certain existing short and intermediate term loans and leases, as well as fund a debt service reserve fund. The Series 2006B Bond proceeds were substantially used to refund the remaining outstanding principal of the Series 2001B Bonds and establish a debt service reserve fund.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2010 and 2009

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

Series 2001 Bonds

During 2001, the Alliance issued \$26,000 Hospital First Mortgage Revenue Bonds (Series 2001A) and \$60,175 Hospital First Mortgage Revenue Bonds (Series 2001B). The Series 2001A Bonds were subject to optional tender by Bond holders. Effective July 1, 2007, the Alliance entered into an agreement whereby the beneficial owners of the Series 2001A Bonds have irrevocably waived their rights to tender the Bonds under the provisions of the respective Bond Indenture. The waiver will continue in effect through the maturity of the 2001A Bonds. The Series 2001B Bonds were refunded and redeemed in 2006.

Series 2000 Bonds

The Hospital First Mortgage Revenue Refunding (Series 2000A Bonds) and First Mortgage Revenue Refunding Bonds (Series 2000B Bonds), were used to advance refund previously existing indebtedness as well as fund a required debt service reserve fund. The Hospital First Mortgage Revenue Bonds (Series 2000C Taxable Bonds) were intended to refinance certain mortgage indebtedness of BRMM, and to refund other previously existing indebtedness. The proceeds from the sale of the First Mortgage Bonds (Series 2000D Taxable Bonds) were used primarily to fund working capital for the Alliance.

The Series 2000A Bonds included at issue date \$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.

The advance refunding of previously issued debt requires funds to be placed in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments. 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, and the debt and escrowed securities are not considered liabilities or assets of the Alliance. Therefore, such debt has been derecognized.

Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2010 due to previous advance refundings of the Series 2000A Bonds, Series 2000B Bonds, Series 1998C Bonds, and Series 1991 Bonds, totaled approximately \$585,960.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

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

documents, including United States Treasury obligations, an investment contract with MBIA Insurance Corporation (MBIA) in the 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.

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.

Other Bonds, Notes Payable and Financing Arrangements

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 NCH Series 2001 Hospital Refunding and Improvement Revenue Bonds are secured by revenues and a lien on certain real and personal property of NCH. The JMH Series 1998 Hospital Refunding and Improvement Revenue Bonds are secured by pledged gross receipts of JMH, as defined in the Master Trust indenture.

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, 2010 are as follows:

<i>Year Ending June 30,</i>		
2011	\$	28,131
2012		35,002
2013		30,312
2014		28,035
2015		31,898
Thereafter		<u>930,227</u>
		1,083,605
	Net discount	<u>(632)</u>
	\$	<u><u>1,082,973</u></u>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

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

The Alliance, NCH 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, NCH and JMH are in compliance with all such covenants at June 30, 2010.

In connection with the tax-exempt bonds, the Alliance is required every five years, and at maturity, to remit to the Internal Revenue Service amounts which are due related to positive arbitrage on the borrowed funds. The Alliance performs such computations when required and recognizes any liability at that time. Management does not believe there are any significant arbitrage liabilities at June 30, 2010 or 2009.

In September 2010, in order to reduce credit risk and expenses, the Alliance replaced the existing letters of credit related to the Series 2007B, Series 2008A and Series 2008B Bonds with letters of credit held by several different financial institutions. The term of the letter of credit facility is for three years. As a part of this restructuring, the existing Bonds in these series were repaid through a remarketing of sub-series of each respective bond issue created per the mandatory tender and letter of credit substitution provisions.

NOTE G--SELF-INSURANCE PROGRAMS

The Alliance is 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 also provides professional liability coverage for certain affiliates and joint ventures.

The Alliance is 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 and \$1,000 annual aggregate retention. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

At June 30, 2010, 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, 2010 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Alliance

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE G--SELF-INSURANCE PROGRAMS - Continued

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, 2010 and 2009 was \$12,601 and \$12,887, respectively. The discount rate utilized was 5% at June 30, 2010 and 2009.

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, including a catastrophic claims reserve based on historical claims in excess of \$75.

NOTE H--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates to net patient service revenue as presented in the accompanying Consolidated Statements of Operations and Changes in Net Assets is as follows for the years ended June 30:

	<u>2010</u>	<u>2009</u>
Inpatient service charges	\$ 1,848,590	\$ 1,630,110
Outpatient service charges	1,669,705	1,253,097
Gross patient service charges	3,518,295	2,883,207
Less:		
Estimated contractual adjustments and other discounts	2,417,082	1,929,061
Estimated uncollectible self-pay - Note B	111,565	86,760
Charity care	61,378	44,488
	<u>2,590,025</u>	<u>2,060,309</u>
Net patient service revenue	<u>\$ 928,270</u>	<u>\$ 822,898</u>

NOTE I--THIRD-PARTY REIMBURSEMENT

The Alliance renders services to patients under contractual arrangements with Medicare, Medicaid, TennCare, Blue Cross and various other commercial payors. 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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE I--THIRD-PARTY REIMBURSEMENT - Continued

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. The amount recognized totaled \$8,700 and \$11,137 for the years ended June 30, 2010 and 2009, respectively. Such payments are not guaranteed in future periods.

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 based on Medicare cost reimbursement principles and settled through the filing of an annual Medicaid cost report.

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. 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. 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 2011, although the amount of any change cannot be estimated. The impact of final settlements of cost reports or changes in estimates decreased net patient service revenue by \$3,540 in 2009. The impact of final settlements of cost reports or changes in estimates were not significant in 2010.

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, 2010.

The Alliance has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, preferred provider organizations and employer groups. The basis

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE I--THIRD-PARTY REIMBURSEMENT - Continued

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 retirement plan (the Plan) which covers substantially all employees. The Plan is a defined contribution plan which consists mainly of employer-funded contributions. During 2010 and 2009, the Alliance made contributions to the Plan under a stratified system, whereby the Alliance's contribution percentage is based on each employee's years of service. In addition, the Alliance sponsors a 403(b) plan which is funded solely by employees' contributions. The Alliance does not make any discretionary or matching contributions into the 403(b) plan. 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, 2010 and 2009 was \$13,311 and \$10,590, respectively.

NCH maintains a defined benefit pension plan and a post-retirement employee benefit plan. The accrued unfunded pension liability was \$1,942 and \$1,972, and the accrued unfunded post-retirement liability was \$3,843 and \$4,821 at June 30, 2010 and 2009, 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 date, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed \$1,303 and \$1,716 to the plan during 2010 and 2009, respectively. Other assets at June 30, 2010 and 2009 include \$7,077 and \$5,827, 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. The benefits for substantially all employees previously participating in the SEBP plan have been transferred into the 457(f) plan.

NOTE K--CONCENTRATIONS OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia which is considered a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. Net patient service revenue from Washington County, Tennessee operations were approximately 54% and 59% of total net patient service revenue for 2010 and 2009, respectively.

The mix of receivables from patients and third-party payors based on charges at established rates is as follows as of June 30:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE K--CONCENTRATIONS OF RISK - Continued

	<u>2010</u>	<u>2009</u>
Medicare	42%	40%
TennCare/Medicaid	15%	17%
Commercial	25%	31%
Other third-party payors	10%	5%
Patients	8%	7%
	<u>100%</u>	<u>100%</u>

Approximately 98% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2010 and 2009. Admitting physicians are primarily practitioners in the regional area.

Two of the Alliance's Virginia hospitals' employees are covered under collective bargaining agreements. These agreements expire in January 2011.

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 and notes, 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, 2010 and 2009, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of \$32,447 and \$35,448, respectively, related to operating losses which expire through 2025. BRMM had state net operating loss carryforwards of \$59,860 and \$58,771, respectively, which expire through 2025. 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.

At June 30, 2010 and 2009, SWCH had federal and state net operating loss carryforwards of \$4,376 and \$3,923, respectively, which expire through 2029. CHC files separate federal and state tax returns. CHC had a net deferred tax liability of \$58 at June 30, 2010 and a net deferred tax asset of \$55 at June 30, 2009; the differences are due primarily to temporary timing differences related to depreciation and net operating loss carryforwards. The net operating loss carryforwards may be offset against future taxable income to the extent permitted by the Internal Revenue Code and tax codes of the Commonwealth of Virginia.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE L--INCOME TAXES - Continued

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--RELATED PARTY TRANSACTIONS

The Alliance enters into transactions with entities affiliated with certain members of the Board of Directors including transactions to construct Alliance facilities and provide professional services to the Alliance. Board members refrain from discussion and abstain from voting on transactions with entities with which they are related.

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES

Construction in Progress: Construction in progress at June 30, 2010 represents costs incurred related to various hospital and medical office building facility renovations and additions. 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 approximately \$223,847 at June 30, 2010. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

Physician Contracts: BRMM employs physicians to provide services to BRMM's physician practices through employment agreements which provide annual compensation, plus incentives based upon specified productivity levels. These contracts have various terms.

In addition, the Alliance has entered into contractual relationships with non-employed physicians to provide services in Upper East Tennessee and Southwest Virginia. These contracts guarantee certain base payments and allowable expenses and have terms of varying lengths. Upon completion of the respective guarantee period, amounts drawn and outstanding under each agreement are treated as a loan bearing interest at various rates and are subject to repayment over a specified period. The physician note may also be amortized by virtue of the physician's continued practice in the specified community during the repayment period. A net receivable of \$1,818 and \$2,770 related to these agreements is included in the accompanying Consolidated Balance Sheets at June 30, 2010 and 2009, respectively.

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 degree. 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 June 30, 2010 and 2009 includes \$5,571 and \$3,880, respectively, related to students in

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

school, graduates working at the Alliance and amounts due from others who are no longer in the scholarship program.

Promises to Give: The Alliance has recorded certain unconditional promises to give to unrelated organizations. At June 30, 2010, \$1,768 is due within one year, and an additional \$644 is due within five years and is included in other long-term liabilities.

Operating Leases and Maintenance Contracts: Total lease expense for the years ended June 30, 2010 and 2009 was \$10,216 and \$9,412, 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:

<u>Year Ending June 30,</u>	
2011	\$ 1,686
2012	1,560
2013	1,345
2014	1,000
2015	835
Thereafter	<u>3,808</u>
	<u>\$ 10,234</u>

Estimated future minimum payments under various noncancellable maintenance contracts with remaining terms in excess of one year at June 30, 2010 total in the aggregate \$3,720 through 2015.

Asset Retirement Obligation: The Alliance has identified asbestos in certain facilities and is required by law to dispose of it in a special manner if the facility undergoes major renovations or is demolished; otherwise, the Alliance is not required to remove the asbestos from the facility. The Alliance has complied with regulations by treating the asbestos so that it presents no known immediate or future safety concerns. An asset retirement obligation has been established to the extent that sufficient information exists upon which to estimate the liability.

Other: During 2007, the Alliance received a Certificate of Need (CON) application to build a new 80-bed hospital in Washington County, Tennessee. When this new facility (FWCH) is opened in 2011, acute care services are planned to be discontinued or reduced at both NSH and JCSH. Management anticipates that the NSH and JCSH facilities will continue to be fully utilized by the

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

Alliance in its operations and, therefore, no change to their estimated useful lives is anticipated. However, it is reasonably possible management's estimates related to the continuing use of these facilities could change in the near term. The carrying value of buildings and improvements related to these facilities is \$12,493 at June 30, 2010.

During 2007, the Alliance filed a Certificate of Public Need (COPN) application to build a new 57-bed hospital in Smyth County, Virginia. The COPN has been approved by the applicable Commonwealth of Virginia agencies. Construction is expected to begin in 2011 and total costs are expected to be \$68,216.

The Alliance is a party to various transactions and agreements in the normal course of business, which include purchase and re-purchase agreements, put arrangements and other commitments, which may bind the Alliance to undertake additional transactions or activities in the future.

NOTE O--RENTAL INCOME UNDER OPERATING LEASES

The Alliance leases rental properties to third parties, most of whom are physician practices, for various terms, generally five years. The following is a schedule by year and in the aggregate of minimum future rental income due under noncancellable operating leases at June 30, 2010:

<u>Year Ending June 30,</u>	
2011	\$ 1,648
2012	1,545
2013	995
2014	730
2015	615
Thereafter	<u>858</u>
Total minimum future rentals	<u>\$ 6,391</u>

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2010 and 2009, 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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS - Continued

Investment in Joint Ventures: It is not practical to estimate the fair market value of the investments in joint ventures.

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 due to uncertainty of when these amounts may be paid. Other long-term liabilities are not discounted.

Long-Term Debt and Capital Leases: 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.

The Alliance's significant capital leases and vendor contracts were negotiated with various entities and are considered unique. It is not practicable to estimate the fair value of these obligations under current conditions. Other capital lease obligations are not significant.

The estimated fair value of the Alliance's financial instruments that have carrying values different from fair value is as follows at June 30:

	<i>2010</i>		<i>2009</i>	
	<i>Carrying Value</i>	<i>Estimated Fair Value</i>	<i>Carrying Value</i>	<i>Estimated Fair Value</i>
FINANCIAL LIABILITIES:				
Long-term debt	\$ 1,082,973	\$ 1,105,778	\$ 1,072,250	\$ 988,263

NOTE Q--FAIR VALUE MEASUREMENT

FASB ASC 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 be corroborated by observable market data.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE Q--FAIR VALUE MEASUREMENT - Continued

- 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 assets and liabilities recorded at fair value on a recurring basis as of June 30, 2010 and 2009:

	<i>June 30, 2010</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>
Trading securities	\$ 209,644	\$ 164,510	\$ 16,526	\$ 28,608
Assets whose use is limited	177,180	177,180	-	-
Total assets	<u>\$ 386,824</u>	<u>\$ 341,690</u>	<u>\$ 16,526</u>	<u>\$ 28,608</u>
Fair value of derivative agreements	<u>\$ (134,300)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ (134,300)</u>
	<i>June 30, 2009</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>
Trading securities	\$ 235,065	\$ 191,918	\$ 13,116	\$ 30,031
Assets whose use is limited	186,414	186,414	-	-
Total assets	<u>\$ 421,479</u>	<u>\$ 378,332</u>	<u>\$ 13,116</u>	<u>\$ 30,031</u>
Fair value of derivative agreements	<u>\$ (126,217)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ (126,217)</u>

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 observable market-based inputs, including forward interest rate curves. The fair values of interest rate swap 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 based on observable market forward interest rate curves and the underlying notional amount. The Alliance also

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2010 and 2009

NOTE Q--FAIR VALUE MEASUREMENT - Continued

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, 2010 and 2009 resulted in a decrease in the fair value of the related liability of \$10,085 and \$7,914, 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.

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, 2010 and 2009:

	<i>Trading Securities</i>	<i>Derivatives, Net</i>
July 1, 2008	\$ 32,187	\$ (87,295)
Total unrealized/realized losses in the performance indicator, net	(9,298)	(42,128)
Purchases, issuance and settlements and other, net	1,015	3,206
Transfers in (out), net	6,127	-
June 30, 2009	30,031	(126,217)
Total unrealized/realized losses in the performance indicator, net	(1,546)	(8,607)
Purchases, issuance and settlements and other, net	1,446	524
Transfers in (out), net	(1,323)	-
June 30, 2010	<u>\$ 28,608</u>	<u>\$ (134,300)</u>
Net losses included in the performance indicator which are attributable to the change in unrealized gains or losses relating to assets still held at June 30, 2009	<u>\$ (9,298)</u>	<u>\$ (43,172)</u>
Net losses included in the performance indicator which are attributable to the change in unrealized gains or losses relating to assets still held at June 30, 2010	<u>\$ (1,920)</u>	<u>\$ (27,116)</u>

On July 1, 2009, the Alliance adopted the provisions of FASB ASC 820 related to non-financial assets and liabilities recognized or disclosed at fair value on a non-recurring basis. The Alliance does not have any non-financial liabilities recognized or disclosed at fair value on a non-recurring basis. Assets subject to this guidance primarily include certain goodwill, property and equipment

MOUNTAIN STATES HEALTH ALLIANCE

*Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)*

Years Ended June 30, 2010 and 2009

NOTE Q--FAIR VALUE MEASUREMENT - Continued

and investments in unconsolidated affiliates. There were no significant assets or liabilities that were re-measured at fair value on a non-recurring basis during the fiscal year ended June 30, 2010.

NOTE R--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION

Direct expenses by functional classification are as follows for the years ended June 30:

	<u>2010</u>		<u>2009</u>
Healthcare services	\$ 795,725	\$	686,779
Administrative and general	124,338		135,994
Other	8,625		10,168
	<u>\$ 928,688</u>	<u>\$</u>	<u>832,941</u>

Supplemental Schedules

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet (Dollars in Thousands)

June 30, 2010

	<i>Blue Ridge Medical Management *</i>	<i>Other Obligated Group Members</i>	<i>Eliminations</i>	<i>Total Obligated Group</i>	<i>Mountain States Properties</i>	<i>Other Entities</i>	<i>Eliminations</i>	<i>Total</i>
ASSETS								
CURRENT ASSETS								
Cash and cash equivalents	\$ 1,043	\$ 204,966	\$ -	\$ 206,009	\$ 7,566	\$ 20,951	\$ -	\$ 234,526
Current portion of investments	-	9,588	-	9,588	14,120	4,759	-	28,467
Patient accounts receivable, less estimated allowances for contractual adjustments and uncollectible accounts	4,457	84,416	-	88,873	-	36,707	-	125,580
Other receivables, net	352	10,277	-	10,629	788	6,509	-	17,926
Inventories and prepaid expenses	192	18,977	-	19,169	183	9,811	-	29,163
TOTAL CURRENT ASSETS	6,044	328,224	-	334,268	22,657	78,737	-	435,662
INVESTMENTS, less amounts required to meet current obligations	17,166	266,104	-	283,270	18,765	284,721	-	586,756
PROPERTY, PLANT AND EQUIPMENT, net	9,152	463,652	-	472,804	66,295	156,499	-	695,598
EQUITY IN AFFILIATES	138,930	391,644	(160,670)	369,904	-	-	(369,904)	-
OTHER ASSETS								
Goodwill, net of accumulated amortization	6,246	143,276	-	149,522	-	1,830	-	151,352
Net deferred financing, acquisition costs and other charges, less current portion	176	28,458	-	28,634	1,540	645	-	30,819
Other assets	10,695	8,087	-	18,782	3,608	6,923	-	29,313
TOTAL OTHER ASSETS	17,117	179,821	-	196,938	5,148	9,398	-	211,484
	\$ 188,409	\$ 1,629,445	\$ (160,670)	\$ 1,657,184	\$ 112,865	\$ 529,355	\$ (369,904)	\$ 1,929,500

* Management Services Organization only

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet - Continued
(Dollars in Thousands)

June 30, 2010

	<i>Blue Ridge Medical Management *</i>	<i>Other Obligated Group Members</i>	<i>Eliminations</i>	<i>Total Obligated Group</i>	<i>Mountain States Properties</i>	<i>Other Entities</i>	<i>Eliminations</i>	<i>Total</i>
LIABILITIES AND NET ASSETS								
CURRENT LIABILITIES								
Accrued interest payable	\$ -	\$ 15,550	\$ -	\$ 15,550	\$ 4	\$ 485	\$ -	\$ 16,039
Current portion of long-term debt and capital lease obligations	550	23,743	-	24,293	50	3,788	-	28,131
Current portion of estimated fair value of derivatives	-	-	-	-	10,740	-	-	10,740
Accounts payable and accrued expenses	2,159	76,098	-	78,257	1,317	19,653	-	99,227
Accrued salaries, compensated absences and amounts withheld	2,695	31,604	-	34,299	-	12,981	-	47,280
Payables to (receivables from) affiliates, net	9,392	(10,146)	-	(754)	(33,334)	34,088	-	-
Estimated amounts due to third-party payors, net	-	7,983	-	7,983	-	2,172	-	10,155
TOTAL CURRENT LIABILITIES	14,796	144,832	-	159,628	(21,223)	73,167	-	211,572
OTHER LIABILITIES								
Long-term debt and capital lease obligations, less current portion	5,515	1,006,038	-	1,011,553	1,144	42,145	-	1,054,842
Estimated fair value of derivatives, less current portion	-	123,308	-	123,308	252	-	-	123,560
Deferred revenue	-	20,092	-	20,092	-	353	-	20,445
Estimated professional liability self-insurance	2,229	5,075	-	7,304	-	2,237	-	9,541
Other long-term liabilities	5,199	1,598	-	6,797	-	5,831	-	12,628
TOTAL LIABILITIES	27,739	1,300,943	-	1,328,682	(19,827)	123,733	-	1,432,588
MINORITY INTERESTS	-	-	-	-	-	168,410	-	168,410
NET ASSETS								
Unrestricted net assets	160,670	317,434	(160,670)	317,434	132,692	226,356	(359,048)	317,434
Temporarily restricted net assets	-	10,941	-	10,941	-	10,729	(10,729)	10,941
Permanently restricted net assets	-	127	-	127	-	127	(127)	127
TOTAL NET ASSETS	160,670	328,502	(160,670)	328,502	132,692	237,212	(369,904)	328,502
	\$ 188,409	\$ 1,629,445	\$ (160,670)	\$ 1,657,184	\$ 112,865	\$ 529,355	\$ (369,904)	\$ 1,929,500

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Operations and Changes in Net Assets (Dollars in Thousands)

Year Ended June 30, 2010

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Mountain States Properties	Other Entities	Eliminations	Total
CHANGES IN UNRESTRICTED NET ASSETS:								
Revenue, gains and support:								
Net patient service revenue	\$ 32,979	\$ 657,122	\$ (1,556)	\$ 688,545	\$ -	\$ 239,921	\$ (196)	\$ 928,270
Other operating revenue	24,046	3,914	(18,087)	9,873	7,430	32,519	(33,813)	16,009
Equity in net gain of affiliates	6,702	4,959	(5,460)	6,201	-	15	(6,216)	-
TOTAL REVENUE, GAINS AND SUPPORT	63,727	665,995	(25,103)	704,619	7,430	272,455	(40,225)	944,279
Expenses:								
Salaries and wages	15,053	225,269	-	240,322	139	87,975	(2,773)	325,663
Physician salaries and wages	28,752	1,133	-	29,885	-	49,009	(24,405)	54,489
Contract labor	873	3,460	-	4,333	-	2,499	(286)	6,546
Employee benefits	5,152	43,758	(1,615)	47,295	39	22,587	(1,559)	68,362
Fees	2,206	76,192	(18,018)	60,380	830	21,867	(535)	82,542
Supplies	2,200	132,563	-	134,763	1	40,898	(193)	175,469
Utilities	510	10,078	-	10,588	1,010	4,595	-	16,193
Other	4,024	39,787	(11)	43,800	2,611	25,482	(4,253)	67,640
Depreciation	1,059	42,890	-	43,949	2,585	21,902	-	68,436
Amortization	266	12,711	-	12,977	-	146	-	13,123
Estimated provision for bad debts	1,522	3,822	-	5,344	-	2,617	-	7,961
Interest and taxes	(1,279)	41,601	-	40,322	1,409	4,787	(4,254)	42,264
TOTAL EXPENSES	60,338	633,264	(19,644)	673,958	8,624	284,364	(38,258)	928,688
OPERATING INCOME	3,389	32,731	(5,459)	30,661	(1,194)	(11,909)	(1,967)	15,591
Nonoperating gains (losses):								
Interest and dividend income	546	10,904	-	11,450	791	9,311	(4,254)	17,298
Net realized gains on the sale of securities	128	1,543	-	1,671	-	714	-	2,385
Net unrealized gains on securities	596	8,083	-	8,679	1,312	5,027	-	15,018
Derivative related income	-	2,622	-	2,622	1,772	-	-	4,394
Loss on early extinguishment of debt	-	(3,029)	-	(3,029)	-	-	-	(3,029)
Change in estimated fair value of derivatives	-	(10,865)	-	(10,865)	2,258	-	-	(8,607)
Other nonoperating gains (losses)	800	2,502	-	3,302	533	(3,323)	-	512
Net assets released from restrictions used for operations	-	-	-	-	-	1,113	-	1,113
NET NONOPERATING GAINS	2,070	11,760	-	13,830	6,666	12,842	(4,254)	29,084
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES, BEFORE MINORITY INTERESTS	5,459	44,491	(5,459)	44,491	5,472	933	(6,221)	44,675

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Operations and Changes in Net Assets - Continued
(Dollars in Thousands)

Year Ended June 30, 2010

	<i>Blue Ridge Medical Management *</i>	<i>Other Obligated Group Members</i>	<i>Eliminations</i>	<i>Total Obligated Group</i>	<i>Mountain States Properties</i>	<i>Other Entities</i>	<i>Eliminations</i>	<i>Total</i>
Minority interest in consolidated subsidiaries' net gain	-	-	-	-	-	(3,162)	-	(3,162)
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	5,459	44,491	(5,459)	44,491	5,472	(2,229)	(6,221)	41,513
Other changes in unrestricted net assets:								
Pension and other defined benefit plan adjustments	-	-	-	-	-	1,589	-	1,589
Net assets released from restrictions used for the purchase of property, plant and equipment	-	-	-	-	-	2,283	-	2,283
INCREASE IN UNRESTRICTED NET ASSETS	5,459	44,491	(5,459)	44,491	5,472	1,643	(6,221)	45,385
DECREASE IN TEMPORARILY RESTRICTED NET ASSETS	-	(393)	-	(393)	-	(844)	-	(1,237)
DECREASE IN PERMANENTLY RESTRICTED NET ASSETS	-	-	-	-	-	(50)	-	(50)
INCREASE IN TOTAL NET ASSETS	5,459	44,098	(5,459)	44,098	5,472	749	(6,221)	44,098
NET ASSETS, BEGINNING OF YEAR	155,211	284,404	(155,211)	284,404	127,220	236,463	(363,683)	284,404
NET ASSETS, END OF YEAR	\$ 160,670	\$ 328,502	\$ (160,670)	\$ 328,502	\$ 132,692	\$ 237,212	\$ (369,904)	\$ 328,502

*Management Services Organization only.

MOUNTAIN STATES HEALTH ALLIANCE

Note to Supplemental Schedules

Year Ended June 30, 2010

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. In accordance with Article Six, Section 6.6 of the Amended and Restated Master Trust Indenture between Mountain States Health Alliance and the Bank of New York Trust Company, NA as Master Trustee, those members pledged include Johnson City Medical Center Hospital, Indian Path Medical Center and Pavilion, North Side Hospital, Sycamore Shoals Hospital, Johnson City Specialty Hospital, Johnson County Community Hospital, Russell County Medical Center and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group (Obligated Group).

The supplemental consolidating schedules include the accounts of the members of the Obligated Group after elimination of all significant intergroup accounts and transactions. Certain other subsidiaries of the Alliance, Mountain States Properties, Inc. (MSP) and all other affiliates (Other Entities), 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.

MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Schedules)

Years Ended June 30, 2011 and 2010



MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements and Supplemental Schedules

Years Ended June 30, 2011 and 2010

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited the accompanying consolidated balance sheets of Mountain States Health Alliance and subsidiaries (the Alliance) as of June 30, 2011 and 2010 and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Alliance's management. 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 of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing 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 over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe our audits provide a reasonable basis for our 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 subsidiaries as of June 30, 2011 and 2010 and the results of their operations, changes in net assets and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The supplemental schedules, as listed in the accompanying index, are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

As discussed in Note B, the Alliance adopted Financial Accounting Standards Board Accounting Standards Codification 958-10, *Consolidation*, and applicable portions of 958-805, *Not-for-Profit Entities*, during 2011.

Peeling Yeobly; Amundt PC

Knoxville, Tennessee
October 26, 2011

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets
(Dollars in Thousands)

	<i>June 30,</i>	
	<i>2011</i>	<i>2010</i>
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 112,768	\$ 234,526
Current portion of investments	116,175	25,092
Patient accounts receivable, less estimated allowances for uncollectible accounts of \$53,366 in 2011 and \$45,941 in 2010	134,611	125,580
Other receivables, net	19,614	17,926
Inventories and prepaid expenses	28,965	29,163
TOTAL CURRENT ASSETS	412,133	432,287
INVESTMENTS, less amounts required to meet current obligations	581,376	590,131
PROPERTY, PLANT AND EQUIPMENT, net	797,418	695,598
OTHER ASSETS		
Goodwill - Note B	148,666	151,352
Net deferred financing, acquisition costs and other charges, less current portion	29,844	30,819
Other assets	28,448	29,313
TOTAL OTHER ASSETS	206,958	211,484
	\$ 1,997,885	\$ 1,929,500

	<i>June 30,</i>	
	<i>2011</i>	<i>2010</i>
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	\$ 20,047	\$ 16,039
Current portion of long-term debt and capital lease obligations	28,162	28,131
Current portion of estimated fair value of derivatives	102,609	10,740
Accounts payable and accrued expenses	98,819	99,227
Accrued salaries, compensated absences and amounts withheld	57,800	47,280
Estimated amounts due to third-party payors, net	14,813	10,155
TOTAL CURRENT LIABILITIES	322,250	211,572
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	1,040,923	1,054,842
Estimated fair value of derivatives, less current portion	8,123	123,560
Deferred revenue	19,267	20,445
Estimated professional liability self-insurance	9,692	9,541
Other long-term liabilities	14,352	12,628
TOTAL LIABILITIES	1,414,607	1,432,588
COMMITMENTS AND CONTINGENCIES -		
Notes D, F, G, and N		
NET ASSETS		
Unrestricted net assets		
Mountain States Health Alliance	400,395	317,485
Noncontrolling interests in subsidiaries - Note B	171,984	168,359
TOTAL UNRESTRICTED NET ASSETS	572,379	485,844
Temporarily restricted net assets		
Mountain States Health Alliance	10,715	10,890
Noncontrolling interests in subsidiaries - Note B	57	51
TOTAL TEMPORARILY RESTRICTED NET ASSETS	10,772	10,941
Permanently restricted net assets		
	127	127
TOTAL NET ASSETS	583,278	496,912
	\$ 1,997,885	\$ 1,929,500

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2011</i>	<i>2010</i>
Revenue, gains and support:		
Net patient service revenue	\$ 960,254	\$ 928,270
Other operating revenue	15,871	16,009
TOTAL REVENUE, GAINS AND SUPPORT	<u>976,125</u>	<u>944,279</u>
Expenses:		
Salaries and wages	342,208	325,663
Physician salaries and wages	59,249	54,489
Contract labor	5,964	6,546
Employee benefits	67,139	68,362
Fees	85,919	82,542
Supplies	169,362	175,469
Utilities	17,300	16,193
Other	69,647	69,154
Depreciation	87,499	68,436
Amortization - Note B	2,559	13,123
Estimated provision for bad debts	6,174	7,961
Interest and taxes	44,153	42,264
TOTAL EXPENSES	<u>957,173</u>	<u>930,202</u>
OPERATING INCOME	18,952	14,077
Nonoperating gains (losses):		
Interest and dividend income	16,224	17,298
Net realized gains on the sale of securities	1,957	2,385
Net unrealized gains on securities	22,168	15,018
Derivative related income	5,072	4,394
Loss on early extinguishment of debt - Note F	-	(3,029)
Change in estimated fair value of derivatives	23,049	(8,607)
Other nonoperating gains (losses)	(2,653)	512
Net assets released from restrictions used for operations	1,893	2,627
NET NONOPERATING GAINS	<u>67,710</u>	<u>30,598</u>
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	<u>\$ 86,662</u>	<u>\$ 44,675</u>

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

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

Year Ended June 30, 2011

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	\$ 83,269	\$ 3,393	\$ 86,662
Pension and other defined benefit plan adjustments	620	617	1,237
Cumulative effect of a change in accounting principle - Note B	(2,965)	-	(2,965)
Net assets released from restrictions used for the purchase of property, plant and equipment	1,946	-	1,946
Distributions to noncontrolling interests	-	(270)	(270)
Repurchases of noncontrolling interests and other	40	(115)	(75)
INCREASE IN UNRESTRICTED NET ASSETS	82,910	3,625	86,535
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	3,612	58	3,670
Net assets released from restrictions	(3,787)	(52)	(3,839)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	(175)	6	(169)
INCREASE IN TOTAL NET ASSETS	82,735	3,631	86,366
NET ASSETS, BEGINNING OF YEAR	328,502	168,410	496,912
NET ASSETS, END OF YEAR	\$ 411,237	\$ 172,041	\$ 583,278

MOUNTAIN STATES HEALTH ALLIANCE

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

Year Ended June 30, 2010

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over			
Expenses and Losses	\$ 42,372	\$ 2,303	\$ 44,675
Pension and other defined benefit plan adjustments	796	793	1,589
Net assets released from restrictions used for the			
purchase of property, plant and equipment	2,283	-	2,283
Distributions to noncontrolling interests	-	(151)	(151)
Repurchases of noncontrolling interests and other	(63)	(38)	(101)
INCREASE IN UNRESTRICTED NET ASSETS	45,388	2,907	48,295
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	3,585	88	3,673
Net assets released from restrictions	(4,825)	(85)	(4,910)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	(1,240)	3	(1,237)
PERMANENTLY RESTRICTED NET ASSETS:			
Net assets released from restrictions by donor	(50)	-	(50)
INCREASE IN TOTAL NET ASSETS	44,098	2,910	47,008
NET ASSETS, BEGINNING OF YEAR	284,404	165,500	449,904
NET ASSETS, END OF YEAR	\$ 328,502	\$ 168,410	\$ 496,912

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2011</i>	<i>2010</i>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase in net assets	\$ 86,366	\$ 47,008
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	90,472	81,982
Loss on early extinguishment of debt	-	3,029
Cumulative effect of a change in accounting principle	2,965	-
Change in estimated fair value of derivatives	(23,049)	8,607
Equity in net income of joint ventures, net	(898)	(1,117)
Gain on sale of assets held for resale and disposal of assets	(367)	(548)
Amounts received on interest rate swap settlements	(5,072)	(4,394)
Income recognized through forward sale agreements	(864)	(864)
Capital Appreciation Bond accretion and other	2,738	2,071
Restricted contributions	(3,670)	(2,159)
Pension and other defined benefit plan adjustments	(1,237)	598
Increase (decrease) in cash due to change in:		
Net patient accounts receivable	(9,031)	3,232
Other receivables	(2,802)	(1,246)
Inventories and prepaid expenses	(643)	(4,640)
Trading securities	(123,966)	(13,368)
Other assets	(3,632)	(1,159)
Accrued interest payable	4,008	3,989
Accounts payable and accrued expenses	2,741	(855)
Accrued salaries, compensated absences and amounts withheld	11,361	(2,289)
Estimated amounts due from/to third-party payors, net	4,658	3,757
Other long-term liabilities	2,961	(201)
Estimated professional liability self-insurance	151	(471)
Total adjustments	(53,176)	73,954
NET CASH PROVIDED BY OPERATING ACTIVITIES	33,190	120,962
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property, plant and equipment, property held for resale and property held for expansion, net	(172,786)	(172,240)
Additions to goodwill	(279)	-
Net decrease in assets limited as to use	81,383	50,362
Purchases of held-to-maturity securities	(41,060)	(28,175)
Net distribution from joint ventures and unconsolidated affiliates	1,057	1,162
Proceeds from sale of property, plant and equipment and property held for resale	812	9,565
NET CASH USED IN INVESTING ACTIVITIES	(130,873)	(139,326)

	<i>Year Ended June 30,</i>	
	<i>2011</i>	<i>2010</i>
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt and capital lease obligations, including deposits to escrow	(37,735)	(226,315)
Payment of acquisition and financing costs	(1,716)	(3,565)
Proceeds from issuance of long-term debt and other financing arrangements	5,954	235,158
Net amounts received on interest rate swap settlements	5,072	4,394
Restricted contributions received	4,350	3,382
NET CASH (USED IN) PROVIDED BY FINANCING ACTIVITIES	(24,075)	13,054
NET DECREASE IN CASH AND CASH EQUIVALENTS	(121,758)	(5,310)
CASH AND CASH EQUIVALENTS, beginning of year	234,526	239,836
CASH AND CASH EQUIVALENTS, end of year	\$ 112,768	\$ 234,526

SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:

Cash paid for interest	\$ 39,507	\$ 38,666
Cash paid for federal and state income taxes	\$ 739	\$ 446
Construction related payables in accounts payable and accrued expenses	\$ 11,384	\$ 14,847
Property purchased through capital lease arrangement	\$ 15,951	\$ -
Increase in receivable from sale of property	\$ -	\$ 1,483
Decrease in land held for expansion related to property exchange transaction	\$ -	\$ 3,432
Land held for expansion placed in use	\$ 4,904	\$ -

During the year ended June 30, 2010, the Alliance refinanced previously issued debt of \$184,050.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

NOTE A--ORGANIZATION AND OPERATIONS

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The initial funds for the establishment of the Alliance in 1945 were provided by individuals and various institutions. Membership of the Alliance consists of individuals and institutions who have contributed at least \$100 to the capital fund of the Alliance and are entitled to vote at the annual election of the Board of Directors.

The primary operations of the Alliance consist of ten acute and specialty care hospitals, as follows:

- Johnson City Medical Center (JCMC) - licensed for 658 beds
- Smyth County Community Hospital (SCCH) - licensed for 279 beds
- Indian Path Medical Center (IPMC) - licensed for 261 beds
- Norton Community Hospital (NCH) - licensed for 129 beds
- Sycamore Shoals Hospital (SSH) - licensed for 121 beds
- Johnston Memorial Hospital (JMH) - licensed for 116 beds
- Franklin Woods Community Hospital (FWCH) - licensed for 80 beds
- Russell County Medical Center (RCMC) - licensed for 78 beds
- Dickenson Community Hospital (DCH) - licensed for 25 beds
- Johnson County Community Hospital (JCCH) - licensed for 2 beds

FWCH opened in July 2010, replacing operations at North Side Hospital (NSH) and Johnson City Specialty Hospital (JCSH). NSH and JCSH were licensed for 91 beds and 23 beds, respectively, prior to the opening of FWCH and a total of 64 beds were transferred within the Alliance.

The Alliance has a 50.1% interest in JMH. JMH is also the sole member of Abingdon Physician Partners (APP), a non-taxable corporation that owns and manages physician practices.

The Alliance has a 50.1% interest in NCH. NCH is also the sole member or shareholder of DCH and Norton Community Physician Services, LLC (NCPS), a taxable corporation that consists of physician practices and a pharmacy and; Community Home Care (CHC), a taxable corporation that provides home medical equipment.

The Alliance has an 80% interest in SCCH. SCCH is the sole shareholder of Southwest Community Health Services, Inc. (SWCH), a taxable entity that operates a pharmacy and provides other health services.

The activities and accounts of JMH, NCH and SCCH are included in the accompanying consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

NOTE A--ORGANIZATION AND OPERATIONS - Continued

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices and provides other healthcare services to patients in Tennessee and Virginia. BRMM also operates as a medical office real estate developer by owning, selling and leasing real estate to physician practices and other entities. BRMM is either the sole shareholder, a significant shareholder, or member of the following organizations:

Mountain States Physician Group, Inc. (MSPG): A company that contracts with physicians to provide services to BRMM physician practices.

Mountain States Properties, Inc. (MSPI): An entity that owns and manages certain real estate (primarily medical office buildings) and provides rehabilitation and fitness services. In addition, MSPI is a counter-party to various financing transactions, including interest rate swaps.

Mediserve Medical Equipment of Kingsport, Inc. (Mediserve): A company that provides durable medical equipment services.

Synergy Health Group LLC: An affiliation of member hospitals that work together to maximize cost savings opportunities through aggregated buying power.

Kingsport Ambulatory Surgery Center (KASC) (d.b.a. Kingsport Day Surgery): A joint venture operating as an outpatient surgery center which performs procedures primarily in otolaryngology, orthopedics, ophthalmology, and general surgery. BRMM has a 43% ownership of KASC at June 30, 2011 and 2010; however, BRMM maintains control over KASC through a management agreement. As such, the accounts and activities of KASC are included in the accompanying consolidated financial statements.

Piney Flats Urgent Care (PFUC): A for-profit entity that provides urgent care patient services. BRMM has a 75% ownership of PFUC. The accounts and activities of PFUC are included in the accompanying consolidated financial statements.

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc. (MSF), a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance. The Alliance is also the beneficiary of the Mountain States Health Alliance Auxiliary (Auxiliary), a not-for-profit organization formed to coordinate volunteer activities of the Alliance. The activities and accounts of MSF and the Auxiliary are included in the accompanying consolidated financial statements.

The Alliance is a majority shareholder of Integrated Solutions Health Network, LLC (ISHN). The primary function of ISHN is to establish, operate and administer a provider-sponsored health care

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE A--ORGANIZATION AND OPERATIONS - Continued

delivery network. The accounts and activities of ISHN are included in the accompanying consolidated financial statements.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation: The accompanying consolidated financial statements include the accounts of the Alliance and its subsidiaries after elimination of all significant intercompany accounts and transactions. The Alliance classifies those activities directly associated with its mission of providing healthcare services, as well as other activities deemed significant to its operations, as operating activities.

Noncontrolling Interests in Subsidiaries: Noncontrolling interests represent the portion of equity (net assets) in a subsidiary not attributable, directly or indirectly, to a parent organization. Effective July 1, 2010, the Alliance adopted Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958-810, *Consolidation*. ASC 958-810 amends the accounting for, and the financial statement presentation of, noncontrolling interests in a subsidiary within consolidated financial statements. ASC 958-810 requires that a noncontrolling interest in the net assets of a subsidiary be accounted for and reported as net assets and provides revised guidance on the treatment of income and losses attributable to the noncontrolling interest and changes in ownership interests in a subsidiary.

The Alliance adopted ASC 958-810 during 2011 and reclassified \$168,410 of noncontrolling interests from minority interest to net assets as of June 30, 2010. These amounts are reflected net of distributions and pension and other defined benefit plan adjustments within net assets in the Consolidated Balance Sheets. The Alliance attributed an Excess of Revenue, Gains and Support over Expenses and Losses of \$3,393 and \$2,303 for the years ending June 30, 2011 and 2010, respectively, to the noncontrolling interests in JMH, NCH, SCCH, KASC, PFUC and ISHN based on the noncontrolling interests' respective ownership percentage. None of the noncontrolling interests include redemption features.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

limited as to use or uninvested amounts included in investment portfolios are not included as cash and cash equivalents on the Consolidated Balance Sheets.

Investments: Investments as reported in the Consolidated Balance Sheets include trading securities, held-to-maturity securities and assets limited as to use (Note C). FASB ASC 958-320, *Investments – Debt and Equity Securities*, allows not-for-profit organizations to report in a manner similar to business entities by identifying securities as available-for-sale or held-to-maturity and to exclude the unrealized gains and losses on those securities from the Performance Indicator (as defined below). Investments which the Alliance has the positive intent and ability to hold to maturity are considered as held-to-maturity. Substantially all other investments (including assets limited as to use) are considered as trading securities. Management annually evaluates the held-to-maturity investment portfolio and recognizes any “other-than-temporary” losses as deductions from the Performance Indicator. Management’s 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, 2011.

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 pursuant to FASB ASC 825, *Financial Instruments*. Guaranteed investment contracts are reported at contract value.

Realized gains and losses on trading securities and assets limited as to use are computed using the specific identification method for cost determination. Interest and dividend income is reported net of related investment fees.

Investments in joint ventures are reported under the equity method of accounting, which approximates the Alliance’s equity in the underlying net book value, unless the ownership structure requires consolidation. Other assets include investments in joint ventures of \$2,367 and \$2,418 at June 30, 2011 and 2010, respectively.

Inventories: Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market.

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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Amortization of building and equipment held under capital lease is shown as a part of depreciation expense and accumulated depreciation in the accompanying consolidated financial statements.

Interest costs incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The amount capitalized is net of investment earnings on assets limited as to use derived from borrowings designated for capital assets. Renewals and betterments are capitalized and depreciated over their useful life, whereas costs of maintenance and repairs are expensed as incurred.

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 2011 and 2010.

Other assets include property held for resale and property held for expansion of \$4,230 and \$9,135, respectively, at June 30, 2011 and 2010. During 2011, property held for expansion totaling approximately \$4,905 was transferred to property, plant and equipment in conjunction with the construction of FWCH. Property held for resale and property held for expansion primarily represent 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 2011 and 2010.

Goodwill: Goodwill represents the difference between the acquisition cost of assets and the estimated fair value of net tangible and any separately identified intangible assets. Prior to July 1, 2010, the Alliance amortized goodwill associated with its not-for-profit subsidiaries under the straight-line method over various estimated useful lives ranging from 10 to 25 years. However, effective July 1, 2010, ASC 958-805, *Not-for-Profit Entities*, requires the not-for-profit entities within the Alliance to cease amortization of goodwill, perform a transitional impairment test and perform annual impairment testing in the future.

As a result of its transitional impairment testing as of July 1, 2010, management determined that approximately \$2,965 of goodwill associated with one of its reporting units was impaired, and such impairment has been reflected as the Cumulative Effect of a Change in Accounting Principle in the 2011 Consolidated Statement of Changes in Net Assets. Based upon this transitional testing, management does not believe any remaining goodwill acquired by its not-for-profit entities to be

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

impaired. The reporting unit for evaluation of substantially all such goodwill is the Alliance's aggregate acute-care operations.

For goodwill acquired by its for-profit subsidiaries, the Alliance does not amortize goodwill and annually performs impairment testing. Based upon this annual impairment testing, management has determined that there is no impairment related to goodwill associated with its for-profit subsidiaries.

Deferred Financing, Acquisition Costs and Other Charges: Other assets, including deferred financing, acquisition costs and other charges, total \$29,844 and \$30,819 at June 30, 2011 and 2010, respectively. Deferred financing costs are amortized over the life of the respective bond issue principally using the average bonds outstanding method. Other intangible assets include licenses and similar assets and are being amortized over the intangible's estimated useful life under the straight-line method.

Prior to 2009, the Alliance routinely financed interest rate swap and other derivative transaction issuance costs through modification of future settlement terms. As such, the unamortized issuance costs of these derivatives are included as deferred financing costs in the accompanying Consolidated Balance Sheets and are being amortized over the term of the respective derivative instrument. The unpaid issuance costs are included as a part of the estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. Beginning in 2009, interest rate swap and derivative transaction issuance costs are expensed as incurred.

Derivative Financial Instruments: As further described in Note D, the Alliance is a party to interest rate swap and other derivative agreements. 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. Changes in the estimated fair value of these derivatives are included in the Consolidated Statements of Operations as part of nonoperating gains (losses). Net settlements and other related income of derivatives are also reflected as a part of the Performance Indicator (described below).

These fair values are based on the estimated amount the Alliance would receive, or be required to pay, to enter into equivalent agreements at the valuation date. The fair value of various derivatives are netted on the Consolidated Balance Sheets based on management's evaluation of the settlement provisions in the master contract. Gross positions of these derivatives are disclosed in Note D. Due to the nature of these financial instruments, such estimates of fair value are subject to significant change in the near term.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims (Note G) 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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

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 payors. 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 payors 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, prior experience 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 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.

In addition to the charity care services described above, 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*

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

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, pension and related adjustments, and distributions to, or contributions from, owners 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. Taxable entities account for income taxes in accordance with FASB ASC 740, *Income Taxes* (Note L). The Alliance has no significant uncertain tax positions at June 30, 2011 and 2010.

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 Consolidated Statements of Changes in Net Assets as net assets released from restrictions. Permanently restricted net assets have been restricted by donors to be maintained by the Alliance in perpetuity.

Fair Value Measurement: The Alliance had previously adopted FASB ASC 820, *Fair Value Measurements and Disclosures*, which defines fair value, establishes a framework for measuring fair value under generally accepted accounting principles and expands disclosures about fair value measurements.

In January 2010, the FASB issued ASU 2010-06, *Fair Value Measurements and Disclosures (Topic 820) - Improving Disclosures about Fair Value Measurements* (ASU 2010-06). ASU 2010-06 requires new disclosures regarding significant transfers in and out of Levels 1 and 2, as well as information about activity in Level 3 fair value measurements, including presenting information about purchases, sales, issuances and settlements on a gross versus a net basis in the Level 3 activity roll forward. In addition, ASU 2010-06 clarifies existing disclosures regarding input and valuation techniques, as well as the level of disaggregation for each class of assets and liabilities. The Alliance adopted ASU 2010-06 in 2011, except for the disclosures related to purchases, sales, issuance and settlements, which will be effective for the Alliance beginning July 1, 2012. The adoption of ASU 2010-06 did not, and is not expected to, have an impact on the Alliance's consolidated financial statements.

Subsequent Events: The Alliance evaluated all events or transactions that occurred after June 30, 2011, through October 26, 2011, the date the consolidated financial statements were available to be

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

issued. During this period management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2011 consolidated financial statements, other than as discussed in Notes D, F and S.

New Accounting Pronouncements: In August 2010, the FASB issued Accounting Standards Update (ASU) 2010-23, *Health Care Entities – Measuring Charity Care for Disclosure*. ASU 2010-23 is intended to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care. ASU 2010-23 requires that cost, identified as the direct and indirect costs of providing the charity care, be used as the measurement basis for disclosure purposes. ASU 2010-23 also requires disclosure of the method used to identify or determine such costs. The Hospital will adopt ASU 2010-23 in fiscal year 2012. Management does not expect the adoption of ASU 2010-23 to have a material impact on the consolidated financial statements.

In August 2010, the FASB issued ASU 2010-24, *Health Care Entities – Presentation of Insurance Claims and Related Insurance Recoveries*. The amendments in the ASU clarify that a health care entity may not net insurance recoveries against related claim liabilities. In addition, the amount of the claim liability must be determined without consideration of insurance recoveries. ASU 2010-24 is effective for the Alliance beginning July 1, 2011 and management is currently evaluating the impact of this ASU on the consolidated financial statements.

In July 2011, the FASB issued ASU 2011-07, *Healthcare Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and Allowance for Doubtful Accounts for Certain Healthcare Entities*, which will require certain healthcare entities to reclassify the provision for bad debts associated with providing patient care from an operating expense to a deduction from net patient service revenue in the Consolidated Statements of Operations. Additionally, ASU 2011-07 requires enhanced disclosures about an entity's policies for recognizing revenue and assessing bad debts and qualitative and quantitative information about changes in the allowance for doubtful accounts. The Alliance intends to adopt ASU 2011-07 in fiscal year 2013. Management does not expect the adoption of ASU 2011-07 to have a material impact on the consolidated financial statements.

Reclassifications: Certain 2010 amounts have been reclassified to conform with the 2011 presentation in the accompanying consolidated financial statements.

NOTE C--INVESTMENTS

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2011 and 2010

NOTE C--INVESTMENTS - Continued

	<u>2011</u>	<u>2010</u>
Designated or restricted:		
Under safekeeping agreements	\$ 28,349	\$ 52,050
Under guarantee agreements	92,720	89,486
By Board for capital improvements	4	2,776
Under bond indenture agreements:		
For debt service and interest payments	67,874	78,612
For capital acquisitions	28,835	76,241
	<u>217,782</u>	<u>299,165</u>
Less: amount required to meet current obligations	(116,175)	(25,092)
	<u>\$ 101,607</u>	<u>\$ 274,073</u>

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

	<u>2011</u>	<u>2010</u>
Cash, cash equivalents and money market funds	\$ 115,579	\$ 170,897
U.S. Government securities	1,795	1,795
U.S. Agency securities	7,688	12,319
Guaranteed investment contracts	92,720	114,154
	<u>\$ 217,782</u>	<u>\$ 299,165</u>

Trading securities consist of the following at June 30:

	<u>2011</u>	<u>2010</u>
Cash, cash equivalents and money market funds	\$ 29,159	\$ 4,799
U.S. Government securities	9,409	3,137
U.S. Agency securities	31,551	13,760
Corporate and foreign bonds	126,543	11,688
Municipal obligations	451	1,461
Preferred and asset backed securities	8,945	7,023
U.S. equity securities	94,834	139,168
Other	32,718	28,608
	<u>\$ 333,610</u>	<u>\$ 209,644</u>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE C--INVESTMENTS - Continued

Held-to-Maturity securities are carried at amortized cost and consist of the following at June 30:

	<u>2011</u>		<u>2010</u>
Cash, cash equivalents and money market funds	\$ 753	\$	1,131
Corporate and foreign bonds	135,745		103,968
Municipal obligations	9,661		1,315
	<u>\$ 146,159</u>	\$	<u>106,414</u>

Held-to-maturity securities had gross unrealized gains and losses of \$6,838 and \$276, respectively, at June 30, 2011 and \$5,525 and \$607, respectively at June 30, 2010. At June 30, 2011, the Alliance held nine securities within the held-to-maturity portfolio with a fair value and unrealized loss of \$549 and \$44, respectively, which had been at an unrealized loss position for over one year. At June 30, 2010, the Alliance held one security within the held-to-maturity portfolio with a fair value and unrealized loss of \$591 and \$166, respectively, which had been at an unrealized loss position for over one year. At June 30, 2011, the contractual maturities of held-to-maturity securities were \$13,816 due in one year or less, \$55,563 due from one to five years and \$76,780 due after five years. At June 30, 2010, the contractual maturities of held-to-maturity securities were \$13,389 due in one year or less, \$48,447 due from one to five years and \$44,578 due after five years.

At June 30, 2011 and 2010, the Alliance held investments in certain limited partnerships and hedge funds of \$32,718 and \$28,608, respectively, that have a wide range of investment strategies with various levels of risk. These funds are included within trading securities and do not have readily determinable fair values. The funds are reported at estimated fair market value pursuant to FASB ASC 825, *Financial Instruments*.

The Alliance has investments in several joint ventures and corporations which are accounted for under the equity method of accounting.

As a part of the acquisition of membership interests in JMH, SCCH and NCH, the Alliance has committed to invest \$132,000, \$48,100, and \$45,000, respectively. Cumulative amounts expended at June 30, 2011 under these commitments are approximately \$150,184.

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is a party to a number of derivative transactions. These derivatives have not been designated as hedges and are valued at estimated fair value in the accompanying Consolidated Balance Sheets. Management's primary objective in holding such derivatives is to introduce a variable rate component into its fixed rate debt structure. Under the terms of these agreements, changes in the interest rate environment could have a significant effect on the Alliance.

MOUNTAIN STATES HEALTH ALLIANCE

*Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE D--DERIVATIVE TRANSACTIONS - Continued

These derivative agreements require that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. Such investments are included as assets limited as to use. As of June 30, 2011, management believes the Alliance was fully collateralized with respect to the derivative agreements and management does not believe such collateral is exposed to third-party credit risk. Further, certain of the agreements contain requirements regarding maintenance of financial and liquidity ratios. Management has represented the Alliance is in compliance with all such covenants at June 30, 2011.

Interest Rate Swaps: The Alliance is a party to six interest rate swap agreements with Merrill Lynch as the counterparty. The terms of five of these agreements were modified without settlement during 2011 and no gain or loss was realized. However, such modifications did impact the estimated fair value of these interest rate swaps. A liability, representing the estimated net fair value of these swaps, of \$8,123 and \$33,910 was recognized by the Alliance as of June 30, 2011 and 2010, respectively.

The following is a summary of five of these interest rate swap agreements at June 30, 2011:

<i>Swap</i>	<i>Notional Amount</i>	<i>Term</i>	<i>Payments by:</i>		<i>Estimated Fair Value</i>
			<i>Counterparty</i>	<i>Alliance</i>	
A	\$ 170,000	4/2008-4/2026	1.265% through April 2013; 1.07% through April 2014; then 71.10% of USD-ISDA Swap Rate	0.00% through April 2014, then USD-SIFMA Municipal Swap Index	\$ 3,028
B	95,000	4/2008-4/2026	1.265% through April 2013; 1.08% through April 2014; then 71.18% of USD-ISDA Swap Rate	0.00% through April 2014, then USD-SIFMA Municipal Swap Index	1,729
C	173,030	4/2008-4/2034	1.315% through April 2013; 1.12% through April 2014; then 72.35% of USD-ISDA Swap Rate	0.00% through April 2014, then USD-SIFMA Municipal Swap Index	741
D	82,055	12/2007-7/2033	¹⁾ 3.493% through July 2012; then 0% ²⁾ USD-LIBOR-BBA through July 2012, then 67% USD- LIBOR-BBA	¹⁾ 4.41% through July 2012; then .312% ²⁾ USD-SIFMA	(9,363)
E	50,000	2/2008-7/2038	67.00% of USD-LIBOR-BBA plus .145%	USD-SIFMA	(3,918)

Deferred financing and acquisition costs, net of amortization, include \$6,480 and \$6,823 at June 30, 2011 and 2010, respectively, related to these swaps.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE D--DERIVATIVE TRANSACTIONS - Continued

In addition to the swaps described above, the Alliance and Merrill Lynch are also parties to a total return swap in the notional amount of \$23,100 which has an estimated fair value of \$(340) and \$(252) at June 30, 2011 and 2010, respectively. The agreement consists of the following:

- An agreement that requires the Alliance to pay a variable rate of USD-SIFMA Municipal Swap Index through July 1, 2012 (or termination of the swap) on a notional amount equal to the outstanding 2001A Hospital Revenue and Improvement Bonds (the 2001A Reference Bonds). The Alliance receives a fixed rate of 6.25% of the outstanding 2001A Reference Bonds.
- A “total return provision” under which the Alliance will pay (or receive) an amount equal to the product of the outstanding 2001A Reference Bonds multiplied by the difference between the outstanding 2001A Reference Bonds and the 2001A Reference Bonds’ market price at termination, as defined in the agreement. In the event the swap does not terminate prior to July 1, 2012, there would be no settlement of this component as there would be no outstanding 2001A Reference Bonds.

The Alliance is also party to a total return swap with Lehman Brothers as the counterparty. Lehman Brothers filed for bankruptcy in September 2008. The Alliance subsequently received notification from Lehman Brothers Special Financing, Inc. indicating the intent of the counterparty to terminate this agreement effective January 1, 2009. The Alliance and Lehman Brothers Special Financing, Inc. have been unable to reach a settlement agreement. In September 2010, the Alliance was issued a subpoena to furnish certain documentation related to the transaction. A protocol has been put into place by the bankruptcy court whereby the parties are to undergo alternate dispute resolution, including non-binding arbitration, which management anticipates will occur in 2012.

The fair value of these swaps is undeterminable at January 1, 2009, as prior to the termination date Lehman Brothers liquidated the underlying referenced securities, making a valuation not commercially viable. An estimated liability of \$10,565 and \$10,740 was recognized by the Alliance as of June 30, 2011 and 2010, respectively. Management believes that the liability as recorded at June 30, 2011 is sufficient to cover any exposure arising from litigation in this matter. However, it is reasonably possible management’s estimate may change in the near term, although the amount of any change cannot be estimated. Due to the termination of this agreement, the estimated liability is included as a current liability in the accompanying Consolidated Balance Sheets.

A third party holds collateral with a fair market value of approximately \$13,381 and \$13,570, respectively, at June 30, 2011 and 2010, with respect to these Lehman derivative agreements. Such collateral is included as current assets limited as to use.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE D--DERIVATIVE TRANSACTIONS - Continued

The arrangement consists of nine agreements each with three separate components (described below) with notional values of \$23,600, \$8,000, and \$8,750 each. The swaps generally consist of the following:

- An arrangement that calls for the Alliance to pay a variable rate (SIFMA Municipal Swap Index) plus certain fixed payment amounts and receive a payment equal to the interest paid by the Alliance on a portion of its early extinguished, but still outstanding, 2000A and 2000B Hospital Mortgage Revenue Refunding Bonds (the Reference Bonds) (whose fixed rates range from 7.50% to 7.75%).
- An arrangement that requires the Alliance to pay a fixed rate of 4.211% through either July 1, 2025, 2029 or 2033 (or termination of the swap) on the outstanding Reference Bonds and receive a variable rate of 67% of USD-LIBOR-BBA on the outstanding Reference Bonds; and
- A “total return provision” under which the Alliance will pay (or receive) the difference between the outstanding Reference Bonds, multiplied by 132%, less the fair value of the Reference Bonds on the date of termination and any fixed interest payments made under the arrangements described above. In the event the swaps do not terminate prior to their stated termination dates (2025, 2029 or 2033), there would be no settlement of this component as there would be no outstanding Reference Bonds.

The swap also contains an agreement that consists of two separate components:

- An arrangement that requires the Alliance to pay a fixed rate of 2.98% through July 1, 2016 (or termination of the swap) on the outstanding, but previously defeased, 1991 Hospital Revenue and Improvement Bonds (the 1991 Reference Bonds) and receive a variable rate of 67% of USD-LIBOR-BBA on the outstanding 1991 Reference Bonds; and
- A “fixed payor provision” under which the Alliance will pay (or receive) the difference between the outstanding 1991 Reference Bonds multiplied by 100% and any fixed interest payments made as required under the agreement minus the outstanding 1991 Reference Bonds multiplied by the average market price at termination. In the event the swaps do not terminate prior to their stated termination date (2016), there would be no settlement of this component as there would be no outstanding 1991 Reference Bonds.

Interest Rate Swap Option: In June 2004, the Alliance entered into an agreement with Bear Stearns (acquired by JP Morgan) whereby Bear Stearns has purchased from the Alliance an option to enter

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE D--DERIVATIVE TRANSACTIONS - Continued

into an interest rate swap agreement (swaption) with the Alliance on July 1, 2011, which is an optional redemption date related to the Alliance's early extinguished 2000A and 2000B Bonds (Note F). The purpose of this agreement was to effectively sell the call features related to the early extinguished Series 2000A and 2000B Bonds. As consideration under this agreement, the Alliance received a total of \$42,500 in upfront payments as the swaption premium. Such amounts were initially recorded as estimated fair value of derivatives in the Consolidated Balance Sheets. Beginning 30 calendar days prior to July 1, 2011 and terminating 30 calendar days prior to July 1, 2015, the counterparty has the periodic right to exercise the swaption.

The underlying interest rate swap transactions to which the swaption transaction relates have the following terms:

<i>Swap</i>	<i>Notional Amount</i>	<i>Term</i>	<i>Payments by:</i>	
			<i>Counterparty</i>	<i>Alliance</i>
2000A	Ranging from \$148,170 through July 1, 2018 to \$23,000 through July 2033	30 days following the exercise date through July 2033	64% of USD-LIBOR-BBA	Fixed amounts ranging from 7.13% upon execution to 7.50% through July 2033, based on notional amount
2000B	Ranging from \$76,240 through July 1, 2021 to \$8,800 through July 2033	30 days following the exercise date through July 2033	64% of USD-LIBOR-BBA	Fixed amounts ranging from 7.54% upon execution to 8.00% through July 2033, based on notional amount

The Alliance retained the right to terminate the swaption at any time prior to May 17, 2011 at its fair market value. A liability of \$92,044 and \$89,650, representing the estimated fair value of the swaption at June 30, 2011 and 2010, respectively, is included in estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. As a derivative financial instrument, this swaption is extremely sensitive to changes in long-term interest rates and other elements in the financial marketplace. As such, estimates of fair value are subject to significant changes in the near term.

Deferred financing and acquisition costs include \$0 and \$434 at June 30, 2011 and 2010, respectively, related to the costs of this transaction. The change in estimated fair value of derivatives in the accompanying Statements of Operations for 2011 and 2010 includes an unrealized loss of \$2,394 and \$11,628, respectively, related to this derivative.

The interest rate swap option, described above, was terminated on October 13, 2011. To effectuate this termination, the Alliance transferred a portion of a Guaranteed Investment Contract (GIC), described below, to the third party as a termination payment. A gain of approximately \$3,000 was recognized on this termination.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE D--DERIVATIVE TRANSACTIONS - Continued

Forward Sale Agreements: In June 2004, the Alliance entered into two related forward sale agreements with the counterparty to the swaption agreements and the Master Trustee of the Series 2000 Bonds. The forward sale agreements originally related to the Debt Service Reserve Fund and to the Debt Service Fund, respectively, (collectively, the "Funds"), as established under provisions of the Master Trust Indenture related to the issuance of the Series 2000 Bonds. In consideration of the future earnings on the Funds, the counterparty paid the Master Trustee a total of \$30,000 during 2005, to be held on behalf of the Alliance. In June 2006, one of these agreements was amended to also relate to the Series 2000C, 2000D, 2006A and 2006B Bonds, and to remove the Series 2000A Bonds from consideration under the agreement. As the original intent of these Funds was to secure debt service payments under the above referenced Bonds, the agreement requires these funds to be held under a guaranty agreement as further described below.

In connection with the issuance of the Series 2007 Bonds and the derecognition of a portion of the Series 2000A Bonds, all of the outstanding Series 2000B Bonds, and all of the outstanding 2006B Bonds (Note F), one of these agreements as it relates to the Series 2000A and 2000B Bonds was partially terminated. As such, during 2008 the Alliance reduced its liability with respect to the portion related to the Series 2000A and 2000B Bonds, and paid the counterparty \$6,186 under the terms of the agreement. The agreement was amended in fiscal year 2011 to include the Series 2010A Bonds and to remove the Series 2000B and 2006B Bonds.

A liability of \$19,001 and \$19,864 representing the unamortized payments from the counterparty is included as part of deferred revenue in the accompanying Consolidated Balance Sheets as of June 30, 2011 and 2010, respectively. Amounts are being recognized as investment income over the life of the agreements.

Pursuant to these agreements, the counterparty required that the Alliance's obligations under the swaption and forward sale agreements be collateralized under a guarantee agreement in favor of the counterparty. Due to various requirements of the Master Trust Indenture, the Alliance transferred to MSF a total of \$42,500 that was in turn deposited with the counterparty as collateral in a GIC. Amounts received under the forward sale agreements were also deposited into the GIC. All GIC deposits earn interest compounded at 4.14% for the first year, and at 3.5% thereafter through July 1, 2011. The GIC deposits as of June 30, 2011 and 2010 totaled \$92,720 and \$89,486, respectively. The GIC was substantially utilized on October 13, 2011 to terminate the interest rate swap option agreement discussed above and, as such, is included in the current portion of assets whose use is limited in the Consolidated Balance Sheet at June 30, 2011.

NOTE E--PROPERTY, PLANT AND EQUIPMENT

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2011 and 2010

NOTE E--PROPERTY, PLANT AND EQUIPMENT - Continued

	<i>2011</i>	<i>2010</i>
Land	\$ 63,749	\$ 58,037
Buildings and leasehold improvements	454,852	407,104
Property and improvements held for leasing	80,568	84,421
Equipment	532,767	479,523
Buildings and equipment held under capital lease	42,720	22,679
	<u>1,174,656</u>	<u>1,051,764</u>
Less: Allowances for depreciation and amortization	(586,471)	(569,913)
	588,185	481,851
Construction in progress (Note N)	209,233	213,747
	<u>\$ 797,418</u>	<u>\$ 695,598</u>

Accumulated depreciation and amortization on property and improvements held for leasing purposes is \$23,348 and \$21,543 at June 30, 2011 and 2010, respectively. Net interest capitalized was \$10,640 and \$11,117 for the years ended June 30, 2011 and 2010, respectively.

The Alliance is constructing replacement facilities for SCCH and JMH and is also performing various renovations on existing hospital facilities. During 2011 and 2010, management of the Alliance assessed the planned current and future use of the existing NSH, SCCH and JMH facilities as well as certain other facilities, and adjusted their estimated useful lives accordingly.

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

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

<i>Description</i>	<i>Maturities</i>	<i>Rates</i>	<i>Outstanding Balance</i>	
			<i>2011</i>	<i>2010</i>
2010A Hospital Revenue Bonds, net of unamortized premium of \$1,056 and \$1,096 at June 30, 2011 and 2010, respectively	\$38,660 uninsured serially, through 2020 \$14,985 unsecured term bonds, due July 1, 2025 \$19,385 unsecured term bonds, due July 1, 2030	3.00% to 5.00% 5.38% 5.63%	\$ 169,137	\$ 169,176
	\$39,570 unsecured term bonds, due July 1, 2038 \$55,480 unsecured term bonds, due July 1, 2038	6.50% 6.00%		
2010B Hospital Revenue Bonds, net of unamortized premium of \$711 and \$753 at June 30, 2011 and 2010, respectively	\$27,330 unsecured serially, through 2020 \$4,355 unsecured term bonds, due July 1, 2023 \$4,250 unsecured term bonds, due July 1, 2028	2.50% to 5.00% 5.00% 5.50%	36,646	36,688
2009A Hospital Revenue Bonds, net of unamortized discount of \$121 and \$126 at June 30, 2011 and 2010, respectively	\$725 unsecured term bonds, due July 1, 2019 \$1,730 unsecured term bonds, due July 1, 2029 \$3,105 unsecured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	5,439	5,434

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

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

Description	Maturities	Rates	Outstanding Balance	
			2011	2010
2009B Hospital Revenue Bonds	\$5,535 uninsured term bonds, due July 1, 2038	8.00%	5,535	5,535
2009C Hospital Revenue Bonds, net of unamortized discount of \$2,421 and \$2,508 at June 30, 2011 and 2010, respectively	\$21,100 uninsured term bonds, due July 1, 2019 \$20,000 uninsured term bonds, due July 1, 2029 \$74,855 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	113,534	113,447
2008A Hospital Revenue Bonds	\$13,245 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.07% at June 30, 2011	13,245	13,245
2008B Hospital Revenue Bonds	\$53,855 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.07% at June 30, 2011	53,855	54,050
2007A Hospital Revenue Bonds	Uninsured term bonds, due July 1, 2038, redeemed in 2011	NA	-	4,305
2007B Taxable Hospital Revenue Bonds, bifurcated into sub-series B-1, B-2 and B-3 during 2011	\$307,900 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 0.11% to 0.16% at June 30, 2011	307,900	314,190
2007C Hospital Revenue Bonds	Uninsured term bonds, due July 1, 2032, redeemed in 2011	NA	-	1,900
2006A Hospital First Mortgage Revenue Bonds, net of unamortized premium of \$147 and \$153 at June 30, 2011 and 2010, respectively	\$6,580 uninsured serially, through 2019 \$7,375 uninsured term bonds, due July 1, 2026 \$20,505 uninsured term bonds, due July 1, 2031 \$135,175 uninsured term bonds, due July 1, 2036	5.00% 5.25% 5.50% 5.50%	169,782	170,473
2001A Hospital First Mortgage Revenue Bonds	\$23,100 term bonds, due July 1, 2026, subject to early redemption or tender	6.85%	23,100	23,900
2001 Hospital Refunding and Improvement Revenue Bonds (NCH), net of unamortized discount of \$34 and \$38 at June 30, 2011 and 2010, respectively	\$1,465 insured term bonds, due December 1, 2012 \$1,635 insured term bonds, due December 1, 2014 \$8,815 insured term bonds, due December 1, 2022	5.75% 6.00% 6.00%	11,876	12,547
2000A Hospital First Mortgage Revenue Refunding Bonds	\$30,358 insured Capital Appreciation Bonds, interest and principal due July 1, 2026 through 2030	6.63%	30,358	28,417
2000C Hospital First Mortgage Revenue Bonds	\$34,325 insured term bonds, due July 1, 2026	8.50%	34,325	35,335
2000D First Mortgage Taxable Bonds	\$14,790 insured term bonds, due July 1, 2026	8.50%	14,790	15,225
1998 Hospital Refunding and Improvement Revenue Bonds (JMH)	\$6,495 uninsured term bonds, due July 1, 2016 \$7,620 uninsured term bonds, due July 1, 2028	5.25% 5.38%	14,115	15,240
Capitalized lease obligations secured by buildings and equipment	Maturing through 2027	3.18% to 13.01%	16,153	16,715
\$7,500 promissory note secured by assets of Mediserve Medical Equipment of Kingsport, Inc.	Monthly principal and interest payments of \$56 beginning February 2007 maturing December 2011; remaining principal due January 2012	LIBOR + 1.10%	5,473	6,064
Capitalized lease obligations secured by equipment	Various monthly payments of monthly principal and interest	Various	587	1,325
Master installment payment agreement	Paid-off in 2011	Unspecified	-	2,194
\$1,409 unsecured promissory note	Monthly principal and interest payments of \$23 beginning July 2008 through September 2013; remaining principal and accrued interest due October 2014; note was paid-off in 2011	LIBOR + 1.25%	-	920
\$10,221 note payable secured by property	Various annual principal and interest payments through April 2013; note was paid-off in 2011	6.25%	-	7,836
\$1,065 note payable secured by land	Monthly interest-only payments through October 2011; remaining principal and accrued interest due November 2011	5.50%	572	1,065
\$6,332 promissory note secured by substantially all assets of the Alliance	Monthly principal payments of \$35 plus accrued interest beginning July 2010 maturing June 2015; remaining principal due July 2015	LIBOR + 2.00%	5,945	6,332
\$3,955 note payable secured by property	Monthly principal and interest payments of \$27 beginning July 2010 maturing May 2015; remaining principal due June 2015	3.00%	3,743	3,955

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

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

Description	Maturities	Rates	Outstanding Balance	
			2011	2010
Note payable under Master Financing Agreement, secured by Equipment	Monthly principal and interest payments of \$166 beginning July 2010 maturing June 2017	4.62%	10,431	11,900
Note payable under Master Financing Agreement, secured by Equipment	Monthly principal and interest payments of \$56 beginning July 2010 maturing June 2017	3.75%	3,580	4,100
\$4,926 convertible construction loan secured by property and assigned rents	Monthly interest-only payments through January 2011 followed by monthly principal and interest payments of \$25 maturing December 2014; remaining principal and accrued interest due January 2015; note was paid-off in 2011	Prime (stated minimum and maximum interest rates of 3.75% and 6.75%, respectively)	-	1,195
\$1,885 line of credit secured by property	Monthly interest-only payments through March 2011 followed by monthly principal and interest payments of \$9 maturing February 2015; remaining principal and accrued interest due March 2015	Prime - 0.50% (stated minimum and maximum interest rates of 3.50% and 6.25%, respectively)	1,873	265
\$1,593 note payable, secured by equipment	Various annual principal payments through July 2014	Unspecified	1,593	-
Capitalized lease obligation secured by medical office building (JMH)	Maturing through 2026	9.72%	15,498	-
			1,069,085	1,082,973
	Less current portion		(28,162)	(28,131)
			<u>\$ 1,040,923</u>	<u>\$ 1,054,842</u>

In September 2010, in order to reduce credit risk and expenses, the Alliance replaced the existing letters of credit related to the Series 2007B, Series 2008A and Series 2008B Bonds with letters of credit held by several different financial institutions. The substitute letters of credit entitle the Master Trustee to draw amounts equal to the principal amounts of the respective series of Bonds outstanding and up to 37 days interest at a rate of 12%. The substitute letters of credit expire on September 29, 2013 unless renewed or replaced.

Series 2010 Bonds: In April 2010, the Alliance issued \$168,080 (Series 2010A) and \$35,935 Series 2010B fixed rate Hospital Refunding Revenue Bonds (collectively, the Series 2010 Bonds). Proceeds of the Series 2010A and the Series 2010B Bonds were used to refinance outstanding indebtedness, specifically related to the Alliance's facilities in Tennessee and in Virginia, respectively, fund debt service reserve funds and pay costs of issuance. The Alliance recognized a \$3,029 loss on early extinguishment of debt representing the write off of previously deferred and unamortized financing costs related to the refinanced Series 2008A and the Series 2007A and 2007C debt issues discussed below.

Series 2009 Bonds

In March 2009, the Alliance issued \$5,560 (Series 2009A), \$5,535 (Series 2009B) and \$115,955 (Series 2009C) fixed rate Hospital Revenue Bonds (collectively, the Series 2009 Bonds). The proceeds of Series 2009 Bonds were used to refinance a portion of the outstanding Series 2006C Taxable Notes, which were originally issued to finance a capital commitment to SCCH and purchase certain leased assets, finance the acquisition of a majority ownership in JMH, fund a debt service

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

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

reserve fund and pay costs of issuance. The portion of the 2006C taxable notes which were not refinanced with the Series 2009 Bonds were repaid with cash on hand.

In connection with its acquisition of a majority ownership in JMHS, the Alliance assumed the then outstanding long-term debt of JMHS, totaling \$33,906, including the JMHS Series 1998 Hospital Refunding and Improvement Revenue Bonds as further described in the table above.

Series 2008 Bonds

In February 2008, the Alliance issued \$72,770 (Series 2008A) and \$54,230 (Series 2008B) variable rate Hospital Revenue Bonds (collectively, the Series 2008 Bonds). The proceeds of Series 2008 Bonds were primarily used to finance certain future capital projects for the Alliance's hospital facilities and for the repayment of previously issued 2008 Taxable Notes used for the acquisition of RCMC. As discussed above, the payment of principal and interest on the Series 2008 Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit. A portion (\$59,525) of the Series 2008A Bonds were repaid from proceeds of the Series 2010 Bonds.

The variable rate of interest on the Series 2008 Bonds is determined weekly by the Remarketing Agent (Merrill Lynch), as the rate equal to the lowest rate which, in regard to general financial conditions and other special conditions bearing on the rate, would produce as nearly as possible a par bid for the Series 2008 Bonds in the secondary market. In no event shall the variable rate on the Series 2008 Bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the State of Tennessee for the Series 2008A Bonds or the Commonwealth of Virginia for the Series 2008B Bonds. The Alliance has the option, upon written approval of the holder of the letters of credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate.

The Series 2008 Bonds are subject to optional and mandatory tender for purchase prior to maturity at the option of the holder, upon conversion to a fixed rate, upon conversion to a medium-term rate period, prior to the effective date of any substitute letter of credit, or upon the termination of the letters of credit. The optional and mandatory tender provisions generally call for the Master Trustee to purchase the outstanding Series 2008 Bonds at a purchase price equal to the principal amount thereof plus accrued interest upon a stated date as described in the tender notice delivered to the bond holders.

Series 2007 Bonds

In December 2007, the Alliance issued \$104,355 (Series 2007A), \$327,170 (Series 2007B taxable) and \$36,575 (Series 2007C) variable rate Hospital Revenue Bonds (collectively, the Series 2007 Bonds). The proceeds of Series 2007 Bonds were primarily used to early extinguish a portion of the

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

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

outstanding Series 2000A Bonds, all of the outstanding 2000B Bonds, all of the outstanding Series 1994 Bonds, and all of the outstanding Series 2006B Bonds; to finance the acquisition of a majority ownership in NCH, and to finance certain capital improvements and equipment acquisitions for the Alliance's hospital facilities. A portion of the outstanding Series 2007A (\$91,685) and Series 2007C (\$32,840) Bonds were repaid from proceeds of the Series 2010 Bonds. The remaining outstanding Series 2007A and Series 2007C Bonds were redeemed in 2011.

In 2011 during the letter of credit restructuring, the existing 2007B Bonds were repaid through a remarketing of Sub-Series 2007B-1, 2007B-2 and 2007B-3 (collectively, the Sub-Series 2007B Bonds), created per the mandatory tender and letter of credit substitution provisions. As discussed above, the payment of principal and interest on the Sub-Series 2007B Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit.

The variable rate of interest on the Series 2007 Bonds is determined weekly in the same manner as described above for the Series 2008 Bonds. In no event shall the variable rate on the bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the State of Tennessee. The Alliance has the option, upon written approval of the holder of the letters of credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate. Upon such conversion, the bonds become subject to mandatory tender for purchase.

The Sub-Series 2007 Bonds are subject to optional and mandatory tender in the same manner as described above for the Series 2008 Bonds. In addition, the Sub-Series 2007B Bonds are subject to a special mandatory tender with respect to its conversion from taxable debt to tax-exempt debt. As discussed in Note S, certain of the Sub-Series 2007B Bonds were redeemed subsequent to year end.

Series 2006 Bonds

During 2006, the Alliance issued \$173,030 Hospital First Mortgage Revenue Bonds (Series 2006A) and \$66,500 Hospital First Mortgage Variable Rate Revenue Bonds (Series 2006B). The proceeds from the sale of the Series 2006A Bonds were used to finance certain future and prior capital projects for the Alliance's hospital facilities and to refund certain existing indebtedness, specifically the Series 2001B Bonds (discussed below) and certain existing short and intermediate term loans and leases, as well as fund a debt service reserve fund. The Series 2006B Bond proceeds were substantially used to refund the remaining outstanding principal of the Series 2001B Bonds and establish a debt service reserve fund.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

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

Series 2001 Bonds

During 2001, the Alliance issued \$26,000 Hospital First Mortgage Revenue Bonds (Series 2001A) and \$60,175 Hospital First Mortgage Revenue Bonds (Series 2001B). The Series 2001A Bonds were subject to optional tender by Bond holders. Effective July 1, 2007, the Alliance entered into an agreement whereby the beneficial owners of the Series 2001A Bonds have irrevocably waived their rights to tender the Bonds under the provisions of the respective Bond Indenture. The waiver will continue in effect through the maturity of the 2001A Bonds. The Series 2001B Bonds were refunded and redeemed in 2006.

Series 2000 Bonds

The Hospital First Mortgage Revenue Refunding (Series 2000A Bonds) and First Mortgage Revenue Refunding Bonds (Series 2000B Bonds), were used to advance refund previously existing indebtedness as well as fund a required debt service reserve fund. The Hospital First Mortgage Revenue Bonds (Series 2000C Taxable Bonds) were intended to refinance certain mortgage indebtedness of BRMM, and to refund other previously existing indebtedness. The proceeds from the sale of the First Mortgage Bonds (Series 2000D Taxable Bonds) were used primarily to fund working capital for the Alliance.

The Series 2000A Bonds included at issue date \$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.

The advance refunding of previously issued debt requires funds to be placed in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments. 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, and the debt and escrowed securities are not considered liabilities or assets of the Alliance. Therefore, such debt has been derecognized.

Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2011 due to previous advance refundings of the Series 2000A Bonds, Series 2000B Bonds, Series 1998C Bonds, and Series 1991 Bonds, totaled approximately \$525,025.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

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

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.

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.

Other Bonds, Notes Payable and Financing Arrangements

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 NCH Series 2001 Hospital Refunding and Improvement Revenue Bonds are secured by revenues and a lien on certain real and personal property of NCH. The JMH Series 1998 Hospital Refunding and Improvement Revenue Bonds are secured by pledged gross receipts of JMH, as defined in the Master Trust indenture.

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, 2011 are as follows:

<i>Year Ending</i> <i>June 30,</i>		
2012	\$	28,162
2013		32,230
2014		28,706
2015		34,504
2016		33,585
Thereafter		912,560
		<hr/> 1,069,747
	Net discount	(662)
		<hr/> <hr/> \$ 1,069,085

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

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

The Alliance, NCH 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, NCH and JMH are in compliance with all such covenants at June 30, 2011.

In connection with the tax-exempt bonds, the Alliance is required every five years, and at maturity, to remit to the Internal Revenue Service amounts which are due related to positive arbitrage on the borrowed funds. The Alliance performs such computations when required and recognizes any liability at that time. Management does not believe there are any significant arbitrage liabilities at June 30, 2011 or 2010.

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 and \$1,000 annual aggregate retention. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

At June 30, 2011, 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, 2011 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Alliance 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, 2011 and 2010 was \$13,531 and \$12,601, respectively. The discount rate utilized was 5% at June 30, 2011 and 2010.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE G--SELF-INSURANCE PROGRAMS - Continued

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, including a catastrophic claims reserve based on historical claims in excess of \$75.

NOTE H--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates to net patient service revenue as presented in the accompanying Consolidated Statements of Operations is as follows for the years ended June 30:

	<u>2011</u>	<u>2010</u>
Inpatient service charges	\$ 1,983,340	\$ 1,848,590
Outpatient service charges	1,807,247	1,669,705
Gross patient service charges	3,790,587	3,518,295
Less:		
Estimated contractual adjustments and other discounts	2,647,514	2,417,082
Estimated uncollectible self-pay	110,387	111,565
Charity care	72,432	61,378
	<u>2,830,333</u>	<u>2,590,025</u>
Net patient service revenue	<u>\$ 960,254</u>	<u>\$ 928,270</u>

NOTE I--THIRD-PARTY REIMBURSEMENT

The Alliance renders services to patients under contractual arrangements with Medicare, Medicaid, TennCare, Blue Cross and various other commercial payors. 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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE I--THIRD-PARTY REIMBURSEMENT - Continued

also receives additional supplemental payments from the State of Tennessee. The amount recognized totaled \$11,480 and \$7,811 for the years ended June 30, 2011 and 2010, respectively. Such payments are not guaranteed in future periods.

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 based on Medicare cost reimbursement principles and settled through the filing of an annual Medicaid cost report.

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. 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. 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 2012, although the amount of any change cannot be estimated. The impact of final settlements of cost reports or changes in estimates decreased net patient service revenue by \$4,570 in 2011. The impact of final settlements of cost reports or changes in estimates were not significant in 2010.

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, 2011.

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 retirement plan (the Plan) which covers substantially all employees. The Plan is a defined contribution plan which consists mainly of employer-funded contributions. During

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

NOTE J--EMPLOYEE BENEFIT PLANS - Continued

2011 and 2010, the Alliance made contributions to the Plan under a stratified system, whereby the Alliance's contribution percentage is based on each employee's years of service. In addition, the Alliance sponsors a 403(b) plan which is funded solely by employees' contributions. The Alliance does not make any discretionary or matching contributions into the 403(b) plan. 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, 2011 and 2010 was \$12,682 and \$13,311, respectively.

NCH maintains a defined benefit pension plan and a post-retirement employee benefit plan. The accrued unfunded pension liability was \$1,313 and \$1,942, and the accrued unfunded post-retirement liability was \$3,761 and \$3,843 at June 30, 2011 and 2010, 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 date, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed \$929 and \$1,303 to the plan during 2011 and 2010, respectively. Other assets at June 30, 2011 and 2010 include \$7,888 and \$7,077, 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. The benefits for substantially all employees previously participating in the SEBP plan have been transferred into the 457(f) plan.

NOTE K--CONCENTRATIONS OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia which is considered a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. Net patient service revenue from Washington County, Tennessee operations were approximately 54% of total net patient service revenue for each of the years 2011 and 2010.

The mix of receivables from patients and third-party payors based on charges at established rates is as follows as of June 30:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

NOTE K--CONCENTRATIONS OF RISK - Continued

	<i>2011</i>	<i>2010</i>
Medicare	40%	42%
TennCare/Medicaid	12%	15%
Commercial	27%	25%
Other third-party payors	9%	10%
Patients	12%	8%
	<u>100%</u>	<u>100%</u>

Approximately 98% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2011 and 2010. Admitting physicians are primarily practitioners in the regional area.

Two of the Alliance's Virginia hospitals' employees are covered under collective bargaining agreements which extend through February 2, 2014.

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 and notes, 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. At June 30, 2011, the Alliance also had deposits in financial institutions significantly in excess of the Federal Deposit Insurance Corporation's limits.

NOTE L--INCOME TAXES

BRMM and its subsidiaries file a consolidated federal tax return and separate state tax returns. As of June 30, 2011 and 2010, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of \$34,822 and \$32,447, respectively, related to operating losses which expire through 2030. At June 30, 2011 and 2010, BRMM had state net operating loss carryforwards of \$65,979 and \$59,860, respectively, which expire through 2025. 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.

At June 30, 2011 and 2010, SWCH had federal and state net operating loss carryforwards of \$4,875 and \$4,376, respectively, which expire through 2030. CHC files separate federal and state tax returns. At June 30, 2011 and 2010, CHC had a net deferred tax liability of \$69 and \$58, respectively, due primarily to temporary timing differences related to depreciation. The net operating loss carryforwards may be off-set against future taxable income to the extent permitted by the Internal Revenue Code and tax codes of the Commonwealth of Virginia.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2011 and 2010

NOTE L--INCOME TAXES - Continued

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--RELATED PARTY TRANSACTIONS

The Alliance enters into transactions with entities affiliated with certain members of the Board of Directors including transactions to construct Alliance facilities and provide professional services to the Alliance. Board members refrain from discussion and abstain from voting on transactions with entities with which they are related.

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES

Construction in Progress: Construction in progress at June 30, 2011 represents costs incurred related to various hospital and medical office building facility renovations and additions. 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 approximately \$98,721 at June 30, 2011. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

Physician Contracts: BRMM employs physicians to provide services to BRMM's physician practices through employment agreements which provide annual compensation, plus incentives based upon specified productivity levels. These contracts have various terms.

In addition, the Alliance has entered into contractual relationships with non-employed physicians to provide services in Upper East Tennessee and Southwest Virginia. These contracts guarantee certain base payments and allowable expenses and have terms of varying lengths. Upon completion of the respective guarantee period, amounts drawn and outstanding under each agreement are treated as a loan bearing interest at various rates and are subject to repayment over a specified period. The physician note may also be amortized by virtue of the physician's continued practice in the specified community during the repayment period. A net receivable of \$1,407 and \$1,818 related to these agreements is included in the accompanying Consolidated Balance Sheets at June 30, 2011 and 2010, respectively.

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 degree. 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 June 30, 2011 and 2010 includes \$7,250 and \$5,571, respectively, related to students in

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

school, graduates working at the Alliance and amounts due from others who are no longer in the scholarship program.

Promises to Give: The Alliance has recorded certain unconditional promises to give to unrelated organizations. At June 30, 2011, \$1,568 is due within one year, and an additional \$180 is due within five years and is included in other long-term liabilities.

Operating Leases and Maintenance Contracts: Total lease expense for the years ended June 30, 2011 and 2010 was \$9,362 and \$10,216, 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:

<u>Year Ending June 30,</u>	
2012	\$ 2,846
2013	2,631
2014	2,286
2015	2,121
2016	1,285
Thereafter	<u>9,914</u>
	<u>\$ 21,083</u>

Estimated future minimum payments under various noncancellable maintenance contracts with remaining terms in excess of one year at June 30, 2011 total in the aggregate \$1,422 through 2016.

Asset Retirement Obligation: The Alliance has identified asbestos in certain facilities and is required by law to dispose of it in a special manner if the facility undergoes major renovations or is demolished; otherwise, the Alliance is not required to remove the asbestos from the facility. The Alliance has complied with regulations by treating the asbestos so that it presents no known immediate or future safety concerns. An asset retirement obligation has been established to the extent that sufficient information exists upon which to estimate the liability.

Other: The Alliance is a party to various transactions and agreements in the normal course of business, which include purchase and re-purchase agreements, put arrangements and other commitments, which may bind the Alliance to undertake additional transactions or activities in the future. In addition, the Alliance has agreed to guarantee a portion of the outstanding indebtedness of a joint venture. Management estimates that the fair value of the guarantee of this debt is immaterial as of June 30, 2011.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

Healthcare Industry: Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

In March 2010, Congress adopted comprehensive health care insurance legislation, *Patient Care Protection and Affordable Care Act* and *Health Care and Education Reconciliation Act*. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens by 2019 through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

NOTE O--RENTAL INCOME UNDER OPERATING LEASES

The Alliance leases rental properties to third parties, most of whom are physician practices, for various terms, generally five years. The following is a schedule by year and in the aggregate of minimum future rental income due under noncancellable operating leases at June 30, 2011:

<u>Year Ending June 30,</u>	
2012	\$ 1,742
2013	1,219
2014	958
2015	796
2016	397
Total minimum future rentals	<u>\$ 5,112</u>

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2011 and 2010, 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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS - Continued

Investment in Joint Ventures: It is not practical to estimate the fair market value of the investments in joint ventures.

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 due to uncertainty of when these amounts may be paid. Other long-term liabilities are not discounted.

Long-Term Debt and Capital Leases: 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.

The Alliance's significant capital leases and vendor contracts were negotiated with various entities and are considered unique. It is not practicable to estimate the fair value of these obligations under current conditions. Other capital lease obligations are not significant.

The estimated fair value of the Alliance's financial instruments that have carrying values different from fair value is as follows at June 30:

	<i>2011</i>		<i>2010</i>	
	<i>Carrying Value</i>	<i>Estimated Fair Value</i>	<i>Carrying Value</i>	<i>Estimated Fair Value</i>
FINANCIAL LIABILITIES:				
Long-term debt	\$ 1,069,085	\$ 1,046,675	\$ 1,082,973	\$ 1,105,778

NOTE Q--FAIR VALUE MEASUREMENT

FASB ASC 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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE Q--FAIR VALUE MEASUREMENT - Continued

assets and liabilities in markets that are not active; or other inputs that are observable or can 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 assets and liabilities recorded at fair value on a recurring basis as of June 30, 2011 and 2010:

	<i>June 30, 2011</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>
Trading securities	\$ 333,610	\$ 164,953	\$ 135,939	\$ 32,718
Assets whose use is limited	117,170	117,170	-	-
Total assets	<u>\$ 450,780</u>	<u>\$ 282,123</u>	<u>\$ 135,939</u>	<u>\$ 32,718</u>
Fair value of derivative agreements - Note D	<u>\$ (110,732)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ (110,732)</u>
	<i>June 30, 2010</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>
Trading securities	\$ 209,644	\$ 164,510	\$ 16,526	\$ 28,608
Assets whose use is limited	177,180	177,180	-	-
Total assets	<u>\$ 386,824</u>	<u>\$ 341,690</u>	<u>\$ 16,526</u>	<u>\$ 28,608</u>
Fair value of derivative agreements - Note D	<u>\$ (134,300)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ (134,300)</u>

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 observable market-based inputs, including forward interest rate curves. The fair values of interest rate swap 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 based on observable

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE Q--FAIR VALUE MEASUREMENT - Continued

market forward interest rate curves 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, 2011 and 2010 resulted in a decrease in the fair value of the related liability of \$7,940 and \$10,085, 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.

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, 2011 and 2010:

	<i>Trading Securities</i>	<i>Derivatives, Net</i>
July 1, 2009	\$ 30,031	\$ (126,217)
Total unrealized/realized losses in the Performance Indicator, net	(1,546)	(8,607)
Purchases, issuance and settlements and other, net	1,446	524
Transfers in (out), net	(1,323)	-
June 30, 2010	28,608	(134,300)
Total unrealized/realized gains in the Performance Indicator, net	2,847	23,049
Purchases, issuance and settlements and other, net	1,263	519
June 30, 2011	\$ 32,718	\$ (110,732)

There were no changes in valuation techniques in 2011 or 2010. During 2011, as part of the transitional test of goodwill impairment, the Alliance recognized goodwill impairment of \$2,965 based primarily on the fair value of the reporting unit, utilizing the income approach. Remaining goodwill determined not to be impaired, for this specific reporting unit, is included in the Consolidated Balance Sheet at \$2,900. There were no significant assets or liabilities that were re-measured at fair value on a non-recurring basis during the fiscal year ended June 30, 2010.

NOTE R--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION

Direct expenses by functional classification are as follows for the years ended June 30:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE R--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION - Continued

	<i>2011</i>	<i>2010</i>
Healthcare services	\$ 817,397	\$ 795,725
Administrative and general	130,543	125,852
Other	9,233	8,625
	<u>\$ 957,173</u>	<u>\$ 930,202</u>

NOTE S--SUBSEQUENT EVENTS

Acquisition: Subsequent to June 30, 2011, the Alliance purchased the stock of a pharmacy provider for approximately \$6,700. The Alliance has not completed an allocation of the purchase price although it is anticipated significant intangible assets will be recognized upon such allocation.

Debt: In October 2011, the Alliance (along with BRMMC, NCH and SCCH) issued \$85,260 of Series 2011 Tax-exempt Hospital Revenue Bonds through The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the Tennessee Bonds) and \$110,580 through the Industrial Development Authority of Smyth, Virginia (the Virginia Bonds). Such bonds were issued on parity with the outstanding bond indebtedness of the Alliance as of June 30, 2011. The Bonds bear interest at a variable rate determined by a remarketing agent based upon a weekly rate period. Additionally, the Alliance issued \$15,960 of Series 2011 Taxable Bonds. NCH and SCCH were also admitted as members of the Alliance Obligated Group.

The proceeds from the Tennessee Bonds will be issued to finance certain capital acquisitions in the State of Tennessee and pay issuance costs related to these Bonds. The proceeds from the Virginia Bonds will be used to refinance \$11,200 of 2001 NCH Hospital Refunding and Improvement Revenue Bonds, finance capital acquisitions for NCH, JMH and SCCH and to pay issuance costs associated with these Bonds. The Series 2011 Taxable Bonds proceeds will be used to finance capital acquisitions of SCCH and BRMMC and pay issuance costs. The timely payment of the Tennessee and the Virginia Bonds is secured by a letter of credit which expires October 19, 2014. The Alliance also redeemed \$115,135 of the Series 2007B-1 Revenue Bonds and \$29,405 of the Series 2007B-3 Revenue Bonds.

Management further anticipates issuance of an additional \$25,000 of tax-exempt bonds for the benefit of JMH. JMH is not a member of the Mountain States Health Alliance Obligated Group.

Subsequent to June 30, 2011, JMH exercised their right to purchase a facility previously held under a capital lease for total consideration of \$16,051. \$2,093 was paid directly to the third party and the remaining \$13,958 was by assumption of a promissory note with payments through 2013. The promissory note bears interest at a variable rate of LIBOR plus 1.5%. Additionally, JMH assumed an interest rate swap in the notional amount of \$13,940. JMH pays a fixed rate of 7.46%

MOUNTAIN STATES HEALTH ALLIANCE

*Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)*

Years Ended June 30, 2011 and 2010

NOTE S--SUBSEQUENT EVENTS - Continued

and receives a variable rate of LIBOR plus 1.5%. The interest rate swap has a termination date of August 15, 2012.

Supplemental Schedules

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet (Dollars in Thousands)

June 30, 2011

	<i>Blue Ridge Medical Management *</i>	<i>Other Obligated Group Members</i>	<i>Eliminations</i>	<i>Total Obligated Group</i>	<i>Other Entities</i>	<i>Mountain States Properties</i>	<i>Eliminations</i>	<i>Total</i>
ASSETS								
CURRENT ASSETS								
Cash and cash equivalents	\$ 450	\$ 85,976	\$ -	\$ 86,426	\$ 17,023	\$ 9,319	\$ -	\$ 112,768
Current portion of investments	-	7,629	-	7,629	94,775	13,771	-	116,175
Patient accounts receivable, less estimated allowances for uncollectible accounts	4,476	96,083	-	100,559	34,052	-	-	134,611
Other receivables, net	848	13,434	-	14,282	4,552	780	-	19,614
Inventories and prepaid expenses	553	18,783	-	19,336	9,477	152	-	28,965
TOTAL CURRENT ASSETS	6,327	221,905	-	228,232	159,879	24,022	-	412,133
INVESTMENTS, less amounts required to meet current obligations	19,193	337,367	-	356,560	190,937	33,879	-	581,376
EQUITY IN AFFILIATES	139,582	387,825	(155,611)	371,796	-	-	(371,795)	-
PROPERTY, PLANT AND EQUIPMENT, net	10,696	469,613	-	480,309	258,342	58,766	-	797,418
OTHER ASSETS								
Goodwill	3,281	143,276	-	146,557	2,109	-	-	148,666
Net deferred financing, acquisition costs and other charges, less current portion	168	27,991	-	28,159	568	1,117	-	29,844
Other assets	8,467	10,154	-	18,621	7,265	2,562	-	28,448
TOTAL OTHER ASSETS	11,916	181,421	-	193,337	9,942	3,679	-	206,958
	\$ 187,714	\$ 1,598,131	\$ (155,611)	\$ 1,630,234	\$ 619,100	\$ 120,346	\$ (371,795)	\$ 1,997,885

* Management Services Organization only

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet - Continued (Dollars in Thousands)

June 30, 2011

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities	Mountain States Properties	Eliminations	Total
LIABILITIES AND NET ASSETS								
CURRENT LIABILITIES								
Accrued interest payable	\$ -	\$ 19,607	\$ -	\$ 19,607	\$ 440	\$ -	\$ -	\$ 20,047
Current portion of long-term debt and capital lease obligations	550	23,724	-	24,274	3,888	-	-	28,162
Current portion of estimated fair value of derivatives	-	92,044	-	92,044	-	10,565	-	102,609
Accounts payable and accrued expenses	3,463	66,494	-	69,957	27,645	1,217	-	98,819
Accrued salaries, compensated absences and amounts withheld	3,093	40,177	-	43,270	14,530	-	-	57,800
Payables to (receivables from) affiliates, net	11,094	(81,319)	-	(70,225)	94,632	(24,407)	-	-
Estimated amounts due to third-party payors, net	-	12,547	-	12,547	2,266	-	-	14,813
TOTAL CURRENT LIABILITIES	18,200	173,274	-	191,474	143,401	(12,625)	-	322,250
OTHER LIABILITIES								
Long-term debt and capital lease obligations, less current portion	4,923	979,774	-	984,697	56,226	-	-	1,040,923
Estimated fair value of derivatives, less current portion	-	7,783	-	7,783	-	340	-	8,123
Deferred revenue	-	19,167	-	19,167	100	-	-	19,267
Estimated professional liability self-insurance	2,285	4,494	-	6,779	2,913	-	-	9,692
Other long-term liabilities	6,695	2,402	-	9,097	5,255	-	-	14,352
TOTAL LIABILITIES	32,103	1,186,894	-	1,218,997	207,895	(12,285)	-	1,414,607
NET ASSETS								
UNRESTRICTED NET ASSETS								
Unrestricted net assets								
Mountain States Health Alliance	155,478	400,395	(155,478)	400,395	228,554	132,631	(361,185)	400,395
Noncontrolling interests in subsidiaries	-	-	-	-	171,984	-	-	171,984
TOTAL UNRESTRICTED NET ASSETS	155,478	400,395	(155,478)	400,395	400,538	132,631	(361,185)	572,379
Temporarily restricted net assets								
Mountain States Health Alliance	133	10,715	(133)	10,715	10,483	-	(10,483)	10,715
Noncontrolling interests in subsidiaries	-	-	-	-	57	-	-	57
TOTAL TEMPORARILY RESTRICTED NET ASSETS	133	10,715	(133)	10,715	10,540	-	(10,483)	10,772
Permanently restricted net assets	-	127	-	127	127	-	(127)	127
TOTAL NET ASSETS	155,611	411,237	(155,611)	411,237	411,205	132,631	(371,795)	583,278
	\$ 187,714	\$ 1,598,131	\$ (155,611)	\$ 1,630,234	\$ 619,100	\$ 120,346	\$ (371,795)	\$ 1,997,885

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Operations (Dollars in Thousands)

Year Ended June 30, 2011

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities	Mountain States Properties	Eliminations	Total
Revenue, gains and support:								
Net patient service revenue	\$ 35,353	\$ 683,224	\$ (1,702)	\$ 716,875	\$ 243,487	\$ -	\$ (108)	\$ 960,254
Other operating revenue	26,855	3,657	(20,748)	9,764	39,423	7,807	(41,123)	15,871
Equity in net gain (loss) of affiliates	974	(3,283)	2,051	(258)	-	-	258	-
TOTAL REVENUE, GAINS AND SUPPORT	63,182	683,598	(20,399)	726,381	282,910	7,807	(40,973)	976,125
Expenses:								
Salaries and wages	17,287	235,564	-	252,851	92,108	150	(2,901)	342,208
Physician salaries and wages	32,631	1,010	-	33,641	55,417	-	(29,809)	59,249
Contract labor	866	3,234	-	4,100	2,123	-	(259)	5,964
Employee benefits	4,874	45,591	(1,743)	48,722	20,414	35	(2,032)	67,139
Fees	3,544	81,194	(20,612)	64,126	22,251	713	(1,171)	85,919
Supplies	1,745	129,126	-	130,871	38,594	2	(105)	169,362
Utilities	455	11,386	-	11,841	4,452	1,007	-	17,300
Other	4,778	38,479	(95)	43,162	28,206	3,230	(4,951)	69,647
Depreciation	1,476	59,635	-	61,111	23,666	2,722	-	87,499
Amortization	23	2,188	-	2,211	348	-	-	2,559
Estimated provision for bad debts	353	4,097	-	4,450	1,724	-	-	6,174
Interest and taxes	(1,228)	42,204	-	40,976	3,248	1,374	(1,445)	44,153
TOTAL EXPENSES	66,804	653,708	(22,450)	698,062	292,551	9,233	(42,673)	957,173
OPERATING INCOME (LOSS)	(3,622)	29,890	2,051	28,319	(9,641)	(1,426)	1,700	18,952
Nonoperating gains (losses):								
Interest and dividend income	662	9,810	-	10,472	6,552	645	(1,445)	16,224
Net realized gains on the sale of securities	73	1,449	-	1,522	435	-	-	1,957
Net unrealized gains on securities	1,311	13,664	-	14,975	7,949	(756)	-	22,168
Derivative related income	-	3,512	-	3,512	-	1,560	-	5,072
Change in estimated fair value of derivatives	-	23,137	-	23,137	-	(88)	-	23,049
Other nonoperating gains (losses)	(475)	1,245	-	770	(3,430)	4	3	(2,653)
Net assets released from restrictions used for operations	-	562	-	562	1,331	-	-	1,893
NET NONOPERATING GAINS	1,571	53,379	-	54,950	12,837	1,365	(1,442)	67,710
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	\$ (2,051)	\$ 83,269	\$ 2,051	\$ 83,269	\$ 3,196	\$ (61)	\$ 258	\$ 86,662

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Changes in Net Assets (Dollars in Thousands)

Year Ended June 30, 2011

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities		Total Other Entities	Mountain States Properties	Eliminations	Total
					Mountain States Health Alliance	Noncontrolling Interests				
UNRESTRICTED NET ASSETS:										
Excess of Revenue, Gains and Support over										
Expenses and Losses	\$ (2,051)	\$ 83,269	\$ 2,051	\$ 83,269	\$ (197)	\$ 3,393	\$ 3,196	\$ (61)	\$ 258	\$ 86,662
Pension and other defined benefit plan adjustments	-	620	-	620	620	617	1,237	-	(620)	1,237
Cumulative effect of a change in accounting principle	(2,965)	(2,965)	2,965	(2,965)	-	-	-	-	-	(2,965)
Net assets released from restrictions used for the purchase of property, plant and equipment	-	1,946	-	1,946	1,946	-	1,946	-	(1,946)	1,946
Distributions to noncontrolling interests	-	-	-	-	-	(270)	(270)	-	-	(270)
Repurchases of noncontrolling interests and other	(43)	40	43	40	(182)	(115)	(297)	-	182	(75)
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	(5,059)	82,910	5,059	82,910	2,187	3,625	5,812	(61)	(2,126)	86,535
TEMPORARILY RESTRICTED NET ASSETS:										
Restricted grants and contributions	-	3,612	-	3,612	2,990	58	3,048	-	(2,990)	3,670
Net assets released from restrictions	-	(3,787)	-	(3,787)	(3,225)	(52)	(3,277)	-	3,225	(3,839)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	-	(175)	-	(175)	(235)	6	(229)	-	235	(169)
INCREASE (DECREASE) IN TOTAL NET ASSETS	(5,059)	82,735	5,059	82,735	1,952	3,631	5,583	(61)	(1,891)	86,366
NET ASSETS, BEGINNING OF YEAR	160,670	328,502	(160,670)	328,502	237,212	168,410	405,622	132,692	(369,904)	496,912
NET ASSETS, END OF YEAR	\$ 155,611	\$ 411,237	\$ (155,611)	\$ 411,237	\$ 239,164	\$ 172,041	\$ 411,205	\$ 132,631	\$ (371,795)	\$ 583,278

*Management Services Organization only.

MOUNTAIN STATES HEALTH ALLIANCE

Note to Supplemental Schedules

Year Ended June 30, 2011

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. In accordance with Article Six, Section 6.6 of the Amended and Restated Master Trust Indenture between Mountain States Health Alliance and the Bank of New York Trust Company, NA as Master Trustee, those members pledged 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 and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group (Obligated Group).

The supplemental consolidating schedules include the accounts of the members of the Obligated Group after elimination of all significant intergroup accounts and transactions. Certain other subsidiaries of the Alliance, Mountain States Properties, Inc. (MSP) and all other affiliates (Other Entities), 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.

MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Schedules)

Years Ended June 30, 2012 and 2011



MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Schedules)

Years Ended June 30, 2012 and 2011

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited the accompanying consolidated balance sheets of Mountain States Health Alliance and subsidiaries (the Alliance) as of June 30, 2012 and 2011 and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Alliance's management. 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 of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing 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 over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe our audits provide a reasonable basis for our 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 subsidiaries as of June 30, 2012 and 2011 and the results of their operations, changes in net assets and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplemental information as listed in the accompanying index 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 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 financial statements as a whole.

Knoxville, Tennessee
October 26, 2012

Pershing Yoakley & Associates PC

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets
(Dollars in Thousands)

	<i>June 30,</i>	
	<i>2012</i>	<i>2011</i>
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 65,107	\$ 112,768
Current portion of investments - Note C	36,557	116,175
Patient accounts receivable, less estimated allowances for uncollectible accounts of \$52,911 in 2012 and \$53,366 in 2011	150,690	134,611
Other receivables, net	23,008	19,614
Inventories and prepaid expenses	28,810	28,965
TOTAL CURRENT ASSETS	304,172	412,133
INVESTMENTS, less amounts required to meet current obligations	560,697	581,376
PROPERTY, PLANT AND EQUIPMENT, net	865,456	797,418
OTHER ASSETS		
Goodwill	154,391	148,666
Net deferred financing, acquisition costs and other charges	28,187	29,844
Other assets	28,144	28,448
TOTAL OTHER ASSETS	210,722	206,958

\$ 1,941,047 \$ 1,997,885

	<i>June 30,</i>	
	2012	2011
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	\$ 18,525	\$ 20,047
Current portion of long-term debt and capital lease obligations	32,477	28,162
Current portion of estimated fair value of derivatives - Note D	10,395	102,609
Accounts payable and accrued expenses	108,870	98,819
Accrued salaries, compensated absences and amounts withheld	55,589	57,800
Estimated amounts due to third-party payors, net	18,060	14,813
TOTAL CURRENT LIABILITIES	243,916	322,250
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	1,048,098	1,040,923
Estimated fair value of derivatives, less current portion	8,986	8,123
Deferred revenue	3,134	19,267
Estimated professional liability self-insurance	9,344	9,692
Other long-term liabilities	16,822	14,352
TOTAL LIABILITIES	1,330,300	1,414,607
COMMITMENTS AND CONTINGENCIES - Notes D, F, G, and N		
NET ASSETS		
Unrestricted net assets		
Mountain States Health Alliance	436,388	400,395
Noncontrolling interests in subsidiaries	162,959	171,984
TOTAL UNRESTRICTED NET ASSETS	599,347	572,379
Temporarily restricted net assets		
Mountain States Health Alliance	11,223	10,715
Noncontrolling interests in subsidiaries	50	57
TOTAL TEMPORARILY RESTRICTED NET ASSETS	11,273	10,772
Permanently restricted net assets	127	127
TOTAL NET ASSETS	610,747	583,278
	\$ 1,941,047	\$ 1,997,885

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	2012	2011
Revenue, gains and support:		
Patient service revenue, net of contractual allowances and discounts	\$ 1,075,050	\$ 1,062,123
Provision for bad debts	(122,917)	(116,248)
Net patient service revenue	<u>952,133</u>	<u>945,875</u>
Other operating revenue	39,407	24,868
TOTAL REVENUE, GAINS AND SUPPORT	991,540	970,743
Expenses:		
Salaries and wages	358,607	342,208
Physician salaries and wages	65,706	59,249
Contract labor	6,375	5,964
Employee benefits	69,600	67,139
Fees	97,959	85,919
Supplies	170,186	168,261
Utilities	17,289	17,300
Other	76,285	69,647
Depreciation	73,060	87,499
Amortization	2,245	2,559
Interest and taxes	45,903	44,153
TOTAL EXPENSES	983,215	949,898
OPERATING INCOME	8,325	20,845
Nonoperating gains (losses):		
Interest and dividend income	15,213	16,224
Net realized gains (losses) on the sale of securities	(2,595)	1,957
Change in net unrealized gains on securities	(2,884)	22,168
Derivative related income	7,515	5,072
Loss on early extinguishment of debt - Note F	(2,636)	-
Change in estimated fair value of derivatives	(6,198)	23,049
Other nonoperating gains (losses)	11,236	(2,653)
NET NONOPERATING GAINS	19,651	65,817
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	\$ 27,976	\$ 86,662

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

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

Year Ended June 30, 2012

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
UNRESTRICTED NET ASSETS:			
Excess (Deficit) of Revenue, Gains and Support over Expenses and Losses	\$ 31,702	\$ (3,726)	\$ 27,976
Pension and other defined benefit plan adjustments	(1,119)	(1,115)	(2,234)
Net assets released from restrictions used for the purchase of property, plant and equipment	1,550	-	1,550
Distributions to noncontrolling interests	-	(324)	(324)
Repurchases of noncontrolling interests	3,860	(3,860)	-
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	35,993	(9,025)	26,968
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	3,860	39	3,899
Net assets released from restrictions	(3,352)	(46)	(3,398)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	508	(7)	501
INCREASE (DECREASE) IN TOTAL NET ASSETS	36,501	(9,032)	27,469
NET ASSETS, BEGINNING OF YEAR	411,237	172,041	583,278
NET ASSETS, END OF YEAR	\$ 447,738	\$ 163,009	\$ 610,747

MOUNTAIN STATES HEALTH ALLIANCE

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

Year Ended June 30, 2011

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	\$ 83,269	\$ 3,393	\$ 86,662
Pension and other defined benefit plan adjustments	620	617	1,237
Cumulative effect of a change in accounting principle - Note B	(2,965)	-	(2,965)
Net assets released from restrictions used for the purchase of property, plant and equipment	1,946	-	1,946
Distributions to noncontrolling interests	-	(270)	(270)
Repurchases of noncontrolling interests and other	40	(115)	(75)
INCREASE IN UNRESTRICTED NET ASSETS	82,910	3,625	86,535
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	3,612	58	3,670
Net assets released from restrictions	(3,787)	(52)	(3,839)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	(175)	6	(169)
INCREASE IN TOTAL NET ASSETS	82,735	3,631	86,366
NET ASSETS, BEGINNING OF YEAR	328,502	168,410	496,912
NET ASSETS, END OF YEAR	\$ 411,237	\$ 172,041	\$ 583,278

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2012</i>	<i>2011</i>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase in net assets	\$ 27,469	\$ 86,366
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	75,777	90,472
Loss on early extinguishment of debt	2,636	-
Cumulative effect of a change in accounting principle	-	2,965
Change in estimated fair value of derivatives	6,198	(23,049)
Equity in net income of joint ventures, net	(979)	(898)
Loss (gain) on disposal of assets	446	(367)
Amounts received on interest rate swap settlements	(7,515)	(5,072)
Gain on escrow restructuring - Note F	(5,337)	-
Income recognized through forward sale agreements	(864)	(864)
Gain on termination of swaption and forward sale agreements - Note D	(7,766)	-
Capital Appreciation Bond accretion and other	3,159	2,738
Restricted contributions	(3,899)	(3,670)
Pension and other defined benefit plan adjustments	2,234	(1,237)
Increase (decrease) in cash due to change in:		
Patient accounts receivable	(16,079)	(9,031)
Other receivables, net	(3,501)	(2,802)
Inventories and prepaid expenses	155	(643)
Trading securities	21,646	(123,966)
Other assets	(2,733)	(3,632)
Accrued interest payable	(1,522)	4,008
Accounts payable and accrued expenses	4,131	2,741
Accrued salaries, compensated absences and amounts withheld	(2,211)	11,361
Estimated amounts due to third-party payors, net	3,247	4,658
Other long-term liabilities	236	2,961
Estimated professional liability self-insurance	(348)	151
Total adjustments	<u>67,111</u>	<u>(53,176)</u>
NET CASH PROVIDED BY OPERATING ACTIVITIES	94,580	33,190
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property, plant and equipment	(132,890)	(172,786)
Additions to goodwill	(5,725)	(279)
Net decrease in assets limited as to use	85,947	81,383
Purchases of held-to-maturity securities	(9,516)	(41,060)
Net distribution from joint ventures and unconsolidated affiliates	882	1,057
Proceeds from sale of property, plant and equipment	<u>1,881</u>	<u>812</u>
NET CASH USED IN INVESTING ACTIVITIES	(59,421)	(130,873)

	<i>Year Ended June 30,</i>	
	<i>2012</i>	<i>2011</i>
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt and capital lease obligations, including deposits to escrow	(71,997)	(37,735)
Payment of acquisition and financing costs	(2,742)	(1,716)
Proceeds from issuance of long-term debt and other financing arrangements	67,451	5,954
Payment on termination of swaption	(93,353)	-
Gain on escrow restructuring	5,337	-
Net amounts received on interest rate swap settlements	7,515	5,072
Restricted contributions received	4,969	4,350
NET CASH USED IN FINANCING ACTIVITIES	<u>(82,820)</u>	<u>(24,075)</u>
NET DECREASE IN CASH AND CASH EQUIVALENTS	(47,661)	(121,758)
CASH AND CASH EQUIVALENTS, beginning of year	112,768	234,526
CASH AND CASH EQUIVALENTS, end of year	<u>\$ 65,107</u>	<u>\$ 112,768</u>

SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:

Cash paid for interest	<u>\$ 41,168</u>	<u>\$ 39,507</u>
Cash paid for federal and state income taxes	<u>\$ 336</u>	<u>\$ 739</u>
Construction related payables in accounts payable and accrued expenses	<u>\$ 6,821</u>	<u>\$ 11,384</u>
Property acquired through capital lease arrangement	<u>\$ 13,959</u>	<u>\$ 15,951</u>
Payable on termination of forward sale agreements in accounts payable and accrued expenses	<u>\$ 13,429</u>	<u>\$ -</u>
Land held for expansion placed in use	<u>\$ 1,610</u>	<u>\$ 4,904</u>

During the year ended June 30, 2012, the Alliance refinanced previously issued debt of \$174,547.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements (Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE A--ORGANIZATION AND OPERATIONS

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The initial funds for the establishment of the Alliance in 1945 were provided by individuals and various institutions. Membership of the Alliance consists of individuals and institutions who have contributed at least \$100 to the capital fund of the Alliance and are entitled to vote at the annual election of the Board of Directors.

The primary operations of the Alliance consist of ten acute and specialty care hospitals, as follows:

- Johnson City Medical Center (JCMC) - licensed for 658 beds
- Indian Path Medical Center (IPMC) - licensed for 261 beds
- Smyth County Community Hospital (SCCH) - licensed for 153 beds
- Norton Community Hospital (NCH) - licensed for 129 beds
- Sycamore Shoals Hospital (SSH) - licensed for 121 beds
- Johnston Memorial Hospital (JMH) - licensed for 116 beds
- Franklin Woods Community Hospital (FWCH) - licensed for 80 beds
- Russell County Medical Center (RCMC) - licensed for 78 beds
- Dickenson Community Hospital (DCH) - licensed for 25 beds
- Johnson County Community Hospital (JCCH) - licensed for 2 beds

The Alliance has a 50.1% interest in JMH. JMH is also the sole member of Abingdon Physician Partners (APP), a non-taxable corporation that owns and manages physician practices.

The Alliance has a 50.1% interest in NCH. NCH is also the sole member or shareholder of DCH and Norton Community Physician Services, LLC (NCPS), a taxable corporation that consists of physician practices and a pharmacy and; Community Home Care (CHC), a taxable corporation that provides home medical equipment.

The Alliance has an 80% interest in SCCH. SCCH is the sole shareholder of Southwest Community Health Services, Inc. (SWCH), a taxable entity that operates a pharmacy and provides other health services.

The activities and accounts of JMH, NCH and SCCH are included in the accompanying consolidated financial statements.

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices and provides other healthcare services to patients in Tennessee and Virginia. BRMM also operates as a medical office real estate developer by

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE A--ORGANIZATION AND OPERATIONS - Continued

owning, selling and leasing real estate to physician practices and other entities. BRMM is either the sole shareholder, a significant shareholder, or member of the following organizations:

Mountain States Physician Group, Inc. (MSPG): A company that contracts with physicians to provide services to BRMM physician practices.

Mountain States Properties, Inc. (MSPI): An entity that owns and manages certain real estate (primarily medical office buildings) and provides rehabilitation and fitness services. In addition, MSPI is counter-party to an interest rate swap.

Mediserve Medical Equipment of Kingsport, Inc. (Mediserve): A company that provides durable medical equipment services.

Kingsport Ambulatory Surgery Center (KASC) (d.b.a. Kingsport Day Surgery): A joint venture operating as an outpatient surgery center which performs procedures primarily in otolaryngology, orthopedics, ophthalmology, and general surgery. BRMM has a 43% ownership of KASC and maintains control over KASC through a management agreement. The accounts and activities of KASC are included in the accompanying consolidated financial statements.

Piney Flats Urgent Care (PFUC): A for-profit entity that provides urgent care patient services. BRMM has a 75% ownership of PFUC. The accounts and activities of PFUC are included in the accompanying consolidated financial statements.

Wilson Pharmacy, Inc. (Wilson): In August 2012, BRMM acquired Wilson, a Company that owns and operates retail pharmacies. BRMM purchased 100% of the total issued and outstanding capital stock of Wilson for \$8,114 and recognized goodwill of \$5,725.

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc. (MSF), a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance. The Alliance is also the beneficiary of the Mountain States Health Alliance Auxiliary (Auxiliary), a not-for-profit organization formed to coordinate volunteer activities of the Alliance. The activities and accounts of MSF and the Auxiliary are included in the accompanying consolidated financial statements.

The Alliance is a majority shareholder of Integrated Solutions Health Network, LLC (ISHN). The primary function of ISHN is to establish, operate and administer a provider-sponsored health care delivery network. The accounts and activities of ISHN are included in the accompanying consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation: The accompanying consolidated financial statements include the accounts of the Alliance and its subsidiaries after elimination of all significant intercompany accounts and transactions. The Alliance classifies those activities directly associated with its mission of providing healthcare services, as well as other activities deemed significant to its operations, as operating activities.

Noncontrolling Interests in Subsidiaries: The Alliance's accompanying consolidated financial statements include all assets, liabilities, revenues, expenses, and changes in net assets, including amounts attributable to the noncontrolling interest. Noncontrolling interests represent the portion of equity (net assets) into a subsidiary not attributable, directly or indirectly, to the Alliance. For the years ending June 30, 2012 and 2011, the Alliance attributed an Excess (Deficit) of Revenue, Gains and Support over Expenses and Losses of (\$3,726) and \$3,393, respectively, to the noncontrolling interests in JMH, NCH, SCCH, KASC, PFUC and ISHN based on the noncontrolling interests' respective ownership percentage.

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 on the Consolidated Balance Sheets.

Investments: Investments as reported in the Consolidated Balance Sheets include trading securities, held-to-maturity securities and assets limited as to use (Note C). The Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958-320, *Investments – Debt and Equity Securities*, allows not-for-profit organizations to report in a manner similar to business entities by identifying securities as available-for-sale or held-to-maturity and to exclude the unrealized gains and losses on those securities from the Performance Indicator (as defined below). Investments which the Alliance has the positive intent and ability to hold to maturity are considered as held-to-maturity. Substantially all other investments are considered as trading securities. Management annually evaluates the held-to-maturity investment portfolio and recognizes any "other-than-temporary" losses as deductions from the Performance Indicator. Management's evaluation considers the amount of decline in fair value, as well as the time period of any such decline.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Management does not believe any investment classified as held-to-maturity is other-than-temporarily impaired at June 30, 2012.

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 pursuant to FASB ASC 825, *Financial Instruments*. Guaranteed investment contracts are reported at contract value.

Realized gains and losses on trading securities and assets limited as to use are computed using the specific identification method for cost determination. Interest and dividend income is reported net of related investment fees.

Investments in joint ventures are reported under the equity method of accounting, which approximates the Alliance's equity in the underlying net book value, unless the ownership structure requires consolidation. Other assets include investments in joint ventures of \$2,153 and \$2,367 at June 30, 2012 and 2011, respectively.

Inventories: Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

the carrying amount of the asset, a write-down to estimated fair value is recorded. The Alliance did not recognize any impairment losses during 2012 and 2011.

Other assets include property held for resale and property held for expansion of \$2,620 and \$4,230, respectively, at June 30, 2012 and 2011. During 2012, property held for expansion totaling approximately \$1,610 was transferred to property, plant and equipment in conjunction with the construction of a replacement facility for SCCH. During 2011, property held for expansion totaling approximately \$4,904 was transferred to property, plant and equipment in conjunction with the construction of FWCH. Property held for resale and property held for expansion primarily represent 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 2012 and 2011.

Goodwill: Goodwill represents the difference between the acquisition cost of assets and the estimated fair value of net tangible and any separately identified intangible assets. Effective July 1, 2010, the Alliance adopted ASC 350, *Intangibles – Goodwill and Other*, which requires goodwill to be evaluated for impairment at least annually. Upon adoption of ASC 350, the Alliance was required to perform a transitional impairment test. As a result of this testing, management determined that as of July 1, 2010 approximately \$2,965 of goodwill associated with one of its reporting units was impaired, and such impairment has been reflected as the Cumulative Effect of a Change in Accounting Principle in the 2011 Consolidated Statement of Changes in Net Assets.

In September 2011, the FASB issued Accounting Standards Update (ASU) 2011-08 which allows entities to use a qualitative approach to determine whether the fair value of a reporting unit is more likely than not impaired. The Alliance early adopted the provisions of this ASU and, based upon this qualitative analysis, management does not believe it is more likely than not that goodwill associated with any of its reporting units is impaired as of June 30, 2012. The reporting unit for evaluation of substantially all such goodwill is the Alliance's aggregate acute-care operations.

Deferred Financing, Acquisition Costs and Other Charges: Other assets, including deferred financing, acquisition costs and other charges, total \$28,187 and \$29,844 at June 30, 2012 and 2011, respectively. Deferred financing costs are amortized over the life of the respective bond issue principally using the average bonds outstanding method. Other intangible assets include licenses and similar assets and are being amortized over the intangible's estimated useful life under the straight-line method.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Prior to 2009, the Alliance routinely financed interest rate swap and other derivative transaction issuance costs through modification of future settlement terms. As such, the unamortized issuance costs of these derivatives are included as deferred financing costs in the accompanying Consolidated Balance Sheets and are being amortized over the term of the respective derivative instrument. The unpaid issuance costs are included as a part of the estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. Subsequent to 2009, interest rate swap and derivative transaction issuance costs were expensed as incurred.

Derivative Financial Instruments: As further described in Note D, the Alliance is a party to interest rate swap and other derivative agreements. 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. Changes in the estimated fair value of these derivatives are included in the Consolidated Statements of Operations as part of nonoperating gains (losses). Net settlements and other related income of derivatives are also reflected as a part of the Performance Indicator (described below).

These fair values are based on the estimated amount the Alliance would receive, or be required to pay, to enter into equivalent agreements at the valuation date and include an estimated credit value adjustment. The fair value of various derivatives are netted on the Consolidated Balance Sheets based on management's evaluation of the settlement provisions in the master contract. Gross positions of these derivatives are disclosed in Note D. Due to the nature of these financial instruments, such estimates of fair value are subject to significant change in the near term.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims (Note G) 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 payors. 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 payors emphasize revenue recognition only when collections are reasonably assured.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

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. 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 his or her 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. The estimated direct and indirect cost of providing these services totaled approximately \$24,709 and \$18,158 in 2012 and 2011, respectively. Such costs are determined using a ratio of cost to charges analysis with indirect cost allocated under a reasonable and systematic approach.

In addition to the charity care services described above, 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 (Deficit) 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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

caption *Excess (Deficit) 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, pension and related adjustments, and distributions to, or contributions from, owners 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. Taxable entities account for income taxes in accordance with FASB ASC 740, *Income Taxes* (Note L). The Alliance has no significant uncertain tax positions at June 30, 2012 and 2011.

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 Consolidated Statements of 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 nonoperating gains (losses) in the Consolidated Statements of Operations. Permanently restricted net assets have been restricted by donors to be maintained by the Alliance in perpetuity.

Fair Value Measurement: The Alliance had previously adopted FASB ASC 820, *Fair Value Measurements and Disclosures*, which defines fair value, establishes a framework for measuring fair value under generally accepted accounting principles and expands disclosures about fair value measurements.

Subsequent Events: The Alliance evaluated all events or transactions that occurred after June 30, 2012, through October 26, 2012, 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, 2012 consolidated financial statements, other than as discussed in Notes D and S.

New Accounting Pronouncements: In July 2011, the FASB issued ASU 2011-07, *Healthcare Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and Allowance for Doubtful Accounts for Certain Healthcare Entities*, which requires certain healthcare entities reclassify the provision for bad debts associated with providing patient care from an operating expense to a deduction from net patient service revenue in the Consolidated

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Statements of Operations. Additionally, ASU 2011-07 requires enhanced disclosures about an entity's policies for recognizing revenue and assessing bad debts and qualitative and quantitative information about changes in the allowance for doubtful accounts. The Alliance retroactively adopted ASU 2011-07 in fiscal year 2012. The adoption of ASU 2011-07 did not have a material impact on the 2012 or 2011 consolidated financial statements.

In August 2010, the FASB issued ASU 2010-24, *Health Care Entities – Presentation of Insurance Claims and Related Insurance Recoveries* (ASU 2010-24). The amendments in ASU 2010-24 clarify that a healthcare entity may not net insurance recoveries against related claim liabilities. In addition, the amount of the claim liability must be determined without consideration of insurance recoveries. The Alliance adopted ASU 2010-24 prospectively during 2012. The adoption of ASU 2010-24 did not have a material impact on the consolidated financial statements.

In August 2010, the FASB issued ASU 2010-23, *Health Care Entities – Measuring Charity Care for Disclosure*. ASU 2010-23 is intended to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care. ASU 2010-23 requires that cost, identified as the direct and indirect costs of providing the charity care, be used as the measurement basis for disclosure purposes. ASU 2010-23 also requires disclosure of the method used to identify or determine such costs. The Alliance adopted ASU 2010-23 in 2012. The adoption of ASU 2010-23 did not have a material impact on the consolidated financial statements.

Reclassifications: Certain 2011 amounts have been reclassified to conform with the 2012 presentation in the accompanying consolidated financial statements.

NOTE C--INVESTMENTS

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

	<u>2012</u>		<u>2011</u>
Designated or restricted:			
Under safekeeping agreements and other	\$ 24,026	\$	28,349
Under guarantee agreements	-		92,720
By Board for capital improvements	4		4

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE C--INVESTMENTS - Continued

	<u>2012</u>	<u>2011</u>
Under bond indenture agreements:		
For debt service and interest payments	77,602	67,874
For capital acquisitions	29,578	28,835
	<u>131,210</u>	<u>217,782</u>
Less: amount required to meet current obligations	<u>(36,557)</u>	<u>(116,175)</u>
	<u>\$ 94,653</u>	<u>\$ 101,607</u>

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

	<u>2012</u>	<u>2011</u>
Cash, cash equivalents and money market funds	\$ 80,304	\$ 115,579
U.S. Government securities	8,582	1,795
U.S. Agency securities	40,398	7,688
Municipal obligations	1,926	-
Guaranteed investment contract	-	92,720
	<u>\$ 131,210</u>	<u>\$ 217,782</u>

Trading securities consist of the following at June 30:

	<u>2012</u>	<u>2011</u>
Cash, cash equivalents and money market funds	\$ 5,186	\$ 29,159
U.S. Government securities	10,697	9,409
U.S. Agency securities	26,165	31,551
Corporate and foreign bonds	52,581	32,895
Municipal obligations	961	451
Preferred and asset backed securities	11,183	8,945
U.S. equity securities	28,344	21,774
Mutual funds	141,968	166,708
Other	34,880	32,718
	<u>\$ 311,965</u>	<u>\$ 333,610</u>

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE C--INVESTMENTS - Continued

	<u>2012</u>	<u>2011</u>
Cash, cash equivalents and money market funds	\$ 298	\$ 753
Corporate and foreign bonds	138,232	135,745
Municipal obligations	15,549	9,661
	<u>\$ 154,079</u>	<u>\$ 146,159</u>

Held-to-maturity securities had gross unrealized gains and losses of \$11,432 and \$33, respectively, at June 30, 2012 and \$6,838 and \$276, respectively at June 30, 2011. At June 30, 2012, the Alliance held no securities within the held-to-maturity portfolio which had been at an unrealized loss position for over one year. At June 30, 2011, the Alliance held nine securities within the held-to-maturity portfolio with a fair value and unrealized loss of \$549 and \$44, respectively, which had been at an unrealized loss position for over one year. At June 30, 2012, the contractual maturities of held-to-maturity securities were \$11,225 due in one year or less, \$67,532 due from one to five years and \$75,322 due after five years. At June 30, 2011, the contractual maturities of held-to-maturity securities were \$13,816 due in one year or less, \$55,563 due from one to five years and \$76,780 due after five years.

At June 30, 2012 and 2011, the Alliance held investments in certain limited partnerships and hedge funds of \$34,880 and \$32,718, respectively, that have a wide range of investment strategies with various levels of risk. These funds are included within trading securities and do not have readily determinable fair values. The funds are reported at estimated fair market value pursuant to FASB ASC 825, *Financial Instruments*.

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is a party to a number of derivative transactions. These derivatives have not been designated as hedges and are valued at estimated fair value in the accompanying Consolidated Balance Sheets. Management's primary objective in holding such derivatives is to introduce a variable rate component into its fixed rate debt structure. Under the terms of these agreements, changes in the interest rate environment could have a significant effect on the Alliance.

These derivative agreements require that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. Such investments are included as assets limited as to use. As of June 30, 2012, management believes the Alliance was fully collateralized with respect to the derivative agreements and management does not believe such collateral is exposed to third-party credit risk.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE D--DERIVATIVE TRANSACTIONS - Continued

Interest Rate Swaps: The Alliance is a party to six interest rate swap agreements with Bank of America, Merrill Lynch as the counterparty. The terms of five of these agreements were modified without settlement during 2011. No gain or loss was realized as a result of the modifications although such modifications did impact the estimated fair value of the interest rate swaps. A liability, representing the estimated net fair value of these swaps, of \$8,765 and \$8,123 was recognized by the Alliance as of June 30, 2012 and 2011, respectively.

The following is a summary of five of these interest rate swap agreements at June 30, 2012:

<i>Swap</i>	<i>Notional Amount</i>	<i>Term</i>	<i>Payments by:</i>		<i>Estimated Fair Value</i>
			<i>Counterparty</i>	<i>Alliance</i>	
A	\$ 170,000	4/2008-4/2026	1.265% through April 2013; 1.07% through April 2014; then 71.10% of USD-ISDA Swap Rate	0.00% through April 2014, then USD-SIFMA	\$ 3,500
B	95,000	4/2008-4/2026	1.265% through April 2013; 1.08% through April 2014; then 71.18% of USD-ISDA Swap Rate	0.00% through April 2014, then USD-SIFMA	1,983
C	173,030	4/2008-4/2034	1.315% through April 2013; 1.12% through April 2014; then 72.35% of USD-ISDA Swap Rate	0.00% through April 2014, then USD-SIFMA	(513)
D	82,055	12/2007-7/2033	3.493% through July 2012; then 0% USD-LIBOR-BBA through July 2012, then 67% USD- LIBOR-BBA	4.41% through July 2012; then .312% USD-SIFMA	(9,520)
E	50,000	2/2008-7/2038	67.00% of USD-LIBOR-BBA plus .145%	USD-SIFMA	(3,895)

Deferred financing and acquisition costs, net of amortization, include \$6,135 and \$6,480 at June 30, 2012 and 2011, respectively, related to these swaps.

In addition to the interest rate swaps described above, the Alliance and Bank of America, Merrill Lynch are also parties to a total return swap. The notional amount of the total return swap is equal to the outstanding 2001A Hospital Revenue and Improvement Bonds which was \$22,300 at June 30, 2012. The estimated fair value of the total return swap was \$(320) and \$(340) at June 30, 2012 and 2011, respectively. The terms of the swap were modified without settlement during 2012. No gain or loss was realized as a result of the modifications although such modifications did impact the swap's estimated fair value. The payment terms, as amended consist of the following:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE D--DERIVATIVE TRANSACTIONS - Continued

- Beginning July 1, 2012, the Alliance will pay a variable rate of USD-SIFMA plus basis points ranging from 65 to 400, depending on the Alliance's bond rating as set forth by Standard and Poor's Ratings Service and Moody's Investors Service. The Alliance will receive a fixed rate of 4.50% and settlements will be made semi-annually through July 1, 2015.
- A "total return provision" under which the Alliance will pay (or receive) an amount equal to the product of the outstanding 2001A Reference Bonds multiplied by the difference between the outstanding 2001A Reference Bonds and the 2001A Reference Bonds' market price at termination, as defined in the agreement.

In addition to the six interest rate swaps discussed above, the Alliance is also a party to an interest rate swap with Regions Bank (the Regions swap) and an interest rate swap with First Tennessee Bank National Association (the FTB swap). The Regions swap was entered into in July 2011 and terminates in August 2012. The FTB swap was entered into in June 2010 and terminates in July 2015. The notional amounts of the Regions swap and FTB swap were \$13,727 and \$5,524, respectively, at June 30, 2012. A liability, representing the estimated net fair value of these swaps, of \$221 was recognized by the Alliance as of June 30, 2012. The estimated fair value of the FTB swap was not significant at June 30, 2011.

The Alliance was previously a party to a total return swap with Lehman Brothers as the counterparty. Lehman Brothers filed for bankruptcy in September 2008. The Alliance subsequently received notification from Lehman Brothers Special Financing, Inc. indicating the intent of the counterparty to terminate this agreement effective January 1, 2009. The Alliance and Lehman Brothers Special Financing, Inc. were unable to reach a settlement agreement at the time the swap was terminated.

An estimated liability related to the agreement of \$10,395 and \$10,565 was recognized by the Alliance at June 30, 2012 and 2011. In addition, a third party holds investments with a fair market value of approximately \$13,809 and \$13,381, respectively, at June 30, 2012 and 2011 as collateral. The collateral and estimated liability related to this agreement are classified as current in the accompanying Consolidated Balance Sheets.

At June 30, 2012, the parties were undergoing alternate dispute resolution, including non-binding arbitration. Subsequent to year end, the parties reached a tentative settlement agreement. In full settlement of the liability, the Alliance will pay the counterparty \$7,375 from the funds held as collateral and the remaining collateral will be returned to the Alliance.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE D--DERIVATIVE TRANSACTIONS - Continued

Interest Rate Swap Option: In June 2004, the Alliance entered into an agreement with Bear Stearns (acquired by JP Morgan) whereby Bear Stearns purchased from the Alliance an option to enter into an interest rate swap agreement (swaption) with the Alliance beginning July 1, 2011, which is an optional redemption date related to the Alliance's early extinguished 2000A and 2000B Bonds (Note F). The purpose of this agreement was to effectively sell the call features related to the early extinguished Series 2000A and 2000B Bonds. As consideration under this agreement, the Alliance received a total of \$42,500 in upfront payments as the swaption premium. Such amounts were initially recorded as estimated fair value of derivatives in the Consolidated Balance Sheets.

During 2012, the counterparty expressed their intent to exercise the swaption on January 1, 2012 and the Alliance exercised its right to terminate the swaption at its fair market value. The swaption was terminated on October 13, 2011. To effectuate the termination, the Alliance transferred \$93,353 of a Guaranteed Investment Contract (GIC), described below, to the third party as a termination payment. A gain of \$3,058 was recognized on the termination, which is included within other nonoperating gains (losses) in the accompanying 2012 Consolidated Statement of Operations.

A liability of \$92,044, representing the estimated fair value of the swaption at June 30, 2011, respectively, is included in estimated fair value of derivatives in the accompanying 2011 Consolidated Balance Sheet. The change in estimated fair value of derivatives in the accompanying Consolidated Statements of Operations for 2012 and 2011 includes an unrealized loss of \$4,676 and \$2,394, respectively, related to this derivative, prior to termination.

Forward Sale Agreements: In June 2004, the Alliance entered into two related forward sale agreements with the counterparty to the swaption agreements and the Master Trustee of the Series 2000 Bonds. The forward sale agreements originally related to the Debt Service Reserve Fund and to the Debt Service Fund, respectively, (collectively, the "Funds"), as established under provisions of the Master Trust Indenture related to the issuance of the Series 2000 Bonds. In consideration of the future earnings on the Funds, the counterparty paid the Master Trustee a total of \$30,000 during 2005, to be held on behalf of the Alliance. As the original intent of these Funds was to secure debt service payments under the above referenced Bonds, the agreement requires these funds to be held under a guaranty agreement as further described below.

In June 2006, one of these agreements was amended to also relate to the Series 2000C, 2000D, 2006A and 2006B Bonds, and to remove the Series 2000A Bonds from consideration under the agreement. In connection with the issuance of the Series 2007 Bonds and the derecognition of a portion of the Series 2000A Bonds, all of the outstanding Series 2000B Bonds, and all of the outstanding 2006B Bonds (Note F), one of these agreements as it relates to the Series 2000A and 2000B Bonds was partially terminated. As such, during 2008 the Alliance reduced its liability with respect to the portion related to the Series 2000A and 2000B Bonds, and paid the counterparty

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE D--DERIVATIVE TRANSACTIONS - Continued

\$6,186 under the terms of the agreement. The agreement was amended in fiscal year 2011 to include the Series 2010A Bonds and to remove the Series 2000B and 2006B Bonds.

Amounts were being recognized as investment income over the life of the agreements. A liability of \$19,001 representing the unamortized payments from the counterparty at June 30, 2011 is included as part of deferred revenue in the accompanying 2011 Consolidated Balance Sheet.

In June 2012, the Alliance and the counterparty terminated the two forward sale agreements. To effectuate the termination, the Alliance agreed to pay \$13,429 to the counterparty. At June 30, 2012, the termination payable was included in accounts payable and accrued expenses in the accompanying 2012 Consolidated Balance Sheet. The Alliance recognized a gain of \$4,708 on the termination of these agreements, which is included within other nonoperating gains (losses) in the accompanying 2012 Consolidated Statement of Operations.

Pursuant to these agreements, the counterparty required that the Alliance's obligations under the swaption and forward sale agreements be collateralized under a guarantee agreement in favor of the counterparty. Due to various requirements of the Master Trust Indenture, the Alliance had previously transferred to MSF a total of \$42,500 that was in turn deposited with the counterparty as collateral in a GIC. Amounts received under the forward sale agreements were also deposited into the GIC. All GIC deposits earn interest compounded at 4.14% for the first year, and at 3.5% thereafter through July 1, 2011. The GIC deposits as of June 30, 2011 totaled \$92,720. The GIC was substantially utilized on October 13, 2011 to terminate the swaption discussed above and, as such, is included in the current portion of assets whose use is limited in the 2011 Consolidated Balance Sheet.

NOTE E--PROPERTY, PLANT AND EQUIPMENT

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

	<u>2012</u>	<u>2011</u>
Land	\$ 69,356	\$ 63,749
Buildings and leasehold improvements	661,146	454,852
Property and improvements held for leasing	74,914	80,568
Equipment	571,774	532,767
Buildings and equipment held under capital lease	20,540	42,720
	<u>1,397,730</u>	<u>1,174,656</u>

MOUNTAIN STATES HEALTH ALLIANCE

*Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE E--PROPERTY, PLANT AND EQUIPMENT - Continued

	<u>2012</u>	<u>2011</u>
Less: Allowances for depreciation and amortization	(626,552)	(586,471)
	771,178	588,185
Construction in progress (Note N)	94,278	209,233
	<u>\$ 865,456</u>	<u>\$ 797,418</u>

Accumulated depreciation and amortization on property and improvements held for leasing purposes is \$22,951 and \$23,348 at June 30, 2012 and 2011, respectively. Net interest capitalized was \$3,110 and \$10,640 for the years ended June 30, 2012 and 2011, respectively.

During 2012, the Alliance executed an Amendment and Mutual Release Agreement with a vendor whereby the Alliance waived its right to take any action with respect to prior contracts in exchange for professional services in future periods, primarily related to accelerated deployment of information systems. The Alliance recognized approximately \$3,200 in 2012 as additions to property, plant and equipment with an offsetting gain related to the agreed-upon value of such professional services. The Alliance anticipates recognition of additional amounts in future periods as such services are provided.

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

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

<i>Description</i>	<i>Maturities</i>	<i>Rates</i>	<i>Outstanding Balance</i>	
			<i>2012</i>	<i>2011</i>
2011A Hospital Revenue Bonds	\$65,260 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 0.19% at June 30, 2012	\$ 65,260	\$ -
2011B Hospital Revenue Bonds	\$20,000 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 0.19% at June 30, 2012	20,000	-
2011C Hospital Revenue Bonds	\$49,875 uninsured term bonds, due July 1, 2031, subject to early redemption or tender	Variable, 0.16% at June 30, 2012	49,875	-
2011D Hospital Revenue Bonds	\$60,705 uninsured term bonds, due July 1, 2031, subject to early redemption or tender	Variable, 0.19% at June 30, 2012	60,705	-
2011E Taxable Bonds	\$15,960 uninsured term bonds, due July 1, 2026, subject to early redemption or tender	Variable, 0.24% at June 30, 2012	15,960	-
2011 Hospital Facility Revenue Refunding and Improvement Bonds (JMHI)	\$24,870 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 1.2% at June 30, 2012	24,870	-
2010A Hospital Revenue Bonds, net of unamortized premium of \$1,017 and \$1,056 at June 30, 2012 and 2011, respectively	\$32,515 uninsured serially, through 2020 \$14,985 uninsured term bonds, due July 1, 2025 \$19,385 uninsured term bonds, due July 1, 2030 \$39,570 uninsured term bonds, due July 1, 2038 \$55,480 uninsured term bonds, due July 1, 2038	3.00% to 5.00% 5.38% 5.63% 6.50% 6.00%	162,952	169,137

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2012 and 2011

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

Description	Maturities	Rates	Outstanding Balance	
			2012	2011
2010B Hospital Revenue Bonds, net of unamortized premium of \$669 and \$711 at June 30, 2012 and 2011, respectively	\$23,855 uninsured serially, through 2020 \$4,355 uninsured term bonds, due July 1, 2023 \$4,250 uninsured term bonds, due July 1, 2028	2.50% to 5.00% 5.00% 5.50%	33,129	36,646
2009A Hospital Revenue Bonds, net of unamortized discount of \$117 and \$121 at June 30, 2012 and 2011, respectively	\$725 uninsured term bonds, due July 1, 2019 \$1,730 uninsured term bonds, due July 1, 2029 \$3,105 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	5,443	5,439
2009B Hospital Revenue Bonds	\$5,535 uninsured term bonds, due July 1, 2038	8.00%	5,535	5,535
2009C Hospital Revenue Bonds, net of unamortized discount of \$2,334 and \$2,421 at June 30, 2012 and 2011, respectively	\$21,100 uninsured term bonds, due July 1, 2019 \$20,000 uninsured term bonds, due July 1, 2029 \$74,855 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	113,621	113,534
2008A Hospital Revenue Bonds	\$13,245 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.19% at June 30, 2012	13,245	13,245
2008B Hospital Revenue Bonds	\$52,930 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.19% at June 30, 2012	52,930	53,855
2007B Taxable Hospital Revenue Bonds, bifurcated into sub-series B-1, B-2 and B-3 during 2011	\$156,760 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 0.20% to 0.23% at June 30, 2012	156,760	307,900
2006A Hospital First Mortgage Revenue Bonds, net of unamortized premium of \$141 and \$147 at June 30, 2012 and 2011, respectively	\$5,940 uninsured serially, through 2019 \$7,375 uninsured term bonds, due July 1, 2026 \$20,505 uninsured term bonds, due July 1, 2031 \$135,175 uninsured term bonds, due July 1, 2036	5.00% 5.25% 5.50% 5.50%	169,136	169,782
2001A Hospital First Mortgage Revenue Bonds, re-issued in 2012	\$22,300 term bonds, due July 1, 2026, subject to early redemption or tender	4.50% as re-issued	22,300	23,100
2001 Hospital Refunding and Improvement Revenue Bonds (NCH), net of unamortized discount of \$34 June 30, 2011	Redeemed in 2012	N/A	-	11,876
2000A Hospital First Mortgage Revenue Refunding Bonds	\$32,431 insured Capital Appreciation Bonds, interest and principal due July 1, 2026 through 2030	6.63%	32,431	30,358
2000C Hospital First Mortgage Revenue Bonds	\$33,230 insured term bonds, due July 1, 2026	8.50%	33,230	34,325
2000D First Mortgage Taxable Bonds	\$14,315 insured term bonds, due July 1, 2026	8.50%	14,315	14,790
1998 Hospital Refunding and Improvement Revenue Bonds (JMH)	Redeemed in 2012	N/A	-	14,115
Capitalized lease obligation	Lease paid-off in 2012	N/A	-	13,656
\$7,500 promissory note	Note paid-off in 2012	N/A	-	5,473
Capitalized lease obligations secured by equipment	Various monthly payments of monthly principal and interest	Various	1,645	2,518
\$1,065 note payable	Note paid-off in 2012	N/A	-	572
\$6,332 promissory note	Promissory note paid-off in 2012	N/A	-	5,945
\$3,955 note payable	Note paid-off in 2012	N/A	-	3,743
Notes payable under Master Financing Agreement	Notes paid-off in 2012	N/A	-	14,011
\$1,885 line of credit	Line of credit paid-off in 2012	N/A	-	1,873
\$1,593 note payable, secured by equipment	Various annual principal payments through July 2014	Unspecified	1,343	1,593
Capitalized lease obligation secured by medical office building (JMH)	Maturing through 2026 - Note S	9.72%	15,498	15,952
Master installment payment agreement	Various quarterly payments through May 2014	Unspecified	4,438	112

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

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

<i>Description</i>	<i>Maturities</i>	<i>Rates</i>	<i>Outstanding Balance</i>	
			<i>2012</i>	<i>2011</i>
Master installment payment agreement, secured by equipment	Various quarterly payments through May 2014	Unspecified	3,032	-
\$1,870 note payable, secured by land	Monthly principal payments of \$10 through maturity in July 2015	Unspecified	1,870	-
\$1,052 in promissory notes secured by assets of Emmaus Community Healthcare, LLC	Various monthly principal and interest payments through 2019	3.00% - 3.75%	1,052	-
			1,080,575	1,069,085
	Less current portion		(32,477)	(28,162)
			\$ 1,048,098	\$ 1,040,923

Series 2011 Bonds: In October 2011, the Alliance issued \$65,260 (Series 2011A) and \$20,000 (Series 2011B) variable rate tax-exempt Hospital Revenue Bonds through The Health and Educational Facilities Board of the City of Johnson City, Tennessee, \$49,875 (Series 2011C) and \$60,705 (Series 2011D) variable rate tax-exempt Hospital Revenue Bonds through the Industrial Development Authority of Smyth, Virginia and \$15,960 (Series 2011E) variable rate Taxable Bonds (collectively, the Series 2011 Bonds). The Series 2011 Bonds bear interest at a variable rate determined by a remarketing agent based upon a weekly rate period. The proceeds from the Series 2011A and Series 2011B Bonds were used to finance certain capital acquisitions in the State of Tennessee and pay issuance costs related to these Bonds. The proceeds from the Series 2011C and 2011D Bonds were used to refinance the 2001 NCH Hospital Refunding and Improvement Revenue Bonds, finance capital acquisitions for NCH, JMH and SCCH and to pay issuance costs associated with these Bonds. The Series 2011E Bond proceeds were used to refinance certain capital acquisitions of SCCH and BRMMC and pay issuance costs. The timely payment of the Series 2011 Bonds is secured by a letter of credit which expires October 19, 2014.

In November 2011, JMH issued \$24,870 (JMH Series 2011) variable rate tax-exempt Hospital Facility Revenue Refunding and Improvement Bonds through the Industrial Development Authority of Smyth County. The JMH Series 2011 Bonds bear interest at a variable rate determined by a remarketing agent based upon a weekly rate period. The proceeds from the JMH Series 2011 Bonds were used to refinance the 1998 Hospital Refunding and Improvement Revenue Bonds, refinance existing indebtedness incurred to finance capital acquisitions and to pay issuance costs associated with the Bonds.

Series 2010 Bonds: In April 2010, the Alliance issued \$168,080 (Series 2010A) and \$35,935 (Series 2010B) fixed rate Hospital Refunding Revenue Bonds (collectively, the Series 2010 Bonds). Proceeds of the Series 2010A and the Series 2010B Bonds were used to refinance outstanding indebtedness, specifically related to the Alliance's facilities in Tennessee and in Virginia, respectively, fund debt service reserve funds and pay costs of issuance.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

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

Series 2009 Bonds: In March 2009, the Alliance issued \$5,560 (Series 2009A), \$5,535 (Series 2009B) and \$115,955 (Series 2009C) fixed rate Hospital Revenue Bonds (collectively, the Series 2009 Bonds). The proceeds of Series 2009 Bonds were used to refinance a portion of the outstanding Series 2006C Taxable Notes, which were originally issued to finance a capital commitment to SCCH and purchase certain leased assets, finance the acquisition of a majority ownership in JMHI, fund a debt service reserve fund and pay costs of issuance. The portion of the 2006C taxable notes which were not refinanced with the Series 2009 Bonds were repaid with cash on hand.

Series 2008 Bonds: In February 2008, the Alliance issued \$72,770 (Series 2008A) and \$54,230 (Series 2008B) variable rate Hospital Revenue Bonds (collectively, the Series 2008 Bonds). The proceeds of Series 2008 Bonds were primarily used to finance certain future capital projects for the Alliance's hospital facilities and for the repayment of previously issued 2008 Taxable Notes used for the acquisition of RCMC. The payment of principal and interest on the Series 2008 Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit. A portion (\$59,525) of the Series 2008A Bonds were repaid from proceeds of the Series 2010 Bonds.

Series 2007 Bonds: In December 2007, the Alliance issued \$104,355 (Series 2007A), \$327,170 (Series 2007B taxable) and \$36,575 (Series 2007C) variable rate Hospital Revenue Bonds (collectively, the Series 2007 Bonds). The proceeds of Series 2007 Bonds were primarily used to early extinguish a portion of the outstanding Series 2000A Bonds, all of the outstanding 2000B Bonds, all of the outstanding Series 1994 Bonds, and all of the outstanding Series 2006B Bonds; to finance the acquisition of a majority ownership in NCH, and to finance certain capital improvements and equipment acquisitions for the Alliance's hospital facilities. A portion of the outstanding Series 2007A (\$91,685) and Series 2007C (\$32,840) Bonds were repaid from proceeds of the Series 2010 Bonds.

During 2011, the remaining outstanding Series 2007A and Series 2007C Bonds were redeemed and the existing 2007B Bonds were repaid through a remarketing of Sub-Series 2007B-1, 2007B-2 and 2007B-3 (collectively, the Sub-Series 2007B Bonds), created per the mandatory tender and letter of credit substitution provisions. The payment of principal and interest on the Sub-Series 2007B Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit.

During 2012, the Alliance redeemed \$115,135 of the Series 2007B-1 Bonds and \$29,405 of the Series 2007B-3 Bonds.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

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

Series 2006 Bonds: During 2006, the Alliance issued \$173,030 Hospital First Mortgage Revenue Bonds (Series 2006A) and \$66,500 Hospital First Mortgage Variable Rate Revenue Bonds (Series 2006B). The proceeds from the sale of the Series 2006A Bonds were used to finance certain future and prior capital projects for the Alliance's hospital facilities and to refund certain existing indebtedness, specifically the Series 2001B Bonds (discussed below) and certain existing short and intermediate term loans and leases, as well as fund a debt service reserve fund. The Series 2006B Bond proceeds were substantially used to refund the remaining outstanding principal of the Series 2001B Bonds and establish a debt service reserve fund.

Series 2001 Bonds: During 2001, the Alliance issued \$26,000 Hospital First Mortgage Revenue Bonds (Series 2001A) and \$60,175 Hospital First Mortgage Revenue Bonds (Series 2001B). The Series 2001A Bonds were subject to optional tender by Bond holders. The Series 2001B Bonds were refunded and redeemed in 2006. The Alliance redeemed the 2001A Bonds and released a new Series 2001A to Bank of America Merrill Lynch during 2012.

Series 2000 Bonds: The Hospital First Mortgage Revenue Refunding (Series 2000A Bonds) and First Mortgage Revenue Refunding Bonds (Series 2000B Bonds), were used to advance refund previously existing indebtedness as well as fund a required debt service reserve fund. The Hospital First Mortgage Revenue Bonds (Series 2000C Taxable Bonds) were used to refinance certain mortgage indebtedness of BRMM, and to refund other previously existing indebtedness. The proceeds from the sale of the First Mortgage Bonds (Series 2000D Taxable Bonds) were used primarily to fund working capital for the Alliance.

The Series 2000A Bonds included at issue date \$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.

Derecognized Bonds: The advance refunding of previously issued debt requires funds to be placed in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments. 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, and the debt and escrowed securities are not considered liabilities or assets of the Alliance. Therefore, such debt has been derecognized.

Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2012 due to previous advance refundings of the Series 2000A Bonds, Series 2000B Bonds, Series 1998C Bonds, and Series 1991 Bonds, totaled approximately \$483,625.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

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

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.

During 2012, the Alliance instructed the trustee of the 1998C Bonds to liquidate certain investments held in the related irrevocable trust account and to redeem a portion of the 1998C Bonds with the proceeds from the liquidation. The fair value of the liquidated assets exceeded the payment necessary to redeem the 1998C Bonds and the excess was paid to the Alliance. As a result of this transaction, the Alliance recognized a gain of \$5,337, net of fees, which is included in other nonoperating gains (losses) in the accompanying 2012 Consolidated Statement of Operations.

Variable Rate Issuances: The variable rate of interest on the Series 2011, Series 2008 and Series 2007 Bonds is determined weekly by the Remarketing Agent, as the rate equal to the lowest rate which, in regard to general financial conditions and other special conditions bearing on the rate, would produce as nearly as possible a par bid for the Bonds in the secondary market. In no event shall the variable rate on the Bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the applicable State of issue. The Alliance has the option, upon written approval of the holder of the letters of credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate.

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.

Other Bonds, Notes Payable and Financing Arrangements: 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 JMH Series 2011 Hospital Refunding and Improvement Revenue Bonds are secured by pledged revenues of JMH, as defined in the Credit Agreement.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

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

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, 2012 are as follows:

<u><i>Year Ending June 30,</i></u>	
2013	\$ 32,477
2014	33,414
2015	29,932
2016	31,315
2017	31,006
Thereafter	<u>923,055</u>
	1,081,199
Net discount	<u>(624)</u>
	<u>\$ 1,080,575</u>

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, 2012.

In connection with the tax-exempt bonds, the Alliance is required every five years, and at maturity, to remit to the Internal Revenue Service amounts which are due related to positive arbitrage on the borrowed funds. The Alliance performs such computations when required and recognizes any liability at that time. Management does not believe there are any significant arbitrage liabilities at June 30, 2012 or 2011.

During 2012, the Alliance recognized a \$2,636 loss on early extinguishment of debt representing the write off of previously deferred and unamortized financing costs generally related to the refinanced or otherwise redeemed portion of the Series 2007B Bonds, Series 1998 JMH Bonds and the Series 2001 NCH Bonds.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

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 and \$1,000 annual aggregate retention. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

At June 30, 2012, 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, 2012 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Alliance 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, 2012 and 2011 was \$12,896 and \$13,531, respectively. The discount rate utilized was 5% at June 30, 2012 and 2011.

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, including a catastrophic claims reserve based on historical claims in excess of \$75.

NOTE H--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates to net patient service revenue as presented in the accompanying Consolidated Statements of Operations is as follows for the years ended June 30:

	<u>2012</u>	<u>2011</u>
Inpatient service charges	\$ 2,095,036	\$ 1,983,340
Outpatient service charges	1,982,154	1,791,858
Gross patient service charges	4,077,190	3,775,198

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE H--NET PATIENT SERVICE REVENUE - Continued

	<u>2012</u>	<u>2011</u>
Less:		
Estimated contractual adjustments and other discounts	2,899,678	2,640,909
Charity care	102,462	72,166
Provision for bad debts	122,917	116,248
	<u>3,125,057</u>	<u>2,829,323</u>
Net patient service revenue	<u>\$ 952,133</u>	<u>\$ 945,875</u>

Net patient service revenue by major payor source for the years ended June 30, 2012 and 2011, net of contractual allowances and self-pay discounts (before the provision for bad debts), is as follows:

	<u>2012</u>	<u>2011</u>
Third-party payors	\$ 968,101	\$ 957,828
Self-pay	106,949	104,295
Patient service revenue	<u>\$ 1,075,050</u>	<u>\$ 1,062,123</u>

Deductibles and copayments under third-party payment programs, which are included within the third-party payor amounts above, are the patient's responsibility and the Alliance considers these amounts in its determination of the provision for bad debts based on prior collection experience. Accounts receivable are also reduced by an allowance for doubtful accounts. In evaluating the collectibility of accounts receivable, the Alliance analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Alliance analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary, for expected uncollectible deductibles and copayments or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely. For receivables associated with self-pay patients, which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill, the Alliance records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between discounted rates and the amounts actually collected after all reasonable collection efforts have been exhausted is charged against the allowance for doubtful accounts.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE H--NET PATIENT SERVICE REVENUE - Continued

The Alliance's allowance for doubtful accounts totaled \$52,911 and \$53,366 at June 30, 2012 and 2011, respectively. The allowance for doubtful accounts decreased from 28% of patient accounts receivable, net of contractual allowances, at June 30, 2011 to 26% of patient accounts receivable, net of contractual allowances, as of June 30, 2012. Write-offs, net of recoveries, for the years ending June 30, 2012 and 2011 were \$123,373 and \$108,823, respectively, and relate primarily to self-pay patients. Write-offs of third-party payor accounts were not significant in the years ending June 30, 2012 and 2011. The Alliance has not experienced significant changes in write-off trends and has not changed its charity care policy for the year ended June 30, 2012. 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, Blue Cross and various other commercial payors. 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. The amount recognized totaled \$11,300 and \$11,480 for the years ended June 30, 2012 and 2011, respectively. In addition, during 2012 the Alliance recognized \$4,894 from TennCare related to the implementation and meaningful use of electronic medical records as provided by the Health Information Technology for Economics and Clinical Health (HITECH) Act. Such payments are included within other operating revenue in the accompanying 2012 Consolidated Statement of Operations and are not guaranteed in future periods.

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 based on Medicare cost reimbursement principles and settled through the filing of an annual Medicaid cost report.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued ***(Dollars in Thousands)***

Years Ended June 30, 2012 and 2011

NOTE I--THIRD-PARTY REIMBURSEMENT - Continued

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. 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. 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 2013, although the amount of any change cannot be estimated. The impact of final settlements of cost reports or changes in estimates decreased net patient service revenue by \$1,556 and \$4,570 in 2012 and 2011, respectively.

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, 2012.

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 retirement plan (the Plan) which covers substantially all employees. The Plan is a defined contribution plan which consists mainly of employer-funded contributions. During 2012 and 2011, the Alliance made 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, 2012 and 2011 was \$15,072 and \$12,682, respectively.

NCH maintains a defined benefit pension plan and a post-retirement employee benefit plan. The accrued unfunded pension liability was \$2,560 and \$1,313, and the accrued unfunded post-retirement liability was \$4,554 and \$3,761 at June 30, 2012 and 2011, respectively.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE J--EMPLOYEE BENEFIT PLANS - Continued

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 date, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed \$1,734 and \$929 to the plan during 2012 and 2011, respectively. Other assets at June 30, 2012 and 2011 include \$9,675 and \$7,888, 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.

NOTE K--CONCENTRATIONS OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia which is considered a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. Net patient service revenue from Washington County, Tennessee operations were approximately 53% and 53% of total net patient service revenue for 2012 and 2011, respectively.

The mix of receivables from patients and third-party payors based on charges at established rates is as follows as of June 30:

	<i>2012</i>	<i>2011</i>
Medicare	36%	40%
TennCare/Medicaid	14%	12%
Commercial	26%	27%
Other third-party payors	13%	9%
Patients	11%	12%
	<u>100%</u>	<u>100%</u>

Approximately 96% and 96% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2012 and 2011, respectively. Admitting physicians are primarily practitioners in the regional area.

Two of the Alliance's Virginia hospitals' employees are covered under collective bargaining agreements which extend through February 2014 and January 2015, respectively.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE K--CONCENTRATIONS OF RISK - Continued

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. At June 30, 2012, the Alliance also had deposits in financial institutions significantly in excess of the Federal Deposit Insurance Corporation's limits.

NOTE L--INCOME TAXES

BRMM and its subsidiaries file a consolidated federal tax return and separate state tax returns. As of June 30, 2012 and 2011, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of \$38,888 and \$34,822, respectively, related to operating loss carryforwards which expire through 2031. At June 30, 2012 and 2011, BRMM had state net operating loss carryforwards of \$69,999 and \$65,979, respectively, which expire through 2026. 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.

At June 30, 2012 and 2011, SWCH had federal and state net operating loss carryforwards of \$5,614 and \$4,875, respectively, which expire through 2031. The net operating loss carryforwards may be off-set against future taxable income to the extent permitted by the Internal Revenue Code and tax codes of the Commonwealth of Virginia.

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--RELATED PARTY TRANSACTIONS

The Alliance enters into transactions with entities affiliated with certain members of the Board of Directors including transactions to construct Alliance facilities and provide professional services to the Alliance. Board members refrain from discussion and abstain from voting on transactions with entities with which they are related.

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES

Construction in Progress: Construction in progress at June 30, 2012 represents costs incurred related to various hospital and medical office building facility renovations and additions. The Alliance has outstanding contracts and other commitments related to the completion of these

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

projects, and the cost to complete these projects is estimated to be approximately \$100,312 at June 30, 2012. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

Physician Contracts: BRMM employs physicians to provide services to BRMM's physician practices through employment agreements which provide annual compensation, plus incentives based upon specified productivity levels. These contracts have various terms.

In addition, the Alliance has entered into contractual relationships with non-employed physicians to provide services in Upper East Tennessee and Southwest Virginia. These contracts guarantee certain base payments and allowable expenses and have terms of varying lengths. Amounts drawn and outstanding under each agreement are treated as a loan bearing interest at various rates and are subject to repayment over a specified period. The physician notes may also be amortized by virtue of the physician's continued practice in the specified community during the repayment period. A net receivable of \$1,436 and \$1,407 related to these agreements is included in the accompanying Consolidated Balance Sheets at June 30, 2012 and 2011, respectively.

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 degree. 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, 2012 and 2011 include \$8,005 and \$7,250, 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 allowance.

Promises to Give: The Alliance has recorded certain unconditional promises to give to unrelated organizations. At June 30, 2012, \$1,354 is due within one year, and an additional \$100 is due within five years and is included in other long-term liabilities.

Operating Leases and Maintenance Contracts: Total lease expense for the years ended June 30, 2012 and 2011 was \$8,823 and \$9,362, 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:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

<u><i>Year Ending June 30,</i></u>	
2013	\$ 4,661
2014	4,476
2015	4,253
2016	3,997
2017	2,332
Thereafter	8,008
	<u>\$ 27,727</u>

Asset Retirement Obligation: The Alliance has identified asbestos in certain facilities and is required by law to dispose of it in a special manner if the facility undergoes major renovations or is demolished; otherwise, the Alliance is not required to remove the asbestos from the facility. The Alliance has complied with regulations by treating the asbestos so that it presents no known immediate or future safety concerns. An asset retirement obligation has been established to the extent that sufficient information exists upon which to estimate the liability.

Other: The Alliance is a party to various transactions and agreements in the normal course of business, which include purchase and re-purchase agreements, put arrangements and other commitments, which may bind the Alliance to undertake additional transactions or activities in the future. In addition, the Alliance has agreed to guarantee a portion of the outstanding indebtedness of a joint venture. Management estimates that the fair value of the guarantee of this debt is immaterial as of June 30, 2012.

Healthcare Industry: Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

In March 2010, Congress adopted comprehensive health care insurance legislation, *Patient Care Protection and Affordable Care Act* and *Health Care and Education Reconciliation Act*. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens by 2019 through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE O--RENTAL INCOME UNDER OPERATING LEASES

The Alliance leases rental properties to third parties, most of whom are physician practices, for various terms, generally five years. The following is a schedule by year and in the aggregate of minimum future rental income due under noncancellable operating leases at June 30, 2012:

<u>Year Ending June 30,</u>		
2013	\$	1,574
2014		1,454
2015		1,339
2016		762
2017		405
Thereafter		116
Total minimum future rentals	<u>\$</u>	<u>5,650</u>

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2012 and 2011, 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.

Investment in Joint Ventures: It is not practical to estimate the fair market value of the investments in joint ventures.

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 due to uncertainty of when these amounts may be paid. Other long-term liabilities are not discounted.

Long-Term Debt and Capital Leases: 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.

The Alliance's significant capital leases and vendor contracts were negotiated with various entities and are considered unique. It is not practicable to estimate the fair value of these obligations under current conditions. Other capital lease obligations are not significant.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS - Continued

The estimated fair value of the Alliance's financial instruments that have carrying values different from fair value is as follows at June 30:

	2012		2011	
	<i>Carrying Value</i>	<i>Estimated Fair Value</i>	<i>Carrying Value</i>	<i>Estimated Fair Value</i>
FINANCIAL LIABILITIES:				
Long-term debt	\$ 1,080,575	\$ 1,150,201	\$ 1,069,085	\$ 1,046,675

NOTE Q--FAIR VALUE MEASUREMENT

FASB ASC 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 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 assets and liabilities recorded at fair value on a recurring basis as of June 30, 2012 and 2011:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE Q--FAIR VALUE MEASUREMENT - Continued

	Total	Level 1	Level 2	Level 3
June 30, 2012				
Cash, cash equivalents and money market funds	\$ 85,017	\$ 85,017	\$ -	\$ -
U.S. Government securities	15,693	15,693	-	-
U.S. Agency securities	62,437	62,437	-	-
Corporate and foreign bonds	52,581	-	52,581	-
Municipal obligations	961	-	961	-
Preferred and asset backed securities	11,183	-	11,183	-
U.S. equity securities	28,344	28,344	-	-
Mutual funds	141,968	97,600	44,368	-
Other	34,880	-	-	34,880
Total assets	\$ 433,064	\$ 289,091	\$ 109,093	\$ 34,880
Fair value of derivative agreements - Note D	\$ (19,381)	\$ -	\$ -	\$ (19,381)
June 30, 2011				
Cash, cash equivalents and money market funds	\$ 142,031	\$ 142,031	\$ -	\$ -
U.S. Government securities	11,204	11,204	-	-
U.S. Agency securities	34,054	34,054	-	-
Corporate and foreign bonds	32,895	-	32,895	-
Municipal obligations	451	-	451	-
Preferred and asset backed securities	8,945	-	8,945	-
U.S. equity securities	21,774	21,774	-	-
Mutual funds	166,708	73,060	93,648	-
Other	32,718	-	-	32,718
Total assets	\$ 450,780	\$ 282,123	\$ 135,939	\$ 32,718
Fair value of derivative agreements - Note D	\$ (110,732)	\$ -	\$ -	\$ (110,732)

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, 2012 and 2011 resulted in a decrease in the fair value of the related liability of \$5,726 and \$7,940, respectively.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2012 and 2011

NOTE Q--FAIR VALUE MEASUREMENT - Continued

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.

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, 2012 and 2011:

	<i>Trading Securities</i>	<i>Derivatives, Net</i>
July 1, 2010	\$ 28,608	\$ (134,300)
Total unrealized/realized gains in the Performance Indicator, net	2,847	23,049
Net investment income	1,263	519
June 30, 2011	32,718	(110,732)
Total unrealized/realized gains in the Performance Indicator, net	1,466	(6,198)
Net investment income	1,221	515
Purchases	5,107	-
Settlements	-	97,034
Distributions	(5,632)	-
June 30, 2012	\$ 34,880	\$ (19,381)

There were no changes in valuation techniques in 2012 or 2011. During 2011, as part of the transitional test of goodwill impairment, the Alliance recognized goodwill impairment of \$2,965 based primarily on the fair value of the reporting unit, utilizing the income approach. Remaining goodwill determined not to be impaired, for this specific reporting unit, is included in the Consolidated Balance Sheets at \$2,900.

NOTE R--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 enterprise, other indicators contained in these consolidated financial statements are considered important in evaluating how well management has discharged their stewardship responsibilities.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

NOTE S--SUBSEQUENT EVENTS

In September 2012, the Alliance issued \$55,000 (Series 2012A) fixed rate and \$28,095 (Series 2012B) variable rate tax-exempt Hospital Revenue Bonds through The Health and Educational Facilities Board of the City of Johnson City, Tennessee, and \$9,785 (Series 2012C) variable rate tax-exempt Hospital Revenue Bonds through the Industrial Development Authority of Wise, Virginia (collectively, the Series 2012 Bonds). The proceeds from the Series 2012A Bonds will be used to finance a surgery center project at JCMC and pay issuance costs related to these Bonds. The proceeds from the Series 2012B and 2012C Bonds will be used to finance or refinance capital improvements and equipment acquisitions and to pay issuance costs associated with these Bonds. The timely payment of the Series 2012B and Series 2012C Bonds is secured by irrevocable transferable direct-pay letters of credit.

In July 2012, the Trustee of the previously derecognized 1998C Bonds liquidated certain investments held in the related irrevocable trust account and redeemed a portion of the 1998C Bonds with the proceeds from the liquidation. The fair value of the liquidated assets exceeded the payment necessary to redeem the 1998C Bonds and the excess was paid to the Alliance. As a result of this transaction, the Alliance recognized a gain of \$13,847, net of fees.

Subsequent to June 30, 2012, JMH exercised their purchase option related to a medical office building previously held under a capital lease. The purchase price was \$17,529 which was financed through a taxable private placement bond issuance.

Supplemental Schedules

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet (Dollars in Thousands)

June 30, 2012

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities	Mountain States Properties	Eliminations	Total
ASSETS								
CURRENT ASSETS								
Cash and cash equivalents	\$ 1,482	\$ 36,881	\$ -	\$ 38,363	\$ 22,006	\$ 4,738	\$ -	\$ 65,107
Current portion of investments	-	22,745	-	22,745	3	13,809	-	36,557
Patient accounts receivable, less estimated allowances for uncollectible accounts	5,051	116,629	-	121,680	29,010	-	-	150,690
Other receivables, net	1,624	18,852	-	20,476	3,120	412	(1,000)	23,008
Inventories and prepaid expenses	832	20,951	-	21,783	6,924	103	-	28,810
TOTAL CURRENT ASSETS	8,989	216,058	-	225,047	61,063	19,062	(1,000)	304,172
INVESTMENTS, less amounts required to meet current obligations	19,348	395,778	-	415,126	100,811	44,760	-	560,697
EQUITY IN AFFILIATES	143,050	318,231	(157,099)	304,182	-	-	(304,182)	-
PROPERTY, PLANT AND EQUIPMENT, net	13,559	598,415	-	611,974	199,990	53,492	-	865,456
OTHER ASSETS								
Goodwill	9,007	143,276	-	152,283	2,108	-	-	154,391
Net deferred financing, acquisition costs and other charges	302	26,776	-	27,078	602	507	-	28,187
Other assets	8,887	12,145	-	21,032	4,550	2,562	-	28,144
TOTAL OTHER ASSETS	18,196	182,197	-	200,393	7,260	3,069	-	210,722
	\$ 203,142	\$ 1,710,679	\$ (157,099)	\$ 1,756,722	\$ 369,124	\$ 120,383	\$ (305,182)	\$ 1,941,047

* Management Services Organization only

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet - Continued (Dollars in Thousands)

June 30, 2012

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities	Mountain States Properties	Eliminations	Total
LIABILITIES AND NET ASSETS								
CURRENT LIABILITIES								
Accrued interest payable	\$ 46	\$ 18,455	\$ -	\$ 18,501	\$ 24	\$ -	\$ -	\$ 18,525
Current portion of long-term debt and capital lease obligations	-	29,824	-	29,824	2,653	-	-	32,477
Current portion of estimated fair value of derivatives	-	-	-	-	-	10,395	-	10,395
Accounts payable and accrued expenses	4,191	94,352	-	98,543	9,297	1,030	-	108,870
Accrued salaries, compensated absences and amounts withheld	3,704	40,121	-	43,825	11,764	-	-	55,589
Payables to (receivables from) affiliates, net	15,321	3,118	-	18,439	8,365	(26,804)	-	-
Estimated amounts due to third-party payors, net	-	16,607	-	16,607	1,453	-	-	18,060
TOTAL CURRENT LIABILITIES	23,262	202,477	-	225,739	33,556	(15,379)	-	243,916
OTHER LIABILITIES								
Long-term debt and capital lease obligations, less current portion	13,676	994,014	-	1,007,690	41,408	-	(1,000)	1,048,098
Estimated fair value of derivatives, less current portion	-	8,534	-	8,534	133	319	-	8,986
Deferred revenue	-	2,929	-	2,929	205	-	-	3,134
Estimated professional liability self-insurance	2,268	5,975	-	8,243	1,101	-	-	9,344
Other long-term liabilities	6,837	9,839	-	16,676	146	-	-	16,822
TOTAL LIABILITIES	46,043	1,223,768	-	1,269,811	76,549	(15,060)	(1,000)	1,330,300
NET ASSETS								
Unrestricted net assets								
Mountain States Health Alliance	157,099	436,388	(157,099)	436,388	164,117	135,443	(299,560)	436,388
Noncontrolling interests in subsidiaries	-	39,123	-	39,123	117,377	-	6,459	162,959
TOTAL UNRESTRICTED NET ASSETS	157,099	475,511	(157,099)	475,511	281,494	135,443	(293,101)	599,347
Temporarily restricted net assets								
Mountain States Health Alliance	-	11,223	-	11,223	10,955	-	(10,955)	11,223
Noncontrolling interests in subsidiaries	-	50	-	50	(1)	-	1	50
TOTAL TEMPORARILY RESTRICTED NET ASSETS	-	11,273	-	11,273	10,954	-	(10,954)	11,273
Permanently restricted net assets	-	127	-	127	127	-	(127)	127
TOTAL NET ASSETS	157,099	486,911	(157,099)	486,911	292,575	135,443	(304,182)	610,747
	\$ 203,142	\$ 1,710,679	\$ (157,099)	\$ 1,756,722	\$ 369,124	\$ 120,383	\$ (305,182)	\$ 1,941,047

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Operations (Dollars in Thousands)

Year Ended June 30, 2012

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities	Mountain States Properties	Eliminations	Total
Revenue, gains and support:								
Patient service revenue, net of contractual allowances and discounts	\$ 50,213	\$ 824,899	\$ (2,165)	\$ 872,947	\$ 202,108	\$ -	\$ (5)	\$ 1,075,050
Provision for bad debts	(4,397)	(95,440)	-	(99,837)	(23,080)	-	-	(122,917)
Net patient service revenue	45,816	729,459	(2,165)	773,110	179,028	-	(5)	952,133
Other operating revenue	39,451	15,163	(29,595)	25,019	67,543	8,398	(61,553)	39,407
Equity in net gain (loss) of affiliates	3,332	(17,848)	(1,488)	(16,004)	-	-	16,004	-
TOTAL REVENUE, GAINS AND SUPPORT	88,599	726,774	(33,248)	782,125	246,571	8,398	(45,554)	991,540
Expenses:								
Salaries and wages	21,613	268,799	-	290,412	72,358	451	(4,614)	358,607
Physician salaries and wages	43,468	1,162	-	44,630	62,704	-	(41,628)	65,706
Contract labor	777	3,864	-	4,641	2,382	9	(657)	6,375
Employee benefits	7,416	51,007	(2,236)	56,187	17,510	85	(4,182)	69,600
Fees	4,025	100,938	(29,034)	75,929	25,946	517	(4,433)	97,959
Supplies	2,454	135,733	-	138,187	32,124	40	(165)	170,186
Utilities	626	12,222	-	12,848	3,476	965	-	17,289
Other	7,538	47,568	(490)	54,616	23,471	4,077	(5,879)	76,285
Depreciation	1,395	49,959	-	51,354	19,458	2,248	-	73,060
Amortization	30	2,161	-	2,191	54	-	-	2,245
Interest and taxes	(1,169)	42,976	-	41,807	3,018	1,112	(34)	45,903
TOTAL EXPENSES	88,173	716,389	(31,760)	772,802	262,501	9,504	(61,592)	983,215
OPERATING INCOME (LOSS)	426	10,385	(1,488)	9,323	(15,930)	(1,106)	16,038	8,325
Nonoperating gains (losses):								
Interest and dividend income	673	10,841	-	11,514	2,401	1,332	(34)	15,213
Net realized gains (losses) on the sale of securities	21	611	-	632	(3,227)	-	-	(2,595)
Change in net unrealized gains on securities	(455)	(3,758)	-	(4,213)	133	1,196	-	(2,884)
Derivative related income	-	6,051	-	6,051	-	1,464	-	7,515
Loss on early extinguishment of debt	-	(2,553)	-	(2,553)	(83)	-	-	(2,636)
Change in estimated fair value of derivatives	-	(6,086)	-	(6,086)	(133)	21	-	(6,198)
Other nonoperating gains (losses)	823	12,485	-	13,308	(1,977)	(95)	-	11,236
NET NONOPERATING GAINS	1,062	17,591	-	18,653	(2,886)	3,918	(34)	19,651
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	\$ 1,488	\$ 27,976	\$ (1,488)	\$ 27,976	\$ (18,816)	\$ 2,812	\$ 16,004	\$ 27,976

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

**Consolidating Statement of Changes in Net Assets
(Dollars in Thousands)**

Year Ended June 30, 2012

	<i>Blue Ridge</i>	<i>Other Obligated Group Members</i>			<i>Total Obligated Group</i>	<i>Other Entities</i>		<i>Total Other Entities</i>	<i>Mountain States Properties</i>	<i>Eliminations</i>	<i>Total</i>
	<i>Medical Management *</i>	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Eliminations</i>		<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>				
UNRESTRICTED NET ASSETS:											
Excess (deficit) of revenue, gains and support over expenses and losses	\$ 1,488	\$ 31,702	\$ (3,726)	\$ (1,488)	\$ 27,976	\$ (12,729)	\$ (6,087)	\$ (18,816)	\$ 2,812	\$ 16,004	\$ 27,976
Pension and other defined benefit plan adjustments	-	(1,119)	(1,115)	-	(2,234)	(9)	(9)	(18)	-	18	(2,234)
Net assets released from restrictions used for the purchase of property, plant and equipment	-	1,550	-	-	1,550	1,550	-	1,550	-	(1,550)	1,550
Distributions to noncontrolling interests	-	-	(324)	-	(324)	-	(324)	(324)	-	324	(324)
Repurchases of noncontrolling interests	-	3,860	(3,860)	-	-	-	-	-	-	-	-
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	1,488	35,993	(9,025)	(1,488)	26,968	(11,188)	(6,420)	(17,608)	2,812	14,796	26,968
TEMPORARILY RESTRICTED NET ASSETS:											
Restricted grants and contributions	-	3,860	39	-	3,899	3,036	12	3,048	-	(3,048)	3,899
Net assets released from restrictions	-	(3,352)	(46)	-	(3,398)	(3,255)	(22)	(3,277)	-	3,277	(3,398)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	-	508	(7)	-	501	(219)	(10)	(229)	-	229	501
INCREASE (DECREASE) IN TOTAL NET ASSETS	1,488	36,501	(9,032)	(1,488)	27,469	(11,407)	(6,430)	(17,837)	2,812	15,025	27,469
NET ASSETS, BEGINNING OF YEAR	155,611	411,237	-	(155,611)	411,237	239,164	172,041	411,205	132,631	(371,795)	583,278
ADDITION OF OBLIGATED MEMBERS	-	-	54,025	-	54,025	(52,559)	(54,054)	(106,613)	-	52,588	-
NET ASSET TRANSFER	-	-	(5,820)	-	(5,820)	-	5,820	5,820	-	-	-
NET ASSETS, END OF YEAR	\$ 157,099	\$ 447,738	\$ 39,173	\$ (157,099)	\$ 486,911	\$ 175,198	\$ 117,377	\$ 292,575	\$ 135,443	\$ (304,182)	\$ 610,747

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Note to Supplemental Schedules

Year Ended June 30, 2012

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. In accordance with Article Six, Section 6.6 of 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, those members pledged in 2011 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 and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group (Obligated Group). In 2012, NCH and SCCH (hospitals only) were admitted into the Obligated Group. These entities' operations since admission (including noncontrolling interests) are included as part of the Obligated Group results for 2012 in the accompanying consolidated statements of operations and changes in net assets.

The supplemental consolidating schedules include the accounts of the members of the Obligated Group after elimination of all significant intergroup accounts and transactions. Certain other subsidiaries of the Alliance, Mountain States Properties, Inc. (MSP) and all other affiliates (Other Entities), 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.

MOUNTAIN STATES HEALTH ALLIANCE

**Audited Consolidated Financial Statements
(and Supplemental Schedules)**

Years Ended June 30, 2013 and 2012



MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Schedules)

Years Ended June 30, 2013 and 2012

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

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, 2013 and 2012, 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, 2013 and 2012, 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.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplemental consolidating 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.

Pearlman Yorkley & Associates PC

Knoxville, Tennessee
October 24, 2013

MOUNTAIN STATES HEALTH ALLIANCE***Consolidated Balance Sheets***
(Dollars in Thousands)

	<i>June 30,</i>	
	<i>2013</i>	<i>2012</i>
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 74,902	\$ 65,107
Current portion of investments - Note C	20,386	36,557
Patient accounts receivable, less estimated allowances for uncollectible accounts of \$49,449 in 2013 and \$52,696 in 2012	164,187	147,466
Other receivables, net	33,468	30,190
Inventories and prepaid expenses	31,073	28,810
TOTAL CURRENT ASSETS	324,016	308,130
INVESTMENTS, less amounts required to meet current obligations	601,352	560,697
PROPERTY, PLANT AND EQUIPMENT, net	884,293	853,625
OTHER ASSETS		
Goodwill	154,391	154,391
Net deferred financing, acquisition costs and other charges	28,480	28,187
Other assets	46,544	39,975
TOTAL OTHER ASSETS	229,415	222,553
	\$ 2,039,076	\$ 1,945,005

	<i>June 30,</i>	
	<i>2013</i>	<i>2012</i>
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	\$ 19,706	\$ 18,525
Current portion of long-term debt and capital lease obligations	34,417	32,477
Current portion of estimated fair value of derivatives - Note D	-	10,395
Accounts payable and accrued expenses	94,302	108,870
Accrued salaries, compensated absences and amounts withheld	63,665	55,589
Estimated amounts due to third-party payors, net	26,775	22,018
TOTAL CURRENT LIABILITIES	238,865	247,874
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	1,090,348	1,048,098
Estimated fair value of derivatives, less current portion	8,185	8,986
Deferred revenue	2,216	3,134
Estimated professional liability self-insurance	8,758	9,344
Other long-term liabilities	17,721	16,822
TOTAL LIABILITIES	1,366,093	1,334,258
COMMITMENTS AND CONTINGENCIES - Notes D, F, G, and N		
NET ASSETS		
Unrestricted net assets		
Mountain States Health Alliance	490,414	436,388
Noncontrolling interests in subsidiaries	169,614	162,959
TOTAL UNRESTRICTED NET ASSETS	660,028	599,347
Temporarily restricted net assets		
Mountain States Health Alliance	12,776	11,223
Noncontrolling interests in subsidiaries	52	50
TOTAL TEMPORARILY RESTRICTED NET ASSETS	12,828	11,273
Permanently restricted net assets	127	127
TOTAL NET ASSETS	672,983	610,747
	\$ 2,039,076	\$ 1,945,005

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2013</i>	<i>2012</i>
Revenue, gains and support:		
Patient service revenue, net of contractual allowances and discounts	\$ 1,045,245	\$ 1,075,050
Provision for bad debts	(112,497)	(122,917)
Net patient service revenue	932,748	952,133
Premium revenue	1,003	-
Net investment gain	40,980	9,734
Net derivative gain	7,118	1,317
Other revenue, gains and support	77,455	50,643
TOTAL REVENUE, GAINS AND SUPPORT	1,059,304	1,013,827
Expenses:		
Salaries and wages	355,590	358,607
Physician salaries and wages	74,258	65,706
Contract labor	3,942	6,375
Employee benefits	74,590	69,600
Fees	105,891	97,959
Supplies	162,955	170,186
Utilities	16,857	17,289
Medical costs	1,039	-
Other	80,211	76,285
Loss on early extinguishment of debt - Note F	-	2,636
Depreciation	78,941	73,060
Amortization	2,260	2,245
Interest and taxes	43,203	45,903
TOTAL EXPENSES	999,737	985,851
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	\$ 59,567	\$ 27,976

MOUNTAIN STATES HEALTH ALLIANCE

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

Year Ended June 30, 2013

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	\$ 52,692	\$ 6,875	\$ 59,567
Pension and other defined benefit plan adjustments	(172)	(171)	(343)
Net assets released from restrictions used for the purchase of property, plant and equipment	1,506	-	1,506
Distributions to noncontrolling interests	-	(49)	(49)
INCREASE IN UNRESTRICTED NET ASSETS	54,026	6,655	60,681
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	4,969	21	4,990
Net assets released from restrictions	(3,416)	(19)	(3,435)
INCREASE IN TEMPORARILY RESTRICTED NET ASSETS	1,553	2	1,555
INCREASE IN TOTAL NET ASSETS	55,579	6,657	62,236
NET ASSETS, BEGINNING OF YEAR	447,738	163,009	610,747
NET ASSETS, END OF YEAR	\$ 503,317	\$ 169,666	\$ 672,983

MOUNTAIN STATES HEALTH ALLIANCE

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

Year Ended June 30, 2012

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
UNRESTRICTED NET ASSETS:			
Excess (Deficit) of Revenue, Gains and Support over Expenses and Losses	\$ 31,702	\$ (3,726)	\$ 27,976
Pension and other defined benefit plan adjustments	(1,119)	(1,115)	(2,234)
Net assets released from restrictions used for the purchase of property, plant and equipment	1,550	-	1,550
Distributions to noncontrolling interests	-	(324)	(324)
Repurchases of noncontrolling interests	3,860	(3,860)	-
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	35,993	(9,025)	26,968
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	3,860	39	3,899
Net assets released from restrictions	(3,352)	(46)	(3,398)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	508	(7)	501
INCREASE (DECREASE) IN TOTAL NET ASSETS	36,501	(9,032)	27,469
NET ASSETS, BEGINNING OF YEAR	411,237	172,041	583,278
NET ASSETS, END OF YEAR	\$ 447,738	\$ 163,009	\$ 610,747

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2013</i>	<i>2012</i>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase in net assets	\$ 62,236	\$ 27,469
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	81,786	75,777
Provision for bad debts	112,497	122,917
Loss on early extinguishment of debt	-	2,636
Change in estimated fair value of derivatives	(457)	6,198
Equity in net income of joint ventures, net	(636)	(979)
Loss (gain) on disposal of assets	(1)	446
Amounts received on interest rate swap settlements	(6,661)	(7,515)
Gain on escrow restructuring - Note F	(13,847)	(5,337)
Gain on swap settlement - Note D	(3,020)	-
Income recognized through forward sale agreements	-	(864)
Gain on termination of swaption and forward sale agreements - Note D	-	(7,766)
Capital Appreciation Bond accretion and other	3,910	3,159
Restricted contributions	(4,990)	(3,899)
Pension and other defined benefit plan adjustments	343	2,234
Increase (decrease) in cash due to change in:		
Patient accounts receivable	(129,218)	(138,996)
Other receivables, net	(3,192)	(3,501)
Inventories and prepaid expenses	(2,263)	155
Trading securities	(17,845)	107,593
Other assets	(1,073)	(2,733)
Accrued interest payable	1,181	(1,522)
Accounts payable and accrued expenses	(20,263)	4,131
Accrued salaries, compensated absences and amounts withheld	8,076	(2,211)
Estimated amounts due to third-party payers, net	4,757	3,247
Other long-term liabilities	556	236
Estimated professional liability self-insurance	(586)	(348)
Total adjustments	<u>9,054</u>	<u>153,058</u>
NET CASH PROVIDED BY OPERATING ACTIVITIES	71,290	180,527
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property, plant and equipment	(105,751)	(132,890)
Purchases of land held for expansion	(5,769)	-
Additions to goodwill	-	(5,725)
Purchases of held-to-maturity securities	(8,722)	(9,516)
Net distribution from joint ventures and unconsolidated affiliates	732	882
Proceeds from sale of property, plant and equipment	335	1,881
NET CASH USED IN INVESTING ACTIVITIES	(119,175)	(145,368)

	<i>Year Ended June 30,</i>	
	<i>2013</i>	<i>2012</i>
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt and capital lease obligations, including deposits to escrow	(75,066)	(71,997)
Payment of acquisition and financing costs	(2,314)	(2,742)
Proceeds from issuance of long-term debt and other financing arrangements	117,085	67,451
Payment on termination of derivative agreements - Note D	(7,375)	(93,353)
Gain on escrow restructuring - Note F	13,847	5,337
Net amounts received on interest rate swap settlements	6,661	7,515
Restricted contributions received	4,842	4,969
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	<u>57,680</u>	<u>(82,820)</u>
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	9,795	(47,661)
CASH AND CASH EQUIVALENTS, beginning of year	65,107	112,768
CASH AND CASH EQUIVALENTS, end of year	<u>\$ 74,902</u>	<u>\$ 65,107</u>

SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:

Cash paid for interest	<u>\$ 37,023</u>	<u>\$ 41,168</u>
Cash paid for federal and state income taxes	<u>\$ 616</u>	<u>\$ 336</u>
Construction related payables in accounts payable and accrued expenses	<u>\$ 11,598</u>	<u>\$ 6,821</u>
Property acquired through capital lease arrangement	<u>\$ -</u>	<u>\$ 13,959</u>
Payable on termination of forward sale agreements in accounts payable and accrued expenses	<u>\$ -</u>	<u>\$ 13,429</u>
Land held for expansion placed in use	<u>\$ -</u>	<u>\$ 1,610</u>

During the year ended June 30, 2012, the Alliance refinanced previously issued debt of \$174,547.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements (Dollars in Thousands)

Years Ended June 30, 2013 and 2012

NOTE A--ORGANIZATION AND OPERATIONS

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The initial funds for the establishment of the Alliance in 1945 were provided by individuals and various institutions.

The primary operations of the Alliance consist of ten acute and specialty care hospitals, as follows:

- Johnson City Medical Center (JCMC) - licensed for 658 beds
- Indian Path Medical Center (IPMC) - licensed for 261 beds
- Smyth County Community Hospital (SCCH) - licensed for 153 beds
- Norton Community Hospital (NCH) - licensed for 129 beds
- Sycamore Shoals Hospital (SSH) - licensed for 121 beds
- Johnston Memorial Hospital (JMH) - licensed for 116 beds
- Franklin Woods Community Hospital (FWCH) - licensed for 80 beds
- Russell County Medical Center (RCMC) - licensed for 78 beds
- Dickenson Community Hospital (DCH) - licensed for 25 beds
- Johnson County Community Hospital (JCCH) - licensed for 2 beds

The Alliance has a 50.1% interest in JMH. JMH is also the sole member of Abingdon Physician Partners (APP), a non-taxable corporation that owns and manages physician practices.

The Alliance has a 50.1% interest in NCH. NCH is also the sole member or shareholder of DCH and Norton Community Physician Services, LLC (NCPS), a taxable corporation that consists of physician practices and a pharmacy and Community Home Care (CHC), a taxable corporation that provides home medical equipment.

The Alliance has an 80% interest in SCCH. SCCH is the sole shareholder of Southwest Community Health Services, Inc. (SWCH), a taxable entity that operates a pharmacy and provides other health services.

The activities and accounts of JMH, NCH and SCCH are included in the accompanying consolidated financial statements.

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices and provides other healthcare services to patients in Tennessee and Virginia. BRMM also operates as a medical office real estate developer by owning, selling and leasing real estate to physician practices and other entities. BRMM is either the sole shareholder, a significant shareholder, or member of the following consolidated organizations:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2013 and 2012

NOTE A--ORGANIZATION AND OPERATIONS - Continued

Mountain States Physician Group, Inc. (MSPG): A company that contracts with physicians to provide services to BRMM physician practices.

Mountain States Properties, Inc. (MSPI): An entity that owns and manages certain real estate (primarily medical office buildings) and provides rehabilitation and fitness services.

Mediserve Medical Equipment of Kingsport, Inc. (Mediserve): A company that provides durable medical equipment services.

Kingsport Ambulatory Surgery Center (KASC) (d.b.a. Kingsport Day Surgery): A joint venture operating as an outpatient surgery center which performs procedures primarily in otolaryngology, orthopedics, ophthalmology, and general surgery. BRMM has a 43% ownership of KASC and maintains control over KASC through a management agreement. The accounts and activities of KASC are included in the accompanying consolidated financial statements.

Piney Flats Urgent Care (PFUC): A for-profit entity that provides urgent care patient services. BRMM has a 75% ownership of PFUC. The accounts and activities of PFUC are included in the accompanying consolidated financial statements.

Wilson Pharmacy, Inc. (Wilson): In August 2012, BRMM acquired Wilson, a company that owns and operates retail pharmacies. BRMM purchased 100% of the total issued and outstanding capital stock of Wilson for \$8,114 and recognized goodwill of \$5,725.

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc. (MSF), a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance. The Alliance is also the beneficiary of the Mountain States Health Alliance Auxiliary (Auxiliary), a not-for-profit organization formed to coordinate volunteer activities of the Alliance. The activities and accounts of MSF and the Auxiliary are included in the accompanying consolidated financial statements.

The Alliance is a 99.6% shareholder of Integrated Solutions Health Network, LLC (ISHN). The primary function of ISHN is to establish, operate and administer a provider-sponsored health care delivery network. ISHN is the sole shareholder of the following subsidiaries:

CrestPoint Health Insurance Company (CHIC): A for-profit insurance company licensed in the State of Tennessee which provides network access and administration and third-party Medicare administrator services. During 2013, CHIC entered into a risk-based contract with the Center for Medicare & Medicaid Services (CMS) to provide or arrange for the provision of healthcare

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE A--ORGANIZATION AND OPERATIONS - Continued

services to senior citizens who have Medicare Part A, Medicare Part B and Medicare Part D entitlements.

AnewCare Collaborative (AnewCare): A for-profit accountable care organization which began participating in the CMS's Medicare Shared Savings Program (MSSP) in July 2012.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

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

Noncontrolling Interests in Subsidiaries: The Alliance's accompanying consolidated financial statements include all assets, liabilities, revenues, expenses, and changes in net assets, including amounts attributable to the noncontrolling interests. Noncontrolling interests represent the portion of equity (net assets) in a subsidiary not attributable, directly or indirectly, to the Alliance. For the years ending June 30, 2013 and 2012, the Alliance attributed an Excess (Deficit) of Revenue, Gains and Support over Expenses and Losses of \$6,875 and (\$3,726), respectively, to the noncontrolling interests in JMH, NCH, SCCH, KASC, PFUC and ISHN based on the noncontrolling interests' respective ownership percentage.

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 on the Consolidated Balance Sheets.

Investments: Investments as reported in the Consolidated Balance Sheets include trading securities and held-to-maturity securities (Note C). The Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958-320, *Investments – Debt and Equity Securities*, allows not-for-profit organizations to report in a manner similar to business entities by identifying securities as available-for-sale or held-to-maturity and to exclude the unrealized gains and losses on

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

those securities from the Performance Indicator (as defined below). Investments which the Alliance has the positive intent and ability to hold to maturity are considered as held-to-maturity. Substantially all other investments are considered as trading securities.

On June 30, 2013, the Alliance determined that it no longer intended to hold certain of its held-to-maturity investment portfolios to maturity and reclassified investments with an amortized cost of \$161,929 into the trading designation. As a result, the Alliance recognized net unrealized gains of approximately \$8,255 in the accompanying 2013 Consolidated Statement of Operations. The investments that remain designated as held-to-maturity are limited as to use under a safekeeping agreement or are otherwise unavailable for disposition.

Management annually evaluates investments designated as held-to-maturity and recognizes any "other-than-temporary" losses as deductions from the Performance Indicator (as defined below). Management's 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, 2013.

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 pursuant to FASB ASC 825, *Financial Instruments*.

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.

Investments in joint ventures are generally reported under the equity method of accounting, which approximates the Alliance's equity in the underlying net book value, unless the ownership structure requires consolidation. Other assets include investments in joint ventures of \$2,057 and \$2,153 at June 30, 2013 and 2012, respectively. Subsequent to June 30, 2013, the Alliance liquidated a portion of its investment in one joint venture (Note S).

Inventories: Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

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 2013 and 2012.

Other assets include property held for resale and property held for expansion of \$20,220 and \$14,451, respectively, at June 30, 2013 and 2012. Property held for resale and property held for expansion primarily represent 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 2013 and 2012.

Goodwill: Goodwill represents the difference between the acquisition cost of assets and the estimated fair value of net tangible and any separately identified intangible assets. In accordance with ASC 350, *Intangibles – Goodwill and Other*, goodwill is evaluated for impairment at least annually. The reporting unit for evaluation of the majority of the Alliance's goodwill is the aggregate acute-care operations. Management performed an evaluation of goodwill for impairment considering qualitative and quantitative factors and does not believe it is more likely than not that goodwill associated with any of its reporting units is impaired as of June 30, 2013.

Deferred Financing, Acquisition Costs and Other Charges: Other assets, including deferred financing, acquisition costs and other charges, total \$28,480 and \$28,187 at June 30, 2013 and 2012, respectively. Deferred financing costs are amortized over the life of the respective bond issue principally using the average bonds outstanding method. Other intangible assets include licenses and similar assets and are being amortized over the intangible's estimated useful life under the straight-line method.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Prior to 2009, the Alliance routinely financed interest rate swap and other derivative transaction issuance costs through modification of future settlement terms. As such, the unamortized issuance costs of these derivatives are included as deferred financing costs in the accompanying Consolidated Balance Sheets and are being amortized over the term of the respective derivative instrument. The unpaid issuance costs are included as a part of the estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. Subsequent to 2009, interest rate swap and derivative transaction issuance costs were expensed as incurred.

Derivative Financial Instruments: As further described in Note D, 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. Changes in the estimated fair value of these derivatives are included in the Consolidated Statements of Operations as part of net derivative gain.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims (Note G) 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. Additions to the allowance for uncollectible accounts result from the

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

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 his or her 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. The estimated direct and indirect cost of providing these services totaled approximately \$24,354 and \$24,709 in 2013 and 2012, respectively. Such costs are determined using a ratio of cost to charges analysis with indirect cost allocated.

In addition to the charity care services described above, 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 (Deficit) 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 (Deficit) 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. Taxable entities account for income taxes in accordance with FASB ASC 740, *Income*

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Taxes (Note L). The Alliance has no significant uncertain tax positions at June 30, 2013 and 2012. At June 30, 2013, tax returns for 2009 through 2013 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: Premiums earned include premiums from individuals and Medicare. Medicare revenue includes premiums 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. CHIC evaluated the need for a premium deficiency reserve and recorded an estimated reserve of \$1,500 at June 30, 2013.

Medicare Shared Savings Program (MSSP): AnewCare, an Accountable Care Organization (ACO), 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. ACOs 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. The program is based on performance periods, the first of which specific to AnewCare is the period of July 2012 to December 2013. Utilizing statistical data and the methodology employed by CMS, AnewCare has estimated and recognized \$2,644 of net shared savings through June 30, 2013. Variability is inherent in the estimation methodology and due to uncertainties in the estimation; it is probable that management's estimates of shared savings, if any, will change by the end of the performance period, and such change could be significant.

Electronic Health Record 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 electronic health

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2013 and 2012

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

record (EHR) technology. The incentive payments are calculated based upon estimated discharges, charity care and other input data and are predicated upon the Alliance's attainment of program and attestation criteria and are subject to regulatory audit. During the years ending June 30, 2013 and 2012, the Alliance recognized EHR incentive revenues of \$22,474 and \$4,894, respectively, comprised of \$17,340 of Medicare revenues in 2013 and \$5,134 and \$4,894 of Medicaid revenues in 2013 and 2012, 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 CHIC members by third-party providers, which have been incurred but not provided to CHIC. The estimate for incurred but not reported claims is based on actuarial projections of costs using historical paid claims and industry data. Due to uncertainties in the estimation, it is at least reasonably possible that management's estimates of incurred but not reported claims will change in 2014, although the amount of the change cannot be estimated.

Fair Value Measurement: The Alliance had previously adopted FASB ASC 820, *Fair Value Measurements and Disclosures*, which defines fair value, establishes a framework for measuring fair value under generally accepted accounting principles and expands disclosures about fair value measurements.

Subsequent Events: The Alliance evaluated all events or transactions that occurred after June 30, 2013, through October 24, 2013, 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, 2013 consolidated financial statements, other than as discussed in Note S.

Reclassifications: Certain 2012 amounts have been reclassified to conform with the 2013 presentation in the accompanying consolidated financial statements. Prior to 2013, the Alliance classified only those activities directly associated with its mission of providing healthcare services, as well as other activities deemed significant to its operations, as operating activities. In 2013, the Alliance no longer presents an intermediate measure of operating income (loss) and the 2012 Consolidated Statement of Operations has been reformatted to be consistent with this presentation.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2013 and 2012

NOTE C--INVESTMENTS

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

	<i>2013</i>	<i>2012</i>
Designated or restricted:		
Under safekeeping agreements and other	\$ 10,350	\$ 24,026
By Board for capital improvements	-	4
Under bond indenture agreements:		
For debt service and interest payments	60,823	77,602
For capital acquisitions	36,989	29,578
	<u>108,162</u>	<u>131,210</u>
Less: amount required to meet current obligations	<u>(20,386)</u>	<u>(36,557)</u>
	<u><u>\$ 87,776</u></u>	<u><u>\$ 94,653</u></u>

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

	<i>2013</i>	<i>2012</i>
Cash, cash equivalents and money market funds	\$ 57,190	\$ 80,304
U.S. Government securities	11,164	8,582
U.S. Agency securities	30,407	40,398
Corporate and foreign bonds	7,530	-
Municipal obligations	1,871	1,926
	<u>\$ 108,162</u>	<u>\$ 131,210</u>

Trading securities consist of the following at June 30:

	<i>2013</i>	<i>2012</i>
Cash, cash equivalents and money market funds	\$ 9,488	\$ 5,186
U.S. Government securities	18,481	10,697
U.S. Agency securities	19,620	26,165
Corporate and foreign bonds	172,350	52,581
Municipal obligations	17,749	961
Preferred and asset backed securities	3,491	11,183
U.S. equity securities	10,944	28,344
Mutual funds	186,028	141,968
Other	37,353	34,880
	<u>\$ 475,504</u>	<u>\$ 311,965</u>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE C--INVESTMENTS - Continued

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

	<u>2013</u>	<u>2012</u>
Cash, cash equivalents and money market funds	\$ 75	\$ 298
Corporate and foreign bonds	33,060	138,232
Municipal obligations	4,937	15,549
	<u>\$ 38,072</u>	<u>\$ 154,079</u>

Held-to-maturity securities had gross unrealized gains and losses of \$15 and \$1,421, respectively, at June 30, 2013 and \$11,432 and \$33, respectively at June 30, 2012. At June 30, 2013 and 2012, the Alliance held no securities within the held-to-maturity portfolio which had been at an unrealized loss position for over one year. At June 30, 2013, the contractual maturities of held-to-maturity securities were \$2,702 due in one year or less, \$17,923 due from one to five years and \$17,447 due after five years. At June 30, 2012, the contractual maturities of held-to-maturity securities were \$11,225 due in one year or less, \$67,532 due from one to five years and \$75,322 due after five years.

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

	<u>2013</u>	<u>2012</u>
Interest and dividend income, net of fees	\$ 13,881	\$ 15,213
Net realized (losses) gains on the sale of securities	3,074	(2,595)
Change in net unrealized gains on securities	24,025	(2,884)
	<u>\$ 40,980</u>	<u>\$ 9,734</u>

At June 30, 2013 and 2012, the Alliance held investments in certain limited partnerships and hedge funds with a recorded value of \$37,353 and \$34,880, respectively, that have a wide range of investment strategies with various levels of risk. These funds are included within trading securities and do not have readily determinable fair values. The funds are reported at estimated fair market value pursuant to FASB ASC 825, *Financial Instruments*.

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is a party to a number of derivative transactions. These derivatives have not been designated as hedges and are valued at estimated fair value in the accompanying Consolidated Balance Sheets. Management's primary objective in holding such derivatives is to introduce a

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2013 and 2012

NOTE D--DERIVATIVE TRANSACTIONS - Continued

variable rate component into its fixed rate debt structure. Under the terms of these agreements, changes in the interest rate environment could have a significant effect on the Alliance. Deferred financing and acquisition costs, net of amortization, include \$5,791 and \$6,135 at June 30, 2013 and 2012, respectively, related to these swaps.

These derivative agreements require that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. As of June 30, 2013, the Alliance was not required to post additional collateral. Such investments totaling \$13,809 are included as assets limited as to use in the accompanying 2012 Consolidated Balance Sheet.

The following is a summary of the interest rate swap agreements at June 30, 2013 and 2012:

<i>Notional Amount</i>	<i>Term</i>	<i>Counterparty</i>	<i>Payments by:</i>		<i>Estimated Fair Value</i>	
			<i>Receive</i>	<i>Pay</i>	<i>2013</i>	<i>2012</i>
\$ 170,000	4/2008-4/2026	Bank of America, Merrill Lynch	1.27% 7/2012-4/2013 1.07% 5/2013-6/2013	0.00%	\$ 3,895	\$ 3,500
95,000	4/2008-4/2026	Bank of America, Merrill Lynch	1.27% 7/2012-4/2013 1.08% 5/2013-6/2013	0.00%	2,205	1,983
173,030	4/2008-4/2034	Bank of America, Merrill Lynch	1.32% 7/2012-4/2013 1.12% 5/2013-6/2013	0.00%	(710)	(513)
82,055	12/2007-7/2033	Bank of America, Merrill Lynch	67% USD-LIBOR-BBA	0.312% + USD-SIFMA	(9,322)	(9,520)
50,000	2/2008-7/2038	Bank of America, Merrill Lynch	67% (USD-LIBOR-BBA + 0.15%)	USD-SIFMA	(4,218)	(3,895)
21,400	7/2007-7/2015	Bank of America, Merrill Lynch	1.05% + USD-SIFMA	4.50%	35	(320)
5,524	Various	Various	Various	Various	(70)	(221)
					<u>\$ (8,185)</u>	<u>\$ (8,986)</u>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE D--DERIVATIVE TRANSACTIONS - Continued

The terms of five of these agreements were modified without settlement during 2013. No gain or loss was realized as a result of the modifications although such modifications did impact the estimated fair value of the interest rate swaps as of June 30, 2013.

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

	<u>2013</u>	<u>2012</u>
Settlement income and other	\$ 6,661	\$ 7,515
Change in estimated fair value	457	(6,198)
	<u>\$ 7,118</u>	<u>\$ 1,317</u>

These fair values are based on the estimated amount the Alliance would receive, or be required to pay, to enter into equivalent agreements at the valuation date and include an estimated credit value adjustment. The fair value of various derivatives are netted on the Consolidated Balance Sheets based on management's evaluation of the settlement provisions in the master contract. Gross positions of these derivatives are indicated in the table above. Due to the nature of these financial instruments, such estimates of fair value are subject to significant change in the near term.

The Alliance was previously a party to a total return swap with Lehman Brothers as the counterparty. Lehman Brothers filed for bankruptcy in September 2008. The Alliance subsequently received notification from Lehman Brothers Special Financing, Inc. indicating the intent of the counterparty to terminate this agreement effective January 1, 2009. The Alliance and Lehman Brothers Special Financing, Inc. were unable to reach a settlement agreement at the time the swap was terminated. An estimated liability related to the agreement of \$10,395 was recognized by the Alliance at June 30, 2012. In addition, a third party held investments with a fair market value of approximately \$13,809, at June 30, 2012, as collateral. In 2013, the parties reached a settlement agreement and in full settlement of the liability, the Alliance paid the counterparty \$7,375 from the funds held as collateral and the remaining collateral was returned to the Alliance. A gain of approximately \$3,020 was recognized on the settlement, which is included within other revenue, gains and support in the accompanying 2013 Consolidated Statement of Operations.

In June 2004, the Alliance entered into an agreement with Bear Stearns (acquired by JP Morgan) whereby Bear Stearns purchased from the Alliance an option to enter into an interest rate swap agreement (swaption) with the Alliance beginning July 1, 2011. During 2012, the counterparty expressed their intent to exercise the swaption on January 1, 2012 and the Alliance exercised its right to terminate the swaption at its fair market value. To effectuate the termination, the Alliance transferred \$93,353 of a Guaranteed Investment Contract (GIC), to the third party as a termination payment. A gain of \$3,058 was recognized on the termination, which is included within other

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE D--DERIVATIVE TRANSACTIONS - Continued

revenue, gains and support in the accompanying 2012 Consolidated Statement of Operations. Net derivative gain in the accompanying 2012 Consolidated Statement of Operations includes an unrealized loss of \$4,676 related to this derivative, prior to termination.

Also in June 2004, the Alliance entered into two related forward sale agreements with the counterparty to the swaption agreements and the Master Trustee of the Series 2000 Bonds. In June 2012, the Alliance and the counterparty terminated the agreements. To effectuate the termination, the Alliance agreed to pay \$13,429 to the counterparty. The termination payable is included in accounts payable and accrued expenses in the accompanying 2012 Consolidated Balance Sheet. The Alliance recognized a gain of \$4,708 on the termination of these agreements, which is included within other revenue, gains and support in the accompanying 2012 Consolidated Statement of Operations.

NOTE E--PROPERTY, PLANT AND EQUIPMENT

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

	<u>2013</u>	<u>2012</u>
Land	\$ 60,180	\$ 57,525
Buildings and leasehold improvements	718,489	661,146
Property and improvements held for leasing	77,767	74,914
Equipment	664,469	571,774
Buildings and equipment held under capital lease	671	20,540
	<u>1,521,576</u>	<u>1,385,899</u>
Less: Allowances for depreciation and amortization	<u>(704,002)</u>	<u>(626,552)</u>
	817,574	759,347
Construction in progress (Note N)	66,719	94,278
	<u>\$ 884,293</u>	<u>\$ 853,625</u>

Accumulated depreciation and amortization on property and improvements held for leasing purposes is \$25,146 and \$22,951 at June 30, 2013 and 2012, respectively. Net interest capitalized was \$4,163 and \$3,110 for the years ended June 30, 2013 and 2012, respectively.

During 2012, the Alliance executed an Amendment and Mutual Release Agreement with a vendor whereby the Alliance waived its right to take any action with respect to prior contracts in exchange for professional services in future periods, primarily related to accelerated deployment of information

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2013 and 2012

NOTE E--PROPERTY, PLANT AND EQUIPMENT - Continued

systems. The Alliance recognized approximately \$3,386 and \$3,799 in 2013 and 2012 as additions to property, plant and equipment with an offsetting gain related to the agreed-upon value of such professional services. The Alliance anticipates recognition of additional amounts in future periods as such services are provided.

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

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

Description	Maturities	Rates	Outstanding Balance	
			2013	2012
2012A Hospital Revenue Bonds, net of unamortized premium of \$1,817 at June 30, 2013	\$55,000 uninsured term bonds, due August 15, 2042, subject to early redemption	5.00%	\$ 56,817	\$ -
2012B Hospital Revenue Bonds	\$28,095 uninsured term bonds, due August 15, 2042, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	28,095	-
2012C Hospital Revenue Bonds	\$9,785 uninsured term bonds, due August 15, 2042, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	9,785	-
2011A Hospital Revenue Bonds	\$61,185 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	61,185	65,260
2011B Hospital Revenue Bonds	\$20,000 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	20,000	20,000
2011C Hospital Revenue Bonds	\$48,974 uninsured term bonds, due July 1, 2031, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	48,974	49,875
2011D Hospital Revenue Bonds	\$60,705 uninsured term bonds, due July 1, 2031, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	60,705	60,705
2011E Taxable Bonds	\$15,960 uninsured term bonds, due July 1, 2026, subject to early redemption or tender	Variable, 0.17% at June 30, 2013	15,960	15,960
2011 Hospital Facility Revenue Refunding and Improvement Bonds (JMH)	\$23,095 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 1.14% at June 30, 2013	23,095	24,870
2010A Hospital Revenue Bonds, net of unamortized premium of \$978 and \$1,017 at June 30, 2013 and 2012, respectively	\$28,780 uninsured serially, through 2020 \$14,985 uninsured term bonds, due July 1, 2025 \$19,230 uninsured term bonds, due July 1, 2030 \$39,570 uninsured term bonds, due July 1, 2038 \$55,480 uninsured term bonds, due July 1, 2038	3.00% to 5.00% 5.38% 5.63% 6.50% 6.00%	159,023	162,952
2010B Hospital Revenue Bonds, net of unamortized premium of \$626 and \$669 at June 30, 2013 and 2012, respectively	\$20,295 uninsured serially, through 2020 \$4,355 uninsured term bonds, due July 1, 2023 \$4,250 uninsured term bonds, due July 1, 2028	2.50% to 5.00% 5.00% 5.50%	29,526	33,129
2009A Hospital Revenue Bonds, net of unamortized discount of \$113 and \$117 at June 30, 2013 and 2012, respectively	\$655 uninsured term bonds, due July 1, 2019 \$1,730 uninsured term bonds, due July 1, 2029 \$3,105 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	5,377	5,443
2009B Hospital Revenue Bonds	\$5,470 uninsured term bonds, due July 1, 2038	8.00%	5,470	5,535
2009C Hospital Revenue Bonds, net of unamortized discount of \$2,246 and \$2,334 at June 30, 2013 and 2012, respectively	\$18,800 uninsured term bonds, due July 1, 2019 \$20,000 uninsured term bonds, due July 1, 2029 \$74,855 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	111,409	113,621
2008A Hospital Revenue Bonds	\$13,245 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	13,245	13,245
2008B Hospital Revenue Bonds	\$51,965 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	51,965	52,930
2007B Taxable Hospital Revenue Bonds, sub-series B-1 and B-2	\$123,335 uninsured term bonds, due July 1, 2033, subject to early redemption or tender, sub-series B-3 redeemed in 2013	Variable, 0.17% to 0.18% at June 30, 2013	123,335	156,760

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2013 and 2012

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

<i>Description</i>	<i>Maturities</i>	<i>Rates</i>	<i>Outstanding Balance</i>	
			<i>2013</i>	<i>2012</i>
2006A Hospital First Mortgage Revenue Bonds, net of unamortized premium of \$135 and \$141 at June 30, 2013 and 2012, respectively	\$5,295 uninsured serially, through 2019 \$7,375 uninsured term bonds, due July 1, 2026 \$20,505 uninsured term bonds, due July 1, 2031 \$135,175 uninsured term bonds, due July 1, 2036	5.00% 5.25% 5.50% 5.50%	168,485	169,136
2001A Hospital First Mortgage Revenue Bonds	\$21,400 term bonds, due July 1, 2026, subject to early redemption or tender	4.50%	21,400	22,300
2000A Hospital First Mortgage Revenue Refunding Bonds	\$34,645 insured Capital Appreciation Bonds, interest and principal due July 1, 2026 through 2030	6.63%	34,645	32,431
2000C Hospital First Mortgage Revenue Bonds	\$32,040 insured term bonds, due July 1, 2026	8.50%	32,040	33,230
2000D First Mortgage Taxable Bonds	\$13,800 insured term bonds, due July 1, 2026	8.50%	13,800	14,315
Capitalized lease obligations secured by equipment	Various monthly payments of principal and interest	Various	1,240	1,645
\$1,593 note payable, secured by equipment	Various annual principal payments through July 2014	Unspecified	896	1,343
Capitalized lease obligation secured by medical office building (JMH)	Lease was paid-off in 2013	N/A	-	15,498
Master installment payment agreement	Various quarterly payments through May 2014	Unspecified	2,320	4,438
Master installment payment agreement, secured by equipment	Various quarterly payments through May 2014	Unspecified	1,503	3,032
\$1,640 note payable, secured by land	Monthly principal payments of \$10 through maturity in July 2015	Unspecified	1,640	1,870
\$985 in promissory notes secured by assets of Emmaus Community Healthcare, LLC	Various monthly principal and interest payments through 2019	3.00% - 3.75%	985	1,052
\$17,607 term note	Monthly principal and interest payments of \$60 beginning November 2012 maturing September 2015; remaining principal due October 2015	Variable, 1.14% at June 30, 2013	17,607	-
\$4,238 in notes payable, secured by land	Annual principal payments of \$215 beginning October 2013 maturing October 2015; remaining principal due October 2016. Interest is payable monthly.	Variable, 0.19% at June 30, 2013	4,238	-
			1,124,765	1,080,575
	Less current portion		(34,417)	(32,477)
			\$ 1,090,348	\$ 1,048,098

Series 2012 Bonds: In September 2012, the Alliance issued \$55,000 (Series 2012A) fixed rate and \$28,095 (Series 2012B) variable rate tax-exempt Hospital Revenue Bonds through The Health and Educational Facilities Board of the City of Johnson City, Tennessee, and \$9,785 (Series 2012C) variable rate tax-exempt Hospital Revenue Bonds through the Industrial Development Authority of Wise, Virginia (collectively, the Series 2012 Bonds). The proceeds from the Series 2012A Bonds will be used to finance a surgery center project at JCMC and pay issuance costs related to these Bonds. The proceeds from the Series 2012B and 2012C Bonds will be used to finance or refinance capital improvements and equipment acquisitions and to pay issuance costs associated with these Bonds. The timely payment of the Series 2012B and Series 2012C Bonds is secured by irrevocable transferable direct-pay letters of credit which expire September 17, 2015.

Series 2011 Bonds: In October 2011, the Alliance issued \$65,260 (Series 2011A) and \$20,000 (Series 2011B) variable rate tax-exempt Hospital Revenue Bonds through The Health and

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2013 and 2012

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

Educational Facilities Board of the City of Johnson City, Tennessee, \$49,875 (Series 2011C) and \$60,705 (Series 2011D) variable rate tax-exempt Hospital Revenue Bonds through the Industrial Development Authority of Smyth, Virginia and \$15,960 (Series 2011E) variable rate Taxable Bonds (collectively, the Series 2011 Bonds). The proceeds from the Series 2011A and Series 2011B Bonds were used to finance certain capital acquisitions in the State of Tennessee and pay issuance costs related to these Bonds. The proceeds from the Series 2011C and 2011D Bonds were used to refinance the 2001 NCH Hospital Refunding and Improvement Revenue Bonds, finance capital acquisitions for NCH, JMH and SCCH and to pay issuance costs associated with these Bonds. The Series 2011E Bond proceeds were used to refinance certain capital acquisitions of SCCH and BRMM and pay issuance costs. The timely payment of the Series 2011 Bonds is secured by a letter of credit which expires October 19, 2014.

In November 2011, JMH issued \$24,870 (JMH Series 2011) variable rate tax-exempt Hospital Facility Revenue Refunding and Improvement Bonds through the Industrial Development Authority of Smyth County. The proceeds from the JMH Series 2011 Bonds were used to refinance the 1998 Hospital Refunding and Improvement Revenue Bonds, refinance existing indebtedness incurred to finance capital acquisitions and to pay issuance costs associated with the Bonds.

Series 2010 Bonds: In April 2010, the Alliance issued \$168,080 (Series 2010A) and \$35,935 (Series 2010B) fixed rate Hospital Refunding Revenue Bonds (collectively, the Series 2010 Bonds). Proceeds of the Series 2010A and the Series 2010B Bonds were used to refinance outstanding indebtedness, specifically related to the Alliance's facilities in Tennessee and in Virginia, respectively, fund debt service reserve funds and pay costs of issuance.

Series 2009 Bonds: In March 2009, the Alliance issued \$5,560 (Series 2009A), \$5,535 (Series 2009B) and \$115,955 (Series 2009C) fixed rate Hospital Revenue Bonds (collectively, the Series 2009 Bonds). The proceeds of Series 2009 Bonds were used to refinance a portion of the outstanding Series 2006C Taxable Notes, which were originally issued to finance a capital commitment to SCCH and purchase certain leased assets, finance the acquisition of a majority ownership in JMH, fund a debt service reserve fund and pay costs of issuance. The portion of the 2006C taxable notes which were not refinanced with the Series 2009 Bonds were repaid with cash on hand.

Series 2008 Bonds: In February 2008, the Alliance issued \$72,770 (Series 2008A) and \$54,230 (Series 2008B) variable rate Hospital Revenue Bonds (collectively, the Series 2008 Bonds). The proceeds of Series 2008 Bonds were primarily used to finance certain future capital projects for the Alliance's hospital facilities and for the repayment of previously issued 2008 Taxable Notes used for the acquisition of RCMC. The payment of principal and interest on the Series 2008 Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable,

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

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

transferable, direct-pay letter of credit. A portion (\$59,525) of the Series 2008A Bonds were repaid from proceeds of the Series 2010 Bonds.

Series 2007 Bonds: In December 2007, the Alliance issued \$104,355 (Series 2007A), \$327,170 (Series 2007B taxable) and \$36,575 (Series 2007C) variable rate Hospital Revenue Bonds (collectively, the Series 2007 Bonds). The proceeds of Series 2007 Bonds were primarily used to early extinguish a portion of the outstanding Series 2000A Bonds, all of the outstanding 2000B Bonds, all of the outstanding Series 1994 Bonds, and all of the outstanding Series 2006B Bonds; to finance the acquisition of a majority ownership in NCH, and to finance certain capital improvements and equipment acquisitions for the Alliance's hospital facilities. A portion of the outstanding Series 2007A (\$91,685) and Series 2007C (\$32,840) Bonds were repaid from proceeds of the Series 2010 Bonds.

During 2012, the Alliance redeemed \$115,135 of the Series 2007B-1 Bonds and \$29,405 of the Series 2007B-3 Bonds. The Alliance redeemed \$26,530 of the Series 2007B-3 Bonds during 2013. The payment of principal and interest on the outstanding Sub-Series 2007B Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit.

Series 2006 Bonds: During 2006, the Alliance issued \$173,030 Hospital First Mortgage Revenue Bonds (Series 2006A) and \$66,500 Hospital First Mortgage Variable Rate Revenue Bonds (Series 2006B). The proceeds from the sale of the Series 2006A Bonds were used to finance certain future and prior capital projects for the Alliance's hospital facilities and to refund certain existing indebtedness, specifically the Series 2001B Bonds (discussed below) and certain existing short and intermediate term loans and leases, as well as fund a debt service reserve fund. The Series 2006B Bond proceeds were substantially used to refund the remaining outstanding principal of the Series 2001B Bonds and establish a debt service reserve fund.

Series 2001 Bonds: During 2001, the Alliance issued \$26,000 Hospital First Mortgage Revenue Bonds (Series 2001A). The Alliance redeemed the 2001A Bonds and released a new Series 2001A to Bank of America Merrill Lynch during 2012.

Series 2000 Bonds: The Hospital First Mortgage Revenue Refunding (Series 2000A Bonds) and First Mortgage Revenue Refunding Bonds (Series 2000B Bonds), were used to advance refund previously existing indebtedness as well as fund a required debt service reserve fund. The Hospital First Mortgage Revenue Bonds (Series 2000C Taxable Bonds) were used to refinance certain mortgage indebtedness of BRMM, and to refund other previously existing indebtedness. The

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

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

proceeds from the sale of the First Mortgage Bonds (Series 2000D Taxable Bonds) were used primarily to fund working capital for the Alliance.

The Series 2000A Bonds included at issue date \$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.

Derecognized Bonds: The advance refunding of previously issued debt requires funds to be placed in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments. 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, and the debt and escrowed securities are not considered liabilities or assets of the Alliance. Therefore, such debt has been derecognized. Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2013 due to previous advance refundings of the Series 2000A Bonds, Series 2000B Bonds, Series 1998C Bonds, and Series 1991 Bonds, totaled approximately \$213,060.

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.

The Alliance instructed the trustee of the 1998C Bonds to liquidate certain investments held in the related irrevocable trust account and to redeem a portion of the 1998C Bonds with the proceeds from the liquidation. The fair value of the liquidated assets exceeded the payment necessary to redeem the 1998C Bonds and the excess was paid to the Alliance. As a result of this transaction, the Alliance recognized a net gain in 2013 and 2012 of \$13,847 and \$5,337, respectively, which is included in other revenue, gains and support in the accompanying Consolidated Statements of Operations.

Variable Rate Issuances: The variable rate of interest on the Series 2012, Series 2011, Series 2008 and Series 2007 Bonds is determined weekly by the Remarketing Agent, as the rate equal to the lowest rate which, in regard to general financial conditions and other special conditions bearing on the rate, would produce as nearly as possible a par bid for the Bonds in the secondary market. In no

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

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

event shall the variable rate on the Bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the applicable State of issue. The Alliance has the option, upon written approval of the holder of the letters of credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate.

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.

Other Bonds, Notes Payable and Financing Arrangements: 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 JMH Series 2011 Hospital Refunding and Improvement Revenue Bonds are secured by pledged revenues of JMH, as defined in the Credit Agreement.

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, 2013 are as follows:

<u>Year Ending June 30,</u>		
2014	\$	34,417
2015		28,191
2016		45,427
2017		32,290
2018		29,253
Thereafter		<u>953,990</u>
		1,123,568
	Net premium	<u>1,197</u>
		<u>\$ 1,124,765</u>

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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2013 and 2012

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

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, 2013.

In connection with the tax-exempt bonds, the Alliance is required every five years, and at maturity, to remit to the Internal Revenue Service amounts which are due related to positive arbitrage on the borrowed funds. The Alliance performs such computations when required and recognizes any liability at that time. Management does not believe there are any significant arbitrage liabilities at June 30, 2013 or 2012.

During 2012, the Alliance recognized a \$2,636 loss on early extinguishment of debt representing the write off of previously deferred and unamortized financing costs generally related to the refinanced or otherwise redeemed portion of the Series 2007B Bonds, Series 1998 JMH Bonds and the Series 2001 NCH Bonds.

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 and \$1,000 annual aggregate retention. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

At June 30, 2013, 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, 2013 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Alliance 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, 2013 and 2012 was \$12,348 and \$12,896, respectively. The discount rate utilized was 5% at June 30, 2013 and 2012.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2013 and 2012

NOTE G--SELF-INSURANCE PROGRAMS - Continued

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, including a catastrophic claims reserve based on historical claims in excess of \$75. Such amount is included in accounts payable and accrued expenses in the Consolidated Balance Sheets.

NOTE H--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates to net patient service revenue as presented in the accompanying Consolidated Statements of Operations is as follows for the years ended June 30:

	<u>2013</u>		<u>2012</u>
Inpatient service charges	\$ 2,086,519	\$	2,095,036
Outpatient service charges	2,120,400		1,982,154
Gross patient service charges	4,206,919		4,077,190
Less:			
Estimated contractual adjustments and other discounts	3,058,580		2,899,678
Charity care	103,094		102,462
Provision for bad debts	112,497		122,917
	<u>3,274,171</u>		<u>3,125,057</u>
Net patient service revenue	<u>\$ 932,748</u>	<u>\$</u>	<u>952,133</u>

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

	<u>2013</u>		<u>2012</u>
Third-party payers	946,979	\$	968,101
Patients	98,266		106,949
Patient service revenue	<u>\$ 1,045,245</u>	<u>\$</u>	<u>1,075,050</u>

Patient deductibles and copayments under third-party payment programs are included within the patient amounts above.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued ***(Dollars in Thousands)***

Years Ended June 30, 2013 and 2012

NOTE H--NET PATIENT SERVICE REVENUE - Continued

Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts. For receivables associated with services provided to patients who have third-party coverage, the Alliance analyzes contractually due amounts and provides an allowance for uncollectible accounts and a provision for bad debts, if necessary, for expected uncollectible deductibles and copayments on accounts for which the third-party payer has not paid or for payers who are known to be having financial difficulties that make the realization of amounts due unlikely. For receivables associated with patients, which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill, the Alliance records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between rates and the amounts actually collected after all reasonable collections efforts have been exhausted is charged against the allowance for uncollectible accounts.

The Alliance's allowance for doubtful accounts totaled \$49,449 and \$52,696 at June 30, 2013 and 2012, respectively. The allowance for doubtful accounts decreased from 26% of patient accounts receivable, net of contractual allowances, at June 30, 2012 to 23% of patient accounts receivable, net of contractual allowances, as of June 30, 2013. During 2013, MSHA began recording contractual allowances at time-of-billing for three additional payers, two of whom are MSHA's largest commercial payers. Previously, MSHA had recorded an allowance for bad debt for those three payers in addition to an estimated allowance for contractual adjustments. As a result of a more accurate methodology for recording contractual allowances for those three payers, MSHA was able to decrease its allowance for bad debts by a minimal amount. 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, Blue Cross 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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE I--THIRD-PARTY REIMBURSEMENT - Continued

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. These supplemental payments recognized totaled \$8,455 and \$11,300 for the years ended June 30, 2013 and 2012, respectively. Such payments are not guaranteed in future periods.

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 based on Medicare cost reimbursement principles and settled through the filing of an annual Medicaid cost report.

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. During 2013, the State of Virginia outsourced its Medicaid program to six managed care organizations. ISHN provides the provider network for Southwest Virginia to five Virginia Medicaid managed care organizations; two of which are on an exclusive basis. ISHN is not at-risk under these contracts.

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 2014, although the amount of any change cannot be estimated. The impact of final settlements of cost reports or changes in estimates increased net patient service revenue by \$1,328 in 2013 and decreased net patient service revenue by \$1,556 in 2012.

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, 2013.

The Alliance has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, preferred provider organizations and employer groups. The basis

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued ***(Dollars in Thousands)***

Years Ended June 30, 2013 and 2012

NOTE I--THIRD-PARTY REIMBURSEMENT - Continued

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 retirement plan (the Plan) which covers substantially all employees. The Plan is a defined contribution plan which consists principally of employer-funded contributions. During 2013 and 2012, the Alliance made 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, 2013 and 2012 was \$16,121 and \$15,072, respectively.

NCH maintains a defined benefit pension plan and a post-retirement employee benefit plan. The accrued unfunded pension liability was \$3,028 and \$2,560, and the accrued unfunded post-retirement liability was \$4,943 and \$4,554 at June 30, 2013 and 2012, 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 date, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed \$1,020 and \$1,734 to the plan during 2013 and 2012, respectively. Other assets at June 30, 2013 and 2012 include \$10,721 and \$9,675, 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. The Alliance contributed \$294 and \$452 to the Section 457(f) plan during 2013 and 2012, respectively.

NOTE K--CONCENTRATION OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia which is considered a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payer agreements. Net patient service revenue from Washington County, Tennessee operations were approximately 51% and 51% of total net patient service revenue for 2013 and 2012, respectively.

The mix of receivables from patients and third-party payers based on charges at established rates is as follows as of June 30:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2013 and 2012

NOTE K--CONCENTRATION OF RISK - Continued

	<u>2013</u>	<u>2012</u>
Medicare	38%	36%
TennCare/Medicaid	16%	14%
Commercial	28%	26%
Other third-party payers	9%	13%
Patients	9%	11%
	<u>100%</u>	<u>100%</u>

Approximately 88% and 94% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2013 and 2012, respectively. Admitting physicians are primarily practitioners in the regional area.

Two of the Alliance's Virginia hospitals' employees are covered under collective bargaining agreements which extend through February 2014 and January 2015, respectively.

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, 2013 and 2012, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of \$33,620 and \$35,968, respectively, related to operating loss carryforwards which expire through 2031. At June 30, 2013 and 2012, BRMM had state net operating loss carryforwards of \$70,347 and \$69,403, respectively, which expire through 2027. 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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE L--INCOME TAXES - Continued

At June 30, 2013 and 2012, SWCH had federal and state net operating loss carryforwards of \$5,906 and \$5,614, respectively, which expire through 2032. The net operating loss carryforwards may be off-set against future taxable income to the extent permitted by the Internal Revenue Code and tax codes of the Commonwealth of Virginia.

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--RELATED PARTY TRANSACTIONS

The Alliance enters into transactions with entities affiliated with certain members of the Board of Directors including transactions to construct Alliance facilities and provide professional services to the Alliance. Board members refrain from discussion and abstain from voting on transactions with entities with which they are related.

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES

Construction in Progress: Construction in progress at June 30, 2013 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 approximately \$39,110 at June 30, 2013. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

Physician Contracts: BRMM employs physicians to provide services to BRMM's physician practices through employment agreements which provide annual compensation, plus incentives based upon specified productivity levels. These contracts have various terms.

In addition, the Alliance has entered into contractual relationships with non-employed physicians to provide services in Upper East Tennessee and Southwest Virginia. These contracts guarantee certain base payments and allowable expenses and have terms of varying lengths. Amounts drawn and outstanding under each agreement are treated as a loan bearing interest at various rates and are subject to repayment over a specified period. The physician notes may also be amortized by virtue of the physician's continued practice in the specified community during the repayment period. A net receivable of \$884 and \$1,436 related to these agreements is included in the accompanying Consolidated Balance Sheets at June 30, 2013 and 2012, respectively.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

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 degree. 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, 2013 and 2012 include \$9,021 and \$8,005, 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, 2013 and 2012 was \$8,739 and \$8,823, 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:

<u>Year Ending June 30,</u>		
2014	\$	5,165
2015		6,044
2016		4,491
2017		2,459
2018		1,848
Thereafter		<u>6,297</u>
	\$	<u>26,304</u>

Asset Retirement Obligation: The Alliance has identified asbestos in certain facilities and is required by law to dispose of it in a special manner if the facility undergoes major renovations or is demolished; otherwise, the Alliance is not required to remove the asbestos from the facility. The Alliance has complied with regulations by treating the asbestos so that it presents no known immediate or future safety concerns. An asset retirement obligation has been established to the extent that sufficient information exists upon which to estimate the liability.

Other: The Alliance is a party to various transactions and agreements in the normal course of business, which include purchase and re-purchase agreements, put arrangements and other commitments, which may bind the Alliance to undertake additional transactions or activities in the future. In addition, the Alliance has agreed to guarantee a portion of the outstanding indebtedness of a joint venture. Management estimates that the fair value of the guarantee of this debt is immaterial as of June 30, 2013.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

Healthcare Industry: Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

In March 2010, Congress adopted comprehensive health care insurance legislation, *Patient Care Protection and Affordable Care Act* and *Health Care and Education Reconciliation Act*. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens by 2019 through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

NOTE O--RENTAL INCOME UNDER OPERATING LEASES

The Alliance leases rental properties to third parties, most of whom are physician practices, for various terms, generally five years. The following is a schedule by year and in the aggregate of minimum future rental income due under noncancellable operating leases at June 30, 2013:

<u>Year Ending June 30,</u>	
2014	\$ 1,779
2015	1,487
2016	727
2017	379
2018	248
Thereafter	225
Total minimum future rentals	<u>\$ 4,845</u>

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2013 and 2012, 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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2013 and 2012

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS - Continued

Investment in Joint Ventures: It is not practical to estimate the fair market value of the investments in joint ventures.

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 due to uncertainty of when these amounts may be paid. Other long-term liabilities are not discounted.

Long-Term Debt: 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.

The estimated fair value of the Alliance's financial instruments that have carrying values different from fair value is as follows at June 30:

	2013		2012	
	<i>Carrying Value</i>	<i>Estimated Fair Value</i>	<i>Carrying Value</i>	<i>Estimated Fair Value</i>
FINANCIAL LIABILITIES:				
Long-term debt	\$ 1,124,765	\$ 1,167,846	\$ 1,080,575	\$ 1,150,201

NOTE Q--FAIR VALUE MEASUREMENT

FASB ASC 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 be corroborated by observable market data. The Alliance's Level 2 investments are valued primarily using the market valuation approach.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2013 and 2012

NOTE Q--FAIR VALUE MEASUREMENT - Continued

- 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 assets and liabilities recorded at fair value on a recurring basis and long-term debt as disclosed at fair value as of June 30, 2013 and 2012:

	Total	Level 1	Level 2	Level 3
June 30, 2013				
Cash, cash equivalents and money market funds	\$ 66,075	\$ 66,075	\$ -	\$ -
U.S. Government securities	25,905	25,905	-	-
U.S. Agency securities	45,997	45,997	-	-
Corporate and foreign bonds	179,880	-	179,880	-
Municipal obligations	17,749	-	17,749	-
Preferred and asset backed securities	3,491	-	3,491	-
U.S. equity securities	10,944	10,944	-	-
Mutual funds	186,028	125,479	60,548	-
Other	37,353	-	-	37,353
Total assets	\$ 573,422	\$ 274,400	\$ 261,668	\$ 37,353
Fair value of derivative agreements - Note D	\$ (8,185)	\$ -	\$ -	\$ (8,185)
Fair value of long-term debt	\$ (1,167,846)	\$ -	\$ -	\$ (1,167,846)

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2013 and 2012

NOTE Q--FAIR VALUE MEASUREMENT - Continued

	Total	Level 1	Level 2	Level 3
June 30, 2012				
Cash, cash equivalents and money market funds	\$ 85,017	\$ 85,017	\$ -	\$ -
U.S. Government securities	15,693	15,693	-	-
U.S. Agency securities	62,437	62,437	-	-
Corporate and foreign bonds	52,581	-	52,581	-
Municipal obligations	961	-	961	-
Preferred and asset backed securities	11,183	-	11,183	-
U.S. equity securities	28,344	28,344	-	-
Mutual funds	141,968	97,600	44,368	-
Other	34,880	-	-	34,880
Total assets	\$ 433,064	\$ 289,091	\$ 109,093	\$ 34,880
Fair value of derivative agreements - Note D	\$ (19,381)	\$ -	\$ -	\$ (19,381)
Fair value of long-term debt	\$ (1,150,201)	\$ -	\$ -	\$ (1,150,201)

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, 2013 and 2012 resulted in a decrease in the fair value of the related liability of \$3,080 and \$5,726, 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.

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, 2013 and 2012:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2013 and 2012

NOTE Q--FAIR VALUE MEASUREMENT - Continued

	<i>Trading Securities</i>	<i>Derivatives, Net</i>
July 1, 2011	\$ 32,718	\$ (110,732)
Total unrealized/realized gains in the Performance Indicator, net	1,466	(6,198)
Net investment income	1,221	515
Purchases	5,107	-
Settlements	-	97,034
Distributions	(5,632)	-
June 30, 2012	34,880	(19,381)
Total unrealized/realized gains in the Performance Indicator, net	1,614	457
Net investment income	1,360	399
Purchases	807	-
Settlements	-	10,340
Distributions	(1,308)	-
June 30, 2013	\$ 37,353	\$ (8,185)

There were no changes in valuation techniques in 2013 or 2012.

NOTE R--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 S--SUBSEQUENT EVENTS

On March 28, 2013, the Alliance executed an agreement to acquire Unicoi County Memorial Hospital (UCMH), a 48-bed acute care hospital located in Erwin, Tennessee. UCMH has approximately 250 employees and offers emergency, surgical, and home health services. Nursing home services are provided in a 46 licensed bed long term care facility. The Alliance will fund the acquisition from cash flow and intends to construct a new acute care hospital in Erwin, Tennessee. After consideration of the revenues and expenses expected from operation of the facility, management of the Alliance does not expect this acquisition to have a material effect on the Alliance. The Tennessee attorney general's office is expected to approve the transaction and the Alliance anticipates that Unicoi County Memorial Hospital will become a member of Mountain States Health Alliance on or around November 1, 2013.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2013 and 2012

NOTE S--SUBSEQUENT EVENTS - Continued

In July 2013, the Alliance issued \$16,235 (Series 2013A) tax-exempt variable rate Hospital Revenue Bonds and \$99,680 (Series 2013B) variable rate Taxable Hospital Refunding Revenue Bonds through The Health and Educational Facilities Board of the City of Johnson City, Tennessee. The proceeds from the Series 2013A Bonds will be used to finance or refinance capital improvements and equipment acquisitions and pay issuance costs related to these Bonds. The proceeds from the Series 2013B Bonds will be used to refund \$97,915 of the Series 2007B-2 Bonds and to pay issuance costs associated with these Bonds. Contemporaneously with the issuance of the Series 2013A and Series 2013B Bonds, the Alliance refunded the Series 2008A, Series 2008B, Series 2011C, Series 2011D, Series 2012B and Series 2012C through private placements with financial institutions.

At June 30, 2013 and 2012, the Alliance owned membership units in Premier, Inc. Subsequent to yearend Premier, as part of a reorganization, converted to a publically traded entity. As part of its reorganization, certain of the Alliance's membership units were redeemed for approximately \$3,000 and a gain was recognized on the sale of these units. Unredeemed units continue to be held by the Alliance and may be effectively exchanged for Class A common stock of Premier ratably over a seven year period. The unredeemed membership units may be exchanged for up to 723 thousand Class A shares.

Supplemental Schedules

MOUNTAIN STATES HEALTH ALLIANCE

***Consolidating Balance Sheet
(Dollars in Thousands)***

June 30, 2013

	<i>Blue Ridge Medical Management *</i>	<i>Other Obligated Group Members</i>	<i>Eliminations</i>	<i>Total Obligated Group</i>	<i>Other Entities</i>	<i>Mountain States Properties</i>	<i>Eliminations</i>	<i>Total</i>
ASSETS								
CURRENT ASSETS								
Cash and cash equivalents	\$ 659	\$ 48,607	\$ -	\$ 49,266	\$ 25,137	\$ 499	\$ -	\$ 74,902
Current portion of investments	-	20,387	-	20,387	(1)	-	-	20,386
Patient accounts receivable, less estimated allowance for uncollectible accounts	6,928	128,708	-	135,636	28,551	-	-	164,187
Other receivables, net	649	20,580	-	21,229	12,862	377	(1,000)	33,468
Inventories and prepaid expenses	605	23,068	-	23,673	7,333	67	-	31,073
TOTAL CURRENT ASSETS	8,841	241,350	-	250,191	73,882	943	(1,000)	324,016
INVESTMENTS, less amounts required to meet current obligations	19,735	416,147	-	435,882	110,109	55,361	-	601,352
EQUITY IN AFFILIATES	146,284	333,086	(161,250)	318,120	-	-	(318,120)	-
PROPERTY, PLANT AND EQUIPMENT, net	18,743	614,210	-	632,953	197,192	54,148	-	884,293
OTHER ASSETS								
Goodwill	7,575	144,708	-	152,283	2,108	-	-	154,391
Net deferred financing, acquisition costs and other charges	270	26,800	-	27,070	860	550	-	28,480
Other assets	9,663	28,193	-	37,856	6,126	2,562	-	46,544
TOTAL OTHER ASSETS	17,508	199,701	-	217,209	9,094	3,112	-	229,415
	\$ 211,111	\$ 1,804,494	\$ (161,250)	\$ 1,854,355	\$ 390,277	\$ 113,564	\$ (319,120)	\$ 2,039,076

* Management Services Organization only

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet - Continued (Dollars in Thousands)

June 30, 2013

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities	Mountain States Properties	Eliminations	Total
LIABILITIES AND NET ASSETS								
CURRENT LIABILITIES								
Accrued interest payable	\$ 46	\$ 19,622	\$ -	\$ 19,668	\$ 38	\$ -	\$ -	\$ 19,706
Current portion of long-term debt and capital lease obligations	13	31,422	-	31,435	2,982	-	-	34,417
Accounts payable and accrued expenses	5,543	74,934	-	80,477	12,902	923	-	94,302
Accrued salaries, compensated absences and amounts withheld	3,836	44,713	-	48,549	15,116	-	-	63,665
Payables to (receivables from) affiliates, net	16,697	2,194	-	18,891	7,738	(26,629)	-	-
Estimated amounts due to third-party payers, net	-	25,970	-	25,970	805	-	-	26,775
TOTAL CURRENT LIABILITIES	26,135	198,855	-	224,990	39,581	(25,706)	-	238,865
OTHER LIABILITIES								
Long-term debt and capital lease obligations, less current portion	13,663	1,036,740	-	1,050,403	40,945	-	(1,000)	1,090,348
Estimated fair value of derivatives	-	8,220	-	8,220	-	(35)	-	8,185
Deferred revenue	-	2,130	-	2,130	86	-	-	2,216
Estimated professional liability self-insurance	2,576	5,198	-	7,774	984	-	-	8,758
Other long-term liabilities	7,487	10,058	-	17,545	176	-	-	17,721
TOTAL LIABILITIES	49,861	1,261,201	-	1,311,062	81,772	(25,741)	(1,000)	1,366,093
NET ASSETS								
Unrestricted net assets								
Mountain States Health Alliance	161,250	490,414	(161,250)	490,414	171,901	139,305	(311,206)	490,414
Noncontrolling interests in subsidiaries	-	39,923	-	39,923	123,945	-	5,746	169,614
TOTAL UNRESTRICTED NET ASSETS	161,250	530,337	(161,250)	530,337	295,846	139,305	(305,460)	660,028
Temporarily restricted net assets								
Mountain States Health Alliance	-	12,776	-	12,776	12,531	-	(12,531)	12,776
Noncontrolling interests in subsidiaries	-	53	-	53	1	-	(2)	52
TOTAL TEMPORARILY RESTRICTED NET ASSETS	-	12,829	-	12,829	12,532	-	(12,533)	12,828
Permanently restricted net assets								
	-	127	-	127	127	-	(127)	127
TOTAL NET ASSETS	161,250	543,293	(161,250)	543,293	308,505	139,305	(318,120)	672,983
	\$ 211,111	\$ 1,804,494	\$ (161,250)	\$ 1,854,355	\$ 390,277	\$ 113,564	\$ (319,120)	\$ 2,039,076

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Operations (Dollars in Thousands)

Year Ended June 30, 2013

	Blue Ridge Medical Management *	Other Obligated Group Members	Eliminations	Total Obligated Group	Other Entities	Mountain States Properties	Eliminations	Total
Revenue, gains and support:								
Patient service revenue, net of contractual allowances and discounts	\$ 60,981	\$ 800,370	\$ (2,002)	\$ 859,349	\$ 185,896	\$ -	\$ -	\$ 1,045,245
Provision for bad debts	(5,851)	(84,508)	-	(90,359)	(22,138)	-	-	(112,497)
Net patient service revenue	55,130	715,862	(2,002)	768,990	163,758	-	-	932,748
Premium revenue	-	-	-	-	1,003	-	-	1,003
Net investment gain	2,029	27,241	-	29,270	7,543	4,230	(63)	40,980
Net derivative gain	-	5,803	-	5,803	133	1,182	-	7,118
Other revenue, gains and support	47,477	46,942	(36,666)	57,753	86,929	8,384	(75,611)	77,455
Equity in net gain (loss) of affiliates	3,380	731	(4,151)	(40)	-	-	40	-
TOTAL REVENUE, GAINS AND SUPPORT	108,016	796,579	(42,819)	861,776	259,366	13,796	(75,634)	1,059,304
Expenses:								
Salaries and wages	23,274	271,876	-	295,150	65,919	430	(5,909)	355,590
Physician salaries and wages	52,482	1,354	-	53,836	70,450	-	(50,028)	74,258
Contract labor	1,169	1,505	-	2,674	1,545	-	(277)	3,942
Employee benefits	8,493	56,307	(2,067)	62,733	17,033	57	(5,233)	74,590
Fees	4,997	114,967	(36,005)	83,959	28,619	692	(7,379)	105,891
Supplies	2,989	133,185	-	136,174	26,976	13	(208)	162,955
Utilities	604	12,172	-	12,776	3,065	1,019	(3)	16,857
Medical Costs	-	-	-	-	1,039	-	-	1,039
Other	8,981	48,958	(596)	57,343	25,324	4,118	(6,574)	80,211
Depreciation	1,828	58,199	-	60,027	16,664	2,250	-	78,941
Amortization	34	2,179	-	2,213	47	-	-	2,260
Interest and taxes	(986)	42,213	-	41,227	684	1,355	(63)	43,203
TOTAL EXPENSES	103,865	742,915	(38,668)	808,112	257,365	9,934	(75,674)	999,737
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	\$ 4,151	\$ 53,664	\$ (4,151)	\$ 53,664	\$ 2,001	\$ 3,862	\$ 40	\$ 59,567

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Changes in Net Assets (Dollars in Thousands)

Year Ended June 30, 2013

	Blue Ridge	Other Obligated Group Members			Total Obligated Group	Other Entities			Total Other Entities	Mountain States		Total
	Medical Management *	Mountain States Health Alliance	Noncontrolling Interests	Eliminations		Mountain States Health Alliance	Noncontrolling Interests	Properties		Eliminations		
UNRESTRICTED NET ASSETS:												
Excess of Revenue, Gains and Support over												
Expenses and Losses	\$ 4,151	\$ 52,692	\$ 972	\$ (4,151)	\$ 53,664	\$ (2,539)	\$ 4,540	\$ 2,001	\$ 3,862	\$ 40	\$ 59,567	
Pension and other defined benefit plan adjustments	-	(172)	(171)	-	(343)	(2)	(2)	(4)	-	4	(343)	
Net assets released from restrictions used for the												
purchase of property, plant and equipment	-	1,506	-	-	1,506	1,506	-	1,506	-	(1,506)	1,506	
Distributions to noncontrolling interests	-	-	-	-	-	-	(49)	(49)	-	-	(49)	
Net asset transfers	-	-	-	-	-	8,820	2,080	10,900	-	(10,900)	-	
INCREASE IN UNRESTRICTED NET ASSETS	4,151	54,026	801	(4,151)	54,827	7,785	6,569	14,354	3,862	(12,362)	60,681	
TEMPORARILY RESTRICTED NET ASSETS:												
Restricted grants and contributions	-	4,969	18	-	4,987	4,556	8	4,564	-	(4,561)	4,990	
Net assets released from restrictions	-	(3,416)	(16)	-	(3,432)	(2,980)	(8)	(2,988)	-	2,985	(3,435)	
INCREASE IN TEMPORARILY RESTRICTED NET ASSETS	-	1,553	2	-	1,555	1,576	-	1,576	-	(1,576)	1,555	
INCREASE IN TOTAL NET ASSETS	4,151	55,579	803	(4,151)	56,382	9,361	6,569	15,930	3,862	(13,938)	62,236	
NET ASSETS, BEGINNING OF YEAR	157,099	447,738	39,173	(157,099)	486,911	175,198	117,377	292,575	135,443	(304,182)	610,747	
NET ASSETS, END OF YEAR	\$ 161,250	\$ 503,317	\$ 39,976	\$ (161,250)	\$ 543,293	\$ 184,559	\$ 123,946	\$ 308,505	\$ 139,305	\$ (318,120)	\$ 672,983	

*Management Services Organization only.

MOUNTAIN STATES HEALTH ALLIANCE

Note to Supplemental Schedules

Year Ended June 30, 2013

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. In accordance with Article Six, Section 6.6 of 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, those members pledged 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 and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group (Obligated Group). In 2012, NCH and SCCH (hospitals only) were admitted into the Obligated Group.

The supplemental consolidating schedules include the accounts of the members of the Obligated Group after elimination of all significant intergroup accounts and transactions. Certain other subsidiaries of the Alliance, Mountain States Properties, Inc. (MSP) and all other affiliates (Other Entities), 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.

MOUNTAIN STATES HEALTH ALLIANCE

**Audited Consolidated Financial Statements
(and Supplemental Schedules)**

Years Ended June 30, 2014 and 2013



MOUNTAIN STATES HEALTH ALLIANCE

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

Years Ended June 30, 2014 and 2013

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

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, 2014 and 2013, 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 consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with 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, 2014 and 2013, 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.

Other Matter

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.

Patrick Yarbally: Associate PC

Knoxville, Tennessee
October 29, 2014

MOUNTAIN STATES HEALTH ALLIANCE***Consolidated Balance Sheets
(Dollars in Thousands)***

	<i>June 30,</i>	
	<i>2014</i>	<i>2013</i>
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 59,185	\$ 74,902
Current portion of investments	25,029	20,386
Patient accounts receivable, less estimated allowances for uncollectible accounts of \$47,853 in 2014 and \$49,449 in 2013	161,318	164,187
Other receivables, net	45,502	33,468
Inventories and prepaid expenses	30,838	31,073
TOTAL CURRENT ASSETS	321,872	324,016
INVESTMENTS, less amounts required to meet current obligations	648,475	601,352
PROPERTY, PLANT AND EQUIPMENT, net	881,429	884,293
OTHER ASSETS		
Goodwill	156,613	154,391
Net deferred financing, acquisition costs and other charges	25,841	28,480
Other assets	48,350	46,544
TOTAL OTHER ASSETS	230,804	229,415
	<u>\$ 2,082,580</u>	<u>\$ 2,039,076</u>

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets - Continued
(Dollars in Thousands)

	<i>June 30,</i>	
	<i>2014</i>	<i>2013</i>
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	\$ 18,648	\$ 19,706
Current portion of long-term debt and capital lease obligations	30,618	34,417
Accounts payable and accrued expenses	87,126	94,302
Accrued salaries, compensated absences and amounts withheld	72,181	63,665
Estimated amounts due to third-party payers, net	10,463	26,775
TOTAL CURRENT LIABILITIES	219,036	238,865
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	1,075,069	1,090,348
Estimated fair value of derivatives	10,603	8,185
Estimated professional liability self-insurance	8,957	8,758
Other long-term liabilities	35,974	19,937
TOTAL LIABILITIES	1,349,639	1,366,093
COMMITMENTS AND CONTINGENCIES - Notes D, F, G, and N		
NET ASSETS		
Unrestricted net assets		
Mountain States Health Alliance	541,979	490,414
Noncontrolling interests in subsidiaries	178,547	169,614
TOTAL UNRESTRICTED NET ASSETS	720,526	660,028
Temporarily restricted net assets		
Mountain States Health Alliance	12,204	12,776
Noncontrolling interests in subsidiaries	84	52
TOTAL TEMPORARILY RESTRICTED NET ASSETS	12,288	12,828
Permanently restricted net assets		
	127	127
TOTAL NET ASSETS	732,941	672,983
	\$ 2,082,580	\$ 2,039,076

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2014</i>	<i>2013</i>
Revenue, gains and support:		
Patient service revenue, net of contractual allowances and discounts	\$ 1,050,426	\$ 1,045,245
Provision for bad debts	(122,642)	(112,497)
Net patient service revenue	927,784	932,748
Premium revenue	10,683	1,003
Net investment gain	50,703	40,980
Net derivative gain	3,219	7,118
Other revenue, gains and support	62,457	77,455
TOTAL REVENUE, GAINS AND SUPPORT	1,054,846	1,059,304
Expenses and losses:		
Salaries and wages	340,589	355,590
Physician salaries and wages	77,636	74,258
Contract labor	4,282	3,942
Employee benefits	69,173	74,590
Fees	115,606	105,891
Supplies	163,699	162,955
Utilities	17,052	16,857
Medical costs	10,292	1,039
Other	79,980	80,211
Loss on early extinguishment of debt - Note F	4,622	-
Depreciation	69,437	78,941
Amortization	1,742	2,260
Interest and taxes	44,392	43,203
TOTAL EXPENSES AND LOSSES	998,502	999,737
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	\$ 56,344	\$ 59,567

MOUNTAIN STATES HEALTH ALLIANCE

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

Year Ended June 30, 2014

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
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 Changes in Net Assets - Continued***
(Dollars in Thousands)***Year Ended June 30, 2013***

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	\$ 52,692	\$ 6,875	\$ 59,567
Pension and other defined benefit plan adjustments	(172)	(171)	(343)
Net assets released from restrictions used for the purchase of property, plant and equipment	1,506	-	1,506
Distributions to noncontrolling interests	-	(49)	(49)
INCREASE IN UNRESTRICTED NET ASSETS	54,026	6,655	60,681
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	4,969	21	4,990
Net assets released from restrictions	(3,416)	(19)	(3,435)
INCREASE IN TEMPORARILY RESTRICTED NET ASSETS	1,553	2	1,555
INCREASE IN TOTAL NET ASSETS	55,579	6,657	62,236
NET ASSETS, BEGINNING OF YEAR	447,738	163,009	610,747
NET ASSETS, END OF YEAR	\$ 503,317	\$ 169,666	\$ 672,983

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2014</i>	<i>2013</i>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase in net assets	\$ 59,958	\$ 62,236
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	71,789	81,786
Provision for bad debts	122,642	112,497
Loss on early extinguishment of debt	4,622	-
Change in estimated fair value of derivatives	2,761	(457)
Equity in net income of joint ventures, net	(369)	(636)
Loss (gain) on disposal of assets	(3,489)	(1)
Amounts received on interest rate swap settlements	(5,980)	(6,661)
Gain on escrow restructuring	-	(13,847)
Gain on swap settlement	-	(3,020)
Capital Appreciation Bond accretion and other	2,629	3,910
Restricted contributions	(4,781)	(4,990)
Pension and other defined benefit plan adjustments	(388)	343
Increase (decrease) in cash due to change in:		
Patient accounts receivable	(115,380)	(129,218)
Other receivables, net	(11,880)	(3,192)
Inventories and prepaid expenses	959	(2,263)
Trading securities	(46,451)	(17,845)
Other assets	(2,492)	(1,073)
Accrued interest payable	(1,058)	1,181
Accounts payable and accrued expenses	(6,666)	(20,263)
Accrued salaries, compensated absences and amounts withheld	8,006	8,076
Estimated amounts due to third-party payers, net	(16,312)	4,757
Estimated professional liability self-insurance	199	(586)
Other long-term liabilities	16,425	556
Total adjustments	<u>14,786</u>	<u>9,054</u>
NET CASH PROVIDED BY OPERATING ACTIVITIES	74,744	71,290
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property, plant and equipment	(63,851)	(105,751)
Purchases of land held for expansion	(573)	(5,769)
Acquisitions, net of cash acquired	(4,256)	-
Purchases of held-to-maturity securities	(5,978)	(8,722)
Net distribution from joint ventures and unconsolidated affiliates	661	732
Proceeds from sale of property, plant and equipment	<u>2,858</u>	<u>335</u>
NET CASH USED IN INVESTING ACTIVITIES	(71,139)	(119,175)

MOUNTAIN STATES HEALTH ALLIANCE

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

	<i>Year Ended June 30,</i>	
	<i>2014</i>	<i>2013</i>
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt and capital lease obligations, including deposits to escrow	(38,768)	(75,066)
Payment of acquisition and financing costs	(3,826)	(2,314)
Proceeds from issuance of long-term debt and other financing arrangements	11,916	117,085
Payment on termination of derivative agreements	-	(7,375)
Gain on escrow restructuring	-	13,847
Net amounts received on interest rate swap settlements	5,980	6,661
Restricted contributions received	5,376	4,842
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	(19,322)	57,680
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	(15,717)	9,795
CASH AND CASH EQUIVALENTS, beginning of year	74,902	65,107
CASH AND CASH EQUIVALENTS, end of year	\$ 59,185	\$ 74,902

SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:

Cash paid for interest	\$ 40,546	\$ 37,023
Cash paid for federal and state income taxes	\$ 854	\$ 616
Construction related payables in accounts payable and accrued expenses	\$ 8,604	\$ 11,598
Supplemental cash flow information regarding acquisitions - Note A:		
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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements (Dollars in Thousands)

Years Ended June 30, 2014 and 2013

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 initial funds for the establishment of the Alliance in 1945 were provided by individuals and various institutions.

The primary operations of the Alliance consist of eleven acute and specialty care hospitals, as follows:

- Johnson City Medical Center (JCMC) - licensed for 658 beds
- Indian Path Medical Center (IPMC) - licensed for 261 beds
- Smyth County Community Hospital (SCCH) - licensed for 153 beds
- Norton Community Hospital (NCH) - licensed for 129 beds
- Sycamore Shoals Hospital (SSH) - licensed for 121 beds
- Johnston Memorial Hospital (JMH) - licensed for 116 beds
- Franklin Woods Community Hospital (FWCH) - licensed for 80 beds
- Russell County Medical Center (RCMC) - licensed for 78 beds
- Unicoi County Memorial Hospital (UCMH) - licensed for 48 beds
- Dickenson Community Hospital (DCH) - licensed for 25 beds
- Johnson County Community Hospital (JCCH) - licensed for 2 beds

The Alliance has a 50.1% interest in JMH. JMH is also the sole member of Abingdon Physician Partners (APP), a non-taxable corporation that owns and manages physician practices.

The Alliance has a 50.1% interest in NCH. NCH is also the sole member or shareholder of DCH and Norton Community Physician Services, LLC (NCPS), a taxable corporation that consists of physician practices and a pharmacy and Community Home Care (CHC), a taxable corporation that provides home medical equipment.

The Alliance has an 80% interest in SCCH. SCCH is the sole shareholder of Southwest Community Health Services, Inc. (SWCH), a taxable entity that operates a pharmacy and provides other health services.

The activities and accounts of JMH, NCH and SCCH are included in the accompanying consolidated financial statements.

Effective November 1, 2013, the Alliance acquired substantially all the assets, and certain liabilities, of Unicoi County Memorial Hospital from Unicoi County, Tennessee. To effectuate the acquisition, the Alliance paid approximately \$2,500 and committed to construct a new facility within five years.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued ***(Dollars in Thousands)***

Years Ended June 30, 2014 and 2013

The accounts and activities of UCMH since acquisition are included in the accompanying consolidated financial statements.

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices and provides other healthcare services to patients in Tennessee and Virginia. BRMM is either the sole shareholder, a significant shareholder, or member of the following consolidated organizations:

Mountain States Physician Group, Inc. (MSPG): A company that contracts with physicians to provide services to BRMM physician practices.

Mountain States Properties, Inc. (MSPI): A company that owns and manages real estate (primarily medical office buildings) and provides rehabilitation and fitness services.

Mediserve Medical Equipment of Kingsport, Inc. (Mediserve): A company that provides durable medical equipment services.

Kingsport Ambulatory Surgery Center (KASC) (d.b.a. Kingsport Day Surgery): A joint venture operating as an outpatient surgery center which performs procedures primarily in otolaryngology, orthopedics, ophthalmology, and general surgery. BRMM has a 43% ownership of KASC and maintains control over KASC through a management agreement. The accounts and activities of KASC are included in the accompanying consolidated financial statements.

Emmaus Community Healthcare LLC (d.b.a. Piney Flats Urgent Care (PFUC)): A for-profit entity that provides urgent care patient services. BRMM has a 75% ownership of PFUC. The accounts and activities of PFUC are included in the accompanying consolidated financial statements.

Mountain States Pharmacy (MSP): A for-profit company that owns and operates retail pharmacies.

East Tennessee Ambulatory Surgery Center (ETASC): Effective January 1, 2014, BRMM acquired a controlling 66.1% ownership in ETASC and recognized approximately \$2,244 of goodwill as a result of the transaction. The accounts and activities of ETASC since acquisition are included in the accompanying consolidated financial statements.

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc. (MSF), a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance. The Alliance is also the beneficiary of the Mountain States Health Alliance Auxiliary (Auxiliary), a not-for-profit organization formed to coordinate volunteer activities of the Alliance.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued ***(Dollars in Thousands)***

Years Ended June 30, 2014 and 2013

The activities and accounts of MSF and the Auxiliary are included in the accompanying consolidated financial statements.

The Alliance is a 99.8% shareholder of Integrated Solutions Health Network, LLC (ISHN). The primary function of ISHN is to establish, operate and administer a provider-sponsored health care delivery network. ISHN is the sole shareholder of the following subsidiaries:

CrestPoint Health Insurance Company (CHIC): A for-profit insurance company licensed in the State of Tennessee which provides network access and administration and third-party administrator services. CHIC has a risk-based contract with the Center for Medicare & Medicaid Services (CMS) to provide or arrange for the provision of healthcare services to senior citizens who have Medicare Part A, Medicare Part B and Medicare Part D entitlements.

AnewCare Collaborative (AnewCare): A for-profit accountable care organization which participates in CMS's Medicare Shared Savings Program.

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.

Noncontrolling Interests in Subsidiaries: The Alliance's accompanying consolidated financial statements include all assets, liabilities, revenues, expenses, and changes in net assets, including amounts attributable to the noncontrolling interests. Noncontrolling interests represent the portion of equity (net assets) in a subsidiary not attributable, directly or indirectly, to the Alliance. For the years ending June 30, 2014 and 2013, the Alliance attributed an Excess of Revenue, Gains and Support over Expenses and Losses of \$8,286 and \$6,875, respectively, to the noncontrolling interests in JMH, NCH, SCCH, KASC, PFUC, ETASC and ISHN based on the noncontrolling interests' respective ownership percentage.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

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 pursuant to The Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 825, *Financial Instruments*. 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.

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. On June 30, 2013, the Alliance determined that it no longer intended to hold certain of its held-to-maturity investment portfolios to maturity and reclassified investments with an amortized cost of \$161,929 into the trading designation. As a result, the Alliance recognized net unrealized gains of approximately \$8,255 in the accompanying 2013 Consolidated Statement of Operations. The investments that remain designated as held-to-maturity are limited as to use under a safekeeping agreement or are otherwise unavailable for disposition.

Management annually evaluates investments designated as held-to-maturity and recognizes any "other-than-temporary" losses as deductions from the Performance Indicator (as defined below). Management's 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, 2014.

Investments in joint ventures are generally reported under the equity method of accounting, which approximates the Alliance's equity in the underlying net book value, unless the ownership structure requires consolidation. Other assets include investments in joint ventures of \$1,364 and \$2,057 at June 30, 2014 and 2013, respectively.

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. During 2014, the Alliance changed its estimates of depreciable lives for certain classes of property and equipment. Management evaluated the useful lives of certain classes of equipment and determined that, based on information available to them, the previously assigned lives were not consistent with actual usage of such assets. As a result,

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

management extended the depreciable lives of certain classes of property and equipment to better reflect the actual usage pattern. The impact of this change in estimated useful lives was to decrease depreciation expense in the Consolidated Statement of Operations for the year ended June 30, 2014 by approximately \$7,500.

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 2014 and 2013.

Other assets include property held for resale and property held for expansion of \$20,793 and \$20,220, respectively, at June 30, 2014 and 2013. Property held for resale and property held for expansion primarily represent 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 2014 and 2013.

Goodwill: Goodwill represents the difference between the acquisition cost of assets and the estimated fair value of net tangible and any separately identified intangible assets. Goodwill is evaluated for impairment at least annually. The reporting unit for evaluation of the majority of the Alliance's goodwill is the aggregate acute-care operations. Management performed an evaluation of goodwill for impairment considering qualitative and quantitative factors and does not believe the goodwill associated with any of its reporting units is impaired as of June 30, 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 \$25,841 and \$28,480 at June 30, 2014 and 2013, respectively.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

Deferred financing costs are amortized over the life of the respective bond issue principally using the average bonds outstanding method.

Prior to 2009, the Alliance routinely financed interest rate swap and other derivative transaction issuance costs through modification of future settlement terms. As such, the unamortized issuance costs of these derivatives are included as deferred financing costs in the accompanying Consolidated Balance Sheets and are being amortized over the term of the respective derivative instrument. The unpaid issuance costs are included as a part of the estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. Beginning in 2009, interest rate swap and derivative transaction issuance costs were expensed as incurred.

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. Changes in the estimated fair value of these derivatives are included in the Consolidated Statements of Operations as part of net derivative gain.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

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 his or her 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 approximately \$109,550 and \$103,084 during 2014 and 2013, respectively. The estimated direct and indirect cost of providing these services totaled approximately \$23,733 and \$24,709 in 2014 and 2013, 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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

significant uncertain tax positions at June 30, 2014 and 2013. At June 30, 2014, tax returns for 2010 through 2013 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: Premiums earned include premiums from individuals and Medicare. Medicare revenue includes premiums 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. CHIC evaluated the need for a premium deficiency reserve and recorded an estimated reserve of \$2,000 at June 30, 2014.

Medicare Shared Savings Program (MSSP): AnewCare, an Accountable Care Organization (ACO), 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. ACOs 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. The program is based on performance periods, the first of which specific to AnewCare was the period of July 2012 to December 2013. Utilizing statistical data and the methodology employed by CMS, AnewCare estimated and recognized \$2,644 of net shared savings through June 30, 2013. Upon completion of the initial performance period, total net shared savings of \$4,745 were recognized. For the second performance period, AnewCare has estimated \$1,625 of net shared savings as of June 30, 2014. Variability is inherent in the estimation methodology and due to uncertainties in the estimation; it is probable that management's estimates of shared savings, if any, will change by the end of the second performance period, and such change could be significant.

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

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, 2014 and 2013, the Alliance recognized EHR incentive revenues of \$18,269 and \$22,474, 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 CHIC members by third-party providers, which have been incurred but not reported to CHIC. The estimate for incurred but not reported claims is based on actuarial projections of costs using historical paid claims and industry data. Due to uncertainties in the estimation, it is at least reasonably possible that management's estimates of incurred but not reported claims will change in 2015, although the amount of the change cannot be estimated.

Subsequent Events: The Alliance evaluated all events or transactions that occurred after June 30, 2014, through October 29, 2014, 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, 2014 consolidated financial statements, other than as discussed in Note Q.

Reclassifications: Certain 2013 amounts have been reclassified to conform with the 2014 presentation in the accompanying consolidated financial statements.

NOTE C--INVESTMENTS

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

	<u>2014</u>	<u>2013</u>
Designated or restricted:		
Under safekeeping agreements	\$ 8,220	\$ 8,254
By Board to satisfy regulatory requirements	6,759	2,096
Under bond indenture agreements:		
For debt service and interest payments	55,123	60,823
For capital acquisitions	16,127	36,989
	<u>86,229</u>	<u>108,162</u>
Less: amount required to meet current obligations	(25,029)	(20,386)
	<u>\$ 61,200</u>	<u>\$ 87,776</u>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

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

	<u>2014</u>		<u>2013</u>
Cash, cash equivalents and money market funds	\$ 54,437	\$	57,190
U.S. Government securities	8,683		11,164
U.S. Agency securities	19,835		30,407
Corporate and foreign bonds	2,354		7,530
Municipal obligations	920		1,871
	<u>\$ 86,229</u>	\$	<u>108,162</u>

Trading securities consist of the following at June 30:

	<u>2014</u>		<u>2013</u>
Cash, cash equivalents and money market funds	\$ 47,126	\$	9,488
U.S. Government securities	30,721		18,481
U.S. Agency securities	39,084		19,620
Corporate and foreign bonds	96,749		172,350
Municipal obligations	21,409		17,749
Preferred and asset backed securities	3,497		3,491
U.S. equity securities	1,868		10,944
Mutual funds	253,301		186,028
Alternative investments	54,761		37,353
	<u>\$ 548,516</u>	\$	<u>475,504</u>

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

	<u>2014</u>		<u>2013</u>
Cash, cash equivalents and money market funds	\$ 220	\$	75
Corporate and foreign bonds	35,131		33,060
Municipal obligations	3,408		4,937
	<u>\$ 38,759</u>	\$	<u>38,072</u>

Held-to-maturity securities had gross unrealized gains and losses of \$206 and \$456, respectively, at June 30, 2014 and \$15 and \$1,421, respectively, at June 30, 2013. 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,

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

2013, the Alliance held no securities within the held-to-maturity portfolio which had been in an unrealized loss position for over one year. At June 30, 2014, the contractual maturities of held-to-maturity securities were \$17,625 due in one year or less, \$5,411 due from one to five years and \$15,723 due after five years.

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

	<u>2014</u>	<u>2013</u>
Interest and dividend income, net of fees	\$ 12,074	\$ 13,881
Net realized gains on the sale of securities	15,311	3,074
Change in net unrealized gains on securities	23,318	24,025
	<u>\$ 50,703</u>	<u>\$ 40,980</u>

The Alliance is a member of Premier Inc.'s (Premier) group purchasing organization and in connection with this membership, the Alliance held a non-controlling interest in Premier that was accounted for using the cost method of accounting. In October 2013, Premier completed an initial public offering (IPO) and a restructuring of the company. In connection with the restructuring, the Alliance received 860,499 Class B Units and concurrently sold approximately 16% of the units back to Premier. The Alliance recognized a gain of approximately \$3,500 on the sale, which is included within other revenue, gains and support in the 2014 Consolidated Statement of Operations.

The Alliance has the ability to convert its remaining Class B units into cash or Premier's Class A common stock over a seven year vesting period. The Alliance recorded an investment in Premier relative to the estimated fair value of the remaining Class B units of approximately \$14,713. 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 2014 Consolidated Balance Sheet. The liability is being amortized as a vendor incentive over the seven year vesting period. During 2014, the Alliance recognized approximately \$2,995 related to the first vesting period (Tranche 1), which is included within other revenue, gains and support in the 2014 Consolidated Statement of Operations.

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is a party to a number of derivative transactions. These derivatives have not been designated as hedges and are valued at estimated fair value in the accompanying Consolidated Balance Sheets. Management's primary objective in holding such derivatives is to introduce a variable rate component into its fixed rate debt structure. Under the terms of these agreements, changes in the interest rate environment could have a significant effect on the Alliance. Net deferred

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2014 and 2013

financing, acquisition costs and other charges include \$5,447 and \$5,791 at June 30, 2014 and 2013, respectively, related to these swaps.

The Alliance is subject to an enforceable master netting arrangement in the form of an ISDA agreement with Bank of America, Merrill Lynch. Under the terms of this agreement, offsetting of derivative contracts is permitted in the event of default of either party to the agreement. The ISDA agreement requires that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. As of June 30, 2014 and 2013, the Alliance was not required to post additional collateral.

The following is a summary of the interest rate swap agreements at June 30, 2014 and 2013:

Notional Amount	Term	Counterparty	Payments:		Estimated Fair Value	
			Receive	Pay	2014	2013
\$170,000	4/2006-4/2026	Bank of America, Merrill Lynch	1.07% 4/2013-4/2014 1.14% 5/2014-4/2016	0.00%	\$ 3,089	\$ 3,895
\$95,000	4/2006-4/2026	Bank of America, Merrill Lynch	1.08% 4/2013-4/2014 1.14% 5/2014-4/2016	0.00%	1,748	2,205
\$173,030	4/2006-4/2034	Bank of America, Merrill Lynch	1.12% 4/2013-4/2014 1.16% 5/2014-4/2016	0.00%	(1,884)	(710)
\$82,055	12/2007-7/2033	Bank of America, Merrill Lynch	67% USD-LIBOR-BBA	0.312% + USD-SIFMA	(9,365)	(9,322)
\$50,000	2/2008-7/2038	Bank of America, Merrill Lynch	67% (USD-LIBOR-BBA + 0.15%)	USD-SIFMA	(4,210)	(4,218)
\$20,400	7/2007-7/2015	Bank of America, Merrill Lynch	1.05% + USD-SIFMA	4.50%	63	35
					(10,559)	(8,115)
\$4,680	7/2010-7/2015	First Tennessee Bank	0.00%	USD-LIBOR-BBA	(44)	(70)
					\$ (10,603)	\$ (8,185)

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

	2014	2013
Settlement income and other	\$ 5,980	\$ 6,661
Change in estimated fair value	(2,761)	457
	\$ 3,219	\$ 7,118

These fair values are based on the estimated amount the Alliance would receive, or be required to pay, to enter into equivalent agreements at the valuation date and include an estimated credit value

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

adjustment. Due to the nature of these financial instruments, such estimates of fair value are subject to significant change in the near term.

The Alliance was a party to a total return swap which terminated in 2009. In 2013, the Alliance and counterparty reached a settlement agreement. A gain of approximately \$3,020 was recognized on the settlement, which is included within other revenue, gains and support in the accompanying 2013 Consolidated Statement of Operations.

NOTE E--PROPERTY, PLANT AND EQUIPMENT

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

	<u>2014</u>	<u>2013</u>
Land	\$ 60,722	\$ 60,180
Buildings and leasehold improvements	760,853	718,489
Property and improvements held for leasing	80,824	77,767
Equipment and information technology infrastructure	700,748	664,469
Buildings and equipment held under capital lease	340	671
	<u>1,603,487</u>	<u>1,521,576</u>
Less: Allowances for depreciation and amortization	<u>(757,641)</u>	<u>(704,002)</u>
	845,846	817,574
Construction in progress (Note N)	35,583	66,719
	<u>\$ 881,429</u>	<u>\$ 884,293</u>

Accumulated depreciation and amortization on property and improvements held for leasing purposes is \$27,500 and \$25,146 at June 30, 2014 and 2013, respectively. Net interest capitalized was \$1,533 and \$4,419 for the years ended June 30, 2014 and 2013, respectively.

The Alliance entered into an Amendment and Mutual Release Agreement with a vendor whereby the Alliance waived its right to take any action with respect to prior contracts in exchange for professional services, primarily related to accelerated deployment of information systems. The Alliance recognized approximately \$282 and \$3,386 in 2014 and 2013, respectively, as additions to property, plant and equipment with an offsetting gain related to the agreed-upon value of such professional services. The Alliance anticipates recognition of additional amounts in future periods.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2014 and 2013

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

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

<i>Description</i>	<i>Rate as of June 30, 2014</i>	<i>Outstanding Balance</i>	
		<i>2014</i>	<i>2013</i>
2013 Hospital Revenue and Refunding Revenue Bonds:			
\$61,180 variable rate tax-exempt term bond, due August 2031	1.13%	\$ 328,665	\$ -
\$48,600 variable rate tax-exempt term bond, due August 2032	0.91%		
\$13,350 variable rate tax-exempt term bond, due August 2038	1.13%		
\$89,620, variable rate tax-exempt term bonds, due August 2042	1.10% - 1.21%		
\$16,235, variable rate tax-exempt term bond, due August 2043	0.05%		
\$99,680 variable rate taxable term bond due August 2043	0.12%		
2012 Hospital Revenue Bonds:			
(net of unamortized premium of \$1,756 and \$1,817 at June 30, 2014 and 2013, respectively)			
\$55,000 fixed rate tax-exempt term bond, due August 2042	5.00%	56,756	94,697
2011 Hospital Revenue and Refunding and Improvement Bonds:			
\$6,445 variable rate taxable term bond, due July 2026	0.12%	104,710	229,919
\$76,930 variable rate tax-exempt term bonds, due July 2033	0.07%		
\$21,335 variable rate tax-exempt term bond, due July 2033 (JMH)	1.10%		
2010 Hospital Revenue Refunding Bonds:			
(net of unamortized premium of \$1,523 and \$1,604 at June 30, 2014 and 2013, respectively)			
\$41,600 fixed rate tax-exempt serial bonds, through 2020	4.00% to 5.00%	180,993	188,549
\$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 \$2,267 and \$2,359 at June 30, 2014 and 2013, respectively)			
\$16,990 fixed rate tax-exempt term bonds, due July 2019	7.25%	119,813	122,256
\$21,730 fixed rate tax-exempt term bonds, due July 2029	7.50%		
\$83,360 fixed rate tax-exempt term bonds, due July 2038	7.75% - 8.00%		
2008 Hospital Revenue Bond:			
Refunded in 2014			
		-	65,210
2007B Taxable Hospital Revenue Bonds:			
\$19,515 variable rate taxable term bond due July 2019	0.13%	19,515	123,335
2006 Hospital First Mortgage Revenue Bonds:			
(net of unamortized premium of \$129 and \$135 at June 30, 2014 and 2013, respectively)			
\$4,680 fixed rate tax-exempt serial bonds, through 2019	5.00%	167,864	168,485
\$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:			
\$20,400 fixed rate tax-exempt term bond, due July 2026	4.50%	20,400	21,400

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

<i>Description</i>	<i>Rate as of June 30, 2014</i>	<i>Outstanding Balance</i>	
		<i>2014</i>	<i>2013</i>
2000 Hospital First Mortgage Revenue and Refunding Bonds:			
\$43,995 fixed rate tax-exempt term bonds, due July 2026	8.50%	81,006	80,485
\$37,011 fixed rate tax-exempt Capital Appreciation Bonds, 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	806	1,240
Master installment payment agreements			
Various payments through May 2014	Unspecified	-	3,823
Notes payable secured by real estate			
Various principal and interest payments through 2017	Various	5,542	5,878
Promissory notes secured by assets of PFUC			
Various monthly principal and interest payments through 2019	3.00% - 3.75%	918	985
Term note			
Monthly principal payments of \$60 plus variable rate interest beginning November 2012 through September 2015; remaining principal due October 2015	1.14%	16,883	17,607
Notes payable secured by equipment			
Various monthly principal and interest payments through 2016	Various	790	896
Promissory note secured by assets of KASC			
Monthly principal payments of \$7 beginning April 2014 through February 2019; remaining principal due March 2019	3.25%	431	-
Promissory note secured by assets of ETASC			
Monthly principal payments of \$8 plus variable rate interest beginning January 2011 through August 2015; remaining principal due September 2015	3.25%	595	-
		1,105,687	1,124,765
Less current portion		(30,618)	(34,417)
		<u>\$ 1,075,069</u>	<u>\$ 1,090,348</u>

Series 2013 Bonds: In July 2013, the Alliance issued \$16,235 (Series 2013A) Hospital Revenue Bonds, \$99,680 (Series 2013B) Hospital Refunding Revenue Bonds, \$13,350 (Series 2013C) Hospital Refunding Revenue Bonds and \$28,310 (Series 2013G) Hospital Revenue Bonds through The Health and Educational Facilities Board of the City of Johnson City, Tennessee and \$61,180 (Series 2013D) Hospital Refunding Revenue Bonds, \$9,880 (Series 2013E) Hospital Refunding Revenue Bonds, \$51,430 (Series 2013F) Hospital Refunding Revenue Bonds and \$48,600 (Series 2013H) Hospital Refunding Revenue Bonds through the Industrial Development Authority of Smyth County, Virginia (collectively, the Series 2013 Bonds).

The proceeds from the Series 2013A Bonds were used to finance or refinance capital improvements and equipment acquisitions and to pay issuance costs associated with these Bonds. The proceeds from the remaining Series 2013 Bonds were used to refinance outstanding indebtedness, specifically related to the Series 2007B-2, 2008A, 2008B, 2011C, 2011D, 2012B and 2012C Bonds, and to pay issuance costs associated with these Bonds.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

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 \$81,006 and \$80,485 at June 30, 2014 and 2013, respectively. Under terms of these policies, the insurer guarantees the Alliance's payment of principal and interest. At June 30, 2014 and 2013, the Alliance held \$212,360 and \$417,290, respectively, in variable rate demand bonds with letter of credit support and \$240,530 and \$39,055, 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 advance refunded previously issued 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, and the debt is not a considered liability of the Alliance. Therefore, such debt has been derecognized. Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2014 due to previous advance refundings totaled approximately \$196,290.

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.

The Alliance instructed the trustee of the advance refunded 1998C Bonds to liquidate certain investments held in the related irrevocable trust account and to redeem a portion of the 1998C Bonds with the proceeds from the liquidation. The fair value of the liquidated assets exceeded the payment necessary to redeem the 1998C Bonds and the excess was paid to the Alliance. As a result of this transaction, the Alliance recognized a net gain of \$13,847 which is included in other revenue, gains and support in the accompanying 2013 Consolidated Statements of Operations.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

Financing Arrangements: The Alliance has granted a deed of trust on JCMC and SSH to secure the payment of the outstanding bonds 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 JMH Series 2011 Hospital Refunding and Improvement Revenue Bonds are secured by pledged revenues of JMH, as defined in the Credit Agreement.

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, 2014.

During 2014, the Alliance recognized a \$4,622 loss on early extinguishment of debt representing the write off of previously deferred and unamortized financing costs generally related to the refunded portion of the Series 2012 Bonds, Series 2008 Bonds, Series 2011 Bonds and Series 2007B Bonds.

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, 2014 are as follows:

<u>Year Ending June 30,</u>	
2015	\$ 30,618
2016	42,329
2017	27,647
2018	24,793
2019	25,924
Thereafter	<u>953,235</u>
	1,104,546
Net premium	<u>1,141</u>
	<u>\$ 1,105,687</u>

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-

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

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 and \$1,000 annual aggregate retention. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

At June 30, 2014, 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, 2014 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Alliance 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, 2014 and 2013 was \$13,220 and \$12,348, respectively. The discount rate utilized was 5% at June 30, 2014 and 2013.

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, including a catastrophic claims reserve based on historical claims in excess of \$75. 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:

	<u>2014</u>	<u>2013</u>
Third-party payers	\$ 937,150	\$ 946,979
Patients	113,276	98,266
Patient service revenue	<u>\$ 1,050,426</u>	<u>\$ 1,045,245</u>

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

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2014 and 2013

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 \$47,853 and \$49,449 at June 30, 2014 and 2013, respectively. The allowance for doubtful accounts remained consistent at 23% of patient accounts receivable, net of contractual allowances, at June 30, 2014 and 2013. Management's estimate of the allowance for doubtful accounts is a significant 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 through the essential access program. These payments recognized totaled \$6,225 and \$8,455 for the years ended June 30, 2014 and 2013, respectively. Additionally, during the year ending June 30, 2014, the Alliance recorded approximately \$4,097 related to additional supplemental funding through the State of Tennessee as management believes such funding is applicable to 2014. Such payments are not guaranteed in future periods.

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 were based on Medicare cost reimbursement principles and settled through the filing of an annual Medicaid cost report through December 31, 2013. Beginning January 1, 2014, 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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2014 and 2013

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 \$6,201 and \$1,328 in 2014 and 2013, 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 2015, although the amount of any change cannot be estimated.

During 2014, the Alliance recognized \$5,600 of estimated receivables from amounts previously recouped as a result of audits and reviews of governmental programs. Such amounts are based on the Alliance's historical experience with appeals of such recoupments. However, such amounts are subject to significant changes in the near term.

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, 2014.

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 retirement plan (the Plan) which covers substantially all employees. The Plan is a defined contribution plan which consists principally of employer-funded contributions. During 2014 and 2013, the Alliance made 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, 2014 and 2013 was \$13,850 and \$16,121, respectively.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

NCH maintains a defined benefit pension plan and a post-retirement employee benefit plan. The accrued unfunded pension liability was \$2,086 and \$3,028, and the accrued unfunded post-retirement liability was \$5,857 and \$4,943 at June 30, 2014 and 2013, 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 date, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed \$511 and \$1,020 to the plan during 2014 and 2013, respectively. Other assets at June 30, 2014 and 2013 include \$11,302 and \$10,721, 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. The Alliance contributed \$231 and \$294 to the Section 457(f) plan during 2014 and 2013, respectively.

NOTE K--CONCENTRATION OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia which is considered a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payer agreements. Net patient service revenue from Washington County, Tennessee operations were approximately 52% and 51% of total net patient service revenue in 2014 and 2013, respectively.

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.

	<u>2014</u>	<u>2013</u>
Medicare	39%	38%
TennCare/Medicaid	18%	16%
Commercial	28%	28%
Other third-party payers	8%	9%
Patients	7%	9%
	<u>100%</u>	<u>100%</u>

Approximately 88% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2014 and 2013. Admitting physicians are primarily practitioners in the regional area.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued ***(Dollars in Thousands)***

Years Ended June 30, 2014 and 2013

Employees at two of the Alliance's Virginia hospitals are covered under a collective bargaining agreement which extends through February 2017.

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, 2014 and 2013, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of \$27,085 and \$33,620, respectively, related to operating loss carryforwards, which expire through 2031. At June 30, 2014 and 2013, BRMM had state net operating loss carryforwards of \$74,191 and \$71,637, respectively, which expire through 2028. 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.

At June 30, 2014 and 2013, SWCH had federal and state net operating loss carryforwards of \$5,884 and \$5,906, respectively, which expire through 2033. The net operating loss carryforwards may be off-set against future taxable income to the extent permitted by the Internal Revenue Code and tax codes of the Commonwealth of Virginia.

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--RELATED PARTY TRANSACTIONS

The Alliance enters into transactions with entities affiliated with certain members of the Board of Directors including transactions to construct Alliance facilities and provide professional services to the Alliance. Board members refrain from discussion and abstain from voting on transactions with entities with which they are related.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2014 and 2013

NOTE N—OTHER COMMITMENTS AND CONTINGENCIES

Construction in Progress: Construction in progress at June 30, 2014 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 approximately \$48,844 at June 30, 2014. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

Physician Contracts: BRMM employs physicians to provide services to BRMM's physician practices through employment agreements which provide annual compensation, plus incentives based upon specified productivity and performance (quality measures). These contracts have various terms.

In addition, the Alliance has entered into contractual relationships with non-employed physicians to provide services in Upper East Tennessee and Southwest Virginia. These contracts guarantee certain base payments and allowable expenses and have terms of varying lengths. Amounts drawn and outstanding under each agreement are treated as a loan bearing interest at various rates and are subject to repayment over a specified period. The physician notes may also be amortized by virtue of the physician's continued practice in the specified community during the repayment period. A net receivable of \$853 and \$884 related to these agreements is included in the accompanying Consolidated Balance Sheets at June 30, 2014 and 2013, respectively.

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 degree. 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, 2014 and 2013 include \$8,685 and \$9,021, 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, 2014 and 2013 was \$7,901 and \$8,739, 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:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

<u>Year Ending June 30,</u>	
2015	\$ 6,996
2016	6,389
2017	4,084
2018	3,292
2019	3,025
Thereafter	12,500
	<u>\$ 36,286</u>

Other: The Alliance is a party to various transactions and agreements in the normal course of business, which include purchase and re-purchase agreements, put arrangements and other commitments, which may bind the Alliance to undertake additional transactions or activities in the future.

Healthcare Industry: Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

NOTE O—FAIR VALUE MEASUREMENT

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2014 and 2013, 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, 2014 and 2013, is approximately \$38,508 and \$36,666, 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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

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, 2014 and 2013, is approximately \$1,172,357 and \$1,168,846, 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 ASC 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 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, 2014 and 2013:

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2014 and 2013

	<i>Total</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>
June 30, 2014				
Cash, cash equivalents and money market funds	\$ 95,459	\$ 95,459	\$ -	\$ -
U.S. Government securities	35,569	35,569	-	-
U.S. Agency securities	54,905	54,905	-	-
Corporate and foreign bonds	99,103	-	99,103	-
Municipal obligations	21,409	-	21,409	-
Preferred and asset backed securities	3,497	-	3,497	-
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	<u>\$ 634,585</u>	<u>\$ 364,868</u>	<u>\$ 255,004</u>	<u>\$ 14,713</u>
Derivative agreements	<u>\$ (10,603)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ (10,603)</u>
June 30, 2013				
Cash, cash equivalents and money market funds	\$ 66,075	\$ 66,075	\$ -	\$ -
U.S. Government securities	25,905	25,905	-	-
U.S. Agency securities	45,997	45,997	-	-
Corporate and foreign bonds	179,880	-	179,880	-
Municipal obligations	17,749	-	17,749	-
Preferred and asset backed securities	3,491	-	3,491	-
U.S. equity securities	10,944	10,944	-	-
Mutual funds	186,028	125,479	60,548	-
Alternative investments	37,353	-	37,353	-
Total assets	<u>\$ 573,422</u>	<u>\$ 274,400</u>	<u>\$ 299,021</u>	<u>\$ -</u>
Derivative agreements	<u>\$ (8,185)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ (8,185)</u>

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, consistent with the provisions of FASB ASC 820, *Fair Value Measurement*. 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.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2014 and 2013

The Alliance's investment in Premier's Class B units do 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, 2014 and 2013 resulted in a decrease in the fair value of the related liability of \$4,584 and \$3,080, 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.

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, 2014 and 2013:

	<i>Alternative Investment</i>	<i>Derivatives, Net</i>
July 1, 2012	\$ -	\$ (19,381)
Total unrealized/realized gains in the Performance Indicator, net	-	457
Net investment income	-	399
Settlements	-	10,340
June 30, 2013	-	(8,185)
Total unrealized/realized gains in the Performance Indicator, net	-	(2,761)
Net investment income	-	343
Additions	14,713	-
June 30, 2014	\$ 14,713	\$ (10,603)

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2014 and 2013

NOTE P--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 Q--SUBSEQUENT EVENTS

The Alliance signed an agreement to form a joint venture with HealthSouth Corporation to own and operate James H. & Cecile C. Quillen Rehabilitation Hospital (Quillen). At closing, HealthSouth will obtain a 50.1% ownership of the free-standing 60-bed inpatient rehabilitation hospital. Quillen will be managed by HealthSouth Corporation under a long-term management contract. The formation of the joint venture is subject to customary closing conditions including regulatory approvals. Management anticipates closing the joint venture transaction by the end of the calendar year 2014.

Supplemental Schedules

MOUNTAIN STATES HEALTH ALLIANCE

***Consolidated Balance Sheets
(Smyth County Community Hospital and Subsidiary and
Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)***

June 30, 2014

	<i>Smyth County Community Hospital and Subsidiary</i>	<i>Norton Community Hospital and Subsidiaries</i>
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 2,465	\$ 5,581
Patient accounts receivable, less estimated allowances for uncollectible accounts	7,099	10,583
Other receivables, net	1,235	1,706
Inventories and prepaid expenses	1,035	1,882
Estimated amounts due from third-party payers, net	-	113
Receivables from affiliates, net	560	319
TOTAL CURRENT ASSETS	12,394	20,184
INVESTMENTS, less amounts required to meet current obligations	21,335	30,089
PROPERTY, PLANT AND EQUIPMENT, net	71,083	45,438
OTHER ASSETS		
Net deferred financing, acquisition costs and other charges	148	218
Other assets	741	-
TOTAL OTHER ASSETS	889	218
	\$ 105,701	\$ 95,929

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, 2014

	<i>Smyth County Community Hospital and Subsidiary</i>	<i>Norton Community Hospital and Subsidiaries</i>
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	\$ 16	\$ 15
Current portion of long-term debt and capital lease obligations	1,102	147
Accounts payable and accrued expenses	2,125	4,007
Accrued salaries, compensated absences and amounts withheld	2,171	4,503
Estimated amounts due to third-party payers, net	35	-
TOTAL CURRENT LIABILITIES	5,449	8,672
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	15,966	21,096
Estimated professional liability self-insurance	395	567
Other long-term liabilities	943	7,646
TOTAL LIABILITIES	22,753	37,981
NET ASSETS		
Unrestricted net assets	82,938	57,786
Temporarily restricted net assets	10	162
TOTAL NET ASSETS	82,948	57,948
	\$ 105,701	\$ 95,929

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, 2014

	<i>Smyth County Community Hospital and Subsidiary</i>	<i>Norton Community Hospital and Subsidiaries</i>
UNRESTRICTED NET ASSETS:		
Revenue, gains and support:		
Patient service revenue, net of contractual allowances and discounts	\$ 45,406	\$ 77,273
Provision for bad debts	(4,138)	(9,611)
Net patient service revenue	41,268	67,662
Net investment gain	2,148	1,904
Other revenue, gains and support	2,975	5,629
TOTAL REVENUE, GAINS AND SUPPORT	46,391	75,195
Expenses and losses:		
Salaries and wages	17,620	23,622
Physician salaries and wages	261	5,906
Contract labor	112	533
Employee benefits	3,611	8,554
Fees	9,284	9,059
Supplies	5,300	8,319
Utilities	976	1,301
Other	4,740	9,256
Loss on early extinguishment of debt	177	321
Depreciation	4,276	4,420
Amortization	27	8
Interest and taxes	162	349
TOTAL EXPENSES AND LOSSES	46,546	71,648
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	(155)	3,547
Pension and postretirement liability adjustments	-	388
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	(155)	3,935

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, 2014

	<i>Smyth County Community Hospital and Subsidiary</i>	<i>Norton Community Hospital and Subsidiaries</i>
TEMPORARILY RESTRICTED NET ASSETS:		
Restricted grants and contributions	17	97
Net assets released from restrictions	(43)	(26)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	(26)	71
INCREASE (DECREASE) IN TOTAL NET ASSETS	(181)	4,006
NET ASSETS, BEGINNING OF YEAR	83,129	53,942
NET ASSETS, END OF YEAR	\$ 82,948	\$ 57,948

MOUNTAIN STATES HEALTH ALLIANCE

***Consolidating Balance Sheet
(Obligated Group and Other Entities)
(Dollars in Thousands)***

June 30, 2014

	<i>Obligated Group</i>	<i>Other Entities</i>	<i>Eliminations</i>	<i>Total</i>
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	\$ 27,419	\$ 31,766	\$ -	\$ 59,185
Current portion of investments	25,029	-	-	25,029
Patient accounts receivable, less estimated allowance for uncollectible accounts	134,586	26,732	-	161,318
Other receivables, net	29,894	15,608	-	45,502
Inventories and prepaid expenses	22,856	7,982	-	30,838
TOTAL CURRENT ASSETS	239,784	82,088	-	321,872
INVESTMENTS, less amounts required to meet current obligations	449,295	199,180	-	648,475
EQUITY IN AFFILIATES	336,532	-	(336,532)	-
PROPERTY, PLANT AND EQUIPMENT, net	639,370	242,059	-	881,429
OTHER ASSETS				
Goodwill	152,283	4,330	-	156,613
Net deferred financing, acquisition costs and other charges	24,506	1,335	-	25,841
Other assets	39,995	8,355	-	48,350
TOTAL OTHER ASSETS	216,784	14,020	-	230,804
	\$ 1,881,765	\$ 537,347	\$ (336,532)	\$ 2,082,580

MOUNTAIN STATES HEALTH ALLIANCE

***Consolidating Balance Sheet – Continued
(Obligated Group and Other Entities)
(Dollars in Thousands)***

June 30, 2014

	<i>Obligated Group</i>	<i>Other Entities</i>	<i>Eliminations</i>	<i>Total</i>
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accrued interest payable	\$ 18,613	\$ 35	\$ -	\$ 18,648
Current portion of long-term debt and capital lease obligations	27,311	3,307	-	30,618
Accounts payable and accrued expenses	71,739	15,387	-	87,126
Accrued salaries, compensated absences and amounts withheld	54,710	17,471	-	72,181
Payables to (receivables from) affiliates, net	13,760	(13,760)	-	-
Estimated amounts due to third-party payers, net	10,068	395	-	10,463
TOTAL CURRENT LIABILITIES	196,201	22,835	-	219,036
OTHER LIABILITIES				
Long-term debt and capital lease obligations, less current portion	1,037,407	37,662	-	1,075,069
Estimated fair value of derivatives, net	10,666	(63)	-	10,603
Estimated professional liability self-insurance	7,747	1,210	-	8,957
Other long-term liabilities	33,495	2,479	-	35,974
TOTAL LIABILITIES	1,285,516	64,123	-	1,349,639
NET ASSETS				
Unrestricted net assets				
Mountain States Health Alliance	541,979	329,803	(329,803)	541,979
Noncontrolling interests in subsidiaries	41,855	131,402	5,290	178,547
TOTAL UNRESTRICTED NET ASSETS	583,834	461,205	(324,513)	720,526
Temporarily restricted net assets				
Mountain States Health Alliance	12,204	11,887	(11,887)	12,204
Noncontrolling interests in subsidiaries	84	5	(5)	84
TOTAL TEMPORARILY RESTRICTED NET ASSETS	12,288	11,892	(11,892)	12,288
Permanently restricted net assets				
	127	127	(127)	127
TOTAL NET ASSETS	596,249	473,224	(336,532)	732,941
	\$ 1,881,765	\$ 537,347	\$ (336,532)	\$ 2,082,580

MOUNTAIN STATES HEALTH ALLIANCE

***Consolidating Statement of Operations
(Obligated Group and Other Entities)
(Dollars in Thousands)***

Year Ended June 30, 2014

	<i>Obligated Group</i>	<i>Other Entities</i>	<i>Eliminations</i>	<i>Total</i>
Revenue, gains and support:				
Patient service revenue, net of contractual allowances and discounts	\$ 873,422	\$ 178,164	\$ (1,160)	\$ 1,050,426
Provision for bad debts	(103,913)	(18,729)	-	(122,642)
Net patient service revenue	769,509	159,435	(1,160)	927,784
Premium revenue	-	10,683	-	10,683
Net investment gain	34,846	15,889	(32)	50,703
Net derivative gain	2,497	722	-	3,219
Other revenue, gains and support	71,579	98,296	(107,418)	62,457
Equity in net gain of affiliates	1,510	11,182	(12,692)	-
TOTAL REVENUE, GAINS AND SUPPORT	879,941	296,207	(121,302)	1,054,846
Expenses:				
Salaries and wages	283,993	62,198	(5,602)	340,589
Physician salaries and wages	57,829	74,738	(54,931)	77,636
Contract labor	2,833	1,692	(243)	4,282
Employee benefits	59,268	15,483	(5,578)	69,173
Fees	116,527	33,896	(34,817)	115,606
Supplies	138,127	25,731	(159)	163,699
Utilities	13,087	3,969	(4)	17,052
Medical Costs	-	10,292	-	10,292
Other	56,890	29,828	(6,738)	79,980
Loss on early extinguishment of debt	4,622	-	-	4,622
Depreciation	52,544	16,893	-	69,437
Amortization	1,691	51	-	1,742
Interest and taxes	42,734	1,680	(22)	44,392
TOTAL EXPENSES	830,145	276,451	(108,094)	998,502
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	\$ 49,796	\$ 19,756	\$ (13,208)	\$ 56,344

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

***Consolidating Statement of Changes in Net Assets
(Obligated Group and Other Entities)
(Dollars in Thousands)***

Year Ended June 30, 2014

	<i>Obligated Group</i>		<i>Total Obligated Group</i>	<i>Other Entities</i>		<i>Total Other Entities</i>	<i>Eliminations</i>	<i>Total</i>
	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>		<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>			
UNRESTRICTED NET ASSETS:								
Excess of Revenue, Gains and Support over Expenses and Losses	\$ 48,057	\$ 1,739	\$ 49,796	\$ 14,412	\$ 5,344	\$ 19,756	\$ (13,208)	\$ 56,344
Pension and other defined benefit plan adjustments	194	194	388	(10)	(9)	(19)	19	388
Net assets released from restrictions used for the purchase of property, plant and equipment	3,313	-	3,313	3,313	-	3,313	(3,313)	3,313
Noncontrolling interest in acquired subsidiary	-	-	-	-	914	914	-	914
Distributions to noncontrolling interests	-	-	-	-	(461)	(461)	-	(461)
Net asset transfers	-	-	-	882	1,669	2,551	(2,551)	-
INCREASE IN UNRESTRICTED NET ASSETS	51,564	1,933	53,497	18,597	7,457	26,054	(19,053)	60,498
TEMPORARILY RESTRICTED NET ASSETS:								
Restricted grants and contributions	4,693	52	4,745	4,047	42	4,089	(4,053)	4,781
Net assets released from restrictions	(5,264)	(22)	(5,286)	(4,691)	(38)	(4,729)	4,694	(5,321)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	(571)	30	(541)	(644)	4	(640)	641	(540)
INCREASE IN TOTAL NET ASSETS	50,993	1,963	52,956	17,953	7,461	25,414	(18,412)	59,958
NET ASSETS, BEGINNING OF YEAR	503,317	39,976	543,293	323,864	123,946	447,810	(318,120)	672,983
NET ASSETS, END OF YEAR	\$ 554,310	\$ 41,939	\$ 596,249	\$ 341,817	\$ 131,407	\$ 473,224	\$ (336,532)	\$ 732,941

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Note to Supplemental Schedules

Year Ended June 30, 2014

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 schedules include 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 11.4

Attachment G

Mountain States EMMA - Annual Disclosures for 2010 to 2015 and Material Event Disclosures



**Fiscal Year 2010
(ending June 30, 2010)**

Annual Financial & Operating Data

**Mountain States Health Alliance
Patient Origin
FY 2010 (ended June 30, 2010)**

County	IP Cases	% of Total	Cumulative %
Washington, TN	15,835	26.3%	26.3%
Sullivan, TN	7,612	12.7%	39.0%
Carter, TN	6,408	10.7%	49.7%
Wise, VA	4,365	7.3%	56.9%
Smyth, VA	3,593	6.0%	62.9%
Washington, VA	3,536	5.9%	68.8%
Russell, VA	2,841	4.7%	73.5%
Greene, TN	2,647	4.4%	77.9%
Johnson, TN	1,941	3.2%	81.2%
Unicoi, TN	1,884	3.1%	84.3%
Hawkins, TN	1,527	2.5%	86.8%
Dickenson, VA	1,430	2.4%	89.2%
All Other	6,483	10.8%	100.0%
Grand Total	60,102	100.0%	

Source: JARS, Paragon, and Internal VA Facility reports

Note: excludes Franklin Marion Manor

Note2: Excludes normal newborns

**Mountain States Health Alliance
Patient Origin
FY 2010 (ended June 30, 2010)**

County	IP Cases	% of Total	Cumulative %
<i>Core Service Area</i>			
Washington, TN	15,835	26.3%	26.3%
Sullivan, TN	7,612	12.7%	39.0%
Carter, TN	6,408	10.7%	49.7%
Wise, VA	4,365	7.3%	56.9%
Smyth, VA	3,593	6.0%	62.9%
Washington, VA	3,536	5.9%	68.8%
Russell, VA	2,841	4.7%	73.5%
Greene, TN	2,647	4.4%	77.9%
Johnson, TN	1,941	3.2%	81.2%
Unicoi, TN	1,884	3.1%	84.3%
Hawkins, TN	1,527	2.5%	86.8%
Dickenson, VA	1,430	2.4%	89.2%
Scott, VA	799	1.3%	90.5%
Core Service Area	54,418	90.5%	
<i>Non-Core Service Area</i>			
Tazewell, VA	500	0.8%	91.4%
Buchanan, VA	251	0.4%	91.8%
Avery, NC	232	0.4%	92.2%
Wythe, VA	180	0.3%	92.5%
Mitchell, NC	159	0.3%	92.7%
Lee, VA	157	0.3%	93.0%
Hamblen, TN	156	0.3%	93.3%
Letcher, KY	147	0.2%	93.5%
Cocke, TN	131	0.2%	93.7%
Harlan, KY	124	0.2%	93.9%
Grayson, VA	98	0.2%	94.1%
Hancock, TN	49	0.1%	94.2%
Watauga, NC	3	0.0%	94.2%
Yancey, NC	3	0.0%	94.2%
Non-Core Service Area	2,190	3.6%	
Core & Non-Core	56,608	94.2%	
All Other	3,494	5.8%	100.0%
Grand Total	60,102	100.0%	

Source: JARS, Paragon, and Internal VA Facility reports

Note: excludes Franklin Marion Manor

Note2: Excludes normal newborns

Mountain States Health Alliance
Gross Patient Revenues by Source of Payment (Payor Mix)
FY 2010 (ended June 30, 2010)

	Fiscal Year Ended <u>June 30, 2010</u>
Medicare	43.4%
TennCare/Medicaid	14.3
Managed Care/ Commercial and Other	34.2
<u>Private Pay</u>	<u>8.2</u>
Total	100.0%

Source: Mountain States Health Alliance

**Mountain States Health Alliance
Utilization Information
FY 2010 (ended June 30, 2010)**

	Fiscal Year Ended <u>June 30, 2010</u>
Average Daily Census	800
Occupancy Rate	46.2%
Patient Days	291,986
Admissions	60,102
Average Length of Stay	4.86
Outpatient Visits	1,607,790
Licensed Beds	1,789

Source: Mountain States Health Alliance

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2010
 Historical Maximum Annual Debt Service Coverage

Calculation:	First Quarter Ended	Second Quarter Ended	Third Quarter Ended	Fourth Quarter Ended	Twelve Months Ended	Twelve Months Ended	Twelve Months Ended	Twelve Months Ended	Obligated Group
	Sept. 30, 2009 ¹	Dec. 31, 2009 ¹	March 31, 2010 ¹	June 30, 2010 ¹	Sept. 30, 2009	Dec. 31, 2009	March 30, 2010	June 30, 2010	Audited Year-End June 30, 2010 ²
Income available for debt service									
Excess of revenue over expenses (before extraord. items)	\$ 3,236,871	\$ 12,165,862	\$ 6,225,171	\$ 22,163,150	\$ 29,781,379	\$ 42,802,162	\$ 39,430,252	\$ 41,932,739	
Plus depreciation expense	16,535,240	17,045,395	17,501,848	17,370,624	58,544,379	62,970,190	67,845,061	68,453,105	
Plus amortization expense	1,486,304	3,251,451	3,199,498	3,327,134	10,723,405	11,071,873	11,354,342	13,122,700	
Plus interest expense	13,224,853	8,772,593	9,589,626	11,225,726	48,066,366	43,105,894	42,711,129	42,862,665	
Total income available for debt service	<u>137,933,072</u>	<u>164,941,204</u>	<u>146,064,572</u>	<u>216,346,536</u>	<u>147,115,529</u>	<u>159,950,119</u>	<u>161,340,784</u>	<u>166,371,209</u>	<u>141,077,000</u>
Maximum annual debt service	<u>78,282,495</u>	<u>69,701,000</u>	<u>69,674,000</u>	<u>79,730,000</u>	<u>78,282,495</u>	<u>69,701,000</u>	<u>69,674,000</u>	<u>79,730,000</u>	<u>77,187,000</u>
Maximum annual debt service coverage	<u>1.8</u>	<u>2.4</u>	<u>2.1</u>	<u>2.7</u>	<u>1.9</u>	<u>2.3</u>	<u>2.3</u>	<u>2.1</u>	<u>1.8</u>

Footnotes

1- Annualized quarterly total income available for debt service

2- Obligated Group only, Audited Historical Maximum Annual Debt Service Coverage, Total income available for debt service includes Depreciation, Amortization, and Interest expenses



**Fiscal Year 2011
(ending June 30, 2011)**

Annual Financial & Operating Data

**Mountain States Health Alliance
Facilities Patient Origin
FY 2010 (ended June 30, 2010)**

County	Discharges	% of Total
Washington, TN	16,167	26.9%
Sullivan, TN	7,753	12.9%
Carter, TN	6,371	10.6%
Wise, VA ¹	4,327	7.2%
Greene, TN	2,644	4.4%
Smyth, VA	3,606	6.0%
Unicoi, TN	1,863	3.1%
Johnson, TN	1,923	3.2%
Hawkins, TN	1,503	2.5%
Russell, VA	3,306	5.5%
Dickenson, VA	1,442	2.4%
Scott, VA	902	1.5%
Washington, VA ²	4,207	7.0%
Core Subtotal	56,014	93.2%
Non-Core Subtotal	3,006	5.0%
Other Areas Subtotal	1,082	1.8%
Grand Total	60,102	100.0%

Source: Mountain States Health Alliance - Fiscal year data excludes normal newborns. Acquired facilities have been included from date of acquisition forward.

Mountain States Health Alliance
Gross Patient Revenues by Source of Payment (Payor Mix)
FY 2011 (ended June 30, 2011)

	Fiscal Year Ended <u>June 30, 2011</u>
Medicare	43.7%
TennCare/Medicaid	13.7
Managed Care/ Commercial and Other	34.2
<u>Private Pay</u>	<u>8.4</u>
Total	100.0%

Source: Mountain States Health Alliance

**Mountain States Health Alliance
Utilization Information
FY 2011 (ended June 30, 2011)**

	Fiscal Year Ended <u>June 30, 2011</u>
Occupancy Rate (licensed)	47%
Patient Days	288,167
Admissions	61,035
Average Daily Census	789
Average Length of Stay (days)	4.7
Outpatient Visits	1,590,962
ER Visits	242,677
Surgical Cases	39,230
Births	4,511
Newborn Days	9,287
Licensed Beds	1,749

Source: Mountain States Health Alliance

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2011
 Historical Maximum Annual Debt Service Coverage

Calculation:	First Quarter Ended	Second Quarter Ended	Third Quarter Ended	Fourth Quarter Ended	Twelve Months Ended	Twelve Months Ended	Twelve Months Ended	Twelve Months Ended	Obligated Group
	Sept. 30, 2010 ¹	Dec. 31, 2010 ¹	March 31, 2011 ¹	June 30, 2011 ¹	Sept. 30, 2010	Dec. 31, 2010	March 31, 2011	June 30, 2011	Audited Year-End June 30, 2011 ²
Income available for debt service									
Excess of revenue over expenses (before extraord. items)	\$ 1,711,973	\$ 6,875,346	\$ 10,390,905	\$ 19,425,059	\$ 42,266,156	\$ 36,975,640	\$ 41,141,374	\$ 38,403,281	
Plus depreciation expense	21,008,221	21,836,099	21,874,052	22,781,081	72,926,088	77,716,792	82,088,996	87,499,453	
Plus amortization expense	517,483	623,485	620,188	797,985	10,295,566	7,667,600	5,088,290	2,559,141	
Plus interest expense	12,902,670	11,790,091	10,836,477	9,801,705	42,490,615	45,508,113	46,754,964	45,330,943	
Total income available for debt service	<u>144,561,388</u>	<u>164,500,084</u>	<u>174,886,488</u>	<u>211,223,320</u>	<u>167,978,425</u>	<u>167,868,145</u>	<u>175,073,624</u>	<u>173,792,818</u>	<u>145,340,000</u>
Maximum annual debt service	<u>77,187,000</u>	<u>75,202,000</u>	<u>70,580,000</u>	<u>67,624,650</u>	<u>77,187,000</u>	<u>75,202,000</u>	<u>70,580,000</u>	<u>67,624,650</u>	<u>65,678,000</u>
Maximum annual debt service coverage	<u>1.9</u>	<u>2.2</u>	<u>2.5</u>	<u>3.1</u>	<u>2.2</u>	<u>2.2</u>	<u>2.5</u>	<u>2.6</u>	<u>2.2</u>

Footnotes

1- Annualized quarterly total income available for debt service

2- Obligated Group only, Audited Historical Maximum Annual Debt Service Coverage, Total income available for debt service includes Depreciation, Amortization, and Interest expenses



**Fiscal Year 2012
(ending June 30, 2012)**

Annual Financial & Operating Data

**Mountain States Health Alliance
Facilities Patient Origin
FY 2012 (ended June 30, 2012)**

County	Discharges	% of Total
Washington, TN	16,724	26.9%
Sullivan, TN	7,971	12.8%
Carter, TN	6,738	10.8%
Wise, VA ¹	4,286	6.9%
Greene, TN	2,450	3.9%
Smyth, VA	3,582	5.8%
Unicoi, TN	2,092	3.4%
Johnson, TN	2,052	3.3%
Hawkins, TN	1,520	2.4%
Russell, VA	3,183	5.1%
Dickenson, VA	1,407	2.3%
Scott, VA	963	1.6%
Washington, VA ²	5,109	8.2%
Core Subtotal	58,077	93.5%
Non-Core Subtotal	2,840	4.6%
Other Areas Subtotal	1,185	1.9%
Grand Total	62,102	100.0%

Source: Mountain States Health Alliance - Fiscal year data excludes normal newborns. Acquired facilities have been included from date of acquisition forward.

Mountain States Health Alliance
Gross Patient Revenues by Source of Payment (Payor Mix)
FY 2012 (ended June 30, 2012)

	Fiscal Year Ended <u>June 30, 2012</u>
Medicare	44.1%
TennCare/Medicaid	14.2
Managed Care/ Commercial and Other	33.2
<u>Private Pay</u>	<u>8.5</u>
Total	100.0%

Source: Mountain States Health Alliance

**Mountain States Health Alliance
Utilization Information
FY 2012 (ended June 30, 2012)**

	Fiscal Year Ended <u>June 30, 2011</u>
Occupancy Rate (licensed)	48%
Patient Days	292,910
Admissions	61,154
Average Daily Census	800
Average Length of Stay (days)	4.8
Outpatient Visits	1,592,335
ER Visits	246,821
Surgical Cases	36,971
Births	4,288
Newborn Days	9,116
Licensed Beds	1,623

Source: Mountain States Health Alliance

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2012
 Historical Maximum Annual Debt Service Coverage

Calculation:	First Quarter Ended	Second Quarter Ended	Third Quarter Ended	Fourth Quarter Ended	Twelve Months Ended	Twelve Months Ended	Twelve Months Ended	Twelve Months Ended	Obligated Group
	Sept. 30, 2011 ¹	Dec. 31, 2011 ¹	March 31, 2012 ¹	June 30, 2012 ¹	Sept. 30, 2011	Dec. 31, 2011	March 31, 2012	June 30, 2012	Audited Year-End
									June 30, 2012 ²
Income available for debt service									
Excess of revenue over expenses (before extraord. items)	\$ 14,663,165	\$ 1,831,046	\$ 3,366,688	\$ 25,813,207	\$ 51,354,475	\$ 46,310,175	\$ 39,285,958	\$ 45,674,106	
Plus depreciation expense	17,827,079	17,631,863	18,726,373	18,624,326	84,318,311	80,114,075	76,966,396	72,809,641	
Plus amortization expense	541,220	575,931	555,332	572,842	2,582,878	2,535,324	2,470,468	2,245,325	
Plus interest expense	12,398,271	11,705,382	11,390,297	10,480,259	44,849,920	44,765,211	45,319,031	45,997,585	
Total income available for debt service	181,812,444	126,976,888	136,154,760	221,962,536	183,105,584	173,724,785	164,041,853	166,726,657	145,732,000
Maximum annual debt service	68,198,673	67,893,000	67,879,000	67,854,000	68,198,673	67,893,000	67,879,000	67,854,000	77,211,000
Maximum annual debt service coverage	2.7	1.9	2.0	3.3	2.7	2.6	2.4	2.5	1.9

Footnotes

1- Annualized quarterly total income available for debt service

2- Obligated Group only, Audited Historical Maximum Annual Debt Service Coverage, Total income available for debt service includes *Depreciation, Amortization, and Interest expenses*



**Fiscal Year 2013
(ending June 30, 2013)**

Annual Financial & Operating Data

Historical Maximum Annual Debt Service Coverage Ratio

**Mountain States Health Alliance
Facilities Patient Origin
FY 2013 (ending June 30, 2013)**

County	Discharges	% of Total
Washington, TN	16,169	27.18%
Sullivan, TN	7,423	12.48%
Carter, TN	6,532	10.98%
Washington, VA	4,937	8.30%
Wise, VA	4,133	6.95%
Smyth, VA	3,457	5.81%
Russell, VA	2,864	4.81%
Greene, TN	2,170	3.65%
Unicoi, TN	2,085	3.51%
Johnson, TN	1,925	3.24%
Hawkins, TN	1,475	2.48%
Dickenson, VA	1,303	2.19%
Scott, VA	1,027	1.73%
Core Subtotal	55,500	93.30%
Non-Core Subtotal	2,823	4.75%
Other Areas Subtotal	1,160	1.95%
Grand Total	59,483	100.00%

Source: Mountain States Health Alliance - Fiscal year data excludes normal newborns.

Mountain States Health Alliance
Gross Patient Revenues by Source of Payment (Payor Mix)
FY 2013 (ending June 30, 2013)

	Fiscal Year ending <u>June 30, 2013</u>
Medicare	44.5%
TennCare/Medicaid	14.0
Managed Care/ Commercial and Other	32.7
<u>Private Pay</u>	<u>8.8</u>
Total	100.0%

Source: Mountain States Health Alliance

**Mountain States Health Alliance
Utilization Information
FY 2013 (ending June 30, 2013)**

	Fiscal Year ending <u>June 30, 2013</u>
Occupancy Rate (licensed)	49%
Patient Days	278,559
Admissions	58,103
Average Daily Census	763
Average Length of Stay (days)	4.8
Outpatient Visits	1,664,622
ER Visits	249,415
Surgical Cases	35,914
Births	4,306
Newborn Days	8,567
Licensed Beds	1,623

Source: Mountain States Health Alliance

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2013
 Historical Maximum Annual Debt Service Coverage (Audited)

	First Quarter ending Sept. 30, 2012 ¹	Second Quarter ending Dec. 31, 2012 ¹	Third Quarter ending March 31, 2013 ¹	Fourth Quarter ending June 30, 2013 ¹	Twelve Months ending Sept. 30, 2012	Twelve Months ending Dec. 31, 2012	Twelve Months ending March 31, 2012	Twelve Months ending June 30, 2013	<i>Obligated Group</i> Audited Year-End June 30, 2013 ²
Calculation:									
Income available for debt service									
Excess of revenue over expenses (before extraord. items)	\$ 580,909	\$ 12,922,730	\$ 6,096,225	\$ 19,898,689	\$ 31,591,850	\$ 42,683,534	\$ 45,413,071	\$ 39,498,553	
Plus depreciation expense	18,781,446	18,430,748	19,310,396	20,909,754	73,764,008	74,562,893	75,146,916	77,432,344	
Plus amortization expense	564,570	562,414	560,137	572,416	2,268,675	2,255,158	2,259,963	2,259,537	
Plus interest expense	10,839,700	11,019,640	10,583,341	10,811,975	44,415,638	43,729,896	42,922,940	43,254,656	
Total income available for debt service	123,066,500	171,742,128	146,200,396	208,771,336	152,040,171	163,231,481	165,742,890	162,445,090	132,740,000
Maximum annual debt service	71,229,000	71,601,000	71,589,000	71,554,000	71,229,000	71,601,000	71,589,000	71,554,000	73,739,000
Maximum annual debt service coverage	1.7	2.4	2.0	2.9	2.1	2.3	2.3	2.3	1.8

Footnotes

1- Annualized quarterly total income available for debt service

2- *Obligated Group only*, Audited Historical Maximum Annual Debt Service Coverage, Total income available for debt service (Historical) includes *Depreciation, Amortization, and Interest expenses*



**Fiscal Year 2014
(ending June 30, 2014)**

Annual Financial & Operating Data

Historical Maximum Annual Debt Service Coverage Ratio

**Mountain States Health Alliance
Facilities Patient Origin
FY 2014 (ending June 30, 2014)**

County	Discharges	% of Total
Core Service Area		
Washington, TN	16,205	27.18%
Sullivan, TN	7,217	12.10%
Carter, TN	6,687	11.21%
Washington, VA	4,822	8.09%
Wise, VA	3,795	6.36%
Smyth, VA	3,397	5.70%
Russell, VA	2,629	4.41%
Greene, TN	2,282	3.83%
Unicoi, TN	3,334	5.59%
Johnson, TN	2,057	3.45%
Hawkins, TN	1,456	2.44%
Dickenson, VA	1,122	1.88%
Scott, VA	924	1.55%
Total - Core	55,927	93.79%
Non-Core	2,760	4.63%
Outside Service Area	945	1.58%
Grand Total	59,632	100.00%

Source: Mountain States Health Alliance - Fiscal year data excludes normal newborns.

Mountain States Health Alliance

Gross Patient Revenues by Source of Payment (Payor Mix) FY 2014 (ending June 30, 2014)

	Fiscal Year ending <u>June 30, 2014</u>
Medicare	31.6%
Managed Medicare	19.5%
TennCare/Medicaid	14.5%
Managed Care/Commercial/Other	26.8%
<u>Private Pay</u>	<u>7.6%</u>
TOTAL	100.0%

Utilization Information FY 2014 (ending June 30, 2014)

	Fiscal Year ending <u>June 30, 2014</u>
Occupancy Rate (licensed)	48%
Patient Days	274,569
Admissions	57,040
Average Daily Census	752
Average Length of Stay (days)	4.81
Outpatient Visits	1,693,521
ER Visits	239,606
Surgical Cases	30,238
Births	4,213
Newborn Days	7,746
Licensed Beds	1,717

Source: Mountain States Health Alliance

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2014
 Historical Maximum Annual Debt Service Coverage (Audited)

Calculation:	Q1 ending	Q2 ending	Q3 ending	Q4 ending	12 mos. ending	12 mos. ending	12 mos. ending	12 mos. ending	<i>Obligated Group</i> Audited Year-End
	Sept. 30, 2013	Dec. 31, 2013	March 31, 2014	June 30, 2014	Sept. 30, 2013	Dec. 31, 2013	March 31, 2014	June 30, 2014	June 30, 2014 ¹
Income available for debt service									
Excess of revenue over expenses (before extraord. items)	\$ 4,218,630	\$ (961,068)	\$ (113,320)	\$ 31,607,527	\$ 43,136,274	\$ 29,252,476	\$ 23,042,931	\$ 34,751,769	
Plus depreciation expense	19,284,204	19,047,262	19,273,023	11,832,248	77,935,102	78,551,616	78,514,243	69,436,737	
Plus amortization expense	552,983	400,273	398,992	389,509	2,247,950	2,085,809	1,924,664	1,741,757	
Plus interest expense	11,002,163	11,304,337	11,169,392	10,925,089	43,417,119	43,701,816	44,287,867	44,400,981	
Subtotal	35,057,980	29,790,804	30,728,087	54,754,373	166,736,445	153,591,717	147,769,705	150,331,244	
Annualized quarterly total income available for debt service	<i>x 4</i>	<i>x 4</i>	<i>x 4</i>	<i>x 4</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	
Total income available for debt service	140,231,920	119,163,216	122,912,348	219,017,492	166,736,445	153,591,717	147,769,705	150,331,244	129,271,000
Maximum annual debt service	70,909,000	70,867,000	70,827,000	70,804,000	70,909,000	70,867,000	70,827,000	70,804,000	73,905,000
Maximum annual debt service coverage	1.98	1.68	1.74	3.09	2.35	2.17	2.09	2.12	1.75

Footnotes

1- *Obligated Group only*, Audited Historical Maximum Annual Debt Service Coverage, Total income available for debt service (Historical) includes *Depreciation, Amortization, and Interest expenses*.



First Quarter ending September 30, 2009

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended September 30, 2009

	Actual
THREE MONTHS YEAR TO DATE	
<u>Patient Revenue</u>	
Inpatient Revenue	461,325,969
Outpatient Revenue	417,669,048
Total Gross Patient Revenue	<u>878,995,017</u>
<u>Deductions from Revenue</u>	
Contractual Adjustments	602,017,671
Charity	12,235,478
Contra Revenue - Self Pay	33,496,289
Cost of Goods Sold	<u>368,844</u>
Total Deductions	<u>648,118,281</u>
Net Patient Service Revenue	<u>230,876,735</u>
Other Operating Revenue	4,560,660
Total Operating Revenue	<u>235,437,396</u>
<u>Operating Expense</u>	
Salaries	81,368,607
Physician Salaries	13,148,857
Contract Labor	2,295,050
Employee Benefits	18,966,469
Fees	20,982,702
Supplies	45,143,128
Utilities	4,154,350
Other Expense	16,666,166
Depreciation	16,535,240
Amortization	3,344,620
Bad Debt	2,004,430
Interest & Taxes	13,249,787
Management Fees	0
Total Operating Expense	<u>237,859,406</u>
Net Operating Income	<u>(2,422,010)</u>
Net Investment Income	4,997,693
Realized Gain on Investments	346,650
Gain / (Loss) from Affiliates	188,523
Gain / (Loss) on Disposal	(8,941)
Loss on Extinguishment of LTD / Derivatives	0
Minority Interest	(2,078,365)
Taxes - Non Operating	(24,933)
Incentive Pay	(13,543)
Other Non Operating Income / (Expense)	393,482
Total Revenue Over Expense Before CFV of Derivatives	<u>1,378,556</u>
Change in Fair Value of Interest Rate Swaps	9,717,658
Change in Fair Value of Call Option	<u>(4,304,815)</u>
Total Excess Revenue Over Expense	<u>6,791,398</u>
Net Unrealized Gain / (Loss) on Investments	16,750,429
Total Increase in Unrestricted Net Assets	<u>23,541,828</u>
EBITDA	<u>34,533,136</u>

Mountain States Health Alliance
Consolidated Balance Sheet
At September 30, 2009

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	259,740,449
Current Portion AWUIL	2,693,512
Accounts Receivable (Net)	130,388,642
Other Receivables	16,052,742
Due From Affiliates	(0)
Due From Third Party Payors	(0)
Inventories	18,814,488
Prepaid Expense	11,563,012
	439,252,845
 <u>ASSETS WHOSE USE IS LIMITED</u>	 305,180,746
 <u>OTHER INVESTMENTS</u>	 285,031,276
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,128,821,466
Less Allowances for Depreciation	522,027,499
	606,793,967
 <u>OTHER ASSETS</u>	
Pledges Receivable	5,888,327
Long Term Compensation Investment	13,635,963
Investments in Unconsolidated Subsidiaries	4,212,739
Land / Equipment Held for Resale	33,062
Assets Held for Expansion	10,898,042
Investments in Subsidiaries	(0)
Goodwill	159,843,518
Deferred Charges and Other	31,171,409
	225,683,060
 <u>TOTAL ASSETS</u>	 1,861,941,893
 <u>LIABILITIES AND FUND BALANCE</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	86,814,701
Accrued Salaries, Benefits, and PTO	55,967,466
Accrued Interest	8,361,368
Due to Affiliates	108
Due to Third Party Payors	12,453,757
Current Portion of Long Term Debt	33,313,161
	196,910,561
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	6,301,849
Long Term Debt	1,019,561,041
Estimated Fair Value of Interest Rate Swaps	38,345,026
Call Option Liability	82,326,922
Deferred Income	21,171,148
Professional Liability Self-Insurance and Other	20,379,008
	1,188,084,993
 <u>TOTAL LIABILITIES</u>	 1,384,995,555
 <u>MINORITY INTEREST</u>	 167,527,530
 <u>FUND BALANCE</u>	 309,418,808
 <u>TOTAL LIABILITIES AND FUND BALANCE</u>	 1,861,941,893

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2010 - First Quarter ended September 30, 2009
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>First Quarter Ended Sept. 30, 2009 ¹</u>	<u>Twelve Months Ended Sept 30, 2009</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 3,236,871	\$ 29,781,379
Plus depreciation expense	16,535,240	58,544,379
Plus amortization expense	1,486,304	10,723,405
<u>Plus interest expense</u>	<u>13,224,853</u>	<u>48,066,366</u>
Total income available for debt service	<u><u>137,933,072</u></u>	<u><u>147,115,529</u></u>
Maximum annual debt service	<u>78,282,495</u>	<u>78,282,495</u>
Maximum annual debt service coverage	<u><u>1.8</u></u>	<u><u>1.9</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



Second Quarter ending December 31, 2009

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At December 31, 2009

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	250,959,242
Current Portion AWUIL	5,029,407
Accounts Receivable (Net)	134,921,848
Other Receivables	16,853,163
Due From Affiliates	0
Due From Third Party Payors	0
Inventories	19,869,237
Prepaid Expense	9,760,362
	437,393,259
 <u>ASSETS WHOSE USE IS LIMITED</u>	 268,359,916
 <u>OTHER INVESTMENTS</u>	 315,814,039
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,164,796,789
Less Allowances for Depreciation	538,318,261
	626,478,528
 <u>OTHER ASSETS</u>	
Pledges Receivable	5,682,523
Long Term Compensation Investment	13,585,860
Investments in Unconsolidated Subsidiaries	4,253,856
Land / Equipment Held for Resale	46,971
Assets Held for Expansion	10,902,042
Investments in Subsidiaries	(0)
Goodwill	157,067,477
Deferred Charges and Other	30,559,897
	222,098,626
 <u>TOTAL ASSETS</u>	 1,870,144,368
 <u>LIABILITIES AND FUND BALANCE</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	84,786,620
Accrued Salaries, Benefits, and PTO	46,023,310
Accrued Interest	15,065,099
Due to Affiliates	8,474
Due to Third Party Payors	16,814,205
Current Portion of Long Term Debt	30,649,911
	193,347,619
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	6,755,022
Long Term Debt	1,019,776,932
Estimated Fair Value of Interest Rate Swaps	18,223,457
Call Option Liability	83,147,451
Deferred Income	21,583,249
Professional Liability Self-Insurance and Other	20,224,854
	1,169,710,964
 <u>TOTAL LIABILITIES</u>	 1,363,058,584
 <u>MINORITY INTEREST</u>	 167,626,539
 <u>FUND BALANCE</u>	 339,459,245
 <u>TOTAL LIABILITIES AND FUND BALANCE</u>	 1,870,144,368

NOTE: JCMC includes Home Care Services

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended December 31, 2009

	Actual	SIX MONTHS YEAR TO DATE
<i>Patient Revenue</i>		
Inpatient Revenue	941,164,396	
Outpatient Revenue	842,243,568	
Total Gross Patient Revenue	1,783,407,964	
<i>Deductions from Revenue</i>		
Contractual Adjustments	1,229,969,923	
Charity	27,235,155	
Contra Revenue - Self Pay	58,186,601	
Cost of Goods Sold	778,321	
Total Deductions	1,316,170,000	
Net Patient Service Revenue	467,237,964	
Other Operating Revenue	8,852,074	
Total Operating Revenue	476,090,038	
<i>Operating Expense</i>		
Salaries	160,879,021	
Physician Salaries	27,222,226	
Contract Labor	3,676,434	
Employee Benefits	42,610,826	
Fees	41,555,821	
Supplies	89,529,390	
Utilities	8,078,169	
Other Expense	33,936,860	
Depreciation	33,580,634	
Amortization	6,596,070	
Bad Debt	3,674,005	
Interest & Taxes	25,847,619	
Management Fees	0	
Total Operating Expense	477,187,075	
Net Operating Income	(1,097,037)	
Net Investment Income	11,320,428	
Realized Gain on Investments	967,704	
Gain / (Loss) from Affiliates	376,467	
Gain / (Loss) on Disposal	(45,485)	
Loss on Extinguishment of LTD / Derivatives	(0)	
Minority Interest	(2,229,774)	
Taxes - Non Operating	(50,315)	
Incentive Pay	(37,013)	
Other Non Operating Income / (Expense)	488,822	
Total Revenue Over Expense Before CFV of Derivatives	9,693,798	
Change in Fair Value of Interest Rate Swaps	29,707,026	
Change in Fair Value of Call Option	(5,125,344)	
Total Excess Revenue Over Expense	34,275,480	
Net Unrealized Gain / (Loss) on Investments	19,275,269	
Total Increase in Unrestricted Net Assets	53,550,749	
EBITDA	75,768,436	

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2010 - Second Quarter ended December 31, 2009
 Historical Maximum Annual Debt Service Coverage

	Second Quarter Ended Dec. 31, 2009 ¹	Twelve Months Ended Dec. 31, 2009
<u>Calculation:</u>		
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 12,165,862	\$ 42,802,162
Plus depreciation expense	17,045,395	62,970,190
Plus amortization expense	3,251,451	11,071,873
<u>Plus interest expense</u>	<u>8,772,593</u>	<u>43,105,894</u>
Total income available for debt service	<u><u>164,941,204</u></u>	<u><u>159,950,119</u></u>
Maximum annual debt service	<u>69,701,000</u>	<u>69,701,000</u>
Maximum annual debt service coverage	<u><u>2.4</u></u>	<u><u>2.3</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



Third Quarter ending March 31, 2010

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At March 31, 2010

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	250,877,461
Current Portion AWUIL	5,917,078
Accounts Receivable (Net)	144,068,420
Other Receivables	16,829,054
Due From Affiliates	0
Due From Third Party Payors	(0)
Inventories	19,376,076
Prepaid Expense	9,863,536
	<u>446,931,625</u>
 <u>ASSETS WHOSE USE IS LIMITED</u>	 <u>253,142,906</u>
 <u>OTHER INVESTMENTS</u>	 <u>322,980,410</u>
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	 <u>1,201,717,327</u>
Land, Buildings and Equipment	1,201,717,327
Less Allowances for Depreciation	554,169,632
	<u>647,547,695</u>
 <u>OTHER ASSETS</u>	 <u>5,610,067</u>
Pledges Receivable	5,610,067
Long Term Compensation Investment	13,226,130
Investments in Unconsolidated Subsidiaries	4,231,164
Land / Equipment Held for Resale	57,635
Assets Held for Expansion	10,905,673
Investments in Subsidiaries	(0)
Goodwill	153,948,082
Deferred Charges and Other	30,200,635
	<u>218,179,386</u>
 <u>TOTAL ASSETS</u>	 <u>1,888,782,022</u>
 <u>LIABILITIES AND FUND BALANCE</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	87,165,133
Accrued Salaries, Benefits, and PTO	52,840,668
Accrued Interest	8,143,646
Due to Affiliates	349
Due to Third Party Payors	21,401,780
Current Portion of Long Term Debt	29,962,606
	<u>199,514,183</u>
 <u>OTHER NON CURRENT LIABILITIES</u>	 <u>6,869,364</u>
Long Term Compensation Payable	6,869,364
Long Term Debt	1,017,552,370
Estimated Fair Value of Interest Rate Swaps	22,857,545
Call Option Liability	88,849,412
Deferred Income	22,397,944
Professional Liability Self-Insurance and Other	20,797,942
	<u>1,179,324,576</u>
 <u>TOTAL LIABILITIES</u>	 <u>1,378,838,759</u>
 <u>MINORITY INTEREST</u>	 <u>167,916,925</u>
 <u>FUND BALANCE</u>	 <u>342,026,338</u>
 <u>TOTAL LIABILITIES AND FUND BALANCE</u>	 <u>1,888,782,022</u>

NOTE: JCMC includes Home Care Services

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended March 31, 2010

	Actual	NINE MONTHS YEAR TO DATE
<i>Patient Revenue</i>		
Inpatient Revenue	1,414,876,256	
Outpatient Revenue	1,258,787,337	
Total Gross Patient Revenue	2,673,663,593	
<i>Deductions from Revenue</i>		
Contractual Adjustments	1,839,488,989	
Charity	43,720,250	
Contra Revenue - Self Pay	86,737,745	
Cost of Goods Sold	1,201,089	
Total Deductions	1,971,148,074	
Net Patient Service Revenue	702,515,519	
Other Operating Revenue	13,104,118	
Total Operating Revenue	715,619,636	
<i>Operating Expense</i>		
Salaries	242,569,879	
Physician Salaries	40,724,039	
Contract Labor	4,914,098	
Employee Benefits	66,429,941	
Fees	61,812,659	
Supplies	134,048,731	
Utilities	12,165,321	
Other Expense	51,817,096	
Depreciation	51,082,481	
Amortization	9,795,567	
Bad Debt	5,346,184	
Interest & Taxes	31,561,158	
Management Fees	0	
Total Operating Expense	712,267,153	
Net Operating Income	3,352,483	
Net Investment Income	15,819,379	
Realized Gain on Investments	2,012,591	
Gain / (Loss) from Affiliates	545,507	
Gain / (Loss) on Disposal	23,148	
Loss on Extinguishment of LTD / Derivatives	(0)	
Minority Interest	(2,541,659)	
Taxes - Non Operating	(75,781)	
Incentive Pay	(40,723)	
Other Non Operating Income / (Expense)	674,643	
Total Revenue Over Expense Before CFV of Derivatives	19,769,589	
Change in Fair Value of Interest Rate Swaps	24,943,613	
Change in Fair Value of Call Option	(10,827,305)	
Total Excess Revenue Over Expense	33,885,897	
Net Unrealized Gain / (Loss) on Investments	22,233,993	
Total Increase in Unrestricted Net Assets	56,119,891	
EBITDA	112,284,576	

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2010 - Third Quarter ended March 31, 2010
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Third Quarter Ended</u> <u>March 31, 2010 ¹</u>	<u>Twelve Months Ended</u> <u>March 31, 2010</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 6,225,171	\$ 39,430,252
Plus depreciation expense	17,501,848	67,845,061
Plus amortization expense	3,199,498	11,354,342
<u>Plus interest expense</u>	<u>9,589,626</u>	<u>42,711,129</u>
Total income available for debt service	<u><u>146,064,572</u></u>	<u><u>161,340,784</u></u>
Maximum annual debt service	<u>69,674,000</u>	<u>69,674,000</u>
Maximum annual debt service coverage	<u><u>2.1</u></u>	<u><u>2.3</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



Fourth Quarter ending June 30, 2010

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended June 30, 2010

	Actual	TWELVE MONTHS YEAR TO DATE
<i>Patient Revenue</i>		
Inpatient Revenue	1,880,898,728	
Outpatient Revenue	1,698,088,934	
Total Gross Patient Revenue	3,578,987,662	
<i>Deductions from Revenue</i>		
Contractual Adjustments	2,457,162,327	
Charity	61,377,910	
Contra Revenue - Self Pay	111,735,699	
Cost of Goods Sold	1,687,733	
Total Deductions	2,631,963,669	
Net Patient Service Revenue	947,023,994	
Other Operating Revenue	17,732,528	
Total Operating Revenue	964,756,521	
<i>Operating Expense</i>		
Salaries	323,818,274	
Physician Salaries	54,465,353	
Contract Labor	6,546,022	
Employee Benefits	88,857,571	
Fees	82,625,555	
Supplies	175,332,378	
Utilities	16,192,488	
Other Expense	67,748,190	
Depreciation	68,453,105	
Amortization	13,122,700	
Bad Debt	7,968,919	
Interest & Taxes	42,762,071	
Consolidation Allocation	0	
Total Operating Expense	947,892,625	
Net Operating Income	16,863,896	
Net Investment Income	22,110,574	
Realized Gain on Investments	2,385,122	
Gain / (Loss) from Affiliates	802,540	
Gain / (Loss) on Disposal	689,707	
Loss on Extinguishment of LTD / Derivatives	(3,028,733)	
Minority Interest	(2,409,599)	
Taxes - Non Operating	(100,594)	
Incentive Pay	(5,127)	
Other Non Operating Income / (Expense)	1,596,221	
Total Revenue Over Expense Before CFV of Derivatives	38,904,006	
Change in Fair Value of Interest Rate Swaps	(2,452,351)	
Change in Fair Value of Call Option	(16,240,044)	
Total Excess Revenue Over Expense	20,211,611	
Net Unrealized Gain / (Loss) on Investments	14,613,209	
Total Increase in Unrestricted Net Assets	34,824,820	
EBITDA	166,371,209	

Mountain States Health Alliance
Comparative Balance Sheet

	June 30 2010
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	240,828,980
Current Portion AWUIL	11,894,633
Accounts Receivable (Net)	126,059,052
Other Receivables	17,604,233
Due From Affiliates	0
Due From Third Party Payors	0
Inventories	21,654,085
Prepaid Expense	9,268,376
	427,309,360
<u>ASSETS WHOSE USE IS LIMITED</u>	287,643,583
<u>OTHER INVESTMENTS</u>	310,761,535
<u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,261,244,391
Less Allowances for Depreciation	569,929,390
	691,315,001
<u>OTHER ASSETS</u>	
Pledges Receivable	4,678,670
Long Term Compensation Investment	13,143,765
Investments in Unconsolidated Subsidiaries	4,176,588
Land / Equipment Held for Resale	57,635
Assets Held for Expansion	7,466,022
Investments in Subsidiaries	(0)
Goodwill	151,351,899
Deferred Charges and Other	29,816,046
	210,690,624
<u>TOTAL ASSETS</u>	1,927,720,104
<u>LIABILITIES AND FUND BALANCE</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	93,872,739
Accrued Salaries, Benefits, and PTO	45,347,807
Accrued Interest	16,411,281
Due to Affiliates	15,700
Due to Third Party Payors	10,203,113
Current Portion of Long Term Debt	37,792,529
	203,643,169
<u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	6,068,300
Long Term Debt	1,045,262,277
Estimated Fair Value of Interest Rate Swaps	50,122,746
Call Option Liability	94,262,151
Deferred Income	20,332,071
Professional Liability Self-Insurance and Other	19,809,591
	1,235,857,136
<u>TOTAL LIABILITIES</u>	1,439,500,305
<u>MINORITY INTEREST</u>	167,763,364
<u>FUND BALANCE</u>	
Restricted Fund Balance	11,018,722
Unrestricted Fund Balance	309,437,714
	320,456,435
<u>TOTAL LIABILITIES AND FUND BALANCE</u>	1,927,720,104

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2010 - Fourth Quarter ending June 30, 2010
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Fourth Quarter Ended June 30, 2010 ¹</u>	<u>Twelve Months Ended June 30, 2010</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 22,163,150	\$ 41,932,739
Plus depreciation expense	17,370,624	68,453,105
Plus amortization expense	3,327,134	13,122,700
<u>Plus interest expense</u>	<u>11,225,726</u>	<u>42,862,665</u>
Total income available for debt service	<u><u>216,346,536</u></u>	<u><u>166,371,209</u></u>
Maximum annual debt service	<u>79,730,000</u>	<u>79,730,000</u>
Maximum annual debt service coverage	<u><u>2.7</u></u>	<u><u>2.1</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



First Quarter ending September 30, 2010

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At September 30, 2010

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	213,674,908
Current Portion AWUIL	2,788,012
Accounts Receivable (Net)	135,195,389
Other Receivables	16,774,612
Due From Affiliates	(0)
Due From Third Party Payors	(0)
Inventories	22,106,563
Prepaid Expense	6,637,788
	<u>397,177,272</u>
<u>ASSETS WHOSE USE IS LIMITED</u>	<u>264,897,418</u>
<u>OTHER INVESTMENTS</u>	<u>340,679,685</u>
<u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,315,549,053
Less Allowances for Depreciation	590,888,356
	<u>724,660,697</u>
<u>OTHER ASSETS</u>	
Pledges Receivable	6,241,385
Long Term Compensation Investment	13,766,693
Investments in Unconsolidated Subsidiaries	4,179,248
Land / Equipment Held for Resale	57,635
Assets Held for Expansion	2,561,921
Investments in Subsidiaries	(0)
Goodwill	151,351,899
Deferred Charges and Other	30,437,591
	<u>208,596,372</u>
<u>TOTAL ASSETS</u>	<u>1,936,011,443</u>
<u>LIABILITIES AND FUND BALANCE</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	99,737,209
Accrued Salaries, Benefits, and PTO	55,849,614
Accrued Interest	10,688,761
Due to Affiliates	60,889
Due to Third Party Payors	15,033,777
Current Portion of Long Term Debt	30,552,667
	<u>211,922,918</u>
<u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	6,691,229
Long Term Debt	1,034,369,760
Estimated Fair Value of Interest Rate Swaps	43,870,367
Call Option Liability	92,342,944
Deferred Income	20,493,472
Professional Liability Self-Insurance and Other	16,800,112
	<u>1,214,567,884</u>
<u>TOTAL LIABILITIES</u>	<u>1,426,490,802</u>
<u>MINORITY INTEREST</u>	<u>169,724,968</u>
<u>FUND BALANCE</u>	<u>339,795,674</u>
<u>TOTAL LIABILITIES AND FUND BALANCE</u>	<u>1,936,011,443</u>

NOTE: JCMC includes Home Care Services

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended September 30, 2010

	THREE MONTHS YEAR TO DATE
	Actual
<u>Patient Revenue</u>	
Inpatient Revenue	481,282,306
Outpatient Revenue	451,293,466
Total Gross Patient Revenue	<u>932,575,772</u>
<u>Deductions from Revenue</u>	
Contractual Adjustments	643,928,302
Charity	17,583,897
Contra Revenue - Self Pay	34,055,939
Cost of Goods Sold	370,216
Total Deductions	<u>695,938,354</u>
Net Patient Service Revenue	<u>236,637,418</u>
Other Operating Revenue	4,129,800
Total Operating Revenue	<u>240,767,218</u>
<u>Operating Expense</u>	
Salaries	83,438,082
Physician Salaries	14,375,328
Contract Labor	1,579,455
Employee Benefits	16,854,103
Fees	22,096,615
Supplies	43,719,753
Utilities	4,768,128
Other Expense	18,804,028
Depreciation	21,008,221
Amortization	517,483
Bad Debt	2,090,721
Interest & Taxes	12,878,291
Consolidation Allocation	(0)
Total Operating Expense	<u>242,130,208</u>
Net Operating Income	<u>(1,362,990)</u>
Net Investment Income	4,100,830
Realized Gain on Investments	248,185
Gain / (Loss) from Affiliates	266,366
Gain / (Loss) on Disposal	100
Loss on Extinguishment of LTD / Derivatives	0
Minority Interest	(1,314,650)
Taxes - Non Operating	(24,380)
Incentive Pay	(26,586)
Other Non Operating Income / (Expense)	(174,903)
Total Revenue Over Expense Before CFV of Derivatives	<u>1,711,972</u>
Change in Fair Value of Interest Rate Swaps	647,956
Change in Fair Value of Call Option	(2,692,508)
Total Excess Revenue Over Expense	<u>(332,580)</u>
Net Unrealized Gain / (Loss) on Investments	9,737,722
Total Increase in Unrestricted Net Assets	<u>9,405,143</u>
EBITDA	<u>36,140,347</u>

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2011 - First Quarter ended September 30, 2010
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>First Quarter Ended Sept. 30, 2010 ¹</u>	<u>Twelve Months Ended Sept 30, 2010</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 1,711,973	\$ 42,266,156
Plus depreciation expense	21,008,221	72,926,088
Plus amortization expense	517,483	10,295,566
<u>Plus interest expense</u>	<u>12,902,670</u>	<u>42,490,615</u>
Total income available for debt service	<u><u>144,561,388</u></u>	<u><u>167,978,425</u></u>
Maximum annual debt service	<u>77,187,000</u>	<u>77,187,000</u>
Maximum annual debt service coverage	<u><u>1.9</u></u>	<u><u>2.2</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



Second Quarter ending December 31, 2010

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At December 31, 2010

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	228,461,122
Current Portion AWUIL	4,091,145
Accounts Receivable (Net)	128,049,621
Other Receivables	17,007,252
Due From Affiliates	11,241
Due From Third Party Payors	0
Inventories	22,270,441
Prepaid Expense	7,550,483
	<u>407,441,304</u>
 <u>ASSETS WHOSE USE IS LIMITED</u>	 <u>230,760,493</u>
 <u>OTHER INVESTMENTS</u>	 <u>349,292,980</u>
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	 <u>1,348,176,585</u>
Land, Buildings and Equipment	611,593,936
Less Allowances for Depreciation	(263,417,351)
	<u>736,582,649</u>
 <u>OTHER ASSETS</u>	 <u>6,062,966</u>
Pledges Receivable	6,062,966
Long Term Compensation Investment	14,280,228
Investments in Unconsolidated Subsidiaries	2,341,676
Land / Equipment Held for Resale	1,680,908
Assets Held for Expansion	2,561,921
Investments in Subsidiaries	(0)
Goodwill	151,626,899
Deferred Charges and Other	30,180,135
	<u>208,734,732</u>
 <u>TOTAL ASSETS</u>	 <u>1,932,812,158</u>
 <u>LIABILITIES AND FUND BALANCE</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	88,073,194
Accrued Salaries, Benefits, and PTO	46,439,013
Accrued Interest	20,768,063
Due to Affiliates	49,340
Due to Third Party Payors	15,201,781
Current Portion of Long Term Debt	30,499,252
	<u>201,030,643</u>
 <u>OTHER NON CURRENT LIABILITIES</u>	 <u>7,204,764</u>
Long Term Compensation Payable	7,204,764
Long Term Debt	1,031,400,862
Estimated Fair Value of Interest Rate Swaps	27,565,593
Call Option Liability	89,539,951
Deferred Income	19,341,393
Professional Liability Self-Insurance and Other	17,386,022
	<u>1,192,438,584</u>
 <u>TOTAL LIABILITIES</u>	 <u>1,393,469,228</u>
 <u>MINORITY INTEREST</u>	 <u>169,785,137</u>
 <u>FUND BALANCE</u>	 <u>369,557,793</u>
 <u>TOTAL LIABILITIES AND FUND BALANCE</u>	 <u>1,932,812,158</u>

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended December 31, 2010

	Actual	SIX MONTHS YEAR TO DATE
<i>Patient Revenue</i>		
Inpatient Revenue	974,966,163	
Outpatient Revenue	888,262,809	
Total Gross Patient Revenue	<u>1,863,228,972</u>	
<i>Deductions from Revenue</i>		
Contractual Adjustments	1,305,435,656	
Charity	32,490,763	
Contra Revenue - Self Pay	56,043,105	
Cost of Goods Sold	715,303	
Total Deductions	<u>1,394,684,827</u>	
Net Patient Service Revenue	<u>468,544,145</u>	
Other Operating Revenue	8,320,365	
Total Operating Revenue	<u>476,864,510</u>	
<i>Operating Expense</i>		
Salaries	164,986,537	
Physician Salaries	29,571,698	
Contract Labor	3,207,143	
Employee Benefits	32,695,380	
Fees	43,836,666	
Supplies	85,803,262	
Utilities	9,001,354	
Other Expense	36,791,484	
Depreciation	42,844,321	
Amortization	1,140,968	
Bad Debt	3,350,346	
Interest & Taxes	24,643,879	
Consolidation Allocation	(2)	
Total Operating Expense	<u>477,873,036</u>	
Net Operating Income	<u>(1,008,525)</u>	
Net Investment Income	10,667,284	
Realized Gain on Investments	452,246	
Gain / (Loss) from Affiliates	497,691	
Gain / (Loss) on Disposal	26,478	
Loss on Extinguishment of LTD / Derivatives	0	
Minority Interest	(1,417,820)	
Taxes - Non Operating	(48,884)	
Incentive Pay	(42,248)	
Other Non Operating Income / (Expense)	(538,903)	
Total Revenue Over Expense Before CFV of Derivatives	<u>8,587,318</u>	
Change in Fair Value of Interest Rate Swaps	16,821,907	
Change in Fair Value of Call Option	110,485	
Total Excess Revenue Over Expense	<u>25,519,710</u>	
Net Unrealized Gain / (Loss) on Investments	15,533,357	
Total Increase in Unrestricted Net Assets	<u>41,053,067</u>	
EBITDA	<u>77,265,368</u>	

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2011 - Second Quarter ended December 31, 2010
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>First Quarter Ended</u> <u>Dec. 31, 2010 ¹</u>	<u>Twelve Months Ended</u> <u>Dec 31, 2010</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 6,875,346	\$ 36,975,640
Plus depreciation expense	21,836,099	77,716,792
Plus amortization expense	623,485	7,667,600
<u>Plus interest expense</u>	<u>11,790,091</u>	<u>45,508,113</u>
Total income available for debt service	<u><u>164,500,084</u></u>	<u><u>167,868,145</u></u>
Maximum annual debt service	<u>75,202,000</u>	<u>75,202,000</u>
Maximum annual debt service coverage	<u><u>2.2</u></u>	<u><u>2.2</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



Third Quarter ending March 31, 2011

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At March 31, 2011

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	196,814,231
Current Portion AWUJL	19,731,901
Accounts Receivable (Net)	132,866,321
Other Receivables	19,583,403
Due From Affiliates	0
Due From Third Party Payors	0
Inventories	21,969,267
Prepaid Expense	6,941,489
	<u>397,906,613</u>
 <u>ASSETS WHOSE USE IS LIMITED</u>	 <u>206,560,463</u>
 <u>OTHER INVESTMENTS</u>	 <u>398,079,527</u>
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,379,991,528
Less Allowances for Depreciation	630,305,152
	<u>749,686,376</u>
 <u>OTHER ASSETS</u>	
Pledges Receivable	6,029,966
Long Term Compensation Investment	15,616,802
Investments in Unconsolidated Subsidiaries	2,484,458
Land / Equipment Held for Resale	57,635
Assets Held for Expansion	4,172,572
Investments in Subsidiaries	(0)
Goodwill	151,626,899
Deferred Charges and Other	29,868,130
	<u>209,856,461</u>
 <u>TOTAL ASSETS</u>	 <u><u>1,962,089,440</u></u>
 <u>LIABILITIES AND FUND BALANCE</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	93,267,778
Accrued Salaries, Benefits, and PTO	57,159,150
Accrued Interest	11,831,754
Due to Affiliates	8,848
Due to Third Party Payors	20,110,463
Current Portion of Long Term Debt	30,088,797
	<u>212,466,791</u>
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	8,512,637
Long Term Debt	1,030,849,599
Estimated Fair Value of Interest Rate Swaps	16,866,827
Call Option Liability	89,533,470
Deferred Income	19,460,577
Professional Liability Self-Insurance and Other	17,768,104
	<u>1,182,991,214</u>
 <u>TOTAL LIABILITIES</u>	 <u>1,395,458,005</u>
 <u>MINORITY INTEREST</u>	 <u>170,465,340</u>
 <u>FUND BALANCE</u>	 <u>396,166,095</u>
 <u>TOTAL LIABILITIES AND FUND BALANCE</u>	 <u><u>1,962,089,440</u></u>

NOTE: JCMC includes Home Care Services

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended March 31, 2011

	Actual	NINE MONTHS YEAR TO DATE
<i>Patient Revenue</i>		
Inpatient Revenue	1,488,076,618	
Outpatient Revenue	1,347,028,744	
Total Gross Patient Revenue	<u>2,835,105,361</u>	
<i>Deductions from Revenue</i>		
Contractual Adjustments	1,993,905,142	
Charity	53,416,054	
Contra Revenue - Self Pay	77,786,546	
Cost of Goods Sold	1,068,764	
Total Deductions	<u>2,126,176,506</u>	
Net Patient Service Revenue	<u>708,928,855</u>	
Other Operating Revenue	12,318,481	
Total Operating Revenue	<u>721,247,336</u>	
<i>Operating Expense</i>		
Salaries	250,469,982	
Physician Salaries	44,332,202	
Contract Labor	4,714,112	
Employee Benefits	50,121,369	
Fees	64,911,158	
Supplies	127,985,969	
Utilities	13,166,390	
Other Expense	54,879,589	
Depreciation	64,718,373	
Amortization	1,761,156	
Bad Debt	4,526,931	
Interest & Taxes	35,456,049	
Consolidation Allocation	(0)	
Total Operating Expense	<u>717,043,280</u>	
Net Operating Income	<u>4,204,056</u>	
Net Investment Income	14,808,828	
Realized Gain on Investments	1,852,843	
Gain / (Loss) from Affiliates	643,704	
Gain / (Loss) on Disposal	287,244	
Loss on Extinguishment of LTD / Derivatives	0	
Minority Interest	(2,205,522)	
Taxes - Non Operating	(73,189)	
Incentive Pay	(47,747)	
Other Non Operating Income / (Expense)	(491,994)	
Total Revenue Over Expense Before CFV of Derivatives	<u>18,978,223</u>	
Change in Fair Value of Interest Rate Swaps	27,392,695	
Change in Fair Value of Call Option	116,967	
Total Excess Revenue Over Expense	<u>46,487,884</u>	
Net Unrealized Gain / (Loss) on Investments	21,132,547	
Total Increase in Unrestricted Net Assets	<u>67,620,432</u>	
EBITDA	<u>120,986,990</u>	

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2011 - Third Quarter ended March 31, 2011
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Third Quarter Ended</u> <u>March 31, 2011</u> ¹	<u>Twelve Months Ended</u> <u>March 31, 2011</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 10,390,905	\$ 41,141,374
Plus depreciation expense	21,874,052	82,088,996
Plus amortization expense	620,188	5,088,290
<u>Plus interest expense</u>	<u>10,836,477</u>	<u>46,754,964</u>
Total income available for debt service	<u><u>174,886,488</u></u>	<u><u>175,073,624</u></u>
Maximum annual debt service	<u>70,580,000</u>	<u>70,580,000</u>
Maximum annual debt service coverage	<u><u>2.5</u></u>	<u><u>2.5</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



Fourth Quarter ending June 30, 2011

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At June 30, 2011

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	112,932,971
Current Portion AWUIL	23,454,508
Accounts Receivable (Net)	135,023,319
Other Receivables	19,604,661
Due From Affiliates	28,533
Due From Third Party Payors	10,878,498
Inventories	23,092,574
Prepaid Expense	5,843,619
	<u>330,858,681</u>
 <u>ASSETS WHOSE USE IS LIMITED</u>	 <u>194,326,848</u>
 <u>OTHER INVESTMENTS</u>	 <u>479,986,878</u>
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,378,817,815
Less Allowances for Depreciation	586,470,519
	<u>792,347,296</u>
 <u>OTHER ASSETS</u>	
Pledges Receivable	5,098,134
Long Term Compensation Investment	16,800,250
Investments in Unconsolidated Subsidiaries	2,366,851
Land / Equipment Held for Resale	57,635
Assets Held for Expansion	4,172,572
Investments in Subsidiaries	(0)
Goodwill	151,630,733
Deferred Charges and Other	29,192,400
	<u>209,318,575</u>
 <u>TOTAL ASSETS</u>	 <u>2,006,838,277</u>
 <u>LIABILITIES AND FUND BALANCE</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	95,243,819
Accrued Salaries, Benefits, and PTO	57,788,998
Accrued Interest	20,079,964
Due to Affiliates	0
Due to Third Party Payors	25,914,943
Current Portion of Long Term Debt	28,050,459
	<u>227,078,183</u>
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	8,796,085
Long Term Debt	1,040,922,529
Estimated Fair Value of Interest Rate Swaps	20,573,187
Call Option Liability	92,044,033
Deferred Income	19,539,126
Professional Liability Self-Insurance and Other	16,189,889
	<u>1,198,064,849</u>
 <u>TOTAL LIABILITIES</u>	 <u>1,425,143,032</u>
 <u>MINORITY INTEREST</u>	 <u>171,608,431</u>
 <u>FUND BALANCE</u>	 <u>410,086,815</u>
 <u>TOTAL LIABILITIES AND FUND BALANCE</u>	 <u>2,006,838,277</u>

NOTE: JCMC includes Home Care Services

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended June 30, 2011

	Actual	TWELVE MONTHS YEAR TO DATE
<i>Patient Revenue</i>		
Inpatient Revenue	1,983,339,667	
Outpatient Revenue	<u>1,806,960,043</u>	
Total Gross Patient Revenue	<u>3,790,299,709</u>	
<i>Deductions from Revenue</i>		
Contractual Adjustments	2,647,862,693	
Charity	72,431,617	
Contra Revenue - Self Pay	109,876,805	
Cost of Goods Sold	<u>1,495,076</u>	
Total Deductions	<u>2,831,666,192</u>	
Net Patient Service Revenue	<u>958,633,517</u>	
Other Operating Revenue	17,366,079	
Total Operating Revenue	<u>975,999,596</u>	
<i>Operating Expense</i>		
Salaries	336,039,676	
Physician Salaries	59,248,821	
Contract Labor	5,963,680	
Employee Benefits	67,209,284	
Fees	85,918,912	
Supplies	169,362,052	
Utilities	17,300,334	
Other Expense	68,894,786	
Depreciation	87,499,453	
Amortization	2,559,141	
Bad Debt	6,327,970	
Interest & Taxes	45,233,433	
Consolidation Allocation	(1)	
Total Operating Expense	<u>951,557,540</u>	
Net Operating Income	<u>24,442,056</u>	
Net Investment Income	21,257,492	
Realized Gain on Investments	1,956,856	
Gain / (Loss) from Affiliates	829,906	
Gain / (Loss) on Disposal	517,406	
Loss on Extinguishment of LTD / Derivatives	0	
Minority Interest	(3,348,613)	
Taxes - Non Operating	(97,510)	
Incentive Pay	(6,168,474)	
Other Non Operating Income / (Expense)	<u>(985,838)</u>	
Total Revenue Over Expense Before CFV of Derivatives	<u>38,403,281</u>	
Change in Fair Value of Interest Rate Swaps	23,556,934	
Change in Fair Value of Call Option	<u>(2,393,596)</u>	
Total Excess Revenue Over Expense	<u>59,566,619</u>	
Net Unrealized Gain / (Loss) on Investments	<u>22,168,046</u>	
Total Increase in Unrestricted Net Assets	<u>81,734,665</u>	
EBITDA	<u>173,792,818</u>	

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2011 - Fourth Quarter ending June 30, 2011
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Fourth Quarter Ended June 30, 2011 ¹</u>	<u>Twelve Months Ended June 30, 2011</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 19,425,059	\$ 38,403,281
Plus depreciation expense	22,781,081	87,499,453
Plus amortization expense	797,985	2,559,141
<u>Plus interest expense</u>	<u>9,801,705</u>	<u>45,330,943</u>
Total income available for debt service	<u><u>211,223,320</u></u>	<u><u>173,792,818</u></u>
Maximum annual debt service	<u>67,624,650</u>	<u>67,624,650</u>
Maximum annual debt service coverage	<u><u>3.1</u></u>	<u><u>2.6</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



First Quarter ending September 30, 2011

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At September 30, 2011

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	64,300,196
Current Portion AWUIL	109,199,591
Accounts Receivable (Net)	149,341,619
Other Receivables	20,152,422
Due From Affiliates	4,030
Due From Third Party Payors	(0)
Inventories	23,859,579
Prepaid Expense	7,540,923
	<u>374,398,359</u>
 <u>ASSETS WHOSE USE IS LIMITED</u>	 <u>115,741,993</u>
 <u>OTHER INVESTMENTS</u>	 <u>449,962,997</u>
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,420,882,984
Less Allowances for Depreciation	599,341,389
	<u>821,541,594</u>
 <u>OTHER ASSETS</u>	
Pledges Receivable	5,138,314
Long Term Compensation Investment	16,174,730
Investments in Unconsolidated Subsidiaries	2,229,839
Land / Equipment Held for Resale	72,215
Assets Held for Expansion	4,172,572
Investments in Subsidiaries	(0)
Goodwill	153,044,114
Deferred Charges and Other	28,699,891
	<u>209,531,675</u>
 <u>TOTAL ASSETS</u>	 <u>1,971,176,619</u>
 <u>LIABILITIES AND NET ASSETS</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	90,150,023
Accrued Salaries, Benefits, and PTO	48,981,245
Accrued Interest	11,147,685
Due to Affiliates	(0)
Due to Third Party Payors	18,737,435
Call Option Liability	96,720,200
Current Portion of Long Term Debt	38,169,177
	<u>303,905,765</u>
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	8,170,566
Long Term Debt	1,029,138,229
Estimated Fair Value of Interest Rate Swaps	31,931,345
Deferred Income	22,492,593
Professional Liability Self-Insurance and Other	15,866,850
	<u>1,107,599,581</u>
 <u>TOTAL LIABILITIES</u>	 <u>1,411,505,346</u>
 <u>NET ASSETS</u>	 <u>392,344,900</u>
<u>NONCONTROLLING INTERESTS IN SUBSIDIARIES</u>	<u>167,326,373</u>
 <u>TOTAL LIABILITIES AND NET ASSETS</u>	 <u>1,971,176,619</u>

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended September 30, 2011

	Actual	THREE MONTHS YEAR TO DATE
<i>Patient Revenue</i>		
Inpatient Revenue	516,300,287	
Outpatient Revenue	497,252,005	
Total Gross Patient Revenue	<u>1,013,552,292</u>	
<i>Deductions from Revenue</i>		
Contractual Adjustments	718,898,800	
Charity	23,744,659	
Contra Revenue - Charity	26,410,270	
Total Deductions	<u>769,053,728</u>	
Net Patient Service Revenue	<u>244,498,564</u>	
Other Operating Revenue	5,130,084	
Total Operating Revenue	<u>249,628,648</u>	
<i>Operating Expense</i>		
Salaries	88,084,292	
Provider Salaries	15,641,333	
Contract Labor	1,341,337	
Employee Benefits	17,033,289	
Fees	24,150,387	
Supplies	42,262,882	
Utilities	4,889,861	
Other Expense	19,752,155	
Depreciation	17,827,079	
Amortization	541,220	
Bad Debt	1,578,344	
Interest & Taxes	12,398,271	
Consolidation Allocation	1	
Total Operating Expense	<u>245,500,452</u>	
Net Operating Income	<u>4,128,196</u>	
Net Investment Income	5,377,592	
Realized Gain on Investments	17,983	
Gain / (Loss) from Affiliates	45,573	
Gain / (Loss) on Disposal	81,701	
Loss on Extinguishment of LTD / Derivatives	0	
Minority Interest	4,714,526	
Taxes - Non Operating	(23,376)	
Incentive Pay	(955)	
Other Non Operating Income / (Expense)	321,924	
Total Revenue Over Expense Before CFV of Derivatives	<u>14,663,165</u>	
Change in Fair Value of Interest Rate Swaps	(13,372,957)	
Change in Fair Value of Call Option	(4,676,167)	
Total Excess Revenue Over Expense	<u>(3,385,960)</u>	
Net Unrealized Gain / (Loss) on Investments	(14,372,757)	
Increase in Unrestricted Net Assets Before Change in Accounting Principle	<u>(17,758,716)</u>	
Cumulative Effect of Change in Accounting Principle	0	
Total Increase in Unrestricted Net Assets	<u>(17,758,716)</u>	
EBITDA	<u>45,453,111</u>	

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2012 - First Quarter ended September 30, 2011
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>First Quarter Ended</u> <u>Sept. 30, 2011 ¹</u>	<u>Twelve Months Ended</u> <u>Sept 30, 2011</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 14,663,165	\$ 51,354,475
Plus depreciation expense	17,827,079	84,318,311
Plus amortization expense	541,220	2,582,878
<u>Plus interest expense</u>	<u>12,398,271</u>	<u>44,849,920</u>
Total income available for debt service	<u><u>181,812,444</u></u>	<u><u>183,105,584</u></u>
Maximum annual debt service	<u>68,198,673</u>	<u>68,198,673</u>
Maximum annual debt service coverage	<u><u>2.7</u></u>	<u><u>2.7</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



Second Quarter ending December 31, 2011

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At December 31, 2011

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	81,053,337
Current Portion AWUIL	21,654,148
Accounts Receivable (Net)	152,452,826
Other Receivables	19,872,272
Due From Affiliates	2,131
Due From Third Party Payors	(0)
Inventories	24,724,080
Prepaid Expense	6,496,847
	<u>306,255,642</u>
 <u>ASSETS WHOSE USE IS LIMITED</u>	 <u>115,107,811</u>
 <u>OTHER INVESTMENTS</u>	 <u>458,349,572</u>
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,424,255,602
Less Allowances for Depreciation	589,490,992
	<u>834,764,610</u>
 <u>OTHER ASSETS</u>	
Pledges Receivable	5,028,709
Long Term Compensation Investment	17,169,413
Investments in Unconsolidated Subsidiaries	2,475,775
Land / Equipment Held for Resale	82,785
Assets Held for Expansion	4,172,572
Investments in Subsidiaries	(0)
Goodwill	152,767,657
Deferred Charges and Other	28,861,665
	<u>210,558,575</u>
 <u>TOTAL ASSETS</u>	 <u>1,925,036,209</u>
 <u>LIABILITIES AND NET ASSETS</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	92,555,814
Accrued Salaries, Benefits, and PTO	51,971,362
Accrued Interest	19,465,976
Due to Affiliates	(3,438)
Due to Third Party Payors	23,386,222
Call Option Liability	0
Current Portion of Long Term Debt	30,864,716
	<u>218,240,651</u>
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	8,798,592
Long Term Debt	1,057,698,338
Estimated Fair Value of Interest Rate Swaps	26,234,487
Deferred Income	29,984,080
Professional Liability Self-Insurance and Other	16,095,909
	<u>1,138,811,406</u>
 <u>TOTAL LIABILITIES</u>	 <u>1,357,052,057</u>
 <u>NET ASSETS</u>	 <u>401,058,217</u>
<u>NONCONTROLLING INTERESTS IN SUBSIDIARIES</u>	<u>166,925,936</u>
 <u>TOTAL LIABILITIES AND NET ASSETS</u>	 <u>1,925,036,209</u>

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended December 31, 2011

	Actual	SIX MONTHS YEAR TO DATE
<i>Patient Revenue</i>		
Inpatient Revenue	1,049,086,418	
Outpatient Revenue	989,925,112	
Total Gross Patient Revenue	<u>2,039,011,531</u>	
<i>Deductions from Revenue</i>		
Contractual Adjustments	1,457,464,984	
Charity	48,910,746	
Contra Revenue - Charity	50,595,885	
Total Deductions	<u>1,556,971,614</u>	
Net Patient Service Revenue	<u>482,039,916</u>	
Other Operating Revenue	10,468,203	
Total Operating Revenue	<u>492,508,119</u>	
<i>Operating Expense</i>		
Salaries	176,165,601	
Provider Salaries	32,294,569	
Contract Labor	3,064,189	
Employee Benefits	33,605,394	
Fees	48,000,878	
Supplies	85,261,609	
Utilities	9,027,912	
Other Expense	39,189,202	
Depreciation	35,458,942	
Amortization	1,117,151	
Bad Debt	3,361,725	
Interest & Taxes	24,079,649	
Consolidation Allocation	(0)	
Total Operating Expense	<u>490,626,818</u>	
Net Operating Income	<u>1,881,301</u>	
Net Investment Income	12,051,021	
Realized Gain on Investments	(2,842,240)	
Gain / (Loss) from Affiliates	276,486	
Gain / (Loss) on Disposal	81,421	
Loss on Extinguishment of LTD / Derivatives	(2,636,011)	
Minority Interest	4,968,713	
Taxes - Non Operating	(47,382)	
Incentive Pay	(14,492)	
Other Non Operating Income / (Expense)	139,382	
Total Revenue Over Expense Before CFV of Derivatives	<u>13,858,199</u>	
Change in Fair Value of Interest Rate Swaps	(8,119,147)	
Change in Fair Value of Call Option	(4,676,167)	
Total Excess Revenue Over Expense	<u>1,062,885</u>	
Net Unrealized Gain / (Loss) on Investments	(10,219,779)	
Increase in Unrestricted Net Assets Before Change in Accounting Principle	<u>(9,156,894)</u>	
Cumulative Effect of Change in Accounting Principle	0	
Total Increase in Unrestricted Net Assets	<u>(9,156,894)</u>	
EBITDA	<u>77,197,333</u>	

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2012 - Second Quarter ended December 31, 2011
 Historical Maximum Annual Debt Service Coverage

	Second Quarter Ended Dec. 31, 2011 ¹	Twelve Months Ended Dec. 31, 2011
<u>Calculation:</u>		
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 1,831,046	\$ 46,310,175
Plus depreciation expense	17,631,863	80,114,075
Plus amortization expense	575,931	2,535,324
<u>Plus interest expense</u>	<u>11,705,382</u>	<u>44,765,211</u>
Total income available for debt service	<u><u>126,976,888</u></u>	<u><u>173,724,785</u></u>
Maximum annual debt service	<u>67,893,000</u>	<u>67,893,000</u>
Maximum annual debt service coverage	<u><u>1.9</u></u>	<u><u>2.6</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



Third Quarter ending March 31, 2012

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At March 31, 2012

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	57,243,110
Current Portion AWUIL	18,913,874
Accounts Receivable (Net)	156,395,275
Other Receivables	19,362,559
Due From Affiliates	683
Due From Third Party Payors	0
Inventories	23,354,508
Prepaid Expense	7,900,145
	<u>283,170,153</u>
 <u>ASSETS WHOSE USE IS LIMITED</u>	 <u>102,737,844</u>
 <u>OTHER INVESTMENTS</u>	 <u>469,524,957</u>
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,456,352,073
Less Allowances for Depreciation	608,003,319
	<u>848,348,754</u>
 <u>OTHER ASSETS</u>	
Pledges Receivable	5,033,312
Long Term Compensation Investment	17,739,313
Investments in Unconsolidated Subsidiaries	2,448,586
Land / Equipment Held for Resale	82,785
Assets Held for Expansion	4,172,572
Investments in Subsidiaries	(0)
Goodwill	152,767,657
Deferred Charges and Other	28,680,909
	<u>210,925,134</u>
 <u>TOTAL ASSETS</u>	 <u>1,914,706,842</u>
 <u>LIABILITIES AND NET ASSETS</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	92,489,943
Accrued Salaries, Benefits, and PTO	51,056,206
Accrued Interest	10,563,345
Due to Affiliates	0
Due to Third Party Payors	11,968,915
Call Option Liability	0
Current Portion of Long Term Debt	29,963,804
	<u>196,042,213</u>
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	9,368,492
Long Term Debt	1,051,141,230
Estimated Fair Value of Interest Rate Swaps	15,333,143
Deferred Income	29,320,606
Professional Liability Self-Insurance and Other	16,446,955
	<u>1,121,610,426</u>
 <u>TOTAL LIABILITIES</u>	 <u>1,317,652,639</u>
 <u>NET ASSETS</u>	 <u>432,011,647</u>
<u>NONCONTROLLING INTERESTS IN SUBSIDIARIES</u>	<u>165,042,556</u>
 <u>TOTAL LIABILITIES AND NET ASSETS</u>	 <u>1,914,706,842</u>

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended March 31, 2012

	Actual	NINE MONTHS YEAR TO DATE
<i>Patient Revenue</i>		
Inpatient Revenue	1,594,461,642	
Outpatient Revenue	1,501,008,991	
Total Gross Patient Revenue	3,095,470,633	
<i>Deductions from Revenue</i>		
Contractual Adjustments	2,215,121,543	
Charity	75,402,523	
Contra Revenue - Charity	80,224,504	
Total Deductions	2,370,748,569	
Net Patient Service Revenue	724,722,064	
Other Operating Revenue	15,817,593	
Total Operating Revenue	740,539,657	
<i>Operating Expense</i>		
Salaries	267,704,901	
Provider Salaries	48,901,790	
Contract Labor	4,598,270	
Employee Benefits	51,405,717	
Fees	72,085,367	
Supplies	129,891,857	
Utilities	13,080,247	
Other Expense	58,055,206	
Depreciation	54,185,314	
Amortization	1,672,483	
Bad Debt	5,065,047	
Interest & Taxes	35,445,537	
Consolidation Allocation	(0)	
Total Operating Expense	742,091,735	
Net Operating Income	(1,552,078)	
Net Investment Income	16,862,123	
Realized Gain on Investments	396,150	
Gain / (Loss) from Affiliates	483,089	
Gain / (Loss) on Disposal	286,246	
Loss on Extinguishment of LTD / Derivatives	(2,636,011)	
Minority Interest	2,991,994	
Taxes - Non Operating	(71,791)	
Incentive Pay	(22,433)	
Other Non Operating Income / (Expense)	487,596	
Total Revenue Over Expense Before CFV of Derivatives	17,224,887	
Change in Fair Value of Interest Rate Swaps	2,654,368	
Gain / (Loss) in Swaption / Call Option	(4,676,167)	
Total Excess Revenue Over Expense	15,203,088	
Net Unrealized Gain / (Loss) on Investments	2,756,617	
Increase in Unrestricted Net Assets Before Change in Accounting Principle	17,959,704	
Cumulative Effect of Change in Accounting Principle	0	
Total Increase in Unrestricted Net Assets	17,959,704	
EBITDA	111,236,022	

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2012 - Third Quarter ended March 31, 2012
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Third Quarter Ended</u> <u>March 31, 2012 ¹</u>	<u>Twelve Months Ended</u> <u>March 31, 2012</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 3,366,688	\$ 39,285,958
Plus depreciation expense	18,726,373	76,966,396
Plus amortization expense	555,332	2,470,468
<u>Plus interest expense</u>	<u>11,390,297</u>	<u>45,319,031</u>
Total income available for debt service	<u><u>136,154,760</u></u>	<u><u>164,041,853</u></u>
Maximum annual debt service	<u>67,879,000</u>	<u>67,879,000</u>
Maximum annual debt service coverage	<u><u>2.0</u></u>	<u><u>2.4</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



Fourth Quarter ending June 30, 2012

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At June 30, 2012

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	65,107,478
Current Portion AWUIL	36,556,863
Accounts Receivable (Net)	151,099,630
Other Receivables	23,342,106
Due From Affiliates	(0)
Due From Third Party Payors	(0)
Inventories	23,207,980
Prepaid Expense	5,214,129
	<u>304,528,184</u>
 <u>ASSETS WHOSE USE IS LIMITED</u>	 <u>94,655,402</u>
 <u>OTHER INVESTMENTS</u>	 <u>466,043,661</u>
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,487,969,557
Less Allowances for Depreciation	626,302,140
	<u>861,667,417</u>
 <u>OTHER ASSETS</u>	
Pledges Receivable	4,302,229
Long Term Compensation Investment	19,049,718
Investments in Unconsolidated Subsidiaries	2,431,219
Land / Equipment Held for Resale	57,635
Assets Held for Expansion	2,561,921
Investments in Subsidiaries	(0)
Goodwill	153,082,632
Deferred Charges and Other	28,159,300
	<u>209,644,654</u>
 <u>TOTAL ASSETS</u>	 <u>1,936,539,318</u>
 <u>LIABILITIES AND NET ASSETS</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	103,357,075
Accrued Salaries, Benefits, and PTO	55,441,176
Accrued Interest	18,524,949
Due to Affiliates	(0)
Due to Third Party Payors	18,914,006
Call Option Liability	0
Current Portion of Long Term Debt	32,774,037
	<u>229,011,243</u>
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	9,375,836
Long Term Debt	1,049,098,131
Estimated Fair Value of Interest Rate Swaps	19,381,031
Deferred Income	3,133,674
Professional Liability Self-Insurance and Other	15,121,888
	<u>1,096,110,560</u>
 <u>TOTAL LIABILITIES</u>	 <u>1,325,121,803</u>
 <u>NET ASSETS</u>	 <u>447,711,812</u>
<u>NONCONTROLLING INTERESTS IN SUBSIDIARIES</u>	<u>163,705,703</u>
 <u>TOTAL LIABILITIES AND NET ASSETS</u>	 <u>1,936,539,318</u>

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended June 30, 2012

	Actual	TWELVE MONTHS YEAR TO DATE
<i>Patient Revenue</i>		
Inpatient Revenue	2,095,036,076	
Outpatient Revenue	<u>1,982,153,858</u>	
Total Gross Patient Revenue	<u>4,077,189,934</u>	
<i>Deductions from Revenue</i>		
Contractual Adjustments	2,900,865,230	
Charity	102,462,014	
Contra Revenue - Charity	115,859,919	
Provision for Bad Debt	<u>7,057,091</u>	
Total Deductions	<u>3,126,244,253</u>	
Net Patient Service Revenue	<u>950,945,681</u>	
Premium Revenue	0	
Other Operating Revenue	<u>37,558,809</u>	
Total Other Operating Revenue	<u>37,558,809</u>	
Total Operating Revenue	<u>988,504,490</u>	
<i>Operating Expense</i>		
Salaries	355,861,320	
Provider Salaries	65,706,018	
Contract Labor	6,375,046	
Employee Benefits	68,606,885	
Fees	97,906,470	
Supplies	170,183,926	
Utilities	17,289,129	
Other Expense	75,578,539	
Medical Costs	0	
Depreciation	72,809,640	
Amortization	2,245,325	
Interest & Taxes	45,902,806	
Consolidation Allocation	(1)	
Total Operating Expense	<u>978,465,103</u>	
Net Operating Income	<u>10,039,388</u>	
Net Investment Income	22,766,794	
Realized Gain on Investments	5,170,970	
Gain / (Loss) from Affiliates	644,531	
Gain / (Loss) on Disposal	446,228	
Loss on Extinguishment of LTD / Derivatives	(2,636,011)	
Minority Interest	4,328,847	
Taxes - Non Operating	(94,781)	
Incentive Pay	(2,741,994)	
Other Non Operating Income / (Expense)	<u>5,114,121</u>	
Total Revenue Over Expense Before CFV of Derivatives	<u>43,038,093</u>	
Change in Fair Value of Interest Rate Swaps	(1,521,348)	
Gain / (Loss) in Swaption / Call Option	<u>(4,676,167)</u>	
Total Excess Revenue Over Expense	<u>36,840,578</u>	
Net Unrealized Gain / (Loss) on Investments	<u>(2,920,893)</u>	
Increase in Unrestricted Net Assets Before Change in Accounting Principle	<u>33,919,684</u>	
Cumulative Effect of Change in Accounting Principle	0	
Total Increase in Unrestricted Net Assets	<u>33,919,684</u>	
EBITDA	<u>166,726,657</u>	

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2012 - Fourth Quarter ended June 30, 2012
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Fourth Quarter ended June 30, 2012 ¹</u>	<u>Twelve Months ended June 30, 2012</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 25,813,207	\$ 45,674,106
Plus depreciation expense	18,624,326	72,809,641
Plus amortization expense	572,842	2,245,325
<u>Plus interest expense</u>	<u>10,480,259</u>	<u>45,997,585</u>
Total income available for debt service	<u><u>221,962,536</u></u>	<u><u>166,726,657</u></u>
Maximum annual debt service	<u>67,854,000</u>	<u>67,854,000</u>
Maximum annual debt service coverage (x)	<u><u>3.3</u></u>	<u><u>2.5</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



First Quarter ending September 30, 2012

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At September 30, 2012

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	95,135,962
Current Portion AWUIL	16,320,622
Accounts Receivable (Net)	155,912,321
Other Receivables	22,734,190
Due From Affiliates	2,138
Due From Third Party Payors	(0)
Inventories	23,494,167
Prepaid Expense	7,023,481
	320,622,881
 <u>ASSETS WHOSE USE IS LIMITED</u>	 127,745,513
<u>OTHER INVESTMENTS</u>	477,553,250
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,512,780,071
Less Allowances for Depreciation	645,372,485
	867,407,586
 <u>OTHER ASSETS</u>	
Pledges Receivable	4,373,669
Long Term Compensation Investment	19,693,049
Investments in Unconsolidated Subsidiaries	2,074,042
Land / Equipment Held for Resale	57,635
Assets Held for Expansion	2,561,921
Investments in Subsidiaries	0
Goodwill	154,391,425
Deferred Charges and Other	29,446,672
	212,598,413
 <u>TOTAL ASSETS</u>	 2,005,927,643
 <u>LIABILITIES AND NET ASSETS</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	88,841,293
Accrued Salaries, Benefits, and PTO	54,992,519
Accrued Interest	10,256,641
Due to Affiliates	0
Due to Third Party Payors	19,714,606
Call Option Liability	0
Current Portion of Long Term Debt	32,268,476
	206,073,535
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	9,927,484
Long Term Debt	1,117,046,085
Estimated Fair Value of Interest Rate Swaps	11,805,149
Deferred Income	17,460,510
Professional Liability Self-Insurance and Other	17,096,816
	1,173,336,045
 <u>TOTAL LIABILITIES</u>	 1,379,409,580
 <u>NET ASSETS</u>	 460,351,620
<u>NONCONTROLLING INTERESTS IN SUBSIDIARIES</u>	166,166,444
 <u>TOTAL LIABILITIES AND NET ASSETS</u>	 2,005,927,643

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended September 30, 2012

	Actual	THREE MONTHS YEAR TO DATE
<i>Patient Revenue</i>		
Inpatient Revenue	513,368,161	
Outpatient Revenue	521,455,394	
Total Gross Patient Revenue	1,034,823,555	
<i>Deductions from Revenue</i>		
Contractual Adjustments	749,947,356	
Charity	23,176,465	
Contra Revenue - Charity	32,010,141	
Provision for Bad Debt	2,025,973	
Total Deductions	807,159,935	
Net Patient Service Revenue	227,663,620	
Premium Revenue	0	
Other Operating Revenue	10,922,537	
Total Other Operating Revenue	10,922,537	
Total Operating Revenue	238,586,157	
<i>Operating Expense</i>		
Salaries	88,263,642	
Provider Salaries	17,322,931	
Contract Labor	1,342,146	
Employee Benefits	16,580,956	
Fees	26,804,479	
Supplies	38,406,897	
Utilities	4,762,610	
Other Expense	20,030,752	
Medical Costs	0	
Depreciation	18,781,447	
Amortization	564,571	
Interest & Taxes	10,824,107	
Consolidation Allocation	0	
Total Operating Expense	243,684,538	
Net Operating Income	(5,098,381)	
Net Investment Income	4,296,224	
Realized Gain on Investments	3,227,757	
Gain / (Loss) from Affiliates	159,553	
Gain / (Loss) on Disposal	(6,393)	
Loss on Extinguishment of LTD / Derivatives	0	
Minority Interest	(2,042,117)	
Taxes - Non Operating	(15,593)	
Incentive Pay	(1,369)	
Other Non Operating Income / (Expense)	61,227	
Total Revenue Over Expense Before CFV of Derivatives	580,909	
Change in Fair Value of Interest Rate Swaps	7,448,107	
Gain / (Loss) in Swaption / Call Option	0	
Total Excess Revenue Over Expense	8,029,016	
Net Unrealized Gain / (Loss) on Investments	5,726,184	
Increase in Unrestricted Net Assets Before Change in Accounting Principle	13,755,200	
Cumulative Effect of Change in Accounting Principle	0	
Total Increase in Unrestricted Net Assets	13,755,200	
EBITDA	30,766,626	

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2013 - First Quarter ended September 30, 2012
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>First Quarter Ended</u> <u>Sept. 30, 2012 ¹</u>	<u>Twelve Months Ended</u> <u>Sept. 30, 2012</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 580,909	\$ 31,591,850
Plus depreciation expense	18,781,446	73,764,008
Plus amortization expense	564,570	2,268,675
<u>Plus interest expense</u>	<u>10,839,700</u>	<u>44,415,638</u>
Total income available for debt service	<u><u>123,066,500</u></u>	<u><u>152,040,171</u></u>
Maximum annual debt service	<u>71,229,000</u>	<u>71,229,000</u>
Maximum annual debt service coverage	<u><u>1.7</u></u>	<u><u>2.1</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



Second Quarter ending December 31, 2012

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At December 31, 2012

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	72,522,316
Current Portion AWUIL	18,371,776
Accounts Receivable (Net)	161,171,175
Other Receivables	26,900,445
Due From Affiliates	0
Due From Third Party Payors	(0)
Inventories	23,547,473
Prepaid Expense	6,897,408
	<u>309,410,592</u>
 <u>ASSETS WHOSE USE IS LIMITED</u>	 <u>117,319,461</u>
 <u>OTHER INVESTMENTS</u>	 <u>486,289,022</u>
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,544,089,935
Less Allowances for Depreciation	663,881,642
	<u>880,208,294</u>
 <u>OTHER ASSETS</u>	
Pledges Receivable	4,304,553
Long Term Compensation Investment	18,650,484
Investments in Unconsolidated Subsidiaries	2,075,377
Land / Equipment Held for Resale	57,635
Assets Held for Expansion	2,561,921
Investments in Subsidiaries	(0)
Goodwill	154,391,425
Deferred Charges and Other	29,164,429
	<u>211,205,823</u>
 <u>TOTAL ASSETS</u>	 <u>2,004,433,193</u>
 <u>LIABILITIES AND NET ASSETS</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	87,954,363
Accrued Salaries, Benefits, and PTO	56,984,043
Accrued Interest	19,631,277
Due to Affiliates	1,632
Due to Third Party Payors	20,777,422
Call Option Liability	0
Current Portion of Long Term Debt	31,166,563
	<u>216,515,299</u>
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	8,856,219
Long Term Debt	1,097,503,333
Estimated Fair Value of Interest Rate Swaps	(1,003,336)
Deferred Income	20,837,959
Professional Liability Self-Insurance and Other	17,832,002
	<u>1,144,026,176</u>
 <u>TOTAL LIABILITIES</u>	 <u>1,360,541,476</u>
 <u>NET ASSETS</u>	 <u>476,607,779</u>
<u>NONCONTROLLING INTERESTS IN SUBSIDIARIES</u>	<u>167,283,937</u>
 <u>TOTAL LIABILITIES AND NET ASSETS</u>	 <u>2,004,433,193</u>

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended December 31, 2012

	Actual	SIX MONTHS YEAR TO DATE
<i>Patient Revenue</i>		
Inpatient Revenue	1,044,578,961	
Outpatient Revenue	1,040,531,773	
Total Gross Patient Revenue	2,085,110,734	
<i>Deductions from Revenue</i>		
Contractual Adjustments	1,508,394,194	
Charity	45,109,393	
Contra Revenue - Charity	59,916,824	
Provision for Bad Debt	3,676,413	
Total Deductions	1,617,096,824	
Net Patient Service Revenue	468,013,910	
Premium Revenue	0	
Other Operating Revenue	26,613,621	
Total Other Operating Revenue	26,613,621	
Total Operating Revenue	494,627,531	
<i>Operating Expense</i>		
Salaries	175,067,697	
Provider Salaries	36,510,784	
Contract Labor	1,979,395	
Employee Benefits	34,768,201	
Fees	52,886,638	
Supplies	81,033,755	
Utilities	8,905,789	
Other Expense	41,026,789	
Medical Costs	0	
Depreciation	37,212,195	
Amortization	1,126,985	
Interest & Taxes	21,828,156	
Consolidation Allocation	0	
Total Operating Expense	492,346,385	
Net Operating Income	2,281,146	
Net Investment Income	10,509,870	
Realized Gain on Investments	3,508,255	
Gain / (Loss) from Affiliates	364,238	
Gain / (Loss) on Disposal	17,009	
Loss on Extinguishment of LTD / Derivatives	0	
Minority Interest	(3,159,610)	
Taxes - Non Operating	(31,184)	
Incentive Pay	(2,386)	
Other Non Operating Income / (Expense)	16,302	
Total Revenue Over Expense Before CFV of Derivatives	13,503,640	
Change in Fair Value of Interest Rate Swaps	9,815,602	
Gain / (Loss) in Swaption / Call Option	0	
Total Excess Revenue Over Expense	23,319,242	
Net Unrealized Gain / (Loss) on Investments	6,609,380	
Increase in Unrestricted Net Assets Before Change in Accounting Principle	29,928,622	
Cumulative Effect of Change in Accounting Principle	0	
Total Increase in Unrestricted Net Assets	29,928,622	
EBITDA	73,702,159	

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2013 - Second Quarter ending December 31, 2012
 Historical Maximum Annual Debt Service Coverage

	Second Quarter Ended Dec. 31, 2012 ¹	Twelve Months Ended Dec. 31, 2012
<u>Calculation:</u>		
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 12,922,730	\$ 42,683,534
Plus depreciation expense	18,430,748	74,562,893
Plus amortization expense	562,414	2,255,158
<u>Plus interest expense</u>	<u>11,019,640</u>	<u>43,729,896</u>
Total income available for debt service	<u><u>171,742,128</u></u>	<u><u>163,231,481</u></u>
Maximum annual debt service	<u>71,601,000</u>	<u>71,601,000</u>
Maximum annual debt service coverage	<u><u>2.4</u></u>	<u><u>2.3</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



Third Quarter ending March 31, 2013

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At March 31, 2013

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	73,352,628
Current Portion AWUIL	5,212,489
Accounts Receivable (Net)	164,024,912
Other Receivables	23,517,570
Due From Affiliates	636
Due From Third Party Payors	0
Inventories	24,078,303
Prepaid Expense	7,015,190
	<u>297,201,728</u>
<u>ASSETS WHOSE USE IS LIMITED</u>	<u>102,622,574</u>
<u>OTHER INVESTMENTS</u>	<u>502,612,889</u>
<u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,575,927,555
Less Allowances for Depreciation	683,321,293
	<u>892,606,262</u>
<u>OTHER ASSETS</u>	
Pledges Receivable	4,458,688
Long Term Compensation Investment	19,575,019
Investments in Unconsolidated Subsidiaries	2,091,800
Land / Equipment Held for Resale	57,635
Assets Held for Expansion	2,561,921
Investments in Subsidiaries	(0)
Goodwill	154,391,425
Deferred Charges and Other	28,172,925
	<u>211,309,413</u>
<u>TOTAL ASSETS</u>	<u>2,006,352,865</u>
<u>LIABILITIES AND NET ASSETS</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	90,640,509
Accrued Salaries, Benefits, and PTO	51,014,707
Accrued Interest	10,503,068
Due to Affiliates	0
Due to Third Party Payors	16,375,246
Call Option Liability	0
Current Portion of Long Term Debt	30,190,255
	<u>198,723,784</u>
<u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	9,207,056
Long Term Debt	1,095,563,648
Estimated Fair Value of Interest Rate Swaps	(2,698,493)
Deferred Income	26,092,951
Professional Liability Self-Insurance and Other	18,672,249
	<u>1,146,837,411</u>
<u>TOTAL LIABILITIES</u>	<u>1,345,561,194</u>
<u>NET ASSETS</u>	<u>492,682,341</u>
<u>NONCONTROLLING INTERESTS IN SUBSIDIARIES</u>	<u>168,109,330</u>
<u>TOTAL LIABILITIES AND NET ASSETS</u>	<u>2,006,352,865</u>

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended March 31, 2013

	Actual	NINE MONTHS YEAR TO DATE
<i><u>Patient Revenue</u></i>		
Inpatient Revenue	1,569,450,231	
Outpatient Revenue	1,562,768,011	
Total Gross Patient Revenue	3,132,218,241	
<i><u>Deductions from Revenue</u></i>		
Contractual Adjustments	2,262,494,966	
Charity	74,479,884	
Contra Revenue - Charity	83,546,696	
Provision for Bad Debt	4,848,545	
Total Deductions	2,425,370,091	
Net Patient Service Revenue	706,848,151	
Premium Revenue	471,233	
Other Operating Revenue	36,059,160	
Total Other Operating Revenue	36,530,393	
Total Operating Revenue	743,378,543	
<i><u>Operating Expense</u></i>		
Salaries	263,591,834	
Provider Salaries	55,350,206	
Contract Labor	2,998,620	
Employee Benefits	53,321,379	
Fees	79,322,400	
Supplies	122,138,050	
Utilities	12,787,934	
Other Expense	61,605,650	
Medical Costs	435,777	
Depreciation	56,522,591	
Amortization	1,687,121	
Interest & Taxes	32,403,734	
Consolidation Allocation	0	
Total Operating Expense	742,165,296	
Net Operating Income	1,213,247	
Net Investment Income	14,659,126	
Realized Gain on Investments	3,643,343	
Gain / (Loss) from Affiliates	585,187	
Gain / (Loss) on Disposal	17,009	
Loss on Extinguishment of LTD / Derivatives	0	
Minority Interest	(3,985,002)	
Taxes - Non Operating	(38,947)	
Incentive Pay	(4,639)	
Other Non Operating Income / (Expense)	3,510,540	
Total Revenue Over Expense Before CFV of Derivatives	19,599,865	
Change in Fair Value of Interest Rate Swaps	11,425,980	
Gain / (Loss) in Swaption / Call Option	0	
Total Excess Revenue Over Expense	31,025,845	
Net Unrealized Gain / (Loss) on Investments	14,962,030	
Increase in Unrestricted Net Assets Before Change in Accounting Principle	45,987,874	
Cumulative Effect of Change in Accounting Principle	0	
Total Increase in Unrestricted Net Assets	45,987,874	
EBITDA	110,252,258	

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2013 - Third Quarter ending March 31, 2013
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Third Quarter Ending March 31, 2013 ¹</u>	<u>Twelve Months Ending March 31, 2013</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 6,096,225	\$ 45,413,071
Plus depreciation expense	19,310,396	75,146,916
Plus amortization expense	560,137	2,259,963
<u>Plus interest expense</u>	<u>10,583,341</u>	<u>42,922,940</u>
Total income available for debt service	<u><u>146,200,396</u></u>	<u><u>165,742,890</u></u>
Maximum annual debt service	<u>71,589,000</u>	<u>71,589,000</u>
Maximum annual debt service coverage	<u><u>2.0</u></u>	<u><u>2.3</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



Fourth Quarter ending June 30, 2013

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At June 30, 2013

	Consolidated
ASSETS	
<i>CURRENT ASSETS</i>	
Cash and Cash Equivalents	74,902,108
Current Portion AWJUL	20,385,598
Accounts Receivable (Net)	168,272,830
Other Receivables	25,523,427
Due From Affiliates	36
Due From Third Party Payors	3,112,967
Inventories	24,043,749
Prepaid Expense	7,029,053
	323,269,769
<i>ASSETS WHOSE USE IS LIMITED</i>	87,805,220
<i>OTHER INVESTMENTS</i>	513,575,142
<i>PROPERTY, PLANT AND EQUIPMENT</i>	
Land, Buildings and Equipment	1,603,510,722
Less Allowances for Depreciation	702,493,560
	901,017,162
<i>OTHER ASSETS</i>	
Pledges Receivable	4,383,340
Long Term Compensation Investment	19,884,279
Investments in Unconsolidated Subsidiaries	2,066,667
Land / Equipment Held for Resale	57,635
Assets Held for Expansion	2,561,921
Investments in Subsidiaries	(0)
Goodwill	154,391,425
Deferred Charges and Other	28,363,290
	211,708,557
<i>TOTAL ASSETS</i>	2,037,375,850
<i>LIABILITIES AND NET ASSETS</i>	
<i>CURRENT LIABILITIES</i>	
Accounts Payable and Accrued Expense	92,173,952
Accrued Salaries, Benefits, and PTO	57,972,900
Accrued Interest	19,706,043
Due to Affiliates	0
Due to Third Party Payors	26,245,178
Current Portion of Long Term Debt	34,416,694
	230,514,768
<i>OTHER NON CURRENT LIABILITIES</i>	
Long Term Compensation Payable	9,159,811
Long Term Debt	1,090,347,906
Estimated Fair Value of Interest Rate Swaps	8,185,050
Deferred Income	2,216,201
Professional Liability Self-Insurance and Other	16,435,454
	1,126,344,423
<i>TOTAL LIABILITIES</i>	1,356,859,191
<i>NET ASSETS</i>	510,256,734
<i>NONCONTROLLING INTERESTS IN SUBSIDIARIES</i>	170,259,925
<i>TOTAL LIABILITIES AND NET ASSETS</i>	2,037,375,850

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended June 30, 2013

	Actual
TWELVE MONTHS YEAR TO DATE	
<i>Patient Revenue</i>	
Inpatient Revenue	2,086,518,100
Outpatient Revenue	<u>2,120,400,485</u>
Total Gross Patient Revenue	4,206,918,585
<i>Deductions from Revenue</i>	
Contractual Adjustments	3,057,729,934
Charity	103,093,623
Contra Revenue - Charity	105,565,107
Provision for Bad Debt	<u>6,931,980</u>
Total Deductions	3,273,320,644
Net Patient Service Revenue	<u>933,597,941</u>
Premium Revenue	1,002,843
Other Operating Revenue	<u>60,411,972</u>
Total Other Operating Revenue	<u>61,414,815</u>
Total Operating Revenue	<u>995,012,756</u>
<i>Operating Expense</i>	
Salaries	349,840,902
Provider Salaries	74,257,857
Contract Labor	3,941,874
Employee Benefits	74,695,245
Fees	105,929,651
Supplies	162,955,174
Utilities	16,857,010
Other Expense	78,711,392
Medical Costs	2,539,401
Depreciation	77,432,345
Amortization	2,259,537
Interest & Taxes	43,202,890
Consolidation Allocation	0
Total Operating Expense	<u>992,623,278</u>
Net Operating Income	<u>2,389,478</u>
Net Investment Income	20,570,323
Realized Gain on Investments	3,721,867
Gain / (Loss) from Affiliates	701,288
Gain / (Loss) on Disposal	(1,129)
Loss on Extinguishment of LTD / Derivatives	0
Minority Interest	(6,135,598)
Taxes - Non Operating	(51,766)
Incentive Pay	21,495
Other Non Operating Income / (Expense)	<u>18,282,597</u>
Total Revenue Over Expense Before CFV of Derivatives	<u>39,498,554</u>
Change in Fair Value of Interest Rate Swaps	456,715
Gain / (Loss) in Swaption / Call Option	0
Total Excess Revenue Over Expense	<u>39,955,269</u>
Net Unrealized Gain / (Loss) on Investments	<u>23,376,858</u>
Increase in Unrestricted Net Assets Before Change in Accounting Principle	<u>63,332,126</u>
Cumulative Effect of Change in Accounting Principle	0
Total Increase in Unrestricted Net Assets	<u>63,332,126</u>
EBITDA	<u>162,445,092</u>

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2013 - Fourth Quarter ending June 30, 2013
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Fourth Quarter Ending June 30, 2013 ¹</u>	<u>Twelve Months Ending June 30, 2013</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 19,898,689	\$ 39,498,553
Plus depreciation expense	20,909,754	77,432,344
Plus amortization expense	572,416	2,259,537
<u>Plus interest expense</u>	<u>10,811,975</u>	<u>43,254,656</u>
Total income available for debt service	<u><u>208,771,336</u></u>	<u><u>162,445,090</u></u>
 Maximum annual debt service	 <u>71,554,000</u>	 <u>71,554,000</u>
 Maximum annual debt service coverage	 <u><u>2.9</u></u>	 <u><u>2.3</u></u>

Footnotes

1- Annualized quarterly total income available for debt service



First Quarter ending September 30, 2013

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At September 30, 2013

	Consolidated
ASSETS	
<i>CURRENT ASSETS</i>	
Cash and Cash Equivalents	53,053,082
Current Portion AWUIL	4,218,870
Accounts Receivable (Net)	165,633,374
Other Receivables	35,761,272
Due From Affiliates	40,510
Due From Third Party Payors	0
Inventories	23,773,081
Prepaid Expense	8,398,963
	<u>290,879,154</u>
<i>ASSETS WHOSE USE IS LIMITED</i>	<u>73,542,745</u>
<i>OTHER INVESTMENTS</i>	<u>553,286,955</u>
<i>PROPERTY, PLANT AND EQUIPMENT</i>	
Land, Buildings and Equipment	1,610,275,566
Less Allowances for Depreciation	723,300,565
	<u>886,975,002</u>
<i>OTHER ASSETS</i>	
Pledges Receivable	4,026,182
Long Term Compensation Investment	20,559,873
Investments in Unconsolidated Subsidiaries	1,985,032
Land / Equipment Held for Resale	7,508,959
Assets Held for Expansion	12,710,794
Investments in Subsidiaries	(0)
Goodwill	154,391,425
Deferred Charges and Other	26,992,274
	<u>228,174,538</u>
<i>TOTAL ASSETS</i>	<u>2,032,858,393</u>
LIABILITIES AND NET ASSETS	
<i>CURRENT LIABILITIES</i>	
Accounts Payable and Accrued Expense	91,417,634
Accrued Salaries, Benefits, and PTO	56,413,240
Accrued Interest	9,694,752
Due to Affiliates	0
Due to Third Party Payors	28,631,019
Current Portion of Long Term Debt	26,047,888
	<u>212,204,533</u>
<i>OTHER NON-CURRENT LIABILITIES</i>	
Long Term Compensation Payable	9,799,813
Long Term Debt	1,081,595,702
Estimated Fair Value of Interest Rate Swaps	10,209,645
Deferred Income	9,197,050
Professional Liability Self-Insurance and Other	17,553,898
	<u>1,128,356,108</u>
<i>TOTAL LIABILITIES</i>	<u>1,340,560,641</u>
<i>NET ASSETS</i>	521,545,936
<i>NONCONTROLLING INTERESTS IN SUBSIDIARIES</i>	170,751,816
<i>TOTAL LIABILITIES AND NET ASSETS</i>	<u>2,032,858,393</u>

Mountain States Health Alliance
Statement of Revenue and Expense
For the Period Ended September 30, 2013

	Actual
THREE MONTHS YEAR TO DATE	
<i>Patient Revenue</i>	
Inpatient Revenue	549,595,104
Outpatient Revenue	584,371,070
Total Gross Patient Revenue	1,133,966,174
<i>Deductions from Revenue</i>	
Contractual Adjustments	847,578,602
Charity	26,372,445
Contra Revenue - Charity	30,169,144
Provision for Bad Debt	1,911,927
Total Deductions	906,032,117
Net Patient Service Revenue	227,934,057
Premium Revenue	574,348
Other Operating Revenue	13,643,777
Total Other Operating Revenue	14,218,125
Total Operating Revenue	242,152,181
<i>Operating Expense</i>	
Salaries	84,520,923
Provider Salaries	19,367,769
Contract Labor	1,139,990
Employee Benefits	16,321,814
Fees	28,609,361
Supplies	40,594,679
Utilities	4,439,581
Other Expense	19,713,728
Medical Costs	484,379
Depreciation	19,284,204
Amortization	552,983
Interest & Taxes	10,990,317
Consolidation Allocation	(0)
Total Operating Expense	246,019,729
Net Operating Income	(3,867,547)
Net Investment Income	3,892,133
Realized Gain on Investments	977,572
Gain / (Loss) from Affiliates	184,358
Gain / (Loss) on Disposal	2,615,175
Loss on Extinguishment of LTD / Derivatives	(4,622,060)
Minority Interest	271,702
Taxes - Non Operating	(11,847)
Incentive Pay	17,008
Other Non Operating Income / (Expense)	148,877
Total Revenue Over Expense Before CFV of Derivatives	(394,629)
Change in Fair Value of Interest Rate Swaps	(2,111,258)
Gain / (Loss) in Swaption / Call Option	0
Total Excess Revenue Over Expense	(2,505,888)
Net Unrealized Gain / (Loss) on Investments	21,780,005
Increase in Unrestricted Net Assets Before Change in Accounting Principle	19,274,118
Cumulative Effect of Change in Accounting Principle	0
Total Increase in Unrestricted Net Assets	19,274,118
EBITDA	35,066,781

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2014 - First Quarter ended September 30, 2013
 Historical Maximum Annual Debt Service Coverage

	First Quarter Ended Sept. 30, 2013 ¹	Twelve Months Ended Sept. 30, 2013
<u>Calculation:</u>		
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 4,218,630	\$ 43,136,274
Plus depreciation expense	19,284,204	77,935,102
Plus amortization expense	552,983	2,247,950
<u>Plus interest expense</u>	11,002,163	43,417,119
Total income available for debt service	<u>140,231,920</u>	<u>166,736,445</u>
Maximum annual debt service	<u>70,909,000</u>	<u>70,909,000</u>
Maximum annual debt service coverage	<u>2.0</u>	<u>2.4</u>

Footnotes

1- Annualized quarterly total income available for debt service



Second Quarter ending December 31, 2013

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At December 31, 2013

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	27,595,930
Current Portion AWUIL	21,735,663
Accounts Receivable (Net)	165,644,754
Other Receivables	35,297,064
Due From Affiliates	394
Due From Third Party Payors	(0)
Inventories	25,196,779
Prepaid Expense	7,525,857
	<u>282,996,440</u>
<u>ASSETS WHOSE USE IS LIMITED</u>	<u>69,656,659</u>
<u>OTHER INVESTMENTS</u>	<u>577,438,013</u>
<u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,612,871,088
Less Allowances for Depreciation	731,630,943
	<u>881,240,144</u>
<u>OTHER ASSETS</u>	
Pledges Receivable	3,998,250
Long Term Compensation Investment	21,983,850
Investments in Unconsolidated Subsidiaries	1,663,053
Land / Equipment Held for Resale	7,508,959
Assets Held for Expansion	13,134,006
Investments in Subsidiaries	(0)
Goodwill	155,715,265
Deferred Charges and Other	26,755,592
	<u>230,758,975</u>
<u>TOTAL ASSETS</u>	<u>2,042,090,231</u>
<u>LIABILITIES AND NET ASSETS</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	89,776,021
Accrued Salaries, Benefits, and PTO	58,443,444
Accrued Interest	18,933,997
Due to Affiliates	0
Due to Third Party Payors	15,672,853
Current Portion of Long Term Debt	23,402,258
	<u>206,228,573</u>
<u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	10,801,776
Long Term Debt	1,082,008,813
Estimated Fair Value of Interest Rate Swaps	13,496,134
Deferred Income	13,182,577
Professional Liability Self-Insurance and Other	18,198,587
	<u>1,137,687,887</u>
<u>TOTAL LIABILITIES</u>	<u>1,343,916,461</u>
<u>NET ASSETS</u>	528,329,327
<u>NONCONTROLLING INTERESTS IN SUBSIDIARIES</u>	169,844,443
<u>TOTAL LIABILITIES AND NET ASSETS</u>	<u>2,042,090,231</u>

Mountain States Health Alliance
Statement of Revenue and Expense (Consolidated)
For the Period Ended December 31, 2013

SIX MONTHS YEAR TO DATE

	Actual
<i>Revenue, Gains and Support</i>	
Patient Service Revenue, Net of Contractual Allowances and Discounts	511,421,253
Provision for Bad Debt	(56,453,041)
Net Patient Service Revenue	454,968,212
Premium Revenue	1,158,468
Net Investment Gain	45,085,166
Net Derivative Gain	(2,521,780)
Other Revenue, Gains and Support	24,468,138
Total Revenue, Gains and Support	523,158,203
<i>Expense</i>	
Salaries and Wages	167,248,755
Provider Salaries	38,818,072
Contract Labor	2,038,407
Employee Benefits	33,033,162
Fees	57,891,142
Supplies	80,832,395
Utilities	8,383,068
Medical Costs	1,140,528
Other Expense	42,842,333
Loss on Extinguishment of LTD / Derivatives	4,622,060
Depreciation	38,331,465
Amortization	953,256
Interest & Taxes	22,284,852
Total Expenses	498,419,495
Excess of Revenue, Gains and Support over Expenses and Losses	24,738,708

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2014 - Second Quarter ending December 31, 2013
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	Second Quarter ending Dec. 31, 2013	Twelve Months ending Dec. 31, 2013
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ (961,068)	\$ 29,252,476
Plus depreciation expense	19,047,262	78,551,616
Plus amortization expense	400,273	2,085,809
<u>Plus interest expense</u>	11,304,337	43,701,816
Subtotal	29,790,804	153,591,717
<i>Annualized quarterly total income available for debt service</i>	<u>x 4</u>	<u>n/a</u>
Total income available for debt service	119,163,216	153,591,717
Maximum annual debt service	70,867,000	70,867,000
Maximum annual debt service coverage	1.7	2.2



Third Quarter ending March 31, 2014

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet
At March 31, 2014

	Consolidated
<u>ASSETS</u>	
<i>CURRENT ASSETS</i>	
Cash and Cash Equivalents	55,626,290
Current Portion AWUIL	8,293,720
Accounts Receivable (Net)	168,414,370
Other Receivables	30,651,417
Due From Affiliates	0
Due From Third Party Payors	0
Inventories	24,976,575
Prepaid Expense	8,958,865
	296,921,238
 <i>ASSETS WHOSE USE IS LIMITED</i>	 65,034,653
 <i>OTHER INVESTMENTS</i>	 578,879,514
 <i>PROPERTY, PLANT AND EQUIPMENT</i>	
Land, Buildings and Equipment	1,620,770,253
Less Allowances for Depreciation	746,465,808
	874,304,445
 <i>OTHER ASSETS</i>	
Pledges Receivable	4,804,368
Long Term Compensation Investment	22,131,092
Investments in Unconsolidated Subsidiaries	1,402,295
Land / Equipment Held for Resale	7,508,959
Assets Held for Expansion	13,134,006
Investments in Subsidiaries	(0)
Goodwill	155,786,750
Deferred Charges and Other	26,385,796
	231,153,266
 <i>TOTAL ASSETS</i>	 2,046,293,116
 <u>LIABILITIES AND NET ASSETS</u>	
<i>CURRENT LIABILITIES</i>	
Accounts Payable and Accrued Expense	84,580,303
Accrued Salaries, Benefits, and PTO	49,232,075
Claims Payable	4,913,723
Accrued Interest	9,625,764
Due to Affiliates	99
Due to Third Party Payors	15,241,213
Current Portion of Long Term Debt	44,433,183
	208,026,359
 <i>OTHER NON CURRENT LIABILITIES</i>	
Long Term Compensation Payable	10,947,418
Long Term Debt	1,081,616,264
Estimated Fair Value of Interest Rate Swaps	11,553,477
Deferred Income	15,799,291
Professional Liability Self-Insurance and Other	17,386,154
	1,137,302,604
 <i>TOTAL LIABILITIES</i>	 1,345,328,964
 <i>NET ASSETS</i>	 530,952,971
<i>NONCONTROLLING INTERESTS IN SUBSIDIARIES</i>	170,011,181
 <i>TOTAL LIABILITIES AND NET ASSETS</i>	 2,046,293,116

Mountain States Health Alliance
Statement of Revenue and Expense (Consolidated)
For the Month Ended March 31, 2014

NINE MONTHS YEAR TO DATE

	<u>Actual</u>
<i>Revenue, Gains and Support</i>	
Patient Service Revenue, Net of Contractual Allowances and Discounts	769,036,410
Provision for Bad Debt	(81,094,609)
Net Patient Service Revenue	687,941,801
Premium Revenue	5,760,058
Net Investment Gain	47,825,620
Net Derivative Gain	814,281
Other Revenue, Gains and Support	34,154,686
Total Revenue, Gains and Support	776,496,445
<i>Expense</i>	
Salaries and Wages	250,005,814
Provider Salaries	57,586,519
Contract Labor	2,847,148
Employee Benefits	51,613,788
Fees	87,473,663
Supplies	122,064,425
Utilities	12,625,745
Medical Costs	5,405,232
Other Expense	62,382,085
Loss on Extinguishment of LTD / Derivatives	4,622,060
Depreciation	57,604,488
Amortization	1,352,248
Interest & Taxes	33,443,528
Consolidation Allocation	0
Total Expenses	749,026,744
Excess of Revenue, Gains and Support over Expenses and Losses	27,469,701

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2014 - Third Quarter ending March 31, 2014
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Third Quarter ending March 31, 2014</u>	<u>Twelve Months ending March 31, 2014</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ (113,320)	\$ 23,042,931
Plus depreciation expense	19,273,023	78,514,243
Plus amortization expense	398,992	1,924,664
<u>Plus interest expense</u>	<u>11,169,392</u>	<u>44,287,867</u>
Subtotal	30,728,087	147,769,705
<i>Annualized quarterly total income available for debt service</i>	<i>x 4</i>	<i>n/a</i>
 Total income available for debt service	 <u>122,912,348</u>	 <u>147,769,705</u>
 Maximum annual debt service	 <u>70,827,000</u>	 <u>70,827,000</u>
 Maximum annual debt service coverage	 <u>1.7</u>	 <u>2.1</u>



Fourth Quarter ending June 30, 2014

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet (Unaudited)
At June 30, 2014

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	59,184,792
Current Portion AWUIL	25,028,568
Accounts Receivable (Net)	166,524,980
Other Receivables	44,832,880
Due From Affiliates	124
Due From Third Party Payors	(0)
Inventories	24,527,319
Prepaid Expense	6,310,892
	<u>326,409,555</u>
 <u>ASSETS WHOSE USE IS LIMITED</u>	 <u>61,200,439</u>
 <u>OTHER INVESTMENTS</u>	 <u>587,274,223</u>
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,639,069,493
Less Allowances for Depreciation	757,640,754
	<u>881,428,739</u>
 <u>OTHER ASSETS</u>	
Pledges Receivable	3,656,370
Long Term Compensation Investment	22,536,324
Investments in Unconsolidated Subsidiaries	1,426,430
Land / Equipment Held for Resale	7,508,959
Assets Held for Expansion	13,284,006
Investments in Subsidiaries	(0)
Goodwill	156,709,485
Deferred Charges and Other	26,061,706
	<u>231,183,279</u>
 <u>TOTAL ASSETS</u>	 <u>2,087,496,235</u>
 <u>LIABILITIES AND NET ASSETS</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	82,812,043
Accrued Salaries, Benefits, and PTO	72,368,503
Claims Payable	4,929,177
Accrued Interest	18,647,518
Due to Affiliates	0
Due to Third Party Payors	10,462,932
Current Portion of Long Term Debt	29,894,210
	<u>219,114,383</u>
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	11,229,829
Long Term Debt	1,076,099,170
Estimated Fair Value of Interest Rate Swaps	10,602,538
Deferred Income	1,362,811
Professional Liability Self-Insurance and Other	20,065,231
	<u>1,119,359,578</u>
 <u>TOTAL LIABILITIES</u>	 <u>1,338,473,961</u>
 <u>NET ASSETS</u>	 <u>569,634,105</u>
<u>NONCONTROLLING INTERESTS IN SUBSIDIARIES</u>	<u>179,388,169</u>
 <u>TOTAL LIABILITIES AND NET ASSETS</u>	 <u>2,087,496,235</u>

Mountain States Health Alliance
Statement of Revenue and Expense (Unaudited)
For the Period Ended June 30, 2014

TWELVE MONTHS YEAR TO DATE

	Actual
<u>Revenue, Gains and Support</u>	
Patient Service Revenue, Net of Contractual Allowances and Discounts	1,053,379,301
Provision for Bad Debt	(120,388,269)
Net Patient Service Revenue	932,991,032
Premium Revenue	10,682,764
Net Investment Gain	65,425,307
Net Derivative Gain	3,218,556
Other Revenue, Gains and Support	52,072,621
Total Revenue, Gains and Support	1,064,390,280
<u>Expense</u>	
Salaries and Wages	340,589,134
Provider Salaries	77,636,096
Contract Labor	4,282,340
Employee Benefits	69,298,183
Fees	116,019,476
Supplies	163,764,999
Utilities	17,072,249
Medical Costs	9,973,675
Other Expense	80,190,905
Loss on Extinguishment of LTD / Derivatives	4,622,060
Depreciation	69,436,735
Amortization	1,741,757
Interest & Taxes	44,354,682
Consolidation Allocation	0
Total Expenses	998,982,291
Excess of Revenue, Gains and Support over Expenses and Losses	65,407,989

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2014 - Fourth Quarter ending June 30, 2014
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Fourth Quarter ending June 30, 2014</u>	<u>Twelve Months ending June 30, 2014</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 31,607,527	\$ 34,751,769
Plus depreciation expense	11,832,248	69,436,737
Plus amortization expense	389,509	1,741,757
<u>Plus interest expense</u>	<u>10,925,089</u>	<u>44,400,981</u>
Subtotal	54,754,373	150,331,244
<i>Annualized quarterly total income available for debt service</i>	<i>x 4</i>	<i>n/a</i>
 Total income available for debt service	 <u>219,017,492</u>	 <u>150,331,244</u>
 Maximum annual debt service	 <u>70,804,000</u>	 <u>70,804,000</u>
 Maximum annual debt service coverage	 <u>3.1</u>	 <u>2.1</u>



Fiscal Year 2015
First Quarter ending September 30, 2014

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet (Unaudited)
At September 30, 2014

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	51,813,063
Current Portion AWUJL	3,742,881
Accounts Receivable (Net)	160,897,853
Other Receivables	37,048,436
Due From Affiliates	2,130
Due From Third Party Payors	(0)
Inventories	25,641,856
Prepaid Expense	8,040,432
	<u>287,186,651</u>
 <u>ASSETS WHOSE USE IS LIMITED</u>	 <u>53,739,173</u>
 <u>OTHER INVESTMENTS</u>	 <u>590,088,596</u>
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,648,718,208
Less Allowances for Depreciation	773,631,534
	<u>875,086,673</u>
 <u>OTHER ASSETS</u>	
Pledges Receivable	3,344,315
Long Term Compensation Investment	23,544,007
Investments in Unconsolidated Subsidiaries	1,196,104
Land / Equipment Held for Resale	7,508,959
Assets Held for Expansion	13,314,006
Investments in Subsidiaries	0
Goodwill	156,608,494
Deferred Charges and Other	25,437,528
	<u>230,953,413</u>
 <u>TOTAL ASSETS</u>	 <u>2,037,054,506</u>
 <u>LIABILITIES AND NET ASSETS</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	86,667,302
Accrued Salaries, Benefits, and PTO	51,372,395
Claims Payable	4,915,330
Accrued Interest	9,453,588
Due to Affiliates	(0)
Due to Third Party Payors	12,753,133
Current Portion of Long Term Debt	31,006,721
	<u>196,168,468</u>
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	11,337,511
Long Term Debt	1,052,372,136
Estimated Fair Value of Interest Rate Swaps	10,328,246
Deferred Income	14,095,374
Professional Liability Self-Insurance and Other	20,379,020
	<u>1,108,512,286</u>
 <u>TOTAL LIABILITIES</u>	 <u>1,304,680,754</u>
 <u>NET ASSETS</u>	 <u>551,940,190</u>
<u>NONCONTROLLING INTERESTS IN SUBSIDIARIES</u>	<u>180,433,562</u>
 <u>TOTAL LIABILITIES AND NET ASSETS</u>	 <u>2,037,054,506</u>

Mountain States Health Alliance
Statement of Revenue and Expense (Unaudited)
For the Period Ended September 30, 2014

THREE MONTHS YEAR TO DATE

	Actual
<u>Revenue, Gains and Support</u>	
Patient Service Revenue, Net of Contractual Allowances and Discounts	271,180,538
<u>Provision for Bad Debt</u>	(30,017,572)
Net Patient Service Revenue	241,162,965
Premium Revenue	5,507,322
Net Investment Gain	(6,100,738)
Net Derivative Gain	1,752,202
Other Revenue, Gains and Support	6,013,836
Total Revenue, Gains and Support	248,335,587
<u>Expense</u>	
Salaries and Wages	84,106,971
Provider Salaries	19,446,678
Contract Labor	1,523,287
Employee Benefits	15,598,994
Fees	28,535,746
Supplies	42,385,574
Utilities	4,697,635
Medical Costs	5,066,012
Other Expense	20,950,211
Loss on Extinguishment of LTD / Derivatives	-
Depreciation	16,853,152
Amortization	405,277
Interest & Taxes	11,092,737
<u>Consolidation Allocation</u>	-
Total Expenses	250,662,273
Excess of Revenue, Gains and Support over Expenses and Losses	(2,326,686)

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2015 - First Quarter ending Sept 30, 2014
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>First Quarter ending September 30, 2014</u>	<u>Twelve Months ending September 30, 2014</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 5,265,220	\$ 35,798,359
Plus depreciation expense	16,853,152	67,005,685
Plus amortization expense	405,276	1,594,050
<u>Plus interest expense</u>	<u>11,104,959</u>	<u>44,503,777</u>
Subtotal	33,628,607	148,901,871
<i>Annualized quarterly total income available for debt service</i>	<i>x 4</i>	<i>n/a</i>
Total income available for debt service	<u>134,514,428</u>	<u>148,901,871</u>
Maximum annual debt service	<u>67,252,000</u>	<u>67,252,000</u>
Maximum annual debt service coverage	<u>2.0</u>	<u>2.2</u>



Fiscal Year 2015
Second Quarter ending December 31, 2014

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet (Unaudited)
At December 31, 2014

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	75,917,297
Current Portion AWUJL	21,343,233
Accounts Receivable (Net)	164,636,729
Other Receivables	30,394,689
Due From Affiliates	(0)
Due From Third Party Payors	(0)
Inventories	26,381,249
Prepaid Expense	7,442,748
	<u>326,115,945</u>
 <u>ASSETS WHOSE USE IS LIMITED</u>	 <u>54,550,132</u>
 <u>OTHER INVESTMENTS</u>	 <u>587,217,484</u>
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,638,495,196
Less Allowances for Depreciation	782,954,710
	<u>855,540,486</u>
 <u>OTHER ASSETS</u>	
Pledges Receivable	3,320,065
Long Term Compensation Investment	24,342,806
Investments in Unconsolidated Subsidiaries	5,131,425
Land / Equipment Held for Resale	7,508,959
Assets Held for Expansion	13,344,006
Investments in Subsidiaries	0
Goodwill	156,602,310
Deferred Charges and Other	25,030,972
	<u>235,280,541</u>
 <u>TOTAL ASSETS</u>	 <u>2,058,704,588</u>
 <u>LIABILITIES AND NET ASSETS</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	85,971,554
Accrued Salaries, Benefits, and PTO	55,967,615
Claims Payable	7,325,569
Accrued Interest	18,358,521
Due to Affiliates	22
Due to Third Party Payors	11,142,946
Current Portion of Long Term Debt	24,634,754
	<u>203,400,982</u>
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	11,786,311
Long Term Debt	1,052,239,157
Estimated Fair Value of Interest Rate Swaps	8,388,107
Deferred Income	24,469,405
Professional Liability Self-Insurance and Other	21,249,203
	<u>1,118,132,182</u>
 <u>TOTAL LIABILITIES</u>	 <u>1,321,533,164</u>
 <u>NET ASSETS</u>	 <u>555,450,609</u>
<u>NONCONTROLLING INTERESTS IN SUBSIDIARIES</u>	<u>181,720,814</u>
 <u>TOTAL LIABILITIES AND NET ASSETS</u>	 <u>2,058,704,588</u>

Mountain States Health Alliance
Statement of Revenue and Expense (Unaudited)
For the Period Ended December 31, 2014

SIX MONTHS YEAR TO DATE

	Actual
<u>Revenue, Gains and Support</u>	
Patient Service Revenue, Net of Contractual Allowances and Discounts	548,325,880
Provision for Bad Debt	(58,876,681)
Net Patient Service Revenue	489,449,200
Premium Revenue	11,326,369
Net Investment Gain	(9,342,493)
Net Derivative Gain	5,140,372
Other Revenue, Gains and Support	14,405,497
Total Revenue, Gains and Support	510,978,944
<u>Expense</u>	
Salaries and Wages	167,224,674
Provider Salaries	39,167,751
Contract Labor	2,833,258
Employee Benefits	34,500,734
Fees	57,512,860
Supplies	87,365,444
Utilities	8,649,766
Medical Costs	10,682,295
Other Expense	44,029,561
Loss on Extinguishment of LTD / Derivatives	0
Depreciation	33,837,702
Amortization	812,576
Interest & Taxes	22,165,123
Consolidation Allocation	1
Total Expenses	508,781,746
Excess of Revenue, Gains and Support over Expenses and Losses	2,197,198

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2015 - Second Quarter ending Dec. 31, 2014
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Second Quarter ending December 31, 2014</u>	<u>Twelve Months ending December 31, 2014</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 11,362,660	\$ 48,122,087
Plus depreciation expense	16,984,550	64,942,973
Plus amortization expense	407,299	1,601,076
<u>Plus interest expense</u>	<u>11,082,686</u>	<u>44,282,126</u>
Subtotal	39,837,195	158,948,262
<i>Annualized quarterly total income available for debt service</i>	<i>x 4</i>	<i>n/a</i>
Total income available for debt service	<u>159,348,780</u>	<u>158,948,262</u>
Maximum annual debt service	<u>67,240,000</u>	<u>67,240,000</u>
Maximum annual debt service coverage	<u>2.4</u>	<u>2.4</u>



Fiscal Year 2015
Third Quarter ending March 31, 2015

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Consolidated Balance Sheet (Unaudited)
At March 31, 2015

	Consolidated
<u>ASSETS</u>	
<u>CURRENT ASSETS</u>	
Cash and Cash Equivalents	66,697,783
Current Portion AWUIL	8,766,960
Accounts Receivable (Net)	177,184,581
Other Receivables	29,556,831
Due From Affiliates	3,607
Due From Third Party Payors	0
Inventories	26,595,071
Prepaid Expense	9,056,403
	317,861,237
 <u>ASSETS WHOSE USE IS LIMITED</u>	 53,472,246
 <u>OTHER INVESTMENTS</u>	 613,990,075
 <u>PROPERTY, PLANT AND EQUIPMENT</u>	
Land, Buildings and Equipment	1,646,398,411
Less Allowances for Depreciation	799,540,545
	846,857,866
 <u>OTHER ASSETS</u>	
Pledges Receivable	3,293,981
Long Term Compensation Investment	24,779,130
Investments in Unconsolidated Subsidiaries	5,150,938
Land / Equipment Held for Resale	7,508,959
Assets Held for Expansion	14,310,717
Investments in Subsidiaries	0
Goodwill	156,596,125
Deferred Charges and Other	24,677,269
	236,317,118
 <u>TOTAL ASSETS</u>	 2,068,498,542
 <u>LIABILITIES AND NET ASSETS</u>	
<u>CURRENT LIABILITIES</u>	
Accounts Payable and Accrued Expense	86,782,632
Accrued Salaries, Benefits, and PTO	50,937,845
Claims Payable	7,076,164
Accrued Interest	9,380,091
Due to Affiliates	(0)
Due to Third Party Payors	13,390,443
Current Portion of Long Term Debt	24,332,448
	191,899,622
 <u>OTHER NON CURRENT LIABILITIES</u>	
Long Term Compensation Payable	12,186,841
Long Term Debt	1,052,651,287
Estimated Fair Value of Interest Rate Swaps	3,594,920
Deferred Income	24,775,531
Professional Liability Self-Insurance and Other	22,078,311
	1,115,286,890
 <u>TOTAL LIABILITIES</u>	 1,307,186,512
 <u>NET ASSETS</u>	 574,094,938
<u>NONCONTROLLING INTERESTS IN SUBSIDIARIES</u>	187,217,092
 <u>TOTAL LIABILITIES AND NET ASSETS</u>	 2,068,498,542

Mountain States Health Alliance
Statement of Revenue and Expense (Unaudited)
For the Period Ended March 31, 2015

NINE MONTHS YEAR TO DATE

	Actual
<u>Revenue, Gains and Support</u>	
Patient Service Revenue, Net of Contractual Allowances and Discounts	840,390,491
Provision for Bad Debt	-100,375,420
Net Patient Service Revenue	740,015,071
Premium Revenue	21,492,711
Net Investment Gain	1,617,630
Net Derivative Gain	11,382,997
Other Revenue, Gains and Support	16,375,449
Total Revenue, Gains and Support	790,883,858
<u>Expense</u>	
Salaries and Wages	252,527,296
Provider Salaries	56,840,825
Contract Labor	4,316,492
Employee Benefits	54,797,727
Fees	88,105,565
Supplies	131,862,997
Utilities	12,634,273
Medical Costs	20,005,846
Other Expense	64,250,281
Loss on Extinguishment of LTD / Derivatives	0
Depreciation	50,634,568
Amortization	1,174,794
Interest & Taxes	32,931,495
Consolidation Allocation	1
Total Expenses	770,082,160
Excess of Revenue, Gains and Support over Expenses and Losses	20,801,698

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2015 - Third Quarter ending March 31, 2015
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Third Quarter ending March 31, 2015</u>	<u>Twelve Months ending March 31, 2015</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 4,894,660	\$ 53,130,067
Plus depreciation expense	16,796,866	62,466,816
Plus amortization expense	362,218	1,564,302
<u>Plus interest expense</u>	<u>10,776,560</u>	<u>43,889,294</u>
Subtotal	32,830,304	161,050,479
<i>Annualized quarterly total income available for debt service</i>	<i>x 4</i>	<i>n/a</i>
Total income available for debt service	<u>131,321,216</u>	<u>161,050,479</u>
Maximum annual debt service	<u>67,246,000</u>	<u>67,246,000</u>
Maximum annual debt service coverage	<u>2.0</u>	<u>2.4</u>



Fiscal Year 2015
Fourth Quarter ending June 30, 2015

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Comparative Balance Sheet (Unaudited)
As of June 30, 2015 and June 30, 2014

	June 30 2015	June 30 2014
ASSETS		
<u>CURRENT ASSETS</u>		
Cash and Cash Equivalents	79,713,574	59,184,792
Current Portion AWUIL	19,597,595	25,028,568
Accounts Receivable (Net)	162,379,523	161,318,003
Other Receivables	30,350,162	45,502,067
Due From Affiliates	-0	124
Due From Third Party Payors	-0	-0
Inventories	26,646,561	24,527,319
Prepaid Expense	7,322,824	6,310,892
	<u>326,010,238</u>	<u>321,871,765</u>
<u>ASSETS WHOSE USE IS LIMITED</u>	<u>59,208,918</u>	<u>61,200,439</u>
<u>OTHER INVESTMENTS</u>	<u>635,332,874</u>	<u>587,274,223</u>
<u>PROPERTY, PLANT AND EQUIPMENT</u>		
Land, Buildings and Equipment	1,662,193,378	1,639,069,493
Less Allowances for Depreciation	815,104,790	757,640,754
	<u>847,088,588</u>	<u>881,428,739</u>
<u>OTHER ASSETS</u>		
Pledges Receivable	3,260,254	3,656,370
Long Term Compensation Investment	25,284,264	22,536,324
Investments in Unconsolidated Subsidiaries	5,179,805	1,364,290
Land / Equipment Held for Resale	4,631,959	7,508,959
Assets Held for Expansion	14,684,441	13,284,006
Investments in Subsidiaries	0	-0
Goodwill	156,596,125	156,612,617
Deferred Charges and Other	24,754,992	25,841,391
	<u>234,391,841</u>	<u>230,803,956</u>
<u>TOTAL ASSETS</u>	<u>2,102,032,459</u>	<u>2,082,579,122</u>
<u>LIABILITIES AND NET ASSETS</u>		
<u>CURRENT LIABILITIES</u>		
Accounts Payable and Accrued Expense	90,259,474	81,879,383
Accrued Salaries, Benefits, and PTO	70,482,499	72,180,545
Claims Payable	8,167,693	5,247,746
Accrued Interest	18,159,055	18,647,518
Due to Affiliates	22	0
Due to Third Party Payors	5,484,417	10,462,932
Current Portion of Long Term Debt	40,286,349	30,617,770
	<u>232,839,509</u>	<u>219,035,895</u>
<u>OTHER NON CURRENT LIABILITIES</u>		
Long Term Compensation Payable	12,250,293	11,229,829
Long Term Debt	1,031,660,759	1,075,068,610
Estimated Fair Value of Interest Rate Swaps	7,643,937	10,602,538
Deferred Income	15,259,244	13,080,719
Professional Liability Self-Insurance and Other	19,632,236	20,619,965
	<u>1,086,446,470</u>	<u>1,130,601,660</u>
<u>TOTAL LIABILITIES</u>	<u>1,319,285,979</u>	<u>1,349,637,555</u>
<u>NET ASSETS</u>		
Restricted Net Assets	13,676,360	12,416,607
Unrestricted Net Assets	576,600,846	541,894,085
Noncontrolling Interests in Subsidiaries	192,469,274	178,630,875
	<u>782,746,480</u>	<u>732,941,567</u>
<u>TOTAL LIABILITIES AND NET ASSETS</u>	<u>2,102,032,459</u>	<u>2,082,579,122</u>

Mountain States Health Alliance
Statement of Revenue and Expense (Unaudited)
The quarters and fiscal years to date ended June 30, 2015 and June 30, 2014

	FY15 QTR 4	FY14 QTR 4	FY15 FYTD	FY14 FYTD
<u>Revenue, Gains and Support</u>				
Patient Service Revenue, Net of Contractual Allowances and Discounts	289,795,372	281,389,328	1,130,185,863	1,050,425,737
Provision for Bad Debt	-27,144,493	-41,547,073	-127,519,913	-122,641,682
Net Patient Service Revenue	262,650,879	239,842,254	1,002,665,950	927,784,055
Premium Revenue	10,691,293	4,922,706	32,184,004	10,682,764
Net Investment Gain	15,362,124	2,876,463	16,979,754	50,702,083
Net Derivative Gain	-2,563,842	2,404,275	8,819,155	3,218,556
Other Revenue, Gains and Support	4,970,810	22,672,266	21,346,260	56,826,952
Total Revenue, Gains and Support	291,111,264	272,717,964	1,081,995,122	1,049,214,410
<u>Expense</u>				
Salaries and Wages	92,652,303	90,583,320	345,179,598	340,589,134
Provider Salaries	20,501,384	20,049,577	77,342,209	77,636,096
Contract Labor	1,092,149	1,435,192	5,408,641	4,282,340
Employee Benefits	22,541,095	17,559,713	77,338,822	69,173,502
Fees	32,182,587	28,132,750	120,288,152	115,606,414
Supplies	44,177,145	41,634,341	176,040,142	163,698,766
Utilities	4,162,439	4,426,345	16,796,712	17,052,090
Medical Costs	11,918,777	4,887,012	31,924,623	10,292,244
Other Expense	17,620,554	17,597,906	81,870,835	79,979,992
Loss on Extinguishment of LTD / Derivatives	0	0	0	4,622,060
Depreciation	16,575,758	11,832,247	67,210,326	69,436,735
Amortization	382,197	389,509	1,556,991	1,741,757
Interest & Taxes	10,764,099	10,948,228	43,695,595	44,391,756
Consolidation Allocation	-0	0	1	0
Total Expenses	274,570,488	249,476,141	1,044,652,648	998,502,886
Excess of Revenue, Gains and Support over Expenses and Losses	16,540,776	23,241,823	37,342,474	50,711,524

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2015 - Fourth Quarter ending June 30, 2015
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Fourth Quarter ending June 30, 2015</u>	<u>Twelve Months ending June 30, 2015</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 19,342,946	\$ 40,865,486
Plus depreciation expense	16,575,758	67,210,326
Plus amortization expense	382,197	1,556,990
<u>Plus interest expense</u>	<u>10,773,032</u>	<u>43,737,237</u>
Subtotal	47,073,933	153,370,039
<i>Annualized quarterly total income available for debt service</i>	<i>x 4</i>	<i>n/a</i>
Total income available for debt service	<u>188,295,732</u>	<u>153,370,039</u>
Maximum annual debt service	<u>67,254,000</u>	<u>67,254,000</u>
Maximum annual debt service coverage	<u>2.8</u>	<u>2.3</u>



**Fiscal Year 2016
First Quarter ending September 30, 2015**

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Comparative Balance Sheet

	<i>Unaudited</i> September 30 2015	<i>Audited</i> June 30 2015
<u>ASSETS</u>		
<u>CURRENT ASSETS</u>		
Cash and Cash Equivalents	77,172,729	79,713,574
Current Portion AWUIL	3,755,270	19,597,595
Accounts Receivable (Net)	170,905,175	162,255,802
Other Receivables	29,256,971	33,285,941
Due From Affiliates	(0)	(0)
Due From Third Party Payors	(0)	(0)
Inventories	27,702,635	26,646,561
Prepaid Expense	9,949,872	7,322,824
	<u>318,742,652</u>	<u>328,822,296</u>
<u>ASSETS WHOSE USE IS LIMITED</u>	<u>38,804,166</u>	<u>52,470,955</u>
<u>OTHER INVESTMENTS</u>	<u>626,005,435</u>	<u>642,070,837</u>
<u>PROPERTY, PLANT AND EQUIPMENT</u>		
Land, Buildings and Equipment	1,676,587,454	1,662,193,378
Less Allowances for Depreciation	831,337,710	815,104,790
	<u>845,249,743</u>	<u>847,088,588</u>
<u>OTHER ASSETS</u>		
Pledges Receivable	2,986,504	3,260,254
Long Term Compensation Investment	25,296,174	25,284,264
Investments in Unconsolidated Subsidiaries	5,505,881	5,179,805
Land / Equipment Held for Resale	4,631,959	4,631,959
Assets Held for Expansion	16,015,303	14,684,441
Investments in Subsidiaries	0	0
Goodwill	156,583,757	156,596,125
Deferred Charges and Other	24,394,375	24,754,992
	<u>235,413,953</u>	<u>234,391,841</u>
<u>TOTAL ASSETS</u>	<u>2,064,215,950</u>	<u>2,104,844,518</u>
<u>LIABILITIES AND NET ASSETS</u>		
<u>CURRENT LIABILITIES</u>		
Accounts Payable and Accrued Expense	109,709,678	92,133,309
Accrued Salaries, Benefits, and PTO	54,569,179	72,064,537
Claims Payable	8,358,409	8,167,693
Accrued Interest	9,132,413	18,159,055
Due to Affiliates	1,697	22
Due to Third Party Payors	6,628,528	4,781,320
Call Option Liability	0	0
Current Portion of Long Term Debt	40,571,801	40,286,349
	<u>228,971,704</u>	<u>235,592,285</u>
<u>OTHER NON CURRENT LIABILITIES</u>		
Long Term Compensation Payable	12,290,203	12,250,293
Long Term Debt	1,008,805,029	1,031,660,759
Estimated Fair Value of Interest Rate Swaps	(286,953)	2,540,682
Deferred Income	17,656,077	15,259,244
Professional Liability Self-Insurance and Other	19,596,387	19,635,356
	<u>1,058,060,742</u>	<u>1,081,346,335</u>
<u>TOTAL LIABILITIES</u>	<u>1,287,032,447</u>	<u>1,316,938,620</u>
<u>NET ASSETS</u>		
Restricted Net Assets	13,330,874	13,502,164
Unrestricted Net Assets	573,134,720	583,215,057
Noncontrolling Interests in Subsidiaries	190,717,909	191,188,677
	<u>777,183,503</u>	<u>787,905,897</u>
<u>TOTAL LIABILITIES AND NET ASSETS</u>	<u>2,064,215,950</u>	<u>2,104,844,518</u>

Mountain States Health Alliance
Statement of Revenue and Expense (Unaudited)
The quarters and fiscal years to date ended September 30, 2015 and September 30, 2014

	FY16 QTR 1	FY15 QTR 1
<u>Revenue, Gains and Support</u>		
Patient Service Revenue, Net of Contractual Allowances and Discounts	287,186,003	268,400,739
Provision for Bad Debt	<u>(35,555,253)</u>	<u>(30,017,572)</u>
Net Patient Service Revenue	251,630,750	238,383,167
Premium Revenue	10,503,326	5,507,322
Net Investment Gain	(16,922,989)	(6,100,738)
Net Derivative Gain	4,314,779	1,752,202
Other Revenue, Gains and Support	7,945,659	6,013,836
Total Revenue, Gains and Support	<u>257,471,526</u>	<u>245,555,789</u>
<u>Expense</u>		
Salaries and Wages	89,330,105	84,106,971
Provider Salaries	19,932,317	19,446,678
Contract Labor	1,632,523	1,523,287
Employee Benefits	17,965,757	15,598,994
Fees	33,562,105	28,535,746
Supplies	44,106,802	42,385,574
Utilities	4,571,603	4,697,635
Medical Costs	5,515,113	2,286,214
Other Expense	23,015,390	20,950,211
Loss on Extinguishment of LTD / Derivatives	0	0
Depreciation	16,509,516	16,853,152
Amortization	382,703	405,277
Interest & Taxes	10,998,043	11,092,737
Consolidation Allocation	0	(0)
Total Expenses	<u>267,521,976</u>	<u>247,882,475</u>
Excess of Revenue, Gains and Support over Expenses and Losses	<u>(10,050,450)</u>	<u>(2,326,686)</u>

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2016 - First Quarter ending September 30, 2015
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>First Quarter ending September 30, 2015</u>	<u>Twelve Months ending September 30, 2015</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ 6,125,045	\$ 41,725,312
Plus depreciation expense	\$ 16,509,516	\$ 66,866,690
Plus amortization expense	\$ 382,703	\$ 1,534,417
<u>Plus interest expense</u>	\$ 10,998,043	\$ 43,630,321
Subtotal	34,015,307	153,756,740
<i>Annualized quarterly total income available for debt service</i>	<i>x 4</i>	<i>n/a</i>
 Total income available for debt service	 <u>136,061,228</u>	 <u>153,756,740</u>
 Maximum annual debt service	 <u>67,288,000</u>	 <u>67,288,000</u>
 Maximum annual debt service coverage	 <u>2.0</u>	 <u>2.3</u>



*Management Discussion
For the Quarter Ended March 31, 2015
and Nine Months Fiscal Year to Date 2015*

Volumes

Quarter ended March 31, 2015 versus quarter ended March 31, 2014

For the third quarter, strong volume growth continued even with higher than normal inclement winter weather:

- Inpatient admissions were up 1,215 or 8.4%
- Observation patients were down 241 or 4.1%.
- Total "patients in a bed" were up 974 or 4.8%
- Emergency room visits were up 3,960 or 6.8%
- Urgent care visits were up 1,827 or 7.9%
- Surgeries were up 236 or 2.7%

Fiscal Year to Date (Three Quarters)

Compared to the prior year fiscal year to date:

- Inpatient admissions were up 3,989 or 9.5%
- Observation patients were down 965 or 5.2%
- Total "patients in a bed" were up 3,024 or 5.0%
- Emergency room visits were up 12,675 or 7.1%
- Urgent care visits were up 7,425 or 11.4%
- Surgeries were up 1,597 or 6.2%

Statement of Revenue and Expenses

Quarter ended March 31, 2015 versus quarter ended March 31, 2014

Revenue

Net patient service revenue increased \$17.6 million or 7.6% from the same quarter last year due to the volume increases listed above. **Other** revenue declined \$7.7 million or 79.7% mainly due to an increase in minority interest related to the non-wholly owned hospitals. **Premium** revenue increased \$5.5 million or 120.9% due to an increase in covered lives in the system owned health plan.

Expenses

Salaries and benefits increased \$3.8 million or 3.2% as a result of the volume noted above. FTEs per AOB for the quarter declined from 4.33 to 4.27 due to a continued focus on daily labor management.

Supply cost as a % of net for the quarter increased slightly to 17.8% from 17.7% and is mainly due to the higher costs of specialty drugs.

Fees increased \$1.0 million or 3.4% primarily due to an increase in physician fees.

Medical costs increased \$5.1 million or 119% due to an increase in covered lives in the system owned health plan.

All other expenses increased \$.4 million or 1.8% primarily due to an increase in maintenance contracts.

Interest expense declined by \$.4 million or 3.5%.

Depreciation/Amortization expense declined by \$2.5 million or 12.8%.

Operating EBITDA of \$36.4 million was above the same quarter last year by \$9.1 million or 33.1%.

Fiscal Year to Date (Three Quarters)

Net patient service revenue increased \$52.1 million or 7.6% from the same quarter last year due to the volume increases listed above. **Other** revenue declined \$17.8 million or 52.1% due mainly due an increase in minority interest related to the non-wholly owned hospitals and meaningful use dollars received in the prior year. **Premium** revenue increased \$15.7 million or 273.1% due to an increase in covered lives in the system owned health plan.

Salaries and benefits (including contract labor) increased \$6.4 million or 1.8% as a result of the volume noted above. FTEs per AOB of 4.36 declined from 4.54 for the prior fiscal year to date due to a continued focus on daily labor management.

Supply cost as a % of net for the fiscal year to date increase slightly to 17.8% from 17.7% in the prior fiscal year to date. The increase is mainly due to the higher costs of specialty drugs.

Fees increased \$.6 million or 0.7% primarily due to an increase in physician fees.

Medical costs increased \$14.6 million or 270.1% due to an increase in covered lives in the system owned health plan.

All other expenses increased \$1.9 million or 2.5% primarily due to an increase in maintenance contracts.

Interest expense declined by \$.5 million or 1.5%.

Depreciation/Amortization expense declined by \$7.1 million or 12.1%.

Operating EBITDA of \$103.1 million was above the same three quarters last year by \$30.2 million or 41.5%.

Balance Sheet

The only significant changes were a result of the normal annual debt service payments. Other noteworthy items are: (1) increase in net accounts receivable of \$15.9 million due to the increase in volume and increase in utilization of high deductible health plans resulting in an increase in patient liability and a longer collection cycle (2) decrease in the fair value of the interest rate swaps of \$7.0 million and (3) increase in deferred income of \$11.7 million. The deferred income is mainly related to investment earnings and will be included in earnings at the end of the fiscal year.

Statistics:

The following table contains historical utilization statistics and payor mix for the quarters and fiscal years to date ended March 31, 2015 and March 31, 2014.

	Q3 FY15	Q3 FY14	YTD FY15	YTD FY14
Admissions	15,753	14,538	46,182	42,193
Observation Patients	5,630	5,871	17,469	18,434
Patients in Bed	21,383	20,409	63,651	60,627
Patient Days	74,833	71,613	213,313	204,452
Average Length of Stay	4.75	4.93	4.62	4.85
Average Daily Census (incl. observation patients)	894	861	842	813
Emergency Room Visits	62,282	58,322	190,768	178,093
Urgent Care Visits	24,890	23,063	72,384	64,959
Inpatient Surgeries	2,842	2,660	8,453	8,162
Outpatient Surgeries	5,977	5,923	18,817	17,511
Total Surgical Cases	8,819	8,583	27,270	25,673
FTEs	7,077	6,949	7,012	7,015
FTEs per AOB	4.27	4.33	4.36	4.54

Payor Mix	YTD FY15	YTD FY14
Medicare	29.6%	32.0%
Managed Medicare	21.3%	19.7%
TennCare/Medicaid	14.1%	14.5%
Managed Care/Other	27.8%	26.1%
Self-Pay	7.2%	7.7%
	100.0%	100.0%



**Management Discussion
For the Quarter Ended June 30, 2015
and Twelve Months Fiscal Year to Date 2015**

Volumes

Quarter ended June 30, 2015 versus quarter ended June 30, 2014

For the fourth quarter, strong volume growth continued.

Inpatient admissions were up 1,020 or 6.9%

Observation patients were up 154 or 2.7%.

Total "patients in a bed" were up 1,174 or 5.7%

Emergency room visits were up 3,576 or 5.8%

Urgent care visits were up 1,695 or 8.7%

Surgeries were down 215 or 2.3%

Fiscal Year to Date (Four Quarters)

Compared to the prior year fiscal year to date:

Inpatient admissions were up 5,009 or 8.8%

Observation patients were down 811 or 3.3%

Total "patients in a bed" were up 4,198 or 5.2%

Emergency room visits were up 16,251 or 6.8%

Urgent care visits were up 9,120 or 10.8%

Surgeries were up 1,382 or 3.9%

Statement of Revenue and Expenses

Quarter ended June 30, 2015 versus quarter ended June 30, 2014

Revenue

Net patient service revenue increased \$22.8 million or 9.5% from the same quarter last year due to the volume increases listed above. **Other** revenue declined \$17.7 million or 78.1% mainly due to a decrease in Meaningful Use and an increase in minority interest related to the non-wholly owned hospitals. **Premium** revenue increased \$5.8 million or 117.2% due to an increase in covered lives in the system owned health plan.

Expenses

Salaries and benefits increased \$7.2 million or 5.5% as a result of increased medical and pharmacy claims and the volume noted above. FTEs per AOB for the quarter increased slightly from 4.34 to 4.37.

Supply cost as a % of net for the quarter decreased from 17.4% to 16.8%.

Fees increased \$4.0 million or 14.4% primarily due to an increase in physician fees.

Medical costs increased \$7.0 million or 143.9% due to an increase in covered lives in the system owned health plan.

All other expenses decreased \$.2 million or 1.1% primarily due to a decrease in utilities.

Interest expense declined by \$.2 million or 1.7%.

Depreciation/Amortization expense increased by \$4.7 million or 38.8%.

Operating EBITDA of \$42.7 million was below the same quarter last year by \$10.5 million or 19.7% due mainly to a decrease in meaningful use.

Fiscal Year to Date (Four Quarters)

Net patient service revenue increased \$74.9 million or 8.1% from the prior fiscal year due to the volume increases listed above. **Other** revenue declined \$35.5 million or 62.4% due mainly to an increase in minority interest related to the non-wholly owned hospitals, meaningful use dollars and the Medicare Shared Savings received in the prior year.

Premium revenue increased \$21.5 million or 201.3% due to an increase in covered lives in the system owned health plan.

Salaries and benefits (including contract labor) increased \$13.6 million or 2.8% as a result of increased medical and pharmacy claims and the volume noted above. FTEs per AOB of 4.36 declined from 4.49 for the prior fiscal year to date due to a continued focus on daily labor management.

Supply cost as a % of net for the fiscal year to date is equal to the prior fiscal year to date at 17.6%.

Fees increased \$4.7 million or 4.0% primarily due to an increase in physician fees.

Medical costs increased \$21.6 million or 210.2% due to an increase in covered lives in the system owned health plan.

All other expenses increased \$1.6 million or 1.7% primarily due to an increase in maintenance contracts.

Interest expense declined by \$.7 million or 1.6%.

Depreciation/Amortization expense declined by \$2.4 million or 3.4%.

Operating EBITDA of \$145.8 million was above the prior fiscal year by \$19.8 million or 15.7%.

Balance Sheet

The only significant changes were a result of the normal annual debt service payments and an increase in cash and investments of 68.6 million due to improved operating results and market performance.

Statistics:

The following table contains historical utilization statistics and payor mix for the quarters and fiscal years to date ended June 30, 2015 and June 30, 2014.

	Q4 FY15	Q4 FY14	YTD FY15	YTD FY14
Admissions	15,867	14,847	62,049	57,040
Observation Patients	5,938	5,784	23,407	24,218
Patients in Bed	21,805	20,631	85,456	81,258
Patient Days	72,893	70,117	286,206	274,569
Average Length of Stay	4.59	4.72	4.61	4.81
Average Daily Census (incl. observation p:	866	834	848	819
Emergency Room Visits	65,089	61,513	255,857	239,606
Urgent Care Visits	21,265	19,570	93,649	84,529
Inpatient Surgeries	2,857	2,849	11,310	11,011
Outpatient Surgeries	6,370	6,593	25,187	24,104
Total Surgical Cases	9,227	9,442	36,497	35,115
FTEs	7,251	7,010	7,071	7,014
FTEs per AOB	4.37	4.34	4.36	4.49

	YTD FY15	YTD FY14
Payor Mix		
Medicare	29.3%	31.5%
Managed Medicare	21.7%	19.8%
TennCare/Medicaid	14.0%	14.4%
Managed Care/Other	27.9%	26.7%
Self Pay	7.1%	7.5%
	<u>100.0%</u>	<u>100.0%</u>

Exhibit 11.4

Attachment H

Mountain States - Rating Agencies Reports

Fitch Affirms Mountain States Health Alliance at 'BBB'; Outlook Stable Ratings

13 Mar 2009 4:01 PM (EDT)

Fitch Ratings-New York-13 March 2009: Fitch Ratings affirms the 'BBB' underlying rating on approximately \$883 million of outstanding revenue bonds issued on behalf of Mountain States Health Alliance (MSHA). Additionally, Fitch affirms the 'BBB' rating on the hospital revenue bonds series 2008C, 2008D, and 2008E which were delayed in 2008 due to market conditions and will now be issued as series 2009A, 2009B, and 2009C. The bonds will be issued by the Johnson City Health and Educational Facilities Board (VA), Smyth County Industrial Development Authority (VA), and Washington County Industrial Development Authority (VA), respectively. The Rating Outlook is Stable.

The bonds will be issued as fixed-rate, unenhanced tax-exempt bonds, and the proceeds will be used to refund approximately \$10 million of MSHA's series 2006C bonds and to fund a portion of the costs associated with the pending acquisition of Johnson Memorial Hospital (JMH). The bonds are expected to price the week of March 16, 2009.

The assignment and affirmation of the 'BBB' is supported by MSHA's leading market position, solid liquidity relative to expenses, and a history of financial stability. MSHA's acute inpatient market share in its 29 county service area (including JMH), encompassing northeast Tennessee, southwest Virginia, and southeast Kentucky, was 36.9% as of 2008. This compares favorably to MSHA's only major competitor's (Wellmont Health System; rated 'BBB+' by Fitch) 29.5% market share. As of Dec. 31, 2008, MSHA had \$400 million of unrestricted cash and investments, equating to 196 days cash on hand, which compares favorably to Fitch's 'BBB' category median of 123.5 days. The unrestricted cash and investments are down from \$466 million as of June 30, 2008 primarily due to \$80 million in investment losses (\$56 million of which is unrealized) and a \$61 million collateral posting associated with the negative mark-to-market value of MSHA's swap portfolio through the first six months of fiscal 2009. The current investment allocation policy is being reevaluated with a likely result of a more conservative investment policy focusing on fixed-income assets (currently MSHA's long-term investments are 50% invested equities).

MSHA has been generating positive income from operations since fiscal 2003, averaging a 1.2% operating margin through fiscal 2008, as well as robust operating EBITDA margins during the period, averaging 15.4% annually. Through the six-month interim period, MSHA's operating margin is at negative 0.3% comparing favorably to the negative 1.8% margin of same period last year. Management attributes the improved operating performance to conservative recognition of revenue in the interim periods and expects to realize a year end margin of roughly 2%. The year-to-date operating EBITDA margin is healthy at 12.1%.

Credit concerns include MSHA's leveraged financial profile with significant variable rate debt exposure, sizable short-term capital commitments associated with JMH, an extensive derivative program, a high proportion of self-pay and Medicaid (7.3% and 15.3% of gross revenues, respectively), and high bad debt expense. While debt service coverage remains solid at 1.9 times (x) by EBITDA through Dec. 31, 2008, MSHA's Dec. 31, 2008 debt-to-capitalization and proforma MADS as percentage of revenue are very high at 83% and 6.7% compared to Fitch's 'BBB' category medians of 47.1% and 3.3%, respectively. The total amount committed to JMH is \$132 million (see Fitch's Nov. 21, 2008 research report titled 'Mountain States Health Alliance, Tennessee - hosp rev bonds ser 2008C, D, & E' available on the Fitch web site at www.fitchratings.com). Future debt plans are expected to be minimal, but MSHA plans to fund the remainder of its commitment to JMH through internal cash flow over the next 1.5 years, however, debt financing is still an option if market conditions improve markedly.

Historically, MSHA has utilized a sizable swap portfolio which, as of Jan. 31, 2009, has a negative mark-to-market value of \$101.2 million on a notional amount \$925.2 million. MSHA has been required to post collateral of \$73.5 million as of March 1, 2009. In response to the recent volatility of the derivative markets, MSHA is reevaluating its derivative policies and intends to restructure its derivative portfolio over time as market conditions improve. Also of concern is MSHA's significant variable-rate exposure. Approximately two-thirds of the system's total debt is in the form of variable-rate bonds backed by a letter of credit from Regions Bank (rated 'A+/F1' with a Negative Outlook by Fitch) and a consortium of other lenders. Term-out provisions require that MSHA pay the letter of credit (LOC) bank within 367 days after payment is made on the LOC, which could affect MSHA's solid liquidity ratios leading to negative rating pressure.

The Stable Outlook is based on Fitch's expectation that MSHA's liquidity ratios (relative to expenses) will remain strong compared to the 'BBB' medians and that operating performance will remain stable. MSHA expects to generate \$128 million in operating EBITDA for fiscal 2009 (16.4% operating EBITDA margin). Additionally, MSHA is at the end of its hospital

acquisition program (although considerable capital spending is expected to continue) which should allow management to concentrate on integrating its newly acquired affiliates and improving its core operations.

Headquartered in Johnson City, Tennessee, MSHA is a large, integrated health care system with 14 hospitals (1,699 licensed beds) and other related entities, primarily serving Northeast Tennessee, Southwest Virginia, and two neighboring states. In fiscal year 2008, MSHA had total operating income of \$756.3 million. MSHA covenants to provide annual and quarterly financial and operational disclosure to the nationally recognized municipal information securities repositories (NRMSIRSs).

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Fitch Withdraws Unenhanced Rtg on Mountain State Health Alliance 2007B, 2008A, & 2008B Revs

Fitch Ratings-New York-05 October 2010: Fitch Ratings withdraws the 'BBB+/F2' enhanced ratings assigned to the Johnson City Health & Educational Facilities Board, TN hospital revenue bonds (Mountain States Health Alliance), series 2007B and series 2008A and the Russell County Industrial Development Authority, VA hospital revenue bonds (Mountain States Health Alliance), series 2008B (the bonds).

The withdrawal of the ratings is in connection with the Sept. 29, 2010 mandatory tender of all the outstanding bonds as a result of the letter of credit (LOC) substitutions. The Regions Bank LOCs supporting the bonds terminated following the mandatory tender. Fitch has not been asked to rate the bonds based on the substitute LOCs.

The long-term rating has been revised to reflect the underlying 'BBB' rating currently assigned to the bonds.

The remarketing of the Johnson City Health & Educational Facilities Board (TN) (Mountain States Health Alliance) hospital revenue bonds series 2007B does not affect its underlying ratings, according to Fitch.

With this remarketing this bond will receive new CUSIPs:

Johnson City Health & Educational Facilities Board 2007B
478271HK8 (original)

Johnson City Health & Educational Facilities Board 2007B-1
478271JK6 (remarketed)

Johnson City Health & Educational Facilities Board 2007B-2
478271JL4 (remarketed)

Johnson City Health & Educational Facilities Board 2007B-3
478271JM2 (remarketed)

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Applicable Criteria and Related Research:

--'U.S. Municipal Structured Finance Rating Criteria', Aug. 16, 2010;

--'Rating Guidelines for Letter of Credit-Supported Bonds', April 29, 2009.

Applicable Criteria and Related Research:

U.S. Municipal Structured Finance Rating Criteria

(http://www.fitchratings.com/creditedesk/reports/report_frame.cfm?rpt_id=548588)

Rating Guidelines for Letter of Credit-Supported Bonds

(http://www.fitchratings.com/creditedesk/reports/report_frame.cfm?rpt_id=435132)

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Fitch Upgrades Mountain States Health Alliance bonds to 'BBB+' from 'BBB'; Outlook Stable

Ratings
15 Dec 2010 11:45 AM (EST)

Fitch Ratings-New York-15 December 2010: Fitch Ratings has upgraded the rating on Mountain States Health Alliance's (MSHA) outstanding debt to 'BBB+' from 'BBB'. The Rating Outlook is Stable. MSHA has approximately \$1 billion of total outstanding debt with an underlying debt mix of 64% fixed-rate and 36% variable-rate demand bonds (supported by letters of credit).

SECURITY:

MSHA has granted a security interest in its pledged assets and a mortgage on Johnson City Medical Center and Sycamore Shoals Hospital. In addition, there is a debt service reserve fund on certain debt.

RATING RATIONALE:

- The rating upgrade is due to MSHA's strong market position, consistent exceptional operating cash flow margins, and solid days cash on hand.
- MSHA's market position has strengthened over the last two years due to MSHA's acquisition activity, with minimal activity expected in the near future as MSHA continues to integrate the newer facilities into the system.
- MSHA has been significantly investing in its plant with three new replacement facilities and an expansion at its flagship facility, Johnson City Medical Center (JCMC), and capital needs are expected to moderate in the next three to four years.
- MSHA has also reduced the risk in its debt and investment portfolio since 2008.
- The main credit concerns continue to be MSHA's high debt burden, which management has committed to reduce once it reaches their days cash on hand target of 250 (231.5 as of Sept. 30, 2010).

KEY RATING DRIVERS:

- Maintenance of strong operating cash flow and liquidity.
- Upward movement of the rating would be dependent on MSHA reducing its debt burden while maintaining its strong operating cash flow and liquidity position.
- Negative rating pressure would occur if MSHA's financial profile deteriorates.

CREDIT SUMMARY:

The rating upgrade is due to MSHA's strong market position, consistent exceptional cash flow margins, and solid days cash on hand. MSHA was formed in 1998 from the acquisition of five hospitals in Tennessee from Columbia/HCA. Since that time, MSHA has grown to a 14-hospital system through several acquisitions from 2005-2009, which has extended MSHA's service area to Virginia. Management indicated that there are no future acquisitions planned, especially since there are limited sole providers remaining in the service area. MSHA's acute inpatient market share in its 29-county service area was 36.5% in 2009, which compares favorably to MSHA's only major competitor's (Wellmont Health System; rated 'BBB+' by Fitch) 29.5% market share.

MSHA has been investing significantly in its plant, which has totaled approximately 2 times (x) depreciation expense in fiscal 2009 and 2010. Major capital projects include three new replacement hospitals and an expansion of surgical space at the flagship facility. In July 2010, a new 80-bed facility opened (Franklin Woods Community Hospital), which replaced two of MSHA's existing facilities, North Side Hospital and Johnson City Specialty Hospital. The construction was under budget and the new hospital is expected to improve efficiency as a result of the consolidation of services on one campus and better location. The two other replacement facilities are for Johnston Memorial Hospital and Smyth County Community Hospital, which are expected to be completed by May 2011 and November 2011, respectively. MSHA's flagship facility, JCMC, will expand its surgical space with the construction of 16 new surgery suites (by 2013). A portion of this project is expected to be funded by \$45 million of additional debt in fiscal 2012. The high intensity of capital spending is expected through fiscal 2012 with capital commitments of \$99 million in fiscal 2011 and \$110 million in fiscal 2012, and is then expected to return to more moderate levels of approximately \$70 million-\$80 million a year. The main source of funding will be operating cash flow except for \$15 million of unspent bond proceeds and \$45 million of additional debt expected in fiscal 2012. Management's projections include rebuilding the balance sheet to 250 days cash on hand beginning in fiscal 2012.

As of Sept. 30, 2010 MSHA had \$554 million of unrestricted cash and investments, equating to a solid 231.5 days cash on hand, which compares very favorably to Fitch's 'BBB' category median of 122.2 days. Management's target is to maintain approximately 250 days cash on hand and any excess cash flow generated will be used to reduce its debt. MSHA's investment policy was revised in June 2010 and is conservative. The revised policy has allocated at least 110 days cash on hand in highly liquid fixed-income securities, and investments over the 110-day threshold would be invested in no more than 50% equities. Cash-to-debt of 53.6% at Sept. 30, 2010 compares unfavorably to the 'BBB' category median of 75.9% and is reflective of MSHA's sizeable debt load.

MSHA's operating performance in fiscal 2010 has shown improvement despite approximately \$6 million of accelerated depreciation expense. The operating margin improved to 1.7% compared to 0.8% in fiscal 2009 and 0.6% in fiscal 2008. Operating cash flow has consistently been outstanding and is one of the highest in Fitch's portfolio with a 14.8% annual average operating cash flow margin over the last five years compared to the 'BBB' category median of 8.7%. For the interim period (three months ended Sept. 30, 2010), operating performance is ahead of the prior year. Management expects further opportunity for improvement as the Virginia facilities become better integrated into the system in addition to its initiatives related to health care reform.

Fitch's main credit concern is MSHA's sizeable debt load and fairly aggressive capital structure. Despite MSHA's strong operating cash flow,

debt service coverage is adequate at 2.2x by EBITDA for fiscal 2010 compared to 1.8x in fiscal 2009 and Fitch's 'BBB' median of 2.5x. The only future new money debt plans include \$45 million in fiscal 2012, which has been factored into this rating action. Fitch expects MSHA to grow into its debt burden due to limited near-term acquisition activity, moderation of capital spending, and continued strong operating cash flow that should allow for liquidity growth and subsequently the paydown of some debt. Management has stated its intent to reduce its debt load and did pay off an additional \$12 million in capital leases and other debt in fiscal 2010.

MSHA's total outstanding debt is approximately \$1 billion with \$667 million underlying fixed-rate and \$375 million variable-rate demand obligations (VRDOs). The letters of credit (LOC) were successfully replaced in 2010 with three new banks and the agreements contained better covenants. The current LOCs expire in 2013 and the term-out provision under the agreements is three years. MSHA's outstanding swap portfolio includes a \$132 million fixed payor swap, \$438 million of basis swaps, and a \$224 million swaption. The total mark-to-market value of the portfolio was negative \$29.895 million as of Nov. 12, 2010 and MSHA was posting \$5.1 million of collateral (not including the swaption that has a related guaranteed investment contract [GIC] of approximately \$89 million). Management intends to terminate some or all of its fixed payor swaps when market conditions permit and the swaption is expected to terminate in July 2011 when MSHA has the right to terminate, which would result in the release of the GIC. Fitch views MSHA's capital structure as fairly aggressive especially for the rating level; however, Fitch believes its liquidity position as well as strong management and board oversight mitigates this risk.

MSHA recently adopted a new strategic plan that includes the development of an accountable care organization (ACO) to improve the delivery of care. Fitch views MSHA's progress in the ACO strategy favorably, and believes it should lead to lower costs and improved quality of care. MSHA has an integrated network identified and has been participating in various pilot programs (e.g. Premier). Mountain States Medical Group is a key part of the strategy and the number of employed physicians currently totals 230 and is expected to increase further.

The Stable Outlook is based on Fitch's expectation that MSHA will continue to generate strong operating cash flow to service its debt load and capital needs. Fitch expects that over time MSHA will continue to grow its liquidity, which should allow MSHA to reduce its leverage.

Headquartered in Johnson City, Tennessee, MSHA is a large regional health care system with 14 hospitals (1,789 licensed beds) and other related entities, primarily serving northeast Tennessee and southwest Virginia. MSHA has a ranging membership interest (50.1%-80%) in three of the most recent additions to the system (Smyth County Community Hospital, Norton Community Hospital, Johnston Memorial Hospital). In fiscal 2010, MSHA had total operating revenue of \$944 million. MSHA covenants to provide annual and quarterly financial and operational disclosure to the nationally recognized municipal information securities repositories (NRMSIRS).

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Applicable Criteria and Related Research:

--'Revenue-Supported Rating Criteria', dated Oct. 8, 2010
--'Nonprofit Hospitals and Health Systems Rating Criteria', dated Dec. 29, 2009.

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Applicable Criteria and Related Research:

Revenue-Supported Rating Criteria
Nonprofit Hospitals and Health Systems Rating Criteria

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Fitch Upgrades Mountain States Health Alliance bonds to 'BBB+' from 'BBB'; Outlook Stable

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SECURITY:

MSHA has granted a security interest in its pledged assets and a mortgage on Johnson City Medical Center and Sycamore Shoals Hospital. In addition, there is a debt service reserve fund on certain debt.

RATING RATIONALE:

- The rating upgrade is due to MSHA's strong market position, consistent exceptional operating cash flow margins, and solid days cash on hand.
- MSHA's market position has strengthened over the last two years due to MSHA's acquisition activity, with minimal activity expected in the near future as MSHA continues to integrate the newer facilities into the system.
- MSHA has been significantly investing in its plant with three new replacement facilities and an expansion at its flagship facility, Johnson City Medical Center (JCMC), and capital needs are expected to moderate in the next three to four years.
- MSHA has also reduced the risk in its debt and investment portfolio since 2008.
- The main credit concerns continue to be MSHA's high debt burden, which management has committed to reduce once it reaches their days cash on hand target of 250 (231.5 as of Sept. 30, 2010).

KEY RATING DRIVERS:

- Maintenance of strong operating cash flow and liquidity.
- Upward movement of the rating would be dependent on MSHA reducing its debt burden while maintaining its strong operating cash flow and liquidity position.
- Negative rating pressure would occur if MSHA's financial profile deteriorates.

CREDIT SUMMARY:

The rating upgrade is due to MSHA's strong market position, consistent exceptional cash flow margins,

and solid days cash on hand. MSHA was formed in 1998 from the acquisition of five hospitals in Tennessee from Columbia/HCA. Since that time, MSHA has grown to a 14-hospital system through several acquisitions from 2005-2009, which has extended MSHA's service area to Virginia. Management indicated that there are no future acquisitions planned, especially since there are limited sole providers remaining in the service area. MSHA's acute inpatient market share in its 29-county service area was 36.5% in 2009, which compares favorably to MSHA's only major competitor's (Wellmont Health System; rated 'BBB+' by Fitch) 29.5% market share.

MSHA has been investing significantly in its plant, which has totaled approximately 2 times (x) depreciation expense in fiscal 2009 and 2010. Major capital projects include three new replacement hospitals and an expansion of surgical space at the flagship facility. In July 2010, a new 80-bed facility opened (Franklin Woods Community Hospital), which replaced two of MSHA's existing facilities, North Side Hospital and Johnson City Specialty Hospital. The construction was under budget and the new hospital is expected to improve efficiency as a result of the consolidation of services on one campus and better location. The two other replacement facilities are for Johnston Memorial Hospital and Smyth County Community Hospital, which are expected to be completed by May 2011 and November 2011, respectively. MSHA's flagship facility, JCMC, will expand its surgical space with the construction of 16 new surgery suites (by 2013). A portion of this project is expected to be funded by \$45 million of additional debt in fiscal 2012. The high intensity of capital spending is expected through fiscal 2012 with capital commitments of \$99 million in fiscal 2011 and \$110 million in fiscal 2012, and is then expected to return to more moderate levels of approximately \$70 million-\$80 million a year. The main source of funding will be operating cash flow except for \$15 million of unspent bond proceeds and \$45 million of additional debt expected in fiscal 2012. Management's projections include rebuilding the balance sheet to 250 days cash on hand beginning in fiscal 2012.

As of Sept. 30, 2010 MSHA had \$554 million of unrestricted cash and investments, equating to a solid 231.5 days cash on hand, which compares very favorably to Fitch's 'BBB' category median of 122.2 days. Management's target is to maintain approximately 250 days cash on hand and any excess cash flow generated will be used to reduce its debt. MSHA's investment policy was revised in June 2010 and is conservative. The revised policy has allocated at least 110 days cash on hand in highly liquid fixed-income securities, and investments over the 110-day threshold would be invested in no more than 50% equities. Cash-to-debt of 53.6% at Sept. 30, 2010 compares unfavorably to the 'BBB' category median of 75.9% and is reflective of MSHA's sizeable debt load.

MSHA's operating performance in fiscal 2010 has shown improvement despite approximately \$6 million of accelerated depreciation expense. The operating margin improved to 1.7% compared to 0.8% in fiscal 2009 and 0.6% in fiscal 2008. Operating cash flow has consistently been outstanding and is one of the highest in Fitch's portfolio with a 14.8% annual average operating cash flow margin over the last five years compared to the 'BBB' category median of 8.7%. For the interim period (three months ended Sept. 30, 2010), operating performance is ahead of the prior year. Management expects further

opportunity for improvement as the Virginia facilities become better integrated into the system in addition to its initiatives related to health care reform.

Fitch's main credit concern is MSHA's sizeable debt load and fairly aggressive capital structure. Despite MSHA's strong operating cash flow, debt service coverage is adequate at 2.2x by EBITDA for fiscal 2010 compared to 1.8x in fiscal 2009 and Fitch's 'BBB' median of 2.5x. The only future new money debt plans include \$45 million in fiscal 2012, which has been factored into this rating action. Fitch expects MSHA to grow into its debt burden due to limited near-term acquisition activity, moderation of capital spending, and continued strong operating cash flow that should allow for liquidity growth and subsequently the paydown of some debt. Management has stated its intent to reduce its debt load and did pay off an additional \$12 million in capital leases and other debt in fiscal 2010.

MSHA's total outstanding debt is approximately \$1 billion with \$667 million underlying fixed-rate and \$375 million variable-rate demand obligations (VRDOs). The letters of credit (LOC) were successfully replaced in 2010 with three new banks and the agreements contained better covenants. The current LOCs expire in 2013 and the term-out provision under the agreements is three years. MSHA's outstanding swap portfolio includes a \$132 million fixed payor swap, \$438 million of basis swaps, and a \$224 million swaption. The total mark-to-market value of the portfolio was negative \$29.895 million as of Nov. 12, 2010 and MSHA was posting \$5.1 million of collateral (not including the swaption that has a related guaranteed investment contract [GIC] of approximately \$89 million). Management intends to terminate some or all of its fixed payor swaps when market conditions permit and the swaption is expected to terminate in July 2011 when MSHA has the right to terminate, which would result in the release of the GIC. Fitch views MSHA's capital structure as fairly aggressive especially for the rating level; however, Fitch believes its liquidity position as well as strong management and board oversight mitigates this risk.

MSHA recently adopted a new strategic plan that includes the development of an accountable care organization (ACO) to improve the delivery of care. Fitch views MSHA's progress in the ACO strategy favorably, and believes it should lead to lower costs and improved quality of care. MSHA has an integrated network identified and has been participating in various pilot programs (e.g. Premier). Mountain States Medical Group is a key part of the strategy and the number of employed physicians currently totals 230 and is expected to increase further.

The Stable Outlook is based on Fitch's expectation that MSHA will continue to generate strong operating cash flow to service its debt load and capital needs. Fitch expects that over time MSHA will continue to grow its liquidity, which should allow MSHA to reduce its leverage.

Headquartered in Johnson City, Tennessee, MSHA is a large regional health care system with 14 hospitals (1,789 licensed beds) and other related entities, primarily serving northeast Tennessee and southwest Virginia. MSHA has a ranging membership interest (50.1%-80%) in three of the most recent

additions to the system (Smyth County Community Hospital, Norton Community Hospital, Johnston Memorial Hospital). In fiscal 2010, MSHA had total operating revenue of \$944 million. MSHA covenants to provide annual and quarterly financial and operational disclosure to the nationally recognized municipal information securities repositories (NRMSIRS).

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Applicable Criteria and Related Research:

--'Revenue-Supported Rating Criteria', dated Oct. 8, 2010

--'Nonprofit Hospitals and Health Systems Rating Criteria', dated Dec. 29, 2009.

For information on Build America Bonds, visit 'www.fitchratings.com/BABs'.

Applicable Criteria and Related Research:

Revenue-Supported Rating Criteria (http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=564565)

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(http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=493186)

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Fitch Withdraws Underlying Rating on Mountain States Health Alliance, TN VRDBs

Fitch Ratings-New York-08 June 2011: Fitch Ratings withdraws the 'BBB+' unenhanced rating on the following variable rate demand bonds (VRDBs) issued on behalf of Mountain States Health Alliance, TN (Mountain States):

--Johnson City Health & Educational Facilities Board (TN) hospital revenue bonds series 2007B-1, 2007B-2, 2007B-3, and 2008A;

--Russell County Industrial Development Authority (VA) hospital revenue bonds series 2008B.

Fitch was not asked to provide ratings based on the letters of credit supporting these issues, and their unenhanced ratings are not considered by Fitch to be relevant to the agency's coverage of Mountain States.

Fitch's underlying rating for Mountain States' parity obligations remains 'BBB+' with a Stable Rating Outlook.

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Applicable Criteria and Related Research:

--'Revenue-Supported Rating Criteria', dated Oct. 8, 2010;

--'Nonprofit Hospitals and Health Systems Rating Criteria', dated Dec. 29, 2009.

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Fitch Affirms Mountain States Health Alliance (Tennessee) Revs at 'BBB+'; Outlook Stable

Fitch Ratings-New York-13 December 2011: Fitch Ratings affirms the 'BBB+' rating on Mountain States Health Alliance's (MSHA) outstanding debt, which is listed below.

The Rating Outlook is Stable.

SECURITY:

Pledged assets and a mortgage on Johnson City Medical Center and Sycamore Shoals Hospital. In addition, there is a debt service reserve fund on certain debt.

KEY RATING DRIVERS:

STRONG MARKET FOOTPRINT: MSHA is a 14-hospital system that covers a 29-county service area with a leading market position.

CONSISTENT STRONG OPERATING CASH FLOW: MSHA maintains excellent operating cash flow margins, which well exceed the median ratio for its rating level.

HIGH DEBT BURDEN: MSHA's high debt burden remains Fitch's main credit concern. Despite strong operating performance, debt service coverage is adequate for the rating level.

MODERATED CAPITAL SPENDING: After several years of heavy capital investment, a moderation in capital spending is expected beginning in fiscal 2013, which should facilitate further liquidity growth.

CREDIT PROFILE:

The rating affirmation reflects MSHA's continued solid financial performance. Good financial performance has been driven by MSHA's strong market position and focus on cost efficiencies. Upward movement of the rating is limited by its heavy debt burden.

MSHA was formed in 1998 from the acquisition of five hospitals in Tennessee from Columbia/HCA. Since that time, MSHA has grown to a 14-hospital system through several acquisitions from 2005-2009, which has extended MSHA's service area to Virginia. Management indicated that there are no future hospital acquisitions planned, especially since there are limited sole providers remaining in the service area. MSHA's acute inpatient market share in its 29-county service area was 36.8% in 2010, which compares favorably to MSHA's only major competitor's (Wellmont Health System; rated 'BBB+' by Fitch) 30.1% market share.

MSHA's operating performance in fiscal 2011 was in line with last year with an operating margin of 1.9% compared to 1.7% the prior year. Operating cash flow has consistently been outstanding and is one of the highest in Fitch's portfolio with a 15.7% operating EBITDA margin in fiscal 2011 compared to the 'BBB' category median of 8.5%. For the interim period (three months ended Sept. 30, 2011), operating performance is ahead of the prior year and the fiscal 2012 budget includes a 2.1% operating margin.

Solid operating performance has been driven by good volume and management's continued focus on cost initiatives, which include Lean practices. Management has been diligent in eliminating duplicative services and consolidating activities with the growth of the system. Management expects more opportunities for cost reductions as the Virginia facilities are further integrated into the system and brought onto a common information technology platform over the next several years.

As of Sept. 30, 2011 MSHA had \$514 million of unrestricted cash and investments, equating to a solid 208 days cash on hand, which compares very favorably to Fitch's 'BBB' category median of 128.6 days, although this is down from historical levels due to investment performance. Through the three months ended Sept. 30, 2011, MSHA had \$14 million of unrealized losses on investments.

MSHA's investment policy was revised in June 2010 and is conservative. The revised policy has allocated at least 110 days cash on hand in highly liquid fixed-income securities, and investments over the 110-day threshold would be invested in no more than 50% equities.

Cash-to-debt of 50% at Sept. 30, 2011 compares unfavorably to the 'BBB' category median of 79.8% and is reflective of MSHA's sizeable debt load. Management's target is to maintain approximately 250 days cash on hand and any excess cash flow generated will be used to reduce its debt.

Liquidity growth should be aided by a moderation of capital spending. MSHA has been investing significantly in its plant, which totaled approximately 2 times (x) depreciation expense the last three fiscal years. Major capital projects include three new replacement hospitals and an expansion of surgical space at the flagship facility.

Johnston Memorial Hospital's replacement facility opened in July 2011 and was completed within budget. The replacement facility for Smyth County Community Hospital is expected to open in spring 2012. The remaining major capital project is the expansion of surgical space (16 new surgery suites) at MSHA's flagship facility, Johnson City Medical Center. This project is expected to cost \$69 million and a portion will be funded by approximately \$45 million of additional debt sometime in calendar year 2012.

The high intensity of capital spending is expected to drop after fiscal 2012 with capital commitments of \$133 million in fiscal 2012, \$114 million in fiscal 2013 and \$70 million-\$80 million a year thereafter,

compared to \$173 million in fiscal 2011 and \$172 million in fiscal 2010.

Fitch's main credit concern is MSHA's sizeable debt load and fairly aggressive capital structure. Despite MSHA's strong operating cash flow, maximum annual debt service (MADS) coverage is adequate at 2x by operating EBITDA for fiscal 2011 compared to 1.8x in fiscal 2010 and Fitch's 'BBB' median of 2.3x. The only future new money debt plans include \$45 million in fiscal 2013, which should not impact MSHA's current rating level.

Fitch expects MSHA to grow into its debt burden due to limited near-term acquisition activity, moderation of capital spending, and continued strong operating cash flow that should allow for liquidity growth and subsequently the paydown of some debt.

MSHA's total outstanding debt is approximately \$1.1 billion with \$631.7 million underlying fixed-rate and \$484.2 million underlying variable-rate debt. Of the \$484.2 million of variable-rate debt, \$434.7 million are letter of credit (LOC) backed variable-rate demand obligations (VRDOs). The remaining variable-rate exposure is a five-year direct bank loan with SunTrust Bank.

Fitch views MSHA's debt profile as aggressive for its rating level due to its exposure to interest rate, put, remarketing, and renewal risk. All the LOCs (US Bank, PNC Bank, Mizuho Bank) expire on Oct. 19, 2014 and the term-out provision under the agreements is three years. However, unrestricted cash and investments to puttable debt was 1.2x as of Sept. 30, 2011 and the investments are liquid with 96% available within three days.

MSHA reduced its swap exposure with the termination of a swaption in October 2011 and also converted all of its fixed payor swaps to basis swaps, which should result in less mark-to-market volatility. As of Sept. 30, 2011, MSHA posted \$5.8 million of collateral.

One of MSHA's strategies includes being an accountable care organization (ACO) to improve the delivery of care. MSHA's ACO contracting entity, Integrated Solutions Health Network, is in place and will be ready to begin contracting with the federal government in July 2012. Management expects the ACO to facilitate the transformation of care, which should lead to lower costs and improved quality. Mountain States Medical Group is a key part of the strategy and the number of employed physicians currently totals 400 and is expected to increase further.

The Stable Outlook is based on Fitch's expectation that MSHA will continue to generate strong operating cash flow to service its debt load and capital needs. Fitch expects that over time MSHA will continue to grow its liquidity due to a moderation of capital spending, which should allow MSHA to reduce its leverage. Positive rating movement would be dependent on an improvement in debt metrics.

Headquartered in Johnson City, Tennessee, MSHA is a large regional health care system with 14

hospitals (1,789 licensed beds) and other related entities, primarily serving northeast Tennessee and southwest Virginia. MSHA has a ranging membership interest (50.1%-80%) in three of the hospitals in the system (Smyth County Community Hospital, Norton Community Hospital, Johnston Memorial Hospital). In fiscal 2011, MSHA had total operating revenue of \$976 million. MSHA covenants to provide annual and quarterly financial and operational disclosure to the nationally recognized municipal information securities repositories (NRMSIRS).

Outstanding debt:

--\$30,358,000 The Health and Educational Facilities Board of the City of Johnson City, Tennessee, hospital first mortgage revenue refunding bonds, series 2000A;
--\$34,325,000 The Health and Educational Facilities Board of the City of Johnson City, Tennessee, hospital first mortgage revenue bonds, series 2000C;
--\$14,790,000 Mountain States Health Alliance taxable note, series 2000D;
--\$23,100,000 The Health and Educational Facilities Board of the City of Johnson City, Tennessee, hospital first mortgage revenue bonds, series 2001A;
--\$169,630,000 The Health and Educational Facilities Board of the City of Johnson City, Tennessee, hospital first mortgage revenue bonds, series 2006A;
--\$5,560,000 The Health and Educational Facilities Board of the City of Johnson City, Tennessee, hospital revenue bonds, series 2009A;
--\$5,535,000 Industrial Development Authority of Smyth County hospital revenue bonds, series 2009B;
--\$115,955,000 Industrial Development Authority of Washington County Virginia, hospital revenue bonds, series 2009C.

Fitch Ratings has withdrawn its rating on the following bonds due to prerefunding activity:

--Johnson City Health & Educational Facilities Board (TN) (Mountain States Health Alliance) Hospital first mortgage revenue refunding bonds, series 2000B (insured: MBIA Insurance Corp.) (all maturities).

The correct rating history for the prerefunded CUSIPs is now reflected on Fitch's web site at 'www.fitchratings.com'.

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Applicable Criteria and Related Research:

--'Revenue-Supported Rating Criteria', dated June 20, 2011;

--'Nonprofit Hospitals and Health Systems Rating Criteria', dated Aug. 12, 2011.

For information on Build America Bonds, visit www.fitchratings.com/BABs.

Applicable Criteria and Related Research:Revenue-Supported Rating Criteria (http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=637130)

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Fitch Rates Mountain States Health Alliance, TN 2012 Revs 'BBB+'; Affirms Outstanding

Fitch Ratings-New York-14 August 2012: Fitch Ratings assigns a 'BBB+' to the following bonds expected to be issued on behalf of Mountain States Health Alliance (MSHA):

- \$54,900,000 The Health and Educational Facilities Board of the City of Johnson City, TN hospital revenue bonds, series 2012A;
- \$30,230,000 The Health and Educational Facilities Board of the City of Johnson City, TN hospital revenue bonds, series 2012B;
- \$9,785,000 Industrial Development Authority of Wise County, VA hospital revenue bonds, series 2012C.

In addition, Fitch affirms the 'BBB+' rating on MSHA's outstanding debt, which is listed at the bottom of this press release. Some of those ratings are underlying ratings. The Rating Outlook is Stable.

The 2012A bonds are expected to be issued as tax-exempt fixed-rate bonds and the series 2012B and 2012C bonds are expected to be issued as tax-exempt variable rate demand bonds. The 'BBB+' ratings on the series 2012B and 2012C bonds are underlying ratings, and Fitch expects to rate the 2012B and C bonds based on the letter of credit (LOC) support closer to the time of issuance. The 2012A bonds are expected to sell via negotiation the week of Aug. 20.

Proceeds from the series 2012 bonds will be used to fund the expansion of surgical suites at Johnson City Medical Center, fund projects at Norton Community Hospital (VA), reimburse MSHA for prior capital expenditures, and pay the cost of issuance. Maximum annual debt service (MADS), which was provided by the underwriter, increases to \$77.2 million from \$76.3 million. After issuance, MSHA will have approximately \$1.17 billion in outstanding debt, with 57% fixed rate and 43% variable.

SECURITY

The bonds are secured by pledged assets and a mortgage on Johnson City Medical Center and Sycamore Shoals Hospital. In addition, there is a debt service reserve fund on certain series of MSHA debt, but that is not expected for the series 2012 bonds.

KEY RATING DRIVERS

SOLID MARKET FOOTPRINT: MSHA is a 13-hospital system with a leading market position in a sizable 29 county service area.

CONSISTENTLY STRONG OPERATING CASH FLOW: MSHA maintains excellent operating cash flow margins that well exceed the median ratio for its rating level.

HIGH DEBT BURDEN: MSHA's high debt burden remains Fitch's main credit concern. Despite strong operating cash flow, debt service coverage is adequate for the rating level.

CAPITAL SPENDING TO SLOW: MSHA is nearing the end of a cycle of significant capital spending. The last large project remaining is a \$69 million expansion of the operating room suites at Johnson City Medical Center. Bond proceeds of \$55 million from the 2012 debt issuance, along with a cash contribution by MSHA, will pay for the expansion. There is a sizeable reduction in projected capital spending for fiscal 2014-2017, which should facilitate liquidity growth.

CREDIT PROFILE

Headquartered in Johnson City, Tennessee, MSHA was formed in 1998 from the acquisition of five hospitals in Tennessee from Columbia/HCA and has grown into a large regional health care system with 13 hospitals (1,623 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 2012 (June 30 year end; unaudited), MSHA had total operating revenue of \$996 million.

The rating affirmation reflects MSHA's continued sound operating performance. Unaudited fiscal 2012 results show a 1% operating margin, which was lower than last year's 1.9% operating margin. Operating cash flow remained very strong with a 13.2% operating EBITDA margin compared to the 'BBB' category median of 8.5%. While overall inpatient volumes held steady, the slightly lower operating performance partially reflects a shift of inpatient admissions away from surgical admissions, which affected budgeted revenues, but management's continued focus on cost initiatives, which include lean practices, helped sustain the operating performance. MSHA's fiscal 2013 budget is for a 2% operating margin.

MSHA's operating performance was further supported by its leading inpatient market share. MSHA's acute inpatient market share in its 29-county service area was 37.5% in 2011, which compares favorably to MSHA's only major competitor's (Wellmont Health System; rated 'BBB+' by Fitch) 29.7% market share.

As of June 30, 2012, MSHA had \$531.2 million of unrestricted cash and investments, equating to a

solid 214 days cash on hand, which compares very favorably to Fitch's 'BBB' category median of 128.6 days. Days cash on hand was down from the prior year due to a rise in accounts receivable (AR), higher operating expenses, and continued capital spending. MSHA attributes the rise in AR to a software conversion, which disrupted the processing of claims, but believes AR will normalize by calendar year end.

Cash-to-debt of 49.1% at June 30, 2012 compares unfavorably to the 'BBB' category median of 79.8% and is reflective of MSHA's sizeable debt load. Over the medium term, Fitch expects MSHA's liquidity to grow as capital spending moderates. MSHA has been investing significantly in its plant, which totaled approximately 2 times (x) depreciation expense the last three fiscal years. Major capital projects included three new replacement hospitals. The remaining major capital project is the expansion of surgical space (16 new surgery suites) at MSHA's flagship facility, Johnson City Medical Center.

The high intensity of capital spending is expected to drop after fiscal 2012 (\$134.8 million) with projected capital expenditures of \$118.5 million in fiscal 2013, \$74 million in fiscal 2014 and \$58 million in fiscal 2015.

Fitch's main credit concerns are MSHA's sizeable debt load and fairly aggressive capital structure. Despite MSHA's strong operating cash flow, maximum annual debt service (MADS) coverage for fiscal 2012 is adequate at 2.1x by EBITDA compared to 2.3x in fiscal 2011 and Fitch's 'BBB' median of 2.6x. MADS as a percentage of revenue is also elevated at 7.8% as of June 30, 2012, much higher than the 'BBB' median of 3.3%. Beyond the current \$65 million in new money, Fitch expects that MSHA's borrowing will slow as capital spending ebbs, which should provide some easing of the debt burden.

MSHA's pro forma total outstanding debt is approximately \$1.17 billion with \$674.5 million underlying fixed-rate and \$500.1 million underlying variable-rate debt. Of the \$500.1 million of variable rate debt, approximately \$456.8 million are LOC backed variable rate demand obligations. The remaining variable rate exposure is a five year direct bank loan with SunTrust Bank.

Fitch views MSHA's debt profile as aggressive for its rating level due to its exposure to interest rate, put, remarketing, and LOC renewal risk. The LOCs expire between October 2014 and September 2015 and the term-out provision under the agreements is three years. However, unrestricted cash and investments to puttable debt was just over 1x as of June 30, 2012 and the investments are liquid with 96% available within three days.

MSHA has approximately \$592.4 million in outstanding swaps, which are composed of basis swaps and constant maturity basis swaps. Bank of America is the sole counterparty on all of the swaps. The lack of counterparty diversity exposes MSHA to a higher level of counterparty risk. As of July 20, 2012, the aggregate mark to market of the swaps was negative \$11.1 million and no collateral is currently being posted.

Separately, MSHA is posting \$13.8 million on its swaps with Lehman for which MSHA has been negotiating a final termination payment. Fitch expects that the collateral posted will be adequate for the termination payment.

The Stable Outlook is based on Fitch's expectation that MSHA will continue to generate strong operating cash flow to service its debt load. Fitch expects that over time MSHA will continue to grow its liquidity due to a moderation of capital spending, which should allow MSHA to reduce its leverage. Positive rating movement would be dependent on an improvement in debt metrics.

MSHA has continued to move forward on its accountable care organization (ACO). MSHA's ACO contracting entity, Integrated Solutions Health Network (ISHN), is now a recognized ACO and was awarded a three and half year contract with the federal government. The Centers for Medicare and Medicaid Services is in the process of assigning ISHN 17,000 Medicare lives to manage.

MSHA covenants to provide annual and quarterly financial and operational disclosure to EMMA.

Outstanding rated debt:

The Health and Educational Facilities Board of the City of Johnson City, Tennessee:

- \$32,885,459 hospital first mortgage revenue refunding bonds, series 2000A;
- \$33,230,000 hospital first mortgage revenue bonds, series 2000C;
- \$22,300,000 hospital first mortgage revenue bonds, series 2001A;
- \$168,990,000 hospital first mortgage revenue bonds, series 2006A;
- \$5,560,000 hospital revenue bonds, series 2009A;
- \$5,535,000 Industrial Development Authority of Smyth County hospital revenue bonds, series 2009B;
- \$115,955,000 Industrial Development Authority of Washington County Virginia, hospital revenue bonds, series 2009C;
- \$14,315,000 Mountain States Health Alliance first mortgage bonds (taxable), series 2000D.

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Additional information is available at 'www.fitchratings.com'. The ratings above were solicited by, or on behalf of, the issuer, and therefore, Fitch has been compensated for the provision of the ratings.

In addition to the sources of information identified in Fitch's Rating Criteria, this action was additionally informed by information from BofA Merrill Lynch.

Applicable Criteria and Related Research:

--'Revenue-Supported Rating Criteria', June 12, 2012;
--'Nonprofit Hospitals and Health Systems Rating Criteria', July 23, 2012.

For information on Build America Bonds, visit www.fitchratings.com/BABs.

Applicable Criteria and Related Research:

Revenue-Supported Rating Criteria (http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=681015)

Nonprofit Hospitals and Health Systems Rating Criteria
(http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=683418)

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Fitch Rts Mountain States Health Alliance Hospital Rev Bonds, Series 2012B&C 'A-/F1'

Fitch Ratings-New York-12 September 2012: Fitch Ratings assigns ratings of 'A-/F1', Stable Outlook to the \$28,095,000 The Health and Educational Facilities Board of the City of Johnson City, Tennessee hospital revenue bonds (Mountain States Health Alliance) series 2012B and the \$9,785,000 Industrial Development Authority of Wise County (Virginia) hospital revenue bonds (Mountain States Health Alliance) series 2012C. The ratings are based on the support provided by two separate irrevocable direct-pay letters of credit (LOCs) issued by Mizuho Corporate Bank, Ltd., New York Branch (rated 'A-/F1', Stable Outlook) securing each series of bonds.

The bank is obligated to make regularly scheduled payments of principal of and interest on the bonds in addition to payments due upon maturity, acceleration and redemption, as well as purchase price for tendered bonds. The ratings will expire upon the earliest of: (a) Sept. 17, 2015, the stated expiration date of each respective LOC; (b) conversion to an interest rate other than the weekly rate mode; (c) any prior termination of each respective LOC; and (d) defeasance of the bonds. The LOCs provide full and sufficient coverage of principal plus an amount equal to 37 days of interest at a maximum rate of 12% based on a year of 365 days and purchase price for tendered bonds while in the weekly rate mode. The Remarketing Agent for the bonds is Merrill Lynch, Pierce, Fenner & Smith Incorporated. The bonds are expected to be delivered on or about Sept. 18, 2012.

The bonds initially bear interest at a weekly rate but may be converted to a medium-term or a fixed interest rate. While bonds are in the weekly rate mode, interest payments are on the first business day of each month, commencing Oct. 1, 2012. The trustee is obligated to make timely draws on the LOCs to pay principal, interest, and purchase price. Funds drawn under the LOCs are held uninvested, and are free from any lien prior to that of the bondholders.

Holders of the bonds may tender their bonds on any business day, provided the trustee is given the requisite prior notice of the purchase. The bonds are subject to mandatory tender: (1) upon conversion of the interest rate; and (2) upon expiration, substitution or termination of the LOC. The bonds shall be accelerated following trustee's receipt of notice of an event of default under the reimbursement agreement for each respective LOC. Optional and mandatory redemption provisions also apply to the bonds. There are no provisions for the issuance of additional bonds.

Bond proceeds will be loaned to the Mountain States Health Alliance (the Alliance) pursuant to separate loan agreements between each issuer and the Alliance and related entities. The proceeds will be used by the Alliance and related entities to: (i) refinance outstanding capital leases; (ii) finance capital improvements and equipment acquisitions at facilities owned by the Alliance and its affiliates; and (iii) pay certain expenses incurred in connection with the issuance of the series 2012B&C bonds.

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Additional information is available at www.fitchratings.com. The ratings above were solicited by, or on behalf of, the issuer, and therefore, Fitch has been compensated for the provision of the ratings.

Applicable Criteria and Related Research:

--'U.S. Municipal Structured Finance Criteria', Feb. 28, 2012;

--'Rating Guidelines for Letter of Credit-Supported Bonds', June 20, 2012.

Applicable Criteria and Related Research:

U.S. Municipal Structured Finance Criteria

(http://www.fitchratings.com/creditedesk/reports/report_frame.cfm?rpt_id=672570)

Rating Guidelines for Letter of Credit-Supported Bonds

(http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=681737)

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Fitch Affirms Mountain States Health Alliance (TN) Revs at 'BBB+'; Outlook Stable

Fitch Ratings-New York-23 July 2013: Fitch Ratings affirms the 'BBB+' rating on the following Health and Educational Facilities Board of the City of Johnson City, Tennessee, bonds issued on behalf of Mountain States Health Alliance (MSHA):

- \$55,000,000 hospital revenue bonds (Mountain States Health Alliance), series 2012A;
- \$28,095,000 hospital revenue bonds (Mountain States Health Alliance), series 2012B;
- \$5,490,000 hospital revenue bonds, series 2009A;
- \$168,345,000 hospital first mortgage revenue bonds, series 2006A;
- \$21,400,000 hospital first mortgage revenue bonds, series 2001A;
- \$32,431,000 hospital first mortgage revenue refunding bonds, series 2000A;
- \$32,040,000 hospital first mortgage revenue bonds, series 2000C.

In addition, Fitch affirms the following parity debt issued on behalf of MSHA:

- \$9,785,000 Industrial Development Authority of Wise County (Virginia) hospital revenue bonds (Mountain States Health Alliance), series 2012C;
- \$5,470,000 Industrial Development Authority of Smyth County hospital revenue bonds, series 2009B;
- \$113,655,000 Industrial Development Authority of Washington County Virginia, hospital revenue bonds, series 2009C;
- \$13,800,000 Mountain States Health Alliance taxable note, series 2000D.

The Rating Outlook is Stable.

SECURITY

Pledged assets and a mortgage on Johnson City Medical Center and Sycamore Shoals Hospital. In addition, there is a debt service reserve fund on certain series of debt.

KEY RATING DRIVERS

SOLID MARKET FOOTPRINT A CREDIT STRENGTH: MSHA is a 13-hospital system that covers a 29 county service area and maintains a leading 42% market share in its primary service area.

SUFFICIENT OPERATING CASH FLOW: MSHA maintains excellent operating EBITDA margins that well exceed the median ratios for the rating level.

HIGH DEBT BURDEN: MSHA's high debt burden remains Fitch's main credit concern. It pressures MSHA to maintain the strong cash flow levels in order to support debt service that has historically been adequate for the rating level.

MIXED LIQUIDITY INDICATORS: Through the four year historical period, cash and unrestricted investments have remained stable at above \$500 million, with good cash flow offset by high capital spending and a recent rise in accounts receivable. Through the four year historical period days cash on hand (DCOH) has been solid at over 200 days, with the debt liquidity metrics, cushion ratio and cash to debt weaker, again reflecting the higher debt burden.

CAPITAL SPENDING SLOWING: After several years of heavy capital investment (capital spending as a percent of depreciation averaged 195% a year over the last four years), a moderation of capital spending is expected beginning in fiscal 2014.

RATING SENSITIVITIES

WEAKER VOLUMES: MSHA has seen inpatient volumes trend down-a 5% drop in the nine month year-over-year (YOY) interim period, after lower volumes in fiscal 2012. MSHA has managed expenses and continues to initiate other efficiency and revenue measures, but Fitch is concerned about the long term volume trends and their impact on operating performance.

HEALTH CARE REFORM: MSHA is engaged in a handful of programs piloting different payment methods. In the past year, MSHA was involved in a Medicare ACO that reduced cost and inpatient utilization, and should result in an estimated \$5 million payment back to MSHA for shared savings. MSHA's ability to maintain the robust levels of cash flow needed to service its elevated debt burden is a key rating driver as these various programs evolve and grow in scale, rearranging both patient volumes and payment levels and methodologies.

CREDIT PROFILE

Headquartered in Johnson City, Tennessee, MSHA was formed in 1998 from the acquisition of five hospitals in Tennessee from Columbia/HCA and has grown into a large regional health care system with 13 hospitals (1,623 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 and Johnston Memorial Hospital). In fiscal 2012 (June 30 year end), MSHA had total operating revenue of \$996 million.

CONSISTENT OPERATING PERFORMANCE

The rating affirmation reflects MSHA's consistent operating performance.

Audited fiscal 2012 results show a 0.8% operating margin, which was lower than last year's 2.1% operating margin. Operating cash flow was stronger at 12.8%, an operating EBITDA margin better than Fitch's 'BBB' category median of 8.3%. Nine month interim results show a 0.2% operating margin and a 12.4% operating EBITDA margin, consistent with the year end performance and slightly better than the prior year nine month period. Inpatient volume was lower through the nine month interim period but MSHA is managing expenses, including a reduction in workforce, and operations were helped by \$16 million in federal meaningful use funds. However, a continued trend of lower inpatient admissions would be a credit concern.

ADEQUATE LIQUIDITY

As of March 31, 2013, MSHA had \$576 million of unrestricted cash and investments, equating to a solid 230.5 DCOH, which compares favorably to Fitch's 'BBB' category median of 138.9 days. Cash-to-debt of 51.2% at March 31, 2013, compares unfavorably to the 'BBB' category median of 82.7% and is reflective of MSHA's sizeable debt load. Over the medium term, Fitch expects MSHA's liquidity to grow as capital spending moderates.

CAPITAL SPENDING ABATING

MSHA has been investing significantly in its plant, which totaled approximately 2 times (x) depreciation expense the last three fiscal years. Major capital projects included three new replacement hospitals. The remaining major capital project is the expansion of surgical space (16 new surgery suites) at MSHA's flagship facility, Johnson City Medical Center. The high intensity of capital spending is expected to drop after fiscal 2012 (\$132.9 million) with projected capital expenditures of \$118.5 million in fiscal 2013, \$90 million in fiscal 2014 and \$50 million in fiscal 2015.

HIGH DEBT BURDEN

Fitch's main credit concerns are MSHA's sizeable debt load and fairly aggressive capital structure. Despite MSHA's strong operating cash flow, maximum annual debt service (MADS) coverage for fiscal 2012 is adequate at 2.1x by EBITDA compared to Fitch's 'BBB' median of 2.8x. MADS as a percentage of revenue is also elevated at 7.4% as of June 30, 2012, much higher than the 'BBB' median of 3.3%. However, MSHA is restructuring much of its variable rate debt, and, once complete, MADS is expected to lower to \$70.2 million from \$73.3 million (MADS does not include Johnson Memorial Hospital debt which is outside the obligated group).

DEBT STRUCTURE RISKS

At March 31, 2013, MSHA's total outstanding debt was approximately \$1.1 billion with \$695.8 million underlying fixed-rate and \$433.2 million underlying variable-rate debt. The vast majority of the variable rate debt is LOC backed variable rate demand obligations. MSHA is in the process of restructuring much of this variable rate debt. With the restructuring, MSHA plans to diversify into direct bank

placement debt, as well as stagger the expiration dates of the LOCs to reduce risk. Fitch was not asked to provide an underlying long term rating to these variable rate debt series.

In spite of the MSHA's risk mitigation on its variable rate debt, Fitch continues to view MSHA's debt profile as aggressive for its rating level due to its exposure to interest rate, put, remarketing, and LOC renewal risk. Unrestricted cash and investments to puttable debt was just over 1x as of March 31, 2013 and the investments are liquid with 96% available within three days.

MSHA has approximately \$597.1 million in outstanding swaps, which are composed of basis swaps and constant maturity basis swaps. Bank of America is the counterparty for all but \$5 million of the swaps. The lack of counterparty diversity exposes MSHA to a higher level of counterparty risk. As of April 30, 2013, the aggregate mark to market of the swaps was a negative \$1.8 million and no collateral is currently being posted. Additionally, a swap that MSHA had with Lehman has been settled with MSHA paying out less than it had reserved.

DISCLOSURE

MSHA covenants to provide annual and quarterly financial and operational disclosure to EMMA.

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In addition to the sources of information identified in Fitch's Rating Criteria, this action was additionally informed by information from BofA Merrill Lynch.

Applicable Criteria and Related Research:

--Revenue-Supported Rating Criteria, June 3, 2013;

--U.S. Nonprofit Hospitals and Health Systems Rating Criteria, May 20, 2013.

Applicable Criteria and Related Research:

Revenue-Supported Rating Criteria (http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=709499)

U.S. Nonprofit Hospitals and Health Systems Rating Criteria

(http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=708361)

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Fitch Affirms Mountain States Health Alliance (TN) Revs at 'BBB+'; Outlook Stable

Fitch Ratings-New York-12 February 2014: Fitch Ratings affirms the 'BBB+' rating on the following Health and Educational Facilities Board of the City of Johnson City, Tennessee, bonds issued on behalf of Mountain States Health Alliance (MSHA):

- \$55,000,000 hospital revenue bonds (Mountain States Health Alliance), series 2012A;
- \$5,415,000 hospital revenue bonds, series 2009A;
- \$167,730,000 hospital first mortgage revenue bonds, series 2006A;
- \$20,400,000 hospital first mortgage revenue bonds, series 2001A;
- \$34,645,000 hospital first mortgage revenue refunding bonds, series 2000A;
- \$30,750,000 hospital first mortgage revenue bonds, series 2000C.

In addition, Fitch affirms the following parity debt issued on behalf of MSHA:

- \$5,400,000 Industrial Development Authority of Smyth County hospital revenue bonds, series 2009B;
- \$111,265,000 Industrial Development Authority of Washington County Virginia, hospital revenue bonds, series 2009C;
- \$13,245,000 Mountain States Health Alliance taxable note, series 2000D.

The Rating Outlook is Stable.

SECURITY

Pledged assets and a mortgage on Johnson City Medical Center and Sycamore Shoals Hospital. In addition, there is a debt service reserve fund on certain series of debt.

KEY RATING DRIVERS

SOFTER FY2013 OPERATING PERFORMANCE: Net patient service revenue fell 2% year over year, which led to a drop in MSHA's operating margin to 1.1% from 1.7%. The weaker performance was driven by lower inpatient volumes and a continued rise in observation days.

OPERATING CASH FLOW SUFFICIENT: In spite of the weaker operating margin, MSHA's operating

EBITDA margin remained steady at 13.2%, exceeding Fitch's 'BBB' category median of 9.9%.

HIGH DEBT BURDEN: MSHA's high debt burden remains a key credit concern. It pressures MSHA to maintain the strong cash flow levels in order to support debt service that has historically been adequate for the rating level.

MARKET FOOTPRINT A CREDIT STRENGTH: MSHA is a 14-hospital system that covers a 29 county service area and maintains a leading 53% market share in its primary service area.

MIXED LIQUIDITY INDICATORS: Through the four-year historical period days cash on hand (DCOH) has been solid at over 200 days; however, liquidity metrics relative to debt (cushion ratio and cash to debt) are weaker reflecting the elevated debt burden.

CAPITAL SPENDING SLOWING: After several years of heavy capital investment, a moderation of capital spending is expected beginning in fiscal 2014, which should provide MSHA with a measure of financial flexibility.

RATING SENSITIVITIES

THINNER OPERATING PERFORMANCE: MSHA has been challenged by lower inpatient volume, which has eroded its operating margin. While first quarter volumes are still down year over year, patient service revenue is up along with inpatient surgery volumes. Additionally, MSHA continues to aggressively manage expenses, but a further erosion of its operating margin could lead to negative rating pressure.

REFORM INITIATIVES: MSHA has made material investments in positioning the organization for health care reform. These initiatives include starting up a health plan, forming a Medicare ACO, and increasing physician engagement across the organization. A key for MSHA will be its ability to realize a financial return on these strategies after the initial investment for these initiatives.

CREDIT PROFILE

Headquartered in Johnson City, Tennessee, MSHA was formed in 1998 from the acquisition of five hospitals in Tennessee from Columbia/HCA and has grown into a large regional health care system with 14 hospitals (1,623 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 2013 (June 30 year end), MSHA had total operating revenue of \$1 billion.

At the end of calendar year 2013, MSHA's long serving CEO retired and a new CEO started. Fitch

views the transition as a credit neutral. The retirement was planned in advance, providing MSHA ample time to undertake a thorough search. The new CEO, whom Fitch met with, has extensive industry background, including most recently managing a group of hospitals at a for profit health care organization.

Softer FY13 Performance

From fiscal 2012 to fiscal 2013, MSHA's operating margin fell to 1.1% from 1.7%. The drop in operating performance was driven by a decline in inpatient volume coupled with a rise in observation days, especially at its main tertiary hospital, Johnson City Medical Center (JCMC). In fiscal 2013, JCMC's inpatient volume declined 6.4% from the prior year (compared to a system decline of 5%), while observation days, which are reimbursed at a lower rate than inpatient days, increased 6.2% at both JCMC and across the system.

The lower inpatient volumes led to a year over year decline in net patient service revenue, which declined 4.8% at JCMC (JCMC accounts for approximately 51% of MSHA's patient service revenue) and 2% system wide. Total operating revenue at MSHA did increase but was helped by an additional \$17 million of federal meaning full use funds in fiscal 2013.

As a result, in fiscal 2013, system operating income fell to \$11.5 million from \$16.9 million in fiscal 2012. MSHA is budgeting for an operational improvement in fiscal 2014. To achieve this, MSHA has a strategy to address observation stays through improved physician documentation and physician education and is also implementing cost reductions, including a recent layoff of 161 full-time equivalents. MSHA continues to manage expenses through its LEAN practices as well.

First quarter performance is generally the weakest quarter and in the first quarter of 2014, MSHA operating margin was negative 1.6%, an improvement from a negative 2.6% in the first quarter of fiscal 2013. As important, net patient service revenue grew year over year. Fitch believes that MSHA will be able sustain the rate of operating improvement through the rest of the fiscal year.

Also helping to mitigate the operating margin concerns is MSHA's operating EBITDA, which has remained above category medians. In fiscal 2013, MSHA's operating EBITDA was 13.2%, and it was 11.1% in first quarter 2014, both above the category median of 9%.

HIGH DEBT BURDEN/CAPITAL SPENDING ABATING

MSHA's debt burden is elevated for the rating level and puts added pressure on MSHA to sustain solid cash flow. Both maximum annual debt service (MADS) as a percent of revenue at 7.6% and debt to EBITDA of 9.1x are significantly higher than Fitch's 'BBB' category medians of 3.5% and 3.8x, respectively. MADS coverage by EBITDA in fiscal 2013 was an adequate 2.1x, compared to a median of 3.1x.

However, MSHA is ending an extended period of intense capital investment. Over the last six years, capital spending averaged approximately 180% of depreciation relative to a median of 110.1%. Major capital projects completed over this time include the building of three replacement hospitals. Moving forward, Fitch expects MSHA's capital spending to reduce to a more manageable level, closer to 100% of depreciation. This should help ease MSHA's leveraged position and provide a measure of financial flexibility as MSHA's works to improve operations.

ADEQUATE LIQUIDITY

As of Sept. 30, 2013, MSHA had \$606.3 million of unrestricted cash and investments, equating to a solid 244.6 days cash on hand, which compares favorably to Fitch's 'BBB' category median of 144.7 days. Cash-to-debt of 54.7% compared unfavorably to the 'BBB' category median of 91.7% and also reflects MSHA's sizeable debt load. Unrestricted cash and investments have grown approximately 14% since fiscal year end 2012, when it was at \$531.2 million.

DEBT STRUCTURE

Fitch continues to view MSHA's debt structure as aggressive relative to its rating level, with a number of swaps and approximately \$425 million in variable rate debt. In the last year, MSHA did restructure most of its variable rate debt to mitigate some of the put, renewal, and remarketing risk. Prior to the restructuring, the vast majority of MSHA's variable debt was supported by bank letters of credit (LOCs), with the LOCs expiring on the same date for approximately \$400 million of the debt.

Post-restructuring, MSHA directly placed about half of the variable rate debt (\$211 million) with three different banks, removing near-term put and remarketing risk for that debt. MSHA also negotiated to stagger the timing of the mandatory put dates for the private placements and the expiration dates on the LOCs. These dates now range from three to 10 years, with a maximum amount of debt coming due on any single date at a much more manageable level of \$192 million. Fitch views these changes positively.

MSHA's total outstanding long term debt is approximately \$1.1 billion with approximately 58% fixed rate and 42% variable. MSHA has approximately \$570 million in outstanding swaps, which are composed of basis swaps and constant maturity basis swaps. Bank of America is the counterparty for all of the swaps. The lack of counterparty diversity exposes MSHA to a higher level of counterparty risk. As of November 30, 2013, the aggregate mark to market of the swaps was a negative \$14.1 million. No collateral is currently being posted for the swaps.

DISCLOSURE

MSHA covenants to provide annual and quarterly financial and operational disclosure to EMMA.

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Additional information is available at 'www.fitchratings.com'.

Applicable Criteria and Related Research:

--'U.S. Nonprofit Hospitals and Health Systems Rating Criteria' (May 20, 2013).

Applicable Criteria and Related Research:

U.S. Nonprofit Hospitals and Health Systems Rating Criteria
(http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=708361)

Additional Disclosure

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Fitch Affirms Mountain States Health Alliance (TN) Revs at 'BBB+'; Outlook Stable

Ratings Endorsement Policy
12 Feb 2014 2:23 PM (EST)

Fitch Ratings-New York-12 February 2014: Fitch Ratings affirms the 'BBB+' rating on the following Health and Educational Facilities Board of the City of Johnson City, Tennessee, bonds issued on behalf of Mountain States Health Alliance (MSHA):

- \$55,000,000 hospital revenue bonds (Mountain States Health Alliance), series 2012A;
- \$5,415,000 hospital revenue bonds, series 2009A;
- \$167,730,000 hospital first mortgage revenue bonds, series 2006A;
- \$20,400,000 hospital first mortgage revenue bonds, series 2001A;
- \$34,645,000 hospital first mortgage revenue refunding bonds, series 2000A;
- \$30,750,000 hospital first mortgage revenue bonds, series 2000C.

In addition, Fitch affirms the following parity debt issued on behalf of MSHA:

- \$5,400,000 Industrial Development Authority of Smyth County hospital revenue bonds, series 2009B;
- \$111,265,000 Industrial Development Authority of Washington County Virginia, hospital revenue bonds, series 2009C;
- \$13,245,000 Mountain States Health Alliance taxable note, series 2000D.

The Rating Outlook is Stable.

SECURITY

Pledged assets and a mortgage on Johnson City Medical Center and Sycamore Shoals Hospital. In addition, there is a debt service reserve fund on certain series of debt.

KEY RATING DRIVERS

SOFTER FY2013 OPERATING PERFORMANCE: Net patient service revenue fell 2% year over year, which led to a drop in MSHA's operating margin to 1.1% from 1.7%. The weaker performance was driven by lower inpatient volumes and a continued rise in observation days.

OPERATING CASH FLOW SUFFICIENT: In spite of the weaker operating margin, MSHA's operating EBITDA margin remained steady at 13.2%, exceeding Fitch's 'BBB' category median of 9.9%.

HIGH DEBT BURDEN: MSHA's high debt burden remains a key credit concern. It pressures MSHA to maintain the strong cash flow levels in order to support debt service that has historically been adequate for the rating level.

MARKET FOOTPRINT A CREDIT STRENGTH: MSHA is a 14-hospital system that covers a 29 county service area and maintains a leading 53% market share in its primary service area.

MIXED LIQUIDITY INDICATORS: Through the four-year historical period days cash on hand (DCOH) has been solid at over 200 days; however, liquidity metrics relative to debt (cushion ratio and cash to debt) are weaker reflecting the elevated debt burden.

CAPITAL SPENDING SLOWING: After several years of heavy capital investment, a moderation of capital spending is expected beginning in fiscal 2014, which should provide MSHA with a measure of financial flexibility.

RATING SENSITIVITIES

THINNER OPERATING PERFORMANCE: MSHA has been challenged by lower inpatient volume, which has eroded its operating margin. While first quarter volumes are still down year over year, patient service revenue is up along with inpatient surgery volumes. Additionally, MSHA continues to aggressively manage expenses, but a further erosion of its operating margin could lead to negative rating pressure.

REFORM INITIATIVES: MSHA has made material investments in positioning the organization for health care reform. These initiatives include starting up a health plan, forming a Medicare ACO, and increasing physician engagement across the organization. A key for MSHA will be its ability to realize a financial return on these strategies after the initial investment for these initiatives.

CREDIT PROFILE

Headquartered in Johnson City, Tennessee, MSHA was formed in 1998 from the acquisition of five hospitals in Tennessee from Columbia/HCA and has grown into a large regional health care system with 14 hospitals (1,623 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 2013 (June 30 year end), MSHA had total operating revenue of \$1 billion.

At the end of calendar year 2013, MSHA's long serving CEO retired and a new CEO started. Fitch views the transition as a credit neutral. The retirement was planned in advance, providing MSHA ample time to undertake a thorough search. The new CEO, whom Fitch met with, has extensive industry background, including most recently managing a group of hospitals at a for profit health care organization.

Softer FY13 Performance

From fiscal 2012 to fiscal 2013, MSHA's operating margin fell to 1.1% from 1.7%. The drop in operating performance was driven by a decline in inpatient volume coupled with a rise in observation days, especially at its main tertiary hospital, Johnson City Medical Center (JCMC). In fiscal 2013, JCMC's inpatient volume declined 6.4% from the prior year (compared to a system decline of 5%), while observation days, which are reimbursed at a lower rate than inpatient days, increased 6.2% at both JCMC and across the system.

The lower inpatient volumes led to a year over year decline in net patient service revenue, which declined 4.8% at JCMC (JCMC accounts for approximately 51% of MSHA's patient service revenue) and 2% system wide. Total operating revenue at MSHA did increase but was helped by an additional \$17 million of federal meaning full use funds in fiscal 2013.

As a result, in fiscal 2013, system operating income fell to \$11.5 million from \$16.9 million in fiscal 2012. MSHA is budgeting for an operational improvement in fiscal 2014. To achieve this, MSHA has a strategy to address observation stays through improved physician documentation and physician education and is also implementing cost reductions, including a recent layoff of 161 full-time equivalents. MSHA continues to manage expenses through its LEAN practices as well.

First quarter performance is generally the weakest quarter and in the first quarter of 2014, MSHA operating margin was negative 1.6%, an improvement from a negative 2.6% in the first quarter of fiscal 2013. As important, net patient service revenue grew year over year. Fitch believes that MSHA will be able sustain the rate of operating improvement through the rest of the fiscal year.

Also helping to mitigate the operating margin concerns is MSHA's operating EBITDA, which has remained above category medians. In fiscal 2013, MSHA's operating EBITDA was 13.2%, and it was 11.1% in first quarter 2014, both above the category median of 9%.

HIGH DEBT BURDEN/CAPITAL SPENDING ABATING

MSHA's debt burden is elevated for the rating level and puts added pressure on MSHA to sustain solid cash flow. Both maximum annual debt service (MADS) as a percent of revenue at 7.6% and debt to EBITDA of 9.1x are significantly higher than Fitch's 'BBB' category medians of 3.5% and 3.8x, respectively. MADS coverage by EBITDA in fiscal 2013 was an adequate 2.1x, compared to a median of 3.1x.

However, MSHA is ending an extended period of intense capital investment. Over the last six years, capital spending averaged approximately 180% of depreciation relative to a median of 110.1%. Major capital projects completed over this time include the building of three replacement hospitals. Moving forward, Fitch expects MSHA's capital spending to reduce to a more manageable level, closer to 100% of depreciation. This should help ease MSHA's leveraged position and provide a measure of financial flexibility as MSHA works to improve operations.

ADEQUATE LIQUIDITY

As of Sept. 30, 2013, MSHA had \$606.3 million of unrestricted cash and investments, equating to a solid 244.6 days cash

on hand, which compares favorably to Fitch's 'BBB' category median of 144.7 days. Cash-to-debt of 54.7% compared unfavorably to the 'BBB' category median of 91.7% and also reflects MSHA's sizeable debt load. Unrestricted cash and investments have grown approximately 14% since fiscal year end 2012, when it was at \$531.2 million.

DEBT STRUCTURE

Fitch continues to view MSHA's debt structure as aggressive relative to its rating level, with a number of swaps and approximately \$425 million in variable rate debt. In the last year, MSHA did restructure most of its variable rate debt to mitigate some of the put, renewal, and remarketing risk. Prior to the restructuring, the vast majority of MSHA's variable debt was supported by bank letters of credit (LOCs), with the LOCs expiring on the same date for approximately \$400 million of the debt.

Post-restructuring, MSHA directly placed about half of the variable rate debt (\$211 million) with three different banks, removing near-term put and remarketing risk for that debt. MSHA also negotiated to stagger the timing of the mandatory put dates for the private placements and the expiration dates on the LOCs. These dates now range from three to 10 years, with a maximum amount of debt coming due on any single date at a much more manageable level of \$192 million. Fitch views these changes positively.

MSHA's total outstanding long term debt is approximately \$1.1 billion with approximately 58% fixed rate and 42% variable. MSHA has approximately \$570 million in outstanding swaps, which are composed of basis swaps and constant maturity basis swaps. Bank of America is the counterparty for all of the swaps. The lack of counterparty diversity exposes MSHA to a higher level of counterparty risk. As of November 30, 2013, the aggregate mark to market of the swaps was a negative \$14.1 million. No collateral is currently being posted for the swaps.

DISCLOSURE

MSHA covenants to provide annual and quarterly financial and operational disclosure to EMMA.

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Applicable Criteria and Related Research:

--'U.S. Nonprofit Hospitals and Health Systems Rating Criteria' (May 20, 2013).

Applicable Criteria and Related Research:

U.S. Nonprofit Hospitals and Health Systems Rating Criteria

Additional Disclosure

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Fitch Affirms Mountain States Health Alliance (TN) Revs at 'BBB+'; Outlook Stable

Fitch Ratings-New York-11 February 2015: Fitch Ratings affirms its 'BBB+' rating on Health and Educational Facilities Board of the City of Johnson City, Tennessee, revenue bonds issued on behalf of Mountain States Health Alliance (MSHA) and the parity debt issued on behalf of MSHA listed at the end of the press release:

The Rating Outlook is Stable.

SECURITY

Bonds are secured by pledged assets and a mortgage on Johnson City Medical Center and Sycamore Shoals Hospital. In addition, there is a debt service reserve fund on certain series of debt.

KEY RATING DRIVERS

STRONG PROFITABILITY FROM CORE OPERATIONS: Despite a slight erosion in operating EBITDA margins since fiscal 2011, MSHA's operating EBITDA of 11.8% in fiscal 2014 well exceeds the 'BBB' category median of 7.9%. Through the first quarter ended September 30, (1Q'15) MSHA posted an improved 1.8% operating margin and 12.9% operating EBITDA margin compared to the prior year period.

IMPROVED MANAGEMENT PRACTICES: Fitch believes the new CEO, who started in FY2014, has had a positive impact on performance by instituting a variety of changes and initiatives designed to leverage MSHA's credit strengths and maximize the return on system assets. MSHA is budgeting for a 2.7% operating margin in FY2015, which Fitch believes is achievable.

HIGH DEBT BURDEN: MSHA's debt burden remains a key credit concern which allows little room for erosion in MSHA's strong historical profitability. Maximum annual debt service (MADS) as a percent of revenue at 7% and debt-to-EBITDA of 7.6x are significantly higher than Fitch's 'BBB' category medians of 3.6% and 3.9x, respectively. MADS coverage by EBITDA in FY2014 was an adequate 2.1x, compared to a median of 2.6x.

MIXED LIQUIDITY METRICS: Days cash on hand (DCOH) has averaged 240 through the four-year historical period, in line with management's target and good for the rating level. However, liquidity metrics relative to debt (cushion ratio and cash-to-debt) are weaker, reflecting the elevated debt burden.

RATING SENSITIVITIES

DELEVERAGING PLAN VIEWED POSITIVELY: Management has stated its intent to reduce its leverage position beginning in fiscal 2015. MSHA has developed a plan to pay down roughly \$350 million of debt (above the \$177.4 million of amortizing principal payments) from FY2016 through FY2022 through excess cash flow. The debt reduction plan would mitigate MSHA's debt burden, which continues to be a major credit concern for Fitch. At Sept. 30, 2014, MADS was a very high 7% of revenue relative to a median of 3.6%.

CONTINUED STRONG PERFORMANCE: Sustained strong profitability - MSHA is projecting higher operating margins over the next five years - combined with manageable capital plans and execution of the system's deleveraging plans would likely result in positive rating momentum. Conversely, a material compression of historical operating performance over the near term could pressure the rating.

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 (1,671 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 FY2014 (June 30 year-end), MSHA had total operating revenue of \$1 billion.

STRONGER 2015 PERFORMANCE AFTER SOFT 2014

Fiscal performance has rebounded in 1Q'15 from the year prior. Admissions in the interim period were up 8.2% from the year prior, which led to net patient revenue growth of 5.8% year-over-year (YOY). The system posted a 1.8% operating margin through 1Q'15 which is improved from the negative 1.6% generated in the prior year. Management is projecting improved performance in FY2015 compared to FY2014, which will include the impact of an estimated \$4 million in supply chain savings, as well as the reestablishment of a contract with Cigna, effective October 2014. MSHA had been out of network with Cigna for almost three years, which impacted revenues in FY2012 to FY2014. Longer-term initiatives, around physician recruitment, service line enhancement, quality, safety, patient satisfaction, and efficiencies, should help sustain the improved operating performance.

Operating margin declined to 0.2% in FY2014 from 1.1% in FY2013 reflecting the impact of a shift from

inpatient admissions to observation stays. YOY acute admissions fell by 1.8% from FY2013 to FY2014, while observation stays increased 2.8%. However, Fitch notes system financial performance improved in the latter half of the fiscal year and that momentum has continued into FY2015.

Operating cash flow remains strong, which is key to maintaining the rating because of MSHA's high debt burden. In FY2014, operating EBITDA weakened YOY to 11.8% from 13.2%, but was strong relative to category median of 7.9%. Through 1Q'15, operating EBITDA was 12.9%; an improvement from 11.1% in the prior year period.

Strong 1Q'15 performance was driven by strong admissions growth in MSHA's northeast market, where admissions grew over 11% YOY to 2,969, and net patient revenue was up 6.7%. Improvements were offset somewhat by weakness in the northwest and southeast markets. System-wide observation cases declined 1.8% YOY, following MSHA's efforts relative to clinical documentation. Additionally, cost-containment measures begun in FY2014, such as a 6% reduction in workforce and continued Lean processes, appear to have borne fruit.

HIGH DEBT LOAD

MSHA's debt burden is elevated for the rating level which puts added pressure on it to sustain its strong cash flow. Both MADS as a percent of revenue at 7% and debt-to-EBITDA of 7.6x are significantly higher than Fitch's 'BBB' respective category medians of 3.6% and 3.9x. MADS coverage by EBITDA in FY2014 was an adequate 2.1x, compared to the median of 2.6x.

DELEVERAGING PLAN CREDIT POSITIVE

Management has stated its intention to reduce its high debt burden (60.5% debt-to-capitalization in 2014) through 2022 by using excess operations cash flow to prepay outstanding debt. The deleveraging plan follows an extended period of intense capital spending, which averaged 180% of depreciation in the six years leading up to 2013.

Management is targeting a 43% debt-to-capitalization ratio in 2019 while maintaining liquidity of at least 250 DCOH as part of its deleveraging plan. These efforts feature a good degree of flexibility should operational performance become pressured or capital needs increase from current lower projections. MSHA's capital spending is projected at a more manageable level, closer to 100% of depreciation. Fitch views positively management's plan to lower its debt burden and thus mitigate a key credit concern.

AGGRESSIVE DEBT PROFILE

Fitch continues to view MSHA's debt structure as aggressive relative to its rating level, with a number of swaps and approximately \$473 million in variable rate debt representing 42% of MSHA's total outstanding long-term debt. Roughly half of the variable rate debt (\$211 million) is privately placed with three different banks, and put dates for the private placements and letters of credit are adequately staggered. The maximum amount of debt coming due on any single day is a manageable \$106 million

in July 2018.

MSHA's outstanding swaps have a notional amount of \$590 million, composed of basis swaps, constant maturity basis swaps, and total return swaps. Bank of America is the counterparty for all of the swaps, elevating counterparty risk. As of Nov. 24, 2014, the aggregate mark-to-market of the swaps was a negative \$12.2 million. No collateral is currently being posted for the swaps.

ADEQUATE LIQUIDITY

As of Sept. 30, 2014, MSHA had \$645.6 million of unrestricted cash and investments, equating to a solid 252 DCOH, which compares favorably to Fitch's 'BBB' category median of 145 days. Cash-to-debt of 59.6% compared unfavorably to the 'BBB' category median of 93.6%, reflecting MSHA's sizeable debt load. Positively, unrestricted cash and investments continue to grow, up 21.5% since 2012, when it was at \$531.2 million (representing 212 DCOH).

DISCLOSURE

MSHA covenants to provide annual and quarterly financial and operational disclosure to EMMA.

Fitch affirms the following debt:

- \$55,000,000 hospital revenue bonds (Mountain States Health Alliance), series 2012A;
- \$5,415,000 hospital revenue bonds, series 2009A;
- \$167,730,000 hospital first mortgage revenue bonds, series 2006A;
- \$20,400,000 hospital first mortgage revenue bonds, series 2001A;
- \$34,645,000 hospital first mortgage revenue refunding bonds, series 2000A;
- \$30,750,000 hospital first mortgage revenue bonds, series 2000C.

In addition, Fitch affirms the following parity debt issued on behalf of MSHA:

- \$5,400,000 Industrial Development Authority of Smyth County hospital revenue bonds, series 2009B;
- \$111,265,000 Industrial Development Authority of Washington County Virginia, hospital revenue bonds, series 2009C;
- \$13,245,000 Mountain States Health Alliance taxable note, series 2000D.

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Applicable Criteria and Related Research:

--'Nonprofit Hospitals and Health Systems Rating Criteria', dated May 30, 2014.

Applicable Criteria and Related Research:

U.S. Nonprofit Hospitals and Health Systems Rating Criteria
(http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=746860)

Additional Disclosure

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Fitch Places Mountain States Health Alliance (TN) Revs on Rating Watch Evolving

Fitch Ratings-New York-06 April 2015: Fitch Ratings has placed on Rating Watch Evolving the 'BBB+' rating for Health and Educational Facilities Board of the City of Johnson City, Tennessee, revenue bonds issued on behalf of Mountain States Health Alliance (MSHA) and parity debt issued on behalf of MSHA listed at the end of the press release.

SECURITY

Bonds are secured by pledged assets and a mortgage on Johnson City Medical Center and Sycamore Shoals Hospital. In addition, there is a debt service reserve fund on certain series of debt.

KEY RATING DRIVERS

MERGER ANNOUNCEMENT: Fitch has placed MSHA's 'BBB+' rating on rating watch evolving due the announcement that MSHA and Wellmont (general revenue bonds rated 'BBB+') have signed an agreement to explore a merger. The announcement states that the two organizations are exploring a plan to combine assets and operations to form a new integrated health care system that will include a combined board.

UNDERTAKING DUE DILIGENCE: The organizations plan to enter a period of due diligence, which is expected to conclude by July or August of 2015, and then submit a Certificate of Public Advantage to the Tennessee and a similar application to Virginia by the end of August seeking approval of a merger. Fitch will take rating action at the appropriate time as the process unfolds and clarifying details emerge on the new health system.

RECENT RATING AFFIRMATION: For more information on MSHA see Fitch's press release 'Fitch Affirms Mountain States Health Alliance (TN) Revs at 'BBB+'; Outlook Stable' dated Feb. 11, 2015.

RATING SENSITIVITIES

COMPLETION OF PENDING TRANSACTION: Resolution of the rating watch will be tied to the completion of the pending transaction and the treatment of MSHA's debt 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 (1,671 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 2014 (June 30 year end), MSHA had total operating revenue of \$1 billion.

RATED DEBT

--\$55,000,000 hospital revenue bonds (Mountain States Health Alliance) series 2012A;
--\$5,415,000 hospital revenue bonds series 2009A;
--\$167,730,000 hospital first mortgage revenue bonds series 2006A;
--\$20,400,000 hospital first mortgage revenue bonds series 2001A;
--\$34,645,000 hospital first mortgage revenue refunding bonds series 2000A;
--\$30,750,000 hospital first mortgage revenue bonds series 2000C.

In addition, Fitch places the 'BBB+' rating on the following parity debt issued on behalf of MSHA on Rating Watch Evolving:

--\$5,400,000 Industrial Development Authority of Smyth County hospital revenue bonds series 2009B;
--\$111,265,000 Industrial Development Authority of Washington County Virginia, hospital revenue bonds series 2009C;
--\$13,245,000 Mountain States Health Alliance taxable note series 2000D.

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Additional information is available at 'www.fitchratings.com'.

Applicable Criteria and Related Research:

--'Revenue-Supported Rating Criteria' (June 16, 2014);

--'U.S. Nonprofit Hospitals and Health Systems Rating Criteria'(May 30, 2014).

Applicable Criteria and Related Research:

Revenue-Supported Rating Criteria (http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=750012)

U.S. Nonprofit Hospitals and Health Systems Rating Criteria (http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=746860)

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Moody's Investors Service

Rating Update: MOODY'S AFFIRMS MOUNTAIN STATES HEALTH ALLIANCE'S (TN) Baa1 UNENHANCED RATING IN ANTICIPATION OF UPCOMING REFINANCING STRUCTURE; OUTLOOK REMAINS STABLE

Global Credit Research - 22 Dec 2009

MOUNTAIN STATES HEALTH ALLIANCE HAS A TOTAL OF \$1.01 BILLION OF RATED DEBT PROPOSED TO BE OUTSTANDING

Health Care-Hospital
TN

Opinion

NEW YORK, Dec 22, 2009 -- Moody's Investors Service has affirmed the Baa1 unenhanced rating assigned to Mountain States Health Alliance's (MSHA) \$971 million of rated debt outstanding issued through various authorities (see RATED DEBT section below). The outlook remains stable. MSHA anticipates issuing approximately \$311 million of fixed rate bonds in early 2010 to refund certain outstanding bond issues and establish a debt service reserve fund. The financing documents have not been drafted at this time.

LEGAL SECURITY: The bonds are secured by a security interest in the Pledged Assets (receivables, inventory, equipment, general intangibles, contracts and contract rights, government approvals, fixtures and other personal property, goods, instruments, chattel paper, documents, credits, claims, demands and assets) and a first lien on the Mortgaged Property, which includes the major hospitals, subject to certain permitted liens.

INTEREST RATE DERIVATIVES: MSHA is a party to interest rate swaps and other derivative agreements to establish floating rate exposure and to reduce fixed rate debt service. MSHA holds three basis swaps, two fixed payer swaps and one total return swap with Merrill Lynch Capital Services Inc. (guaranteed by Merrill Lynch & Co) for a total notional amount of \$570 million. The fair market value of the swaps at December 18, 2009 was a liability of \$13.0 million, against which MSHA posted \$0 million in collateral.

MSHA holds eight additional agreements (\$50 million notional amount) with Lehman Brothers Special Financing, Inc. (Lehman) for various notional amounts that are linked fixed payer and total return swaps. Fair market value of the swap at January 31, 2009 was a liability of \$11.0 million, against which MSHA has posted \$12.6 million of collateral (collateral is not included in unrestricted cash). Lehman filed for bankruptcy and the swaps were terminated effective January 1, 2009. There is a dispute between MSHA and Lehman regarding the cost of such termination, which is currently under discussion. MSHA has stated that it believes that the amount of the posted collateral should be sufficient to pay the cost of the terminations.

In addition, MSHA has two outstanding interest rate swaptions, four float contracts and five forward sale agreements with Bear Stearns Capital Markets, Inc. (guaranteed by Bear Stearns Companies, Inc., acquired by JP Morgan) whereby MSHA received advance payments that have been placed in a guaranteed investment contract as collateral against the agreements (this collateral is not included in unrestricted cash). As of November 30, 2009 the liability on the swaptions, float contracts and forward sale agreements exceeded the collateral by \$1.5 million. MSHA has the option to terminate the swaptions on July 1, 2011 at a predetermined price equal to the value of the collateral on deposit with Bear Stearns or to hold the swaptions to maturity and let them expire. Given the terms of the agreements, the collateral held against the derivative transactions and MSHA's credit profile and strong liquidity position, we believe the transactions do not detract from the Baa1 rating.

STRENGTHS

*Multi-hospital system with strong and growing leading market share in a large geographic region where the flagship facility serves as a regional referral center offering a wide array of high-end services for hospitals in Tennessee and Virginia

*Multi-year growth in volumes with acquisitions

*Strong and stable operating cash flow margins in the 11.4% to 16.7% range in each of the past fifteen audit years, with volume increases contributing to cash flow growth; projected operating cash flow margins remain in the double

digits

*Good liquidity position with 242 days cash on hand at fiscal year end (FYE) 2009 (June 30) and 225 days as of September 30, 2009

*Reduction in exposure to variable rate debt and exposure to tenders under letter of credit supported debt, increasing fixed rate debt to 73% from 45% of total debt outstanding; pro forma cash-to-puttable debt at 171%

*Tenured management team

CHALLENGES

*Very high debt burden evidenced by a low 48% cash-to-debt ratio, high 9.9 times debt-to-cash flow ratio and moderate Moody's-adjusted maximum annual debt service coverage of 2.39 times as compared with Moody's Baa1 medians of 72%, 5.7 times and 3.2 times, respectively

*Capital spending projected to remain high in the near term with major spending on consolidation of two smaller Johnson City facilities into a single replacement facility, and capital commitment for investment into new 80% owned Smyth County Community Hospital and capital commitment for Johnston Memorial Hospital; however, no new debt is currently expected in connection with these projects and several have already been financed with debt in whole or in part;

*Sizable and consistent competition from Wellmont Health System, which holds a close but lesser market share (37% vs. 30%) in the extended 29-county service area and a significantly smaller market share (52% versus 37%) in the 13-county core service area, but has been increasing its presence in the extended service area through acquisition

*High 22.3% TennCare/Medicaid and self-pay load

MARKET POSITION/COMPETITIVE STRATEGY: DOMINANT MARKET POSITION IN JOHNSON CITY, WITH LEADING MARKET POSITION IN 13-COUNTY CORE AREA AND 29-COUNTY EXTENDED SERVICE AREA

MSHA, a multi-hospital system operating ten acute care hospitals and 14 facilities in northeastern Tennessee, southwest Virginia, southeast Kentucky and western North Carolina, gains much credit strength from its dominant 90% market share in Washington County, TN where it operates six of its facilities, including its flagship 583-licensed bed Johnson City Medical Center (JCMC), and is the only provider of acute care services. JCMC includes the 60-licensed bed Quillen Rehabilitation Hospital, providing a complete array of rehabilitative services for brain injury, stroke, and spinal cord injury and the 75-licensed bed Woodridge Hospital offering inpatient psychiatric and substance abuse services (purchased in 2005). MSHA also holds a leading 51.8% market position in its combined 13-county primary and secondary service areas (PSA/SSA), and a leading and consistent 36.7% market share in its 29-county extended service area. Competition is limited to one multi-hospital system (Wellmont Health System) and several small independent rural providers. Wellmont Health System operates four of its eight hospitals in MSHA's core market, garnering a distant 37.5% market share in the core service area, but a close 29.5% market share in the extended 29-county service area. Many of the rural hospitals in the primary and secondary service area are affiliated with MSHA through network affiliations.

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MSHA opened its newly constructed free-standing children's hospital in March 2009. It is the region's first free-standing children's hospital. In addition, MSHA is constructing a single 80-bed replacement facility for its North Side Hospital and Johnson City Specialty Hospital facilities. The new hospital will provide much more state-of-the-art care, replacing two much older facilities. Along with the relocation of certain long-term care beds to Quillen and acute care beds to JCMC, the project is estimated to cost \$120 million and to be funded 50% from cash flow and 50% from proceeds of the Series 2008 bonds.

In November 2006, MSHA began an expansion strategy in Virginia with the purchase of an 80% interest in 154-licensed general acute care/109 long-term care bed Smyth County Community Hospital (SCCH) located in Marion, Virginia. MSHA committed to \$48 million in capital improvements with the acquisition, of which \$28 million has yet to

be invested. In October 2007, MSHA acquired a 50.1% equity interest in 129-licensed bed Norton Community Hospital and 25-licensed bed Dickenson Community Hospital (Clintwood). The Series 2007 bond issues included \$52 million to support capital commitments at these new facilities. Effective January 31, 2008 MSHA acquired 78-licensed bed Russell County Medical Center in Lebanon, Virginia. Approximately \$53 million of Series 2008 bond proceeds financed this acquisition and provided funds for capital expenditures. In April 2009 MSHA acquired a 50.1% interest in Johnston Memorial Hospital (revenue bonds rated A3) in Abington, VA, committing to invest \$132 million for capital; \$100 million of the proceeds from the Series 2009C bonds will be used to fund a portion of this commitment.

MSHA's main competitor, Wellmont Health System, has also expanded with the acquisition of 133-licensed bed Mountainview Regional Medical Center also located in Norton, VA, and 50-bed Lee Regional Medical Center located in Pennington Gap, VA. Wellmont Health System is an eight hospital system with hospitals in TN, VA and KY, some of which compete directly with MSHA facilities.

OPERATING PERFORMANCE: OPERATING CASH FLOW MARGIN REMAINS CONSISTENTLY STRONG

FY 2009 operating profit grew to \$6.4 million from \$0.4 million the prior year (including capitalized interest of \$596,000 and \$3.7 million in FY 2009 and FY 2008, respectively), but operating margin remains modest at 0.8%. Operating cash flow increased \$12.0 million to \$120.8 million to generate a strong 14.4% margin. MSHA's operating cash flow margins remain strong and have consistently ranged between 11.4% and 16.7% in each of the past fifteen audit years. The expansion into Virginia along with volume growth contributed to a very good 13.1% growth in revenues in FY 2009. Projected operating cash flow margins remain in the double digit teens.

Debt-to-cash flow improved in FY 2009 but remains high at 9.90 times (Baa1 median of 5.7 times). Moody's-adjusted MADS coverage is adequate at 2.39 times in FY 2009, but again unfavorable to the Baa1 median of 3.2 times. Management is forecasting for improvement in these ratios with major capital projects completed or near completion through 2011. There are no additional facility expansion plans at this time, and management plans to focus on integrating the new Virginia hospitals into the system.

BALANCE SHEET POSITION: DEBT LOAD REMAINS HIGH; ABSOLUTE LIQUIDITY GROWTH BUT RELATIVE LIQUIDITY FLAT TO DECLINING

Unrestricted liquidity improved 12% in FY 2009 to \$515.1 million from \$458.7 million at FYE 2008 despite unfavorable market returns on investments, yet cash on hand remained stable at 242 days due to growth in the expense base with the addition of Johnston Memorial in Virginia. FY 2009 liquidity was unfavorably impacted by the \$18 million cash defeasance of part of the Series 2006C bonds, but favorably impacted by a reduction in capital spending from cash flow. Absolute liquidity continued to grow in the first three months of FY 2010 to reach \$544.8 million yet, again, cash on hand (annualized) declined due to expense growth, to 225 days. Nonetheless, MSHA has maintained greater than 200 days' cash on hand in each of the past six audited years.

The debt load remains high, reaching \$1.072 billion at FYE 2009 with the addition of debt to finance the capital contribution for Johnston Memorial in Virginia and the consolidation of Johnston Memorial's \$34 million of outstanding debt into the financial statements. MSHA's debt-to-revenue of 128% at FYE 2009 is one of the highest in our portfolio. Moody's notes that outstanding debt has increased annually since FY 2002, due largely to expansion into Virginia as well as the major capital projects for the new children's hospital and the replacement hospital for Northside and Johnson Specialty. As a result of the high debt load cash-to-debt remains low at 48% at FYE 2009 (Baa1 median of 72%). Management is forecasting for steady, annual improvement in the cash-to-debt ratio. The only potential near term debt plan is to provide up to \$30 million of capital funding for Smyth Hospital. Moody's will evaluate the impact of additional debt as funding plans are finalized.

With the current refinancing, MSHA is restructuring its debt portfolio to reduce variable rate risk exposure and risk of tendered bonds by refunding certain variable rate debt instruments. We note that approximately \$295 million of outstanding debt is scheduled to remain outstanding as variable rate puttable debt supported by letters of credit (LOCs) that expire in December 2012. MSHA's current liquidity comfortably covers potential puttable debt by 171%. MSHA has 367 days from the provision of a draw for tendered bonds to repay Regions Bank for the draw. Covenants in the LOCs include a maximum annual debt service coverage ratio of no less than 1.3 times for the obligated group, and a days' cash-on-hand ratio for the obligated group. The days cash covenant requires no less than 110 days or a consultant must be brought in, no less than 100 days in any case, and if it falls below 150 days then the debt service reserve funds supported by the LOCs must be fully funded with cash or a letter of credit.

Outlook

The stable outlook reflects our belief that MSHA will continue to generate strong and stable operating cash flow margins to support its high debt load. We believe liquidity will improve barring any major negative fair market value adjustments. Management is considering additional debt in the near-term to support capital investments in recent

hospital acquisitions. We will evaluate the rating impact of future debt issues as plans develop.

What could change the rating--UP

Continued growth in operating cash flow to support the high debt load; material improvement in debt measures; regrowth of liquidity; increased diversification of cash flow

What could change the rating--DOWN

Increase in debt load without commensurate increase in cash flow; notable loss in market share; trend of decline in operating cash flow; material decline or loss of supplemental payments for servicing the Medicaid and indigent populations

KEY INDICATORS

Assumptions & Adjustments:

-Based on financial statements for Mountain States Health Alliance

-First number reflects the audit year ended June 30, 2008

-Second number reflects audit year ended June 30, 2009

-Expenses include capitalized interest of \$0.6 million and \$3.7 million in FY 2009 and FY 2008, respectively

-Investment returns smoothed at 6% unless otherwise noted

*Inpatient admissions: 54,307; 57,127

*Total operating revenues: \$743.6 million; \$839.9 million

*Moody's-adjusted net revenue available for debt service: \$139.2 million; \$154.1 million

*Total debt outstanding: \$938 million; \$1.072 billion

*Maximum annual debt service (MADS): \$54.9 million; \$64.4 million

*MADS Coverage based on reported investment income: 2.66 times; 2.11

*Moody's-adjusted MADS Coverage: 2.53 times; 2.39 times

*Debt-to-cash flow: 10.32 times; 9.90 times

*Days cash on hand: 2424 days; 242 days

*Cash-to-debt: 49%; 48%

*Operating margin: 0.1%; 0.8%

*Operating cash flow margin: 14.7%; 14.4%

RATED DEBT (as of November 30, 2009):

Issued by The Health and Educational Facilities Board of the City of Johnson City, Tennessee:

-Series 2009A fixed rate term bonds (\$5.6 million outstanding), rated Baa1

-Series 2008A Variable Rate Hospital Revenue Bonds variable rate (\$72.8 million outstanding) rated Aa3/VMIG 2 supported by letter of credit with Regions Bank expiring December 14, 2012; Baa1 unenhanced rating

-Series 2008B Variable Rate Hospital Revenue Bonds variable rate (\$54.1 million outstanding) rated Aa3/VMIG 2 supported by letter of credit with Regions Bank expiring December 14, 2012; Baa1 unenhanced rating

-Series 2007A Variable Rate Hospital Revenue Bonds (\$95.9 million outstanding), joint support rating of Aa3/VMIG 2 with letter of credit from Regions Bank expiring December 31, 2012, Baa1 unenhanced rating

-Series 2007B Variable Rate Hospital Revenue Bonds (\$314.2 million outstanding), joint support rating of Aa3/VMIG 2

with letter of credit from Regions Bank expiring December 31, 2012, Baa1 unenhanced rating

-Series 2006A Fixed Rate First Mortgage Revenue Bonds, serial and term bonds (\$170.3 million outstanding), rated Baa1

-Series 2001A Fixed Rate Hospital First Mortgage Revenue Term Bonds (\$23.9 million outstanding), rated Baa1

-Series 2000A Hospital First Mortgage Revenue Refunding Capital Appreciation Bonds (\$26.6 million outstanding), certain bonds insured by MBIA, Baa1 unenhanced rating

-Series 2000C Fixed Rate Hospital First Mortgage Revenue Term Bonds (Taxable) (\$35.3 million outstanding), insured by MBIA, Baa1 unenhanced rating

Issued by Industrial Development Authority of Smyth County, Virginia:

-Series 2009B fixed rate term bonds (\$5.5 million outstanding), rated Baa1

-Series 2007C Variable Rate Hospital Revenue Bonds (\$34.7 million outstanding), joint support rating of Aa3/VMIG2 with letter of credit from Regions Bank expiring December 31, 2012, Baa1 unenhanced rating

Issued by Industrial Development Authority of Washington County, Virginia:

-Series 2009C fixed rate term bonds (\$116.0 million outstanding), rated Baa1

Direct Obligation of Mountain States Health Alliance:

-Series 2000D Fixed Rate First Mortgage Term Bonds (Taxable) (\$15.2 million outstanding), insured by MBIA, Baa1 unenhanced rating

CONTACTS

Obligor: Marvin Eichorn, Senior Vice President and Chief Financial Officer, Mountain States Health Alliance (423) 431-1017

Underwriter: Jeff Newhams, Managing Director, BofA Merrill Lynch (212) 449-0641

Financial Advisor: Steve Pischke, President, The Public Advisory Corporation (540) 687-6755

The last rating action on Mountain States Health Alliance was on March 6, 2009 when the Baa1 ratings were affirmed with a stable outlook.

The principal methodology used in rating Mountain States Health Alliance was Moody's Rating Methodology: Not-For-Profit Hospitals and Health Systems, published in January 2008 and available on www.moody.com in the Rating Methodologies sub-directory under the Research & Ratings tab. Other methodologies and factors that may have been considered in the process of rating Mountain States Health Alliance can also be found in the Rating Methodologies sub-directory on Moody's website.

Analysts

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Moody's Investors Service

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MOODY'S hereby discloses that most issuers of debt securities (including corporate and municipal bonds, debentures, notes and commercial paper) and preferred stock rated by MOODY'S have, prior to assignment of any rating, agreed to pay to MOODY'S for appraisal and rating services rendered by it fees ranging from \$1,500 to approximately \$2,400,000. Moody's Corporation (MCO) and its wholly-owned credit rating agency subsidiary, Moody's Investors Service (MIS), also maintain policies and procedures to address the independence of MIS's ratings and rating processes. Information regarding certain affiliations that may exist between directors of MCO and rated entities, and between entities who hold ratings from MIS and have also publicly reported to the SEC an ownership interest in MCO of more than 5%, is posted annually on Moody's website at www.moodys.com under the heading "Shareholder Relations - Corporate Governance - Director and Shareholder Affiliation Policy."



**New Issue: MOODY'S ASSIGNS Baa1 RATING TO MOUNTAIN STATES HEALTH ALLIANCE'S (TN)
\$228 MILLION OF SERIES 2010A&B BONDS; OUTLOOK IS STABLE**

Global Credit Research - 29 Mar 2010

MOUNTAIN STATES HEALTH ALLIANCE HAS A TOTAL OF \$1.0 BILLION OF RATED DEBT TO BE OUTSTANDING

Johnson City Health & Educ. Fac. Bd., TN
Health Care-Hospital
TN

Moody's Rating

ISSUE	RATING
Series 2010A Hospital Refunding Revenue Bonds	Baa1
Sale Amount \$190,220,000	
Expected Sale Date 03/31/10	
Rating Description Healthcare Revenue Bonds	

Series 2010B Hospital Refunding Revenue Bonds	Baa1
Sale Amount \$37,845,000	
Expected Sale Date 03/31/10	
Rating Description Healthcare Revenue Bonds	

Moody's Outlook Stable

Opinion

NEW YORK, Mar 29, 2010 -- Moody's Investors Service has assigned Baa1 ratings to Mountain States Health Alliance's (MSHA) \$190.2 million of Series 2010A and \$37.8 million of Series 2010B fixed rate refunding revenue bonds to be issued by The Health and Educational Facilities Board of the City of Johnson City, TN and the Industrial Development Authority of Smyth County (Virginia), respectively. The outlook remains stable. At this time we are affirming the Baa1 unenhanced ratings on \$770 million of rated debt to remain outstanding.

USE OF BOND PROCEEDS: The bond proceeds will be used to (1) refund the outstanding Series 2007A, Series 2007C and Series 2008A bonds, (2) establish a debt service reserve fund, and (3) pay the costs of issuance.

LEGAL SECURITY: The bonds are secured by a security interest in the Pledged Assets (receivables, inventory, equipment, general intangibles, contracts and contract rights, government approvals, fixtures and other personal property, goods, instruments, chattel paper, documents, credits, claims, demands and assets) and a first lien on the Mortgaged Property, which includes the major hospitals, subject to certain permitted liens.

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MSHA holds eight additional agreements (\$106 million notional amount) with Lehman Brothers Special Financing, Inc. (Lehman) for various notional amounts that are linked fixed payer and total return swaps. Fair market value of the swap at January 31, 2009 was a liability of \$11.0 million, against which MSHA has posted \$13.2 million of collateral (collateral is not included in unrestricted cash). Lehman filed for bankruptcy and the swaps were terminated effective January 1, 2009. There is a dispute between MSHA and Lehman regarding the cost of such termination, which is currently under discussion. MSHA has stated that it believes that the amount of the posted collateral should be sufficient to pay the cost of the terminations.

In addition, MSHA has two outstanding interest rate swaptions, four float contracts and five forward sale agreements with Bear Stearns Capital Markets, Inc. (guaranteed by Bear Stearns Companies, Inc., acquired by JP Morgan) whereby MSHA received advance payments that have been placed in a guaranteed investment contract as collateral against the agreements (this collateral is not included in unrestricted cash). As of March 18, 2010, liability on the swaptions, float contracts and forward sale agreements exceeded the collateral by \$2.4 million. MSHA has the option to terminate the swaptions on July 1, 2011 at a predetermined price equal to the value of the collateral on deposit with Bear Stearns or to hold the swaptions to maturity and let them expire. Given the terms of the agreements, the collateral held against the derivative transactions and MSHA's credit profile and strong liquidity position, we believe the transactions do not detract from the Baa1 rating.

STRENGTHS

*Multi-hospital system with strong and growing leading market share in a large geographic region where the flagship facility serves as a regional referral center offering a wide array of high-end services for hospitals in Tennessee and Virginia

*Multi-year growth in volumes with acquisitions

*Strong and stable operating cash flow margins in the 11.4% to 16.7% range in each of the past fifteen audit years, with volume increases contributing to cash flow growth; projected operating cash flow margins remain in the double digits

*Good liquidity position with 242 days cash on hand at fiscal year end (FYE) 2009 (June 30) and 244 days as of December 31, 2009

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CHALLENGES

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OPERATING PERFORMANCE: OPERATING CASH FLOW MARGIN REMAINS CONSISTENTLY STRONG

FY 2009 operating profit grew to \$6.4 million from \$0.4 million the prior year (including capitalized interest of \$596,000 and \$3.7 million in FY 2009 and FY 2008, respectively), but operating margin remains modest at 0.8%. Operating cash flow increased \$12.0 million to \$120.8 million to generate a strong 14.4% margin. MSHA's operating cash flow margins remain strong and have consistently ranged between 11.4% and 16.7% in each of the past fifteen audit years. The expansion into Virginia along with volume growth contributed to a very good 13.1% growth in revenues in FY 2009. Projected operating cash flow margins remain in the double digit teens.

Debt-to-cash flow improved in FY 2009 but remains high at 9.90 times (Baa1 median of 5.7 times). Moody's-adjusted MADS coverage is

adequate at 2.39 times in FY 2009, but again unfavorable to the Baa1 median of 3.2 times. Management is forecasting for improvement in these ratios with major capital projects completed or near completion through 2011. There are no additional facility expansion plans at this time, and management plans to focus on integrating the new Virginia hospitals into the system. Through the first six months of FY 2010 operating profit improved \$4 million over the same period of the prior year and operating cash flow improved \$10 million.

BALANCE SHEET POSITION: DEBT LOAD REMAINS HIGH; ABSOLUTE LIQUIDITY GROWTH BUT RELATIVE LIQUIDITY FLAT TO DECLINING

Unrestricted liquidity improved 12% in FY 2009 to \$515.1 million from \$458.7 million at FYE 2008 despite unfavorable market returns on investments, yet cash on hand remained stable at 242 days due to growth in the expense base with the addition of Johnston Memorial in Virginia. FY 2009 liquidity was unfavorably impacted by the \$18 million cash defeasance of part of the Series 2006C bonds, but favorably impacted by a reduction in capital spending from cash flow. Absolute liquidity continued to grow in the first six months of FY 2010 to reach \$567 million and cash on hand (annualized) was stable to FYE 2009 at 244 days.

The debt load remains high, reaching \$1.072 billion at FYE 2009 with the addition of debt to finance the capital contribution for Johnston Memorial in Virginia and the consolidation of Johnston Memorial's \$34 million of outstanding debt into the financial statements. MSHA's debt-to-revenue of 128% at FYE 2009 is one of the highest in our portfolio. Moody's notes that outstanding debt has increased annually since FY 2002, due largely to expansion into Virginia as well as the major capital projects for the new children's hospital and the replacement hospital for Northside and Johnson Specialty. As a result of the high debt load cash-to-debt remains low at 48% at FYE 2009 (Baa1 median of 72%). Management is forecasting for steady, annual improvement in the cash-to-debt ratio. The only potential near term debt plan is to provide up to \$30 million of capital funding for Smyth Hospital. Moody's will evaluate the impact of additional debt as funding plans are finalized.

With the current refinancing, MSHA is restructuring its debt portfolio to reduce variable rate risk exposure and risk of tendered bonds by refunding certain variable rate debt instruments. We note that approximately \$368 million of outstanding debt is scheduled to remain outstanding as variable rate puttable debt supported by letters of credit (LOCs) that expire in December 2012. MSHA's current liquidity comfortably covers potential puttable debt by 151%. MSHA has 367 days from the provision of a draw for tendered bonds to repay Regions Bank for the draw. Covenants in the LOCs include a maximum annual debt service coverage ratio of no less than 1.3 times for the obligated group, and a days' cash-on-hand ratio for the obligated group. The days cash covenant requires no less than 110 days or a consultant must be brought in, no less than 100 days in any case, and if it falls below 150 days then the debt service reserve funds supported by the LOCs must be fully funded with cash or a letter of credit.

Outlook

The stable outlook reflects our belief that MSHA will continue to generate strong and stable operating cash flow margins to support its high debt load. We believe liquidity will improve barring any major negative fair market value adjustments. Management is considering additional debt in the near-term to support capital investments in recent hospital acquisitions. We will evaluate the rating impact of future debt issues as plans develop.

What could change the rating--UP

Continued growth in operating cash flow to support the high debt load; material improvement in debt measures; regrowth of liquidity; increased diversification of cash flow

What could change the rating--DOWN

Increase in debt load without commensurate increase in cash flow; notable loss in market share; trend of decline in operating cash flow; material decline or loss of supplemental payments for servicing the Medicaid and indigent populations

KEY INDICATORS

Assumptions & Adjustments:

-Based on financial statements for Mountain States Health Alliance

-First number reflects the audit year ended June 30, 2008

-Second number reflects audit year ended June 30, 2009

-Expenses include capitalized interest of \$0.6 million and \$3.7 million in FY 2009 and FY 2008, respectively

-Investment returns smoothed at 6% unless otherwise noted

*Inpatient admissions: 54,307; 57,127

*Total operating revenues: \$743.6 million; \$839.9 million

*Moody's-adjusted net revenue available for debt service: \$139.2 million; \$154.1 million

*Total debt outstanding: \$938 million; \$1.072 billion

*Maximum annual debt service (MADS): \$54.9 million; \$64.4 million

*MADS Coverage based on reported investment income: 2.66 times; 2.11

*Moody's-adjusted MADS Coverage: 2.53 times; 2.39 times

*Debt-to-cash flow: 10.32 times; 9.90 times

*Days cash on hand: 2424 days; 242 days

*Cash-to-debt: 49%; 48%

*Operating margin: 0.1%; 0.8%

*Operating cash flow margin: 14.7%; 14.4%

RATED DEBT (as of November 30, 2009):

Issued by The Health and Educational Facilities Board of the City of Johnson City, Tennessee:

-Series 2009A fixed rate term bonds (\$5.6 million outstanding), rated Baa1

-Series 2008A Variable Rate Hospital Revenue Bonds variable rate (\$72.8 million outstanding; \$0 to remain outstanding post financing) rated Aa3/VMIG 2 supported by letter of credit with Regions Bank expiring December 14, 2012; Baa1 unenhanced rating

-Series 2008B Variable Rate Hospital Revenue Bonds variable rate (\$54.1 million outstanding) rated Aa3/VMIG 2 supported by letter of credit with Regions Bank expiring December 14, 2012; Baa1 unenhanced rating

-Series 2007A Variable Rate Hospital Revenue Bonds (\$95.9 million outstanding; \$0 to remain outstanding post financing), joint support rating of Aa3/VMIG 2 with letter of credit from Regions Bank expiring December 31, 2012, Baa1 unenhanced rating

-Series 2007B Variable Rate Hospital Revenue Bonds (\$314.2 million outstanding), joint support rating of Aa3/VMIG 2 with letter of credit from Regions Bank expiring December 31, 2012, Baa1 unenhanced rating

-Series 2006A Fixed Rate First Mortgage Revenue Bonds, serial and term bonds (\$170.3 million outstanding), rated Baa1

-Series 2001A Fixed Rate Hospital First Mortgage Revenue Term Bonds (\$23.9 million outstanding), rated Baa1

-Series 2000A Hospital First Mortgage Revenue Refunding Capital Appreciation Bonds (\$26.6 million outstanding), certain bonds insured by MBIA, Baa1 unenhanced rating

-Series 2000C Fixed Rate Hospital First Mortgage Revenue Term Bonds (Taxable) (\$35.3 million outstanding), insured by MBIA, Baa1 unenhanced rating

Issued by Industrial Development Authority of Smyth County, Virginia:

-Series 2009B fixed rate term bonds (\$5.5 million outstanding), rated Baa1

-Series 2007C Variable Rate Hospital Revenue Bonds (\$34.7 million outstanding; \$0 to remain outstanding post financing), joint support rating of Aa3/VMIG2 with letter of credit from Regions Bank expiring December 31, 2012, Baa1 unenhanced rating

Issued by Industrial Development Authority of Washington County, Virginia:

-Series 2009C fixed rate term bonds (\$116.0 million outstanding), rated Baa1

Direct Obligation of Mountain States Health Alliance:

-Series 2000D Fixed Rate First Mortgage Term Bonds (Taxable) (\$15.2 million outstanding), insured by MBIA, Baa1 unenhanced rating

CONTACTS

Obligor: Marvin Eichorn, Senior Vice President and Chief Financial Officer, Mountain States Health Alliance (423) 431-1017

Underwriter: Jeff Newhams, Managing Director, BofA Merrill Lynch (212) 449-0641

Financial Advisor: Steve Pischke, President, The Public Advisory Corporation (540) 687-6755

The rating assigned to Mountain States Health Alliance was issued on Moody's municipal rating scale. Moody's has announced its plans to recalibrate all U.S. municipal ratings to its global scale and therefore, upon implementation of the methodology published in conjunction with this initiative, the rating will be recalibrated to a global scale rating comparable to other credits with a similar risk profile. Market participants should not view the recalibration of municipal ratings as rating upgrades, but rather as a recalibration of the ratings to a different rating scale. This recalibration does not reflect an improvement in credit quality or a change in our credit opinion for rated municipal debt issuers. For further details regarding the recalibration please visit www.moodys.com/gsr.

The principal methodology used in rating Mountain States Health Alliance was Moody's Rating Methodology: Not-For-Profit Hospitals and Health Systems, published in January 2008 and available on www.moodys.com in the Rating Methodologies sub-directory under the Research & Ratings tab. Other methodologies and factors that may have been considered in the process of rating Mountain States Health Alliance can also be found in the Rating Methodologies sub-directory on Moody's website.

The last rating action on Mountain States Health Alliance was on December 22, 2009 when the Baa1 ratings were affirmed with a stable outlook.

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MOODY'S

INVESTORS SERVICE

New Issue: MOODY'S ASSIGNS Aa3/VMIG 1 LETTER OF CREDIT-BACKED RATING TO THE HEALTH AND EDUCATIONAL FACILITIES BOARD OF CITY OF JOHNSON CITY, TN HOSPITAL REVENUE BONDS (MOUNTAIN STATES HEALTH ALLIANCE) SERIES 2007 B-3

Global Credit Research - 29 Sep 2010

\$58,5 MILLION IN DEBT AFFECTED. THE RATING IS BASED ON THE RATING OF MIZUHO CORPORATE BANK, LTD.

Johnson City Health & Educ. Fac. Bd., TN
Fully Supported
TN

Moody's Rating

ISSUE	RATING
Ser. 2007B-3	Aa3/VMIG 1
Sale Amount	\$58,500,000
Expected Sale Date	09/29/10
Rating Description	LOC

Opinion

NEW YORK, Sep 29, 2010 -- Moody's Investors Service has assigned Aa3/VMIG 1 rating to the Health and Educational Facilities Board of City of Johnson City, TN Hospital Revenue Bonds (Mountain States Health Alliance) Series 2007 B-3 (the Bonds)

RATING RATIONALE

The rating is based upon the irrevocable direct pay letter of credit provided by Mizuho Corporate Bank, Ltd. (the Bank), the structure of the transaction, which ensures timely debt service and purchase price payments to investors; and Moody's evaluation of the creditworthiness of the Bank issuing the letter of credit.

Mizuho Corporate Bank, Ltd. is currently rated Aa3 for long-term bank deposits and Prime-1 for short-term bank deposits.

Interest Rate Modes and Payment

The Bonds will bear interest in a weekly rate mode and interest will be paid on the first business day of each month. The bond trust indenture permits conversion of the Bonds, in whole, to a medium term or fixed interest rate period and upon any conversion the Bonds will be subject to mandatory purchase. The rating applies to the Bonds bearing interest in the weekly period only.

Additional Bonds

No additional bonds shall be issued under the bond trust indenture.

Flow of Funds

The trustee is instructed to draw under the LOC on or before 4:00 p.m., New York City time, on the business day prior to any principal and interest payment date, in accordance with the LOC so as to receive moneys on the next business day in amount sufficient for the payment in full of the principal and interest due on the Bonds. The trustee is also instructed to draw under the LOC by 11:30 a.m., New York City time, on each purchase date to the extent remarketing proceeds are insufficient. Bonds which are purchased by the Bank due to a failed remarketing are held by the trustee and will not be released until the trustee has received confirmation from the Bank stating that the LOC has been reinstated in the amount of the purchase price drawn for such Bonds.

Letter of Credit

The LOC is sized for full principal plus 37 days of interest at the maximum rate applicable to the Bonds (12%) calculated based on 360 days year and will provide coverage for the Bonds while they bear interest in the weekly rate mode.

Draws on the Letter of Credit

Conforming draws for principal and interest presented to the Bank at or before 4:00 p.m., New York City time, on a business day, will be honored by the Bank no later than 2:30 p.m., New York City time, on the next business day. Conforming draws for purchase price presented to the Bank at or before 12:00 noon, New York City time, on a business day, will be honored by such Bank no later than 2:30 p.m., New York City time, on such business day.

Substitution of the Letter of Credit

The Bonds will be subject to mandatory tender on the fifth (5th) business day prior to substitution of the LOC. Draws for purchase price upon the substitution will be made under the existing LOC and the existing LOC will not be surrendered to the Bank for cancellation until after such tender draw is honored.

Reinstatement of Interest Draws

Draws made under the LOC for interest shall be automatically reinstated at the close of business on the date of payment of such interest drawing unless the trustee receives from the Bank a notice by 4:00 p.m. on such payment date stating that the Bank has not been reimbursed for such drawing or that an event of default under the reimbursement agreement has occurred. Upon receipt of such notice the trustee will immediately declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Reimbursement Agreement Defaults

Upon an event of default under the reimbursement agreement, the Bank may direct the trustee to accelerate the Bonds. Upon receipt of such notice, the trustee will declare the principal of and accrued interest on the Bonds immediately due and payable. Interest will cease to accrue one day following the date on which the Bonds are declared immediately due and payable. Upon receipt of such notice the trustee will immediately declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Bond Indenture Events of Default Related to Payment

Upon a failure to pay when due the principal or interest or the purchase price on the Bonds, the trustee may, and at the written request of the Bank or the holders of more than two-thirds (2/3) in aggregate principal amount of the outstanding Bonds shall declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Expiration / Termination of the Letter of Credit

The LOC shall terminate upon the earliest to occur of: (i) September 29, 2013, the stated expiration date; (ii) the business day following conversion of an interest rate of the Bonds to a rate other than a weekly interest rate; (iii) the day which is fifteen (15) days after trustee's receipt of a notice from the Bank stating that an event of default under the reimbursement agreement has occurred and directing acceleration of the Bonds, (iv) the date an acceleration drawing is honored by the Bank; (v) receipt by the Bank of a certificate from the trustee stating that (A) no Bonds remain outstanding and all draws under the LOC have been made and honored, or (B) a substitute LOC has been issued; or (vi) the date on which a stated maturity drawing that causing the stated amount of the LOC to be reduced to \$0 is honored by the Bank.

Optional Tenders

Bondholders may optionally tender their Bonds on any business day during the weekly rate mode with five (5) business days prior written notice to the trustee and the remarketing agent.

Mandatory Purchases

The Bonds are subject to mandatory purchase on: (i) each interest rate conversion date (ii) any interest reset date, (iii) the fifth (5th) business day prior to the effective date of an alternate letter of credit or (iv) the second (2nd) business day prior to the expiration date of the letter of credit.

What Could Change the Rating-Up

Long-term: The long-term rating on the Bonds would be raised if the long-term bank deposits rating on the Bank was upgraded.

Short-term: Not applicable.

What Could Change the Rating-Down

Long-Term: The long-term rating on the Bonds would be lowered if the long-term bank deposit rating on the Bank was downgraded.

Short-Term: The short-term rating on the Bonds would be lowered if the short-term bank deposit rating on the Bank was downgraded.

Contacts

Remarketing Agent: Bank of America Merrill Lynch

Trustee: The Bank of New York Mellon Trust Company

The principal methodology used in rating this issue was Moody's Rating Methodology for Letter of Credit Supported Transactions rating methodology published in August 2005. Other methodologies and factors that may have been considered in the process of rating this issue can also be found on Moody's website.

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New Issue: MOODY'S ASSIGNS Aa3 (ON WATCH FOR DOWNGRADE)/VMIG 1 LETTER OF CREDIT-BACKED RATING TO THE HEALTH AND EDUCATIONAL FACILITIES BOARD OF CITY OF JOHNSON CITY, TN HOSPITAL REVENUE BONDS (MOUNTAIN STATES HEALTH ALLIANCE) SERIES 2007 B-2

Global Credit Research - 29 Sep 2010

\$105.0 MILLION IN DEBT AFFECTED. LONG-TERM JDA RATING BASED ON LONG-TERM RATINGS OF PNC BANK, N.A. AND MOUNTAIN STATES HEALTH ALLIANCE

Johnson City Health & Educ. Fac. Bd., TN
Fully Supported
TN

Moody's Rating

ISSUE	RATING
Ser. 2007B-2 (Taxable)	Aa3/VMIG 1
Sale Amount \$105,000,000	
Expected Sale Date 09/29/10	
Rating Description Joint Default Analysis	

Opinion

NEW YORK, Sep 29, 2010 -- Moody's Investors Service has assigned Aa3 (on watch for downgrade)/VMIG 1 rating to the Health and Educational Facilities Board of City of Johnson City, TN Hospital Revenue Bonds (Mountain States Health Alliance) Series 2007 B-2 (the Bonds)

RATING RATIONALE

The long-term rating is based on a joint default analysis (JDA) which reflects Moody's approach to rating jointly supported transactions. The JDA rating is based upon the long-term rating of PNC Bank, National Association (Bank) as provider of the letter of credit (LOC); the underlying rating of the Bonds; and the structure and legal protections of the transaction which ensures timely debt service payments to investors. The timely payment of purchase price is reflected in the short-term rating of the Bonds. The short-term rating of the Bonds is based upon the short-term rating of the Bank as provider of the letter of credit.

PNC Bank, National Association is currently rated A1 for long-term other senior obligations (OSO) and Prime-1 for short-term OSO. The long-term rating of the Bank is currently on watch for downgrade. Moody's maintains Baa1 underlying rating on the Bonds.

Since a loss to investors would occur only if both the Bank and Mountain States Health Alliance (the Borrower) default in payment, Moody's has assigned the long-term portion of the rating based upon the joint probability of default by both parties. In determining the joint probability of default, Moody's considers the level of default dependence between the Bank and the Borrower. Moody's has determined that there is a high level of default dependence between the Bank and the Borrower. As a result, the joint probability of default for the Bank and the Borrower results in a credit risk consistent with a JDA rating of Aa3 (on watch for downgrade) for the Bonds.

Interest Rate Modes and Payment

The Bonds will bear interest in a weekly rate mode and interest will be paid on the first business day of each month. The bond trust indenture permits conversion of the Bonds, in whole, to a medium term or fixed interest rate period and upon any conversion the Bonds will be subject to mandatory purchase. The rating applies to the Bonds bearing interest in the weekly period only.

Additional Bonds

No additional bonds shall be issued under the bond trust indenture.

Flow of Funds

The trustee is instructed to draw under the LOC on or before 4:00 p.m., New York City time, on the business day prior to any principal and interest payment date, in accordance with the LOC so as to receive moneys on the next business day in amount sufficient for the payment in full of the principal and interest due on the Bonds. If the Bank fails to honor a draw under the applicable LOC, the trustee shall immediately notify the Borrower and demand payment of such amount. The trustee is also instructed to draw under the LOC by 11:30 a.m., New York City time, on each purchase date to the extent remarketing proceeds are insufficient. Bonds which are purchased by the Bank due to a failed remarketing are held by the trustee and will not be released until the trustee has received confirmation from the Bank stating that the LOC has been reinstated in the amount of the purchase price drawn for such Bonds.

Letter of Credit

The LOC is sized for full principal plus 37 days of interest at the maximum rate applicable to the Bonds (12%) calculated based on 360 days year and will provide coverage for the Bonds while they bear interest in the weekly rate mode.

Draws on the Letter of Credit

Conforming draws for principal and interest presented to the Bank at or before 4:00 p.m., Pittsburgh, PA time, on a business day, will be honored by the Bank no later than 2:30 p.m., Pittsburgh, PA time, on the next business day. Conforming draws for purchase price presented to the Bank at or before 12:00 noon, Pittsburgh, PA time, on a business day, will be honored by such Bank no later than 2:30 p.m., Pittsburgh, PA time, on such business day.

Substitution of the Letter of Credit

The Bonds will be subject to mandatory tender on the fifth (5th) business day prior to substitution of the LOC. Draws for purchase price upon the substitution will be made under the existing LOC and the existing LOC will not be surrendered to the Bank for cancellation until after such tender draw is honored.

Reinstatement of Interest Draws

Draws made under the LOC for interest shall be automatically reinstated at the close of business on the date of payment of such interest drawing unless the trustee receives from the Bank a notice by 4:00 p.m. on such payment date stating that the Bank has not been reimbursed for such drawing or that an event of default under the reimbursement agreement has occurred. Upon receipt of such notice the trustee will immediately declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Reimbursement Agreement Defaults

Upon an event of default under the reimbursement agreement, the Bank may direct the trustee to accelerate the Bonds. Upon receipt of such notice, the trustee will declare the principal of and accrued interest on the Bonds immediately due and payable. Interest will cease to accrue one business day following the date on which the Bonds are declared immediately due and payable. Upon receipt of such notice the trustee will immediately declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Bond Indenture Events of Default Related to Payment

Upon a failure to pay when due the principal or interest or the purchase price on the Bonds, the trustee may, and at the written request of the Bank or the holders of more than two-thirds (2/3) in aggregate principal amount of the outstanding Bonds shall declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Expiration / Termination of the Letter of Credit

The LOC shall terminate upon the earliest to occur of: (i) September 29, 2013, the stated expiration date; (ii) the business day following conversion of an interest rate of the Bonds to a rate other than a weekly interest rate; (iii)

the day which is fifteen (15) days after trustee's receipt of a notice from the Bank stating that an event of default under the reimbursement agreement has occurred and directing acceleration of the Bonds, (iv) the date an acceleration drawing is honored by the Bank; (v) receipt by the Bank of a certificate from the trustee stating that (A) no Bonds remain outstanding and all draws under the LOC have been made and honored, or (B) a substitute LOC has been issued; or (vi) the date on which a stated maturity drawing that causing the stated amount of the LOC to be reduced to \$0 is honored by the Bank.

Optional Tenders

Bondholders may optionally tender their Bonds on any business day during the weekly rate mode with five (5) business days prior written notice to the trustee and the remarketing agent.

Mandatory Purchases

The Bonds are subject to mandatory purchase on: (i) each interest rate conversion date (ii) any interest reset date, (iii) the fifth (5th) business day prior to the effective date of an alternate letter of credit or (iv) the second (2nd) business day prior to the expiration date of the letter of credit.

What Could Change the Rating-Up

Long-Term: the long-term rating on the applicable series of Bonds could be upgraded if the long-term OSO rating of the Bank or the long-term rating of the Borrower was upgraded, or if

there was a decrease in the level of default dependence between the Bank and the Borrower.

Short-Term: N/A

What Could Change the Rating-Down

Long-Term: the long-term rating on the Bonds could be lowered if the long term OSO rating of the Bank or the long-term rating of the Borrower was downgraded, or if there is an increase in the level of default dependence between the Bank and the Borrower.

Short-Term: the short-term rating on the Bonds would be lowered if the short-term OSO rating, on the Bank was downgraded.

Contacts

Remarketing Agent: Bank of America Merrill Lynch

Trustee: The Bank of New York Mellon Trust Company

The principal methodologies used in rating this issue were Moody's Rating Methodology Letter of Credit Supported Transactions published in August 2005 and Applying Global Joint Default Analysis to Letter of Credit Backed Transactions in the U.S. Public Finance Sector published in September 2010. Other methodologies and factors that may have been considered in the process of rating this issue can also be found on Moody's website.

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Rating Update: MOODY'S ASSIGNS Aa1 (ON WATCH FOR DOWNGRADE)/VMIG 1 LETTER OF CREDIT-BACKED RATING TO THE HEALTH AND EDUCATIONAL FACILITIES BOARD OF CITY OF JOHNSON CITY, TN HOSPITAL REVENUE BONDS (MOUNTAIN STATES HEALTH ALLIANCE) SERIES 2007 B-1

Global Credit Research - 29 Sep 2010

\$144.4 MILLION IN DEBT AFFECTED. LONG-TERM JDA RATING BASED ON LONG-TERM RATINGS OF U.S. BANK, N.A. AND MOUNTAIN STATES HEALTH ALLIANCE

Johnson City Health & Educ. Fac. Bd., TN
Fully Supported
TN

Opinion

NEW YORK, Sep 29, 2010 -- Moody's Investors Service has assigned Aa1 (on watch for downgrade)/VMIG 1 rating to the Health and Educational Facilities Board of City of Johnson City, TN Hospital Revenue Bonds (Mountain States Health Alliance) Series 2007 B-1 (the Bonds)

RATING RATIONALE

The long-term rating is based on a joint default analysis (JDA) which reflects Moody's approach to rating jointly supported transactions. The JDA rating is based upon the long-term rating of U.S. Bank National Association (Bank) as provider of the letter of credit (LOC); the underlying rating of the Bonds; and the structure and legal protections of the transaction which ensures timely debt service payments to investors. The timely payment of purchase price is reflected in the short-term rating of the Bonds. The short-term rating of the Bonds is based upon the short-term rating of the Bank as provider of the letter of credit.

U.S. Bank National Association is currently rated Aa1 for long-term other senior obligations (OSO) and Prime-1 for short-term OSO. The long-term rating of the Bank is currently on watch for downgrade. Moody's maintains Baa1 underlying rating on the Bonds.

Since a loss to investors would occur only if both the Bank and Mountain States Health Alliance (the Borrower) default in payment, Moody's has assigned the long-term portion of the rating based upon the joint probability of default by both parties. In determining the joint probability of default, Moody's considers the level of default dependence between the Bank and the Borrower. Moody's has determined that there is a high level of default dependence between the Bank and the Borrower. As a result, the joint probability of default for the Bank and the Borrower results in a credit risk consistent with a JDA rating of Aa1 (on watch for downgrade) for the Bonds.

Interest Rate Modes and Payment

The Bonds will bear interest in a weekly rate mode and interest will be paid on the first business day of each month. The bond trust indenture permits conversion of the Bonds, in whole, to a medium term or fixed interest rate period and upon any conversion the Bonds will be subject to mandatory purchase. The rating applies to the Bonds bearing interest in the weekly period only.

Additional Bonds

No additional bonds shall be issued under the bond trust indenture.

Flow of Funds

The trustee is instructed to draw under the LOC on or before 4:00 p.m., New York City time, on the business day prior to any principal and interest payment date, in accordance with the LOC so as to receive moneys on the next business day in amount sufficient for the payment in full of the principal and interest due on the Bonds. If the Bank fails to honor a draw under the applicable LOC, the trustee shall immediately notify the Borrower and demand

payment of such amount. The trustee is also instructed to draw under the LOC by 11:30 a.m., New York City time, on each purchase date to the extent remarketing proceeds are insufficient. Bonds which are purchased by the Bank due to a failed remarketing are held by the trustee and will not be released until the trustee has received confirmation from the Bank stating that the LOC has been reinstated in the amount of the purchase price drawn for such Bonds.

Letter of Credit

The LOC is sized for full principal plus 37 days of interest at the maximum rate applicable to the Bonds (12%) calculated based on 360 days year and will provide coverage for the Bonds while they bear interest in the weekly rate mode.

Draws on the Letter of Credit

Conforming draws for principal and interest presented to the Bank at or before 3:00 p.m., St. Louis, Missouri time, on a business day, will be honored by the Bank no later than 1:30 p.m., St. Louis, Missouri time, on the next business day. Conforming draws for purchase price presented to the Bank at or before 11:00 a.m., St. Louis, Missouri time, on a business day, will be honored by such Bank no later than 1:30 p.m., St. Louis, Missouri time, on such business day.

Substitution of the Letter of Credit

The Bonds will be subject to mandatory tender on the fifth (5th) business day prior to any substitution of the LOC. Draws for purchase price upon the substitution will be made under the existing LOC and the existing LOC will not be surrendered to the Bank for cancellation until after such tender draw is honored.

Reinstatement of Interest Draws

Draws made under the LOC for interest shall be automatically reinstated at the close of business on the date of payment of such interest drawing unless the trustee receives from the Bank a notice by 4:00 p.m. on such payment date stating that the Bank has not been reimbursed for such drawing or that an event of default under the reimbursement agreement has occurred. Upon receipt of such notice the trustee will immediately declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Reimbursement Agreement Defaults

Upon an event of default under the reimbursement agreement, the Bank may direct the trustee to accelerate the Bonds. Upon receipt of such notice, the trustee will declare the principal of and accrued interest on the Bonds immediately due and payable. Interest will cease to accrue one day following the date on which the Bonds are declared immediately due and payable. Upon receipt of such notice the trustee will immediately declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Bond Indenture Events of Default Related to Payment

Upon a failure to pay when due the principal or interest or the purchase price on the Bonds, the trustee may, and at the written request of the Bank or the holders of more than two-thirds (2/3) in aggregate principal amount of the outstanding Bonds shall declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Expiration / Termination of the Letter of Credit

The LOC shall terminate upon the earliest to occur of: (i) September 29, 2013, the stated expiration date; (ii) the business day following conversion of an interest rate of the Bonds to a rate other than a weekly interest rate; (iii) the day which is fifteen (15) days after trustee's receipt of a notice from the Bank stating that an event of default under the reimbursement agreement has occurred and directing acceleration of the Bonds, (iv) the date an acceleration drawing is honored by the Bank; (v) receipt by the Bank of a certificate from the trustee stating that (A) no Bonds remain outstanding and all draws under the LOC have been made and honored, or (B) a substitute LOC has been issued; or (vi) the date on which a stated maturity drawing that causing the stated amount of the LOC to be reduced to \$0 is honored by the Bank.

Optional Tenders

Bondholders may optionally tender their Bonds on any business day during the weekly rate mode with five (5) business days prior written notice to the trustee and the remarketing agent.

Mandatory Purchases

The Bonds are subject to mandatory purchase on: (i) each interest rate conversion date (ii) any interest reset date, (iii) the fifth (5th) business day prior to the effective date of an alternate letter of credit or (iv) the second (2nd) business day prior to the expiration date of the letter of credit.

What Could Change the Rating-Up

Long-Term: the long-term rating on the applicable series of Bonds could be upgraded if the long-term OSO rating of the Bank or the long-term rating of the Borrower was upgraded.

Short-Term: N/A

What Could Change the Rating-Down

Long-Term: the long-term rating on the Bonds could be lowered if the long term OSO rating of the Bank or the long-term rating of the Borrower was downgraded.

Short-Term: the short-term rating on the Bonds would be lowered if the short-term OSO rating, on the Bank was downgraded.

Contacts

Remarketing Agent: Bank of America Merrill Lynch

Trustee: The Bank of New York Mellon Trust Company

The principal methodologies used in rating this issue were Letter of Credit Supported Transactions published in August 2005 and Moody's Approach to Applying the Joint Support Methodology to Rating Letter of Credit-Supported Bonds published in May 2003. Other methodologies and factors that may have been considered in the process of rating this issue can also be found on Moody's website.

REGULATORY DISCLOSURES

Information sources used to prepare the credit rating are the following: parties involved in the ratings and public information.

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Rating Update: MOODY'S UPGRADES TO Aa1 (ON WATCH FOR DOWNGRADE)/VMIG 1 FROM A3/VMIG 2 LETTER OF CREDIT-BACKED RATING OF THE HEALTH AND EDUCATIONAL FACILITIES BOARD OF CITY OF JOHNSON CITY, TN HOSPITAL REVENUE BONDS (MOUNTAIN STATES HEALTH ALLIANCE) SERIES 2008A

Global Credit Research - 29 Sep 2010

\$13.245 MILLION IN DEBT AFFECTED. LONG-TERM JDA RATING IS BASED ON LONG-TERM RATINGS OF U.S BANK, N.A. AND MOUNTAIN STATES HEALTH ALLIANCE

Johnson City Health & Educ. Fac. Bd., TN
Fully Supported
TN

Opinion

NEW YORK, Sep 29, 2010 -- Moody's Investors Service has upgraded to Aa1 (on watch for downgrade)/VMIG 1 from A3/VMIG 2 rating of The Health and Educational Facilities Board of City of Johnson City, TN Hospital Revenue Bonds (Mountain States Health Alliance) Series 2008A (the Bonds) in conjunction with the substitution of the current letter of credit supporting the Bonds provided by Regions Bank with an alternate irrevocable direct-pay letter of credit (LOC) provided by U.S. Bank National Association (Bank).

RATING RATIONALE

The long-term rating is based on a joint default analysis (JDA) which reflects Moody's approach to rating jointly supported transactions. The JDA rating is based upon the long-term rating of the Bank as provider of the letter of credit; the underlying rating of the Bonds; and the structure and legal protections of the transaction which ensures timely debt service payments to investors. The timely payment of purchase price is reflected in the short-term rating of the Bonds. The short-term rating of the Bonds is based upon the short-term rating of the Bank as provider of the letter of credit.

U.S. Bank National Association is currently rated Aa1 for long-term other senior obligations (OSO) and Prime-1 for short-term OSO. The long-term rating of the Bank is currently on watch for downgrade. Moody's maintains Baa1 underlying rating on the Bonds.

Since a loss to investors would occur if both the Bank and Mountain States Health Alliance (the Borrower) default in payment, Moody's has assigned the long-term portion of the rating based upon the joint probability of default by both parties. In determining the joint probability of default, Moody's considers the level of default dependence between the Bank and the Borrower. Moody's has determined that there is a high level of default dependence between the Bank and the Borrower. As a result, the joint probability of default for the Bank and the Borrower results in a credit risk consistent with a JDA rating of Aa1 (on watch for downgrade) for the Bonds.

Interest Rate Modes and Payment

The Bonds will continue to bear interest in a weekly rate mode and interest will be paid on the first business day of each month. The bond trust indenture permits conversion of the Bonds, in whole, to a medium term or fixed interest rate period and upon any conversion the Bonds will be subject to mandatory purchase. The rating applies to the Bonds bearing interest in the weekly period only.

Additional Bonds

No additional bonds shall be issued under the bond trust indenture.

Flow of Funds

The trustee is instructed to draw under the LOC on or before 4:00 p.m., New York City time, on the business day

prior to any principal and interest payment date, in accordance with the LOC so as to receive moneys on the next business day in amount sufficient for the payment in full of the principal and interest due on the Bonds. If the Bank fails to honor a draw under the applicable LOC, the trustee shall immediately notify the Borrower and demand payment of such amount. The trustee is also instructed to draw under the LOC by 11:30 a.m., New York City time, on each purchase date to the extent remarketing proceeds are insufficient. Bonds which are purchased by the Bank due to a failed remarketing are held by the trustee and will not be released until the trustee has received confirmation from the Bank stating that the LOC has been reinstated in the amount of the purchase price drawn for such Bonds.

Letter of Credit

The LOC is sized for full principal plus 37 days of interest at the maximum rate applicable to the Bonds (12%) calculated based on 360 days year and will provide coverage for the Bonds while they bear interest in the weekly rate mode.

Draws on the Letter of Credit

Conforming draws for principal and interest presented to the Bank at or before 3:00 p.m., St. Louis, Missouri time, on a business day, will be honored by the Bank no later than 1:30 p.m., St. Louis, Missouri time, on the next business day. Conforming draws for purchase price presented to the Bank at or before 11:00 a.m., St. Louis, Missouri time, on a business day, will be honored by such Bank no later than 1:30 p.m., St. Louis, Missouri time, on such business day.

Substitution of the Letter of Credit

The Bonds will be subject to mandatory tender on the fifth (5th) business day prior to substitution of the LOC. Draws for purchase price upon the substitution will be made under the existing LOC and the existing LOC will not be surrendered to the Bank for cancellation until after such tender draw is honored.

Reinstatement of Interest Draws

Draws made under the LOC for interest shall be automatically reinstated at the close of business on the date of payment of such interest drawing unless the trustee receives from the Bank a notice by 4:00 p.m. on such payment date stating that the Bank has not been reimbursed for such drawing or that an event of default under the reimbursement agreement has occurred. Upon receipt of such notice the trustee will immediately declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Reimbursement Agreement Defaults

Upon an event of default under the reimbursement agreement, the Bank may direct the trustee to accelerate the Bonds. Upon receipt of such notice, the trustee will declare the principal of and accrued interest on the Bonds immediately due and payable. Interest will cease to accrue one day following the date on which the Bonds are declared immediately due and payable. Upon receipt of such notice the trustee will immediately declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Bond Indenture Events of Default Related to Payment

Upon a failure to pay when due the principal or interest or the purchase price on the Bonds, the trustee may, and at the written request of the Bank or the holders of more than two-thirds (2/3) in aggregate principal amount of the outstanding Bonds shall declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Expiration / Termination of the Letter of Credit

The LOC shall terminate upon the earliest to occur of: (i) September 29, 2013, the stated expiration date; (ii) the business day following conversion of an interest rate of the Bonds to a rate other than a weekly interest rate; (iii) the day which is fifteen (15) days after trustee's receipt of a notice from the Bank stating that an event of default under the reimbursement agreement has occurred and directing acceleration of the Bonds, (iv) the date an acceleration drawing is honored by the Bank; (v) receipt by the Bank of a certificate from the trustee stating that (A) no Bonds remain outstanding and all draws under the LOC have been made and honored, or (B) a substitute

LOC has been issued; or (vi) the date on which a stated maturity drawing that causing the stated amount of the LOC to be reduced to \$0 is honored by the Bank.

Optional Tenders

Bondholders may optionally tender their Bonds on any business day during the weekly rate mode with five (5) business days prior written notice to the trustee and the remarketing agent.

Mandatory Purchases

The Bonds are subject to mandatory purchase on: (i) each interest rate conversion date (ii) any interest reset date, (iii) the fifth (5th) business day prior to the effective date of an alternate letter of credit or (iv) the second (2nd) business day prior to the expiration date of the letter of credit.

What Could Change the Rating-Up

Long-Term: the long-term rating on the applicable series of Bonds could be upgraded if the long-term OSO rating of the Bank or the long-term rating of the Borrower was upgraded.

Short-Term: N/A

What Could Change the Rating-Down

Long-Term: the long-term rating on the Bonds could be lowered if the long term OSO rating of the Bank or the long-term rating of the Borrower was downgraded.

Short-Term: the short-term rating on the Bonds would be lowered if the short-term OSO rating, on the Bank was downgraded.

Contacts

Remarketing Agent: Bank of America Merrill Lynch

Trustee: The Bank of New York Mellon Trust Company

The principal methodologies used in rating this issue were Moody's Rating Methodology Letter of Credit Supported Transactions published in August 2005 and Applying Global Joint Default Analysis to Letter of Credit Backed Transactions in the U.S. Public Finance Sector published in September 2010. Other methodologies and factors that may have been considered in the process of rating this issue can also be found on Moody's website.

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Rating Update: MOODY'S AFFIRMS Aa3/VMIG 1 LETTER OF CREDIT-BACKED RATING TO THE HEALTH AND EDUCATIONAL FACILITIES BOARD OF CITY OF JOHNSON CITY, TN HOSPITAL REVENUE BONDS (MOUNTAIN STATES HEALTH ALLIANCE) SERIES 2007 B-3

Global Credit Research - 25 Oct 2010

\$58.5 MILLION IN DEBT AFFECTED. LONG-TERM JDA RATING BASED ON LONG-TERM RATINGS OF MIZUHO CORPORATE BANK LTD. AND MOUNTAIN STATES HEALTH ALLIANCE

Johnson City Health & Educ. Fac. Bd., TN
Fully Supported
TN

Opinion

NEW YORK, Oct 25, 2010 -- Moody's Investors Service has affirmed Aa3/VMIG 1 rating currently assigned to the Health and Educational Facilities Board of City of Johnson City, TN Hospital Revenue Bonds (Mountain States Health Alliance) Series 2007 B-3 (the Bonds) in connection with the application of the joint default analysis methodology.

RATING RATIONALE

The long term rating which was previously based on the long-term rating of the Bank will now be based on a joint default analysis (JDA) which reflects Moody's approach to rating jointly supported transactions. The JDA rating is based upon the long-term rating of Mizuho Corporate Bank, LTD (Bank) as provider of the letter of credit (LOC); the underlying rating of the Bonds; and the structure and legal protections of the transaction which ensures timely debt service payments to investors. The timely payment of purchase price is reflected in the short-term rating of the Bonds. The short-term rating of the Bonds is based upon the short-term rating of the Bank as provider of the letter of credit.

Mizuho Corporate Bank, LTD is currently rated Aa3 for long-term bank deposits and Prime-1 for short-term bank deposits. Moody's maintains Baa1 underlying rating on the Bonds.

Since a loss to investors would occur only if both the Bank and Mountain States Health Alliance (the Borrower) default in payment, Moody's has assigned the long-term portion of the rating based upon the joint probability of default by both parties. In determining the joint probability of default, Moody's considers the level of default dependence between the Bank and the Borrower. Moody's has determined that there is a high level of default dependence between the Bank and the Borrower. As a result, the joint probability of default for the Bank and the Borrower results in a credit risk consistent with a JDA rating of Aa3 for the Bonds.

Interest Rate Modes and Payment

The Bonds will bear interest in a weekly rate mode and interest will be paid on the first business day of each month. The bond trust indenture permits conversion of the Bonds, in whole, to a medium term or fixed interest rate period and upon any conversion the Bonds will be subject to mandatory purchase. The rating applies to the Bonds bearing interest in the weekly period only.

Additional Bonds

No additional bonds shall be issued under the bond trust indenture.

Flow of Funds

The trustee is instructed to draw under the LOC on or before 4:00 p.m., New York City time, on the business day prior to any principal and interest payment date, in accordance with the LOC so as to receive moneys on the next business day in amount sufficient for the payment in full of the principal and interest due on the Bonds. If the Bank

fails to honor a draw under the LOC, the trustee shall immediately notify the Borrower and demand payment of such amount. The trustee is also instructed to draw under the LOC by 11:30 a.m., New York City time, on each purchase date to the extent remarketing proceeds are insufficient. Bonds which are purchased by the Bank due to a failed remarketing are held by the trustee and will not be released until the trustee has received confirmation from the Bank stating that the LOC has been reinstated in the amount of the purchase price drawn for such Bonds.

Letter of Credit

The LOC is sized for full principal plus 37 days of interest at the maximum rate applicable to the Bonds (12%) calculated based on 360 days year and will provide coverage for the Bonds while they bear interest in the weekly rate mode.

Draws on the Letter of Credit

Conforming draws for principal and interest presented to the Bank at or before 4:00 p.m., New York City time, on a business day, will be honored by the Bank no later than 2:30 p.m., New York City time, on the next business day. Conforming draws for purchase price presented to the Bank at or before 12:00 noon, New York City time, on a business day, will be honored by such Bank no later than 2:30 p.m., New York City time, on such business day.

Substitution of the Letter of Credit

The Bonds will be subject to mandatory tender on the fifth (5th) business day prior to substitution of the LOC. Draws for purchase price upon the substitution will be made under the existing LOC and the existing LOC will not be surrendered to the Bank for cancellation until after such tender draw is honored.

Reinstatement of Interest Draws

Draws made under the LOC for interest shall be automatically reinstated at the close of business on the date of payment of such interest drawing unless the trustee receives from the Bank a notice by 4:00 p.m. New York City time, on such payment date stating that the Bank has not been reimbursed for such drawing or that an event of default under the reimbursement agreement has occurred. Upon receipt of such notice the trustee will immediately declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Reimbursement Agreement Defaults

Upon an event of default under the reimbursement agreement, the Bank may direct the trustee to accelerate the Bonds. Upon receipt of such notice, the trustee will declare the principal of and accrued interest on the Bonds immediately due and payable. Interest will cease to accrue one day following the date on which the Bonds are declared immediately due and payable. Upon receipt of such notice the trustee will immediately declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Bond Indenture Events of Default Related to Payment

Upon a failure to pay when due the principal or interest or the purchase price on the Bonds, the trustee may, and at the written request of the Bank or the holders of more than two-thirds (2/3) in aggregate principal amount of the outstanding Bonds shall declare the principal of and accrued interest on the Bonds due and payable and interest on such Bonds will cease to accrue on the day it becomes payable, which day shall be one business day after declaration of acceleration.

Expiration / Termination of the Letter of Credit

The LOC shall terminate upon the earliest to occur of: (i) September 29, 2013, the stated expiration date; (ii) the business day following conversion of an interest rate of the Bonds to a rate other than a weekly interest rate; (iii) the day which is fifteen (15) days after trustee's receipt of a notice from the Bank stating that an event of default under the reimbursement agreement has occurred and directing acceleration of the Bonds, (iv) the date an acceleration drawing is honored by the Bank; (v) receipt by the Bank of a certificate from the trustee stating that (A) no Bonds remain outstanding and all draws under the LOC have been made and honored, or (B) a substitute LOC has been issued; or (vi) the date on which a stated maturity drawing that causing the stated amount of the LOC to be reduced to \$0 is honored by the Bank.

Optional Tenders

Bondholders may optionally tender their Bonds on any business day during the weekly rate mode with five (5) business days prior written notice to the trustee and the remarketing agent.

Mandatory Purchases

The Bonds are subject to mandatory purchase on: (i) each interest rate conversion date (ii) any interest reset date while the Bonds are in the medium-term rate period, (iii) the fifth (5th) business day prior to the effective date of an alternate letter of credit or (iv) the second (2nd) business day prior to the expiration date of the letter of credit.

What Could Change the Rating-Up

Long-Term: the long-term rating on the Bonds could be upgraded if the Bank's long-term deposits rating or the long-term rating of the Borrower was upgraded, or if there was a decrease in the level of default dependence between the Bank and the Borrower.

Short-Term: N/A

What Could Change the Rating-Down

Long-Term: the long-term rating on the Bonds could be lowered if the Bank's long term deposits rating or the long-term rating of the Borrower was downgraded, or if there is an increase in the level of default dependence between the Bank and the Borrower.

Short-Term: the short-term rating on the Bonds could be lowered if the Bank's short-term deposits rating was downgraded.

Methodology

The principal methodologies used in rating this issue were Moody's Rating Methodology for Letter of Credit Supported Transactions published in August 2005 and Applying Global Joint Default Analysis to Letter of Credit Backed Transactions in the U.S. Public Finance Sector published in September 2010. Other methodologies and factors that may have been considered in the process of rating this issue can also be found on Moody's website.

Contacts

Remarketing Agent: Bank of America Merrill Lynch

Trustee: The Bank of New York Mellon Trust Company

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MOODY'S

INVESTORS SERVICE

New Issue: MOODY'S ASSIGNS LETTER OF CREDIT BACKED RATINGS TO THE MOUNTAIN STATES HEALTH ALLIANCE, SERIES 2011A, 2011B, 2011C, 2011D, AND 2011E

Global Credit Research - 14 Oct 2011

\$211.8 MILLION OF DEBT AFFECTED. RATING IS BASED ON THE JOINT SUPPORT FROM U.S. BANK N.A., PNC BANK, N.A. AND MIZUHO CORPORATE BANK, LTD AS LETTER OF CREDIT PROVIDERS

Johnson City Health & Educ. Fac. Bd., TN
Fully Supported
TN

Moody's Rating

ISSUE	RATING
Ser. 2011B	A2/VMIG 1
Sale Amount	\$20,000,000
Expected Sale Date	10/19/11
Rating Description	DP LOC

Ser. 2011A	Aa2/VMIG 1
Sale Amount	\$65,260,000
Expected Sale Date	10/19/11
Rating Description	DP LOC

Opinion

NEW YORK, Oct 14, 2011 -- Moody's Investors Service ("Moody's") has assigned ratings of: Aa2/VMIG 1 to the Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011A, and A1/VMIG1 to Series 2011B of that same issue; Aa2/VMIG 1 to the Industrial Development Authority of Smyth County, Virginia Hospital Revenue Bonds (Mountain States Health Alliances), Series 2011C, and Aa3/VMIG 1 to Series 2011D of that same issue; and Aa3/VMIG 1 to the Mountain States Health Alliance Taxable Bonds, Series 2011E (collectively, the "Bonds"). The long-term ratings of Series 2011D and 2011E are on review for downgrade in connection with Moody's ongoing review of Mizuho Corporate Bank, Ltd.

The proceeds of the sale of the Bonds will be used to: (a) finance certain capital expenses at Mountain State Health Alliance facilities; (b) refinance \$11.2 million of the Hospital Refunding and Improvement Revenue Bonds (Norton Community Hospital, Inc.), Series 2001 issued by the Industrial Development Authority of the City of Norton, Virginia; and (c) pay certain expenses incurred in connection with the issuance of the Bonds.

SUMMARY RATINGS RATIONALE

The ratings are based upon: (i) direct-pay letters of credit provided by U.S. Bank National Association for Series 2011A and Series 2011C, PNC Bank, National Association for Series 2011B, and Mizuho Corporate Bank, Ltd. for Series 2011D and Series 2011E; (ii) the structure and legal protections of the transaction which ensure timely payment of debt service and purchase price to bondholders; and (iii) Moody's evaluation of the credit quality of the Banks issuing the letters of credit.

Moody's currently rates U.S. Bank N.A. Aa2 for its long-term other senior obligations ("OSO") and Prime-1 for its short-term OSO. PNC Bank, N.A. is currently rated A2 for its long-term OSO and Prime-1 for its short-term OSO. Mizuho Corporate Bank, Ltd's long-term and short-term issuer ratings are currently A1 (on review for downgrade) and Prime-1, respectively.

DETAILED CREDIT DISCUSSION

Interest Rate Modes

The Bonds will be issued in the weekly rate mode and pay interest on the first business day of each month, commencing November 1, 2011. Each letter of credit provides sufficient coverage for the applicable Series of bonds in the weekly rate mode only. The bond documents permit conversion of the interest rate on the Bonds, in whole, to the medium-term rate or fixed rate modes. The Bonds will be subject to mandatory tender upon each conversion. Moody's rating on the Bonds applies only to Bonds bearing interest in the weekly rate modes.

Flow of Funds

The trustee is instructed to draw under the applicable letter of credit by 4:00 p.m. on the business day prior to the payment date in order to receive funds sufficient to pay the principal, and interest accrued thereon, when the same becomes due. The trustee shall also draw for purchase price under the letter of credit by 11:30 a.m., in accordance with its terms thereof, so as to receive sufficient funds by 2:30 p.m. on the same day to pay the purchase price of Bonds tendered on the purchase date to the extent remarketing proceeds received are insufficient. Bonds which are purchased by the applicable bank due to a failed remarketing are held by the trustee and will not be released until the trustee has received written confirmation from that bank stating that the applicable letter of credit has been reinstated in the amount of the purchase price drawn for such Bonds. (All times refer to Eastern Standard Time).

Letters of Credit

Each letter of credit is sized for the full principal amount plus thirty-seven days of interest at a rate of 12%, the maximum rate on the Bonds. Each letter of credit provides sufficient coverage for the applicable Series of bonds while they bear interest in the weekly rate mode only. Each letter of credit is governed by and construed in accordance with the International Standby Practices 1998, International Chamber of Commerce Publication No. 590 (ISP98).

Draws on the Letters of Credit

Conforming draws for principal or interest received by U.S. Bank N.A., for Series 2011A and 2011C, at or before 3:00 p.m. on a business day will be honored by 1:30 p.m. on the next business day. Conforming draws for purchase price received by U.S. Bank N.A. at or before 11:30 a.m. on a business day will be honored by 1:30 p.m. on the same business day. (All times refer to Central Standard Time).

Conforming draws for principal or interest received by PNC Bank, N.A. or Mizuho Corporate Bank, Ltd., supporting Series 2011B, and 2011D and 2011E, respectively, at or before 4:00 p.m. on a business day will be honored by 2:30 p.m. on the next business day. Conforming draws for purchase price received by those banks at or before 12:30 p.m. on a business day will be honored by 2:30 p.m. on the same business day. (All times refer to Eastern Standard Time).

Reinstatement Of Interest Draws

Draws made under each letter of credit for interest shall be automatically reinstated at the close of business on the date of such payment unless the trustee receives written notice from the applicable bank by 3:00 p.m. (Central Standard Time) in the case of Series 2011A or 2011C bonds, or 4:00 p.m. (Eastern Standard Time) in the case of Series 2011B, 2011D, or 2011E on the date of such payment specifying the occurrence of an event of default under the reimbursement agreement and directing the trustee to accelerate the applicable Series of Bonds. With direction to accelerate the applicable Series of bonds, the trustee shall declare bonds of that Series then outstanding to be immediately due and payable, whereupon they shall become and be immediately due and payable. The trustee is instructed to immediately draw on the letter of credit. Interest will cease to accrue one calendar day following the trustee's declaration of acceleration.

Reimbursement Agreement Defaults

In the event of a default under the reimbursement agreement, the applicable bank may, at its option, deliver written notice to the trustee stating that such event of default under the reimbursement agreement has occurred and direct the trustee to accelerate the applicable Series of bonds. With direction to accelerate the applicable Series of Bonds, the trustee shall declare bonds of that Series then outstanding to be immediately due and payable, whereupon they shall become and be immediately due and payable. The trustee is instructed to immediately draw on the letter of credit. Interest will cease to accrue one calendar day following the trustee's declaration of

acceleration. The applicable letter of credit will terminate on the fifteenth calendar day following the trustee's receipt of notice from the applicable bank specifying the occurrence of an event of default under the reimbursement agreement and directing the trustee to accelerate the applicable Series of bonds.

Expiration/Termination of the Letters of Credit

Each letter of credit will terminate upon the earliest to occur of: (i) close of business on October 19, 2014, the stated expiration date of the applicable letter of credit; (ii) the business day following the conversion of all of the applicable Series of bonds to a rate mode other than the weekly rate; (iii) the date the bank receives notice from the trustee specifying that (a) no applicable bonds of a Series remain outstanding and all required draws available under the applicable letter of credit have been made and honored, or (b) an effective substitute letter of credit has been issued to replace the applicable letter of credit; (iv) the date on which an acceleration drawing is honored by the applicable bank; (v) fifteen calendar days following the trustee's receipt of notice from the applicable bank specifying the occurrence of an event of default under the reimbursement agreement and directing the trustee to accelerate the applicable Series of bonds; or, (vi) the date on which a stated maturity drawing is honored by the applicable bank.

Substitution

The Bonds will be subject to mandatory tender on fifth business day prior to the effective date of a substitute letter of credit. Draws for purchase price upon the substitution of the letter of credit will be made under the existing letter of credit and the existing letter of credit will not be surrendered to the bank for cancellation until such tender draw has been honored.

Optional Tenders

Bondholders may optionally tender their Bonds, while the Bonds are in the weekly rate mode, on any business day by providing written notice to the trustee and remarketing agent by 3:00 p.m. at least five business days prior to the purchase date. (All times refer to Eastern Standard Time).

Mandatory Tenders

The Bonds are subject to mandatory tender on: (i) on any interest rate mode conversion date, or any proposed interest rate mode conversion date; (ii) on the fifth business day preceding the effective date of a substitute letter of credit; (iii) on the adjustment date while the Bonds bear interest at the medium-term rate; (iv) on the first calendar day of a weekly rate period following a medium-term rate period; and (v) on the second business day prior to the expiration date of the letter of credit.

What Could Change the Rating - Up

Long-Term: The long-term rating on the applicable Series of bonds could be raised if the long-term rating of the applicable bank was upgraded.

Short-Term: Not applicable.

What Could Change the Rating - Down

Long-Term: The long-term rating on the applicable Series of bonds could be lowered if the long-term rating of the applicable bank was downgraded.

Short-Term: The short-term rating on the applicable Series of bonds would be lowered if the short-term rating of the applicable bank was downgraded.

Key Contacts:

Trustee: The Bank of New York Mellon Trust Company, N.A.

Underwriter: BofA Merrill Lynch (for Series 2011A, 2011B, 2011D, and 2011E) and U.S. Bank N.A. (for Series 2011C)

Remarketing Agent: Merrill Lynch, Pierce, Fenner & Smith (for Series 2011A, 2011B, 2011D, and 2011E) and U.S. Bank N.A. (for Series 2011C)

PRINCIPAL METHODOLOGY USED

The principal methodology used in this rating was Moody's Methodology for Rating U.S. Public Finance Transactions Based on the Credit Substitution Approach (August 2009). Please see the Credit Policy page on www.moodys.com for a copy of this methodology.

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Rating Update: MOODY'S ASSIGNS LETTER OF CREDIT BACKED RATINGS TO THE MOUNTAIN STATES HEALTH ALLIANCE, SERIES 2011A, 2011B, 2011C, 2011D, AND 2011E

Global Credit Research - 17 Oct 2011

\$211.8 MILLION OF DEBT AFFECTED. RATING IS BASED ON THE JOINT SUPPORT FROM U.S. BANK N.A., PNC BANK, N.A. AND MIZUHO CORPORATE BANK, LTD AS LETTER OF CREDIT PROVIDERS

Smyth County Ind. Dev. Auth., VA
Fully Supported
VA

Opinion

NEW YORK, Oct 17, 2011 -- Moody's Investors Service ("Moody's") has assigned ratings of: Aa2/VMIG 1 to the Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011A, and A1/VMIG1 to Series 2011B of that same issue; Aa2/VMIG 1 to the Industrial Development Authority of Smyth County, Virginia Hospital Revenue Bonds (Mountain States Health Alliances), Series 2011C, and Aa3/VMIG 1 to Series 2011D of that same issue; and Aa3/VMIG 1 to the Mountain States Health Alliance Taxable Bonds, Series 2011E (collectively, the "Bonds"). The long-term ratings of Series 2011D and 2011E are on review for downgrade in connection with Moody's ongoing review of Mizuho Corporate Bank, Ltd.

The proceeds of the sale of the Bonds will be used to: (a) finance certain capital expenses at Mountain State Health Alliance facilities; (b) refinance \$11.2 million of the Hospital Refunding and Improvement Revenue Bonds (Norton Community Hospital, Inc.), Series 2001 issued by the Industrial Development Authority of the City of Norton, Virginia; and (c) pay certain expenses incurred in connection with the issuance of the Bonds.

SUMMARY RATINGS RATIONALE

The ratings are based upon: (i) direct-pay letters of credit provided by U.S. Bank National Association for Series 2011A and Series 2011C, PNC Bank, National Association for Series 2011B, and Mizuho Corporate Bank, Ltd. for Series 2011D and Series 2011E; (ii) the structure and legal protections of the transaction which ensure timely payment of debt service and purchase price to bondholders; and (iii) Moody's evaluation of the credit quality of the Banks issuing the letters of credit.

Moody's currently rates U.S. Bank N.A. Aa2 for its long-term other senior obligations ("OSO") and Prime-1 for its short-term OSO. PNC Bank, N.A. is currently rated A2 for its long-term OSO and Prime-1 for its short-term OSO. Mizuho Corporate Bank, Ltd's long-term and short-term issuer ratings are currently A1 (on review for downgrade) and Prime-1, respectively.

DETAILED CREDIT DISCUSSION

Interest Rate Modes

The Bonds will be issued in the weekly rate mode and pay interest on the first business day of each month, commencing November 1, 2011. Each letter of credit provides sufficient coverage for the applicable Series of bonds in the weekly rate mode only. The bond documents permit conversion of the interest rate on the Bonds, in whole, to the medium-term rate or fixed rate modes. The Bonds will be subject to mandatory tender upon each conversion. Moody's rating on the Bonds applies only to Bonds bearing interest in the weekly rate modes.

Flow of Funds

The trustee is instructed to draw under the applicable letter of credit by 4:00 p.m. on the business day prior to the payment date in order to receive funds sufficient to pay the principal, and interest accrued thereon, when the same becomes due. The trustee shall also draw for purchase price under the letter of credit by 11:30 a.m., in accordance with its terms thereof, so as to receive sufficient funds by 2:30 p.m. on the same day to pay the

purchase price of Bonds tendered on the purchase date to the extent remarketing proceeds received are insufficient. Bonds which are purchased by the applicable bank due to a failed remarketing are held by the trustee and will not be released until the trustee has received written confirmation from that bank stating that the applicable letter of credit has been reinstated in the amount of the purchase price drawn for such Bonds. (All times refer to Eastern Standard Time).

Letters of Credit

Each letter of credit is sized for the full principal amount plus thirty-seven days of interest at a rate of 12%, the maximum rate on the Bonds. Each letter of credit provides sufficient coverage for the applicable Series of bonds while they bear interest in the weekly rate mode only. Each letter of credit is governed by and construed in accordance with the International Standby Practices 1998, International Chamber of Commerce Publication No. 590 (ISP98).

Draws on the Letters of Credit

Conforming draws for principal or interest received by U.S. Bank N.A., for Series 2011A and 2011C, at or before 3:00 p.m. on a business day will be honored by 1:30 p.m. on the next business day. Conforming draws for purchase price received by U.S. Bank N.A. at or before 11:30 a.m. on a business day will be honored by 1:30 p.m. on the same business day. (All times refer to Central Standard Time).

Conforming draws for principal or interest received by PNC Bank, N.A. or Mizuho Corporate Bank, Ltd., supporting Series 2011B, and 2011D and 2011E, respectively, at or before 4:00 p.m. on a business day will be honored by 2:30 p.m. on the next business day. Conforming draws for purchase price received by those banks at or before 12:30 p.m. on a business day will be honored by 2:30 p.m. on the same business day. (All times refer to Eastern Standard Time).

Reinstatement Of Interest Draws

Draws made under each letter of credit for interest shall be automatically reinstated at the close of business on the date of such payment unless the trustee receives written notice from the applicable bank by 3:00 p.m. (Central Standard Time) in the case of Series 2011A or 2011C bonds, or 4:00 p.m. (Eastern Standard Time) in the case of Series 2011B, 2011D, or 2011E on the date of such payment specifying the occurrence of an event of default under the reimbursement agreement and directing the trustee to accelerate the applicable Series of Bonds. With direction to accelerate the applicable Series of bonds, the trustee shall declare bonds of that Series then outstanding to be immediately due and payable, whereupon they shall become and be immediately due and payable. The trustee is instructed to immediately draw on the letter of credit. Interest will cease to accrue one calendar day following the trustee's declaration of acceleration.

Reimbursement Agreement Defaults

In the event of a default under the reimbursement agreement, the applicable bank may, at its option, deliver written notice to the trustee stating that such event of default under the reimbursement agreement has occurred and direct the trustee to accelerate the applicable Series of bonds. With direction to accelerate the applicable Series of Bonds, the trustee shall declare bonds of that Series then outstanding to be immediately due and payable, whereupon they shall become and be immediately due and payable. The trustee is instructed to immediately draw on the letter of credit. Interest will cease to accrue one calendar day following the trustee's declaration of acceleration. The applicable letter of credit will terminate on the fifteenth calendar day following the trustee's receipt of notice from the applicable bank specifying the occurrence of an event of default under the reimbursement agreement and directing the trustee to accelerate the applicable Series of bonds.

Expiration/Termination of the Letters of Credit

Each letter of credit will terminate upon the earliest to occur of: (i) close of business on October 19, 2014, the stated expiration date of the applicable letter of credit; (ii) the business day following the conversion of all of the applicable Series of bonds to a rate mode other than the weekly rate; (iii) the date the bank receives notice from the trustee specifying that (a) no applicable bonds of a Series remain outstanding and all required draws available under the applicable letter of credit have been made and honored, or (b) an effective substitute letter of credit has been issued to replace the applicable letter of credit; (iv) the date on which an acceleration drawing is honored by the applicable bank; (v) fifteen calendar days following the trustee's receipt of notice from the applicable bank specifying the occurrence of an event of default under the reimbursement agreement and directing the trustee to accelerate the applicable Series of bonds; or, (vi) the date on which a stated maturity drawing is honored by the

applicable bank.

Substitution

The Bonds will be subject to mandatory tender on fifth business day prior to the effective date of a substitute letter of credit. Draws for purchase price upon the substitution of the letter of credit will be made under the existing letter of credit and the existing letter of credit will not be surrendered to the bank for cancellation until such tender draw has been honored.

Optional Tenders

Bondholders may optionally tender their Bonds, while the Bonds are in the weekly rate mode, on any business day by providing written notice to the trustee and remarketing agent by 3:00 p.m. at least five business days prior to the purchase date. (All times refer to Eastern Standard Time).

Mandatory Tenders

The Bonds are subject to mandatory tender on: (i) on any interest rate mode conversion date, or any proposed interest rate mode conversion date; (ii) on the fifth business day preceding the effective date of a substitute letter of credit; (iii) on the adjustment date while the Bonds bear interest at the medium-term rate; (iv) on the first calendar day of a weekly rate period following a medium-term rate period; and (v) on the second business day prior to the expiration date of the letter of credit.

What Could Change the Rating - Up

Long-Term: The long-term rating on the applicable Series of bonds could be raised if the long-term rating of the applicable bank was upgraded.

Short-Term: Not applicable.

What Could Change the Rating - Down

Long-Term: The long-term rating on the applicable Series of bonds could be lowered if the long-term rating of the applicable bank was downgraded.

Short-Term: The short-term rating on the applicable Series of bonds would be lowered if the short-term rating of the applicable bank was downgraded.

Key Contacts:

Trustee: The Bank of New York Mellon Trust Company, N.A.

Underwriter: BofA Merrill Lynch (for Series 2011A, 2011B, 2011D, and 2011E) and U.S. Bank N.A. (for Series 2011C)

Remarketing Agent: Merrill Lynch, Pierce, Fenner & Smith (for Series 2011A, 2011B, 2011D, and 2011E) and U.S. Bank N.A. (for Series 2011C)

PRINCIPAL METHODOLOGY USED

The principal methodology used in this rating was Moody's Methodology for Rating U.S. Public Finance Transactions Based on the Credit Substitution Approach (August 2009). Please see the Credit Policy page on www.moodys.com for a copy of this methodology.

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Please see ratings tab on the issuer/entity page on www.moody's.com for the last rating action and the rating history.

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INVESTORS SERVICE

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Rating Update: MOODY'S AFFIRMS MOUNTAIN STATES HEALTH ALLIANCE'S (TN) Baa1 BOND RATING; OUTLOOK REMAINS STABLE

Global Credit Research - 26 Apr 2012

APPROXIMATELY \$1.03 BILLION OF RATED DEBT OUTSTANDING

MOUNTAIN STATES HEALTH ALLIANCE, TN
Hospitals & Health Service Providers
TN

Opinion

NEW YORK, April 26, 2012 --Opinion

Moody's Investors Service has affirmed the Baa1 unenhanced ratings assigned to Mountain States Health Alliance's (MSHA) \$821 million of outstanding bonds issued by The Health and Educational Facilities Board of the City of Johnson City, TN, the Industrial Development Authority of Smyth County (Virginia), the Industrial Development Authority of Russell County (Virginia), and directly by MSHA. The Series 2011 bonds (\$211.8 million) are supported by direct pay letters of credit and do not carry unenhanced ratings. The outlook remains stable.

SUMMARY RATING RATIONALE

Leading market share for this multi-hospital system offering a wide-array of high-end services is a key credit strength. MSHA continues a long history of double digit operating cash flow margins with a good cash balance that remains over 200 days despite decline in market values at the end of calendar year 2011. Major capital spending is nearly complete, enabling future growth in liquidity, minor additional debt plans. These strengths are tempered by one of the highest debt loads in our portfolio, generating weak debt measures. One other multi-facility health system provides competitive pressures.

STRENGTHS

*Multi-hospital system with strong and growing leading market share in a large geographic region where the flagship facility serves as a regional referral center offering a wide array of high-end services for hospitals in Tennessee and Virginia

*Multi-year growth in volumes with acquisitions

*Strong and stable operating cash flow margins in the 11.4% to 16.7% range in each of the past seventeen audit years, with volume increases contributing to cash flow growth; projected operating cash flow margins remain in the double digits

*Good liquidity position with 246 days cash on hand at fiscal yearend (FYE) 2011 (June 30) and 217 days as of December 31, 2011

*Major capital spending nearly complete with upcoming opening of Smyth County Community Hospital; minor additional new debt planned for later this year

*Tenured management team

CHALLENGES

*Very high debt burden evidenced by high 110% debt-to-operating revenue, low 55% cash-to-debt ratio, high 7.7 times debt-to-cash flow ratio, and moderate Moody's-adjusted maximum annual debt service coverage of 2.55 times in FY 2011 as compared with Moody's Baa1 medians of 41.2%, 83.4%, 4.8 times and 3.5 times, respectively

*Sizable and consistent competition from Wellmont Health System, which holds a close but lesser market share (37% vs. 30%) in the extended 29-county service area and a significantly smaller market share (52% versus 38%)

in MSHA's 13-county core service area

*High 22.2% TennCare/Medicaid and self-pay load

DETAILED CREDIT DISCUSSION

LEGAL SECURITY: The bonds are secured by a security interest in the Pledged Assets (receivables, inventory, equipment, general intangibles, contracts and contract rights, government approvals, fixtures and other personal property, goods, instruments, chattel paper, documents, credits, claims, demands and assets) and a first lien on the Mortgaged Property, which includes the major hospitals, subject to certain permitted liens.

INTEREST RATE DERIVATIVES: MSHA is a party to interest rate swaps and other derivative agreements to establish floating rate exposure and to reduce fixed rate debt service. MSHA holds four basis swaps and one total return swap with Merrill Lynch Capital Services Inc. (guaranteed by Merrill Lynch & Co) for a total notional amount of \$594 million. The fair market value of the swaps at December 31, 2011 was a liability of \$15.3 million.

MSHA holds eight additional agreements (\$106 million notional amount) with Lehman Brothers Special Financing, Inc. (Lehman) for various notional amounts that are linked fixed payer and total return swaps. Fair market value of these swaps at December 31, 2011 was a liability of \$10.5 million, against which MSHA has posted \$13.2 million of collateral (collateral is not included in unrestricted cash). Lehman filed for bankruptcy and the swaps were terminated effective January 1, 2009. There is a dispute between MSHA and Lehman regarding the cost of such termination, which is currently under discussion. MSHA has stated that it believes that the amount of the posted collateral should be sufficient to pay the cost of the terminations.

In September 2011 MSHA negotiated a full termination of the swaptions at no direct cost.

Two additional swaps, for a notional amount of \$20.2 million and a mark to market liability value of \$618,000 as of December 31, 2011.

RECENT DEVELOPMENTS/RESULTS

Operating cash flow margins continue to be strong at double digit levels, reaching 15.7% in FY 2011 (ended June 30) on operating cash flow of \$153.2 million, up 9.9% and \$139.4 million in FY 2010. As a result, debt-to-cash flow improved to 7.74 times in FY 2011 from 8.88 times in FY 2010 and high 10.22 times just two years earlier in FY 2009. This improvement occurred despite the rapid expansion with facility acquisitions (including equity interests) in Virginia between 2006 and 2009, which contributed to revenue growth to \$976.1 million in FY 2011 from \$678.5 million in FY 2007.

System expansion into southwest Virginia from a concentration in northeastern Tennessee has included the following: November 2006 purchase of 80% interest in Smyth County Community Hospital in Marion; October 2007 purchase of 50.1% interest in Norton Community Hospital that includes Norton Community Hospital in Norton and Dickenson County Community Hospital in Clintwood; January 2008 acquisition of Russell County Medical Center in Lebanon; and April 2009 purchase of 50.1% interest in Johnston Memorial Hospital in Abingdon. Combined, the Virginia hospitals added 627 licensed beds and about 10,000 acute care discharges to the system. Management continues to work on full integration of these facilities into the system with no current plans for additional facility acquisitions.

In addition to expanding in Virginia, in Tennessee MSHA opened a new free standing children's hospital in March 2009, consolidated two smaller facilities in Washington County, and undertook other renovation projects. As a result, the system grew admissions 27% across a four year period to 61,035 admissions in FY 2011 from 48,055 admissions in FY 2007. Outpatient visits and emergency room visits grew a sizable 66.8% and 50.8%, respectively, and total surgeries 26.3% across the same four year period. For the first six months of FY 2012 admissions grew another 3.3%, and outpatient visits by 3.6%.

MSHA's main competitor remains Wellmont Health System (Wellmont). Wellmont, with its flagship hospitals located in Sullivan County in the cities of Bristol and Kingsport, has grown to an eight facility system across northeastern Tennessee and southwest Virginia. MSHA defines its 13 county core service area largely as those nine counties where its acute care facilities are located plus an additional four neighboring counties. Within this 13 county service area MSHA maintains a leading and slightly growing market share, to 51.9% in 2010 from 51.5% in 2007 (management provided data), to Wellmont's 37.9%. In its extended 29 total county service area, management shows a leading 36.8% market share in 2010 compared to Wellmont's 30.1%.

The total system debt load remains high, evidenced through a 110% debt-to-revenue ratio in FY 2011, one of the

highest in our portfolio. The debt structure is a mixture of fixed and variable rate bonds, notes and capital leases. As of December 31, 2011, about 60% of total debt is in a fixed rate mode and 40% in a variable rate mode. Letters of credit on outstanding Series 2007B and Series 2008A & B bonds have been extended to October 19, 2014 (\$252.3 million). The new Series 2011A-E bond letters of credit expire October 19, 2014 (\$211.8 million). Cash-to-demand debt of 116% at December 31, 2011 is down from a stronger 157% at FYE 2011 due to both an increase in debt load and a decline in liquidity. Moody's-adjusted maximum annual debt service (MADS) coverage of 2.55 times in FY 2011 improves in the first half of FY 2012 to an annualized 2.95 times with a decline in MADS with debt restructuring in the fourth quarter of 2011. There is minor additional debt planned for later this year.

Unrestricted liquidity declined \$53.1 million (9%) in the first six months of FY 2012 to \$539.4 million at December 31, 2011 from \$592.5 million at June 30, 2011. Major drivers to the decline included a decline in market value to offset investment returns, debt service payments, capital spending and an increase in accounts receivable. As a result cash on hand declined to 216 days from 246 days, but consistently remains above 200 days. Cash-to-debt, which had improved to 55% in FY 2011 from 48% in FY 2009, declined with the decline in liquidity to 50% as of December 31, 2011, but remains comparable to the 47.9%-64.4% range from 2007-2011.

Outlook

The stable outlook reflects our belief that MSHA will continue to generate strong and stable operating cash flow margins to support its high debt load. We believe liquidity will improve barring any major negative fair market value adjustments.

WHAT COULD MOVE THE RATING UP

Continued growth in operating cash flow to support the high debt load; material improvement in debt measures; regrowth of liquidity; increased diversification of cash flow

WHAT COULD MOVE THE RATING DOWN

Increase in debt load without commensurate increase in cash flow; notable loss in market share; trend of decline in operating cash flow; material decline or loss of supplemental payments for servicing the Medicaid and indigent populations

KEY INDICATORS

Assumptions & Adjustments:

- Based on financial statements for Mountain States Health Alliance
- First number reflects the audit year ended June 30, 2010
- Second number reflects audit year ended June 30, 2011
- Non-operating income excludes loss on early extinguishment of debt and change in fair value of derivatives
- Investment returns smoothed at 6% unless otherwise noted

*Inpatient admissions: 60,101; 61,035

*Total operating revenues: \$944.3 million; \$976.1 million

*Moody's-adjusted net revenue available for debt service: \$175.5 million; \$193.0 million

*Total debt outstanding: \$1.08 billion; \$1.07 billion

*Total comprehensive debt outstanding: \$1.13 billion; \$1.13 billion

*Maximum annual debt service (MADS): \$75.6 million; \$75.6 million

*MADS Coverage based on reported investment income: 2.14 times; 2.32 times

*Moody's-adjusted MADS Coverage: 2.32 times; 2.55 times

*Debt-to-cash flow: 8.88 times; 7.74 times

*Days cash on hand: 235 days; 246 days

*Cash-to-debt: 51%; 55%

*Cash-to-total comprehensive debt: 49%; 53%

*Operating margin: 0.5%; 0.9%

*Operating cash flow margin: 14.8%; 15.7%

RATED DEBT (as of December 31, 2011)

Issued by The Health and Educational Facilities Board of the City of Johnson City, Tennessee:

Series 2011A variable rate bonds (\$65.3 million outstanding), rated Aa2/VMIG 1 supported by letter of credit from US Bank expiring October 19, 2014

-Series 2011B variable rate bonds (\$20.0 million outstanding), rated A2/VMIG 1 supported by letter of credit from PNC Bank expiring October 19, 2014

-Series 2010A fixed rate bonds (\$161.9 million outstanding), rated Baa1

-Series 2009A fixed rate term bonds (\$5.6 million outstanding), rated Baa1

-Series 2008A Variable Rate Hospital Revenue Bonds (\$13.2 million outstanding), rated Aa2/VMIG 1 supported by letter of credit from US Bank expiring October 19, 2014; Baa1 unenhanced rating

-Series 2007B-1 Variable Rate Hospital Revenue Bonds (\$26.2 million outstanding), joint support rating of A1/VMIG 1 with letter of credit from US Bank expiring October 19, 2014, Baa1 unenhanced rating

-Series 2007B-2 Variable Rate Hospital Revenue Bonds (\$102.8 million outstanding), joint support rating of A1/VMIG 1 with letter of credit from PNC Bank expiring October 19, 2014, Baa1 unenhanced rating

-Series 2007B-3 Variable Rate Hospital Revenue Bonds (\$34.2 million outstanding, \$6.4 million of these redeemed on March 1, 2012), joint support rating of Aa3/VMIG 1 with letter of credit from Mizuho Corporate Bank expiring October 19, 2014, Baa1 unenhanced rating

-Series 2006A Fixed Rate First Mortgage Revenue Bonds, serial and term bonds (\$169.0 million outstanding), rated Baa1

-Series 2001A Fixed Rate Hospital First Mortgage Revenue Term Bonds (\$22.3 million outstanding), rated Baa1

-Series 2000A Hospital First Mortgage Revenue Refunding Capital Appreciation Bonds (\$31.4 million outstanding), certain bonds insured by MBIA, Baa1 unenhanced rating

-Series 2000C Fixed Rate Hospital First Mortgage Revenue Term Bonds (Taxable) (\$33.2 million outstanding), insured by MBIA, Baa1 unenhanced rating

Issued by Industrial Development Authority of Smyth County, Virginia:

-Series 2011C variable rate bonds (\$49.9 million outstanding), rated Aa2/VMIG 1 supported by letter of credit from US Bank expiring October 19, 2014

-Series 2011D variable rate bonds (\$60.7 million outstanding), rated A1/VMIG 1 supported by letter of credit from Mizuho Corporate Bank expiring October 19, 2014

-Series 2010B fixed rate bonds (\$32.5 million outstanding), rated Baa1

-Series 2009B fixed rate term bonds (\$5.5 million outstanding), rated Baa1

Issued by Industrial Development Authority of Russell County, Virginia:

-Series 2008B Variable Rate Hospital Revenue Bonds (\$52.9 million outstanding) rated Aa2/VMIG 1 supported by letter of credit with US Bank expiring October 19, 2014; Baa1 unenhanced rating

Issued by Industrial Development Authority of Washington County, Virginia:

-Series 2009C fixed rate term bonds (\$116.0 million outstanding), rated Baa1

Direct Obligation of Mountain States Health Alliance:

-Series 2011E variable rate bonds (Taxable) (\$16.0 million outstanding), rated A1/VMIG 1 supported by letter of credit from Mizuho Corporate Bank expiring October 19, 2014

-Series 2000D Fixed Rate First Mortgage Term Bonds (Taxable) (\$14.3 million outstanding), insured by MBIA, Baa1 unenhanced rating

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Underwriter: Jeffrey Newhams, Managing Director, BOA/Merrill Lynch (646) 743-1375

Financial Advisor: Steve Pischke, President, The Public Advisory Corporation (540) 687-6755

PRINCIPAL METHODOLOGY USED

The principal methodology used in this rating was Not-For-Profit Healthcare Rating Methodology published in March 2012. Please see the Credit Policy page on www.moodys.com for a copy of this methodology.

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INVESTORS SERVICE

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MOODY'S

INVESTORS SERVICE

New Issue: Moody's assigns Baa1 rating to Mountain States Health Alliance's (TN) \$54.9 million of Series 2012A fixed rate revenue bonds; outlook remains stable

Global Credit Research - 15 Aug 2012

Mountain States Health Alliance to have a total of \$1.07 billion of rated debt outstanding

JOHNSON CITY HEALTH & EDUCATIONAL FACILITIES BOARD, TN
Hospitals & Health Service Providers
TN

Moody's Rating

ISSUE	RATING
Fixed Rate Bonds, Series 2012A	Baa1
Sale Amount \$54,920,000	
Expected Sale Date 08/28/12	
Rating Description Revenue: Government Enterprise	

Moody's Outlook STA

Opinion

NEW YORK, August 15, 2012 --Moody's Investors Service has assigned a Baa1 unenhanced rating to Mountain States Health Alliance's (MSHA) \$54.9 million of Series 2012A fixed rate revenue bonds to be issued by The Health and Educational Facilities Board of the City of Johnson City, TN The outlook remains stable.

SUMMARY RATING RATIONALE

Leading market share for this multi-hospital system offering a wide-array of high-end services is a key credit strength. MSHA continues a long history of double digit operating cash flow margins with a good cash balance that remains over 200 days despite decline in market values at the end of calendar year 2011. Major capital spending is nearly complete, enabling future growth in liquidity. These strengths are tempered by a high debt load in comparison to the rest of our portfolio, generating weak debt measures. One other multi-facility health system provides competitive pressures.

STRENGTHS

*Multi-hospital system with strong and growing leading market share in a large geographic region where the flagship facility serves as a regional referral center offering a wide array of high-end services for hospitals in Tennessee and Virginia

*Multi-year growth in volumes with acquisitions

*Strong and stable operating cash flow margins in the 11.4% to 16.7% range in each of the past thirteen audit years and unaudited fiscal year (FY) 2012, with volume increases contributing to cash flow growth; projected operating cash flow margins remain in the double digits

*Good liquidity position with 212 days cash on hand at fiscal yearend (FYE) 2012 (June 30)

*Tenured management team

CHALLENGES

*Very high debt burden evidenced by high 115% debt-to-operating revenue, low 46% cash-to-debt ratio, high 9.2 times debt-to-cash flow ratio, and moderate Moody's-adjusted maximum annual debt service coverage of 2.20 times in FY 2012 as compared with Moody's Baa1 medians of 41.2%, 83.4%, 4.8 times and 3.5 times, respectively

*Sizable and consistent competition from Wellmont Health System, which holds a close but lesser market share (38% vs. 30%) in the extended 29-county service area and a significantly smaller market share (53% versus 37%) in MSHA's 13-county core service area (market share on 2011 data and provided by management)

*High 22.6% TennCare/Medicaid and self-pay load

DETAILED CREDIT DISCUSSION

USE OF BOND PROCEEDS: The Series 2012A-C bond proceeds will be used to (1) help finance certain capital improvements and equipment acquisitions, mainly the new \$66 million Johnson City Medical Center Surgery Tower project and \$10 million of projects at Norton Community Hospital (approximately \$65 million in total will be borrowed), (2) reimburse for prior capital spending (approximately \$26.5 million), (3) refinance certain capital leases (approximately \$5.0 million), and (4) pay the costs of issuance.

LEGAL SECURITY: The bonds are secured by a security interest in the Pledged Assets (receivables, inventory, equipment, general intangibles, contracts and contract rights, government approvals, fixtures and other personal property, goods, instruments, chattel paper, documents, credits, claims, demands and assets) and a first lien on the Mortgaged Property, which includes the flagship hospital, Johnson City Medical Center, subject to certain permitted liens.

INTEREST RATE DERIVATIVES: MSHA is a party to interest rate swaps and other derivative agreements to establish floating rate exposure and to reduce fixed rate debt service. MSHA holds five basis swaps and one total return swap with Merrill Lynch Capital Services Inc. (guaranteed by Merrill Lynch & Co) for a total notional amount of \$591 million. The fair market value of the swaps at July 20, 2012 was a liability of \$11.1 million against which MSHA has no posted collateral.

MSHA holds eight additional agreements (\$106 million notional amount) with Lehman Brothers Special Financing, Inc. (Lehman) for various notional amounts that are linked fixed payer and total return swaps. Fair market value of these swaps at June 30, 2012 was a liability of \$10.4 million, against which MSHA has posted \$13.8 million of collateral (collateral is not included in unrestricted cash). Lehman filed for bankruptcy and the swaps were terminated effective January 1, 2009. There is a dispute between MSHA and Lehman regarding the cost of such termination, which is currently under discussion. MSHA has stated that it believes that the amount of the posted collateral should be sufficient to pay the cost of the terminations.

There are two additional swaps, for a notional amount of \$19.2 million and a mark to market liability of \$221,000 as of June 30, 2012.

MARKET POSITION/COMPETITIVE STRATEGY: DOMINANT MARKET POSITION IN JOHNSON CITY, WITH LEADING MARKET POSITION IN 13-COUNTY CORE AREA AND 29-COUNTY EXTENDED SERVICE AREA

MSHA, a multi-hospital system operating nine acute care hospitals and 12 facilities in northeastern Tennessee, southwest Virginia, southeast Kentucky and western North Carolina, gains much credit strength from its dominant 90% market share in Washington County, TN where it operates seven of its facilities, including its flagship 514-licensed bed Johnson City Medical Center (JCMC), and is the only provider of acute care services. JCMC includes the 60-licensed bed Quillen Rehabilitation Hospital, providing a complete array of rehabilitative services for brain injury, stroke, and spinal cord injury and the 84-licensed bed Woodridge Hospital offering inpatient psychiatric and substance abuse services.

MSHA also holds a leading 52.6% market position in its combined 13-county primary and secondary service areas (PSA/SSA), and a leading and growing 37.6% market share in its 29-county extended service area. Competition is limited to one multi-hospital system (Wellmont Health System) and several small independent rural providers. Wellmont Health System operates four of its eight hospitals in MSHA's core market, garnering a distant 37.0% market share in the core 13-county service area, but a closer 29.6% market share in the extended 29-county service area. Many of the rural hospitals in the primary and secondary service area are affiliated with MSHA through network affiliations.

JCMC is a regional referral center for northeastern Tennessee offering a full array of acute care services, including one of only five state-designated Level III Regional Perinatal Centers and is a Level I trauma center. MSHA also owns Indian Path Medical Center and Pavilion located in Kingsport (Sullivan County), which competes

against the much larger Wellmont facilities, Sycamore Shoals Hospital located in Elizabethton (Carter County) with no direct competition, and the designated critical access hospital Johnson County Community Hospital in Johnson County.

System expansion into southwest Virginia from a concentration in northeastern Tennessee has included the following: November 2006 purchase of 80% interest in Smyth County Community Hospital in Marion; October 2007 purchase of 50.1% interest in Norton Community Hospital that includes Norton Community Hospital in Norton and Dickenson County Community Hospital in Clintwood; January 2008 acquisition of Russell County Medical Center in Lebanon; and April 2009 purchase of 50.1% interest in Johnston Memorial Hospital in Abingdon. Combined, the Virginia hospitals added 627 licensed beds and about 10,000 acute care discharges to the system. Management continues to work on full integration of these facilities into the system with no current plans for additional facility acquisitions.

In addition to expanding in Virginia, in Tennessee MSHA opened a new free standing children's hospital in March 2009, consolidated two smaller facilities in Washington County, and undertook other renovation projects. As a result, the system grew admissions 27% across a four year period to 61,035 admissions in FY 2011 from 48,055 admissions in FY 2007. Outpatient visits and emergency room visits grew a sizable 66.8% and 50.8%, respectively, and total surgeries 26.3% across the same four year period. Several volume metrics continued to grow in FY 2012, with admissions increasing only slightly to 61,154, yet emergency room volumes increasing 1.7% to 246,821 and outpatient visits increasing 3.0% to over 1.59 million. Growth has tempered for surgical cases and births, however. There are no additional facility expansion plans at this time.

OPERATING PERFORMANCE: OPERATING CASH FLOW MARGIN REMAINS CONSISTENTLY STRONG

Operating cash flow margin of 13.3% on unaudited FY 2012 results continues to be strong at double digit levels, though mitigated slightly from the recent peak level of 15.7% in FY 2011 (fiscal year ends June 30). Operating cash flow was tempered 14.5% (\$22 million) by a sizable increase in charity care. As a result, debt-to-cash flow weakened to 9.15 times from 7.74 times in FY 2011, but remains better than levels in fiscal years 2008 and 2009. Correspondingly, Moody's-adjusted maximum annual debt service coverage weakened slightly to 2.20 times from 2.55 times the prior year, and is below the 2.32 times low across the past five audited years.

MSHA continues to work on revenue enhancement and cost reduction efforts. Revenue enhancement initiatives focus on computerized coding, retail initiatives, growth in ambulatory and outpatient volumes, and clinical documentation. For FY 2012 MSHA is budgeting for increases in both admissions and outpatient visits, strategic increases in pricing, meaningful use dollars, increased revenue related to Medicare Shared Savings Program and Medicare Advantage through its health network. Expense initiatives include LEAN, reductions in length of stay, improvements in physician practice losses, reductions in lease expense and control of supply costs. MSHA will reduce contract labor costs, right-size personnel and modify benefits, and focus on other non-clinical expenses. These revenue and expense initiatives are currently underway.

BALANCE SHEET POSITION: DEBT LOAD REMAINS HIGH; LIQUIDITY REMAINS ABOVE 200 DAYS

The total system debt load remains high, evidenced through a 115% debt-to-revenue ratio in FY 2012, one of the highest in our portfolio, along with 9.15 times debt-to-cash flow. The Series 2012 bonds increase debt load 4.1% from our last review based upon December 31, 2011 pro forma debt, and 6.3% over FYE 2011 debt load. No additional debt is planned at this time. The debt structure is a mixture of fixed and variable rate bonds, notes and capital leases. As of June 30, 2012, about 57% of total debt is in a fixed rate mode and 43% in a variable rate mode, and will remain comparable post financing. Pro forma cash-to-demand debt of 106% at June 30, 2012 is down from 116% at December 31, 2011 due to both an increase in debt load and a decline in liquidity. Moody's-adjusted pro forma maximum annual debt service (MADS) coverage of 2.20 times in FY 2012 is down from the prior year and the lowest across the past five audited years, but within range of historical performance.

The current upcoming Series 2012 bond issuances area expected to include Series 2012A fixed rate bonds \$54.9 million new money project bonds, Series 2012B variable rate capital reimbursement and lease refinancing bonds, and Series 2012C variable rate new money project bonds. The variable rate bonds are expected to be supported by letters of credit and rated at a later date. In addition, MSHA will establish an \$18.4 million variable rate taxable note with a bank to refinance existing capital leases for anticipated present value savings (this note will not be rated). Our analysis incorporates all pieces of new debt.

Unrestricted liquidity declined \$68.5 million (11.6%) since FYE 2011 to \$524.1 million at June 30, 2012 from \$592.5 million at June 30, 2011. Major drivers to the decline included a decline in market value to offset investment returns, debt service payments, capital spending and an increase in accounts receivable. As a result cash on

hand declined to 212 days from 246 days, but consistently remains above 200 days. Cash-to-debt, which had improved to 55% in FY 2011, declined with the increase in debt and decline in liquidity to a pro forma 46%, but remains comparable to the 47.9%-64.4% range from 2007-2011.

Outlook

The stable outlook reflects our belief that MSHA will continue to generate strong and stable operating cash flow margins to support its high debt load. We believe liquidity will improve barring any major negative fair market value adjustments.

WHAT COULD MOVE THE RATING UP

Continued growth in operating cash flow to support the high debt load; material improvement in debt measures; regrowth of liquidity; increased diversification of cash flow

WHAT COULD MOVE THE RATING DOWN

Increase in debt load without commensurate increase in cash flow; notable loss in market share; trend of decline in operating cash flow; material decline or loss of supplemental payments for servicing the Medicaid and indigent populations

KEY INDICATORS

Assumptions & Adjustments:

- Based on financial statements for Mountain States Health Alliance
- First number reflects the audit year ended June 30, 2011
- Second number reflects pro forma unaudited year ended June 30, 2012, including the impact from the Series 2012 bonds
- Bad debt is reflected as a revenue reduction in FY 2012
- Non-operating income excludes loss on early extinguishment of debt and change in fair value of derivatives
- Investment returns smoothed at 6% unless otherwise noted
- *Inpatient admissions: 61,035; 61,154
- *Observation stays: 20,894; 22,179
- *Medicare % of gross revenues: 43.7%; 44.1%
- *Medicaid % of gross revenues: 13.7%; 14.1%
- *Total operating revenues (\$): \$976.1 million; \$988.5 million
- *Revenue growth rate (%) (3 yr CAGR): 8.9%; 5.6%
- *Operating margin (%): 0.9%; 1.0%
- *Operating cash flow margin (%): 15.7%; 13.3%
- *Debt to cash flow (x): 7.74x; 9.15x
- *Days cash on hand: 246 days; 212 days
- *Maximum annual debt service (MADS) (\$): \$75.6 million; \$77.2 million
- *MADS coverage with reported investment income (x): 2.32x; 2.16x
- *Moody's-adjusted MADS Coverage with normalized investment income (x): 2.55x; 2.20x
- *Direct debt (\$): \$1.070 billion; \$1.137 billion

*Cash to direct debt (%): 55%; 46%

*Comprehensive debt: \$\$1.126 billion; not available

*Cash to comprehensive debt (%): 53%; not available

*Monthly liquidity to demand debt (%): 149%; not available

RATED DEBT (as of June 30, 2012)

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Issued by Industrial Development Authority of Smyth County, Virginia:

-Series 2011C variable rate bonds (\$49.9 million outstanding), rated Aa2/VMIG 1 supported by letter of credit from US Bank expiring October 19, 2014

-Series 2011D variable rate bonds (\$60.7 million outstanding), rated A1/VMIG 1 supported by letter of credit from Mizuho Corporate Bank expiring October 19, 2014

-Series 2010B fixed rate bonds (\$32.5 million outstanding), rated Baa1

-Series 2009B fixed rate term bonds (\$5.5 million outstanding), rated Baa1

Issued by Industrial Development Authority of Russell County, Virginia:

-Series 2008B Variable Rate Hospital Revenue Bonds (\$52.9 million outstanding) rated Aa2/VMIG 1 supported by letter of credit with US Bank expiring October 19, 2014; Baa1 unenhanced rating

Issued by Industrial Development Authority of Washington County, Virginia:

-Series 2009C fixed rate term bonds (\$116.0 million outstanding), rated Baa1

Direct Obligation of Mountain States Health Alliance:

-Series 2011E variable rate bonds (Taxable) (\$16.0 million outstanding), rated A1/VMIG 1 supported by letter of credit from Mizuho Corporate Bank expiring October 19, 2014

-Series 2000D Fixed Rate First Mortgage Term Bonds (Taxable) (\$14.3 million outstanding), insured by MBIA, Baa1 unenhanced rating

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PRINCIPAL METHODOLOGY USED

The principal methodology used in this rating was Not-For-Profit Healthcare Rating Methodology published in March 2012. Please see the Credit Policy page on www.moody.com for a copy of this methodology.

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Rating Update: Moody's affirms Mountain States Health Alliance's (TN) Baa1; outlook stable

Global Credit Research - 10 Mar 2015

\$590m of rated debt outstanding

JOHNSON CITY HEALTH & EDUCATIONAL FACILITIES BOARD, TN
Hospitals & Health Service Providers
TN

NEW YORK, March 10, 2015 --Moody's Investors Service affirms the Baa1 rating on Mountain States Health Alliance's (MSHA) outstanding debt. The rating outlook is stable.

SUMMARY RATING RATIONALE

The Baa1 rating reflects improved financial performance demonstrated by this large multi-hospital system in eastern Tennessee and southeastern Virginia. Performance is showing good momentum with stronger results through the first half of FY 2015 given a re-invigorated focus on operations, expense management and physician relations under the direction of a new CEO and engaged Board. The rating also incorporates the organization's leading market position in Johnson City and the expansive 29-county service area.

These attributes are mitigated by the organization's leverage position which is very high and unfavorable to Moody's medians. Management is endeavoring over the next several years to de-leverage the system with increased cash flow and a new debt reduction strategy. Above average exposure to Medicare and Medicaid is also a credit risk.

OUTLOOK

The rating outlook is stable and based on our expectation that favorable performance should continue over the near term and the system will continue its efforts to de-leverage.

WHAT COULD MAKE THE RATING GO UP

- Material de-leveraging of the organization with improvement in key debt metrics such as debt-to-revenue, debt-to-cash flow, cash-to-debt and maximum annual debt service coverage that are more in line with A-rated health care systems
- Continued maintenance of favorable financial performance through organic growth and expense management

WHAT COULD MAKE THE RATING GO DOWN

- Departure from historically favorable financial performance that results in weaker debt coverage metrics
- Increase in leverage without enterprise growth
- Decline in absolute and relative liquidity metrics
- Loss of market share

STRENGTHS

- Historically strong financial performance with operating cash flow and operating cash flow margins exceeding Baa1 medians; good momentum demonstrated through the first half of FY 2015 with a 12.9% operating cash flow margin (compared to Baa1 median of 7.9%)
- Days cash is favorable at 255 days, providing ample headroom to the 100 days cash covenant in place under bank lending agreements and well exceeding the Baa1 median of 150; absolute and relative liquidity metrics should show improvement due to a forecasted reduction in capital spending and an increase in debt repayment

- Leading market position in Johnson City and the region for this multi-hospital system providing a wide array of tertiary services allows the system to focus on performance improvement
- Sharp focus on cost management strategies, including increasing productivity and labor management, and solidifying physician relations

CHALLENGES

- Highly leveraged enterprise with debt metrics that are unfavorable to Baa1 medians; debt to revenue is very high at 110% (compared to Baa1 median of 41%); despite the strong cash flow, Moody's adjusted maximum annual debt service is below average at 2.2 times (compared to Baa1 median of 3.2 times)
- Competition is present from a sizable system based 25 miles away in Kingsport, with primary hospitals in Kingsport and Bristol.
- Material exposure to government payors (51% Medicare and 14% TennCare/Medicaid gross revenues) while operating in two states that have not elected to expand Medicaid coverage
- Complex debt structure, including multiple bank agreements and a large swap portfolio, although no collateral postings have been required recently

RECENT DEVELOPMENTS

Recent developments are incorporated in the Detailed Rating Rationale section.

DETAILED RATING RATIONALE

MARKET POSITION: DISTINCTLY LEADING MARKET SHARE IN JOHNSON CITY AND THE REGION

MSHA is a multi-hospital system operating 11 acute care hospitals, the region's only children's hospital, an inpatient psychiatric facility, and other services such as home health, urgent care and rehabilitation in a broad service area that encompasses northeastern Tennessee, southwest Virginia, southeast Kentucky and western North Carolina. Credit strength derives from its 90% market share in Washington County, TN, where it is the only provider of acute care services and operates its flagship, 514-licensed bed Johnson City Medical Center (JCMC). Except for Kingsport, the system reports either the leading market share or is the sole provider in its primary service area. MSHA's Indian Path Medical Center (Kingsport) competes with Holston Valley Medical Center, owned by Wellmont Health System (not rated by Moody's).

Wellmont represents MSHA's primary competition and operates six hospitals. Market share trends provided by management through publicly available data show a growing divergence between the two systems with MSHA increasing market share to 41% in its 29-county extended service area compared to Wellmont's 26% market share, a declining trend (for Wellmont) through Q3 2014. Many of the rural hospitals in the primary and secondary service area are affiliated with MSHA, and primarily refer higher acuity patients to its three "hub" hospitals in Abingdon, VA., Johnson City, TN, and Kingsport, TN.

OPERATING PERFORMANCE, BALANCE SHEET, AND CAPITAL PLANS: ABOVE AVERAGE OPERATING CASH FLOW MARGINS CONTINUE, ADEQUATELY SUPPORTING A HIGH DEBT LOAD

A historical credit strength, MSHA continues to report above average operating cash flow margins although with some declines in recent years. FY 2014 reported a 12.3% margin, on par with FY 2013 but down from higher levels in FY 2010 through FY 2012. Performance through the first half of FY 2015 ending December 31, 2014 shows good momentum without any one-time revenue enhancements, reporting a 12.9% operating cash flow margin. Management expects it will reach its FY 2015 budget of 14.1%. MSHA's above average operating cash flow adequately supports the high debt load.

Management has set a new goal to reach an annual 4% operating margin; this denotes a material change in financial strategy given years of breakeven operating income. Under the direction of a new CEO, MSHA is focusing on costs, operating efficiencies, and integrating many of the assets the system added through various growth strategies over the past decade. A reinvigorated medical staff has also produced growth in volume trends. Over the past year, MSHA enacted a 10% system-wide reduction in non-patient care FTEs through layoffs and attrition. Additionally, benefit plans were changed. These strategies combined translate into \$25 million of annual labor savings. Further, the recent joint venture with HealthSouth (now 51.1% owner) of the Quillen Rehab Center should improve cash flow by \$2 million annually.

MSHA's payor mix has remained fairly stable, but does present material exposure to government payors (51% Medicare and 14% Medicaid in gross revenues). Neither Tennessee nor Virginia elected to expand Medicaid although management reports that 88,000 individuals are now enrolled in Medicaid given the 'woodworking' effect of the exchanges. Tennessee made no cuts to Medicaid in FY 2015 and held rates steady; Virginia held rates steady in FY 2015 following a 7% increase in FY 2014.

Liquidity

Liquidity is below average as long-term debt out sizes absolute liquidity, resulting in cash to debt ratio of 59% (Baa1 median is 104%). Relative liquidity to the size of the enterprise is favorable at 255 days and has historically exceeded 200 days. Unrestricted cash increased and investments grew to \$646 million at the end of FY 2014 from \$588 million at the end of the prior year due to good cash flow, lower capital spending and the use of bond proceeds for capital.

DEBT AND OTHER LIABILITIES

MSHA is highly leveraged as indicated by relative debt metrics compared to medians. Debt to revenue is 110%, compared to the Baa1 median of 41%. Despite lofty cash flow margins, debt service coverage measures are below Baa1 medians given the amount of leverage that the organization services. Moody's-adjusted maximum annual debt service coverage of 2.2 times in FY 2014 was below the Baa1 median of 3.2 times. Likewise, debt to cash flow of 8.9 times is nearly double the Baa1 median of 4.5 times.

To de-leverage the enterprise, management and the board has approved a new plan to accelerate the repayment of debt in conjunction with annual principal payments. In summary, through a combination of scheduled principal amortization and voluntary prepayment, MSHA anticipates paying down \$532 million of debt from FY 2016 through FY 2022. Given that MSHA has completed a number of large capital projects, management anticipates using more of its cash flow for debt repayment. After FY 2015 (\$53 million in capital planned), capital spending will hover at \$45 million per year. While not covenanted to do so, MSHA plans to repay \$70.5 million of debt in FY 2016, followed by \$16 mm in FY 2017, \$107.8 million in 2019, \$46.0 million in 2020, \$55.6 million in 2021 and \$58.8 million in 2022. This does not include the normal repayment of amortizing bond principal that totals an additional \$177 million.

Debt Structure

MSHA maintains 58% fixed rate debt and 42% variable rate. The expiration dates on the various Letters of Credit and the tenors on the direct placements are staggered with the largest amounts expiring in 2018. Master Trust Indenture covenants are the following: 1.3 times historical and maximum annual debt service; consultant call-in required if fails to meet test; 75 days cash measured at FYE. MBIA has a 110 days cash on hand covenant as long as MBIA-insured debt is outstanding. Letters of credit and private placement bank debt covenants are similar but measured more frequently: 1.3 times maximum annual debt service measured on a quarterly rolling basis; 100 days cash on hand measured semi-annually. MSHA has very comfortable headroom to the days cash on hand covenant although more narrow headroom on the rate covenant.

Debt-Related Derivatives

MSHA is a party to several interest rate swaps and other derivative agreements to establish floating rate exposure and to reduce fixed rate debt service. MSHA holds five basis swaps (\$132 million), 3 CMS Basis Swaps (\$438 million) and one total return swap (\$19 million) for a total notional amount of \$589 million. The swaps are long-dated maturities and all are with the same counterparty (Bank of America) which indicates concentration risk. The fair market value of the swaps at November 24, 2014 was a liability of \$12.2 million against which MSHA has no posted collateral.

Pensions and OPEB

MSHA has a defined contribution plan, limiting demands on liquidity.

MANAGEMENT AND GOVERNANCE

In December 2013 a new CEO joined MSHA with a strong background in hospital operations. His arrival follows the planned retirement of the former CEO. All c-suite positions are filled. The Board is highly engaged as evidenced by the approval to de-leverage the system through debt repayment.

KEY STATISTICS

Assumptions & Adjustments:

- Based on financial statements for Mountain States Health Alliance
- First number reflects audit year ended June 30, 2013
- Second number reflects audited year ended June 30, 2014
- Investment returns smoothed at 6% unless otherwise noted
- Comprehensive debt includes direct debt, operating leases, and pension obligation, if applicable
- *Inpatient admissions: 58,103; 57,040
- *Observation stays: 23,554; 24,218
- *Medicare % of gross revenues: 50.6%; 51.3%
- *Medicaid % of gross revenues: 14.6%; 14.4%
- *Total operating revenues (\$): \$994 million; \$1,000 million
- *Revenue growth rate (%) (3 yr CAGR): 2.0%; 1.1%
- *Operating margin (%): -0.5%; 0.7%
- *Operating cash flow margin (%): 12.0%; 12.3%
- *Debt to cash flow (x): 9.5 times; 8.9 times
- *Days cash on hand: 233.8 days; 255.7 days
- *Maximum annual debt service (MADS) (\$): \$77.2 million; \$77.2 million
- *MADS coverage with reported investment income (x): 1.8 times; 2.0 times
- *Moody's-adjusted MADS Coverage with normalized investment income (x): 2.1 times; 2.2 times
- *Direct debt (\$): \$1,123 million; \$1,104 million
- *Cash to debt (%): 52.4%; 58.5%
- *Comprehensive debt (\$): \$1,176 million; \$1,151 million
- *Cash to comprehensive debt (%): 50.0%; 56.1%
- *Monthly liquidity to demand debt (%): 120.8%; 133.9%

OBLIGOR PROFILE

Mountain States Health Alliance is a \$1.0 billion (total revenues in FY 2014) system comprised of 13 hospitals with the flagship, Johnson City Medical Center (514 licensed beds), located in Johnson City, TN (eastern Tennessee).

LEGAL SECURITY

The bonds are secured by a security interest in the Pledged Assets (receivables, inventory, equipment, general intangibles, contracts and contract rights, government approvals, fixtures and other personal property, goods, instruments, chattel paper, documents, credits, claims, demands and assets) and a first lien on the Mortgaged Property, which includes the flagship hospital, Johnson City Medical Center, subject to certain permitted liens. Bank debt is parity to the Master Trust Indenture.

USE OF PROCEEDS

Not applicable

PRINCIPAL METHODOLOGY

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Johnson City Health and
Educational Facilities Board,
Tennessee
Industrial Development Authority of
Smyth County, Virginia
Industrial Development Authority of
Russell County, Virginia
Mountain States Health Alliance,
Tennessee; Joint Criteria; System

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Related Research

Johnson City Health and Educational Facilities Board, Tennessee

Industrial Development Authority of Smyth County, Virginia

Industrial Development Authority of Russell County, Virginia

Mountain States Health Alliance, Tennessee; Joint Criteria; System

Credit Profile		
US\$107.495 mil hosp rev bnds (Mountain States Hlth Alliance) ser 2010A due 07/01/2038		
<i>Long Term Rating</i>	BBB+/Stable	New
US\$104.165 mil taxable hosp rev bnds (Mountain States Hlth Alliance) ser 2010B due 07/01/2038		
<i>Long Term Rating</i>	BBB+/Stable	New
US\$60.525 mil hosp rev bnds (Mountain States Hlth Alliance) ser 2010D due 07/01/2038		
<i>Long Term Rating</i>	BBB+/Stable	New
US\$38.905 mil hosp rev bnds (Mountain States Hlth Alliance) ser 2010C due 07/01/2038		
<i>Long Term Rating</i>	BBB+/Stable	New
Mountain States Health Alliance ICR		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed

Rationale

Standard & Poor's Ratings Services assigned its 'BBB+' long-term rating to the Health and Educational Facilities Board of the City of Johnson City, Tenn.'s \$107.495 million tax-exempt series 2010A and \$104.165 million taxable series 2010B fixed-rate bonds. Standard & Poor's also assigned its 'BBB+' long-term rating to the Industrial Development Authority of Smyth County, Va.'s \$38.905 million series 2010C tax-exempt fixed-rate bonds, and the Industrial Development Authority of Russell County, Va.'s \$60.525 million series 2010D tax-exempt fixed-rate bonds. All series were issued for Mountain States Health Alliance, Tenn. (MSHA). Standard & Poor's also affirmed its 'BBB+' issuer credit rating (ICR) on MSHA and its 'BBB+' long-term rating underlying rating (SPUR) on all other rated bonds issued for MSHA by various issuers. The outlook is stable.

Series 2010A, C, and D bonds will fully refund \$184.8 million of combined 2007A, 2007C, and 2008B series bonds. The series 2010B taxable fixed-rate bonds will refund the next 10 years of principal payments of the series 2007B bonds, an amount equal to \$91.7 million. Other than the funding of a debt service reserve and costs of issuance, no new money is being borrowed.

More specifically the 'BBB+' rating reflects:

- MSHA's excellent business position, which is characterized by solid demographics, a high market share, and a broad range of services;
- Strong management and governance, which is reflected in a favorable performance record since the system's creation in 1998;
- Continued strong financial performance, highlighted by very strong fiscal-year EBIDA margins, a sixth consecutive year of operating profitability in fiscal 2009, and solid liquidity for the rating level based on days' cash on hand; and
- The leveling-off of MSHA sizable capital and debt financing needs as there are few remaining independent hospital acquisition targets in the service area. Future debt increases should be limited as the system can handle most of its remaining capital needs with cash flow.

MSHA's sizable debt and accompanying high leverage remain the system's most significant credit risk. The system has a pro forma debt-to-capital ratio of 78% and a debt burden of 6.8% of revenue. Even with typical EBIDA margins of 14%-18%, maximum annual debt service (MADS) coverage has historically been below median 'BBB+' levels. On a pro forma basis, MADS coverage is 2.0x based on fiscal year-end 2009 results.

Standard & Poor's Debt Derivative Profile (DDP) overall score on MSHA's swap portfolio is '2.5' on a scale of '1.0' to '4.0', whereby '1.0' represents the lowest risk. The overall DDP score of '2.5' reflects Standard & Poor's view that MSHA's swap exposure is a low to moderate credit risk at this time. MSHA has two total return swaps with a total notional amount of \$50 million whose counterparty was Lehman Brothers Special Financing Inc., guaranteed by Lehman Brothers Inc. The timing for termination of those swaps is uncertain pending resolution of issues related to Lehman's bankruptcy. MSHA estimates the mark-to-market value of the Lehman swaps to be negative \$11 million, against which MSHA has posted \$12.6 million of collateral. Standard & Poor's does not count collateral funds as unrestricted liquidity, so the possibility of paying a termination cost is not likely to have a major credit impact.

Merrill Lynch is the counterparty for two other swaps, including a \$438 million constant maturity swap with a mark-to-market value in MSHA's favor of \$7.1 million, and a \$132 million fixed-payer swap with a mark-to-market value of negative \$16.3 million, against which MSHA has no posted collateral (all figures as of Jan. 15, 2010).

MSHA had \$532 million of unrestricted liquidity on Sept. 30, 2009, net of \$13.1 million of posted swap collateral. Should the swaps terminate, there will be a modest negative effect since the swaps generate positive cash flow, including \$1.1 million for the first three months of fiscal 2010. However, MSHA will easily be able to absorb the lost income, given its \$37 million of EBIDA for the first quarter (EBIDA was \$123 million for the full year ended June 2009).

Outlook

The outlook is stable. Additional risk related to MSHA's high debt levels is offset by the business position, benefits of the system's acquisition activity over the past several years, MSHA's favorable record of integrating acquired facilities, and the natural improvement in debt ratios that will occur as the system's results begin to reflect the acquired facilities for a full year in fiscal 2010. Also adding to credit stability is MSHA's history of maintaining solid earnings. However, given that debt service coverage is low for the rating level, the system's high debt burden remains a credit concern. We do not expect a higher rating until MSHA's debt levels moderate. Although not

expected, should balance sheet metrics become more constrained, a lower rating or negative outlook would be likely.

Organizational Profile

Since its formation in 1998, MSHA has nearly tripled its asset base and net patient revenues to roughly \$1.9 billion and \$840 million, respectively. Due in large part to its acquisition strategy, the system's pro forma debt has doubled since 2005 and is now very high at over \$1 billion. The system's growth was accomplished through strategic hospital acquisitions in its core northeastern Tennessee and southwest Virginia service areas. With the 2009 acquisition of a 50.1% stake in Johnston Memorial Hospital (JMH) in Abingdon, Va., MSHA now owns and operates 11 acute-care facilities and one psychiatric hospital, led by the flagship Johnson City Medical Center, a 623-licensed-bed tertiary regional provider. The system's hospital facilities include 1,780 staffed acute-care beds. The system also includes a range of outpatient facilities and ancillary services, such as a home health agency, a hospice, and other facilities including the ownership and management of medical office buildings. The affiliation with JMH completed MSHA's hospital acquisition strategy, which has included the acquisition of five Virginia hospitals over the past three years.

MSHA also operates a number of physician practices employing about 172 physicians. MSHA has steadily reduced losses at the physician practices through a modest attrition in the number of physicians, improvements in compensation when contracts were renewed, and other efficiency measures. However, MSHA does not intend to discontinue the employment of physicians, nor does its competitor, Wellmont, which also has staff physicians as part of its recruiting, retention, and market share strategies.

Since the system's creation in 1998, management and governance have evolved effectively, with a strong central leadership focused on maximizing the system's potential as a whole, as evidenced by the consolidation efforts in its core market of Washington County. In addition, management has broadened the access to managed-care contracts for all of the facilities, while centralizing the negotiations at the system level. It has also centralized other functions like billing and collections, purchasing, and laboratory services. The board improved its effectiveness by reducing its size to a very manageable 13 members, and has upheld its values of strong planning, education, and transparency.

Market Position

The system's defined market area has broadened significantly over with its acquisition activity. The core service area now has 13 counties in Tennessee and Virginia, of which MSHA has approximately 52% market share, including JMH. Today only about 30% of the system's patients originate from its original home county of Washington County, Tenn. In the broader 29-county service area, MSHA has a 37% share, and Wellmont, 30%, with no significant third player.

Wellmont has acquired three hospitals in its secondary service area within the past two to three years and is in the midst of a sizable renovation of its largest campus, Holston Valley Medical Center. We believe that the spate of acquisitions by both health systems over the past several years has largely played out as there are very few remaining independent hospitals in the region. While the service area remains very competitive, its market characteristics remain favorable in terms of population growth and the market's size will continue to support two sizable competitors.

While MSHA's market share is extremely strong in the core Washington County market, Wellmont Health System dominates in adjacent Sullivan County. The nine-hospital Wellmont has two flagship hospitals in Sullivan County, with combined admissions of roughly 30,000, while MSHA has a relatively modest-size facility, Indian Path Medical Center (7,873 admissions in fiscal 2009). Historically, Sullivan County was the only part of MSHA's primary service area where the two systems competed head to head, whereas in other parts of their service areas, MSHA and Wellmont generally did not overlap. However, they are increasingly overlapping in their service areas. For example, MSHA traditionally had no hospitals in Virginia, while Wellmont did. However, recent affiliations with the five Virginia hospitals have thrust MSHA into a service area that traditionally has fed Wellmont's facilities. The two systems now compete head-on in Norton, Va., a two-hospital town where in 2007, MSHA acquired a 50.1% ownership Norton Community Hospital, while Wellmont acquired the other one (Mountain View).

Competition in Sullivan County is likely to heat up soon due to Wellmont's major renovation of its flagship campus, Holston Valley Medical Center, at an estimated cost of more than \$100 million.

Projects Update

Niswonger Children's Hospital

MSHA completed and opened the \$34 million Niswonger Children's Hospital on March 2, 2009. The project, which created the region's first free-standing children's hospital, expanded pediatric services at the Johnson City Medical Center by seven beds. About \$25 million of the project's cost was funded through philanthropy.

Franklin Woods Community Hospital (FWCH)

FWCH is a new \$118 million, 80-bed hospital replacement facility that will replace the inpatient acute-care services at MSHA's North Side Hospital and its Johnson City Specialty Hospital. FWCH is expected to open in May/June 2010. North Side Hospital will remain open and serve outpatients and provide skilled nursing care.

Johnston Memorial Hospital (JMH)

Series 2009E bonds funded MSHA's acquisition of a 50.1% interest in the 135-bed JMH in April 2009. MSHA is building a 250,000-square-foot replacement hospital next to the JMH cancer center in Abingdon, Va., which opened in 2007. The new hospital is scheduled to open in March 2011.

Finances

MSHA demonstrated modest operating performance improvement during fiscal 2009. For the year ended June 30, net operating income climbed to \$7 million, or a 0.83% margin on \$840 million in total operating revenues, compared with \$6.2 million, or a 0.82% margin, on \$756 million in revenues in fiscal 2008. Although inpatient admissions grew to 57,127 in fiscal 2009 from 54,307 in fiscal 2008, volume growth was largely generated from acquisitions, and not same-store volumes, which were flat. Fiscal 2010 will be the first full year of operating results with the acquired facilities, and MSHA is budgeting \$16 million in operating revenues (1.6% margin) on \$1.0 billion in total operating income. The system is forecasting 9.1% inpatient volume growth to 62,305 from 57,127 in 2009. MSHA estimates that it will be eligible for about \$46 million in stimulus payments over the next five years. However, no stimulus funds are included in the system's 2010 budget or five-year forecast.

In 2009 MSHA implemented revenue and expense initiatives including eliminating 126 staffers, restricting hiring,

limiting travel, and eliminating pay increases for management. Additionally, the system closed its Indian Path Pavilion (a behavioral health facility), which will create about \$3 million in annual savings. Management has also identified about \$7.5 million of revenue enhancement opportunities for its operations in southwest Virginia. No TennCare cuts are expected for 2010 and management expects no increase in Virginia Medicaid for 2010. But TennCare cuts are a possibility for 2011. Other expected major payor increases are 5%-7% for fiscal 2010.

EBIDA margin was 14.4% for fiscal 2009. Pro forma MADS coverage, based on MADS of \$71 million, was 1.9x based on June 30, 2009, fiscal year-end results.

Net excess income for the year was \$21.2 million due to \$19.1 million of interest, dividend, and derivative related income that was offset by realized investment losses.

Interim Financial Performance: Sept. 30, 2009 (Three Months)

Through the first three months of fiscal 2010, MSHA reported an operating loss of \$2.4 million on \$235 million in operating revenues. First quarter losses are typical for MSHA since it is their practice is to be very conservative in realizing income early in the year. Last year the system reported a first quarter operating loss of \$546,000 on \$204 million of operating revenues.

Balance Sheet

MSHA's aggressive pace of acquisitions has positioned the system to compete effectively in its core service area; however, those investments have leveraged the system's balance sheet and limited the growth in unrestricted liquidity despite solid operating cash flow.

Unrestricted cash and investments totaled \$515 million at fiscal year-end 2009, equal to 242 days' cash. The system's target asset allocations include maintaining 165 days' cash in high-quality and highly liquid fixed-income investments. Above 165 days' cash, the system may invest in equities up to an allocation limit of 50%. MSHA does not invest in hedge funds or in private equity. Long-term debt to capitalization is high at 79%. Due to high system leverage, year-end cash to debt was 48%, which is well below the median for the current rating. MSHA remains in compliance with all bond covenants. We expect that leverage and liquidity metrics will improve over the next several years now that the system's acquisition program is essentially complete.

Debt Derivative Profile

MSHA's DDP overall score is a '2.5' on a scale of '1' to '4', whereby '1' represents the lowest risk. The score of '2.5' reflects Standard & Poor's view that MSHA's swap exposure is a low to moderate credit risk at this time.

The key components of the overall DDP score of '2.5' are:

- There are strong management practices, including a written swap policy, frequent communication of swap performance to the board, good audit disclosure related to swaps, and the use of independent financial advisers to assist in evaluating swap strategies and performance.
- The termination and collateral-posting risk is offset from a credit standpoint by MSHA's collateral being clearly segregated from unrestricted liquidity, and none of the collateral is included in any of Standard & Poor's

unrestricted liquidity calculations.

Related Research

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- USPF Criteria: Debt Derivative Profile Scores, March 27, 2006
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009

Ratings Detail (As Of January 22, 2010)		
Mountain States Health Alliance		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd, Tennessee		
Mountain States Hlth Alliance, Tennessee		
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance)		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) hosp VRDO ser 2007A		
<i>Long Term Rating</i>	AA/A-2	Affirmed
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) hosp VRDO ser 2007B		
<i>Long Term Rating</i>	AA/A-2	Affirmed
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) hosp VRDO ser 2008A		
<i>Long Term Rating</i>	AA/A-2	Affirmed
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Hlth Alliance) hosp rev bnds (Mountain States Hlth Alliance) ser 2010A due 07/01/2038		
<i>Long Term Rating</i>	NR	
Johnson City Hlth & Ed Fac Brd (Mountain States Hlth Alliance) taxable hosp rev bnds (Mountain States Hlth Alliance) ser 2010B due 07/01/2038		
<i>Long Term Rating</i>	NR	
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance)		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Russell Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Russell Cnty Indl Dev Auth (Mountain States Health Alliance) hosp VRDO ser 2008B		
<i>Long Term Rating</i>	AA/A-2	Affirmed
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Smyth Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Smyth Cnty Indl Dev Auth (Mountain States Health Alliance)		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Smyth Cnty Indl Dev Auth (Mountain States Health Alliance) hosp VRDO ser 2007C		
<i>Long Term Rating</i>	AA/A-2	Affirmed
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed

Ratings Detail (As Of January 22, 2010) (cont.)

Washington Cnty Indl Dev Auth, Virginia

Mountain States Hlth Alliance, Tennessee

Washington Cnty Indl Dev Auth (Mountain States Health Alliance)

<i>Long Term Rating</i>	BBB+/Stable	Affirmed
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Many issues are enhanced by bond insurance.

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Summary:

**Mountain States Health Alliance,
TN's Series 2008A Bonds Rating
Raised To 'AAA/A-1+'; Joint Criteria**

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Summary:

Mountain States Health Alliance, TN's Series 2008A Bonds Rating Raised To 'AAA/A-1+'; Joint Criteria

Credit Profile

Johnson City Hlth & Ed Fac Brd, Tennessee

Mountain States Hlth Alliance, Tennessee

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) hosp VRDO ser 2008A

<i>Long Term Rating</i>	AAA/A-1+	Upgraded
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed

Rationale

Standard & Poor's Ratings Services raised its rating on Johnson City Health and Educational Facilities, Tenn.'s hospital revenue bonds series 2008A, issued on behalf of Mountain States Health Alliance (MSHA), to 'AAA/A-1+' from 'AA-/A-2' based on the substitution of the letter of credit (LOC) to one provided by U.S. Bank N.A. (AA-/A-1+) from the LOC provided by Regions Bank (BBB/A-2). The long term component of the rating is based jointly on the combined rating of MSHA (BBB+) and the LOC provided by U.S. Bank N.A. The short term component of the rating is based solely on the LOC provided by U.S. Bank N.A.

The LOC provides coverage for the payment of principal of and interest on the bonds, including the payment of unremarketed tendered bonds. The LOC provides for a maximum of 37 days of interest coverage at the maximum rate of 12% per annum. If interest is not re-instated following an interest drawing, then the trustee is directed to declare an acceleration with interest ceasing to accrue on the first business day following declaration of acceleration. The LOC is scheduled to expire on Sept. 29, 2013, unless earlier extended or terminated pursuant to their terms.

For more information on MSHA's 'BBB+' issuer credit rating, see "Mountain States Health Alliance, Tennessee," published Jan. 22, 2010, on RatingsDirect on the Global Credit Portal.

Related Criteria And Research

- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009
- Criteria: Joint Support Criteria Update, April 22, 2009
- USPF Criteria: Municipal Applications For Joint Support Criteria, June 25, 2007

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McGRAW-HILL

Summary:

**Mountain States Health Alliance,
TN's Series 2008B Bonds Rating
Raised To 'AAA/A-1+'; Joint Criteria**

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Summary:

Mountain States Health Alliance, TN's Series 2008B Bonds Rating Raised To 'AAA/A-1+'; Joint Criteria

Credit Profile

Russell Cnty Indl Dev Auth, Virginia

Mountain States Hlth Alliance, Tennessee

Russell Cnty Indl Dev Auth (Mountain States Health Alliance) hosp VRDO ser 2008B

<i>Long Term Rating</i>	AAA/A-1+	Upgraded
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed

Rationale

Standard & Poor's Ratings Services raised its rating on Russell County Industrial Development Authority, Va.'s hospital revenue bonds series 2008B, issued on behalf of Mountain States Health Alliance, Tenn. (MSHA), to 'AAA/A-1+' from 'AA-/A-2', based on the substitution of the letter of credit (LOC) to one provided by U.S. Bank N.A. (AA-/A-1+) from one provided by Regions Bank (BBB/A-2). The long-term component of the rating is based jointly (assuming low correlation) on the combined rating of MSHA (BBB+) and the LOC provided by US Bank N.A. The short-term component of the rating is based solely on the LOC provided by U.S. Bank NA.

The LOC provides coverage for the payment of principal of and interest on the bonds, including the payment of unremarketed tendered bonds. The LOC provides for a maximum of 37 days of interest coverage at the maximum rate of 12% per annum. If interest is not re-instated following an interest drawing, then the trustee is directed to declare an acceleration with interest ceasing to accrue on the first business day following declaration of acceleration. The LOC is scheduled to expire on Sept. 29, 2013, unless earlier extended or terminated pursuant to their terms.

For more information on MSHA's 'BBB+' issuer credit rating, see "Mountain States Health Alliance, Tennessee," published Jan. 22, 2010, on RatingsDirect on the Global Credit Portal.

Related Criteria And Research

- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009
- Criteria: Joint Support Criteria Update, April 22, 2009
- USPF Criteria: Municipal Applications For Joint Support Criteria, June 25, 2007

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McGRAW-HILL

Summary:

Mountain States Health Alliance, TN's Series 2007B Bonds Rating Raised To 'AAA/A-1+'; Joint Criteria

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Summary:

Mountain States Health Alliance, TN's Series 2007B Bonds Rating Raised To 'AAA/A-1+'; Joint Criteria

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Johnson City Hlth & Ed Fac Brd, Tennessee

Mountain States Hlth Alliance, Tennessee

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) hosp VRDO Taxable ser 2007B-1

<i>Long Term Rating</i>	AAA/A-1+	Upgraded
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed

Rationale

Standard & Poor's Ratings Services raised its rating on Johnson City Health and Educational Facilities Board, Tenn.'s (Mountain States Health Alliance) hospital revenue bonds series 2007B (taxable) to 'AAA/A-1+' from 'AA-/A-2', following the splitting of the series 2007B bonds into sub-series 2007B-1 (taxable), sub-series 2007B-2 (taxable), and sub-series 2007B-3 (taxable); and the substitution of current letter of credit (LOC) with individual LOCs. The long-term component of the rating on all three sub-series will be based on joint criteria (assuming low correlation). The obligor is rated 'BBB+/Stable'. The series 2007B-1 (taxable) bonds will be enhanced with a LOC provided by U.S. Bank N.A. (AA-/A-1+). The series 2007B-2 (taxable) bonds will be enhanced with a LOC provided by PNC Bank National Association (A+/A-1). The series 2007B-3 (taxable) bonds will be enhanced with a LOC provided by Mizuho Corporate Bank (A+/A-1). The short-term component on the individual series will be based solely on the LOC providers.

The LOCs provide coverage for the payment of principal of and interest on the bonds, including the payment of unremarketed tendered bonds. The LOCs provide for a maximum of 37 days of interest coverage at the maximum rate of 12% per annum. If interest is not reinstated following an interest drawing, then the trustee is directed to declare an acceleration, with interest ceasing to accrue on the first business day following declaration of acceleration. The LOCs are scheduled to expire on Sept. 29, 2013, unless earlier extended or terminated pursuant to their terms.

For more information on MSHA's 'BBB+' ICR rating, see "Mountain States Health Alliance, Tennessee," published Jan. 22, 2010, on RatingsDirect on the Global Credit Portal.

Related Criteria And Research

- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009
- Criteria: Joint Support Criteria Update, April 22, 2009
- USPF Criteria: Municipal Applications For Joint Support Criteria, June 25, 2007

Complete ratings information is available to RatingsDirect subscribers on the Global Credit Portal at

Summary: Mountain States Health Alliance, TN's Series 2007B Bonds Rating Raised To 'AAA/A-1+'; Joint Criteria

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**Johnson City Health and
Educational Facilities Board,
Tennessee
Mountain States Health Alliance;
Joint Criteria; System**

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Related Criteria And Research

Johnson City Health and Educational Facilities Board, Tennessee

Mountain States Health Alliance; Joint Criteria; System

Credit Profile

Mountain States Health Alliance ICR

Long Term Rating

BBB+/Stable

Affirmed

Rationale

Standard & Poor's Ratings Services affirmed its 'BBB+' issuer credit rating (ICR) on Mountain States Health Alliance (MSHA), Tenn. Standard & Poor's also affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on rated bonds issued for MSHA by various issuers. The outlook is stable.

The 'BBB+' ratings reflect our view of:

- MSHA's excellent business position, which is characterized by solid demographics, a high market share, and a broad range of services;
- Strong management and governance, which is reflected in a favorable performance record since the system's creation in 1998;
- Continued strong financial performance, highlighted by very strong fiscal-year EBIDA margins, a seventh consecutive year of operating profitability in fiscal 2010, and solid liquidity for the rating level based on days' cash on hand; and
- The leveling-off of MSHA's sizable capital and debt financing needs as there are few remaining independent hospital acquisition targets in the service area.

According to management, future debt increases will likely be limited as the system can handle most of its remaining capital needs with cash flow. MSHA's sizable debt and accompanying high leverage remain the system's most significant credit risk. The system has a debt-to-capital ratio of 77% and a debt burden of 6.7% of revenue. Even with typical EBIDA margins of 14%-18%, maximum annual debt service (MADS) coverage has historically been below median 'BBB+' levels, although MADS coverage improved to 2.5x based on fiscal year-end 2010 results.

Standard & Poor's Debt Derivative Profile (DDP) overall score on MSHA's swap portfolio is '2.5' on a scale of '1.0' to '4.0', whereby '1.0' represents the lowest risk. The overall DDP score of '2.5' reflects Standard & Poor's view that MSHA's swap exposure reflects low to moderate credit risk at this time. MSHA has two total return swaps with a total notional amount of \$50 million, whose counterparty was Lehman Brothers Special Financing Inc., guaranteed by Lehman Brothers Inc. The timing for the termination of those swaps is uncertain pending the resolution of issues related to Lehman's bankruptcy. MSHA estimates the mark-to-market value of the Lehman swaps to be negative \$11 million, against which MSHA has posted \$12.6 million of collateral. Standard & Poor's does not count collateral funds as unrestricted liquidity, so the possibility of paying a termination cost is not likely to have a material credit impact.

Merrill Lynch is the counterparty for two other swaps, including a \$438 million constant maturity swap with a mark-to-market value in MSHA's favor of \$3.9 million and more than \$2 million positive annual cash flow, and a \$132 million fixed-payer swap with a mark-to-market value of negative \$27 million, against which MSHA had \$5.1 million of posted collateral (all figures as of Nov. 30, 2010).

MSHA had \$550 million of unrestricted liquidity on Sept. 30, 2010, net of \$17.7 million of posted swap collateral. Should the swaps terminate, MSHA will lose the more than \$2 million positive annual cash flow from the swaps; however, MSHA will also be relieved of more than \$4 million of negative carry on its fixed payor swaps if the full portfolio is terminated.

Outlook

The stable outlook reflects our view of MSHA's business position, the benefits of the system's acquisition activity over the past several years, MSHA's favorable record of integrating acquired facilities, and the natural improvement in debt ratios that has started to occur as the system's results have begun to reflect the acquired facilities for a full year. Also adding to credit stability is MSHA's history of maintaining solid earnings. However, given that debt service coverage is low for the rating level, the system's high debt burden remains a credit concern. We do not expect to raise the rating until MSHA's debt levels moderate. Although not expected, should balance sheet metrics weaken, a lower rating or negative outlook would be likely.

Organizational Profile

Since its formation in 1998, MSHA has roughly tripled its asset base and net patient revenues to more than \$1.9 billion and \$930 million, respectively. Due in large part to its acquisition strategy, the system's pro forma debt has doubled since 2005 and is now very high at over \$1 billion. The system's growth was accomplished through strategic hospital acquisitions in its core northeastern Tennessee and southwest Virginia service areas.

MSHA owns and operates 11 acute-care facilities and one psychiatric hospital led by the flagship Johnson City Medical Center, a 623-licensed-bed tertiary regional provider. The system's hospital facilities include 1,780 licensed acute-care beds. The system also includes a range of outpatient facilities and ancillary services, such as a home health agency, a hospice, and other facilities including the ownership and management of medical office buildings. The affiliation with Johnston Memorial Hospital (JMH) in 2009 completed MSHA's hospital acquisition strategy, which has included the acquisition of five Virginia hospitals over the past four years.

As part of its physician integration efforts, MSHA has consolidated its employed physician practices into Mountain States Medical Group, which currently employs about 230 physicians. MSHA has steadily reduced physician practice losses through attrition of less productive physicians, improvements in compensation when contracts are renewed, and other efficiency measures.

Since the system's creation in 1998, management and governance have evolved effectively. A strong central leadership is focused on maximizing the system's potential as a whole, as evidenced by the consolidation efforts in its core market of Washington County. In addition, management has broadened the access to managed-care contracts for all of the facilities, while centralizing the negotiations at the system level. It has also centralized other functions like billing and collections, purchasing, and laboratory services. The board improved its effectiveness by reducing its size to a very manageable 13 members, and has upheld its values of strong planning, education, and

transparency.

Market Position

The system's defined market area has broadened significantly due to its acquisition activity. The core service area encompasses 13 counties in Tennessee and Virginia, of which MSHA has approximately 52% market share. Today only about 30% of the system's patients originate from its original home county of Washington County, Tenn. In the broader 29-county service area, MSHA has a 37% share; MSHA's main competitor, Wellmont, holds about a 30% share. There is no significant third player.

Wellmont has acquired three hospitals in its secondary service area within the past few years and completed a sizable renovation of its largest campus, Holston Valley Medical Center, during the past year. We believe that the spate of acquisitions by both health systems over the past several years has largely played out as there are very few remaining independent hospitals in the region. While the service area remains very competitive, its market characteristics remain favorable in terms of population growth, and the market's size will continue to support two sizable competitors.

While MSHA's market share is extremely strong in the core Washington County market, Wellmont Health System dominates in adjacent Sullivan County. Historically, Sullivan County was the only part of MSHA's primary service area where the two systems competed head to head, whereas in other parts of their service areas, MSHA and Wellmont generally did not overlap. However, they are increasingly overlapping in their service areas. For example, MSHA traditionally had no hospitals in Virginia, while Wellmont did. However, recent affiliations with the five Virginia hospitals have thrust MSHA into a service area that traditionally has fed Wellmont's facilities. The two systems now compete head-on in Norton, Va., a two-hospital town where in 2007, MSHA acquired a 50.1% ownership Norton Community Hospital, while Wellmont acquired the other one (Mountain View).

Projects Update

Smyth County Community Hospital is a \$60 million, 44-bed replacement hospital for the more than 40-year-old local community hospital. Funding for the project is coming from operating reserves, a new market tax credit loan, and vendor financing. The project is expected to be complete by November 2011.

Franklin Woods Community Hospital (FWCH) is a new \$114 million, 80-bed (plus 20 shelled beds) hospital replacement facility that replaced inpatient acute-care services at MSHA's North Side Hospital and its Johnson City Specialty Hospital. FWCH opened in July 2010. North Side Hospital has remained open and provides skilled-nursing care.

Series 2009E bonds funded MSHA's acquisition of a 50.1% interest in the 135-bed JMH in April 2009. MSHA is building a 250,000-square-foot replacement hospital next to the JMH cancer center in Abingdon, Va., which opened in 2007. The new hospital is scheduled to open in May 2011.

Finances

MSHA demonstrated solid operating performance improvement during fiscal 2010. For the year ended June 30, 2010, net operating income climbed to \$13.5 million, or a 1.4% margin, on \$945 million in total operating

revenues, compared with \$7.0 million, or a 0.83% margin, on \$840 million in revenues in fiscal 2009. Although inpatient admissions grew to 60,101 in fiscal 2010 from 57,127 in fiscal 2009, volume growth was largely generated from acquisitions, and not same-store volumes, which were flat. Fiscal 2010 was the first full year of operating results with the acquired facilities, and MSHA's operating performance was slightly weaker than the \$16 million budgeted (1.6% margin). The system is forecasting flat inpatient volume growth of 0.42% (to 60,355) in fiscal 2011. MSHA estimates that it will be eligible for about \$57 million in stimulus payments between 2010 and 2015; however, no stimulus funds are included in the system's five-year forecast.

EBIDA margin was 16.7% for fiscal 2010. MADS coverage, based on MADS of \$65 million, was 2.5x (or 2.3x on an operating lease-adjusted basis) based on June 30, 2010, fiscal year-end results.

Net excess income for the year was \$38.1 million due to \$24.6 million of interest-, dividend-, and derivative-related income.

Interim financial performance

Through the first three months of fiscal 2011 (Sept. 30, 2010), MSHA reported an operating loss of \$2.7 million on \$241 million in operating revenues. First-quarter losses are typical for MSHA since it is the system's practice to be very conservative in realizing income early in the year. Last year the system reported a first-quarter operating loss of \$2.4 million on \$235 million of operating revenues.

Balance Sheet

MSHA's aggressive pace of acquisitions has positioned the system to compete effectively in its core service area; however, those investments have leveraged the system's balance sheet and limited the growth in unrestricted liquidity despite solid operating cash flow.

Unrestricted cash and investments totaled \$576 million (or \$550 million net of cash collateral posted against swaps) at fiscal year-end 2010, equal to 247 days' cash. Long-term debt to capitalization is high, at 77%. Due to high system leverage, year-end cash to debt was 53%, which is well below the median for the current rating. MSHA remains in compliance with all bond covenants. We expect that leverage and liquidity metrics will improve over the next several since the system's acquisition program has been complete. We understand that other than about \$45 million of additional debt that MSHA expects to issue for a surgery center project in 2012, the system's current capital spending plans can be funded with cash flow.

The system's target asset allocations include maintaining 110 days' cash in high-quality and highly liquid fixed-income investments. Above 110 days' cash, the system may invest in equities up to an allocation limit of 50%. MSHA does not invest in hedge funds or in private equity.

Debt Derivative Profile

MSHA's DDP overall score is a '2.5' on a scale of '1' to '4', whereby '1' represents the lowest risk. The score of '2.5' reflects Standard & Poor's view that MSHA's swap exposure is a low to moderate credit risk at this time.

The key components of the overall DDP score of '2.5' are:

- Management practices are strong, and include a written swap policy, frequent communication of swap

performance to the board, good audit disclosure related to swaps, and the use of independent financial advisers to assist in evaluating swap strategies and performance.

- The termination and collateral-posting risk is offset from a credit standpoint by MSHA's collateral being clearly segregated from unrestricted liquidity, and none of the collateral is included in any of Standard & Poor's unrestricted liquidity calculations.

Related Criteria And Research

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- USPF Criteria: Debt Derivative Profile Scores, March 27, 2006
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009

Ratings Detail (As Of January 19, 2011)		
Mountain States Health Alliance		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd, Tennessee		
Mountain States Hlth Alliance, Tennessee		
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance)		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) hosp VRDO ser 2008A		
<i>Long Term Rating</i>	AAA/A-1+	Affirmed
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) hosp VRDO Taxable ser 2007B-1		
<i>Long Term Rating</i>	AAA/A-1+	Affirmed
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Hlth Alliance) hosp rfdg rev bnds ser 2007B-2		
<i>Long Term Rating</i>	AAA/A-1	Affirmed
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Hlth Alliance) hosp rfdg rev bnds ser 2007B-3		
<i>Long Term Rating</i>	AAA/A-1	Affirmed
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance)		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Russell Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Russell Cnty Indl Dev Auth (Mountain States Health Alliance)		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Russell Cnty Indl Dev Auth (Mountain States Health Alliance) hosp VRDO ser 2008B		
<i>Long Term Rating</i>	AAA/A-1+	Affirmed
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Smyth Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Smyth Cnty Indl Dev Auth (Mountain States Health Alliance)		

Ratings Detail (As Of January 19, 2011) (cont.)		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Washington Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Washington Cnty Indl Dev Auth (Mountain States Health Alliance)		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Many issues are enhanced by bond insurance.		

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McGRAW-HILL

Mountain States Health Alliance, Tennessee; Letter of Credit

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Mountain States Health Alliance, Tennessee; Letter of Credit

Credit Profile

US\$15.96 mil hosp rev bnds ser 2011E due 07/01/2026

Long Term Rating

A+/A-1

New

Profile

Expected closing date: Oct. 19, 2011

Maturity date: July 1, 2026

Structure type: Direct-pay letter of credit (LOC)

Obligor: Mountain States Health Alliance

LOC providers: Mizuho Corp. Bank Ltd. (rating dependency*)

Trustee: Bank of New York Mellon Trust Co.

*Standard & Poor's rating on the bonds is linked to its rating on the LOC provider.

Rationale

Standard & Poor's Ratings Services assigned its 'A+/A-1' rating to Mountain States Health Alliance, Tenn.'s taxable bonds series 2011E. The 'A+' long-term component of the rating is based on the irrevocable direct-pay letter of credit (LOC) provided by Mizuho Corp. Bank Ltd. (A+/A-1) and reflects our opinion of the likelihood that bondholders will receive interest and principal payments when due if they do not exercise the put option. The 'A-1+' short-term component of our rating is based on the short-term component of the issuer credit rating on Mizuho Corp. Bank Ltd. (A+/A-1) and reflects our opinion of the likelihood that bondholders will receive interest and principal payments if they exercise the put option.

The LOC fully supports all bond payment obligations when the bonds are in the weekly interest mode. Therefore, our rating applies only during this covered mode. If the bonds are converted to a non-covered rate mode, we will likely withdraw our rating (see the Structural Analysis section for more information).

Transaction Highlights

The debt is variable rate with a bondholder option to demand repayment before the bonds mature (the put or tender option). The bondholders may exercise the put option at any time during the covered mode with appropriate notice to the trustee. Those bondholders choosing to exercise the put option will receive a price equal to par plus accrued interest funded with remarketing proceeds that the trustee holds and, in the event of a failed remarketing, with the amounts available under the LOC.

Structural Analysis

When evaluating the bonds, Standard & Poor's considers various risk factors, as described below.

LOC coverage for the covered mode

The LOC covers 37 days of interest accruals at a maximum interest rate and the entire bond principal amount. We believe the LOC's coverage is sufficient to pay interest and principal while the bonds are in the covered rate mode, even assuming maximum interest rate accruals (see table).

Maximum bond rate:	12%
First interest payment date:	Nov. 1, 2011
Covered mode interest payment date:	First business day of month
LOC interest reinstatement period:	One calendar day
Remedy for non-reinstatement:	Trustee will accelerate the bonds' maturity date, and interest shall cease to accrue one calendar day after declaration.
Interest accrual for covered mode(s):	The accrual period begins on an interest payment date and continues up to, but excluding, the next interest payment date.

Interest rate mode changes

In addition to covered modes, the transaction documents provide that the bonds may be converted to a medium-term or fixed interest rate mode (uncovered modes). While the bonds are in the uncovered modes, a put option is not available. Furthermore, we believe the LOC does not provide enough interest coverage to account for the additional days of interest that would accrue between interest payment dates during the uncovered modes. Despite these issues, we do not believe there is any mode conversion-related risk of a put option loss or an interest shortfall because the bonds are subject to a mandatory tender at par plus accrued interest before the rate mode can be changed.

The transaction terms do not expressly provide for the bonds to operate in multiple modes concurrently.

LOC termination

The transaction structure is such that the LOC could terminate before the bonds mature. If this happens, the bond documents call for the trustee to declare a date to repay the bonds in full before the LOC terminates. Therefore, we believe the LOC termination risk is addressed. The LOC is scheduled to expire on Oct. 19, 2014, unless it is extended or earlier terminates. The trustee shall declare a mandatory tender on the second business day prior to the LOC expiration date. In addition, for other events that cause the LOC to terminate, a mandatory tender funded by the LOC provider is a precondition for LOC cancellation.

LOC provider replacement

The transaction documents provide that the obligor may replace the LOC provider with appropriate notice to bondholders. The condition for replacing an existing LOC provider is that a mandatory tender must occur on the fifth business day prior to LOC replacement.

In our view, the conditions for replacing the LOC mitigate any risk that the existing bondholders would see the rating on their bonds lowered as a consequence of the LOC provider being replaced.

Additional bonds

The transaction terms do not expressly provide for additional bond issuances under the same series.

Ratings Sensitivity

In view of the bond structure, changes to our rating on the bonds in the covered mode can result from, among other things, changes to our rating on the LOC provider or amendments to the transaction's terms. We will maintain a rating on the bonds as long as they are in the covered mode and the LOC has not expired or otherwise terminated. If either of these conditions changes, we will likely withdraw our rating on the bonds.

Other Call Provisions

During the covered mode, bonds are subject to mandatory and optional redemptions. In all cases, the redemption price will at least equal par plus accrued interest and the repayments are backed by the LOC provider.

Related Criteria And Research

Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009

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Johnson City Health & Educational Facilities Board, Tennessee Mountain States Health Alliance; Letter of Credit

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Johnson City Health & Educational Facilities Board, Tennessee

Mountain States Health Alliance; Letter of Credit

Credit Profile

US\$65.26 mil hosp rev bnds (Mountain States Hlth Alliance) ser 2011A dtd 10/19/2011 due 07/01/2033

<i>Long Term Rating</i>	AA-/A-1+	New
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US\$20.0 mil hosp rev bnds (Mountain States Hlth Alliance) ser 2011B dtd 10/19/2011 due 07/01/2033

<i>Long Term Rating</i>	A+/A-1	New
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Profile

Expected closing date: Oct. 19, 2011

Maturity date: July 1, 2033

Structure type: Direct-pay letter of credit (LOC)

Obligor: Mountain States Health Alliance

LOC providers: Series 2011A: U.S. Bank N.A. (rating dependency*); series 2011B: PNC Bank N.A. (rating dependency*)

Trustee: Bank of New York Mellon Trust Co.

*Standard & Poor's rating on the bonds is linked to its rating on the LOC provider.

Rationale

Standard & Poor's Ratings Services assigned its 'AA-/A-1+' and 'A+/A-1' rating to Johnson City Health & Educational Facilities Board, Tenn.'s (Mountain States Health Alliance) hospital revenue bonds series 2011A and 2011B. The 'AA-' long-term component of the rating on the 2011A bonds is based on the irrevocable direct-pay letter of credit (LOC) provided by U.S. Bank N.A. (AA-/A-1+). The 'A+' long-term component of the rating on the 2011B bonds is based on the irrevocable direct-pay LOC provided by PNC Bank N.A. (A+/A-1). The long-term component of each rating reflects our opinion of the likelihood that bondholders will receive interest and principal payments when due if they do not exercise the put option. The 'A-1+' short-term component of the rating on the 2011A bonds is based on the short-term component of the issuer credit rating on U.S. Bank N.A. The 'A-1' short-term component of the rating on the 2011B bonds is based on the short-term component of the issuer credit rating on PNC Bank N.A. The short-term component of the rating reflects our opinion of likelihood that bondholders will receive interest and principal payments if they exercise the put option.

Each LOC fully supports all bond payment obligations when the bonds are in the weekly interest mode. Therefore, our rating applies only during this covered mode. If the bonds are converted to a non-covered rate mode, we will likely withdraw our rating (see the Structural Analysis section for more information).

Transaction Highlights

The debt is variable rate with a bondholder option to demand repayment before the bonds mature (the put or tender option). The bondholders may exercise the put option at any time during the covered mode with appropriate notice to the trustee. Those bondholders choosing to exercise the put option will receive a price equal to par plus accrued interest funded with remarketing proceeds that the trustee holds and, in the event of a failed remarketing, with the amounts available under the LOC.

Structural Analysis

When evaluating the bonds, Standard & Poor's considers various risk factors, as described below.

LOC coverage for the covered mode

Each LOC covers 37 days of interest accruals at a maximum interest rate and the entire bond principal amount. We believe each LOC's coverage is sufficient to pay interest and principal while the bonds are in the covered rate mode, even assuming maximum interest rate accruals (see table).

Maximum bond rate:	12%
First interest payment date:	Nov. 1, 2011
Covered mode interest payment date:	First business day of month
LOC interest reinstatement period:	One calendar day
Remedy for non-reinstatement:	Trustee will accelerate the bonds' maturity date, and interest shall cease to accrue one calendar day after declaration.
Interest accrual for covered mode(s):	The accrual period begins on an interest payment date and continues up to, but excluding, the next interest payment date.

Interest rate mode changes

In addition to covered modes, the transaction documents provide that the bonds may be converted to a medium-term or fixed interest rate mode (uncovered modes). While the bonds are in the uncovered modes, a put option is not available. Furthermore, we believe the LOC does not provide enough interest coverage to account for the additional days of interest that would accrue between interest payment dates during the uncovered modes.

Despite these issues, we do not believe there is any mode conversion-related risk of a put option loss or an interest shortfall because the bonds are subject to a mandatory tender at par plus accrued interest before the rate mode can be changed.

The transaction terms do not expressly provide for the bonds to operate in multiple modes concurrently.

LOC termination

The transaction structure is such that the LOCs could terminate before the bonds mature. If this happens, the bond documents call for the trustee to declare a date to repay the bonds in full before the LOCs terminate. Therefore, we believe LOC termination risk is addressed. Each LOC is scheduled to expire on Oct. 19, 2014, unless it is extended or earlier terminates. The trustee shall declare a mandatory tender on the second business day prior to the LOC expiration date. In addition, for other events that cause the LOC to terminate, a mandatory tender funded by the LOC provider is a precondition for LOC cancellation.

LOC provider replacement

The transaction documents provide that the obligor may replace each LOC provider with appropriate notice to bondholders. The condition for replacing an existing LOC provider is that a mandatory tender must occur on the fifth business day prior to LOC replacement.

In our view, the conditions for replacing the LOC mitigate any risk that the existing bondholders would see the rating on their bonds lowered as a consequence of the LOC provider being replaced.

Additional bonds

The transaction terms do not expressly provide for additional bond issuances under the same series.

Ratings Sensitivity

In view of the bond structure, changes to our rating on the bonds in the covered mode can result from, among other things, changes to our rating on each LOC provider or amendments to the transaction's terms. We will maintain a rating on the bonds as long as they are in the covered mode and each LOC has not expired or otherwise terminated. If either of these conditions changes, we will likely withdraw our rating on the bonds.

Other Call Provisions

During the covered mode, bonds are subject to mandatory and optional redemptions. In all cases, the redemption price will at least equal par plus accrued interest and the repayments are backed by the LOC provider.

Related Criteria And Research

Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009

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Smyth County Industrial Development Authority, Virginia

Mountain States Health Alliance; Letter of Credit

Credit Profile

US\$60.705 mil hosp rev bnds (Mountain States Hlth Alliance) ser 2011D dtd 10/19/2011 due 07/01/2031

<i>Long Term Rating</i>	A+/A-1	New
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US\$49.875 mil hosp rev bnds (Mountain States Hlth Alliance) ser 2011C dtd 10/19/2011 due 07/01/2031

<i>Long Term Rating</i>	AA-/A-1+	New
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Profile:

Expected closing date:	Oct. 19, 2011
Maturity date:	July 1, 2031
Structure type:	Direct-pay letter of credit (LOC)
Obligor:	Mountain States Health Alliance
LOC providers:	Series 2011C: U.S. Bank N.A. (rating dependency*), series 2011D: Mizuho Corp. Bank Ltd. (rating dependency*)

*Standard & Poor's rating on the bonds is linked to its rating on the LOC provider.

Rationale

Standard & Poor's Ratings Services assigned its 'AA-/A-1+' and 'A+/A-1' ratings to Smyth County Industrial Development Authority, Va.'s (Mountain States Health Alliance) hospital revenue bonds series 2011C and 2011D, respectively. The 'AA-' long-term component of the rating on series 2011C is based on the irrevocable direct-pay letter of credit (LOC) provided by U.S. Bank N.A. (AA-/A-1+). The 'A+' long-term component of the rating on series 2011D is based on the irrevocable direct-pay LOC provided by Mizuho Corp. Ltd. (A+/A-1). The long-term component of each rating reflects our opinion of the likelihood that bondholders will receive interest and principal payments when due if they do not exercise the put option. The 'A-1+' short-term component of the rating on series 2011C is based on the short-term component of the issuer credit rating on U.S. Bank N.A. The 'A-1' short-term component of the rating on series 2011D is based on the short-term component of the issuer credit rating on Mizuho Corp. LTD (A-1). The short-term component of the rating reflects our opinion of the likelihood that bondholders will receive interest and principal payments if they exercise the put option.

Each LOC fully supports all bond payment obligations when the bonds are in the weekly interest mode. Therefore, our rating applies only during this covered mode. If the bonds are converted to a non-covered rate mode, we will likely withdraw our rating (see the Structural Analysis section for more information).

Transaction Highlights

The debt is variable rate with a bondholder option to demand repayment before the bonds mature (the put or tender option). The bondholders may exercise the put option at any time during the covered mode with appropriate notice to the trustee. Those bondholders choosing to exercise the put option will receive a price equal to par plus accrued interest funded with remarketing proceeds that the trustee holds and, in the event of a failed remarketing, with the amounts available under the LOC.

Structural Analysis

When evaluating the bonds, Standard & Poor's considers various risk factors, as described below.

LOC coverage for the covered mode

Each LOC covers 37 days of interest accruals at a maximum interest rate and the entire bond principal amount. We believe each LOC's coverage is sufficient to pay interest and principal while the bonds are in the covered rate mode, even assuming maximum interest rate accruals (see table).

Maximum bond rate:	12%
First interest payment date:	Nov. 1, 2011
Covered mode interest payment date:	First business day of month
LOC interest reinstatement period:	One calendar day
Remedy for non-reinstatement:	Trustee will accelerate the bonds' maturity date, and interest shall cease to accrue one calendar day after declaration.
Interest accrual for covered mode(s):	The accrual period begins on an interest payment date and continues up to, but excluding, the next interest payment date.

Interest rate mode changes

In addition to covered modes, the transaction documents provide that the bonds may be converted to a medium-term or fixed interest rate mode (uncovered modes). While the bonds are in the uncovered modes, a put option is not available. Furthermore, we believe the LOC does not provide enough interest coverage to account for the additional days of interest that would accrue between interest payment dates during the uncovered modes.

Despite these issues, we do not believe there is any mode conversion-related risk of a put option loss or an interest shortfall because the bonds are subject to a mandatory tender at par plus accrued interest before the rate mode can be changed.

The transaction terms do not expressly provide for the bonds to operate in multiple modes concurrently.

LOC termination

The transaction structure is such that the LOCs could terminate before the bonds mature. If this happens, the bond documents call for the trustee to declare a date to repay the bonds in full before the LOCs terminate. Therefore, we believe LOC termination risk is addressed. Each LOC is scheduled to expire on Oct. 19, 2014, unless it is extended or earlier terminates. The trustee shall declare a mandatory tender on the second business day prior to the LOC expiration date. In addition, for other events that cause the LOC to terminate, a mandatory tender funded by the LOC provider is a precondition for LOC cancellation.

LOC provider replacement

The transaction documents provide that the obligor may replace each LOC provider with appropriate notice to bondholders. The condition for replacing an existing LOC provider is that a mandatory tender must occur on the fifth business day prior to LOC replacement.

In our view, the conditions for replacing the LOC mitigate any risk that the existing bondholders would see the rating on their bonds lowered as a consequence of the LOC provider being replaced.

Additional bonds

The transaction terms do not expressly provide for additional bond issuances under the same series.

Ratings Sensitivity

In view of the bond structure, changes to our rating on the bonds in the covered mode can result from, among other things, changes to our rating on each LOC provider or amendments to the transaction's terms. We will maintain a rating on the bonds as long as they are in the covered mode and each LOC has not expired or otherwise terminated. If either of these conditions changes, we will likely withdraw our rating on the bonds.

Other Call Provisions

During the covered mode, bonds are subject to mandatory and optional redemptions. In all cases, the redemption price will at least equal par plus accrued interest and the repayments are backed by the LOC provider.

Related Criteria And Research

Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009

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Johnson City Health and Education Facilities Board, Tennessee Mountain States Health Alliance; Joint Criteria; System

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Johnson City Hlth & Ed Fac Brd, Tennessee

Mountain States Hlth Alliance, Tennessee

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) hosp VRDO ser 2011A

<i>Long Term Rating</i>	AAA/A-1	Upgraded
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Rating Assigned

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) hosp VRDO ser 2011B

<i>Long Term Rating</i>	AA+/A-1	Upgraded
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Rating Assigned

Smyth Cnty Indl Dev Auth, Virginia

Mountain States Hlth Alliance, Tennessee

Smyth Cnty Indl Dev Auth (Mountain States Health Alliance) hosp VRDO ser 2011D

<i>Long Term Rating</i>	AAA/A-1	Upgraded
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Rating Assigned

Smyth Cnty Indl Dev Auth (Mountain States Health Alliance) hosp VRDO 2011C

<i>Long Term Rating</i>	AAA/A-1	Upgraded
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Rating Assigned

Rationale

Standard & Poor's Ratings Services assigned its 'BBB+' underlying rating (SPUR) to Mountain States Health Alliance (MSHA), Tenn.'s series 2011A, 2011B, 2011C, 2011D, and 2011E bonds from various issuers. At the same time, Standard & Poor's affirmed its 'BBB+' issuer credit rating (ICR) on MSHA and its 'BBB+' long-term rating and SPUR on existing rated bonds from various issuers for MSHA. The outlook is stable.

The 'BBB+' ratings reflect our view of MSHA's:

- Excellent business position, which is characterized by solid demographics, a high market share, and a broad range of services;
- Strong management and governance, which is reflected in a favorable performance record since the system's creation in 1998;
- Continued strong financial performance, highlighted by very strong fiscal-year EBITDA margins, an eighth consecutive year of operating profitability in fiscal 2011, and solid liquidity for the rating level based on days' cash on hand; and
- More moderate capital spending needs during the next five years and no sizable incremental debt plans, which will likely support further growth in unrestricted liquidity and a reduction in leverage over time.

MSHA's \$235 million series 2011A, 2011B, 2011C, 2011D, and 2011E bonds were issued for a variety of purposes, including refunding taxable series 2007B bonds to convert them to tax-exempt obligations, reimbursing MSHA for projects and equipment funded from cash reserves, funding \$14 million of the \$66 million Smyth County replacement hospital construction project, achieving interest rate and letter of credit (LOC) fee savings, and diversifying the institutions that provide credit enhancements. With the series 2011 debt refinancing, MSHA added Norton Community Hospital and Smyth County Community Hospital to its obligated group -- although analytically Standard & Poor's evaluates the consolidated Mountain States Health Alliance, not the obligated group.

On Oct. 19, 2011, MSHA's series 2011A and series 2011C bonds were assigned an 'A+/A-1' rating based on the irrevocable direct-pay LOCs provided by U.S. Bank N.A. (A+/A-1). Series 2011B was assigned an 'A/A-1' rating based on the LOC provided by PNC Bank N.A. (A/A-1). Series 2011D and series 2011E were assigned an 'A+/A-1' rating based on LOCs provided by Mizuho Corp Ltd (A+/A-1).

With the assignment of the SPURs to the series 2011A, 2011B, 2011C, 2011D, and 2011E bonds, MSHA has requested that Standard & Poor's apply its criteria for rating jointly supported obligations to the bonds, for which both MSHA as the obligor and the direct-pay LOC provider are fully responsible for repayment. Based on the low correlation joint support of MSHA and U.S. Bank N.A., Standard & Poor's assigned its 'AAA/A-1' long-term rating to MSHA's series 2011A and 2011C obligations. Based on low correlation joint support of MSHA and PNC Bank N.A., Standard & Poor's assigned its 'AA+/A-1' long-term rating to MSHA's series 2011B bonds. And, based on the low correlation joint support of MSHA and Mizuho Bank Ltd., Standard & Poor's assigned its 'AAA/A-1' rating to MSHA's 2011D and 2011E series obligations.

As of its June 30, 2011 fiscal year-end, MSHA had \$1.04 billion of long-term debt and capital lease obligations outstanding. We understand MSHA's plans for additional debt during the next few years will likely be limited to a \$50 million issue in fiscal 2013 for the surgery tower project, as the system expects to be able to fund most of its remaining capital needs with cash flow and reserves. However, currently, MSHA's sizable debt and accompanying high leverage remain the system's most significant credit risks, in our view. The system has a debt-to-capital ratio of 69.5% and a debt burden of 6.8% of revenue. Even with typical EBITDA margins of 16% to 18%, maximum annual debt service (MADS) coverage has historically been below median 'BBB+' levels, although MADS coverage levels have improved during the past two years to be consistent with the 'BBB+' median of 2.7x.

Standard & Poor's Debt Derivative Profile (DDP) overall score on MSHA's swap portfolio is '2.5' on a scale of '1.0' to '4.0' in which '1.0' represents the lowest risk. The overall DDP score of '2.5' reflects Standard & Poor's view that MSHA's swap exposure reflects low to moderate credit risk at this time. MSHA has two total return swaps with a total notional amount of \$50 million, whose counterparty was Lehman Brothers Special Financing Inc., guaranteed by Lehman Brothers Inc. The timing for the termination of those swaps is uncertain pending the resolution of issues related to Lehman's bankruptcy although a mediation hearing was scheduled in early December to discuss a settlement related to swap termination. MSHA has posted \$13.8 million of collateral against the Lehman swaps. Standard & Poor's does not count collateral funds as unrestricted liquidity, so the possibility of paying a termination cost is not likely to have a material credit impact.

Bank of America is the counterparty for two other swaps -- a \$438 million constant maturity swap with a negative mark-to-market (MTM) value of \$2.0 million, and \$5.6 million positive annual cash flow, and a \$132 million basis swap (converted from fixed payer to reduce the negative carry and MTM volatility) with an MTM value of negative \$22 million, against which MSHA had \$5.8 million of posted collateral (all figures as of November 2011).

MSHA had \$514 million of unrestricted liquidity on Sept. 30, 2011. Should the swaps terminate, MSHA will lose the positive annual cash flow from the swaps, which historically has exceeded \$2 million annually; however, MSHA will also be relieved of the negative carry on its swaps (currently about \$800,000 per year) if the full portfolio is terminated.

Outlook

The stable outlook reflects our view of MSHA's business position, the benefits of the system's acquisition activity during the past several years, MSHA's favorable record of integrating acquired facilities, and the natural improvement in debt ratios that has started to occur. Also adding to credit stability, in our view, is MSHA's history of maintaining solid earnings. However, the system's high debt burden remains a credit risk, in our view. While we could raise the ratings in the future, we do not expect to do so until MSHA's debt levels moderate, and we would expect long-term debt to total capitalization to decline to a level below 50% without a diminution of MSHA's liquidity. We would also expect that the organization's business position would remain strong, as demonstrated by stable to improving patient volumes and solid cash flow. Although not anticipated, should balance sheet metrics weaken, we could take a negative rating action.

Enterprise Profile

Since its formation in 1998, MSHA has tripled its asset base and more than tripled net patient revenues to almost \$2.0 billion and \$960 million, respectively. Due in large part to the system's acquisition strategy, the system's pro forma debt has doubled since 2005 and is now very high, in our view, at more than \$1 billion. The system's growth was accomplished through strategic hospital acquisitions in its core northeastern Tennessee and southwest Virginia service areas.

MSHA owns and operates 11 acute-care facilities and one psychiatric hospital led by the flagship Johnson City Medical Center, a 514-licensed-bed (including 69 beds associated with Niswonger Children's Hospital) tertiary regional provider. The system's hospital facilities include 1,749 licensed acute-care beds although MSHA's licensed beds will decline to 1,623 once the new, smaller 44-bed Smyth county replacement hospital is completed. The system also includes a range of outpatient facilities and ancillary services, such as a home health agency, a hospice, and other facilities such as the ownership and management of medical office buildings.

As part of its physician integration efforts, MSHA has consolidated its employed physician practices into Mountain States Medical Group, which currently employs about 400 physicians. MSHA has steadily reduced physician practice losses through increased physician leadership including regional Chief Medical Officers, the attrition of less productive physicians, improvements in compensation when contracts are renewed, and other efficiency measures.

Since the system's creation, management and governance have evolved effectively, in our view. A strong central leadership is focused on maximizing the system's potential as a whole, as evidenced by the consolidation efforts in its core market of Washington County. In addition, management has broadened the access to managed-care contracts for all of the facilities while centralizing the negotiations at the system level. It has also centralized other functions like billing and collections, purchasing, and laboratory services. The board improved its effectiveness by reducing its size to a very manageable 13 members, and has upheld its values of strong planning, education, and transparency.

Today, as it approaches the changing health care landscape MSHA's leadership remains focused on quality, ongoing physician integration, smart growth through service line and revenue cycle opportunities, cost reduction initiatives, and on the development and implementation of new accountable care models, initially for the hospital's own employee population (15,000 lives), and for its Medicare patient base.

Market position

The system's defined market area has broadened significantly due to its acquisition activity. The core service area encompasses 13 counties in Tennessee and Virginia, of which MSHA has a 52.3% market share. Currently only 27% of the system's patients originate from its original home county of Washington County, Tenn. In the broader 29-county service area, MSHA has a 37% share; MSHA's main competitor, Wellmont, holds about a 30% share. There is no significant third player.

We believe that the spate of acquisitions by both MSHA and Wellmont have largely played out as there are very few remaining independent hospitals in the region. While the service area remains very competitive, its market characteristics remain favorable in terms of population growth, and the market's size will continue to support two sizable competitors, in our opinion.

While MSHA's market share is extremely strong in the core Washington County market, Wellmont Health System dominates in adjacent Sullivan County. Historically, Sullivan County was the only part of MSHA's primary service area where the two systems competed head to head, whereas in other parts of their service areas, MSHA and Wellmont generally did not overlap. However, they are increasingly overlapping in their service areas. For example, MSHA traditionally had no hospitals in Virginia, while Wellmont did. However, recent affiliations with the five Virginia hospitals have introduced MSHA into a service area that traditionally has fed Wellmont's facilities. The two systems now compete head-on in Norton, Va., a two-hospital town where in 2007 MSHA acquired a 50.1% ownership Norton Community Hospital, while Wellmont acquired the other one (Mountain View).

Projects update

Smyth County Community Hospital is a \$66 million, 44-bed replacement hospital for the more than 40-year-old local community hospital. Funding for the project is coming from series 2011 bonds (\$14 million) and operating reserves. Management expects the project to be complete by April 2012.

Series 2009E bonds funded MSHA's acquisition of a 50.1% interest in the 135-bed Johnson Memorial Hospital (JMH) in April 2009. In July 2011 MSHA completed and opened a 250,000-square-foot Gold LEED certified replacement hospital next to the JMH cancer center in Abingdon, VA.

In January 2012 MSHA commenced a \$69 million surgery tower project at Johnson City Medical Center. The number of operating room suites will remain at 16; however, the renovation will expand the space in each suite to accommodate modern equipment. In addition, the project will structurally allow MSHA to build eight additional floors for a future bed tower when additional capacity is needed (although there are currently no plans to construct the tower). The surgery project will be funded by a \$50 million bond issue in fiscal 2013 and from operations and reserves and a small amount of philanthropy. The project is estimated for completion in October 2013. We understand that MSHA has no other major committed capital projects beyond 2013.

Financial Profile

MSHA again demonstrated solid operating performance improvement during fiscal 2011, in our view. For the fiscal year ended June 30, 2011, net operating income climbed to \$20.5 million, or a 2.1% margin, on \$960 million in total operating revenues, compared with \$13.5 million, or a 1.4% margin, on \$928 million in revenues in fiscal 2010. MSHA's operating performance in fiscal 2011 was on target with budget. Inpatient admissions grew to 61,035 (or 1.6%) in fiscal 2011 from 60,101 in fiscal 2010. Volume growth was supported by an increase in medical admissions. Following several years of growth, outpatient volumes declined to 1.59 million (or 0.82%) in 2011 from 1.60 million in 2010 as MSHA's medical screening initiative shifted many patients to clinics and away from the emergency department, and as payers took a more stringent posture on certain procedures such as imaging. The system is forecasting modest increases in both inpatient and outpatient volume of 1.1% and 2.6%, respectively, in fiscal 2012. MSHA is projecting a fiscal 2012 operating margin of 2.5% and an excess margin of 4.0%, which we consider reasonable, particularly given management's historical ability to meet its targets.

No stimulus funds are included in MSHA's five-year operating income forecast; however, the system estimates that it will be eligible for about \$57 million in stimulus payments between 2012 and 2016 related to its IT investments. Management believes that within three years all of its hospitals will be on one IT platform

For fiscal 2011 MSHA's EBITDA margin was 17.6%, compared with 16.7% for fiscal 2010. MADS coverage, based on MADS of \$68.2 million, was 2.6x (or 2.4x on an operating lease-adjusted basis) based on June 30, 2011 fiscal year-end results.

Net excess income for fiscal 2011 was \$41.1 million due to \$23.3 million of interest, dividend, and derivative-related income.

Interim financial performance

Through the first three months of fiscal 2012 (Sept. 30, 2011), MSHA reported an operating income of \$8.8 million (inclusive of minority interests, as per Standard & Poor's methodology) on \$254 million in operating revenues, which compared favorably with MSHA's first-quarter fiscal 2010 operating loss of \$2.7 million on \$241 million in operating revenues. Historically, first-quarter losses have been typical for MSHA since it is the system's practice to be very conservative in realizing income early in the year. For fiscal 2012 total operating revenues increased by 3.7% relative to the same period last year while operating expenses climbed a more modest 1.4%, on reduced use of contract labor, lower supplies expenses, and reductions in bad debt expense, interest, and depreciation.

Balance sheet

During the past several years MSHA's aggressive pace of acquisitions positioned the system to compete effectively in its core service area. However, those investments leveraged the system's balance sheet and for a while limited the growth in MSHA's unrestricted liquidity despite robust operating cash flow. Given that major acquisition and construction activity is completed, and with a low current 6.5-year average age of plant, we believe that MSHA will likely be able to remain at or near its goal of 250 days' cash and reduce debt outstanding when cash exceeds that level. However, in fiscal 2012 MSHA projects days' cash will decline to 232 from funding capital spending out of cash reserves.

Unrestricted cash and investments totaled \$597 million at fiscal year-end 2011, equal to 251 days' cash. Long-term debt to capitalization is high, in our view, at 69.5%, although MSHA continues to pay down its long-term debt, and

prior to fiscal year-end paid off about \$9.3 million of notes. Due to high system leverage, year-end cash to debt was 57%, which was improved over last year but remains well below the median for the current rating. MSHA remains in compliance with all bond covenants. We anticipate that leverage and liquidity metrics will improve over the next several years since the system's acquisition program and major capital spending initiatives have been completed. We understand that other than about \$50 million of additional debt that MSHA expects to issue for a surgery center project during fiscal 2013, the system's current capital spending plans can be funded with cash flow.

The system's target asset allocations include maintaining 110 days' cash in high-quality and highly liquid fixed-income investments. Above 110 days' cash, the system may invest in equities up to an allocation limit of 50%. MSHA does not invest in hedge funds or in private equity.

Debt Derivative Profile

MSHA's DDP overall score is a '2.5' on a scale of '1' to '4' in which '1' represents the lowest risk. The score of '2.5' reflects Standard & Poor's view that MSHA's swap exposure is a low to moderate credit risk at this time.

The key components of the overall DDP score of '2.5' are:

- Management practices are strong and include a written swap policy, frequent communication of swap performance to the board, good audit disclosure related to swaps, and the use of independent financial advisers to assist in evaluating swap strategies and performance.
- The termination and collateral posting risk is offset from a credit standpoint by the clear segregation of MSHA's collateral from unrestricted liquidity, and none of the collateral is included in any of Standard & Poor's unrestricted liquidity calculations.

In fiscal 2011 MSHA reconfigured its swaps to lock in positive cash flow of \$16 million over three years on \$435 million of constant maturity swaps, and converted its \$132 million of fixed payer swaps to basis swaps, which will reduce their overall MTM volatility and collateral posting requirements. In addition, in 2011 MSHA terminated its swaption agreement with JP Morgan at no incremental cost. MSHA plans to terminate the \$132 million of basis swaps when market conditions allow, and to resolve the Lehman swap termination on \$106 million of total return and fixed payer swaps as soon as possible.

Mountain States Health Alliance, Tennessee Financial Statistics				
	Year-to-date as of Sept. 30, 2011	Fiscal Year Ended		
		2011	2010	2009
Financial performance				
Net patient revenue (\$000s)	244,499	960,254	928,270	822,898
Total operating revenue (\$000s)	254,344	978,018	945,392	839,944
Total operating expenses (\$000s)	245,498	957,518	931,850	832,941
Net nonoperating income (\$000s)	5,739	20,600	24,589	14,234
Operating margin (%)	3.48	2.10	1.43	0.83
Excess margin (%)	5.61	4.12	3.93	2.49
Operating EBIDA margin (%)	15.57	15.82	14.53	14.38
EBIDA margin (%)	17.44	17.56	16.7	15.8
Net available for debt service (\$000s)	45,351	175,311	161,954	134,985

Mountain States Health Alliance, Tennessee Financial Statistics (cont.)				
Maximum annual debt service (\$000s)	68,199	68,199	65,000	65,000
Maximum annual debt service coverage (x)	2.66	2.57	2.49	2.08
Operating lease-adjusted coverage (x)		2.38	2.29	1.94
Liquidity and financial flexibility				
Unrestricted cash and investments (\$000s)	514,263	597,435	578,452	515,066
Unrestricted days' cash on hand	206.6	251.4	248.3	245.9
Unrestricted cash/total long-term debt (%)	50.0	57.4	54.8	49.5
Cash available within 30 days/contingent liability (%)				
Average age of plant (years)	8.2	6.5	7	7.4
Capital expenditures/Depreciation and amortization (%)		191.9	211.2	187.6
Debt and Liability				
Total long-term debt (\$000)	1,029,138	1,040,923	1,054,842	1,040,944
Long-term debt/capitalization (%)	72.4	69.5	77.2	78.5
Contingent liability (\$000)				
Contingent liability/total long-term debt (%)				
Debt burden (%)	6.55	6.81	6.70	7.61

Related Criteria And Research

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- USPF Criteria: Debt Derivative Profile Scores, March 27, 2006
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009

Ratings Detail (As Of January 23, 2012)		
Mountain States Health Alliance hosp VRDO		
Long Term Rating	AAA/A-1	Upgraded
Unenhanced Rating	BBB+(SPUR)/Stable	Rating Assigned
Mountain States Health Alliance		
Unenhanced Rating	BBB+(SPUR)/Stable	Affirmed
Mountain States Health Alliance ICR		
Long Term Rating	BBB+/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd, Tennessee		
Mountain States Hlth Alliance, Tennessee		
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance)		
Long Term Rating	BBB+/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) hosp VRDO ser 2007B2		
Long Term Rating	AA+/A-1	Downgraded
Unenhanced Rating	BBB+(SPUR)/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) hosp VRDO ser 2007B3		
Long Term Rating	AAA/A-1	Affirmed
Unenhanced Rating	BBB+(SPUR)/Stable	Affirmed

Ratings Detail (As Of January 23, 2012) (cont.)		
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance)		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1	Downgraded
Russell Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Russell Cnty Indl Dev Auth (Mountain States Health Alliance)		
<i>Long Term Rating</i>	NR	
Russell Cnty Indl Dev Auth (Mountain States Health Alliance) hosp VRDO ser 2008B		
<i>Long Term Rating</i>	AAA/A-1	Downgraded
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Smyth Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Smyth Cnty Indl Dev Auth (Mountain States Health Alliance)		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Washington Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Washington Cnty Indl Dev Auth (Mountain States Health Alliance)		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Many issues are enhanced by bond insurance.		

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US\$54.90 mil fixed rate bnds ser 2012A		
<i>Long Term Rating</i>	BBB+/Stable	New
US\$30.230 mil hosp rev bnds ser 2012B due 07/01/2035		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	New
US\$9.785 mil var rate structure bnds ser 2012C		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	New
Mountain States Health Alliance ICR		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed

Rationale

Standard & Poor's Ratings Services assigned its 'BBB+' long-term rating to Mountain States Health Alliance (MSHA), Tenn.'s \$54.9 million series 2012A bonds, and its 'BBB+' underlying rating (SPUR) to MSHA's \$30.2 million series 2012B bonds, issued by The Health and Educational Facilities Board of the City of Johnson City, Tenn., and \$9.8 million series 2012C variable-rate structure bonds issued by Wise County Industrial Development Authority.

At the same time, Standard & Poor's affirmed its 'BBB+' issuer credit rating (ICR) on MSHA, and its 'BBB+' long-term rating and SPUR on existing rated bonds from various issuers for MSHA. The outlook on all ratings is stable.

The 'BBB+' ratings reflect our view of MSHA's:

- Excellent business position, which is characterized by solid demographics, a high market share, and a broad range of services;
- Strong management and governance, which is reflected in a favorable performance record since the system's creation in 1998;
- Continued strong financial performance, highlighted by solid EBITDA margins, a 10th consecutive year of operating profitability in fiscal 2012, and solid liquidity for the rating level based on days' cash on hand; and
- More moderate capital spending needs during the next five years, and no sizable incremental debt plans, which will likely support further growth in unrestricted liquidity and a reduction in leverage over time.

Proceeds from MSHA's series 2012 bonds will be used to construct a surgical tower at Johnson City Medical Center, to reimburse \$26.5 million for previous capital spending, and to refinance debt and leases outstanding to achieve interest rate and letter of credit (LOC) fee savings. Concurrent with the issuance of the rated bonds, MSHA is issuing \$18.4 million of taxable variable-rate direct purchase debt to Bank of America that is not being rated. Combined, new money associated with the 2012A, 2012B, and 2012C bonds and unrated direct purchase debt is approximately \$89 million.

While the assigned SPURs on MSHA's \$40 million series 2012B and 2012C obligations are 'BBB+', we expect to assign long-term and short-term ratings of 'A+/A-1' based on credit enhancement provided by irrevocable direct-pay LOCs

from Mizuho Corp. Ltd. (A+/A-1). MSHA has also requested that Standard & Poor's apply its criteria for rating jointly supported obligations, for which both MSHA as the obligor, and Mizuho Bank as LOC provider, are fully responsible for repayment. Based on the low correlation joint support of MSHA and Mizuho, we expect to assign a 'AAA/A-1' joint support rating to the series 2012B and 2012C obligations.

As of its fiscal year ended June 30, 2012 (unaudited), MSHA had \$1.07 billion of long-term debt and capital lease obligations outstanding. We understand that MSHA has no plans to issue a significant amount of additional debt during the next few years as management expects to fund most of its remaining capital needs with cash flow and reserves. MSHA may convert its remaining \$125 million of taxable debt outstanding to tax exempt; however, the conversion would not represent any additional debt other than costs of issuance and any required reserves. Currently MSHA's sizable debt and accompanying high leverage remain the system's most significant credit risks, in our opinion. One of management's goals is to reduce leverage. The system has a pro forma debt to capital ratio of approximately 66% and a debt burden of 7.5% of revenue. Even with typical EBITDA margins of 16% to 18%, maximum annual debt service (MADS) coverage has historically been below median 'BBB+' levels. However, MADS coverage improved modestly during the past two years to approximately 2.6x, and will be 2.1x to 2.3x on a pro forma basis, which is in line with the 'BBB+' median.

MSHA has \$106 million total notional amount of total return and fixed payer swaps whose counterparty was Lehman Brothers Special Financing Inc., guaranteed by Lehman Brothers Inc. The timing for the termination of those swaps is uncertain pending the resolution of issues related to Lehman's bankruptcy and mediation of settlement terms. MSHA has posted \$13.8 million of collateral against the Lehman swaps. Standard & Poor's does not count collateral funds as unrestricted liquidity, so the possibility of paying a termination cost is not likely to have a material credit impact.

Bank of America is the counterparty for five other swaps -- \$438 million constant maturity swaps with a mark-to-market (MTM) value of \$6.6 million and \$5.6 million positive annual cash flow, and \$132 million of basis swaps (converted from fixed payer to reduce the negative carry and MTM volatility) with an MTM value of negative \$17.7 million, against which MSHA has no posted collateral (all figures as of July 20, 2012). MSHA also has a \$21.4 million total return swap in place related to the series 2001A bonds outstanding.

Outlook

The stable outlook reflects our view of MSHA's business position, the benefits of the system's acquisition activity during the past several years, MSHA's favorable record of integrating acquired facilities, and the natural improvement in debt ratios that will likely occur over time. Also adding to credit stability, in our view, is MSHA's history of maintaining solid earnings although we believe the system's high debt burden remains a credit risk. While we could raise the ratings in the future, we do not expect to do so until MSHA's MADS coverage equals or exceeds 3.0x, cash to long-term debt approaches 1.0x, and debt to capitalization declines to roughly 55%. We would also expect that the organization's business position would remain strong, as demonstrated by stable to improving patient volumes and solid cash flow. Although not anticipated, should balance sheet metrics weaken, we could take a negative rating action.

Enterprise Profile

Since its formation in 1998, MSHA has tripled its asset base and more than tripled net patient revenues to almost \$2.0 billion and \$978 million, respectively. Due in large part to the system's acquisition strategy, the system's pro forma debt has approximately doubled since 2005 to more than \$1.0 billion, equal to about 66% of capitalization, which we consider elevated. The system's growth was accomplished through strategic hospital acquisitions in its core northeastern Tennessee and southwest Virginia service areas.

MSHA owns and operates 11 acute-care facilities and one psychiatric hospital, led by the flagship Johnson City Medical Center, a 514-licensed-bed (including 69 beds associated with Niswonger Children's Hospital) tertiary regional provider. The system's hospital facilities include 1,623 licensed acute-care beds. The system also consists of a range of outpatient facilities and ancillary services, such as a home health agency, a hospice, and other facilities such as the ownership and management of medical office buildings.

As part of its physician integration efforts, MSHA has consolidated its employed physician practices into Mountain States Medical Group, which currently employs about 400 physicians. MSHA has steadily reduced physician practice losses through increased physician leadership including regional chief medical officers, the attrition of less productive physicians, improvements in compensation when contracts are renewed, and other efficiency measures.

Management

Since the system's creation, management and governance have evolved effectively, in our view. A strong central leadership team is focused on maximizing the system's potential as a whole, as demonstrated by the consolidation efforts in its core market of Washington County. In addition, management has broadened the access to managed-care contracts for all of the facilities while centralizing the negotiations at the system level. It has also centralized other functions like billing and collections, purchasing, and laboratory services. The board improved its effectiveness by reducing its size to 13 members and has upheld its values of strong planning, education, and transparency.

Today, as it approaches the changing health care landscape MSHA's leadership remains focused on quality, ongoing physician integration, smart growth through service line and revenue cycle opportunities, cost reduction initiatives, and the development and implementation of new accountable care models, initially for the hospital's own employee population (approximately 15,000 lives), and for its Medicare patient base.

Market position

The system's core service area encompasses 13 counties in Tennessee and Virginia, and MSHA has a 53% market share. Currently, only 27% of the system's patients originate from its original home county of Washington County, Tenn. In the broader 29-county service area, MSHA has a 38% share. MSHA's main competitor, Wellmont, holds about a 30% share. There is no significant third player.

We believe that the spate of acquisitions by both MSHA and Wellmont have largely played out as there are very few remaining independent hospitals in the region. While the service area remains competitive, market characteristics remain favorable in terms of population growth, and the market's size will continue to support two sizable competitors, in our opinion.

While MSHA's market share is strong in the core Washington County market, Wellmont Health System dominates in adjacent Sullivan County. Historically, Sullivan County was the only part of MSHA's primary service area where the two systems competed head to head, whereas in other parts of their service areas, MSHA and Wellmont generally did not overlap. However, they are increasingly overlapping in their service areas. MSHA traditionally had no hospitals in Virginia, while Wellmont did. However, affiliations with five Virginia hospitals during the past few years introduced MSHA into a service area that traditionally fed Wellmont's facilities. The two systems now compete head-on in Norton, Va., a two-hospital town where in 2007 MSHA acquired a 50.1% ownership in Norton Community Hospital, while Wellmont acquired the other one (Mountain View).

Recent projects update

In April 2012, MSHA completed a \$66 million, 44-bed replacement facility for the more than 40-year-old Smyth County Community Hospital. Funding for the project came from the series 2011 bonds (\$14 million) and operating reserves.

In January 2012, MSHA commenced a \$69 million surgery tower project at Johnson City Medical Center. The project is being funded with the series 2012A bonds proceeds, operations, reserves, and a small amount of philanthropy. The number of operating room suites will remain at 16; however, the renovation will expand the space in each suite to accommodate modern equipment. In addition, the project will structurally allow MSHA to build eight additional floors for a future bed tower when additional capacity is needed (although there are currently no plans to construct the tower). The project is estimated for completion in October 2013. We understand that MSHA has no other major committed capital projects beyond 2013.

Financial Profile

MSHA again demonstrated good but less robust operating performance in fiscal 2012 compared with fiscal 2011. For the fiscal year ended June 30, net operating income was \$10 million, or a 1.0% margin, on \$996 million in total operating revenues, down from \$21 million, or a 2.1% margin, on \$960 million in total operating revenues in fiscal 2011. According to management, operating performance came in below budget for a variety of reasons, including timing issues surrounding reimbursement; lower-than-budgeted volumes, particularly in inpatient surgeries; and an increase in charity care and bad debts.

For the year, inpatient admissions were flat year over year, at 61,154 (or a 0.2% increase), compared with 61,035 in fiscal 2011, while total surgical cases were down 4% to 36,972 from 38,521. By contrast, outpatient volumes grew to 1.59 million (or 3%) in fiscal 2012 from 1.55 million in fiscal 2011 as more volumes shifted from an inpatient to outpatient setting consistent with industry trends.

Net excess income for fiscal 2012 was solid, in our view, at \$37.9 million (a 3.7% margin) compared with \$41.1 million (or a 4.1% margin) the previous year. MSHA's EBITDA margin was 15.5% in fiscal 2012, compared with 17.6% for fiscal 2011. MADS coverage, based on pro forma MADS of \$68 million to \$77 million, depending upon final pricing, is 2.1x to 2.3x.

Balance sheet

During the past several years, MSHA's aggressive pace of acquisitions positioned the system to compete effectively in its core service area. However, those investments leveraged the system's balance sheet, and for a while limited the growth in MSHA's unrestricted liquidity despite robust operating cash flow. Major acquisition and construction activity is completed, and that the current average age of plant is eight years, which we consider low. As a result, we believe that MSHA will be able to comfortably maintain more than 200 days' cash and over time build back to its goal of 250 days' cash. We understand that management has targeted to reduce debt outstanding when cash exceeds that level.

Unrestricted cash and investments totaled \$534 million at fiscal year-end 2012, equal to 214 days' cash. Pro forma long-term debt to capitalization remains elevated, in our view, at 66%, although we anticipate that leverage and liquidity metrics will improve during the next several years since the system's acquisition program and major capital spending initiatives have been completed. Due to high system leverage, pro forma cash to debt is approximately 48%, which remains well below the median for the current rating. MSHA remains in compliance with all bond covenants. We understand that capital spending plans can be funded with cash flow, in addition to the series 2012 bonds.

The system's target asset allocations include maintaining 110 days' cash in high-quality and highly liquid fixed-income investments. Above 110 days' cash, the system may invest in equities up to an allocation limit of 50%. MSHA does not invest in hedge funds or in private equity.

Mountain States Health Alliance

	Fiscal Year Ended June 30, 2012 (Unaudited)	Fiscal Year Ended June 30,		
		2011	2010	2009
Financial performance				
Net patient revenue (\$000s)	958,003	960,254	928,270	822,898
Total operating revenue (\$000s)	995,562	978,018	945,392	839,944
Total operating expenses (\$000s)	985,523	957,518	931,850	832,941
Operating income (\$000s)	10,039	20,500	13,542	7,003
Operating margin (%)	1.01	2.10	1.43	0.83
Net nonoperating income (\$000s)	27,884	20,600	24,589	14,234
Excess income (\$000s)	43,038	41,100	38,131	21,237
Excess margin (%)	3.71	4.12	3.93	2.49
Operating EBIDA margin (%)	13.16	15.82	14.53	14.38
EBIDA margin (%)	15.52	17.56	16.70	15.80
Net available for debt service (\$000s)	166,727	175,311	161,954	134,985
Maximum annual debt service (\$000s)	77,236	77,236	77,236	77,236
Maximum annual debt service coverage (x)	2.16	2.27	2.10	1.75
Operating lease-adjusted coverage (x)	1.94	2.13	1.99	1.67
Liquidity and financial flexibility				
Unrestricted cash and investments (\$000s)	533,713	597,435	578,452	515,066
Unrestricted days' cash on hand	214.0	251.4	248.3	245.9
Unrestricted cash/total long-term debt (%)	50.9	57.4	54.8	49.5
Average age of plant (years)	8.3	6.5	7.0	7.4
Capital expenditures/depreciation and amortization (%)	179.5	191.9	211.2	187.6

Mountain States Health Alliance (cont.)

Debt and liabilities				
Total long-term debt (\$000s)	1,049,098	1,040,923	1,054,842	1,040,944
Long-term debt/capitalization (%)	63.6	72.2	76.9	79.3
Debt burden (%)	7.51	7.71	7.96	9.04
Pro forma ratios				
Unrestricted days' cash on hand	223.56			
Unrestricted cash/total long-term debt (%)	47.84			
Long-term debt/capitalization (%)	66.02			

Related Criteria And Research

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- USPF Criteria: Contingent Liquidity Risks, March 5, 2012
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009

Ratings Detail (As Of August 16, 2012)**Mountain States Health Alliance, Series 2000D**

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Russell Cnty Indl Dev Auth, Virginia

Mountain States Hlth Alliance, Tennessee

Ser 2008B

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Long Term Rating AAA/A-1 Affirmed

Smyth Cnty Indl Dev Auth, Virginia

Mountain States Hlth Alliance, Tennessee

Seies 2010 B and Series 2009B

Long Term Rating BBB+/Stable Affirmed

The Hlth & Educl Facs Brd of the City of Johnson City, Tennessee

Mountain States Hlth Alliance, Tennessee

ser 2007B2

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Long Term Rating AA+/A-1 Affirmed

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance), ser 2008A

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Long Term Rating AAA/A-1 Affirmed

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance), Series 2000C

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance), Series 2007B-1

Ratings Detail (As Of August 16, 2012) (cont.)		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1	Affirmed
Series 2007B1-3		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1	Affirmed
Series 2010 A&B, 2006A and 2009A		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Washington Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Ser 2009 C		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Many issues are enhanced by bond insurance.		

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Mountain States Health Alliance, Tennessee; Joint Criteria

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Credit Profile

The Hlth & Educl Facs Brd of the City of Johnson City, Tennessee

Mountain States Hlth Alliance, Tennessee

Johnson City Hlth & Educl Facs Brd (Mountain States Hlth Alliance) ser 2012B

<i>Long Term Rating</i>	AAA/A-1	Rating Assigned
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Rating Assigned

Wise Cnty Indl Dev Auth, Virginia

Mountain States Hlth Alliance, Tennessee

Wise Cnty Indl Dev Auth (Mountain States Hlth Alliance) ser 2012C

<i>Long Term Rating</i>	AAA/A-1	Rating Assigned
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Rating Assigned

Profile:

Expected closing date:	Sept. 18, 2012
Maturity date:	Aug. 15, 2042
Structure type:	Direct-pay letter of credit (LOC)
Obligor:	Mountain States Health Alliance
LOC provider:	Mizuho Corp. Bank Ltd. (rating dependency*)
Trustee:	Bank of New York Mellon Trust Co.

*Standard & Poor's rating on the bonds is linked to its rating on the letter of credit provider.

Rationale

Standard & Poor's Ratings Services has assigned its 'AAA/A-1' rating to Johnson City Health & Educational Facilities Board, Tenn.'s (the issuer's) hospital revenue bonds series 2012B and Wise County Industrial Development Authority, Va.'s series 2012C, both issued on behalf of Mountain States Health Alliance (MSHA). At the same time, Standard & Poor's assigned its 'BBB+' underlying rating (SPUR) to the bonds. The 'AAA' long-term component of the rating is based on the application of joint criteria (assuming low correlation) between the irrevocable direct-pay letter of credit (LOC) and the obligor, and reflects our opinion of the likelihood that bondholders will receive interest and principal payments when due if they do not exercise the put option. The 'A-1' short-term component of our rating is based on the short-term component of the rating on Mizuho Corp. Bank Ltd. (A+/A-1), and reflects our opinion of the likelihood that bondholders will receive interest and principal payments if they exercise the put option.

The LOC fully supports all bond payment obligations when the bonds are in the weekly interest mode. Therefore, our rating applies only during this covered mode. If the bonds are converted to a non-covered rate mode, we will likely withdraw our rating (see the Structural Analysis section for more information).

The SPUR reflects our opinion of MSHA's excellent business position, strong management and governance, and

continued solid operating performance, highlighted by a 10th consecutive year of operating profitability, robust EBITDA margins, and good liquidity for the rating level. Additionally, MSHA has no sizable capital needs or incremental debt plans, so it should benefit from growth in its unrestricted liquidity and a reduction in leverage over time.

For more information, please see the report published Aug. 16, 2012, on RatingsDirect on the Global Credit Portal.

Transaction Highlights

The debt is variable rate with a bondholder option to demand repayment before the bonds mature (the put or tender option). The bondholders may exercise the put option at any time during the covered mode with appropriate notice to the trustee. Those bondholders choosing to exercise the put option will receive a price equal to par plus accrued interest funded with remarketing proceeds that the trustee holds and, in the event of a failed remarketing, with the amounts available under the LOC.

Structural Analysis

When evaluating the bonds, Standard & Poor's considers various risk factors, as described below.

LOC coverage for the covered mode

The LOC covers 37 days of interest accruals at a maximum interest rate and the entire bond principal amount. We believe the LOC's coverage is sufficient to pay interest and principal while the bonds are in the covered rate mode, even assuming maximum interest rate accruals (see table).

Maximum bond rate:	12%
First interest payment date:	Oct. 1, 2012
Covered mode interest payment date:	First business day of month
LOC interest reinstatement period:	One calendar day
Remedy for non-reinstatement:	Trustee will accelerate the bonds' maturity date and interest shall cease to accrue one calendar day after declaration.
Interest accrual for covered mode(s):	The accrual period begins on an interest payment date and continues up to, but excluding, the next interest payment date.

In addition to covered modes, the transaction documents provide that the bonds may be converted to a medium-term or fixed interest rate mode (uncovered modes). While the bonds are in the uncovered modes, a put option is not available. Furthermore, we believe the LOC does not provide enough interest coverage to account for the additional days of interest that would accrue between interest payment dates during the uncovered modes. Despite these issues, we do not believe there is any mode conversion-related risk of a put option loss or an interest shortfall because the bonds are subject to a mandatory tender at par plus accrued interest before the rate mode can be changed.

The transaction terms do not provide for the bonds to operate in multiple modes concurrently.

LOC termination

The transaction structure is such that the LOC could terminate before the bonds mature. If this happens, the bond documents call for the trustee to declare a date to repay the bonds in full before the LOC terminates. Therefore, we believe LOC termination risk is addressed. The LOC is scheduled to expire on Sept. 17, 2015, unless it is extended or earlier terminates. The trustee shall declare a mandatory tender on the second business day prior to the LOC expiration date.

LOC provider replacement

The transaction documents provide that the obligor may replace the LOC provider with appropriate notice to bondholders. The condition for replacing an existing LOC provider is that a mandatory tender must occur on the fifth business day prior to LOC replacement.

In our view, the conditions for replacing the LOC mitigate any risk that the existing bondholders would see the rating on their bonds lowered as a consequence of the LOC provider being replaced.

Additional bonds

The transaction terms do not provide for additional bond issuances under the same series.

Ratings Sensitivity

In view of the bond structure, changes to our rating on the bonds in the covered mode can result from, among other things, changes to our rating on the LOC provider or amendments to the transaction's terms. We will maintain a rating on the bonds as long as they are in the covered mode and the LOC has not expired or otherwise terminated. If either of these conditions changes, we will likely withdraw our rating on the bonds.

Other Call Provisions

During the covered mode, bonds are subject to mandatory and optional redemptions. In all cases, the redemption price will at least equal par plus accrued interest and the repayments are backed by the LOC provider.

Related Criteria And Research

- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009
- USPF Criteria: Municipal Applications For Joint Support Criteria, June 25, 2007
- Criteria: Joint Support Criteria Update, April 22, 2009

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SEPTEMBER 5, 2012 5

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Financial Profile

Related Criteria And Research

The Health & Educational Facilities Board of the City of Johnson City, Tennessee

Mountain States Health Alliance; Joint Criteria; System

Credit Profile

Mountain States Health Alliance ICR

Long Term Rating

BBB+/Stable

Affirmed

Rationale

Standard & Poor's Ratings Services affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on existing rated obligations from various issuers for Mountain States Health Alliance (MSHA), Tenn. At the same time, Standard & Poor's affirmed its 'BBB+' issuer credit rating (ICR) on MSHA. The outlook on all ratings is stable.

The 'BBB+' ratings reflect our view of MSHA's:

- Excellent business position, which is characterized by solid demographics, a high market share, and a broad range of services;
- Strong management and governance, which is reflected in a favorable performance record since the system's creation in 1998;
- Continued strong financial performance, highlighted by solid EBITDA margins, a 10th consecutive year of operating profitability in fiscal 2012, and solid liquidity for the rating level based on days' cash on hand; and
- More moderate capital spending needs during the next five years and lack of sizable incremental debt plans, which will likely support further growth in unrestricted liquidity and a reduction in leverage over time.

Despite MSHA's strong business position and consistent operating profitability, system leverage is elevated and remains an offsetting credit factor, in our opinion. MSHA has a debt-to-capital ratio of approximately 65% and a debt burden of 7.2% of revenue. One of management's goals is to reduce leverage, and we believe that will be key to achieving a higher rating. Also, even with typical EBITDA margins of 16% to 18%, maximum annual debt service (MADS) coverage has historically been below median 'BBB+' levels. MADS coverage as of Sept. 30 on annualized basis was 1.7x.

In 2012 MSHA issued \$89 million in new-money debt (in series 2012A, 2012B, and 2012C and including unrated bank direct purchase debt). Proceeds from MSHA's series 2012 bonds were used to construct a surgical tower at Johnson City Medical Center, to reimburse \$26.5 million for previous capital spending, and to refinance debt and leases outstanding to achieve interest rate and letter of credit (LOC) fee savings. Concurrent with the issuance of the rated bonds, MSHA issued \$18.4 million of taxable variable-rate direct purchase debt to Bank of America that was not rated.

While the assigned SPURs on MSHA's \$40 million series 2012B and 2012C obligations are 'BBB+', the long- and

short-term ratings on series 2012B and 2012C bonds are 'AAA/A-1' based on the low correlation joint support of MSHA, and of Mizuho Bank as the LOC provider. Both MSHA and Mizuho are fully responsible for repayment.

As of its fiscal year ended Sept. 30, 2012 (unaudited), MSHA had \$1.12 billion of long-term debt and capital lease obligations outstanding. We understand that MSHA has no plans to issue a significant amount of additional debt during the next few years as management expects to fund most of its remaining capital needs with cash flow and reserves. MSHA may convert its remaining \$129 million of taxable debt outstanding to tax exempt; however, the conversion would not represent any additional debt other than costs of issuance and any required reserves. Currently, MSHA's sizable debt and accompanying high leverage remain the system's most significant credit risks, in our opinion.

In October 2012 MSHA came to a resolution with Lehman Brothers and terminated its \$106 million of total return and fixed payer swaps. The settlement allowed Lehman to retain \$7.4 million of the \$13.8 million of collateral that had been posted by MSHA. The remaining \$6.4 million was returned to MSHA.

Bank of America is the counterparty for five other active swaps -- \$438 million constant maturity swaps with a mark-to-market (MTM) value of \$9.8 million and \$5.6 million positive annual cash flow through February 2014, and \$132 million of basis swaps (converted from fixed payer to reduce the negative carry and MTM volatility) with an MTM value of negative \$17.0 million, against which MSHA has no posted collateral (all figures as of November 2012).

Outlook

The stable outlook reflects our view of MSHA's business position, the benefits of the system's acquisition activity during the past several years, MSHA's favorable record of integrating acquired facilities, and the natural improvement in debt ratios that will likely occur over time. Also adding to credit stability, in our view, is MSHA's history of maintaining solid earnings although we believe the system's high debt burden remains a credit risk. While we could raise the ratings in the future, we do not expect to do so until MSHA's MADS coverage equals or exceeds 3.0x, cash to long-term debt approaches 1.0x, and debt to capitalization declines to roughly 55%. We would also expect that the organization's business position would remain strong, as demonstrated by stable to improving patient volumes and solid cash flow. Although not anticipated, should balance sheet metrics weaken, we could take a negative rating action.

Enterprise Profile

Since its formation in 1998, MSHA has tripled its asset base and more than tripled annual net patient revenues to \$2.0 billion and more than \$950 million, respectively. Due in large part to the system's acquisition strategy, the system's pro forma debt has approximately doubled since 2005 to more than \$1.0 billion, equal to about 65% of capitalization, which we consider elevated. The system accomplished this growth through strategic hospital acquisitions in its core northeastern Tennessee and southwest Virginia service areas.

MSHA owns and operates 11 acute-care facilities and one psychiatric hospital, led by the flagship Johnson City Medical Center, a 514-licensed-bed (including 69 beds associated with Niswonger Children's Hospital) tertiary regional provider. The system's hospital facilities include 1,623 licensed acute-care beds. The system also consists of a range of

outpatient facilities and ancillary services, such as a home health agency, a hospice, and other facilities such as the ownership and management of medical office buildings.

As part of its physician integration efforts, MSHA has consolidated its employed physician practices into Mountain States Medical Group, which currently employs about 400 physicians. MSHA has steadily reduced physician practice losses through increased physician leadership including regional chief medical officers, the attrition of less productive physicians, improvements in compensation when contracts are renewed, and other efficiency measures.

Management

Since the system's creation, management and governance have evolved effectively, in our view. A strong central leadership team is focused on maximizing the system's potential as a whole, as demonstrated by the consolidation efforts in its core market of Washington County. In addition, management has broadened the access to managed-care contracts for all of the facilities while centralizing the negotiations at the system level. It has also centralized other functions like billing and collections, purchasing, and laboratory services. The board improved its effectiveness by reducing its size to 13 members and has upheld its values of strong planning, education, and transparency.

Today, as it approaches the changing health care landscape MSHA's leadership remains focused on quality, ongoing physician integration, smart growth through service line and revenue cycle opportunities, cost reduction initiatives, and the development and implementation of new accountable care models, initially for the hospital's own employee population (approximately 15,000 lives), and for its Medicare patient base.

Market position

The system's core service area encompasses 13 counties in Tennessee and Virginia, and MSHA has a 53% market share. Currently, only 27% of the system's patients originate from its original home county of Washington County, Tenn. In the broader 29-county service area, MSHA has a 38% share. MSHA's main competitor, Wellmont, holds about a 30% share. There is no significant third player.

We believe that the spate of acquisitions by both MSHA and Wellmont have largely played out as there are very few remaining independent hospitals in the region. While the service area remains competitive, market characteristics remain favorable in terms of population growth, and the market's size will continue to support two sizable competitors, in our opinion.

While MSHA's market share is strong in the core Washington County market, Wellmont Health System dominates in adjacent Sullivan County. Historically, Sullivan County was the only part of MSHA's primary service area where the two systems competed head to head, whereas in other parts of their service areas, MSHA and Wellmont generally did not overlap. However, they are increasingly overlapping in their service areas. MSHA traditionally had no hospitals in Virginia, while Wellmont did. However, affiliations with five Virginia hospitals during the past few years introduced MSHA into a service area that traditionally fed Wellmont's facilities. The two systems now compete head-on in Norton, Va., a two-hospital town where in 2007 MSHA acquired a 50.1% ownership in Norton Community Hospital, while Wellmont acquired the other one (Mountain View).

Recent projects update

In April 2012, MSHA completed a \$66 million, 44-bed replacement facility for the more than 40-year-old Smyth County Community Hospital. Funding for the project came from the series 2011 bonds (\$14 million) and operating reserves.

In January 2012, MSHA commenced a \$69 million surgery tower project at Johnson City Medical Center. The project is being funded with the series 2012A bonds proceeds, operations, reserves, and a small amount of philanthropy. The number of operating room suites will remain at 16; however, the renovation will expand the space in each suite to accommodate modern equipment. In addition, the project will structurally allow MSHA to build eight additional floors for a future bed tower when additional capacity is needed (although there are currently no plans to construct the tower). The project is estimated for completion in October 2013. We understand that MSHA has no other major committed capital projects beyond 2013.

Financial Profile

MSHA's operating performance was good in fiscal 2012, in our view, but less robust than in fiscal 2011. For the fiscal year ended June 30, net operating income was \$8.3 million, or a 0.9% margin, on \$992 million in total operating revenues, down from \$21 million, or a 2.1% margin, on \$971 million in total operating revenues in fiscal 2011.

According to management, operating performance came in below budget for a variety of reasons, including timing issues surrounding reimbursement; lower-than-budgeted volumes, particularly in inpatient surgeries; and an increase in charity care and bad debts.

For the year, inpatient admissions were flat year over year, at 61,154 (or a 0.2% increase), compared with 61,035 in fiscal 2011, while total surgical cases declined by 4% to 36,972 from 38,521. By contrast, outpatient volumes grew to 1.59 million (or 3%) in fiscal 2012 from 1.55 million in fiscal 2011 as more volumes shifted from an inpatient to outpatient setting consistent with industry trends.

Net excess income for fiscal 2012 was solid, in our view, at \$39.7 million (a 3.9% margin), compared with \$41.1 million (or a 4.2% margin) the previous year. MSHA's EBITDA margin was 13.1% in fiscal 2012, compared with 15.7% for fiscal 2011. Coverage, based on new MADS of \$71 million, was 2.3x for fiscal 2012.

Balance sheet

During the past several years, MSHA's aggressive pace of acquisitions positioned the system to compete effectively in its core service area. However, those investments leveraged the system's balance sheet, and for a while limited the growth in MSHA's unrestricted liquidity despite robust operating cash flow.

Major acquisition and construction activity is completed, and the current average age of plant is eight years, which we consider low. As a result, we believe that MSHA will be able to comfortably maintain more than 200 days' cash and over time build back to its goal of 250 days' cash. We understand that management has targeted to reduce debt outstanding when cash exceeds that level.

Unrestricted cash and investments totaled \$578 million at Sept. 30, 2012, equal to 231 days' cash. Long-term debt to capitalization remains elevated, in our view, at 65%, although we anticipate that leverage and liquidity metrics will

improve during the next several years since the system's acquisition program and major capital spending initiatives have been completed. Due to high system leverage, cash to debt is approximately 51%, which remains well below the median for the current rating. MSHA remains in compliance with all bond covenants.

The system's target asset allocations include maintaining 110 days' cash in high-quality and highly liquid fixed-income investments. Above 110 days' cash, the system may invest in equities up to an allocation limit of 50%. MSHA does not invest in hedge funds or in private equity.

Mountain States Health Alliance				
		Fiscal Year Ended June 30,		
	Three-Month Interim Ended Sept. 30, 2012	2012	2011	2010
Financial performance				
Net patient revenue (\$000s)	227,664	952,133	960,254	928,270
Total operating revenue (\$000s)	238,587	991,540	978,018	945,392
Total operating expenses (\$000s)	245,727	983,215	957,173	931,850
Operating income (\$000s)	(7,140)	8,325	20,845	13,542
Operating margin (%)	(2.99)	0.84	2.13	1.43
Net nonoperating income (\$000s)	7,721	31,369	20,600	24,589
Excess income (\$000s)	581	39,694	41,445	38,131
Excess margin (%)	0.24	3.88	4.15	3.93
Operating EBIDA margin (%)	9.65	13.06	15.85	14.53
EBIDA margin (%)	N.A.	15.73	17.59	16.70
Net available for debt service (\$000s)	30,751	160,902	175,656	161,954
Maximum annual debt service (\$000s)	71,229	71,229	77,236	77,236
Maximum annual debt service coverage (x)	1.73	2.26	2.27	2.10
Operating lease-adjusted coverage (x)	1.98	2.12	2.14	1.99
Liquidity and financial flexibility				
Unrestricted cash and investments (\$000s)	572,688	518,624	597,435	578,452
Unrestricted days' cash on hand	230.8	208.5	251.5	248.3
Unrestricted cash/total long-term debt (%)	51.3	49.5	57.4	54.8
Average age of plant (years)	8.3	8.3	6.5	7.0
Capital expenditures/depreciation and amortization (%)	N.A.	176.5	191.9	211.2
Debt and liabilities				
Total long-term debt (\$000s)	1,117,046	1,048,098	1,040,923	1,054,842
Long-term debt/capitalization (%)	64.5	63.6	64.5	76.9
Contingent liabilities (\$000s)	499,605	459,605	386,418	N.A.
Contingent liabilities/total long-term debt (%)	44.7	43.9	37.1	N.A.
Debt burden (%)	7.23	6.96	7.71	7.96

N.A.: Not available.

Related Criteria And Research

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- USPF Criteria: Contingent Liquidity Risks, March 5, 2012
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009

Ratings Detail (As Of January 16, 2013)		
Mountain States Health Alliance, Series 2000D		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Series 2011E		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1	Affirmed
Russell Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Ser 2008B		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1+	Affirmed
Smyth Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Seies 2010 B and Series 2009B		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Series 2011C		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1+	Affirmed
Series 2011D		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1	Affirmed
The Hlth & Educl Facs Brd of the City of Johnson City, Tennessee		
Mountain States Hlth Alliance, Tennessee		
ser 2007B2		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AA+/A-1	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance), ser 2008A		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1+	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance), Series 2000C		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance), Series 2007B-1		

Ratings Detail (As Of January 16, 2013) (cont.)

<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1+	Affirmed

Series 2007B1-3

<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1	Affirmed

Series 2010 A&B, 2006A and 2009A

<i>Long Term Rating</i>	BBB+/Stable	Affirmed
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Series 2011A

<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1+	Affirmed

Series 2011B

<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AA+/A-1	Affirmed

Series 2012A

<i>Long Term Rating</i>	BBB+/Stable	Affirmed
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Series 2012B

<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1	Affirmed

Washington Cnty Indl Dev Auth, Virginia

Mountain States Hlth Alliance, Tennessee

Ser 2009 C

<i>Long Term Rating</i>	BBB+/Stable	Affirmed
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Wise Cnty Indl Dev Auth, Virginia

Mountain States Hlth Alliance, Tennessee

Series 2012C

<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1	Affirmed

Many issues are enhanced by bond insurance.

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The Health and Educational Facilities Board of the City of Johnson City, Tennessee Mountain States Health Alliance; Letter of Credit

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Call And Put Provisions

Related Criteria And Research

The Health and Educational Facilities Board of the City of Johnson City, Tennessee Mountain States Health Alliance; Letter of Credit

Credit Profile

US\$99.68 mil taxable hosp rfdg rev bnds (Mountain States Hlth Alliance) ser 2013B

Long Term Rating AA-/A-1+ Affirmed

US\$16.235 mil hosp rev bnds (Mountain States Hlth Alliance) ser 2013A

Long Term Rating AA-/A-1+ Affirmed

Rationale

Profile

Expected closing date: July 30, 2013

Maturity date: Aug. 15, 2043

Structure type: Direct-pay letter of credit

Obligor: Mountain States Health Alliance

LOC provider: U.S. Bank National Association

Trustee: The Bank of New York Mellon Trust Company N.A. (AA-/Stable/A-1+)

Standard & Poor's Ratings Services assigned its 'AA-/A-1+' rating to The Health and Educational Facilities Board of the City of Johnson City, Tenn.'s series 2013A hospital revenue bonds and series 2013B taxable hospital revenue refunding bonds, both issued on behalf of Mountain States Health Alliance.

The 'AA-' long-term component of the rating is based on the long-term issuer credit rating (ICR) of U.S. Bank National Association (AA-/Stable/A-1+), which has entered into an irrevocable letter of credit (LOC) with the trustee, and reflects our opinion of the likelihood that bondholders will receive principal and interest payments when due if they do not exercise the put option. The 'A-1+' short-term component of the rating is based on the LOC provider's short-term ICR and reflects our opinion of the likelihood that bondholders will receive principal and interest payments if they do exercise the put option.

The initial interest rate mode for the bonds, which is fully supported by the LOC, is the weekly mode. The bonds can also be converted to term and fixed rate modes, which are not supported by the LOC. However, pursuant to the trust indenture, any rate mode conversion must be preceded by a mandatory tender (See the Structural Analysis section below for more information).

Transaction Highlights

The debt is variable rate with a bondholder option to demand repayment before the bonds mature (the put or tender option). The bondholders may exercise the put option at any time during the covered mode with appropriate notice to

the trustee. Those bondholders choosing to exercise the put option will receive a price equal to par plus accrued interest funded with remarketing proceeds or amounts available under the LOC.

Structural Analysis

When evaluating the bonds, Standard & Poor's considers various risk factors, as described below.

LOC coverage for the covered mode

The LOC covers the entire bond principal amount, plus interest accruals equal to 37 days. We believe this LOC coverage is sufficient to pay principal, interest, and, in the event of a tender, the purchase price while the bonds are in the weekly mode (the covered mode), even assuming maximum interest rate accruals (see table below).

Maximum bond rate:	12%
Next interest payment date:	Aug. 1, 2013
Covered mode interest payment date:	1st business day of each month
LOC interest reinstatement period:	Automatic reinstatement by close of business on an interest payment date unless prior notice of non-reinstatement is provided
Remedy for nonreinstatement:	Acceleration
Interest accrual for covered mode:	Accrual from the preceding interest payment date to, but not including, the next interest payment date

Interest rate mode changes

The current (and covered) mode is the weekly mode; the transaction terms do not provide for the bonds to operate in multiple modes concurrently. In addition to the covered mode, the transaction documents provide that the bonds may be converted to term and fixed rate modes. While we offer an opinion of the sufficiency of interest coverage only as to the covered mode, it should be noted that the bonds are subject to a mandatory tender at par plus accrued interest before the rate mode can be changed.

LOC termination and expiration

Termination risk is addressed, in our opinion, because by its terms, the LOC cannot terminate prior to expiration while the bonds are outstanding in the covered mode unless the LOC provider is replaced or, following certain events of default, the LOC provider has directed the trustee to draw on the LOC to cover an acceleration.

LOC provider replacement

The transaction documents generally provide that the obligor may replace the LOC provider with appropriate notice to bondholders. However, a mandatory tender must occur prior to the date proposed for the replacement of the LOC provider. In our view, this and other requirements related to LOC provider replacement sufficiently mitigate any risk that the existing bondholders would see the rating on the bonds lowered as a consequence of the LOC provider being replaced.

Additional bonds

The transaction terms do not provide for additional bond issuances.

Ratings Sensitivity

In view of the bond structure, changes to our rating on the bonds in the covered mode can result from, among other things, changes to our rating on the LOC provider or amendments to the transaction's terms. We will maintain a rating on the bonds as long as they are in the covered mode and the LOC has not expired or otherwise terminated. If either of these conditions changes, we will likely withdraw our rating on the bonds.

Call And Put Provisions

The bonds are subject to redemption and tender, both mandatory and optional, under various scenarios. In all cases in the covered mode, the redemption or tender price will at least equal par plus accrued interest and will be fully supported by the LOC. Premiums for tenders or redemptions are not currently supported by the bond documents.

Related Criteria And Research

Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009

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Summary:

Johnson City Health And Education Facilities Board, Tennessee Mountain States Health Alliance; Joint Criteria

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Rationale

Related Criteria And Research

Summary:

Johnson City Health And Education Facilities Board, Tennessee Mountain States Health Alliance; Joint Criteria

Credit Profile

Russell Cnty Indl Dev Auth, Virginia

Mountain States Hlth Alliance, Tennessee

Russell Cnty Indl Dev Auth (Mountain States Health Alliance) VRDO ser 2008B

<i>Long Term Rating</i>	AAA/A-1+	Current
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Current

The Hlth & Educl Facs Brd of the City of Johnson City, Tennessee

Mountain States Hlth Alliance, Tennessee

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) VRDO ser 2007 B1 B2 B3

<i>Long Term Rating</i>	AAA/A-1+	Current
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Current

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) VRDO ser 2007 B1 B2 B3

<i>Long Term Rating</i>	AA+/A-1	Current
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Current

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) VRDO ser 2008A

<i>Long Term Rating</i>	AAA/A-1+	Current
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Current

Rationale

Standard & Poor's Ratings Services confirmed its 'AAA/A-1+' and 'AA+/A-1' ratings on Johnson City Health and Education Facilities Board, Tenn.'s (Mountain States Health Alliance) series 2007-B1, 2007-B2, 2007-B3, and 2008A hospital revenue bonds. At the same time, Standard & Poor's confirmed its 'AAA/A-1+' rating on Russell County Industrial Development Authority, Va.'s (Mountain States Health Alliance) series 2008B hospital revenue bonds. The confirmations reflects extensions of the letters of credit provided by U.S. Bank National Association (for series 2008A and 2008B) and PNC Bank N.A. (for 2007B-1 and 2007B-2) to July 30, 2018, for 2007-B1 and Oct. 19, 2014, for 2007B-2, 2008A, and 2008B. The long-term components of the ratings are based jointly (assuming low correlation) on the ratings on the issues' respective obligors and letter of credit (LOC) providers. The short-term components of the ratings are based solely on the ratings on the respective LOC providers.

Related Criteria And Research

- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009
- USPF Criteria: Municipal Applications For Joint Support Criteria, June 25, 2007

- Criteria: Joint Support Criteria Update, April 22, 2009

Complete ratings information is available to subscribers of RatingsDirect at www.globalcreditportal.com. All ratings affected by this rating action can be found on Standard & Poor's public Web site at www.standardandpoors.com. Use the Ratings search box located in the left column.

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SEPTEMBER 18, 2013 4

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RatingsDirect®

Summary:

Johnson City Health and Educational Facilities Board, Tennessee Mountain States Health Alliance; Joint Criteria

Primary Credit Analyst:

Chi W Tang, New York (1) 212-438-7989; chi.tang@standardandpoors.com

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Johnson City Health and Educational Facilities Board, Tennessee Mountain States Health Alliance; Joint Criteria

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The Hlth & Educl Facs Brd of the City of Johnson City, Tennessee

Mountain States Hlth Alliance, Tennessee

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) VRDO ser 2011A

Long Term Rating AAA/A-1+ Current

Unenhanced Rating BBB+(SPUR)/Stable Current

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance) VRDO ser 2011B

Long Term Rating AA+/A-1 Current

Unenhanced Rating BBB+(SPUR)/Stable Current

Rationale

Standard & Poor's Ratings Services confirmed its 'AAA/A-1+' and 'AA+/A-1' ratings on Johnson City Health and Educational Facilities Board, Tenn.'s (Mountain States Health Alliance) series 2011A and 2011B variable-rate demand revenue bonds, respectively, due to the issues' bank facilities being extended to July 30, 2016, for series 2011B and July 30, 2018, for series 2011A. The long-term components of the ratings are based jointly (assuming low correlation) on the ratings on the obligor, Mountain States Health Alliance (BBB+), and the letter of credit providers: PNC Bank N.A. (A/A-1) for series 2011B, and U.S. Bank National Assn. (AA-/A-1+) for series 2011A. The short-term components of the ratings are based solely on the ratings on PNC Bank N.A. (A-1) and U.S. Bank National Assn. (A-1+) for series 2011B and 2011A, respectively.

Related Criteria And Research

Related Criteria

- USPF Criteria: Municipal Applications For Joint Support Criteria, June 25, 2007
- Criteria: Joint Support Criteria Update, April 22, 2009
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009

Complete ratings information is available to subscribers of RatingsDirect at www.globalcreditportal.com. All ratings affected by this rating action can be found on Standard & Poor's public Web site at www.standardandpoors.com. Use the Ratings search box located in the left column.

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RatingsDirect®

The Health & Educational Facilities Board of the City of Johnson City, Tennessee Mountain States Health Alliance; Joint Criteria; System

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Related Criteria And Research

The Health & Educational Facilities Board of the City of Johnson City, Tennessee

Mountain States Health Alliance; Joint Criteria; System

Credit Profile

Mountain States Health Alliance ICR

Long Term Rating

BBB+/Stable

Affirmed

Rationale

Standard & Poor's Ratings Services affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on existing rated obligations from various issuers for Mountain States Health Alliance (MSHA), Tenn. At the same time, Standard & Poor's affirmed its 'BBB+' issuer credit rating (ICR) on MSHA. The outlook on all ratings is stable.

The 'BBB+' ratings reflect our view of MSHA's strong business position and solid level of unrestricted reserves and corresponding days' cash on hand. These factors are partially offset by the system's light maximum annual debt service (MADS) coverage for the rating level, and high leverage remaining from the aggressive acquisition activity that ended a few years ago.

More specifically, the 'BBB+' ratings reflect our view of MSHA's:

- Excellent business position, which is characterized by solid demographics, a high market share relative to its competition, and a broad range of services;
- Strong management and governance, which is reflected in the system's favorable performance record since its creation in 1998, and our expectation that the system's solid leadership will continue under Alan Levine, who joined MSHA as CEO in January;
- Continued strong financial performance, highlighted by solid EBITDA margins, and an 11th consecutive year of operating profitability in fiscal 2013 -- although results softened compared to previous years -- and solid liquidity for the rating level based on days' cash on hand; and
- Declining capital spending, which will likely support further growth in unrestricted liquidity and a reduction in leverage over time.

Despite MSHA's strong business position and consistent operating profitability, system leverage is elevated and remains an offsetting credit factor, in our opinion. MSHA has a debt-to-capital ratio of approximately 61% (down from 64% at fiscal year-end 2012) and a debt burden of roughly 7% of revenue. One of management's goals is to reduce leverage; we believe that will be key to achieving a higher rating. Also, even with typical EBITDA margins of 15% to 18%, MADS coverage has historically been below median 'BBB+' levels. MADS coverage as of Sept. 30 on an annualized basis was 2.0x.

The 'BBB+' ratings also incorporate our view of MSHA's group credit profile and the obligated group's core status.

Accordingly, the bonds are rated at the same level as the group credit profile. Our determination of the group status of MSHA's obligated group is "core" as the obligated group contains the majority of system assets and accounts for most of its revenues and income.

Bonds that are not otherwise secured by letters of credit (LOCs) are secured by MSHA's gross revenues, or are jointly secured by gross revenues and an irrevocable direct-pay LOC. Various debt issues supported by irrevocable direct pay LOCs for which there is no SPUR (including series 2013A and 2013B) are based solely on the long-term and short-term ratings of the LOC provider. While we are not affirming those ratings herein, we have factored the debt amounts into our analysis of MSHA's overall leverage and debt service capacity.

We are affirming the ratings on several series of bonds, including series 2007B1, 2007B2, 2007B3, 2008A, 2011A, and 2011B, whose ratings are based on the low correlation joint support of both MSHA and the LOC provider. For those bonds, MSHA and the LOC provider are each individually fully responsible for their repayment.

As of its interim period ended Sept. 30, 2013 (unaudited), MSHA had \$1.1 billion of long-term debt and capital lease obligations outstanding. Outstanding debt is split between 58% fixed- and 42% variable-rate obligations. We understand that MSHA has no plans to issue a significant amount of additional debt during the next few years, as management expects to fund its modest capital needs with cash flow and reserves. MSHA may continue to convert its remaining \$117 million of taxable debt to tax-exempt obligations; however, conversion would not result in any additional debt other than for costs of issuance and any required reserves. In our opinion, MSHA's sizable debt and accompanying high leverage remain the system's most significant credit risks.

In addition to its outstanding debt obligations, MSHA has \$570 million of active swaps with Bank of America as the counterparty. The swaps include \$438 million of constant maturity swaps with a mark-to-market (MTM) value of positive \$5.7 million. These swaps generate \$4.9 million of positive annual cash flow. MSHA also has \$132 million of basis swaps with a MTM value of negative \$20 million, against which MSHA has no posted collateral. All amounts are as of November 2013.

Outlook

The stable outlook reflects our view of MSHA's business position supported by the system's past acquisition activity, MSHA's favorable record of integrating acquired facilities, and the natural improvement in debt ratios that is occurring, and that we expect to continue over time. Also adding to credit stability is MSHA's history of maintaining solid earnings, although we believe the system's high debt burden remains a credit risk. While we may raise the ratings in the future, we do not expect to do so until MSHA's MADS coverage equals or exceeds 3.0x, cash to long-term debt reaches 70% to 75%, and debt to capitalization declines to roughly 55%. We will also expect the system's business position to remain strong --demonstrated by stable to improving patient volumes and by sustained robust cash flow. Although not anticipated, if balance sheet metrics weaken, coverage declines to less than 1.7x, or operating margins decline and be sustained at or below 1.0%, we could take a negative rating action.

Enterprise Profile

Since its formation in 1998, MSHA has tripled its asset base and more than tripled annual net patient revenues to just over \$2 billion and more than \$1 billion, respectively. Today, MSHA owns and operates 14 acute-care facilities led by the flagship Johnson City Medical Center, a 514-licensed-bed tertiary regional provider.

The system's hospital facilities include 1,717 licensed acute-care beds, including 94 beds acquired in the October 2013 acquisition of Unicoi County Memorial Hospital. MSHA also consists of a range of outpatient facilities and ancillary services, such as a home health agency and a hospice, and other activities such as the ownership and management of medical office buildings.

MSHA acquired the Unicoi hospital for \$2.5 million plus \$4 million of outstanding Unicoi debt, which was retired at closing. The agreement included a commitment from MSHA to build a 20-bed replacement hospital by 2018. MSHA expects the acquisition will be accretive within 15 months as Unicoi transitions to MSHA's rates, which are current at about 50% of MSHA system levels.

As part of its physician integration efforts, MSHA has consolidated its employed physician practices into Mountain States Medical Group, which employs about 400 physicians. MSHA has steadily reduced physician practice losses through increased physician leadership, including regional chief medical officers, the attrition of less productive physicians, improvements in compensation when contracts are renewed, and other efficiency measures.

Management

Effective Jan. 1, Alan Levine became President and CEO of MSHA, replacing the retiring Dennis Vonderfect. Mr. Levine joined MSHA from Health Management Associates where he served as Group President. Before that he served as Secretary of the Louisiana Department of Health and Hospitals, and Senior Health Policy advisor to Governor Jindal.

Since the system's creation, MSHA's management and governance have evolved effectively, in our view. A strong central leadership team is focused on maximizing the system's potential as a whole and broadening access to managed-care contracts for all of the facilities while centralizing the negotiations at the system level. It has also centralized other functions like billing and collections, purchasing, and laboratory services. The 13-member board has upheld its values of strong planning, education, and transparency.

Today, as it approaches the changing health care landscape, MSHA's leadership, in our view, remains focused on quality, ongoing physician integration, smart growth through service line and revenue cycle opportunities, cost reduction initiatives, and the development and implementation of new accountable care models, for the system's own employed population, and for its Medicare patient base.

Market position

The system's core service area encompasses 13 counties in Tennessee and Virginia where MSHA has about a 53% market share. Currently, fewer than 30% of the system's patients originate from its original home county of Washington County, Tenn. In the broader 29-county service area, MSHA has a 38% share, while Wellmont Health System, MSHA's main competitor, holds about a 30% share. There is no significant third player. While MSHA's market

share is strong in the core Washington County market, Wellmont Health System dominates in adjacent Sullivan County. But, over the past several years the two health systems service areas have increasingly overlapped. Although the service area remains competitive, market characteristics remain favorable in terms of population growth, and the market's size will continue to support two sizable competitors, in our opinion.

Recent projects update

In October 2013 MSHA completed its \$69 million surgery tower project at Johnson City Medical Center. The project was funded with series 2012A bond proceeds, and through operations, reserves, and a small amount of philanthropy. The project left the number of operating room suites at 16, but expanded the space in each suite to accommodate modern equipment. MSHA also renovated and expanded the radiation oncology suite. The project structurally allows MSHA to add eight floors for a future bed tower if the capacity is needed, although there are currently no plans to build those additional floors.

Other than a \$20 million replacement hospital project for the recently acquired Unicoi County Memorial Hospital, we understand that MSHA has no other major committed capital projects beyond 2014.

Financial Profile

Change in accounting for bad debt

In accordance with the publication of our article, "New Bad Debt Accounting Rules Will Alter Some U.S. Not-for-Profit Health Care Ratios But Won't Affect Ratings," published Jan. 19, 2012 on RatingsDirect, we recorded MSHA's fiscal 2012 audit and all subsequent financial statements incorporating the adoption of Financial Accounting Standards Board 2011-07, but not in prior periods. The new accounting treatment means that MSHA's fiscal 2012 and subsequent financial statistics are not directly comparable to the results for fiscal 2011 and prior years. For an explanation of how each financial measure is affected by the change in accounting for bad debt, including the direction and size of the change, please see the above article.

In our view, MSHA's operating performance remained good in fiscal 2013 but it was less robust than it had been in fiscal 2012, primarily due to lower inpatient volumes and the ongoing shift to observations, and to more patient care occurring in an outpatient setting. Reimbursement from both governmental and commercial sources remains under pressure and MSHA, like almost all other acute care providers, continues to incur sizable costs to transform its processes to succeed in the changing health care landscape and under the Affordable Care Act.

For the fiscal year ended June 30, net operating income was \$11.5 million (as per Standard & Poor's methodology), or a 1.1% margin, on \$1.01 billion in total operating revenues. Results were down from \$19.6 million, or a 2% margin, on \$1.00 billion in total operating revenues in fiscal 2012. For the year, inpatient admissions were lower year over year, at 58,103 (or a 5.0% decrease) compared with 61,154 in fiscal 2012 and 61,035 in fiscal 2011. Inpatient volume declines in fiscal 2013 reflect marketwide conditions, as MSHA's system market share remains stable to slightly improved. Management is expecting a same-store reduction in inpatient volumes of about 3% in fiscal 2014 although total admissions will likely be down only about 2% (at 57,809) due to approximately 800 admissions from Unicoi Memorial, which joined MSHA in October (the 800 admissions from Unicoi represent about eight months of inpatient volume from the hospital). Observation volumes continue to grow, increasing by 6% in 2013 to 23,554. Management projects

another 3% growth in observations for fiscal 2014. Management sees an opportunity to reduce the number of observations as a percentage of total admissions through appropriate physician documentation and is working toward that goal. Every 1% shift in observations has a financial impact of approximately \$1.4 million to the system. Outpatient volumes continued their strong growth to 1.67 million (a 4.7% increase) in fiscal 2013 from 1.59 million in fiscal 2012 as more volumes shifted from an inpatient to outpatient setting consistent with industry trends.

Net excess income for fiscal 2013 was solid, in our view although less robust, at \$35.1 million (a 3.4% margin), compared with \$39.7 million (a 3.9% margin) the previous year. MSHA's EBIDA margin was 15.4% in fiscal 2013, compared with 15.7% for fiscal 2012. Coverage, based on MADS of \$71 million, was 2.3x for fiscal 2013.

Interim

On an interim basis for the three months ended Sept. 30, 2013, MSHA had an operating loss of \$3.6 million (as per Standard & Poor's calculations) and excess income of \$4.2 million (1.7% margin), generating cash flow of \$35 million, producing annualized MADS coverage of just under 2.0x. Results year to date reflected continued weak inpatient volume trends.

Five-year financial plan

MSHA's five-year forecast assumes modest 0.5% to 2.7% decreases in inpatient admissions out to 2018. The forecast further assumes no Medicaid expansion in Tennessee or Virginia, and factors in additional declines in Medicare reimbursement. However, supported by reduced length of stay and other operating and cost containment initiatives, management expects to sustain \$150 million to \$160 million of annual EBIDA, which is adequate to comfortably support debt service and further reduce debt, once cash exceeds 250 days.

Balance sheet

MSHA's aggressive acquisition spending ended a few years ago, and while we believe the spending put the system in a better competitive position, it nevertheless resulted in very high leverage, which remains elevated and an impediment to a higher rating. As of Sept. 30, 2013, MSHA's long-term debt to capitalization was 61%, which, due to robust operating cash flow, has continued to improve after being having been as high as 79% in fiscal 2009.

Unrestricted cash and investments totaled \$606 million at Sept. 30, 2013, equal to 245 days' cash, which we view as robust for the rating level; due to high system leverage, however, cash to debt is approximately 56%, which remains well below the median for the current rating. MSHA remains in compliance with all bond covenants.

MSHA's current average age of plant is just under nine years, which we consider low, and the system has only modest capital plans, in our opinion, during the next several years. As a result, we believe that MSHA will be able to comfortably maintain more than 200 days' cash, and over time build back to its goal of 250 days' cash. We understand that management has targeted to reduce debt outstanding when cash exceeds 250 days.

Management plans to spend about \$91 million on capital expenditures in fiscal 2014, primarily on small projects not exceeding \$20 million on an individual basis. Spending for fiscal 2014 represents about 114% of fiscal 2013 depreciation. Between fiscal 2015 and fiscal 2018 capital spending is expected to be moderate, at less than 100% of depreciation. Spending in fiscal years 2015 and 2016 is expected to include the construction of the new 20-bed replacement hospital for Unicoi County, as part of MSHA's hospital affiliation agreement that was effective in

November 2013. Management has no future financing plans as Unicoi and other projects will be funded from operations.

	Fiscal Year Ended June 30,			
	Three-Month Interim Ended Sept. 30, 2013	2013	2012	2011
Financial performance				
Net patient revenue (\$000s)	227,934	932,748	952,133	960,254
Total operating revenue (\$000s)	242,424	1,011,206	1,002,776	978,018
Total operating expenses (\$000s)	246,020	999,737	983,215	957,173
Operating income (\$000s)	(3,596)	11,469	19,561	20,845
Operating margin (%)	(1.48)	1.13	1.95	2.13
Net nonoperating income (\$000s)	7,822	23,616	20,133	20,600
Excess income (\$000s)	4,226	35,085	39,694	41,445
Excess margin (%)	1.69	3.39	3.88	4.15
Operating EBIDA margin (%)	11.23	13.44	14.04	15.85
EBIDA margin (%)	14.01	15.41	15.73	17.59
Net available for debt service (\$000s)	35,053	159,489	160,902	175,656
Maximum annual debt service (\$000s)	70,909	70,909	70,909	70,909
Maximum annual debt service coverage (x)	1.98	2.25	2.27	2.48
Operating lease-adjusted coverage (x)	2.2	2.11	2.13	2.3
Liquidity and financial flexibility				
Unrestricted cash and investments (\$000s)	606,340	588,478	531,151	597,435
Unrestricted days' cash on hand	244.6	233.8	213.5	251.5
Unrestricted cash/total long-term debt (%)	56.1	54	50.7	57.4
Average age of plant (years)	9.1	8.7	8.3	6.5
Capital expenditures/depreciation and amortization (%)	N.A.	130.2	176.5	191.9
Debt and liabilities				
Total long-term debt (\$000s)	1,081,596	1,090,348	1,048,098	1,040,923
Long-term debt/capitalization (%)	61.4	62.3	63.6	64.5
Contingent liabilities (\$000s)	N.A.	478,189	459,605	386,418
Contingent liabilities/total long-term debt (%)	N.A.	43.9	43.9	37.1
Debt burden (%)	7.08	6.85	6.93	7.08

N.A.: Not available.

Related Criteria And Research

Related Criteria

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- USPF Criteria: Municipal Swaps, June 27, 2007
- USPF Criteria: Municipal Applications For Joint Support Criteria, June 25, 2007

- Criteria: Joint Support Criteria Update, April 22, 2009

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- The Outlook For U.S. Not-For-Profit Health Care Providers Is Negative From Increasing Pressures, Dec. 10, 2013
- U.S. Not-For-Profit Health Care System Ratios: Metrics Remain Steady As Providers Navigate An Evolving Environment, Aug. 8, 2013
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013
- U.S. Not-For-Profit Health Care Providers Hone Their Strategies To Manage Transition Risk, May 16, 2012
- U.S. Not-For-Profit Health Care Providers Hone Their Strategies For Reform, May 16, 2011

Ratings Detail (As Of January 22, 2014)

Mountain States Health Alliance, Series 2000D

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Series 2011E

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Long Term Rating AAA/A-1 Affirmed

Russell Cnty Indl Dev Auth, Virginia

Mountain States Hlth Alliance, Tennessee

Ser 2008B

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Long Term Rating AAA/A-1+ Affirmed

Smyth Cnty Indl Dev Auth, Virginia

Mountain States Hlth Alliance, Tennessee

Seies 2010 B and Series 2009B

Long Term Rating BBB+/Stable Affirmed

The Hlth & Educl Facs Brd of the City of Johnson City, Tennessee

Mountain States Hlth Alliance, Tennessee

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance), Series 2000C

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance), Series 2007B-1

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Long Term Rating AAA/A-1+ Affirmed

Series 2010 A&B, 2006A and 2009A

Long Term Rating BBB+/Stable Affirmed

Series 2011A

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Long Term Rating AAA/A-1+ Affirmed

Series 2011B

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Ratings Detail (As Of January 22, 2014) (cont.)

<i>Long Term Rating</i>	AA+/A-1	Affirmed
Series 2012A		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Series 2012B		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1	Affirmed
Washington Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Ser 2009 C		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Wise Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Series 2012C		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AAA/A-1	Affirmed

Many issues are enhanced by bond insurance.

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Mountain States Health Alliance, Tennessee; Joint Criteria; System

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Related Criteria And Research

Mountain States Health Alliance, Tennessee; Joint Criteria; System

Credit Profile

Mountain States Health Alliance ICR

Long Term Rating

BBB+/Stable

Affirmed

Rationale

Standard & Poor's Ratings Services affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on existing rated obligations from various issuers for Mountain States Health Alliance (MSHA), Tenn. At the same time, Standard & Poor's affirmed its 'BBB+' issuer credit rating (ICR) on MSHA. The outlook on all ratings is stable.

The 'BBB+' ratings reflect our view of MSHA's strong business position and solid level of unrestricted reserves and corresponding days' cash on hand. These factors are partly offset by the system's just adequate maximum annual debt service (MADS) coverage for the rating level, and improving, but still high, leverage remaining from the past capital spending and acquisition activity. While our ratings and outlook remain unchanged for now, we believe that MSHA's overall operational and financial trends are positive and, if sustained, will support favorable rating action over the near to intermediate term.

More specifically, the 'BBB+' ratings reflect our view of MSHA's:

- Excellent business position, which is characterized by solid demographics, a robust market share relative to its competition, and a broad range of services;
- Strong management and governance, which is reflected in the system's favorable performance record since its creation in 1998;
- Continued strong financial performance, highlighted by solid EBITDA margins, a 12th consecutive year of operating profitability in fiscal 2014 (although results continued to soften compared to previous years), and solid liquidity for the rating level based on days' cash on hand; and
- Reduced capital spending, which will likely support further growth in unrestricted liquidity and a reduction in leverage over time.

Despite MSHA's strong business position and consistent operating profitability, system leverage is elevated and remains an offsetting credit factor, in our opinion. MSHA has a debt-to-capital ratio of approximately 59% and a debt burden of roughly 7% of revenue. One of management's goals is to reduce leverage, and we believe that is key to achieving a higher rating. Also, even with EBITDA margins of 14% to 16%, MADS coverage has historically been below median 'BBB+' levels. MADS coverage was 2.2x at fiscal year end and about 1.4x as of Sept. 30 on an annualized basis, lower than 2.5x for the 'BBB+' rating median.

The 'BBB+' ratings also incorporate our view of MSHA's group credit profile and the obligated group's core status. Accordingly, the bonds are rated at the same level as the group credit profile. Our determination of the group status of MSHA's obligated group is "core," as the obligated group contains the majority of system assets and accounts for most

of its revenues and income.

Bonds that are not otherwise secured by letters of credit (LOCs) are secured by MSHA's gross revenues or are jointly secured by gross revenues and an irrevocable direct-pay LOC. Various debt issues supported by irrevocable direct pay LOCs for which there is no SPUR (including series 2013A and 2013B) are based solely on the long-term and short-term ratings of the LOC provider. While we are not affirming those ratings herein, we have factored the debt amounts into our analysis of MSHA's overall leverage and debt service capacity.

We are affirming the ratings on bonds, including series 2007B1, 2011A, and 2011B, whose ratings are based on the low correlation joint support of both MSHA and the LOC provider. For those bonds, MSHA and the LOC provider are each individually fully responsible for their repayment.

As of its interim period ended Sept. 30, 2014 (unaudited), MSHA had \$590 million of long-term debt and capital lease obligations outstanding. Outstanding debt is split between approximately 58% fixed- and 42% variable-rate obligations. We understand that MSHA has no plans to issue a significant amount of additional debt during the next few years, as management expects to fund its modest capital needs with cash flow and reserves. Also, management plans for an additional \$30.5 million of debt retirement in fiscal 2015, which we view favorably since, as noted, MSHA's sizable debt and accompanying high leverage remain the system's most significant credit risk, in our opinion.

In addition to its outstanding debt obligations, MSHA has \$590 million swaps with Bank of America as the counterparty. The swaps include \$438 million of constant maturity swaps with a mark-to-market (MTM) value of positive \$3.5 million, a \$132 million basis swap with a MTM of negative \$15.7 million, and a \$20 million total return swap with a positive MTM value of \$320,000. Combined, these swaps generate \$5.4 million of positive annual cash flow. All amounts are as of November 2014.

Outlook

The stable outlook reflects our view of MSHA's sound business position, favorable record of integrating acquired facilities, and improvement in debt ratios, which we expect will continue given modest capital spending needs, although we continue to believe the system's high debt burden remains a rating constraint. While we view MSHA's trends favorably, and, if sustained, we may raise the ratings in the future, we would expect to do so once MSHA's MADS coverage and leverage metrics reach levels more consistent with 'A' category medians. We will also expect the system's business position to remain strong -- demonstrated by stable to improving patient volumes and by sustained robust cash flow. Although not anticipated, if balance sheet metrics weaken, coverage declines, or operating margins decline and are sustained at or below 1.0%, we could consider a negative rating action.

Enterprise Profile

Since its formation in 1998, MSHA has tripled its asset base and more than tripled annual net patient revenues to just over \$2 billion and more than \$1 billion, respectively. Today, MSHA owns and operates 13 acute-care facilities led by the flagship Johnson City Medical Center, a 548-licensed-bed tertiary regional provider. The system's hospital facilities

include 1,669 licensed beds (1,305 acute care beds). MSHA also consists of a range of outpatient facilities and ancillary services, such as a home health agency and a hospice, its own provider sponsored health plan, and other activities such as the ownership and management of medical office buildings. In fiscal 2014, MSHA had combined inpatient admissions of just over 57,000, 1.7 million outpatient visits, and 240,000 emergency department visits. As part of its physician integration efforts, MSHA employs 400 physicians through various physician entities, including Mountain States Medical Group.

Management

In January 2014, Alan Levine became President and CEO of MSHA, replacing the retiring Dennis Vonderfecht. Mr. Levine joined MSHA from Health Management Associates, where he served as Group President; before that, he served as Secretary of the Louisiana Department of Health and Hospitals, and Senior Health Policy advisor to Governor Jindal. Also in 2014, Marvin Eichorn became MSHA's COO after having served as the system's CFO for 16 years. Lynn Krutak, who for over 10 years served as Corporate CFO and CFO for MSHA's Blue Ridge Medical Management Corporation, replaced Mr. Eichorn as CFO.

Since the system's creation, MSHA's management and governance have evolved effectively, in our view. A strong central leadership team is focused on maximizing the system's potential as a whole and broadening access to managed-care contracts for all of the facilities while centralizing the negotiations at the system level. It has also centralized other functions like billing and collections, purchasing, and laboratory services. We believe that the above, as well as other recent organizational changes, will be favorable for the organization. In addition, we believe that MSHA's capable 13-member board provides sound governance to the organization.

Market position

The system's core service area encompasses 13 counties in Tennessee and Virginia, where MSHA continues to have a dominant market share. Currently, fewer than 30% of the system's patients originate from its original home county of Washington County, Tenn. In the broader 29-county service area, MSHA has a 38% share, while Wellmont Health System, MSHA's main competitor, holds about a 27% share. There is no significant third player. While MSHA's market share is strong in the core Washington County market, Wellmont Health System dominates in adjacent Sullivan County. However, over the past several years, the two health systems service areas have increasingly overlapped. Although the service area remains competitive, market characteristics remain favorable in terms of population growth, and, in our opinion, the market's size will continue to support two sizable competitors.

Financial Profile

In our view, MSHA's operating performance remained adequate in fiscal 2014, supported by stabilizing inpatient volumes, reduced labor and benefits expense from staff reductions, and improved personnel and productivity management. Net patient revenues, however, continued to be offset by a sizable and growing provision for bad debts despite the commercial exchanges going live in January 2014. Like almost all other acute care providers, MSHA continues to incur sizable costs to transform its processes to succeed in the changing health care landscape and under the Affordable Care Act. In addition, reimbursement from both governmental and commercial sources remains under pressure.

For the fiscal year ended June 30, net operating income was \$7.0 million (as per Standard & Poor's methodology), or a 0.7% margin, on \$1.0 billion in total operating revenues. Results were down from \$11.5 million, or a 1.1% margin, on \$1.01 billion in total operating revenues in fiscal 2013. For the year, inpatient admissions were modestly lower year over year, at 57,040 (or a 1.8% decrease), compared with 58,103 in fiscal 2013. Like the previous year, the inpatient volume decline in fiscal 2014 reflected market and industry conditions. However, since the fiscal year end, MSHA's inpatient volume trends have improved. For fiscal 2015, patient volumes are expected to increase, with inpatient admissions budgeted to increase to 57,904 and outpatient volumes by about 3.5%, to 1.75 million visits.

Net excess income for fiscal 2014 was solid and improved over fiscal 2013, at \$37.6 million (a 3.7% margin), compared with \$35.1 million (a 3.4% margin) the previous year. MSHA's EBIDA margin was 14.9% in fiscal 2014. Coverage, based on MADS of \$67 million, was 2.3x for fiscal 2014.

Interim

On an interim basis for the three months ended Sept. 30, 2014, MSHA had operating income of \$2.0 million (as per Standard & Poor's calculations) and a net excess before extraordinary items of \$5.3 million, generating cash flow adequate to support annualized MADS coverage of 2.0x.

Five-year financial plan

MSHA's five-year forecast calls for inpatient admissions to increase in fiscal 2015 and then decrease by 4.3% to 4.7% per year until fiscal 2019. The forecast further assumes no Medicaid expansion in Tennessee or Virginia, and factors in additional declines in Medicare reimbursement. However, supported by reduced length of stay and other operating and cost containment initiatives, management expects to sustain \$150 million to \$160 million of annual EBIDA, which is adequate to comfortably support debt service and further reduce debt. For fiscal 2015, MSHA is budgeting operating income of \$29.2 million and EBIDA of \$153 million, which would produce 2.3x MADS.

Balance sheet

MSHA's aggressive acquisition spending ended several years ago, and, while we believe that made the system a stronger competitor, it resulted in high leverage, which has been an impediment to MSHA achieving a higher rating. As of Sept. 30, 2014, MSHA's long-term debt to capitalization was 59%, which, due to robust operating cash flow, has continued to improve from as high as 79% in fiscal 2009.

Unrestricted cash and investments totaled \$642 million at Sept. 30, 2014, equal to 251 days' cash, which we view as robust for the rating level. Due to high system leverage, cash to debt is approximately 61%, which remains well below the median for the current rating. MSHA remains in compliance with all bond covenants.

MSHA's current average age of plant is just under 11 years, which we consider in line with the median, and the system has only modest (in our opinion) capital plans during the next several years. As a result, we believe that MSHA will be able to comfortably maintain robust days' cash and be able to accelerate the reduction of outstanding debt.

Management plans \$31 million of additional debt reductions beyond the required amortization in fiscal 2015.

Management plans to spend about \$53 million on capital expenditures in fiscal 2015, primarily on IT and other small projects. Spending for fiscal 2015 represents about 75% of fiscal 2014 depreciation. Between fiscal 2016 and fiscal 2019, capital spending is expected to be moderate, at well less than 100% of depreciation. Spending in fiscal years

2017 and 2018 is expected to include the construction of the new 20-bed replacement hospital for Unicoi County, as part of MSHA's hospital affiliation agreement that was effective in November 2013. Management has no future financing plans as Unicoi and other projects will be funded from operations.

Mountain States Health Alliance

Selected financial statistics	Three-month interim ended Sept. 30, 2014	Fiscal year ended June 30,		Medians		
		2014	2013	Health care system BBB+ 2013	Health care system A- 2013	
Financial performance						
Net patient revenue (\$000s)	241,163	927,784	932,748	1,049,981	1,567,503	
Total operating revenue (\$000s)	252,684	1,000,924	1,011,206	MNR	MNR	
Total operating expenses (\$000s)	250,663	993,880	999,737	MNR	MNR	
Operating income (\$000s)	2,021	7,044	11,469	MNR	MNR	
Operating margin (%)	0.80	0.70	1.13	0.90	1.50	
Net non-operating income (\$000s)	(6,101)	30,604	23,616	MNR	MNR	
Excess income (\$000s)	(4,080)	37,648	35,085	MNR	MNR	
Excess margin (%)	(1.65)	3.65	3.39	3.00	3.60	
Operating EBIDA margin (%)	12.02	12.25	13.44	8.90	8.40	
EBIDA margin (%)	9.84	14.85	15.41	10.20	9.50	
Net available for debt service (\$000s)	24,271	153,219	159,489	115,667	166,108	
Maximum annual debt service (\$000s)	67,252	67,252	67,252	MNR	MNR	
Maximum annual debt service coverage (x)	1.44	2.28	2.37	2.50	3.40	
Operating lease-adjusted coverage (x)	1.44	2.14	2.21	2.10	2.60	
Liquidity and financial flexibility						
Unrestricted reserves (\$000s)	641,902	646,460	588,478	574,523	761,463	
Unrestricted days' cash on hand	251.0	255.7	233.8	144.60	163.90	
Unrestricted reserves/total long-term debt (%)	61.0	60.1	54.0	106.70	119.60	
Average age of plant (years)	11.2	10.6	8.7	11.50	11.40	
Capital expenditures/depreciation and amortization (%)		89.7	130.2	114.10	124.60	
Debt and liabilities						
Total long-term debt (\$000s)	1,052,372	1,075,069	1,090,348	MNR	MNR	
Long-term debt/capitalization (%)	59.0	59.9	62.3	46.20	42.50	
Debt burden (%)	6.82	6.52	6.50	3.00	2.70	

MNR: Median not reported.

Related Criteria And Research

Related Criteria

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- Criteria: Joint Support Criteria Update, April 22, 2009

- General Criteria: Methodology: Industry Risk, Nov. 20, 2013
- General Criteria: Group Rating Methodology, Nov. 19, 2013

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- U.S. Not-For-Profit Health Care Outlook Remains Negative Despite A Glimmer Of Relief , Dec. 17, 2014
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013
- Standard & Poor's Assigns Industry Risk Assessments To 38 Nonfinancial Corporate Industries, Nov. 20, 2013
- Health Care Organizations See Integration And Greater Transparency As Prescriptions For Success, May 19, 2014

Ratings Detail (As Of January 9, 2015)

Mountain States Health Alliance, Series 2000D

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Smyth Cnty Indl Dev Auth, Virginia

Mountain States Hlth Alliance, Tennessee

Seies 2010 B and Series 2009B

Long Term Rating BBB+/Stable Affirmed

The Hlth & Educl Facs Brd of the City of Johnson City, Tennessee

Mountain States Hlth Alliance, Tennessee

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance), Series 2000C

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Johnson City Hlth & Ed Fac Brd (Mountain States Health Alliance), Series 2007B-1

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Long Term Rating AAA/A-1+ Affirmed

Series 2010 A&B, 2006A and 2009A

Long Term Rating BBB+/Stable Affirmed

Series 2011A

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Long Term Rating AAA/A-1+ Affirmed

Series 2011B

Unenhanced Rating BBB+(SPUR)/Stable Affirmed

Long Term Rating AA+/A-1 Affirmed

Series 2012A

Long Term Rating BBB+/Stable Affirmed

Series 2012B

Unenhanced Rating NR(SPUR) Current

Long Term Rating NR/NR Current

Washington Cnty Indl Dev Auth, Virginia

Mountain States Hlth Alliance, Tennessee

Ser 2009 C

Ratings Detail (As Of January 9, 2015) (cont.)

<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Wise Cnty Indl Dev Auth, Virginia		
Mountain States Hlth Alliance, Tennessee		
Series 2012C		
<i>Unenhanced Rating</i>	NR(SPUR)	Current
<i>Long Term Rating</i>	NR/NR	Current

Many issues are enhanced by bond insurance.

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Exhibit 11.5

Financial Summary for Wellmont

Wellmont Summary for the Fiscal Years
Ended June 30, 2011 through June 30, 2015

Volumes:

Fiscal Year ended June 30, 2011:

Inpatients were up 690 or 1.7% and observation patients were up 1,311 or 13.8% (so total “patients in a bed” were up 2,001 or 3.9%). Emergency room visits were down 1.9% primarily due to utilization trends. Other outpatient volumes were up 3.0%. Surgeries were up 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 of a large cardiology practice in May 2010 and a pulmonology practice in January 2011.

Fiscal Year ended June 30, 2012:

Inpatients were down 1,949 or 4.6% and observation patients were up 2,828 or 26.1% (so total “patients in a bed” were up 879 or 1.7%), 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 of a cardiology practice in October 2011 and a multispecialty practice in January 2012.

Fiscal Year ended June 30, 2013:

Inpatients were down 2,323 or 5.8% and observation patients were up 72 or 0.5% (so total “patients in a bed” were 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.

Fiscal Year ended June 30, 2014:

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.

Fiscal Year ended June 30, 2015:

Inpatients were down 1,320 or 3.8% and observation patients were up 2,488 or 17.5% (so total "patients in a bed" were up 1,168 or 2.4%) primarily due to reduced inpatient utilization from the implementation of the accountable care organizations and high deductible plans in our area and the continued shift to observation patient status. Emergency room visits were up 4.7%, surgeries were down 2.3%, and deliveries were up 1.6%. Outpatient volumes are generally up, especially due to the expansion of infusion centers (visits up 64%) and urgent care centers (visits up 88%).

Statement of Operations:

Fiscal Year ended June 30, 2011:

Net patient revenue increased \$23.2 million and bad debt expense increased \$1.8 million over fiscal 2010, 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 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 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.

Income from operations of \$17.2 million for fiscal 2011 was below fiscal 2010 of \$22.8 million.

Fiscal Year ended June 30, 2012:

Net patient revenue increased \$12.2 million or 1.7% over fiscal 2011. 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 were 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 for fiscal 2012 exceeded fiscal 2011 of \$17.2 million.

Fiscal Year ended June 30, 2013:

Net patient service revenue increased \$14.0 million or 1.9% from fiscal 2012. 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 in fiscal 2013 which is essentially the same as fiscal 2012 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. 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 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 for fiscal 2013 was below fiscal 2012 of \$22.3 million.

Fiscal Year ended June 30, 2014:

Net patient service revenue increased \$5.3 million or 0.7% compared to fiscal 2013. 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 in fiscal 2014 being \$5.1 million below fiscal 2013 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 for fiscal 2014 was below fiscal 2013 of \$15.4 million.

Fiscal Year ended June 30, 2015:

Net patient service revenue increased \$47.7 million or 6.4% compared to fiscal 2014 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 other 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 in fiscal 2015 being \$4.0 million below fiscal 2014 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 for fiscal 2015 was above fiscal 2014 of \$4.8 million.

Balance Sheet and Ratios:

Fiscal Year ended June 30, 2011:

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. Debt to capitalization and debt service coverage both improved. Days cash on hand decreased slightly due to the acquisitions and debt changes.

Fiscal Year ended June 30, 2012:

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.

Fiscal Year ended June 30, 2013:

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.

Fiscal Year ended June 30, 2014:

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.

Fiscal Year ended June 30, 2015:

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 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.

Attachments:

- Attachment A - 2011 Bonds Official Statement for 2011 bonds
- Attachment B - Audits – External audited financial statements for 2011 to 2014
- Attachment C - EMMA – Annual Disclosures for 2011 to 2015 and Material Event Disclosures
- Attachment D - External Auditor Management Letters for 2011 to 2014
- Attachment E- Rating Agencies – Fitch and Standard & Poors Reports

Exhibit 11.5

Attachment A

Wellmont 2011 Bonds Official Statement for 2011 Bonds

\$76,165,000
THE HEALTH, EDUCATIONAL AND HOUSING FACILITIES
BOARD OF THE COUNTY OF SULLIVAN, TENNESSEE
Hospital Revenue Refunding Bonds
(Wellmont Health System Project),
Series 2011

Bond Issuer. The Bonds are being issued by The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee (the “Issuer”).

Beneficiary of Financing. The Bonds are being issued to provide financing for the benefit of Wellmont Health System (the “Corporation”).



Wellmont Health System

Purpose of Financing. The Bonds will be issued for the purpose of refunding bonds previously issued to provide financing for the benefit of the Corporation. See “THE FINANCING PLAN”.

Financing Documents. The Bonds are being issued pursuant to a Bond Trust Indenture dated as of May 1, 2011 (the “Indenture”) between the Issuer and The Bank of New York Mellon Trust Company, N.A., as trustee (the “Trustee”). Proceeds of the Bonds will be loaned to the Corporation pursuant to a Loan Agreement dated as of May 1, 2011 (the “Loan Agreement”) between the Issuer and the Corporation. The loan repayment obligation of the Corporation will be evidenced and secured by a promissory note (the “Series 2011 Obligation”) issued by the Corporation as an obligation under the Master Indenture described herein.

Source of Payment and Security. The Bonds will be limited obligations of the Issuer payable solely out of payments by the Corporation pursuant to the Loan Agreement and payments by the Obligated Group pursuant to the Series 2011 Obligation. Payment of the Bonds is secured by the trust estate established under the Indenture, which includes (i) rights of the Issuer under the Loan Agreement and the Series 2011 Obligation, and (ii) money in the funds and accounts established under the Indenture. The Series 2011 Obligation and all other obligations issued under the Master Indenture will be secured by a pledge and assignment of gross receipts of the Obligated Group and a mortgage on certain operating assets of the Obligated Group. See “SOURCE OF PAYMENT AND SECURITY”.

The Bonds will not be general or full faith and credit obligations of the Issuer. The Bonds will be limited obligations of the Issuer payable solely out of the sources identified in the Indenture. Neither the State of Tennessee nor any of its political subdivisions, agencies or instrumentalities (including without limitation Sullivan County, Tennessee) is liable in any way for payment of the Bonds.

Pricing Terms and Payment Dates. Pricing information for the Bonds, including principal maturities, interest rates, payment dates and authorized denominations, is shown on the inside cover of this Official Statement.

Form and Date of Delivery. The Bonds are being issued under the book entry system maintained by The Depository Trust Company (“DTC”). The Bonds are expected to be delivered on May 5, 2011.

Redemption. The Bonds are subject to redemption prior to maturity as herein described.

Legal Opinions. McGuireWoods LLP, Richmond, Virginia, has served as bond counsel and will deliver its opinion with respect to the Bonds in substantially the form attached as APPENDIX D. In connection with the issuance of the Bonds, Penn, Stuart & Eskridge, A Professional Corporation, Bristol, Tennessee, has served as counsel to the Issuer, Hunter, Smith & Davis, LLP, Kingsport, Tennessee, has served as counsel to the Corporation and the Obligated Group, and Presley Burton & Collier, LLC, Birmingham, Alabama, has served as counsel to the Underwriter.

Tax Status. In the opinion of Bond Counsel, under existing law and subject to conditions described in the sections herein entitled “TAX STATUS” (1) interest on the Bonds is excludable from gross income for federal income tax purposes under Section 103 of the Internal Revenue Code of 1986, as amended (the “Code”), (2) interest on the Bonds is not treated as a preference item in calculating the alternative minimum tax imposed under the Code with respect to individuals and corporations, and (3) interest on the Bonds will be included in the adjusted current earnings of certain corporations for purposes of computing the alternative minimum tax imposed thereon. In the opinion of Bond Counsel, under the existing laws of the State of Tennessee, the Bonds and the interest thereon are exempt from all State of Tennessee state, county and municipal taxation except for inheritance, transfer and estate taxes and except to the extent that the Bonds and the interest thereon are included within the measure of certain privilege and excise taxes imposed under Tennessee law. See the section herein entitled “TAX STATUS.”

Risk Factors. For a description of certain risk factors involved in an investment in the Bonds, see “RISK FACTORS”.

Underwriter. The Bonds are being purchased from the Issuer by the following underwriter:

BofA Merrill Lynch

The date of this Official Statement is May 2, 2011.

\$76,165,000
The Health, Educational and Housing Facilities
Board of the County of Sullivan, Tennessee
Hospital Revenue Refunding Bonds
(Wellmont Health System Project),
Series 2011

PRICING INFORMATION

\$76,165,000 Term Bonds

Maturity (September 1)	Principal Amount	Interest Rate	Price	Yield	Initial CUSIP Number
2026	\$42,385,000	6.00%	100.00%	6.00%	865293 AG9
2032	33,780,000	6.50%	100.00%	6.50%	865293 AH7

Date of Bonds. The Bonds will be dated as of the date of their initial delivery. There will be no accrued interest payable as part of the initial offering price.

Authorized Denominations. The Bonds may be issued in denominations of \$5,000 or any integral multiple thereof.

Interest Payment Dates. Interest on the Bonds is payable on March 1 and September 1 of each year, beginning September 1, 2011.

Principal Payment Dates. The Bonds mature on September 1 in years and amounts as shown above.

Redemption Prior to Maturity. The Bonds are subject to redemption prior to maturity as described herein. See "THE BONDS—Redemption Prior to Maturity."

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APPENDIX F. THE DTC BOOK ENTRY SYSTEM

OFFICIAL STATEMENT

Regarding

\$76,165,000

**The Health, Educational and Housing Facilities
Board of the County of Sullivan, Tennessee
Hospital Revenue Refunding Bonds
(Wellmont Health System Project),
Series 2011**

INTRODUCTION

This Official Statement provides information for use in connection with the offering by The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee (the “Issuer”) of its \$76,165,000 Hospital Revenue Refunding Bonds (Wellmont Health System Project), Series 2011 (the “Bonds”). The Issuer is a public corporation organized under the laws of the State of Tennessee. The Bonds will be issued pursuant to a Bond Trust Indenture dated as of May 1, 2011 (the “Indenture”) between the Issuer and The Bank of New York Mellon Trust Company, N.A., as trustee (in such capacity, the “Trustee”).

The Bonds will be issued to provide financing for the benefit of Wellmont Health System, a Tennessee nonprofit corporation and a 501(c)(3) organization under the Internal Revenue Code (the “Corporation”). The Corporation is headquartered in Kingsport, Tennessee and operates a health care delivery system that includes six acute care hospitals and one critical access hospital that serve northeast Tennessee and southwest Virginia.

The Bonds are being issued for the purpose of refunding bonds previously issued to provide financing for the benefit of the Corporation. Proceeds of the Bonds will also be used to pay costs incurred in connection with the issuance of the Bonds. See “THE FINANCING PLAN”.

The proceeds of the Bonds will be loaned by the Issuer to the Corporation pursuant to a Loan Agreement dated as of May 1, 2011 (the “Loan Agreement”) between the Issuer and the Corporation. Pursuant to the Loan Agreement the Corporation will agree to make payments at times and in amounts sufficient to pay debt service on the Bonds. The Corporation’s loan repayment obligation will be evidenced by a promissory note issued as an obligation (the “Series 2011 Obligation”) under the Master Indenture described below.

The Corporation and certain of its affiliates have entered into a Master Trust Indenture dated as of May 1, 1991, as amended (the “Master Indenture”), with U.S. Bank National Association (as successor to Wachovia Bank, National Association, First Union National Bank, and Dominion Bank of Middle Tennessee), as trustee (the “Master Trustee”). The Corporation and its affiliates that have joined in the execution and delivery of the Master Indenture are referred to in the Master Indenture and this Official Statement as the “Obligated Group”. The Corporation, Wellmont, Inc. (“Wellmont”), Wellmont Foundation (“Wellmont Foundation”) and Wellmont Hawkins County Memorial Hospital, Inc. (“Wellmont Hawkins”) are currently the only members of the Obligated Group. See APPENDIX A for information about the current members of the Obligated Group. Members of the Obligated Group are jointly and severally liable for payment of the obligations issued under the Master Indenture (the “Master Indenture Obligations”). The Master Indenture permits the addition and withdrawal of members of the Obligated Group. Pursuant to the Loan Agreement, the Corporation will covenant not to withdraw from the Obligated Group as long as any Bonds remain outstanding. See APPENDIX C for the pertinent provisions of the Master Indenture. Pursuant to the Master Indenture the Obligated Group has pledged and assigned its gross receipts as security for all Master Indenture Obligations. The Obligated Group has also entered into separate deeds of trust (the “Deeds of Trust”) in the State of Tennessee and the Commonwealth of Virginia in favor of the Master Trustee that create a mortgage lien on certain operating assets of the Obligated Group. The Master Indenture and the Deeds of Trust are for the equal and proportionate benefit and security of all Obligations issued under the Master Indenture. See “SOURCE OF PAYMENT AND SECURITY—The Master Indenture”.

The Bonds will be limited obligations of the Issuer payable solely out of payments by the Corporation pursuant to the Loan Agreement and payments by the Obligated Group pursuant to the Series 2011 Obligation.

The Bonds will not be general or full faith and credit obligations of the Issuer. The Bonds will be limited obligations of the Issuer payable solely out of the sources identified in the Indenture. Neither the State of Tennessee nor any of its political subdivisions, agencies or instrumentalities (including without limitation Sullivan County, Tennessee) is liable in any way for payment of the Bonds.

The Indenture will establish a trust estate (the “Trust Estate”) that will be pledged and assigned to the Trustee. The Trust Estate includes (i) the Issuer’s rights under the Loan Agreement and the Series 2011 Obligation, and (ii) money in the funds and accounts established under the Indenture. The Trust Estate will be held by the Trustee for the equal and proportionate benefit of the holders of the Bonds. See “SOURCE OF PAYMENT AND SECURITY—Trust Estate Created by the Indenture”.

Investment in the Bonds involves a certain degree of risk. See “RISK FACTORS” for a description of those risks.

DEFINITIONS

This section contains the definition of terms frequently used in this Official Statement.

“**Act**” means Sections 48-101-301 to 48-101-318, inclusive, Tennessee Code Annotated, as amended.

“**Authorized Denominations**” means denominations of \$5,000 and any integral multiple thereof.

“**Bonds**” means the bonds offered by this Official Statement.

“**Book Entry System**” means the book entry system maintained by DTC for the registration, transfer, exchange and payment of debt obligations.

“**Business Day**” means any day other than (a) a Saturday or Sunday, (b) a day on which the Bond Trustee is required or permitted by law to close, and (c) a day on which the New York Stock Exchange is closed.

“**Corporation**” means Wellmont Health System, a Tennessee nonprofit corporation and a 501(c)(3) organization under the Internal Revenue Code. The Bonds are being issued to provide financing for the benefit of the Corporation.

“**Deeds of Trust**” means the Tennessee Deed of Trust and the Virginia Deed of Trust.

“**DTC**” means The Depository Trust Company.

“**Financing Documents**” means the Indenture, the Loan Agreement, the Master Indenture, the Series 2011 Obligation and the Deeds of Trust.

“**Gross Receipts**” means the receipts, revenues and other income pledged and assigned by the Obligated Group pursuant to the Master Indenture. See “SOURCE OF PAYMENT AND SECURITY—The Master Indenture” and the definition of Gross Receipts in APPENDIX C – “SUMMARY OF THE FINANCING DOCUMENTS – SUMMARY OF THE MASTER INDENTURE”.

“**Indenture**” means the Bond Trust Indenture dated as of May 1, 2011 between the Issuer and the Trustee.

“**Indenture Funds**” means any fund or account established pursuant to the Indenture. See “SOURCE OF PAYMENT AND SECURITY—Pledge Under Indenture”.

“**Issuer**” means The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, a Tennessee public corporation. The Issuer is the issuer of the Bonds.

“**Loan Agreement**” means the Loan Agreement dated as of May 1, 2011 between the Issuer and the Corporation.

“**Master Indenture**” means the Master Trust Indenture dated as of May 1, 1991, as amended and supplemented, and as further supplemented in connection with the issuance of the Bonds, between the members of the Obligated Group and the Master Trustee.

“**Master Indenture Obligations**” means all obligations issued under the Master Indenture, including the Series 2011 Obligation being issued as evidence and security for the loan repayment obligation of the Corporation.

“**Master Trustee**” means U.S. Bank, National Association (as successor to Wachovia Bank, National Association, First Union National Bank and Dominion Bank of Middle Tennessee), as trustee under the Master Indenture.

“**Mortgaged Facilities**” means property subject to the liens of the Deeds of Trust.

“**Obligated Group**” means the Corporation and the affiliates of the Corporation that have joined in the execution and delivery of the Master Indenture. The current members of the Obligated Group are the Corporation, Wellmont, Wellmont Foundation and Wellmont Hawkins. The Master Indenture permits the addition and withdrawal of members of the Obligated Group. See APPENDIX C for the pertinent provisions of the Master Indenture.

“**Series 2006A Bonds**” means the bonds previously issued to provide financing for the benefit of the Corporation that are being refunded through the issuance of the Bonds. See “THE FINANCING PLAN” herein.

“**Series 2011 Obligation**” means the Master Indenture Obligation being issued as evidence of and security for the Corporation’s loan repayment obligation with respect to the Bonds.

“**Tennessee Deed of Trust**” means collectively:

(A) Deed of Trust, Security Agreement and Fixture Filing dated as of March 1, 2002, from Wellmont Health System and Kingsport Medical Center, Inc., to Jack W. Hyder, Jr., Trustee, filed for record on March 28, 2002, at 8:00 a.m. in Deed Book 1749C, page 738, securing First Union National Bank, as Master Trustee, and BNY Trust Company of Missouri, as Trustee, the sum of \$244,030,000.00 as amended by (i) First Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of February 1, 2003, filed for record on Book 1947C, page 148, said Register’s Office, (ii) Second Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of December 1, 2005, filed for record on Book 2342C, page 154, (iii) Third Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of June 1, 2006, filed for record on Book 2416C, page 0378, (iv) Fourth Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of November 1, 2006, filed for record on Book 2466C, page 289, said Register’s Office, (v) Fifth Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of July 1, 2007, filed for record on Book 2567C, page 695, said Register’s Office, and (vi) Sixth Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of November 1, 2010, filed of record in Book 2924C, page 455, said Register’s Office;

(B) Deed of Trust, Security Agreement and Fixture Filing dated as of August 1, 2009, of record in Book 2807C, page 174, Office of the Register of Deeds for Sullivan County at Blountville, Tennessee, as amended by First Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of November 1, 2010, filed of record in Book 2924C, page 471, said Register’s Office; and

(C) Leasehold Deed of Trust, Security Agreement and Fixture Filing dated as of August 1, 2009, of record in Book 2807C, page 205, Office of the Register of Deeds for Sullivan County at Blountville, Tennessee, as amended by First Amendment to Leasehold Deed of Trust, Security Agreement

and Fixture Filing dated as of November 1, 2010, filed of record in Book 2924C, page 485, said Register's Office.

"Term Bonds" means Bonds subject to scheduled mandatory redemption requirements. Term Bonds are identified in the pricing information included on the inside cover of this Official Statement. See "THE BONDS—Redemption Prior to Maturity".

"Trust Estate" means the trust estate established under the Indenture.

"Trustee" means The Bank of New York Mellon Trust Company, N.A., as trustee under the Indenture.

"Virginia Deed of Trust" means collectively:

(A) Deed of Trust, Assignment of Leases and Rents, Security Agreement and Fixture Filing dated as of July 1, 2007, of record as Instrument No. 200703183, Office of the Circuit Court Clerk for Lee County, Virginia, as amended by First Amendment to Deed of Trust, Assignment of Leases and Rents, Security Agreement and Fixture Filing dated as of November 1, 2010, of record as Instrument No. 201003584, said Circuit Court Clerk's Office; and

(B) Deed of Trust, Assignment of Leases and Rents, Security Agreement and Fixture Filing dated as of July 1, 2007, of record as Instrument No. 0708240, Office of the Circuit Court Clerk for Wise County, Virginia, as amended by First Amendment to Deed of Trust, Assignment of Leases and Rents, Security Agreement and Fixture Filing dated as of November 1, 2010, of record as Instrument No. 1010076, said Circuit Court Clerk's Office.

"Wellmont" means Wellmont, Inc., a Tennessee corporation. Wellmont is a member of the Obligated Group under the Master Indenture.

"Wellmont Foundation" means Wellmont Foundation, a Tennessee nonprofit corporation and a 501(c)(3) organization under the Internal Revenue Code. Wellmont Foundation is a member of the Obligated Group under the Master Indenture.

"Wellmont Hawkins" means Wellmont Hawkins County Memorial Hospital, Inc., a Tennessee nonprofit corporation and a 501(c)(3) organization under the Internal Revenue Code. Wellmont Hawkins is a member of the Obligated Group under the Master Indenture.

THE BONDS

Date, Form of Bonds and Denominations

The Bonds will be dated as of the date of initial delivery. The Bonds will be issuable only as fully registered bonds in denominations of \$5,000 or any multiple thereof.

Book Entry System

The Bonds are being issued in electronic form under the Book Entry System procedures of The Depository Trust Company ("DTC"). While the Bonds are in the Book Entry System, the method and procedures for payment of the Bonds and matters pertaining to transfers and exchanges of the Bonds will be governed by the rules and procedures of the Book Entry System. If the Book Entry System is discontinued, the Indenture contains alternate provisions for the method of payment and for transfers and exchanges. See APPENDIX F for a description of the DTC Book Entry System. See APPENDIX C – "SUMMARY OF THE FINANCING DOCUMENTS – SUMMARY OF CERTAIN PROVISIONS OF THE 2011 BOND INDENTURE" for a description of applicable Indenture provisions if the Book Entry System is terminated.

Pricing Information

See the pricing terms on the inside cover of this Official Statement for principal maturities, interest rates and payment dates for the Bonds. The Bonds will be subject to redemption prior to maturity. See “THE BONDS—Redemption Prior to Maturity”.

Fixed Interest Rates

The Bonds are being issued as fixed rate obligations.

Calculation of Interest Payments

Interest payable on the Bonds will be calculated on the basis of a 360-day year with 12 months of 30 days each.

Redemption Prior to Maturity

The Bonds will be subject to redemption prior to maturity as follows:

(a) **Optional Redemption.** The Bonds are subject to redemption prior to maturity by the Issuer at the option of the Corporation, on or after March 1, 2015, in whole or in part at any time, less than all of such Bonds to be selected by lot or in such other manner as the Trustee determines, at the redemption prices of par plus accrued interest to (but not including) the redemption date.

(b) **Mandatory Bond Sinking Fund Redemption Without Premium.** The Bonds maturing September 1, 2026 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot, at a redemption price equal to the principal amount thereof, without premium, plus accrued interest to the redemption date, beginning on September 1, 2013 and on each September 1 thereafter in the years and in the principal amounts set forth below:

September 1	Principal Amount
2013	\$ 865,000
2014	890,000
2015	990,000
2016	1,390,000
2017	1,155,000
2018	1,205,000
2019	1,285,000
2020	5,585,000
2021	5,595,000
2022	5,895,000
2023	4,090,000
2024	4,280,000
2025	4,480,000
2026 (maturity)	4,680,000

The Bonds maturing September 1, 2032 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot, at a redemption price equal to the principal amount thereof, without premium, plus accrued interest to the redemption date, beginning on September 1, 2027 and on each September 1 thereafter in the years and in the principal amounts set forth below:

September 1	Principal Amount
2027	\$ 4,980,000
2028	5,175,000
2029	5,475,000
2030	5,775,000
2031	6,075,000
2032 (maturity)	6,300,000

In the case of any optional or extraordinary redemption or any purchase and cancellation of any term Bonds that are subject to mandatory sinking fund redemption as described above, the Issuer shall receive credit against its required Bond Sinking Fund deposits with respect to Bonds of the same maturity and interest rate as those being redeemed or purchased.

(c) ***Extraordinary Redemption in Whole or in Part Without Premium.*** The Bonds are also subject to redemption prior to maturity in the event of damage to or destruction of the Property of any member of the Combined Group or any part thereof or the condemnation of the Facilities or any part thereof, if the Net Proceeds of insurance or condemnation received in connection therewith to the extent that Net Proceeds are not applied either to any lawful purposes of the Combined Group or to the repair, replacement, restoration or reconstruction of the affected Facilities pursuant to the Master Indenture, but only to the extent of the funds provided for in the Master Indenture. If called for redemption in the events referred to in the preceding sentence of this paragraph, the Bonds will be subject to redemption at any time, in whole or in part, and if in part, the Corporation may decide the order of maturity or portion of each maturity to be redeemed by lot. Such redemption shall be at the principal amount thereof plus accrued interest to the redemption date, and without premium, from the proceeds of such insurance or condemnation award or such sale but not in excess of the amount of such proceeds applied to such purpose. If no direction is given by the Corporation, the Trustee will redeem Bonds then Outstanding pro rata based on the then Outstanding principal amount in the inverse order of maturity thereof.

Notice of Redemption. While the Bonds are in book-entry form, notice of redemption will be given only to DTC or its nominee. See “THE BONDS—Book Entry System.” Notice of the call for redemption will be given by the Trustee by mailing a copy of the redemption notice (a) by first class mail at least 30 days but not more than 60 days prior to the date fixed for redemption to the owner of each Bond to be redeemed in whole or in part at the address shown on the registration books and (b) by registered or certified mail, facsimile (or other electronic means), or overnight delivery service at least 30 days prior to the date fixed for redemption, to certain following registered securities depositories then in the business of holding substantial amounts of bonds of the type comprising the Bonds and to one or more national information services that disseminate notices of redemption of bonds such as the Bonds. No defect in any notice delivered pursuant to clause (b) above nor any failure to give all or any portion of such notice will in any manner defeat the effectiveness of a call for redemption if notice is given as prescribed in clause (a) above. Any notice mailed as described above will be conclusively presumed to have been duly given, whether or not the owner receives the notice. Failure to mail any such notice, or the mailing of defective notice, to any owner will not affect the proceeding for redemption as to any owner to whom proper notice is mailed.

If at the time of mailing of notice of any optional redemption there has not been deposited with the Trustee moneys sufficient to redeem all the Bonds called for such redemption, such notice may state that it is conditional on the deposit of moneys with the Trustee not later than the redemption date, and such notice will be of no effect unless such moneys are so deposited.

Purchase of Bonds in Lieu of Redemption. The Issuer has irrevocably granted to the Corporation the option to purchase at any time, and from time to time, any Bond which is to be redeemed pursuant to the optional redemption provisions described above on the dates of such redemption and at a purchase price equal to the redemption price. To exercise this option, the Corporation must notify the Trustee not less than five Business Days before the proposed redemption date that amounts available to pay the redemption price of such Bonds shall be applied to purchase such Bonds in lieu of redemption. No notice other than the notice of redemption described under “Notice of Redemption” above must be given in connection with any such purchase in lieu of redemption. On the date fixed for redemption, the Trustee will purchase the Bonds to be redeemed in lieu of such redemption and following such purchase, shall cause such Bonds to be registered in the name of or upon the direction of the

Corporation and deliver them to or as directed by the Corporation. No purchase of Bonds as described in this paragraph will operate to extinguish the indebtedness of the Issuer evidenced thereby. Bonds purchased in lieu of redemption will continue to bear interest at the interest rate in effect on the date of such purchase in lieu of redemption.

SOURCE OF PAYMENT AND SECURITY

Pledge Under Indenture

Pursuant to the Indenture, to secure the payment of the principal of, premium, if any, and interest on the Bonds, the Issuer grants, assigns, transfers, pledges, sets over and confirms and grants a security interest in the property described below (the “Trust Estate”) to the Trustee:

(a) All right, title and interest of the Issuer in and to the Series 2011 Obligation and any additional Obligations pledged under the Indenture and all sums payable in respect of the indebtedness evidenced thereby.

(b) All right, title and interest of the Issuer in and to the Loan Agreement (except for Reserved Rights), including, but not limited to, the present and continuing right to make claim for, collect, receive and receipt for any of the sums, amounts, income, revenues, issues and profits and any other sums of money payable or receivable under the Loan Agreement, to bring actions and proceedings thereunder or for the enforcement thereof, and to do any and all things which the Issuer is or may become entitled to do under the Loan Agreement.

(c) All right, title and interest of the Issuer in moneys and securities from time to time held by the Trustee under the terms of the Indenture, other than moneys held in the Rebate Fund.

(d) Any and all other property rights and interests of every kind and nature from time to time hereafter by delivery or by writing of any kind granted, bargained, sold, alienated, demised, released, conveyed, assigned, transferred, mortgaged, pledged, hypothecated or otherwise subjected to the Indenture, as and for additional security thereunder, by the Corporation or any other person on its behalf or with its written consent or by the Issuer or any other person on its behalf or with its written consent.

The Bonds are limited obligations of the Issuer and are payable solely from the Trust Estate. The Corporation agrees under the Loan Agreement and in the Series 2011 Obligation to make payments thereunder directly to the Trustee.

Pledge of Gross Receipts

The Series 2011 Obligation, along with all other Obligations issued under the Master Indenture, including but not limited to the Series 2003 Obligation, the Series 2005 Obligation, the Series 2006C Obligation, the Series 2007A Obligation and the Series 2010 Obligation, are secured on a parity by a security interest in all of the right, title and interest of the Obligated Group in and to its Gross Receipts. “Gross Receipts” are defined in the Master Indenture as: all receipts, revenues, income, gifts, donations, contributions, grants, bequests, pledges, chattel paper and instruments, and other monies received by or on behalf of the Obligated Group, including, but without limiting the generality of the foregoing, (i) revenues derived from the ownership or operation of Property including insurance and condemnation proceeds with respect to Property or any portion thereof, and (ii) all rights to receive the same, whether in the form of accounts, accounts receivable, contract rights or other rights and the proceeds of such rights, whether now owned, or held or hereafter coming into existence; provided, however, that (a) gifts, contributions, grants (including Hill-Burton Grants), bequests and pledges heretofore or hereafter made and designated or specified by the granting authority, donor or maker thereof as being for specified purposes (inconsistent with the payment of debt service on Indebtedness) and income derived therefrom to the extent required by such designation or specification, and (b) revenues, receipts and income derived from the ownership and operation of Property which secures Non-Recourse Indebtedness shall be excluded from Gross Receipts. See “SOURCE OF PAYMENT AND SECURITY—The Master Indenture” and APPENDIX C – “SUMMARY OF THE FINANCING DOCUMENTS – SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE.”

Deeds of Trust

The Series 2011 Obligation, along with all other Obligations issued under the Master Indenture, including but not limited to the Series 2003 Obligation, the Series 2005 Obligation, the Series 2006C Obligation, the Series 2007A Obligation and the Series 2010 Obligation (collectively, the “Obligations”), are also secured on a parity by the Tennessee Deed of Trust and the Virginia Deed of Trust (collectively, the “Deeds of Trust”) which pledge, grant and convey a security interest in certain real estate and the improvements located thereon (the “Mortgaged Facilities”) owned by the Corporation, subject to Permitted Liens. The Tennessee Deed of Trust does not encumber all real estate and the improvements located thereon which are owned or leased by the Corporation in the State of Tennessee. The Virginia Deed of Trust does not encumber all real estate and the improvements located thereon which are owned or leased by the Corporation in the Commonwealth of Virginia.

The Mortgaged Facilities that will be subject to the lien of the Tennessee Deed of Trust are the following facilities: Wellmont Bristol Regional Medical Center and Wellmont Holston Valley Regional Medical Center. The Mortgaged Facilities that will be subject to the lien of the Virginia Deed of Trust are the following facilities: Mountain View Regional Medical Center and Lee Regional Medical Center. Only these facilities are subject to the Deeds of Trust, and certain adjacent medical office buildings and other non-hospital facilities not listed here are not subject to the Deeds of Trust. The Corporation and the Obligated Group also own and lease certain undeveloped land and other real property not subject to the Tennessee Deed of Trust or the Virginia Deed of Trust, including two additional hospitals.

Series 2011 Obligation

Payments on the Series 2011 Obligation pledged under the Indenture will be the joint and several obligation of the members of the Obligated Group. Notwithstanding uncertainties as to the enforceability of the covenants of the members of the Obligated Group in the Master Indenture to be jointly and severally liable for each Obligation (as described under “RISK FACTORS—Limitation on Enforcement of Remedies – *Limitations on Joint and Several Liability of Obligated Group Members*”), the accounts of the members of the Obligated Group will be combined for financial reporting purposes and will be used in determining whether various covenants and tests contained in the Master Indenture (including tests relating to the incurrence of Additional Indebtedness) are met. The members of the Obligated Group currently consist of the Corporation, Wellmont Hawkins, Wellmont and Wellmont Foundation.

Parity Debt

The Corporation’s obligation under the Loan Agreement to pay debt service on the Bonds will be secured by the Series 2011 Obligation. The Series 2011 Obligation is being issued on a parity with Master Indenture obligations issued to secure the following: (a) \$12,966,415.15 outstanding principal amount of Series 2010 Bonds, (b) \$55,000,000 outstanding principal amount of the Series 2007A Bonds, (c) \$200,000,000 outstanding principal amount of the Series 2006C Bonds, (d) \$59,580,000 outstanding principal amount of the Series 2005 Bonds, (e) \$33,035,000 outstanding principal amount of the Series 2003 Bonds, and (f) any Additional Indebtedness issued, from time to time, under and pursuant to the Master Indenture.

The Loan Agreement provides that the Corporation is required to make designated payments to the Trustee for deposit into the Bond Fund in amounts sufficient to pay the principal of and interest on the Bonds when due.

Limited Obligations

The Bonds and the interest and premium, if any, payable thereon do not constitute a debt or liability of Sullivan County, the State of Tennessee or any political subdivision thereof other than the Issuer, but are payable solely from the funds pledged therefor in accordance with the Indenture. The issuance of the Bonds does not directly, indirectly or contingently, obligate the County, the State or any political subdivision thereof to levy any form of taxation for the payment thereof or to make any appropriation for their payment. The Bonds and the interest and premium, if any, payable thereon do not now and will never constitute a debt of the State within the meaning of the Constitution or the statutes of the State and do not now and will never constitute a charge against the credit or taxing power of the County, the State or any political subdivision thereof. Neither the County nor the State will in

any event be liable for the payment of the principal of, premium, if any, or interest on the Bonds or for the performance of any pledge, mortgage, obligation or agreement of any kind whatsoever which may be undertaken by the Issuer. No breach by the Issuer of any such pledge, mortgage, obligation or agreement may impose any pecuniary liability upon the County or the State or any charge upon its general credit or against its taxing power. The Issuer has no taxing power.

The Master Indenture

The Series 2011 Obligation will be issued as an Obligation under the Master Indenture. The members of the Obligated Group currently consist of the Corporation, Wellmont Hawkins, Wellmont and Wellmont Foundation. The members of the Obligated Group are jointly and severally liable for the payment of the Series 2011 Obligation, all other Obligations issued under the Master Indenture and for performance of the covenants and agreements set forth in the Master Indenture and the Eleventh Supplemental Master Indenture. Subject to certain conditions, the Master Indenture will permit additional entities to become members of the Obligated Group thereunder and will permit members of the Obligated Group to designate any or all of their respective affiliates as Restricted Affiliates for the purposes of the Master Indenture. Members of the Obligated Group will also be obligated to cause their respective Restricted Affiliates (such Restricted Affiliates, together with the Obligated Group, being herein referred to collectively as the “Combined Group”) to make such payments and perform such covenants and agreements as are necessary for the Combined Group to comply with the Master Indenture. The Master Indenture also permits members of the Obligated Group and Restricted Affiliates to withdraw from the Combined Group under specified conditions, whereupon such withdrawing members of the Obligated Group and Restricted Affiliates will cease to be bound by the Master Indenture and no longer obligated to pay the sums due under all Obligations, including the Series 2011 Obligation.

See APPENDIX C – “SUMMARY OF THE FINANCING DOCUMENTS – SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE” for further information regarding the Master Indenture, including a discussion of the conditions under which entities will be permitted to join or withdraw from the Combined Group, the provisions regarding the incurrence of and security for additional Obligations or other Indebtedness and the various financial and operating covenants and agreements to be performed by the Combined Group.

At the time of issuance of the Series 2011 Obligation, the only other Obligations Outstanding under the Master Indenture will be the Series 2003 Obligation, the Series 2005 Obligation, the Series 2006C Obligation, the Series 2007A Obligation and the Series 2010 Obligation.

Additional Indebtedness Under the Master Indenture

The Master Indenture permits the members of the Obligated Group to incur Additional Indebtedness (including Guaranties), all upon the terms and subject to the conditions specified therein. Such Additional Indebtedness may, but need not, be evidenced or secured by an Obligation. See APPENDIX C – “SUMMARY OF THE FINANCING DOCUMENTS – SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE.” Additional Indebtedness may be issued to the Issuer or to persons other than the Issuer. Except to the extent entitled to the benefits of additional security as permitted by the Master Indenture and except for Subordinated Indebtedness, all Obligations issued under the Master Indenture will be equally and ratably secured thereby.

Subject to certain conditions set forth in the Master Indenture, Additional Indebtedness incurred by any member of the Obligated Group may be secured by security which does not extend to any other Indebtedness. Such security may include Liens on the Property (including healthcare facilities) of the members of the Obligated Group, letters or lines of credit or insurance, and could also consist of Liens on cash or securities deposited or held in any depreciation reserve, debt service or interest reserve, debt service or similar fund established pursuant to the terms of any Supplemental Master Indenture, Related Bond Indenture or Related Financing Documents. The Master Indenture provides that Supplemental Master Indentures pursuant to which one or more series of Obligations entitled to additional security are issued may provide for such amendments to provisions of the Master Indenture, including the provisions thereof relating to the exercise of remedies upon the occurrence of an event of default, as are necessary to provide for such security and to permit realization upon such security solely for the benefit of the Obligations secured thereby.

Limitations on Remedies

The rights of the Trustee, the Master Trustee, the holders of Master Indenture Obligations, and the holders of the Bonds may be limited by (i) bankruptcy, insolvency, or other similar laws affecting the enforcement of creditors' rights and (ii) general principles of equity, including the exercise of judicial discretion in appropriate cases. See also "RISK FACTORS".

THE FINANCING PLAN

General

The Bonds are being issued for the purpose of refunding bonds previously issued to provide financing for the Corporation. Proceeds of the Bonds will also be used to pay costs incurred in connection with the issuance of the Bonds. See "Sources and Uses of Funds".

The Refunding Plan

To provide financing for the benefit of the Corporation, the Issuer previously issued its Hospital Revenue Refunding Bonds (Wellmont Health System Project), Tax-Exempt Series 2006A (the "Series 2006A Bonds"), which are now outstanding in the aggregate principal amount of \$76,595,000. The Series 2006A Bonds are not subject to optional redemption until March 1, 2013. In order to refund the Series 2006A Bonds, the Corporation made a tender offer to the holders of the Series 2006A Bonds. The holders of all outstanding Series 2006A Bonds have agreed to tender their Series 2006A Bonds to the Corporation. Proceeds of the Bonds will be used to pay the purchase price of Series 2006A Bonds tendered for purchase. All outstanding Series 2006A Bonds will be purchased by the Corporation on the date of issuance of the Bonds and will be immediately surrendered to the trustee for the Series 2006A Bonds for retirement and cancellation.

Sources and Uses of Funds

The estimated sources and uses of funds for the financing plan are as follows (rounded to the nearest whole dollar):

Table 1. Sources and Uses of Funds

Sources of Funds

Principal amount of Bonds	<u>\$76,165,000</u>
Total sources	\$76,165,000

Uses of Funds

Purchase and retirement of Series 2006A Bonds	\$74,942,165
Costs of issuance of the Bonds ⁽¹⁾	<u>1,222,835</u>
Total uses	\$76,165,000

Note (1) Includes underwriter's discount, legal and accounting fees, printing costs, rating agency fees, and other costs of issuance. Costs of issuance in excess of available Bond proceeds will be paid by the Corporation with its own funds.

Debt Service Requirements on the Bonds

The following table contains the estimated debt service requirements on the Bonds.

Table 2. Debt Service Requirements on Bonds

Bond Year Ending September 1	Debt Service on Bonds		Total Debt Service
	Principal	Interest	
2011	\$ 0	\$ 1,526,947	\$ 1,526,947
2012	0	4,738,800	4,738,800
2013	865,000	4,738,800	5,603,800
2014	890,000	4,686,900	5,576,900
2015	990,000	4,633,500	5,623,500
2016	1,390,000	4,574,100	5,964,100
2017	1,155,000	4,490,700	5,645,700
2018	1,205,000	4,421,400	5,626,400
2019	1,285,000	4,349,100	5,634,100
2020	5,585,000	4,272,000	9,857,000
2021	5,595,000	3,936,900	9,531,900
2022	5,895,000	3,601,200	9,496,200
2023	4,090,000	3,247,500	7,337,500
2024	4,280,000	3,002,100	7,282,100
2025	4,480,000	2,745,300	7,225,300
2026	4,680,000	2,476,500	7,156,500
2027	4,980,000	2,195,700	7,175,700
2028	5,175,000	1,872,000	7,047,000
2029	5,475,000	1,535,625	7,010,625
2030	5,775,000	1,179,750	6,954,750
2031	6,075,000	804,375	6,879,375
2032	<u>6,300,000</u>	<u>409,500</u>	<u>6,709,500</u>
Total	\$76,165,000	\$69,438,697	\$145,603,697

THE ISSUER

The Issuer was incorporated as a public nonprofit corporation on August 31, 1979, by Sullivan County, Tennessee (the "County"), pursuant to the Act. The Issuer was organized to assist hospital institutions in providing facilities and structures for the development and maintenance of the public health, thereby providing County residents with access to adequate medical care and hospital facilities to improve their welfare, prosperity, health and living conditions. The Issuer is authorized by the Act to issue revenue bonds payable solely from the revenues and receipts from such facilities and structures or other sources designated by the Issuer and secured by a pledge of such revenues and receipts. The Issuer may issue bonds to refund any prior issues of its bonds.

Neither the County nor the State will in any event be liable for the payment of principal of, premium, if any, or interest on the Bonds or other bonds issued by the Issuer or for the performance of any pledge, mortgage, obligation or agreement of any kind undertaken by the Issuer. None of the bonds issued by the Issuer, including the Bonds, and none of the Issuer's agreements and obligations are an indebtedness of the County, the State or any political subdivision thereof within the meaning of any constitutional or statutory provision or otherwise. The Issuer has no taxing power.

The Issuer has full power and authority under the Act to enter into the Indenture and the Loan Agreement and to perform its covenants and obligations thereunder.

The Issuer is governed by a seven member Board of Directors appointed by the Board of Commissioners of the County. Members of the Board of Directors serve staggered 6-year terms.

Although the Issuer has consented to the use of this Official Statement in connection with the offer and sale of the Bonds, it has not participated in the preparation of this Official Statement and makes no representation as to its accuracy or completeness.

THE CORPORATION AND THE OBLIGATED GROUP

The Corporation is a nonprofit corporation under the laws of the State of Tennessee and is a 501(c)(3) organization under the Internal Revenue Code. Wellmont Foundation and Wellmont Hawkins are also nonprofit corporations organized under the laws of the State of Tennessee and are also 501(c)(3) organizations under the Internal Revenue Code. Wellmont is a Tennessee corporation. The Corporation, Wellmont, Wellmont Foundation and Wellmont Hawkins are currently the only members of the Obligated Group. For information about the Corporation and the Obligated Group, see APPENDIX A.

RISK FACTORS

General

The Bonds are special limited obligations of the Issuer payable solely from the revenues pledged to the payment of the Bonds in accordance with the Indenture, as described herein. The Bonds do not constitute a debt of the Issuer within any constitutional or statutory provision and do not give rise to a pecuniary liability of the Issuer. No Holder of any of the Bonds shall ever have the right to enforce payment of the Bonds against any property of the Issuer or any funds other than those expressly pledged under the Indenture to the payment thereof. The Bonds are payable solely from and secured by the Trust Estate, as described under "SOURCE OF PAYMENT AND SECURITY."

There are certain factors herein that may adversely affect the Corporation's ability to make timely payments under the Loan Agreement and the Obligated Group's obligation to make timely payments on the Series 2011 Obligation. Such failure could, among other things, result in an acceleration of the Bonds. No representation or assurance can be made that revenues will be realized by the Corporation or the Obligated Group in amounts sufficient to pay maturing principal of, premium, if any, and interest due on the Bonds or payment of the Series 2011 Obligation. Purchasers of the Bonds should bear in mind that the occurrence of any number of events, some of which are specified in more detail below, could adversely affect the revenue-producing ability of the Corporation and the Obligated Group. Further, economic and other conditions, including demand for hospital services, the ability of the Corporation and the Obligated Group to provide the services required by patients, physicians' confidence in the Corporation and the Obligated Group, economic conditions in the service area of the Corporation and the Obligated Group, competition, rates, costs, third-party reimbursement and governmental regulations, may adversely affect the Corporation's and the Obligated Group's revenues and, in turn, the payment of principal of, premium, if any, and interest on the Bonds and payment of the Series 2011 Obligation.

THERE CAN BE NO ASSURANCE THAT THE REVENUES OF THE CORPORATION AND THE OBLIGATED GROUP OR UTILIZATION OF THE OBLIGATED GROUP'S HEALTHCARE FACILITIES WILL NOT DECREASE.

The following risk factors, among others, should be considered in evaluating the ability of the Obligated Group, including the Corporation, to provide sufficient revenues for payment of the principal of, premium, if any, and interest on the Bonds and payment of the Series 2011 Obligation. This discussion of risk factors is not, and is not intended to be, exhaustive.

Market Risk

There can be no assurance that there will be a secondary market for the Bonds. In the absence of such a market for the Bonds could result in investors not being able to resell the Bonds should they need to.

Impact of Market Turmoil

The disruption of the credit and financial markets in the last several years has led to volatility in the securities markets, significant losses in investment portfolios, increased business failures and consumer and business bankruptcies, and is a major cause of the current economic crisis. In response to that disruption, the Dodd-Frank Wall Street Reform and Consumer Protection Act (the “Financial Reform Act”) was enacted and approved by the President on July 21, 2010. The Financial Reform Act includes broad changes to the existing financial regulatory structure, including the creation of new federal agencies to identify and respond to risks to the financial stability of the United States. Additional legislation is pending or under active consideration by Congress and regulatory action is being considered by various Federal agencies and the Federal Reserve Board and foreign governments, which are intended to increase the regulation of domestic and global credit markets. The effects of the Financial Reform Act and of these legislative, regulatory and other governmental actions, if implemented, are unclear.

The health care sector, including the Corporation and the Obligated Group, has been materially and adversely affected by this market turmoil. The consequences of this market turmoil have generally included, among other things, realized and unrealized investment portfolio losses, increased borrowing costs and periodic disruption of access to the capital markets.

The Corporation and the Obligated Group have experienced some impact from current economic conditions, but the payor mix of the Corporation and the Obligated Group is stable. Bad debt of the Corporation and the Obligated Group has increased as employers and insurers shift additional financial responsibility to the patient. Patients have delayed some elective business but outpatient surgical volume is up 6.6 percent for the six-month period ended December 31, 2010 over the six-month period ended December 31, 2009. While the budgets for the States of Tennessee and Virginia are under stress, reductions in amounts provided by the State of Tennessee to the Corporation and the Obligated have been offset by the assessment fee. The Corporation and the Obligated Group expect to receive a cut of approximately \$450,000 for the upcoming year from the State of Virginia. See “RISK FACTORS - Patient Service Revenues” and in APPENDIX A – “Historical Financial Information”, and “Management’s Discussion and Analysis of Financial Information”.

In February 2009, the American Recovery and Reinvestment Act of 2009 (“H.R. 1”) was enacted and includes several provisions that are intended to provide financial relief to the health care sector, most of which will be spent by 2011. These funds include, among other things, a temporary increase in Federal payments to states to fund the Medicaid program, a requirement that states promptly reimburse healthcare providers, and a subsidy to the recently unemployed for health insurance premium costs. H.R. 1 also establishes a framework for the implementation of a nationally-based health information technology program. For more information on this program, see “The HITECH Act” below.

Health Care Reform

In March, 2010, the Patient Protection and Affordable Care Act (the “Health Care Reform Act”) was enacted and approved by the President. Some of the provisions of the Health Care Reform Act took effect immediately, while others will take effect or will be phased in over time, ranging from a few months following approval to ten years. Because of the complexity of the Health Care Reform Act generally, additional legislation is likely to be considered and enacted over time. The Health Care Reform Act will also require the promulgation of substantial regulations with significant effects on the health care industry and third-party payors. In response, third-party payors and suppliers and vendors of goods and services to health care providers are expected to impose new and additional contractual terms and conditions. Thus, the health care industry will be subjected to significant new statutory and regulatory requirements and contractual terms and conditions, and consequently to structural and operational changes and challenges, for a substantial period of time.

A significant component of the Health Care Reform Act is reformation of the sources and methods by which consumers will pay for health care for themselves and their families and by which employers will procure health insurance for their employees and dependents and, as a consequence, expansion of the base of consumers of health care services. One of the primary drivers of the Health Care Reform Act is to provide or make available, or subsidize the premium costs of, health care insurance for some of the millions of currently uninsured (or underinsured) consumers who fall below certain income levels. The Health Care Reform Act proposes to

accomplish that objective through various provisions, summarized as follows: (i) the creation of active markets (referred to as exchanges) in which individuals and small employers can purchase health care insurance for themselves and their families or their employees and dependents, (ii) providing subsidies for premium costs to individuals and families based upon their income relative to federal poverty levels, (iii) mandating that individual consumers obtain and certain employers provide a minimum level of health care insurance, and providing for penalties or taxes on consumers and employers that do not comply with these mandates, (iv) expansion of private commercial insurance coverage generally through such reforms as prohibitions on denials of coverage for pre-existing conditions and elimination of lifetime or annual cost caps, and (v) expansion of existing public programs, including Medicaid, for individuals and families. The Congressional Budget Office (“CBO”) has estimated that in federal fiscal year 2015, 19 million consumers who are currently uninsured will become insured, followed by an additional 11 million consumers in federal fiscal year 2016. To the extent all or any of those provisions produce the expected result, an increase in utilization of health care services by those who are currently avoiding or rationing their health care can be expected and bad debt expenses may be reduced. Associated with increased utilization will be increased variable and fixed costs of providing health care services, which may or may not be offset by increased revenues.

Some of the specific provisions of the Health Care Reform Act that may affect hospital operations, financial performance or financial conditions, including those of the Members of the Obligated Group, are described below. This listing is not, is not intended to be, nor should be considered by the reader as, comprehensive. The Health Care Reform Act is complex and comprehensive, and includes a myriad of new programs and initiatives and changes to existing programs, policies, practices and laws. At this time, management of the Corporation cannot predict the aggregate effect of the Health Care Reform Act upon the Obligated Group, as a whole.

- Commencing upon enactment through September 30, 2019, the annual Medicare market basket updates for hospitals will be reduced. Beginning October 1, 2011, the market basket updates will be subject to productivity adjustments. The reductions in market based updates and the productivity adjustments will have a disproportionately negative effect upon those providers that are relatively more dependent upon Medicare than other providers. Additionally, the reductions in market basket updates will be effective prior to the periods during which insurance coverage and the insured consumer base will expand, which may have an interim negative effect on revenues. The combination of reductions to the market basket updates and the imposition of the productivity adjustments may, in some cases and in some years, result in reductions in Medicare payment per discharge on a year-to-year basis.
- Commencing October 1, 2010 through September 30, 2019, payments under the “Medicare Advantage” programs (Medicare managed care) will be reduced, which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Advantage plans. Those beneficiaries may terminate their participation in those plans and opt for the traditional Medicare fee-for-service program. The reduction in payments to Medicare Advantage programs may also lead to decreased payments to providers by managed care companies operating Medicare Advantage programs. All or any of these outcomes will have a disproportionately negative effect upon those providers with relatively high dependence upon Medicare managed care revenues.
- Commencing October 1, 2012, a value-based purchasing program will be established under the Medicare program designed to provide incentive payments to hospitals based on performance on quality and efficiency measures. These incentive payments are funded through a pool of money collected from all hospital providers.
- Commencing October 1, 2013, Medicare disproportionate share hospital (“DSH”) payments will be reduced initially by 75%. DSH payments will be increased thereafter to account for the national rate of consumers who do not have health care insurance and are provided uncompensated care. Commencing October 1, 2013, each state’s Medicaid DSH allotment from federal funds will be reduced.
- Expansion of Medicaid programs to a broader population with incomes up to 133% of federal poverty levels. CBO has estimated that 16 million consumers who are currently uninsured will

become newly eligible for Medicaid through 2019 as a result of this expansion. Providers operating in markets with large Medicaid and uninsured populations are anticipated to benefit from increased revenues resulting from increased utilization and reductions in bad debt or uncompensated care. The increase in utilization can also be expected to increase in costs of providing that care, which may or may not be balanced by increased revenues.

- Commencing October 1, 2012, Medicare payments that would otherwise be made to hospitals that have a high rate of potentially preventable readmissions of Medicare patients for certain clinical conditions will be reduced by specified percentages to account for those excess and “preventable” hospital readmissions.
- Commencing October 1, 2014, Medicare payments to certain hospitals for hospital-acquired conditions will be reduced by 1%. Commencing July 1, 2011, federal payments to states for Medicaid services related to health care-acquired conditions will be prohibited.
- Commencing October 1, 2011, health care insurers will be required to include quality improvement covenants in their contracts with hospital providers, and will be required to report their progress on such actions to the Secretary of Health and Human Services (“HHS”). Commencing January 1, 2015, health care insurers participating in the health insurance exchanges will be allowed to contract only with hospitals that have implemented programs designed to ensure patient safety and enhance quality of care. The effect of these provisions upon the process of negotiating contracts with insurers or the costs of implementing such programs cannot be predicted.
- With varying effective dates, the Health Care Reform Act enhances the ability to detect and reduce waste, fraud, and abuse in public programs through provider enrollment screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. The Health Care Reform Act requires the development of a database to capture and share health care provider data across federal health care programs and provides for increased penalties for fraud and abuse violations, and increased funding for anti-fraud activities.
- Effective for tax years commencing immediately after approval, additional requirements for tax-exemption will be imposed upon tax-exempt hospitals, including obligations to adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the amount generally charged to insured patients; and control the billing and collection processes. Additionally, effective for tax years commencing January 1, 2013, tax-exempt hospitals must conduct a community needs assessment and adopt an implementation strategy to meet those identified needs. Failure to satisfy these conditions may result in the imposition of fines and the loss of tax-exempt status.
- The establishment of an Independent Payment Advisory Board to develop proposals to improve the quality of care and limitations on cost increases. Beginning January 15, 2019, if the Medicare growth rate exceeds the target the Board is required to develop proposals to reduce the growth rate and require the Secretary of HHS to implement those proposals, unless Congress enacts legislation related to the proposals.

The Health Care Reform Act creates a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models and to implement various demonstration programs and pilot projects to test, evaluate, encourage and expand new payment structures and methodologies to reduce health care expenditures while maintaining or improving quality of care, including bundled payments under Medicare and Medicaid, and comparative effectiveness research programs that compare the clinical effectiveness of medical treatments and develop recommendations concerning practice guidelines and coverage determinations. Other provisions encourage the creation of new health care delivery programs, such as accountable care organizations or combinations of provider organizations, which voluntarily meet quality thresholds to share in the cost savings they achieve for the

Medicare program. The outcomes of these projects and programs, including their effect on payments to providers and financial performance, cannot be predicted.

Lawsuits have been filed and additional ones may be filed challenging the constitutionality of the Health Care Reform Act. Two federal district court judges of the United States District Court for the Eastern District of Virginia and the Northern District of Florida, respectively, have ruled that the “individual mandate,” requiring most individuals to maintain a minimum level of health insurance by 2014 or be subject to a penalty, is unconstitutional, with the District Court judge for the Northern District of Florida concluding that the entire Health Care Reform Act must be declared void. On March 3, 2011, the District Court judge for the Northern District of Florida stayed his ruling pending an appeal to the 11th Circuit U.S. Court of Appeals; an appeal was subsequently filed on March 8, 2011. Similar challenges filed in other District Courts have been dismissed but are on appeal and arguments in a number of other cases remain pending. In addition, on January 19, 2011, the United States House of Representatives approved a bill to overturn the Health Care Reform Act. However, on February 6, 2011, the U. S. Senate rejected a bill to repeal the Health Care Reform Act. The ultimate outcome of these lawsuits, and any additional legislative challenges, and their effect on the Health Care Reform Act is unknown.

Management of the Corporation is analyzing the Health Care Reform Act and will continue to do so in order to assess the effects of the legislation and evolving regulations on current and projected operations, financial performance and financial condition. However, management cannot predict with any reasonable degree of certainty or reliability any interim or ultimate effects of the legislation.

Nonprofit Healthcare Environment

The Obligated Group Members other than Wellmont, Inc. are nonprofit corporations, exempt from federal income taxation as organizations described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the “Code”). As nonprofit tax-exempt organizations, the Obligated Group Members other than Wellmont, Inc. are subject to federal, state and local laws, regulations, rulings and court decisions relating to their organization and operation, including their operation for religious and charitable purposes. At the same time, the Obligated Group Members conduct large-scale complex business transactions and are often the major employers in their geographic areas. There can often be a tension between the rules designed to regulate a wide range of charitable organizations and the day-to-day operations of a complex, multi-state healthcare organization.

Over the past several years, an increasing number of the operations or practices of healthcare providers have been challenged or questioned to determine if they are consistent with the regulatory requirements for nonprofit tax-exempt organizations. These challenges are broader than concerns about compliance with federal and state statutes and regulations, such as Medicare and Medicaid compliance, and instead in many cases are examinations of core business practices of the healthcare organizations. Areas which have come under examination have included pricing practices, billing and collection practices, charitable care, executive compensation, exemption of property from real property taxation, and others. These challenges and questions have come from a variety of sources, including state attorneys general, the Internal Revenue Service (the “IRS”), labor unions, Congress, state legislatures, and patients, and in a variety of forums, including hearings, audits and litigation. These challenges or examinations include the following, among others:

Congressional Hearings. In recent years, three congressional committees have conducted hearings and other proceedings inquiring into various practices of nonprofit hospitals and healthcare providers. The Health Care Reform Act, discussed above, contains many features from previous tax exemption reform proposals. It does not mandate specific levels of charity care for nonprofit hospitals, but it does include a set of sweeping changes applicable to charitable hospitals exempt under Section 501(c)(3) of the Code. The Health Care Reform Act (a) imposes new eligibility requirements for 501(c)(3) hospitals, coupled with an excise tax for failures to meet certain of those requirements; (b) requires mandatory IRS review of the hospital’s entitlement to exemption; (c) sets forth new reporting requirements, including information related to community health needs assessments and audited financial statements; and (d) imposes further reporting requirements on the Secretary of the Treasury regarding charity care levels.

Internal Revenue Service Examination of Compensation Practices. In August 2004, the IRS announced a new enforcement effort to identify and halt abuses by tax-exempt organizations that pay excessive compensation and

benefits to their officers and other insiders. The IRS announced that it would contact nearly 2,000 charities and foundations to seek more information about their compensation practices and procedures. In February 2009, the IRS issued its Hospital Compliance Project Final Report (the “IRS Final Report”) based on its examination of such tax-exempt organizations. The IRS Final Report indicates that the IRS (i) will continue to heavily scrutinize executive compensation arrangements, practices and procedures and (ii) in certain circumstances, may conduct further investigations or impose fines on tax-exempt organizations.

Litigation Relating to Billing and Collection Practices. Lawsuits have been filed alleging, among other things, that hospitals have failed to fulfill their obligations to provide charity care to uninsured patients and have overcharged uninsured patients. Many of these cases have since been dismissed by the courts but a number of cases are still pending in various courts around the country with inconsistent results. While it is not possible to make general predictions, some hospitals and health systems have entered into substantial settlements. Currently, no Obligated Group Members have been named as defendants in any action alleging failure to fulfill obligations to provide charity care to uninsured patients or overcharging uninsured patients.

Challenges to Real Property Tax Exemptions. Recently, the real property tax exemptions afforded to certain nonprofit healthcare providers by state and local taxing authorities have been challenged on the grounds that the healthcare providers were not engaged in charitable activities. These challenges have been based on a variety of grounds, including allegations of aggressive billing and collection practices and excessive financial margins. Several of these disputes have been determined in favor of the taxing authorities or have resulted in settlements. While the Corporation is not aware of any current challenge to the tax exemption afforded to any material real property of the Obligated Group Members, there can be no assurance that these types of challenges will not occur in the future.

The foregoing are some examples of the challenges and examinations facing nonprofit healthcare organizations. They are indicative of a greater scrutiny of the billing, collection and other business practices of these organizations, and may indicate an increasingly more difficult operating environment for healthcare organizations, including the Obligated Group. The challenges and examinations, and any resulting legislation, regulations, judgments, or penalties, could have a material adverse effect on the Obligated Group.

Charity Care

Hospitals are permitted to obtain tax-exempt status under the Code because the provision of health care historically has been treated as a “charitable” enterprise. This treatment arose before most Americans had health insurance, when charitable donations were required to fund the health care provided to the sick and disabled. Some commentators and others have taken the position that, with the onset of employer health insurance and governmental reimbursement programs, there is no longer any justification for special tax treatment for the health care industry, and the availability of tax-exempt status should be eliminated. Federal and state tax authorities are also beginning to demand that tax-exempt hospitals justify their tax-exempt status by documenting their charitable care and other community benefits.

As described above under the caption, “Health Care Reform,” the Health Care Reform Act imposes additional requirements for tax-exemption upon tax-exempt hospitals, including obligations to adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the amounts generally billed to insured patients; and control the billing and collection processes. Additionally, effective for tax years commencing after March 23, 2012, tax-exempt hospitals must conduct a community needs assessment and adopt an implementation strategy to meet those identified needs.

Failure to complete a community health needs assessment in any applicable three-year period can result in a penalty on the organization of up to \$50,000, in addition to possible revocation of status as a section 501(c)(3) organization.

The Health Care Reform Act also imposes new reporting and disclosure requirements on hospital organizations. The IRS is required to review information about a hospital’s community benefit activities at least once every three years. The Health Care Reform Act requires the Secretary of the Treasury, in consultation with the Secretary of HHS, to submit annually a report to Congress with information regarding the levels of charity care, bad debt expenses, unreimbursed costs of government programs, as well as costs incurred by tax-exempt hospitals for

community benefit activities. The Secretary of the Treasury, in consultation with the Secretary of HHS, must conduct a study of the trends in these amounts, and subject a report on such study to Congress not later than five years after the date of enactment of the Health Care Reform Act. These statutorily mandated requirements for periodic review and submission of reports relating to community benefit provided by section 501(c)(3) hospital organizations may increase the likelihood that Congress will consider additional requirements for section 501(c)(3) hospital organizations in the future and may increase IRS scrutiny of particular 501(c)(3) hospital organizations.

Parity Debt and Additional Indebtedness

The Bonds are secured under the Master Indenture on a parity with (a) approximately \$360,581,415 aggregate outstanding principal amount of other long-term Indebtedness and (b) any Additional Indebtedness (as defined in APPENDIX C) issued, from time to time, under and pursuant to the Master Indenture. Additional debt, whether or not secured by the Master Indenture, will increase debt service requirements and could adversely affect debt service coverage on the Bonds and the availability of the Obligated Group to meet its obligations under the Series 2011 Obligation.

Limitations on Enforcement

The enforcement of the Indenture, the security interest in the funds held by the Trustee granted therein, and the rights of the Trustee in funds held under the Indenture may be limited by a number of factors, including: (a) provisions prohibiting the direct payment of amounts due to healthcare providers from Medicaid and Medicare programs to persons other than such providers; (b) certain judicial decisions which cast doubt upon the right of the Trustee, in the event of the bankruptcy of the Corporation or the Obligated Group, to collect and retain accounts receivable from Medicare, TennCare, Medicaid, and other governmental programs; (c) state and federal laws giving super priority to certain kinds of statutory liens, such as tax liens; (d) rights arising in favor of the United States of America or any agency thereof; (e) constructive trusts, equitable or other rights impressed or conferred by a federal or state court in the exercise of its equitable jurisdiction; (f) Bankruptcy Laws which may affect the right of the Trustee to collect and retain accounts receivable from Medicare, TennCare, Medicaid and other governmental programs; (g) state laws affecting the continuation of perfected and first priority security interests granted by the Corporation, the Obligated Group or the Issuer, including the Deed of Trust; and (h) claims that might arise if appropriate financing or continuation statements are not filed in accordance with the Uniform Commercial Code as from time to time in effect in Tennessee and Virginia.

The ability of the Trustee to enforce the terms and agreements set forth in the Loan Agreement and in the Series 2011 Obligation may be limited by laws relating to bankruptcy, insolvency, reorganization or moratorium and by other similar laws affecting creditors' rights. In addition, the Trustee's ability to enforce such terms will depend upon the exercise of various remedies specified by such document which may in many instances require judicial actions that are often subject to discretion and delay or that otherwise may not be readily available or be limited.

The remedies available to the Trustee or to the Owners of the Bonds upon an event of default under the Indenture are in many respects dependent upon judicial actions which are often subject to discretion and delay. Under existing constitutional and statutory law and judicial decisions, including specifically the Bankruptcy Law, the remedies provided in the Indenture and under the Bonds may not be readily available or may be limited.

The Corporation and the Obligated Group

General. The ability of the Corporation to make the payments under the Loan Agreement, the Obligated Group to make payments on the Series 2011 Obligation sufficient to provide debt service on the Bonds and the Obligated Group to make other payments provided for under the Master Indenture depends solely upon the receipt by the Corporation and the Obligated Group of sufficient revenues from their operations in excess of their expenses of operation. A number of risks which could prevent the Corporation and the Obligated Group from receiving such amounts are outlined below. No representation or assurance can be given that revenues will be realized by the Corporation in amounts sufficient to pay principal of, premium, if any, and interest on the Bonds or the Obligated Group in amounts sufficient to pay the Series 2011 Obligation and the other amounts owed under the Master Indenture. Future economic and other conditions, including demand for healthcare services, the ability of the Corporation and the Obligated Group to provide the services required by patients, physicians' confidence in the

Corporation and the Obligated Group, return on investments made by the Corporation, including investments in other enterprises, economic developments in the service area and competition from other healthcare institutions in the service area, together with changes in rates, costs, third party reimbursement and governmental regulation, may adversely affect revenues and expenses and, consequently, the Corporation's and the Obligated Group's ability to make such payments. The future financial condition of the Corporation and the Obligated Group could also be adversely affected by, among other things, legislation, regulatory actions, increased competition from other healthcare providers, demand for healthcare services, demographic changes, changes in the local economy, the increasing cost of malpractice insurance, malpractice claims and other litigation and a number of other conditions which are unpredictable.

While an identification of all additional risk factors possibly affecting operations of the Corporation and the Obligated Group in the future cannot be accomplished, a discussion of certain risk factors follows. This discussion of risk factors is not, and is not intended to be, exhaustive. Some of the changes that are possible in the future include the following:

(a) Legislation or regulations, including federal healthcare reform legislation, which could increase the operating costs of the Corporation and the Obligated Group or further limits the payment of operating costs and the payment or reimbursement of capital costs, would adversely affect the operating costs of the Corporation and the Obligated Group.

(b) Reductions in the funding levels and reimbursement levels of the Medicare, TennCare or Medicaid programs and other legislative and regulatory changes which further reduce Medicare, TennCare or Medicaid reimbursement to hospitals. See "Patent Service Revenues - Medicare and Medicaid Programs" herein.

(c) Future contract negotiations between the Corporation and the Obligated Group, and public and private insurers, health maintenance organizations and preferred provider organizations and efforts of other entities and employers to limit hospitalization costs which could adversely affect the utilization and the level of reimbursement to the Corporation and the Obligated Group.

(d) Increased unemployment or other adverse economic conditions increased cost and decreased availability of health insurance which could increase the proportion of patients who are uninsured or who are otherwise unable to pay fully for the cost of their care, and increased numbers of patients suffering from uninsured illnesses.

(e) There have been and may be in the future a number of state and federal legislative proposals and enactments which have as one of their principal purposes the stimulation of competition in the healthcare industry. Competition from healthcare providers located in the service area of the Corporation and the Obligated Group, from other types of healthcare providers that may offer comparable healthcare services and from alternative or substitute healthcare delivery systems or programs, may decrease utilization of the Corporation's and the Obligated Group's healthcare facilities. In addition, the development of future medical and other scientific advances may result in decreased usage of inpatient hospital facilities. Efforts by insurers, employer-purchasers of healthcare insurance and governmental agencies to reduce utilization of hospital facilities by such means as preventive medicine, improved occupational health and safety standards, the possibility of future unionization and more extensive utilization of outpatient care at facilities not related to the healthcare facilities of the Corporation and the Obligated Group could adversely affect the operations of the Corporation and the Obligated Group. Also, the growth and development of health maintenance organizations, preferred provider organizations and other managed care programs may result in decreased usage of inpatient Corporation and Obligated Group facilities.

(f) In recent years, numerous hospitals have closed their doors, annual admissions to hospitals have dropped and annual patient days have been reduced. In addition to competition from other facilities, a number of other factors have been reducing hospitalization nationwide and in Tennessee. Physicians' practice patterns indicate a trend to fewer inpatient admissions and shorter length of stay for those who are admitted. Third-party payors such as Medicare, Medicaid and Blue Cross have exerted

efforts to contain their costs by reviewing and questioning the need for certain inpatient admissions and the length of hospital stays. Insurers and managed care organizations are attempting to use various cost control methods to attempt to provide employers with adequate but low cost insurance programs for their employees. To minimize the cost of such health insurance programs, insurers and managed care organizations are offering products which include such elements as higher deductibles, pre-admission review, concurrent hospital review, retrospective review and other provisions, which tend to reduce hospital admissions and stays and, accordingly, healthcare revenues. It is impossible to predict at this time the extent to which such trends and actions will affect the Corporation and the Obligated Group and its operations.

(g) Operation of certain healthcare facilities of the Corporation and the Obligated Group necessitates the production of waste products, including certain radioactive wastes, infectious wastes and hazardous wastes as defined in federal and state laws. As the generator of these wastes, the Corporation and the Obligated Group are responsible for compliance with applicable federal, state and local laws and regulations, including the proper handling, labeling, storage, transport and disposal of the wastes, and may incur liability without regard to fault or remedial actions and for personal injury and property damage related to a release or threatened release of these wastes. Such liability could be substantial and may adversely affect the Corporation's and the Obligated Group's financial condition.

(h) Availability of nurses and other qualified healthcare technicians and personnel is an important factor to the Corporation and the Obligated Group. Healthcare facilities nationwide are experiencing a shortage in the number of nurses available and qualified to perform nursing services. The nursing shortage has forced many hospitals to increase nursing salaries and has caused some to cut back operations. Efforts to organize nurses and other nursing and technical personnel into collective bargaining units have resulted at times in adverse labor actions and conditions. The occurrence of any of these events could adversely impact future operations of the Corporation and the Obligated Group.

(i) Unforeseen labor actions could result in a substantial decrease in revenues of the Corporation and the Obligated Group without corresponding decreases in costs.

(j) The occurrence of natural disasters, including hurricanes, floods and earthquakes, may damage the Corporation and the Obligated Group, interrupt utility service thereto, or otherwise impair Corporation and Obligated Group operations and the generation of revenues therefrom. Although the Corporation and the Obligated Group are covered by general property insurance in an amount which management considers to be sufficient to provide for the replacement of such facilities in the event of such a natural disaster, there is no assurance that such insurance would in fact be adequate to do so.

(k) Availability of revenues in the event of bankruptcy of the Corporation, the Obligated Group or related entities. Certain judicial decisions have cast doubt upon the right of a bond trustee, in the event of a hospital's bankruptcy, to collect and retain for the benefit of Bondholders portions of revenues consisting of Medicare, TennCare, Medicaid and other governmental receivables.

(l) Potential depletion of the Medicare Trust Fund, as projected by various studies.

(m) The cost and availability of medical malpractice insurance for medical personnel working or practicing in the hospitals.

(n) Other risk factors may also affect the operation of the Corporation and the Obligated Group, including without limitation the following: (1) the cost and availability of energy; (2) the cost and availability of insurance, such as fire, general comprehensive liability and excess liability, that healthcare facilities of a similar size and type generally carry; (3) uninsured acts of God; (4) imposition of wage and price controls for the healthcare industry; (5) decrease in population in the Corporation's and the Obligated Group's service areas; (6) reduced need for services arising from future medical and scientific advances; (7) preventive medicine; (8) improved occupational health and safety and improved outpatient care which could result in decreased usage of Corporation and Obligated Group facilities; (9) the impact of a pandemic or other need for surge capacity at Corporation and Obligated Group facilities and (10) an increase in the

rate of inflation and difficulties in increasing service charges and other fees, while at the same time maintaining the quantity and quality of healthcare services, may affect the ability of the Corporation and the Obligated Group to maintain sufficient operating margins.

Financial Information. Certain financial and operating information in connection with the Obligated Group (which includes the Corporation) is set forth in APPENDICES A and B. There can be no assurance that the financial results achieved by the Obligated Group in the future will be similar to historical results set forth in APPENDICES A and B. Such future results will vary from historical results, and actual variations may be material. Therefore, the historical operating results of the Obligated Group cannot be taken as a representation that the Corporation will be able to generate sufficient revenues in the future to make payment of principal of, premium, if any, and interest on the Bonds, that the Corporation will be able to generate sufficient revenues in the future to make payments on the Series 2011 Obligation and that the Obligated Group will be able to generate sufficient revenues in the future to make payment on the other indebtedness owed under the Master Indenture.

Risks Related to Corporation and Obligated Group Operations. Through various changes in governmental policy, advances in technology and treatment, increased costs of operations, increased charges, changes in payment methodology, utilization review and greater competition, inpatient hospitalizations have generally decreased in recent years. It is uncertain whether that decrease will continue, and to what extent the factors mentioned above will continue to create operational and economic uncertainty for hospitals. It is now generally acknowledged that hospital operations pose greater complexity and higher risk than in years past and this trend is expected to continue. It is not practical to enumerate each and every operating risk which may result from hospital operations, and certain risks or combinations of risks which are now unanticipated may have material adverse results in the future. Certain risks relating to hospital operations are enumerated below.

Equipment. Technological advances in recent years have accelerated the trend toward the use of sophisticated diagnostic and treatment equipment in hospitals. The availability of certain equipment may be a significant factor in hospital utilization, but in the near future purchase of such equipment may be subject to health planning agency approval on the federal or state level and the ability of the Corporation and the Obligated Group to finance such purchases. The cost of acquiring and maintaining such equipment may affect the ability of Corporation and Obligated Group to maintain sufficient operating margins. There is also the risk of material adverse impact from problems in implementing technology, in particular health care information systems.

Competition. The Corporation's and the Obligated Group's costs and revenues could be substantially affected by future changes in the number and mix of both patients and services brought about by increased competition among healthcare providers and insurers. This competition could take several different forms, including:

- (a) Competition among hospitals to sell their services more cheaply to third-party payors;
- (b) Competition from existing hospitals in the Corporation's and the Obligated Group's service area and from tertiary facilities in surrounding urban centers to offer new services or expand existing services or to reduce charges;
- (c) Competition from nursing homes, home health agencies, ambulatory care facilities, surgical centers, rehabilitation and therapy centers, increasingly sophisticated physician group practices, and other non-hospital providers for many services for which patients currently rely on hospitals;
- (d) Competition for patients from freestanding specialty hospitals which tend to provide only medical procedures with a high financial return, such as orthopedics, thus siphoning off potential revenue from full-service acute care hospitals;
- (e) Competition for patients between physicians, who generally use hospitals, and non-physician practitioners such as nurse-midwives, nurse practitioners, chiropractors, physical and occupational therapists and others, who may not generally use hospitals;

(f) Competition for enrollees between traditional indemnity insurers, whose members generally have a free choice of hospitals and other providers, and health maintenance organizations or other prepaid plans, who either own their own hospitals or contract with hospitals and other providers and thus substantially restrict the providers from whom their members can receive healthcare services; and

(g) Competition from proprietary providers of healthcare, which proprietary providers may have access to equity capital markets to obtain funds with which to compete under financing instruments which generally do not restrict the operational flexibility of such providers to the degree that the tax-exempt capital market restricts the operations of the Corporation and the Obligated Group.

Medical Staff. A significant portion of the Corporation's and the Obligated Group's revenue is derived from charges to patients, or reimbursement from third-party intermediaries on behalf of patients, for treatment delivered to patients admitted to the Corporation's and the Obligated Group's healthcare facilities by members of its medical staff. There is no assurance that the medical staff will continue to do so, or, if they continue to do so, to do so in the same manner and numbers as before. Each physician on the medical staff has the option of admitting a particular patient, with the patient's consent, to one or another acute care hospital with which the physician is or may become affiliated.

Environmental Laws and Regulations. Healthcare providers are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations which address, among other things, provider operations or facilities and properties owned or operated by providers. The types of regulatory requirements faced by healthcare providers include, but are not limited to, air and water quality control requirements, waste management requirements, specific regulatory requirements applicable to asbestos, polychlorinated biphenyls, radioactive substances and other hazardous substances, requirements for providing notice to employees and members of the public about hazardous materials handled by or located at the Corporation's and the Obligated Group's facilities and requirements for training employees in the proper handling and management of hazardous materials and wastes.

In their role as owners and/or operators of properties or facilities, healthcare providers may be subject to liability for investigating and remediating any hazardous substances which have come to be located on the property, including any such substances that may have migrated off the property. Typical healthcare provider operations include, but are not limited to, in various combinations, the handling, use, storage, transportation, incineration, disposal and/or discharge of hazardous, infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants or contaminants. As such, healthcare provider operations are particularly susceptible to the practical, financial and legal risks associated with compliance with such laws and regulations. Such risks may result in damage to individuals, property or the environment, may interrupt operations and/or increase their cost, result in legal liability, damages, injunctions or fines, and result in investigations, administrative proceedings, penalties or other governmental agency actions.

At the present time, management of the Corporation and the Obligated Group is not aware of any pending or threatened claim, investigation or enforcement action regarding environmental issues which, if determined adversely to the Corporation and the Obligated Group, would have material adverse consequences to the operations or financial condition of the Corporation and the Obligated Group. There can be no assurance given, however, that the Corporation and the Obligated Group will not encounter environmental risks in the future, and such risks may result in material adverse consequences to the operations or financial condition of the Corporation and the Obligated Group.

Malpractice Insurance. The Corporation has malpractice and other insurance providing coverage in amounts that it has determined to be adequate to protect its property and operations. Malpractice and other claims, however, could adversely affect the financial position of the Corporation and the Obligated Group, as could substantial increases in the cost of malpractice insurance. There are currently no claims against the Hospital that exceed its insurance coverage limits.

Certain Bankruptcy Risks

In the event of bankruptcy of an Obligated Group Member, the rights and remedies of the Holders of the Bonds are subject to various provisions of the United States Bankruptcy Code. If an Obligated Group Member were to commence a proceeding in bankruptcy, payments made by that Obligated Group Member during the 90-day (or, in some circumstances, one-year) period immediately preceding the commencement may be avoided as preferential transfers to the extent payments allow the recipients thereof to receive more than they would have received in the event of the Obligated Group Member's liquidation and the other requirements set forth in Section 547(b) of the United States Bankruptcy Code have been met. Security interests and other liens granted to or perfected by a Trustee or the Master Trustee during the preference period may also be avoided as preferential transfers to the extent the security interest or other lien secures obligations that arose prior to the date of the grant or perfection. Such a bankruptcy filing would result in the imposition of an automatic stay of the commencement or continuation of any judicial or other proceeding against the Obligated Group Member and its property, and as an automatic stay of any act or proceeding to enforce a lien upon or to otherwise exercise control over its property as well as various other actions to enforce, maintain or enhance the rights of a Trustee and the Subordinate Master Trustee. If the bankruptcy court so ordered, the property of the Obligated Group Member could be used for the reorganization of the Obligated Group Member despite any security interest of the Trustee therein. The rights of the Trustee and the Master Trustee to enforce their respective interests and other liens could be delayed or altered during the pendency of the reorganization.

Such Obligated Group Member could file a plan for the adjustment of its debts in any bankruptcy proceeding which could include provisions modifying or altering the rights of creditors generally, or any class of them, secured or unsecured. The plan, when confirmed by a court, would bind all creditors who had notice or knowledge of the plan and, with certain exceptions, discharges all claims against the debtor to the extent provided for in the plan. No plan may be confirmed unless certain conditions are met, among which are conditions that the plan be feasible and that it shall either have been accepted by each class of claims impaired thereunder or, if the plan is not so accepted, the court shall have determined that the plan is fair and equitable with respect to each class of nonaccepting creditors impaired thereunder and does not discriminate unfairly. A class of claims has accepted the plan if at least two-thirds in dollar amount and more than one-half in number of the class cast votes in its favor.

In addition, the bankruptcy of a health plan or physician group that is a party to a significant managed care arrangement with one or more of the Obligated Group Members could have material adverse effects on the Obligated Group Members.

In the event of bankruptcy or insolvency of an Obligated Group Member, there is no assurance that certain covenants, including tax covenants, contained in the Indenture, the Loan Agreement or the Master Indenture and certain other documents would survive. Accordingly, a debtor or bankruptcy trustee could take action that would adversely affect the exclusion of interest on the Bonds from gross income of the Bondholders for federal income tax purposes.

Patient Service Revenues

Net patient revenues realized by the Obligated Group are derived from a variety of sources and will vary among the individual facilities owned and operated by the Obligated Group Members and also among the various market areas and regions in which the facilities are located. Certain facilities and regions may realize substantially more revenues from private payment programs, such as managed care organizations, than do others.

A substantial portion of the net patient service revenues of the Obligated Group is derived from third-party payors which pay for the services provided to patients covered by third parties for services. These third-party payors include the federal Medicare program, state Medicaid programs (including TennCare) and private health plans and insurers, including health maintenance organizations and preferred provider organizations. Many of those programs make payments to Members of the Obligated Group in amounts that may not reflect the direct and indirect costs of the Members of providing services to patients.

The financial performance of the Obligated Group has been and could be in the future adversely affected by the financial position or the insolvency or bankruptcy of or other delay in receipt of payments from third-party payors that provide coverage for services to their patients.

Medicare, Medicaid and TennCare Programs

Medicare and Medicaid are the commonly used names for reimbursement or payment programs governed by certain provisions of the federal Social Security Act. Medicare is an exclusively federal program, and Medicaid is a combined federal and state program. Medicare provides certain health care benefits to beneficiaries who are 65 years of age or older, blind, disabled or qualify for the End Stage Renal Disease Program. Medicare Part A covers inpatient hospital services, skilled nursing care and some home health care, and Medicare Part B covers physician services and some supplies. Medicaid is designed to pay providers for care given to the medically indigent and others who receive federal aid. Medicaid is funded by federal and state appropriations and administered by the various states. As further discussed under the caption "Medicaid - Tennessee Medicaid Alternative" below, Tennessee implemented a program named TennCare as a Medicaid alternative in 1994. TennCare is a demonstration program under a Section 1115 waiver granted by the Centers for Medicare and Medicaid Services, ("CMS"). For the six months ended December 31, 2010, approximately 31% of the net patient service revenue of the Obligated Group was derived from the Medicare program and approximately 10% of the Obligated Group's net patient service revenue was derived from the combined Medicaid and TennCare programs.

Medicare

Medicare is a federal governmental health insurance system under which physicians, hospitals and other health care providers are reimbursed or paid directly for services provided to eligible elderly and disabled persons and persons with end-stage renal disease. Medicare is administered by CMS. In order to achieve and maintain Medicare certification, a health care provider must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the state in which the provider is located and/or The Joint Commission ("The Joint Commission") or the Healthcare Facilities Accreditation Program. The federal government frequently revises the laws, regulations and policies governing Medicare eligibility, coverage, payment and participation under the Medicare program. At this time, it is not known whether future changes to such laws, regulations or policies will have a material adverse financial effect on the Obligated Group.

The Obligated Group depends significantly on Medicare as a source of revenue. Because of this dependence, changes in the Medicare program may have a material effect on the Obligated Group. Future reductions in Medicare reimbursement, or increases in Medicare reimbursement in amounts less than increases in the costs of providing care, may have a material adverse financial effect on the Obligated Group.

A substantial portion of the Medicare revenues of the Obligated Group is derived from payments made for services rendered to Medicare beneficiaries under a prospective payment system, or PPS. Under a prospective payment system, the amount paid to the provider for an episode of care is established by federal regulation and is not related to the provider's charges or costs of providing that care. Presently, inpatient and outpatient services, skilled nursing care, and home health care are paid on the basis of a prospective payment system. Under inpatient PPS, fixed payment amounts per inpatient discharge are established based on the patient's assigned diagnosis related group, or DRG. DRGs classify treatments for illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis. All services paid under the PPS for hospital outpatient services are classified into groups called ambulatory payment classifications, or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. The capital component of care is paid on a fully prospective basis.

PPS-exempt hospitals and units (inpatient psychiatric, rehabilitation and long-term hospital services) are currently reimbursed for their reasonable costs, subject to a cost per discharge target. These limits are updated annually by an index generally based upon inflationary increases in costs of providing health care services.

From time to time, the factors used in calculating the prospective payments for units of service are modified by CMS, which may reduce revenues for particular services. Additionally, as part of the federal budgetary process, Congress has regularly amended the Medicare law to reduce increases in payments that are otherwise

scheduled to occur, or to provide for reductions in payments for particular services. These actions could adversely affect the revenues of the Obligated Group.

In the Prospective Payment Final Rule for 2008 and in the Prospective Payment Final Rule for 2009 (together, the “IPPS Rules”), CMS included provisions preventing hospitals from assigning patient cases to DRGs with higher payments where a secondary diagnosis warranting higher payment is one of several specified health conditions and was acquired in the hospital. Specifically, the IPPS Rules identify certain conditions, including certain infections and serious preventable errors (“never events”), for which CMS will not reimburse hospitals unless the conditions were present at the time of admission. CMS has also announced its intent to identify additional conditions for which higher payment will be unavailable. Various HMOs and other private insurers have followed suit in refusing to pay for certain hospital-acquired conditions. There can be no assurance that these future payment limitations will not adversely affect the revenues of the Obligated Group. Never events may be more likely to be publicized and may negatively impact a hospital’s reputation, thereby reducing future utilization and potentially increasing the possibility of liability claims.

Additional payments may be made to individual providers. Hospitals that treat a disproportionately large number of low-income patients (Medicaid and Medicare patients eligible to receive supplemental Social Security income) currently receive additional payments in the form of disproportionate share payments. Additional payments are made to hospitals that treat patients who are costlier to treat than the average patient; these additional payments are referred to as “outlier payments.” Eligible hospitals are paid for a portion of their direct and indirect medical education costs. These additional payments are also subject to reductions and modifications in otherwise scheduled increases as a result of amendments to relevant statutory provisions.

The costs of providing a unit of care may exceed the revenues realized from Medicare for providing that service. Additionally, the aggregate costs to a provider of providing care to Medicare beneficiaries may exceed aggregate Medicare revenues received during the relevant fiscal period.

Medicare Audits. Hospitals participating in Medicare are subject to audits and retroactive audit adjustments with respect to reimbursements claimed under the Medicare program. The Members of the Obligated Group receive payments for various services provided to Medicare patients based upon charges or other reimbursement methodologies that are then reconciled annually based upon the preparation and submission of annual cost reports. Estimates for the annual cost reports are reflected as amounts due to/from third-party payors and represent several years of open cost reports due to time delays in the fiscal intermediaries’ audits and the basic complexity of billing and reimbursement regulations. These estimates are adjusted periodically based upon correspondence received from the fiscal intermediary. Medicare regulations also provide for withholding Medicare payment in certain circumstances if it is determined that an overpayment of Medicare funds has been made. In addition, under certain circumstances, payments may be determined to have been made as a consequence of improper claims subject to the Federal False Claims Act or other federal statutes, subjecting the Members of the Obligated Group to civil or criminal sanctions. Management of the Corporation is not aware of any situation whereby a material Medicare payment is being withheld from the Members of the Obligated Group.

CMS enlists Recovery Audit Contractors (“RACs”) to further assure accurate payments to providers. RACs search for potentially improper Medicare payments from prior years that may not have been detected through CMS’s existing program integrity efforts. RACs are private contractors, paid on a contingency fee basis and use their own software and review processes to determine areas for review. Once a RAC identifies a potentially improper claim as a result of an audit, it applies an assessment to the provider’s Medicare reimbursement in an amount estimated to equal the overpayment from the provider pending resolution of the audit. Such audits may result in reduced reimbursement for past alleged overpayments and may slow future Medicare payments to providers pending resolution of appeals process with RACs. Under the Health Care Reform Act, recovery audits were expanded to include Medicaid by requiring states to contract with RACs to conduct such audits. It is unknown what, if any, future impact such reviews will have on the revenues of the Obligated Group. See the caption, “Health Care Reform,” above for changes to the Medicare program in the Health Care Reform Act.

Medicaid

Tennessee Medicaid Alternative. Effective January 1, 1994, Tennessee implemented a healthcare program as an alternative to traditional Medicaid called TennCare. The principal elements of TennCare that distinguish it from Medicaid include: eligibility standards, the nature and content of the standard benefit package, the organization of health services delivery, the methodology of payment and requirement for global budgeting, and preventive care features.

Medicare waiver programs such as TennCare are time-limited, and TennCare's current waiver is set to expire on June 30, 2013 unless it is renewed.

The current TennCare program consists of two programs: (1) TennCare Medicaid, which is for persons who are Medicaid eligible, and (2) TennCare Standard, which is for persons who are not Medicaid eligible but who have been determined to meet the state's criteria as being either uninsured or uninsurable. Historically, individuals in both programs have received the same services. TennCare Standard enrollees with family incomes at or above poverty are required to pay premiums and copays.

TennCare services are offered through several managed care entities. Each enrollee has a Managed Care Organization (MCO) for his primary care and medical/surgical services, a Behavioral Health Organization (BHO) for his mental health and substance abuse treatment services, and a Pharmacy Benefits Manager (PBM) for his pharmacy services. Children under the age of 21 are eligible for dental services, which are provided by a Dental Benefits Manager (DBM). Enrollees are allowed to choose the MCO they wish from among those available in the areas in which they live.

MCOs have traditionally been compensated based on a per member, per month capitation fee for each enrollee, regardless of how many services the enrollee used. However beginning in July 2002, TennCare began utilizing an Administrative Services Only ("ASO") compensation structure. The ASO structure requires MCOs to submit invoices to TennCare for payment of medical services delivered in order to receive a fixed administrative fee.

Because TennCare includes quality monitoring as well as efficiency monitoring, together with limitations on payments, it is expected to cause downward pressure on the economics of healthcare delivery. In addition, TennCare limits payments for educational services, such as those offered by medical schools. Furthermore, funding for hospitals in urban areas which deliver higher levels of acute care may not be adequate to meet the needs of such hospitals. It cannot be predicted whether the funding sources for TennCare will be adequate to meet the funding needs of the program; therefore, if TennCare utilization increases, the financial performance of the providers will be adversely affected. In fiscal year 2010 the Obligated Group received approximately 6% of its gross patient revenues from the treatment of TennCare inpatients and outpatients.

The management of the Obligated Group estimates that the System is paid approximately 60-70 cents on each dollar spent to care for TennCare and Medicaid patients. Treatment of TennCare and Medicaid patients accounted for 13% of the Obligated Group's gross patient service revenues for the fiscal year ended June 30, 2010.

Payments for services provided by the Corporation and the Obligated Group to TennCare beneficiaries are the sole responsibility of the managed care organizations contracting for such services. No assurance can be given that the managed care organizations will be financially able to pay all amounts owed the Corporation or that such amounts will be timely paid.

State Children's Health Insurance Program

The State Children's Health Insurance Program ("SCHIP") is a federally funded insurance program for families which are financially ineligible for Medicaid, but cannot afford commercial health insurance. The CMS administers SCHIP, but each state creates its own program based upon minimum federal guidelines. SCHIP insurance is provided through private health plans contracting with the state.

Each state must periodically submit its SCHIP plan to CMS for review to determine if it meets the federal requirements. If it does not meet the federal requirements, a state can lose its federal funding for the program.

Private Health Plans and Managed Care

Managed care plans generally use discounts and other economic incentives to reduce or limit the cost and utilization of health care services. Payments to the Obligated Group from managed care plans typically are lower than those received from traditional indemnity/commercial insurers. Defined broadly, for the six months ended December 31, 2010, managed care payments constituted approximately 35% of the net patient service revenues of the Obligated Group. There is no assurance that the members of the Obligated Group will maintain managed care contracts or obtain other similar contracts in the future. Failure to maintain contracts could have the effect of reducing the market share of a member of the Obligated Group and the Obligated Group's net patient services revenues. Conversely, participation may maintain or increase the patient base but could result in lower net income or operating losses to the Obligated Group if the members are unable to adequately contain their costs.

The Corporation's management anticipates that the Health Care Reform Act will substantially alter the commercial health care insurance industry. The Health Care Reform Act imposes, over time, increased regulation of the industry, the use and availability of state-based exchanges in which health insurance can be purchased by certain groups and segments of the population, the extension of subsidies and tax credits for premium payments by some consumers and employers and the imposition upon commercial insurers of certain terms and conditions that must be included in contracts with providers. In addition, the Health Care Reform Act imposes many new obligations on states related to health care insurance. It is unclear how the increased federal oversight of state health care may affect future state oversight or affect the Corporation and the other Members of the Obligated Group. The effects of these changes upon the financial condition of any third-party payor that offer health care insurance, rates paid by third-party payors to providers and thus the revenues of the Obligated Group, and upon the operations, results of operations and financial condition of the Obligated Group cannot be predicted.

Many preferred provider organizations, or PPOs, and health maintenance organizations, or HMOs, currently pay providers on a negotiated fee-for-service basis or on a fixed rate per day of care, which, in each case, usually is discounted from the typical charges for the care provided. The discounts offered to HMOs and PPOs may result in payment to a provider that is less than its actual cost. Additionally, the volume of patients directed to a hospital may vary significantly from projections, and/or changes in the utilization of certain services offered by the provider may be dramatic and unexpected, thus further jeopardizing the provider's ability to contain costs.

Some HMOs employ a "capitation" payment method under which hospitals are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" or otherwise directed to receive care at a particular hospital. In a capitation payment system, the hospital assumes a financial risk for the cost and scope of care given to the HMO's enrollees. In some cases, the capitated payment covers total hospital patient care provided. However, if payment under an HMO or PPO contract is insufficient to meet the hospital's costs of care or if utilization by enrollees materially exceeds projections, the financial condition of the hospital could erode rapidly and significantly.

As a consequence of the above factors, the effect of managed care on the Obligated Group's financial condition is difficult to predict and may be different in the future than the financial statements for the current periods reflect.

Dependence Upon Third-Party Payors

The Obligated Group Members' ability to develop and expand their services and, therefore, profitability, is dependent upon their ability to enter into contracts with third-party payors at competitive rates. There can be no assurance that they will be able to attract third-party payors, and where they do, no assurance can be given that they will be able to contract with such payors on advantageous terms. The inability of the Obligated Group Members to contract with a sufficient number of such payors on advantageous terms could have a material adverse effect on the Obligated Group Members' future operations and financial results.

Alternative or Integrated Delivery System Development

Many hospitals and health systems are pursuing strategies with physicians in order to offer an integrated package of health care services, including physician and hospital services, to patients, health care insurers and managed care providers. The Health Care Reform Act encourages the development of health care delivery models that are designed to enhance quality and reduce cost and that will effectively require greater integration between and collaboration among hospitals and physicians by allowing accountable care organizations (“ACOs”) that meet quality thresholds to share in the savings achieved for the Medicare Program. The Health Care Reform Act requires the Secretary of HHS to implement a shared savings program through ACOs requiring integration between hospitals and physicians, that will deliver health care services to Medicare beneficiaries, and to implementation a demonstration project to develop ACOs for pediatric patients under the Medicaid program.

In addition to ACOs, these integration strategies may take many forms, including management service organizations, or MSOs, which may provide physicians or physician groups with a combination of financial and managed care contracting services, office and equipment, office personnel and management information systems. Integration objectives may also be achieved via physician-hospital organizations, or PHOs, organizations which are typically jointly owned or controlled by a hospital and physician group for the purpose of managed care contracting, implementation and monitoring. Other integration structures include hospital-based clinics or medical practice foundations, which may purchase and operate physician practices as well as provide all administrative services to physicians. Many of these integration strategies are capital intensive and may create certain business and legal liabilities for the related hospital or health system.

Often the start-up capitalization for such developments, as well as operational deficits, are funded by the sponsoring hospital or health system. Depending on the size and organizational characteristics of a particular development, these capital requirements may be substantial. In some cases, the sponsoring hospital or health system may be asked to provide a financial guarantee for the debt of a related entity which is carrying out an integrated delivery strategy. In certain of these structures, the sponsoring hospital or health system may have an ongoing financial commitment to support operating deficits, which may be substantial on an annual or aggregate basis.

These types of integrated delivery developments are generally designed to conform to existing trends in the delivery of medicine, to implement anticipated aspects of health care reform, to increase physician availability to the community and/or enhance the managed care capability of the affiliated hospital and physicians. However, these goals may not be achieved, and, if the development is not functionally successful, it may produce materially adverse results that are counterproductive to some or all of the above-stated goals.

All such integrated delivery developments carry with them the potential for legal or regulatory risks in varying degrees. Such developments may call into question compliance with the Medicare fraud and abuse laws, relevant antitrust laws and federal or state tax exemption. Such risks will turn on the facts specific to the implementation, operation or future modification of any integrated delivery system. MSOs which operate at a deficit over an extended period of time may raise significant risks of investigation or challenge regarding the tax-status of health care providers participating in MSOs or compliance with the Medicare fraud and abuse laws. In addition, depending on the type of development, a wide range of governmental billing and other issues may arise, including questions of the authorization of the entity to bill for or on behalf of the physicians involved. Other related legal and regulatory risks may arise, including employment, pension and benefits, and corporate practice of medicine, particularly in the current atmosphere of frequent and often unpredictable changes in federal and state legal requirements regarding health care and medical practice. The potential impact of any such regulatory or legal risks on the Obligated Group Members cannot be predicted with certainty. There can be no assurance that such issues and risks will not lead to material adverse consequences in the future.

Regulatory Environment

Licensing, Surveys, Investigations and Audits

Health facilities, including those of the Obligated Group, are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements relating to Medicare Conditions of Participation, requirements for participation in Medicaid, state

licensing agencies, private payors and the accreditation standards of The Joint Commission. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections, surveys, audits, investigations or other reviews, some of which may require affirmative actions by a member of the Obligated Group.

The Corporation's management currently anticipates no difficulty renewing or continuing currently held licenses, certifications or accreditations, nor does management anticipate a reduction in third-party payments from events that would materially adversely affect the operations or financial condition of the Obligated Group. Nevertheless, actions in any of these areas could result in the loss of utilization or revenues, or the ability of a member of the Obligated Group to operate all or a portion of its health care facilities, and consequently, could have a material and adverse effect on the Obligated Group.

Certificates of Need

The State of Tennessee also administers a similar health planning program which includes certificate of need ("CON") requirements. The CON program requires that capital expenditures above certain limits or the introduction of new health services by or on behalf of a hospital first be approved by the Tennessee Health Facilities Commission before the expenditures are incurred or the new services are initiated. If a hospital desires to undertake a project involving capital expenditures above the limits or to add new health services, there can be no assurance that the expenditure will be granted CON approval. Amendments to or the repeal of the existing CON program could result in the entry of additional providers of healthcare services in the Corporation's and the Obligated Group's service area, thereby increasing competition and thus possibly reducing the demand for the Corporation's and the Obligated Group's services.

Negative Rankings Based on Clinical Outcomes, Cost, Quality, Patient Satisfaction and Other Performance Measures

Health plans, Medicare, Medicaid, TennCare, employers, trade groups and other purchasers of health services, private standard-setting organizations and accrediting agencies increasingly are using statistical and other measures in efforts to characterize, publicize, compare, rank and change the quality, safety and cost of health care services provided by hospitals and physicians. Published rankings such as "score cards," "pay for performance" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals and the members of their medical staffs and to influence the behavior of consumers and providers such as the Obligated Group Members. Currently prevalent are measures of quality based on clinical outcomes of patient care, reduction in costs, patient satisfaction and investment in health information technology. Measures of performance set by others that characterize a hospital negatively may adversely affect its reputation and financial condition.

Civil and Criminal Fraud and Abuse Laws and Enforcement

Federal and state health care fraud and abuse laws regulate both the provision of services to government program beneficiaries and the methods and requirements for submitting claims for services rendered to beneficiaries. Under these laws, individuals and organizations can be penalized for submitting claims for services that are not provided, billed in a manner other than as actually provided, not medically necessary, provided by an improper person, accompanied by an illegal inducement to utilize or refrain from utilizing a service or product, or billed in a manner that does not otherwise comply with applicable government requirements.

Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate healthcare fraud and abuse, including exclusion of the provider from participation in the Medicare/TennCare/Medicaid programs, fines, civil monetary penalties, and suspension of payments and, in the case of individuals, imprisonment. Fraud and abuse may be prosecuted by one or more government entities and/or private individuals, and more than one of the available penalties may be imposed for each violation.

Laws governing fraud and abuse apply to all individuals and healthcare enterprises with which a hospital does business, including other hospitals, home health agencies, long term care entities, infusion providers, pharmaceutical providers, insurers, health maintenance organizations, preferred provider organizations, third party administrators, physicians, physician groups, and physician practice management companies. Fraud and abuse

prosecutions can have a catastrophic effect on a provider and potentially a material adverse impact on the financial condition of other entities in the healthcare delivery system of which that entity is a part.

Based upon the prohibited activity in which the provider has engaged, governmental agencies and officials may bring actions against providers under civil or criminal False Claims Acts, statutes prohibiting referrals for compensation (including the federal “Anti-Kickback Law”) or fee-splitting, or the “Stark law,” which prohibits certain referrals by a physician to certain organizations in which the physician has a financial relationship, unless an exception applies. Many States also have self-referral prohibitions. The civil and criminal monetary assessments and penalties arising out of such investigations and prosecutions may be substantial. Additionally, the provider may be denied participation in the Medicare, TennCare and/or Medicaid programs. If and to the extent any member of the Obligated Group engaged in a prohibited activity and judicial or administrative proceedings concluded adversely to the member, the outcome could materially affect the Obligated Group.

On August 20, 2010, the Corporation filed a Report of Internal Investigation and Self-Assessment (the “Self Report”) with the United States Attorney’s Office in Southwest Virginia. This report was based upon the Corporation’s discovery of certain issues involving office space at a Wellmont-owned medical office building at the Corporation’s Lonesome Pine Hospital in Big Stone Gap, Virginia. The Corporation made certain office space in the medical office building available to certain members of the Lonesome Pine medical staff. Due to changes in personnel and miscommunications within the Corporation’s internal office and administrative functions at Lonesome Pine Hospital, the billing procedures for such lease arrangements lapsed and certain physician groups were not billed for the applicable rent. The Corporation’s investigation concluded that these circumstances were not intentional and were the result of oversights and lapses in internal communication.

Under applicable procedure, the United States Attorney’s Office in Southwest Virginia advised the Office of Inspector General (the “OIG”) of the Corporation’s Self-Report. On October 21, 2010, the Corporation was advised that the OIG had accepted the Corporation’s Self-Report into the OIG’s Self-Report protocol. Subsequently, the Corporation and the OIG negotiated a complete resolution of the Self-Report. The resolution calls for the Corporation to make a settlement payment of approximately \$250,000. The Corporation is awaiting the OIG’s preparation of the necessary settlement documents for the Corporation’s review and signature, at which time the required settlement payment will be made.

Tennessee has several anti-kickback and fee-splitting provisions, some of which apply on an all-payor basis (i.e., not just to governmental payors). Like the federal Anti-Kickback Statute, the Tennessee anti-kickback and fee-splitting provisions generally prohibit inducements or improper remuneration for the referral of patients. These Tennessee laws are broadly worded and generally have not been the subject of interpretation by Tennessee courts or by the Tennessee Attorney General. Therefore, it is difficult to predict the possibility or outcome of adverse enforcement action under these Tennessee laws.

Tennessee also has an all-payor physician self-referral law that prohibits physicians from referring patients to a healthcare entity in which the physician has an investment interest, unless an exception is met. Because the Tennessee physician self-referral law has been subject to limited judicial interpretation, it is difficult to predict the possibility or outcome of adverse enforcement action under this law.

The Health Care Reform Act authorizes the Secretary of HHS to exclude a provider’s participation in Medicare, Medicaid and SCHIP as well as suspend payments to a provider pending an investigation of a credible allegation of fraud against the provider.

The Obligated Group Members have internal policies and procedures and have developed and implemented a compliance program that management believes will effectively reduce exposure for violations of these laws. However, because the government’s enforcement efforts presently are widespread within the industry and may vary from region to region, there can be no assurance that the compliance program will significantly reduce or eliminate the exposure of the Obligated Group to civil or criminal sanctions or adverse administrative determinations.

False Claims Act

The False Claims Act, or FCA makes it illegal to submit or present a false, fictitious or fraudulent claim to the federal government and may include claims that are simply erroneous. FCA investigations and cases have become common in the health care field and may cover a range of activity from intentionally inflated billings, to highly technical billing infractions, to allegations of inadequate care. Violation or alleged violation of the FCA most often results in settlements that require multi-million dollar payments and compliance agreements. The FCA also permits individuals to initiate civil actions on behalf of the government in lawsuits called “qui tam” actions. Qui tam plaintiffs, or “whistleblowers,” share in the damages recovered by the government or recovered independently if the government does not participate. The FCA has become one of the government’s primary weapons against health care fraud. FCA violations or alleged violations could lead to settlements, fines, exclusion or reputation damage that could have a material adverse impact on a hospital. A number of States, including Tennessee, have false claims laws in place that are comparable to the FCA.

Review of Outlier Payments

CMS is reviewing health care providers that are receiving large proportions of their Medicare revenues from outlier payments. Health care providers found to have obtained inappropriately high outlier payments will be subject to further investigation by the CMS Program Integrity Unit and potentially the Office of Inspector General. Management of the Corporation does not believe that any potential review of the Obligated Group Members would materially adversely affect the Obligated Group’s results of operations.

Patient Records and Patient Confidentiality

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) addresses the confidentiality of individuals’ health information. Disclosure of certain broadly defined protected health information is prohibited unless expressly permitted under the provisions of the HIPAA statute and regulations or authorized by the patient. HIPAA’s confidentiality provisions extend not only to patient medical records, but also to a wide variety of health care clinical and financial settings where patient privacy restrictions often impose new communication, operational, accounting and billing restrictions. These add costs and create potentially unanticipated sources of legal liability.

HIPAA imposes civil monetary penalties for violations and criminal penalties for knowingly obtaining or using individually identifiable health information. The penalties range from \$50,000 to \$250,000 and/or imprisonment if the information was obtained or used with the intent to sell, transfer or use the information for commercial advantage, personal gain or malicious harm.

The HITECH Act

Provisions in the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”), enacted as part of H.R. 1, increase the maximum civil monetary penalties for violations of HIPAA and grant enforcement authority of HIPAA to state attorneys general. The HITECH Act also (i) extends the reach of HIPAA beyond “covered entities,” (ii) imposes a breach notification requirement on HIPAA covered entities, (iii) limits certain uses and disclosures of individually identifiable information and (iv) restricts covered entities’ marketing communications.

The HITECH Act also established programs under Medicare and Medicaid to provide incentive payments for the “meaningful use” of certified electronic health record (“EHR”) technology. Beginning in 2011, the Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and eligible hospitals for demonstrating meaningful use of certified EHR technology. Health care providers demonstrate their meaningful use of EHR technology by meeting objectives specified by the Centers for Medicare and Medicaid Services for using health information technology and by reporting on specified clinical quality measures. Beginning in 2015, hospitals and physicians who have not satisfied the performance and reporting criteria for demonstrating meaningful use will have their Medicare payments significantly reduced.

Security Breaches and Unauthorized Releases of Personal Information

Federal and state authorities are increasingly focused on the importance of protecting the confidentiality of individuals' personal information, including patient health information. Many states have enacted laws requiring businesses to notify individuals of security breaches that result in the unauthorized release of personal information. In some states, notification requirements may be triggered even where information has not been used or disclosed, but rather has been inappropriately accessed. State consumer protection laws may also provide the basis for legal action for privacy and security breaches and frequently, unlike HIPAA, authorize a private right of action. In particular, the public nature of security breaches exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement. Failure to comply with restrictions on patient privacy or to maintain robust information security safeguards, including taking steps to ensure that contractors who have access to sensitive patient information maintain the confidentiality of such information, could consequently damage a health care provider's reputation and materially adversely affect business operations.

Patient Transfers

A federal "anti-dumping" statute imposes certain requirements that must be met before transferring a patient to another facility. Failure to comply with the law can result in exclusion from the Medicare, TennCare and/or Medicaid programs as well as civil and criminal penalties. Failure of any Member of the Obligated Group to meet its responsibilities under the law could adversely affect the financial conditions of that Member.

The Corporation's management is not aware of any pending or threatened claim, investigation, or enforcement action regarding patient transfers that, if determined adversely to a Member of the Obligated Group, would have material adverse consequences to the Obligated Group.

Certain Business Transactions

Physician Relations

The primary relationship between a hospital and physicians who practice in it is through the hospital's organized medical staff. Medical staff bylaws, rules and policies establish the criteria and procedures by which a physician may have his or her privileges or membership curtailed, denied or revoked. Physicians who are denied medical staff membership or certain clinical privileges, or who have membership or privileges curtailed, denied or revoked often file legal actions against hospitals. Such action may include a wide variety of claims, some of which could result in substantial uninsured damages to a hospital. In addition, failure of the hospital governing body to adequately oversee the conduct of the medical staff may result in hospital liability to third parties. All hospitals, including those owned and operated by the members of the Obligated Group, are subject to such risk.

Physician Contracting

The Members of the Obligated Group may contract with physician organizations (such as independent physician associations and physician-hospital organizations) to arrange for the provision of physician and ancillary services. Because physician organizations are separate legal entities with their own goals, obligations to shareholders, financial status, and personnel, there are risks involved in contracting with the physician organizations.

The success of the Obligated Group will be partially dependent upon its ability to attract physicians to join the physician organizations and to participate in their networks, and upon the ability of the physicians, including the employed physicians, to perform their obligations and deliver high quality patient care in a cost-effective manner. There can be no assurance that the members of the Obligated Group will be able to attract and retain the requisite number of physicians, or that physicians will deliver high quality health care services. Without paneling a sufficient number and type of providers, the Obligated Group could fail to be competitive, could fail to keep or attract payor contracts, or could be prohibited from operating until its panel provided adequate access to patients. Such occurrences could have a material adverse effect on the business or operations of the Obligated Group.

Affiliations, Merger, Acquisition and Divestiture

The Obligated Group Members evaluate and pursue potential acquisition, merger and affiliation candidates as part of the overall strategic planning and development process. As part of its ongoing planning and property management functions, the Obligated Group reviews the use, compatibility and business viability of many of the operations of the members, and from time to time the members may pursue changes in the use of, or disposition of, their facilities. Likewise, members of the Obligated Group occasionally receive offers from, or conduct discussions with, third parties about the potential acquisition of operations and properties which may become subsidiaries or Affiliates of members of the Obligated Group in the future, or about the potential sale of some of the operations or property which are currently conducted or owned by the members. Discussion with respect to affiliation, merger, acquisition, disposition or change of use of facilities, including those which may affect the members, are held from time to time with other parties. These may be conducted with acute care hospital facilities and may be related to potential affiliation with a member of the Obligated Group. As a result, it is possible that the current organization and assets of the members may change from time to time.

In addition to relationships with other hospitals and physicians, the members of the Obligated Group may consider investments, ventures, affiliations, development and acquisition of other health care-related entities. These may include home health care, long-term care entities or operations, infusion providers, pharmaceutical providers, and other health care enterprises that support the overall operations of the members of the Obligated Group. In addition, the members of the Obligated Group may pursue transactions with health insurers, HMOs, preferred provider organizations, third-party administrators and other health insurance-related businesses. Because of the integration occurring throughout the health care field, management will consider these arrangements if there is a perceived strategic or operational benefit for the Obligated Group. Any initiative may involve significant capital commitments and/or capital or operating risk (including, potentially, insurance risk) in a business in which the members of the Obligated Group may have less expertise than in hospital operations. There can be no assurance that these projects, if pursued, will not lead to material adverse consequences to the Obligated Group.

Antitrust

Enforcement of antitrust laws against health care providers is becoming more common, and antitrust liability may arise in a wide variety of circumstances, including medical staff privilege disputes, third party contracting, physician relations, and joint venture, merger, affiliation and acquisition activities. While the application of federal and state antitrust laws to health care is still evolving, enforcement activities by federal and state agencies appear to be increasing. Violators of antitrust laws could be subject to criminal and civil liability by both federal and state agencies, as well as by private litigants.

Tax Matters

Tax Exemption for Not-For-Profit Corporations

Loss of tax-exempt status by an Obligated Group Member could result in loss of tax exemption of the Bonds and of other tax-exempt debt issued for the benefit of the Obligated Group Members, and defaults in covenants regarding the Bonds and other related tax-exempt debt would likely be triggered. Such an event would have material adverse consequences on the financial condition of the Obligated Group. Management of the Corporation is not aware of any transactions or activities currently ongoing that are likely to result in the revocation of the tax-exempt status of any Obligated Group Member.

The maintenance by each Obligated Group Member (other than Wellmont, Inc.) of its status as an organization described in Section 501(c)(3) of the Code is contingent upon compliance with general rules promulgated in the Code and related regulations regarding the organization and operation of tax-exempt entities, including their operation for charitable and educational purposes and their avoidance of transactions that may cause their assets to inure to the benefit of private individuals. The Internal Revenue Service has announced that it intends to closely scrutinize transactions between not-for-profit corporations and for-profit entities, and in particular has issued audit guidelines for tax-exempt hospitals. Although specific activities of hospitals, such as medical office building leases and compensation arrangements and other contracts with physicians, have been the subject of interpretations by the Internal Revenue Service in the form of Private Letter Rulings, many activities have not been

addressed in any official opinion, interpretation or policy of the Internal Revenue Service. Because the Obligated Group Members conduct large-scale and diverse operations involving private parties, there can be no assurances that certain of their transactions would not be challenged by the Internal Revenue Service.

The Internal Revenue Service has taken the position that hospitals which are in violation of the Anti-Kickback Law may also be subject to revocation of their tax-exempt status. See the information herein under the caption, "RISK FACTORS - Regulatory Environment - Civil and Criminal Fraud and Abuse Laws and Enforcement." As a result, tax-exempt hospitals, such as those of the Obligated Group Members, which have, and will continue to have, extensive transactions with physicians are subject to an increased degree of scrutiny and perhaps enforcement by the Internal Revenue Service.

The Taxpayers Bill of Rights 2, referred to for purposes of this Official Statement as the Intermediate Sanctions Law, allows the Internal Revenue Service to impose "intermediate sanctions" against certain individuals in circumstances involving the violation by tax-exempt organizations of the prohibition against private inurement. Prior to the enactment of the Intermediate Sanctions Law, the only sanction available to the Internal Revenue Service was revocation of an organization's tax-exempt status. Intermediate sanctions may be imposed in situations in which a "disqualified person" (such as an "insider") (i) engages in a transaction with a tax-exempt organization on other than a fair market value basis, (ii) receives unreasonable compensation from a tax-exempt organization or (iii) receives payment in an arrangement that violates the prohibition against private inurement. These transactions are referred to as "excess benefit transactions." A disqualified person who benefits from an excess benefit transaction will be subject to an excise tax equal to 25% of the amount of the excess benefit. Organizational managers who participate in the excess benefit transaction knowing it to be improper are subject to an excise tax equal to 10% of the amount of the excess benefit, subject to a maximum penalty of \$20,000. A second penalty, in the amount of 200% of the excess benefit, may be imposed on the disqualified person (but not upon the organizational manager) if the excess benefit is not corrected within a specified period of time.

In certain cases, the IRS has imposed substantial monetary penalties and future charity care or public benefit obligations on tax-exempt hospitals in lieu of revoking their tax-exempt status, as well as requiring that certain transactions be altered, terminated or avoided in the future and/or requiring governance or management changes. These penalties and obligations are typically imposed on the tax-exempt hospital pursuant to a "closing agreement" with respect to the hospital's alleged violation of Section 501(c)(3) exemption requirements. Given the size of the Obligated Group, the wide range of complex transactions entered into by the Obligated Group Members and uncertainty regarding how tax-exemption requirements may be applied by the IRS, Members are, and will be, at risk for incurring monetary and other liabilities imposed by the IRS through this "closing agreement" or similar process. Like certain of the other business and legal risks described herein which apply to large multi-hospital systems, these liabilities are probable from time to time and could be substantial, in some cases involving millions of dollars, and in extreme cases could be materially adverse.

Bills have been introduced in Congress that would require a tax-exempt hospital to provide a certain amount of charity care and care to Medicare and Medicaid patients in order to maintain its tax-exempt status and avoid the imposition of an excise tax. Other legislation would have conditioned a hospital's tax-exempt status on the delivery of adequate levels of charity care. Congress has not enacted such bills. However, there can be no assurance that similar legislative proposals or judicial actions will not be adopted in the future.

In recent years, the IRS and state, county and local taxing authorities have been undertaking audits and reviews of the operations of tax-exempt hospitals with respect to their exempt activities and the generation of unrelated business taxable income. The Obligated Group Members participate in activities that may generate unrelated business taxable income. Management of the Corporation believes it and the other Obligated Group Members have properly accounted for and reported unrelated business taxable income; nevertheless, an investigation or audit could lead to a challenge which could result in taxes, interest and penalties with respect to unreported unrelated business taxable income and in some cases could ultimately affect the tax-exempt status of a Obligated Group Member as well as the exclusion from gross income for federal income tax purposes of the interest payable on the Bonds and other tax-exempt debt of the Obligated Group Members. In addition, legislation, if any, which may be adopted at the federal, state and local levels with respect to unrelated business income cannot be predicted. Any legislation could have the effect of subjecting a portion of the income of the Obligated Group Members to federal or state income taxes.

Obligated Group Members have been, are being and most likely will be audited regularly by the IRS. Management believes that it has properly complied with the tax laws. Nevertheless, because of the complexity of the tax laws and the presence of issues about which reasonable persons can differ, an audit could result in additional taxes, interest and penalties. An audit could ultimately affect the tax-exempt status of a Obligated Group Member as well as the exclusion from gross income for federal income tax purposes of the interest payable with respect to the Bonds and other tax-exempt debt of the Obligated Group Members.

In addition to the foregoing proposals with respect to income by not-for-profit corporations, various state and local governmental bodies have challenged the tax-exempt status of not-for-profit institutions and have sought to remove the exemption of property from real estate taxes of part or all of the property of various not-for-profit institutions on the grounds that a portion of its property was not being used to further the charitable purposes of the institutions or that the institutions did not provide sufficient care to indigent persons so as to warrant exemption from taxation as a charitable institution. Several of these disputes have been determined in favor of the taxing authorities or have resulted in settlements.

It is not possible to predict the scope or effect of future legislative or regulatory actions with respect to taxation of not-for-profit corporations. There can be no assurance that future changes in the laws and regulations of federal, state or local governments will not materially adversely affect the operations and financial condition of the Obligated Group Members by requiring any of them to pay income or local property taxes.

Tax-Exempt Status of the Bonds

The Code imposes a number of requirements that must be satisfied for interest on state and local obligations, such as the Bonds, to be excludable from gross income for federal income tax purposes. These requirements include limitations on the use of bond proceeds, limitations on the investment earnings of bond proceeds prior to expenditure, a requirement that certain investment earnings on bond proceeds be paid periodically to the United States, and a requirement that the issuers file an information report with the IRS. The Corporation has agreed that it will comply with such requirements. Failure to comply with the requirements stated in the Code and related regulations, rulings and policies may result in the treatment of the interest on the Bonds as taxable. Such adverse treatment may be retroactive to the date of issuance.

Bond Examinations

The IRS has added a new Schedule H to IRS Form 990, on which hospitals and health systems will be required to report how they provide community benefit and to specify certain billing and collection practices. The IRS has also added a new Schedule K to IRS Form 990. This new schedule requests detailed information related to all outstanding bond issues of nonprofit corporations, including, for bonds issued after 2002, information regarding operating, management and research contracts as well as private business use compliance. Filers must complete the entire schedule for tax years beginning in 2009.

Although the Corporation believes that its expenditure and investment of bond proceeds, use of property financed with tax-exempt debt and record retention practices comply with all applicable laws and regulations, there can be no assurance that an IRS review triggered by information submitted on a Schedule H or Schedule K would not adversely affect the market value of the Bonds or of other outstanding tax-exempt indebtedness of the Obligated Group. Additionally, the Bonds or other tax-exempt obligations issued for the benefit of the Obligated Group Members, may be, from time to time, subject to examinations by the IRS. The Corporation received a notice from the IRS dated January 26, 2011 to the effect that the Series 2005 Bonds had been selected for a routine examination to determine compliance with federal tax requirements, together with a Form 4564 Information Document Request requesting certain documentation relating to the Series 2005 Bonds. On March 15, 2011, the Corporation responded to such request providing the requested documentation. Such examination is ongoing. The Corporation believes that the Series 2005 Bonds and other tax-exempt obligations issued for the benefit of the Obligated Group Members properly comply with the tax laws. In addition, Bond Counsel rendered an opinion with respect to the tax-exempt status of the Bonds upon their issuance, as described under the caption "TAX STATUS." No ruling with respect to the tax-exempt status of the Bonds, has been or will be sought from the IRS, however, and the opinions of counsel are

not binding on the IRS or the courts. There can be no assurance that any IRS examination of the Bonds will not adversely affect the market value of the Bonds. See “TAX STATUS” below.

Other Risks

Indigent Care

Tax-exempt hospitals often treat large numbers of “indigent” patients who, for various reasons, are unable to pay for their medical care. Typically, urban, inner-city hospitals, including hospitals owned by certain Obligated Group Members, may treat significant numbers of indigents. These hospitals may be susceptible to economic and political changes which could increase the number of indigent persons or the responsibility for caring for this population. General economic conditions which affect the number of employed individuals who have health insurance coverage will similarly affect the ability of patients to pay for their care. Similarly, changes in governmental policy, which may result in coverage exclusions under local, state and federal healthcare programs (including Medicare and Medicaid) may increase the frequency and severity of indigent treatment in such hospitals. It is also possible that future legislation could require that tax-exempt hospitals maintain minimum levels of indigent care as a condition to federal income tax exemption or local property tax exemption. In sum, indigent care commitments of the Obligated Group Members could constitute a material and adverse financial risk in the future.

Cost of Capital

From time to time, Congress has considered and is considering revisions to the Internal Revenue Code that may prevent or limit access to the tax-exempt debt market to corporations or issuers such as the Obligated Group Members. Such legislation, if enacted into law, may have the effect of increasing the capital costs of the Obligated Group Members.

Interest Rate Swaps

The Corporation has entered into certain interest rate swap transactions with respect to its outstanding bonds. Under certain circumstances, the interest rate swap may be terminated prior to the maturity of the related outstanding bonds. If the interest rate swap is terminated under certain market conditions, the Corporation may owe a termination payment to the applicable swap counterparty. Such a termination payment generally would be based upon the market value of the related interest rate swap on the date of termination and could be substantial. In addition, a partial termination of an interest rate swap could occur to the extent that any outstanding bonds hedged with an interest rate swap is redeemed pursuant to an optional redemption. If such an optional redemption occurs, a termination payment related to the portion of the interest rate swap to be terminated will be owed by either the Corporation or the applicable swap counterparty, depending on market conditions. In the event of an early termination of an interest rate swap, there can be no assurance that (i) the Corporation will receive any termination payment payable to it by the applicable swap counterparty, (ii) the Corporation will have sufficient amounts to pay a termination payment payable by it to the applicable swap counterparty and (iii) the Corporation will be able to obtain a replacement swap agreement with comparable terms. The Corporation has credit risk to the extent the applicable swap counterparty’s credit or ability to perform is reduced.

Bond Ratings

There is no assurance that the ratings assigned to the Bonds will not be lowered or withdrawn at any time, the effect of which could adversely affect the market price for and marketability of the Bonds. See the information herein under the caption “RATINGS.”

Investments

Corporation has significant holdings in a broad range of investments. Market fluctuations have affected and may continue to affect the value of those investments. Those fluctuations may be at times material.

Staffing Shortages

From time to time, the healthcare industry has suffered from a scarcity of nursing and other qualified health care technicians and personnel. Staffing shortages could force the Obligated Group Members to pay higher salaries to nursing and other qualified health care technicians and personnel as competition for such employees intensifies and, in an extreme situation, could lead to difficulty in keeping the facilities licensed to provide nursing care and thus eligible for reimbursement under Medicare, TennCare and Medicaid.

Professional Liability Claims and Liability Insurance

In recent years, the number of professional and general liability suits and the dollar amounts of damage recoveries have increased nationwide, resulting in substantial increases in malpractice insurance premiums. Professional liability and other actions alleging wrongful conduct and seeking punitive damages often are filed against health care providers. Litigation may also arise from the corporate and business activities of the Corporation and its affiliates, employee-related matters, medical staff and provider network matters and denials of medical staff and provider network membership and privileges. As with professional liability, many of these risks are covered by insurance, but some are not. For example, some antitrust claims, business disputes and workers' compensation claims are not covered by insurance or other sources and, in whole or in part, may be a liability of the Corporation and its affiliates if determined or settled adversely. Claims for punitive damages may not be covered by insurance under certain state laws. Although the Members of the Obligated Group currently maintain actuarially determined self-insurance reserves and carry excess malpractice and general liability insurance which management of the Corporation considers adequate, management of the Corporation is unable to predict the availability, cost or adequacy of such insurance in the future.

Other Risk Factors Generally Affecting Health Care Facilities

In the future, the following factors, among others, may adversely affect the operations of health care providers, including the Obligated Group Members or the market value of the Bonds, to an extent that cannot be determined at this time:

a. Hospitals are major employers, combining a complex mix of professional, quasi-professional, technical, clerical, housekeeping, maintenance, dietary and other types of workers in a single operation. As with all large employers, the Obligated Group Members bear a wide variety of risks in connection with their employees. These risks include strikes and other related work actions, contract disputes, discrimination claims, personal tort actions, work-related injuries, exposure to hazardous materials, interpersonal torts (such as between employees, between physicians or management and employees, or between employees and patients), and other risks that may flow from the relationships between employer and employee or between physicians, patients and employees. Many of these risks are not covered by insurance, and certain of them cannot be anticipated or prevented in advance. The Obligated Group Members are subject to all of the risks listed above, and such risks, alone or in combination, could have material adverse consequences to the financial condition or operations of the Obligated Group.

b. Competition from other hospitals and other competitive facilities now or hereafter located in the respective service areas of the facilities operated by the Corporation and the Obligated Group Members may adversely affect revenues of the Obligated Group. Development of health maintenance and other alternative health delivery programs could result in decreased usage of inpatient hospital facilities and other facilities operated by the Obligated Group Members.

c. Cost and availability of any insurance, including self-insurance, such as malpractice, fire, automobile, and general comprehensive liability, that hospitals and other health care facilities of similar size and type as the Obligated Group Members generally carry may adversely affect revenues. The costs of such insurance have increased significantly in the past few years, and such increases are likely to continue in the near future.

d. The occurrences of natural disasters may damage some or all of the facilities, interrupt utility service to some or all of the facilities or otherwise impair the operation of some or all of the facilities operated by the Obligated Group Members or the generation of revenues from some or all of the facilities.

e. Scientific and technological advances, new procedures, drugs and appliances, preventive medicine, occupational health and safety and outpatient health care delivery may reduce utilization and revenues of the facilities. Technological advances in recent years have accelerated the trend toward the use by hospitals of sophisticated and costly equipment and services for diagnosis and treatment. The acquisition and operation of certain equipment or services may continue to be a significant factor in hospital utilization, but the ability of the Obligated Group Members to offer the equipment or services may be subject to the availability of equipment or specialists, governmental approval or the ability to finance these acquisitions or operations.

f. Reduced demand for the services of the Obligated Group Members that might result from decreases in population in their respective service areas.

g. Increased unemployment or other adverse economic conditions in the service areas of the Obligated Group Members which would increase the proportion of patients who are unable to pay fully for the cost of their care.

h. Any increase in the quantity of indigent care provided which is mandated by law or required due to increased needs of the community in order to maintain the charitable status of the Obligated Group Members.

i. Regulatory actions which might limit the ability of the Obligated Group Members to undertake capital improvements to their respective facilities or to develop new institutional health services.

j. The occurrence of a large scale terrorist attack that increases the proportion of patients who are unable to pay fully for the cost of their care and that disrupts the operation of certain health care facilities by resulting in an abnormally high demand for health care services.

k. Instability in the stock market or other investment markets which may adversely affect both the principal value of, and income from, the Corporation's investment portfolio.

CONTINUING DISCLOSURE

The Corporation and the other Obligated Group members (collectively, the "Obligors") will enter into a continuing disclosure agreement (the "Continuing Disclosure Agreement") pursuant to the requirements of Rule 15c2-12 ("Rule 15c2-12") adopted by the Securities and Exchange Commission (the "SEC") under the Securities Exchange Act of 1934, as amended. The Continuing Disclosure Agreement will be entered into by the Obligors for the benefit of the beneficial owners of the Bonds and will obligate the Obligors to provide certain information annually and quarterly and to file notice of the occurrence of certain events. A summary of the Continuing Disclosure Agreement is included in APPENDIX E.

The Corporation serves as the parent organization for affiliated entities, including the members of the Obligated Group. The audited financial statements of the Corporation included in APPENDIX B are consolidated statements that provide financial information with respect to the Corporation and its affiliates described in the audit report, including the other Obligors. The Obligors do not have audited financial statements prepared for the Obligors alone. The Obligors intend to comply with their obligations under the Continuing Disclosure Agreement by continuing to provide audited annual financial statements substantially in the form presented in APPENDIX B.

The Obligors have represented that they are in compliance with all agreements previously entered into by them pursuant to Rule 15c2-12. A failure by the Obligors to comply with the Continuing Disclosure Agreement will not constitute an event of default under the Loan Agreement. Beneficial owners of the Bonds are limited to the remedies described in the Continuing Disclosure Agreement. A failure by the Issuer to comply with the Continuing

Disclosure Agreement must be reported in accordance with Rule 15c2-12 and must be considered by any broker, dealer or municipal securities dealer before recommending the purchase or sale of the Bonds in the secondary market. Consequently, such a failure may adversely affect the transferability and liquidity of the Bonds and their market price.

TAX STATUS

Opinion of Bond Counsel—Federal Income Tax Status of Interest

The opinion of McGuireWoods LLP, Richmond, Virginia, Bond Counsel, will state that, under current law, interest on the Bonds is excludable from gross income for purposes of federal income taxation and is not a specific item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations. For purposes of the alternative minimum tax imposed on corporations (as defined for federal income tax purposes under Section 56 of the Internal Revenue Code of 1986, as amended (the “Code”)), interest on the Bonds must be included in computing adjusted current earnings. See “APPENDIX D – FORM OF APPROVING OPINION OF BOND COUNSEL”.

Bond Counsel will express no opinion regarding other federal tax consequences arising with respect to the Bonds.

Bond Counsel’s opinion speaks as of its date, is based on current legal authority and precedent, covers certain matters not directly addressed by such authority and precedent, and represents Bond Counsel’s judgment as to the proper treatment of interest on the Bonds for federal income tax purposes. Bond Counsel’s opinion does not contain or provide any opinion or assurance regarding the future activities of the Issuer or the Obligated Group or about the effect of future changes in the Code, the applicable regulations, the interpretation thereof or the enforcement thereof by the Internal Revenue Service (the “IRS”). The Issuer and the Corporation have covenanted, however, to comply with the requirements of the Code.

Reliance and Assumptions; Effect of Certain Changes

In delivering its opinion regarding the Bonds, Bond Counsel is relying upon (i) certifications of representatives of the Issuer and the Corporation and other parties as to facts material to the opinion, which Bond Counsel has not independently verified and (ii) the opinion of Hunter, Smith & Davis, LLP, Counsel for the Corporation, to be delivered in connection with the issuance of the Bonds, that the Corporation is an organization described in Section 501(c)(3) of the Code.

In addition, Bond Counsel is assuming continuing compliance with the Covenants (as hereinafter defined) by the Issuer and the Corporation. The Code and the regulations promulgated thereunder contain a number of requirements that must be satisfied after the issuance of the Bonds in order for interest on the Bonds to be and remain excludable from gross income for purposes of federal income taxation. These requirements include, by way of example and not limitation, the requirement that the Corporation maintain its status as an organization described in Section 501(c)(3) of the Code, restrictions on the use, expenditure and investment of the proceeds of the Bonds and the use of the property financed or refinanced by the Bonds, limitations on the source of the payment of and the security for the Bonds, and the obligation to rebate certain excess earnings on the gross proceeds of the Bonds to the Treasury of the United States (the “Treasury”). The Indenture, the Loan Agreement and the Tax Compliance Agreement contain covenants (the “Covenants”) under which the Issuer and the Corporation have agreed to comply with such requirements. Failure by the Issuer or the Corporation to comply with their respective Covenants could cause interest on the Bonds to become includable in gross income for federal income tax purposes retroactively to their date of issue. In the event of noncompliance with the Covenants, the available enforcement remedies may be limited by applicable provisions of law and, therefore, may not be adequate to prevent interest on the Bonds from becoming includable in gross income for federal income tax purposes. Compliance by the Issuer with its respective Covenants does not require the Issuer to make any financial contribution for which it does not receive funds from the Issuer and the Corporation.

Certain requirements and procedures contained, incorporated or referred to in the Indenture, the Loan Agreement and the Tax Compliance Agreement, including the Covenants, may be changed and certain actions may be taken or omitted under the circumstances and subject to the terms and conditions set forth therein. Bond Counsel expresses no opinion concerning any effect on the excludability of interest on the Bonds from gross income for federal income tax purposes of any such subsequent change or action that may be made, taken or omitted upon the advice or approval of counsel other than Bond Counsel.

Certain Collateral Federal Tax Consequences

The following is a brief discussion of certain collateral federal income tax matters with respect to the Bonds. It does not purport to address all aspects of federal taxation that may be relevant to a particular owner thereof. Prospective purchasers of the Bonds, particularly those who may be subject to special rules, are advised to consult their own tax advisors regarding the federal tax consequences of owning or disposing of the Bonds.

Prospective purchasers of the Bonds should be aware that the ownership of tax-exempt obligations may result in collateral federal income tax consequences to certain taxpayers, including, without limitation, financial institutions, certain insurance companies, certain corporations (including S corporations and foreign corporations), certain foreign corporations subject to the “branch profits tax,” individual recipients of Social Security or Railroad Retirement benefits, taxpayers who may be deemed to have incurred or continued indebtedness to purchase or carry tax-exempt obligations and taxpayers attempting to qualify for the earned income tax credit.

In addition, prospective purchasers should be aware that the interest paid on, and the proceeds of the sale of, tax-exempt obligations, including the Bonds, are in many cases required to be reported to the IRS in a manner similar to interest paid on taxable obligations. Additionally, backup withholding may apply to any such payments made after March 31, 2007 to any owner of a Bond who fails to provide an accurate Form W-9 Request for Taxpayer Identification Number and Certification, or a substantially identical form, or to any owner of a Bond who is notified by the IRS of a failure to report all interest and dividends required to be shown on federal income tax returns. The reporting and withholding requirements do not in and of themselves affect the excludability of interest on the Bonds from gross income for federal tax purposes or any other federal tax consequence of purchasing, holding or selling tax-exempt obligations.

Possible Legislative or Regulatory Action

Legislation and regulations affecting tax-exempt bonds are continually being considered by the United States Congress, the Treasury and the IRS. In addition, the IRS has established an expanded audit and enforcement program for tax-exempt bonds. There can be no assurance that legislation enacted or proposed after the date of issue of the Bonds or an audit initiated or other enforcement or regulatory action taken by the Treasury or the IRS involving either the Bonds or other tax-exempt obligations will not have an adverse effect on the tax status or the market price of the Bonds or on the economic value of the tax-exempt status of the interest thereon.

Opinion of Bond Counsel — Tennessee Income Tax Consequences

In the opinion of Bond Counsel, under existing law, the Bonds and the interest thereon are exempt from all State of Tennessee state, county and municipal taxation except for inheritance, transfer and estate taxes and except to the extent that the Bonds and the interest thereon are included within the measure of certain privilege and excise taxes imposed under Tennessee law.

Bond Counsel will express no opinion regarding (i) other Tennessee tax consequences arising with respect to the Bonds or (ii) any consequences arising with respect to the Bonds under the tax laws of any state or local jurisdiction other than Tennessee. Prospective purchasers of the Bonds should consult their own tax advisors regarding state and local tax issues not covered by Bond Counsel's opinion, including the tax status of interest on the Bonds in a particular state or local jurisdiction other than Tennessee.

LEGAL COUNSEL

McGuireWoods LLP, Richmond, Virginia has served as bond counsel to the Corporation with respect to the issuance of the Bonds. Bond counsel will render an opinion with respect to the Bonds in substantially the form attached as APPENDIX D. The opinion of bond counsel should be read in its entirety for a complete understanding of the scope of the opinion and the conclusions expressed. Delivery of the Bonds is contingent upon the delivery of the opinion of bond counsel.

In connection with the issuance of the Bonds, Penn, Stuart & Eskridge, A Professional Corporation, Bristol, Tennessee, has served as counsel to the Issuer, Hunter, Smith & Davis, LLP, Kingsport, Tennessee, has served as counsel to the Corporation and the Obligated Group, and Presley Burton & Collier, LLC, Birmingham, Alabama, has served as counsel to the Underwriter.

INDEPENDENT AUDITORS

The consolidated financial statements of the Corporation as of June 30, 2010 and June 30, 2009 and for the years then ended, included in APPENDIX B to this Official Statement, have been audited by KPMG LLP, independent auditors, as stated in their report included in APPENDIX B.

LITIGATION

To the best of the Issuer's knowledge, there is no litigation pending or threatened (i) restraining or enjoining the issuance or delivery of the Bonds, (ii) contesting or affecting the validity of the Bonds or the proceedings or authority under which they are to be issued, (iii) contesting the creation, organization or existence of the Issuer or the title of any of its present officials to their respective offices, or (iv) contesting the right of the Issuer to enter into the Financing Documents to which it is a party or to secure the Bonds in accordance with the Indenture.

To the best of the Corporation's knowledge, there is no litigation pending or threatened regarding the matters described in the preceding paragraph. For a description of litigation pending against the Corporation and the Obligated Group, see APPENDIX A.

RATINGS

The following ratings have been assigned to the Bonds based on an assessment by each rating agency of the Obligated Group's ability to make payments on the Bonds:

Rating Agency	Rating Assigned
S & P	BBB+
Fitch	BBB+

Any further explanation as to the significance of these ratings may be obtained only from the appropriate rating agency. There is no assurance that any such rating will remain in effect for any given period of time or that the rating will not be revised downward or withdrawn entirely by the rating agency furnishing the same, if, in its judgment, the circumstances so warrant. Any such downward revision or withdrawal of a rating may have an adverse effect on the market price of the Bonds. The above ratings are not recommendations to buy, sell or hold the Bonds.

UNDERWRITING

Merrill Lynch, Pierce, Fenner & Smith Incorporated (the "Underwriter"), will enter into a bond purchase agreement in which the Underwriter will agree to purchase the Bonds, subject to certain conditions precedent, at a purchase price of \$75,934,587.50 (face amount less underwriter's discount of \$230,412.50). The Underwriter will

purchase all of the Bonds if any are purchased. The Underwriter has arranged for the purchase of the Bonds by its affiliate, Bank of America, N.A. (the “Initial Purchaser”). The Initial Purchaser will have the right to sell or distribute the Bonds or interests therein to subsequent purchasers or investors. Under the bond purchase agreement, the Corporation will agree to indemnify the Underwriter against certain costs, claims and liabilities, including certain liabilities arising under the Securities Act of 1933.

FINANCIAL ADVISOR

Ponder & Co. was engaged by the Corporation to provide financial advisory services in connection with the issuance of the Bonds. Ponder & Co. is a national consulting firm that acts as financial advisor to health care organizations in matters of capital formation, including debt financing, interest rate swaps and strategic capital planning.

RELATED PARTIES

Hunter, Smith & Davis, LLP, counsel to the Corporation and the Obligated Group, is regular counsel to the Issuer on matters unrelated to the Corporation and Obligated Group. McGuireWoods LLP, bond counsel, also represents the Trustee, the Master Trustee and the Underwriter in unrelated transactions.

MISCELLANEOUS

Neither this Official Statement nor any advertisement of the Bonds is to be construed as a contract or agreement with the holders of the Bonds. The agreement of the Issuer, the Corporation and the Obligated Group with the holders of the Bonds is fully set forth in the Bonds and the Financing Documents.

No dealer, broker, salesman or other person has been authorized by the Issuer or the Obligated Group to give any information or to make any representation other than as contained in this Official Statement, and, if given or made, such other information or representation must not be relied upon as having been authorized by them.

This Official Statement does not constitute an offer to sell or the solicitation of an offer to buy, nor shall there be any sale of the Bonds by any person in any jurisdiction in which it is unlawful for such person to make such offer, solicitation or sale.

The Bonds have not been registered under The Securities Act of 1933, as amended, or any state securities laws, and neither the Securities and Exchange Commission nor any state regulatory agency will pass upon the accuracy, completeness or adequacy of this Official Statement. Neither the Indenture nor the Master Indenture has been qualified under the Trust Indenture Act of 1939, as amended.

The information in this Official Statement is provided as of the date of this Official Statement. Nothing contained in this Official Statement shall under any circumstances create an implication that there has been no change in such information after the date of this Official Statement.

The information set forth in this Official Statement has been obtained from the sources which are deemed to be reliable but is not guaranteed as to accuracy or completeness. All estimates and assumptions contained herein are believed to be reliable, but no representation is made that such estimates or assumptions are correct or will be realized.

Certain statements contained in this Official Statement reflect forecasts and forward-looking statements, rather than historical facts. In this respect, the words “estimate,” “project,” “anticipate,” “expect,” “intend,” “believe,” and similar expressions are intended to identify forward-looking statements. All such forward-looking statements are expressly qualified by the cautionary statements set forth in this Official Statement.

The summaries and explanations of the provisions of the Bonds and the Financing Documents do not purport to be complete, and reference is made to the pertinent provisions of the Bonds and the Financing Documents

for a complete statement of their provisions. Such documents are on file and available for review during regular business hours upon request at the corporate trust offices of the Trustee, The Bank of New York Mellon Trust Company, N.A., Corporate Trust Services, 900 Ashwood Parkway, Suite 425, Atlanta, Georgia 30338.

In connection with this offering, the Underwriter may engage in transactions that stabilize, maintain or otherwise affect the price of the Bonds. Such transactions may include purchases of the Bonds for the purpose of maintaining the price of the Bonds. Such transactions, if commenced, may be discontinued at any time.

The attached appendices are integral parts of this Official Statement and must be read together with all of the foregoing statements.

APPROVAL OF USE OF OFFICIAL STATEMENT

The delivery of this Official Statement has been duly authorized by the Issuer and the Obligated Group.

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APPENDIX A.
INFORMATION REGARDING THE OBLIGATED GROUP

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APPENDIX A

INFORMATION CONCERNING WELLMONT HEALTH SYSTEM

*The information contained in this Appendix A to this Official Statement
has been obtained from Wellmont Health System*

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INTRODUCTION

Overview

Wellmont Health System (“Wellmont”) is a Tennessee non-profit corporation based in Kingsport, Tennessee and a premier provider of healthcare services in Northeast Tennessee and Southwest Virginia. Wellmont was formed in July 1996 with the merger of Bristol Memorial Hospital in Bristol, Tennessee and Holston Valley Medical Center in Kingsport, Tennessee. Over the past decade, Wellmont has grown to include six additional hospitals, an integrated physician network and several ambulatory sites. Wellmont hospitals offer a broad scope of services ranging from community-based acute care to highly specialized tertiary services including two trauma centers, comprehensive heart care and cancer care.

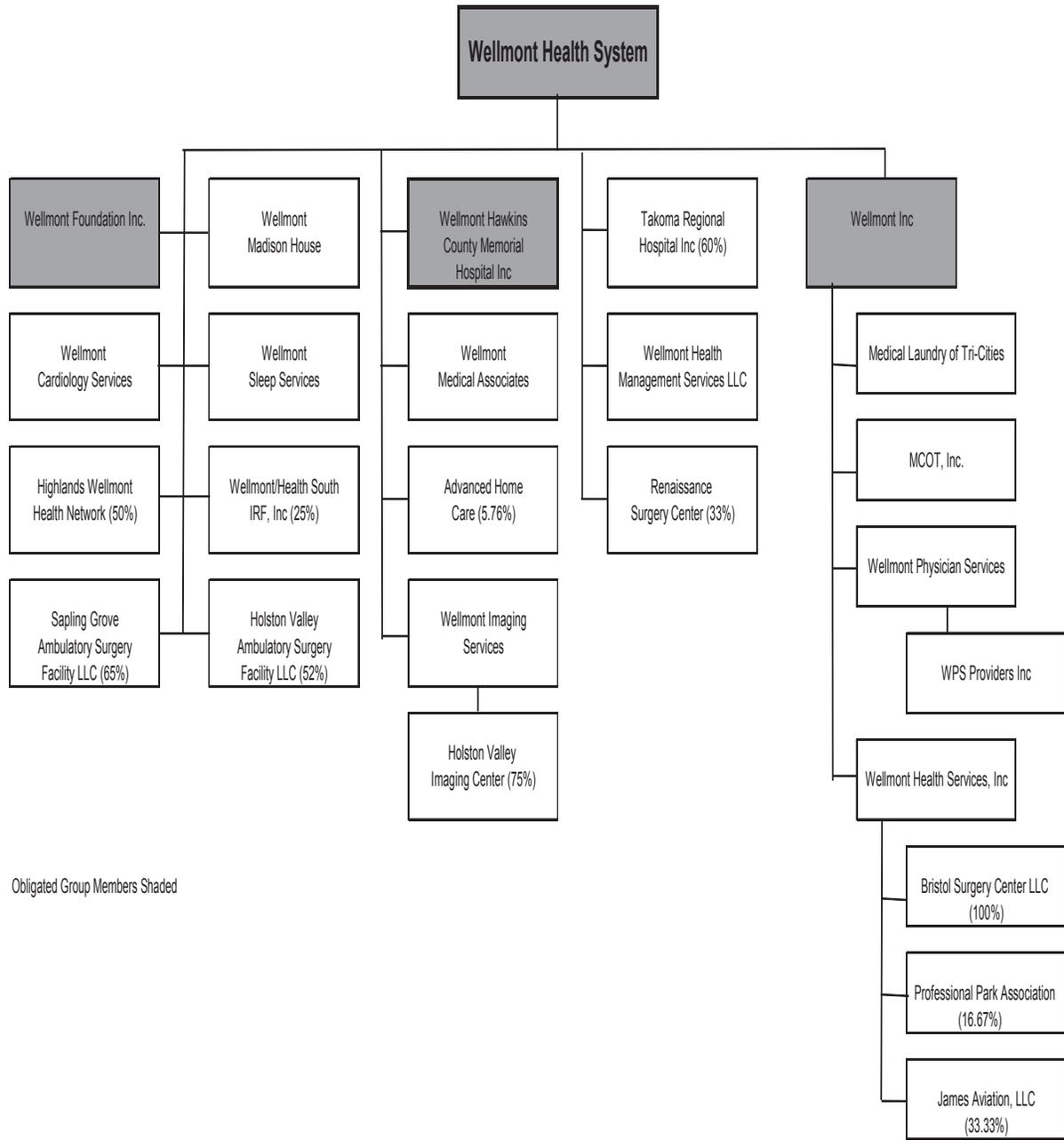
Wellmont owns and operates an integrated health care delivery system providing inpatient, outpatient and other health care services at multiple locations in Northeast Tennessee and Southwest Virginia. Currently, Wellmont owns and operates six acute care hospital facilities and one critical access hospital with a total of 1,253 licensed beds and, through a joint venture, partners to operate an additional acute care hospital facility with 100 licensed beds. The acute care facilities owned by Wellmont include Holston Valley Medical Center, Bristol Regional Medical Center, Mountain View Regional Medical Center in Norton, Virginia, Lee Regional Medical Center in Pennington Gap, Virginia, Lonesome Pine Hospital in Big Stone Gap, Virginia, Hawkins County Memorial Hospital in Rogersville, Tennessee and the critical access hospital, Hancock County Hospital in Sneedville, Tennessee. Wellmont is the majority partner with Adventist Health System at Takoma Regional Hospital, an acute care hospital in Greeneville, Tennessee.

Wellmont also, directly or indirectly, controls, owns or is affiliated with various nonprofit and for-profit corporations and other organizations that currently provide health care and health care-related services throughout the service area. Wellmont and such other entities, as set forth in the organizational chart below, are sometimes collectively referred to in this Appendix A as the “Health System.” In addition to the hospital campuses and ambulatory care centers described above, the Health System also operates medical clinics, ambulatory surgery centers, comprehensive cancer care centers, and imaging facilities as further described herein.

Organization

Obligated Group

Wellmont is a member of the Obligated Group (as defined in Appendix C) under the Master Indenture (as defined in Appendix C). The other members of the Obligated Group include Wellmont Hawkins County Memorial Hospital, Inc. (“WHCMH”), Wellmont, Inc. (“Wellmont, Inc.”), Wellmont Foundation (the “Foundation”) and each other Person (as defined in Appendix C) who becomes a member of the Obligated Group in accordance with the Master Indenture. The Corporation, WHCMH, Wellmont, Inc. and the Foundation are hereinafter in this Appendix A referred to as the Obligated Group. For the fiscal year ended June 30, 2010, the Obligated Group accounted for 89.4% of the System’s total net assets, 87.6% of its operating revenues and 64.7% of its operating income. For financial reporting purposes, the results of operations of System affiliates are consolidated with the results of operations of Members of the Obligated Group. It should be noted that given the subsidiary structure of the Corporation, the assets and associated revenues of the unobligated entities are essentially accessible to support debt of the organization.



FACILITIES

Hospital Campuses

The Health System is licensed to operate 1,253 inpatient beds and, as of December 31, 2010, operated 804 acute care, critical care, psychiatric and rehab beds, 8 hospice beds and 44 long term care beds. The complement of available beds as of December 31, 2010 was as follows:

Available Bed Complement							
As of December 31, 2010							
	Acute Care	Critical Care	Psychiatric	Rehab	Hospice	Long Term Care	Total
Bristol Regional Medical Center	183	29	26		8		246
Holston Valley Medical Center	258	60					318
Mountain View Regional Medical Center	50	4				44	98
Lee Regional Medical Center	52	6					58
Lonesome Pine Hospital	51	6					57
Hawkins County Memorial Hospital	25	4					29
Hancock County Hospital	10						10
Wholly-owned	629	109	26	0	8	44	816
Takoma Regional Hospital	20		10	10			40
TOTAL	649	109	36	10	8	44	856

Bristol Regional Medical Center. Bristol Regional Medical Center, founded in 1925, operates in a state-of-the-art facility that opened in January 1994. The 348-bed facility is situated on a 125-acre campus with easy interstate access. Bristol Regional is staffed by 314 board-certified physicians and 1,779 employees. Centers of excellence include the Wellmont CVA Heart Institute, the J.D. and Lorraine Nicewonder Cancer Center, the Primary Stroke Center, cardiac care, a diabetes treatment center, an emergency department and Level II trauma center, inpatient and outpatient hospice care, neuroscience, occupational health, outpatient services, psychiatric care, rehabilitation services, women’s health and a Level II neonatal intensive care unit. Bristol Regional was the first hospital in the Southeast to offer CyberKnife radiosurgery for the treatment of cancer and other tumors, and it has recently augmented its robotics program with the Da Vinci Robotic Surgery System.

Holston Valley Medical Center. Holston Valley Medical Center has been located in the Kingsport community since 1935. The 505-bed facility is staffed by 439 board-certified physicians and 2,120 employees. Centers of excellence include the Wellmont CVA Heart Institute, the Christine LaGuardia Phillips Cancer Center, a Level I trauma center (one of six in Tennessee), the Holston Valley Regional Children’s Hospital including a Level III neonatal intensive care unit and pediatric intensive care, Madison House, a 27-bed assisted living and adult day care facility, a diabetes treatment center, neuroscience services, outpatient services, rehabilitation services and women’s health. Thompson Reuters has named Holston Valley among its top 50 Heart Hospitals in the United States for 2011 and Holston Valley has been ranked Number 1 in Tennessee for cardiology for two years in a row by HealthGrades. Additionally, Holston Valley is the recipient of the 2011 HealthGrades Coronary Intervention Excellence Award™ and is ranked among the top ten percent in the nation for coronary interventional procedures in 2011. In fact, Holston Valley has been five-star rated for coronary interventional procedures two years in a row, five-star rated for treatment of heart failure three years in a row and ranked among the top ten in Tennessee for overall cardiac services two years in a row.

Mountain View Regional Medical Center. Mountain View Regional Medical Center was founded in the Norton, Virginia in 1948. The hospital joined the Wellmont System in 2007. The 118-bed facility (44 long term care beds) is staffed by 55 board-certified physicians and 240 employees. Medical and surgical services are provided with the support of an emergency room and diagnostic imaging including a 64-slice CT/cardiac imaging. Mountain View Regional Medical Center houses the System's only long term care unit.

Lee Regional Medical Center. Lee Regional Medical Center was founded in Pennington Gap, Virginia in 1930 and has served as the only county hospital for more than 70 years. The hospital joined the Wellmont System in 2007. The 70-bed facility is staffed by 34 board-certified physicians and 227 employees. Lee Regional Medical Center provides 24-hour emergency services, as well as a broad array of inpatient and outpatient medical and surgical services. The hospital also offers outpatient rehabilitation and cardiac stress testing.

Lonesome Pine Hospital. Lonesome Pine Hospital, located in Big Stone Gap, Va., is a 60-bed facility that has served the community since 1973. Lonesome Pine joined the Wellmont System in 1997. The facility is staffed by 104 board-certified physicians and 266 employees. Services include emergency care, intensive care, a medical/surgical/pediatric unit and obstetrics. The Southwest Virginia Cancer Center serving medical and radiation oncology patients is part of Lonesome Pine Hospital operations.

Hawkins County Memorial Hospital. On July 1, 2000, Hawkins County Memorial Hospital became the fourth member hospital in the Wellmont Health System. Established in 1961, the 50-bed, primary-care hospital provides care in a rural setting with a staff of 100 board-certified physicians and 203 employees. Services include emergency care, inpatient and outpatient surgery, occupational therapy, physical therapy and radiology. Outpatient clinics include gynecology, cardiology, gastroenterology, neurology, orthopedics, pulmonology, chemotherapy and urology.

Hancock County Hospital. Hancock County Hospital opened in April 2005. This innovative facility has been designated by the state as a critical-access hospital that provides care to a medically underserved region. The hospital was built through a partnership between the Wellmont System and the Hancock County Commission. Dedicated physicians and a staff of 53 employees provide inpatient and outpatient acute care, emergency care, radiology, laboratory services, respiratory therapy and physical therapy.

Takoma Regional Hospital. Takoma Regional Hospital was founded in 1928 in Greeneville, TN. The 100-bed acute care hospital is owned 60/40 and operated 50/50 through a management agreement with Adventist as a joint venture between Wellmont and Adventist Health System since 2007. The 369 employees provide emergency services, obstetric services, surgery, imaging and diagnostic services to the community.

Physician Clinics

Through its integrated physicians, Wellmont offers a network of primary care and specialty clinics located throughout the service area. The Wellmont Clinic is a physician led, professionally managed organization of 113 physicians and over 590 employees that provide nationally recognized cardiovascular care, medical oncology services, pulmonary and sleep services, surgical services, obstetric and gynecological services, family and internal medicine and hospitalists' services through our clinics and hospitals.

Historical Utilization

The following table sets forth selected historical utilization statistics of the inpatient and specialty care facilities owned and operated by Wellmont for fiscal years ended June 30, 2008, 2009 and 2010 and the six months ended December 31, 2009 and 2010.

	Utilization Statistics				
	Fiscal Year Ended			Six months Ended	
	June 30,			December 31,	
	2008	2009	2010	2009	2010
Hospital Statistics:					
Beds In Service	781	781	781	781	781
Discharges	42,401	42,558	41,380	20,468	20,934
Observations	5,973	8,092	9,530	4,633	4,722
Patients in Bed	48,374	50,650	50,910	25,101	25,656
Patient Days	181,400	183,913	177,715	87,962	90,497
Average Length of Stay (Days)	4.28	4.32	4.29	4.30	4.32
Daily Census ⁽¹⁾	513	526	513	503	517
Percent Occupancy	65.73%	67.35%	65.69%	64.40%	66.20%
Emergency Room Visits	227,181	222,560	212,383	108,847	101,851
Outpatient Registrations excluding ER	N/A	221,942	218,400	110,346	110,880
Deliveries	2,235	2,229	2,238	1,149	1,112
Surgical Cases:					
Inpatient	10,403	10,684	10,372	5,234	5,040
Outpatient	27,018	28,206	26,187	12,716	13,554
Physician Office Visits:	236,555	242,251	258,263	124,735	149,444

⁽¹⁾Daily Census is Patient Days divided by 365 plus observations

Source: Wellmont management

PROGRAMS AND SERVICES

Specialty Services

Wellmont hospitals offer an array of medical specialties and sub-specialties that remain on the forefront of medical innovation through the partnership and drive of our experienced physicians and caregivers, some of the finest in the Southeast. Each of our medical specialties is complemented by a team of caring professionals dedicated to providing our patients and their families the best possible care.

At Wellmont, we believe there is no substitute for expertise. And we also believe each patient deserves to be cared for in an environment of comfort and healing. We deliver superior care with compassion.

Wellmont CVA Heart Institute. The Wellmont CVA Heart Institute provides a comprehensive cardiovascular program, including preventative, diagnostic, and interventional services on a regionally integrated basis. Wellmont's heart program has been repeatedly recognized for quality outcomes by some

of the nation's leading ratings groups and organizations. These awards serve as independent measures of our commitment to quality and provision of the best possible heart care.

The best heart care involves an integrated approach, bringing leading cardiovascular physicians together with cutting-edge cardiovascular technologies and treatments. The Wellmont CVA Heart Institute brings together seamless integration of top-quality heart services on a level never before realized in Northeast Tennessee and Southwest Virginia through the region's only Level One Heart Attack Network.

The Wellmont CVA Heart Institute is:

- 36 leading cardiologists and cardiac surgeons
- Eight member hospitals of Wellmont Health System
- Nine community cardiac offices with locations across Northeast Tennessee and Southwest Virginia

Wellmont Cancer Institute. The Wellmont Cancer Institute provides comprehensive cancer care, including cyberknife robotic radiosurgery, gliasite, image-guided and intensity-modulated radiation therapy, chemotherapy, counseling services, nutritional services, and patient education. More than 20 oncologists and surgeons practice at the Wellmont Cancer Institute. In addition, the Wellmont Cancer Institute performs research on the prevention and treatment of cancer. The Wellmont Cancer Institute locations include:

- The Christine LaGuardia Phillips Cancer Center at Holston Valley Medical Center
- The J.D. and Lorraine Nicewonder Cancer Center at Bristol Regional Medical Center
- Kingsport Hematology Oncology on Holston Valley Medical Center's outpatient campus
- Tri-City Oncology Center on Bristol Regional Medical Center's campus
- Blue Ridge Medical Specialists on the Bristol Regional Medical Center campus
- The Southwest Virginia Cancer Center, Norton, Va.
- Abingdon Hematology Oncology, Abingdon, Va

Wellmont Stroke Center. As the first certified primary stroke center in the region, the Primary Stroke Center at Bristol Regional Medical Center leads the way in exceptional stroke care. Bristol Regional is a founding member of the Appalachian Regional Stroke Center Network (ARSCN).

The Primary Stroke Center at Bristol Regional has full neurological coverage 24 hours a day, seven days a week. The professionals at the stroke center also provide their expertise to the member hospitals of the ARSCN when a patient presents with stroke. Along with Bristol Regional, Lonesome Pine Hospital is a founding member of the ARSCN. Holston Valley Medical Center also provides specialized stroke care.

Wellmont Emergency Services. Wellmont provides emergency services at all eight hospitals with one of the State's six Level I Trauma Centers located at Holston Valley Medical Center and affiliated with East Tennessee State University and its traumatologists. Bristol Regional Hospital offers Level II Trauma Center services. Our Holston Valley and Bristol Regional trauma programs are supported by WellmontOne Air Transport and by MedFlight (a partnership with the Virginia State Police). The emergency departments at all Wellmont Hospitals are staffed with exceptionally trained and highly experienced staff members and physicians to ensure the best care possible. Patient care liaisons and pastoral care staff are available to provide additional resources, spiritual counseling and emotional support.

Other Services

Marsh Regional Blood Center. Since its establishment as the region's first independent blood bank at Holston Valley Community Hospital in 1947, the goal of Marsh Regional Blood Center has been to collect and maintain a local blood supply to meet local needs. Through generous support from donors, it has grown steadily. In 1987, it was officially named Marsh Regional in honor of Lois Marsh, its founder and supervisor for forty years.

Today, Marsh Regional continues to operate as an independent blood center, providing a safe and affordable blood supply to hospitals and other medical facilities throughout Northeast Tennessee and Southwest Virginia. Each year Marsh Regional collects, processes, tests, stores and distributes tens of thousands of units of blood and blood products.

Marsh Regional Blood Center is a member of American Association of Blood Banks and the Tennessee Association of Blood Banks and is a federally inspected and licensed blood center through the Food & Drug Administration.

Wellmont Nurse Connection. Wellmont Nurse Connection provides health information any time, 24 hours a day, seven days a week. Experienced nurses are available to answer questions via a toll free Wellmont Nurse Connection phone line. An online library may be accessed by patients to learn more about a variety of essential health topics.

Wellmont's Healing Environment. Wellmont's Healing Environment utilizes Shepherds, specially trained and empowered caregivers who exhibit a passion for helping patients heal – physically, mentally and spiritually. These Shepherds are dedicated to creating healing spaces around us, healing attitudes within us and healing relationships between us.

The Healing Environment focuses as much energy on healing patients as it does on curing diseases. In a Healing Environment, patients are the focal points. Decisions are made and actions are taken with our patients first and foremost in mind.

The Healing Environment is not a new concept. Its principles are rooted in the basic concepts of medicine and in the idea that we are each capable of being a Good Samaritan. At times, that may involve the simple offering of a kind word or a compassionate heart. And the Healing Environment acknowledges that sometimes, when that is all we have to give, it is also what is most needed.

The Healing Environment is more than a program or a set of guidelines for care. It is a concept that takes care to another level and a set of principles that promotes true healing.

Other Activities

Graduate Medical Education. Wellmont operates seven accredited residency training programs through affiliations with East Tennessee State University and Lincoln Memorial University: two in Family Medicine, two in Internal Medicine, two in General Surgery and one osteopathic family medicine program. Eighty-three full-time residents participate in the seven programs. Wellmont will be adding a new osteopathic orthopedic residency program affiliated with Lincoln Memorial University in July 2011 with 6 additional residents.

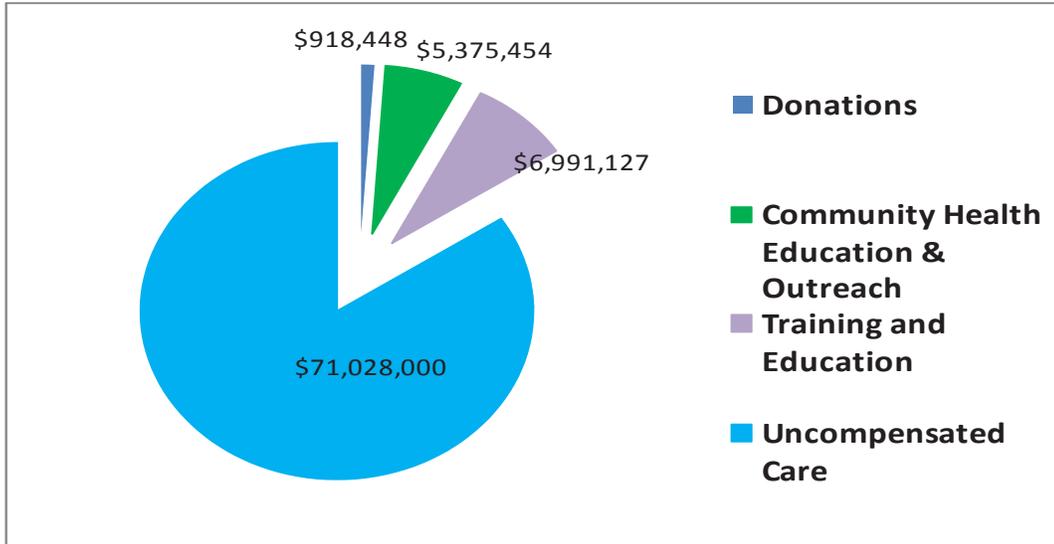
Other Education Programs. Wellmont participates in other education programs for a variety of patient care professions. The 156 programs with 79 different institutions include registered nurse,

certified nursing assistant, physical therapist, surgical technician and respiratory therapist training programs.

Community Health Education. Wellmont offers a variety of courses for the community, as well as for patients and families. Through free health fairs, screenings, lectures and events, we devote significant financial and human resources to help area residents become more aware of their health and wellness. Wellmont serves as the regional affiliate for Children’s Miracle Network Hospitals and the American Heart Association’s Go Red for Women initiative and supports Susan G. Komen for the Cure.

CHARITY CARE

Wellmont offers free or discounted hospital services for those who cannot afford to pay. At Wellmont, a patient with an annual income of less than 200% of the federal poverty level will qualify for a full uncompensated care write-off. In 2010, the cost to Wellmont of providing uncompensated care was \$71 million. Wellmont provides financial assistance for uninsured patients in cases when the annual family income is over 200% of the federal poverty level and the account balance is equal to or greater than 100% of the patients total annual household income. Wellmont has adopted a charity care policy that is designed to ensure that financial constraints are not a barrier to the provision of care.



SERVICE AREA AND COMPETITION

Composition of Service Area

Wellmont’s service area is defined by management at the county level based on patient activity and locations of our campuses. The primary service area (“PSA”) includes the Tennessee counties of Sullivan, Hawkins and Hancock and the Virginia counties of Washington, Wise, Lee and Scott. The Virginia secondary service area (“VSSA”) is defined as Russell, Buchanan, Smyth, Tazewell, Dickenson and Wythe counties. The Tennessee secondary service area (“TSSA”) is defined as Washington, Greene, Carter, Johnson and Unicoi counties. The map below details the service area:



Demographic Information

Below is certain demographic information for Wellmont's Service Area:

WHS Market Population, Growth and Household Income				
	2010	2015	2010-2015	2010 Median
	Total Pop	Total Pop	Growth	HH Income
<u>Primary Service Area</u>				
Sullivan, TN	158,441	159,123	0.4%	\$40,490
Washington, VA	69,294	70,053	1.1%	\$40,298
Wise, VA	49,083	48,461	-1.3%	\$33,715
Hawkins, TN	55,420	57,285	3.4%	\$34,630
Lee, VA	22,479	22,711	1.0%	\$30,703
Scott, VA	23,894	23,834	-0.3%	\$34,695
Hancock, TN	6,074	6,008	-1.1%	\$39,794
	384,685	387,475	0.7%	\$37,711
<u>Secondary Service Area</u>				
Russell, VA	29,223	28,847	-1.3%	\$34,564
Washington, TN	133,110	140,203	5.3%	\$41,280
Buchanan, VA	24,667	23,000	-6.8%	\$28,037
Smyth, VA	32,010	31,185	-2.6%	\$36,892
Tazewell, VA	42,107	41,470	-1.5%	\$36,754
Dickenson, VA	14,730	14,617	-0.8%	\$29,698
Greene, TN	64,833	66,282	2.2%	\$35,725
Carter, TN	46,870	47,657	1.7%	\$32,003
Wythe, VA	31,116	31,418	1.0%	\$40,043
Johnson, TN	19,620	19,902	1.4%	\$28,627
Unicoi, TN	17,894	17,895	0.0%	\$36,135
	456,180	462,476	1.4%	\$33,982

Source: MedStat

<u>Percentage Rate of Unemployment</u>			
	<u>2008</u>	<u>2009</u>	<u>2010</u>
<u>Primary Service Area</u>			
Sullivan, TN	5.4%	8.9%	9.3%
Washington, VA	4.9%	8.5%	9.1%
Wise, VA	4.6%	7.0%	7.5%
Hawkins, TN	6.8%	11.4%	10.3%
Lee, VA	5.3%	7.1%	7.5%
Scott, VA	5.4%	9.5%	10.4%
Hancock, TN	8.4%	15.2%	16.4%
<u>Secondary Service Area</u>			
Russell, VA	5.7%	10.8%	9.6%
Washington, TN	5.7%	8.8%	9.1%
Buchanan, VA	5.0%	9.0%	8.7%
Smyth, VA	6.1%	11.4%	10.8%
Tazewell, VA	4.4%	7.6%	6.7%
Dickenson, VA	5.7%	9.0%	8.4%
Greene, TN	9.5%	15.9%	15.2%
Carter, TN	6.7%	10.3%	10.6%
Wythe, VA	5.3%	10.6%	10.2%
Johnson, TN	5.1%	12.6%	13.8%
Unicoi, TN	7.5%	11.6%	12.2%
Tennessee	6.7%	10.5%	9.7%
Virginia	3.9%	6.7%	6.9%
United States	5.8%	9.3%	9.7%

Source: U.S. Bureau of Labor Statistics

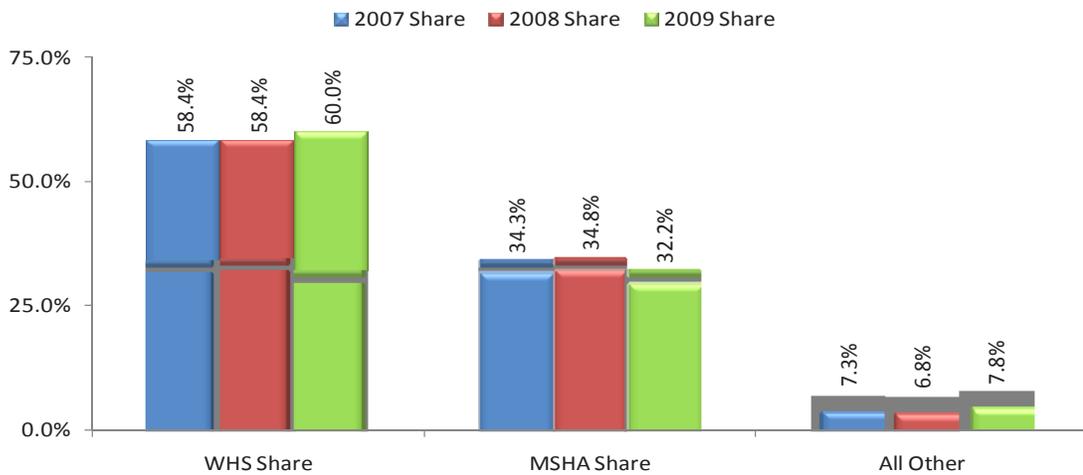
Patient Origin by Service Area

The following tables show patient volume based on service area for Wellmont during fiscal years 2009 and 2010.

Primary Service Area	WHS Inpatient Origin				WHS Outpatient Origin			
	FY 2009	FY 2010	FY 10 % to Total	FY 09 - FY 10 Growth	FY 2009	FY 2010	FY 10 % to Total	FY 09 - FY 10 Growth
<u>Primary Service Area</u>								
Sullivan, TN	14,151	13,885	31.1%	-1.9%	134,629	132,098	34.0%	-1.9%
Washington, VA	5,526	5,626	12.6%	1.8%	44,036	43,122	11.1%	-2.1%
Wise, VA	5,505	5,186	11.6%	-5.8%	56,738	60,429	15.6%	6.5%
Hawkins, TN	4,860	4,795	10.7%	-1.3%	47,731	46,214	11.9%	-3.2%
Lee, VA	3,809	3,651	8.2%	-4.2%	41,653	40,725	10.5%	-2.2%
Scott, VA	2,641	2,640	5.9%	0.0%	17,427	17,440	4.5%	0.1%
Hancock, TN	849	859	1.9%	1.2%	6,472	6,223	1.6%	-3.9%
PSA Total	37,341	36,642	81.9%	-1.9%	348,686	346,251	89.1%	-0.7%
<u>Secondary Service Area</u>								
Russell, VA	1,149	1,124	2.5%	-2.2%	6,187	6,408	1.7%	3.6%
Washington, TN	1,036	1,050	2.4%	1.4%	8,637	8,318	2.1%	-3.7%
Buchanan, VA	835	777	1.7%	-7.0%	2,247	2,452	0.6%	9.1%
Smyth, VA	782	717	1.6%	-8.3%	3,548	3,286	0.9%	-7.4%
Tazewell, VA	752	876	2.0%	16.5%	2,197	2,481	0.6%	12.9%
Dickenson, VA	717	742	1.7%	3.5%	4,895	4,952	1.3%	1.2%
Greene, TN	466	516	1.2%	10.7%	1,982	2,062	0.5%	4.0%
Carter, TN	173	184	0.4%	6.4%	1,276	1,189	0.3%	-6.8%
Wythe, VA	164	148	0.3%	-9.8%	414	432	0.1%	4.4%
Johnson, TN	108	133	0.3%	23.2%	693	648	0.2%	-6.5%
Unicoi, TN	44	27	0.1%	-38.6%	288	223	0.1%	-22.6%
SSA Total	6,226	6,294	14.1%	1.1%	32,364	32,451	8.4%	0.3%
All Other	1,874	1,785	4.0%	-4.8%	11,025	9,984	2.6%	-9.4%
GRAND TOTAL	45,441	44,721	100.0%	-1.6%	392,075	388,686	100.0%	-0.9%

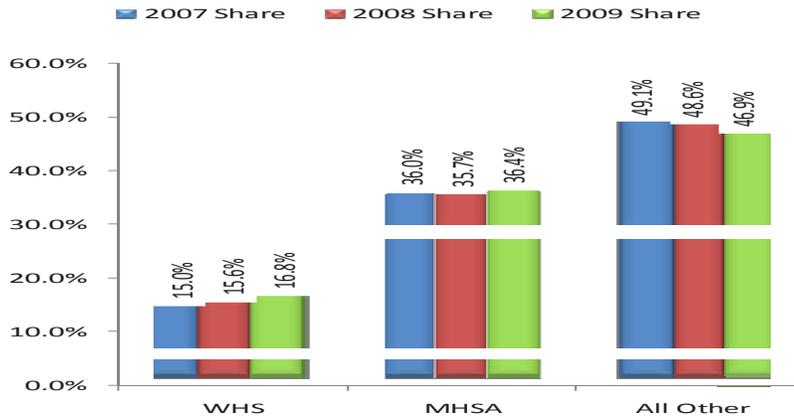
Source: Wellmont Patient Encounter Records

2007-2009 Inpatient Market Share – PSA

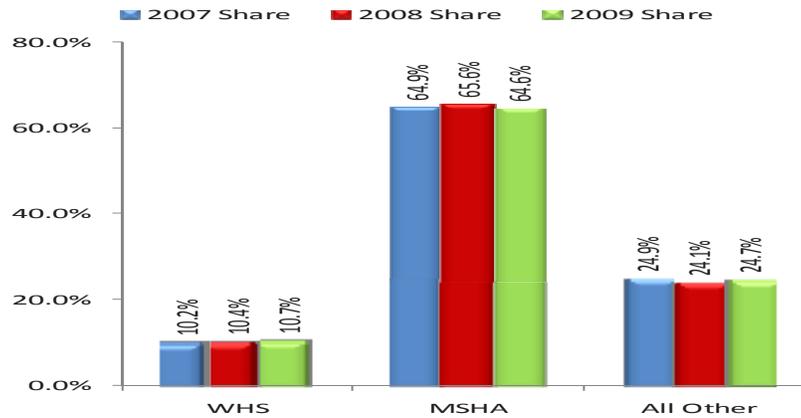


WHS – Wellmont Health System; MSHA – Mountain States Health Alliance

2007-2009 Inpatient Market Share – VSSA



2007-2009 Inpatient Market Share – TSSA



HISTORICAL FINANCIAL INFORMATION

General

The following consolidated financial results of operations and changes in net assets and consolidated balance sheets of Wellmont and its affiliates (all of which are listed in the organizational chart on page A-2 hereof and collectively hereinafter referred to as “Wellmont and Affiliates”) as of and for the years ended June 30, 2008, June 30, 2009 and June 30, 2010 are derived from consolidated financial statements which have been audited by KPMG, LLP, independent auditors. The financial information below and in audited financial statements of Wellmont and Affiliates, included in Appendix B hereto, includes affiliates of Wellmont that are not Members of the Obligated Group. Affiliates of Wellmont which are not Members of the Obligated Group contributed less than 1.5% of the total revenues for the fiscal years ended June 30, 2008, 2009 and 2010 and less than 1.5% of the total revenues for the six-months ended December 31, 2009 and 2010. The data should be read in conjunction with the

consolidated audited financial statements, related notes and other financial information contained herein as Appendix B.

Summary Financial Information

The following consolidated statement of operations and changes in net assets and balance sheets of Wellmont and Affiliates for the three fiscal years ended June 30, 2008, 2009 and 2010 have been derived from the audited consolidated financial statements of Wellmont and Affiliates. The complete audited consolidated financial statements and supplemental information for the fiscal years ended June 30, 2009 and 2010 are included in APPENDIX B – “WELLMONT HEALTH SYSTEM AND AFFILIATES CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTAL INFORMATION” hereto. The following summary consolidated financial information should be read in conjunction with the section herein entitled “MANAGEMENT’S DISCUSSION AND ANALYSIS OF FINANCIAL INFORMATION” and the complete audited consolidated financial statements and related notes that appear in APPENDIX B.

The following consolidated statement of operations and changes in net assets and balance sheets of Wellmont and Affiliates for the six months ended December 31, 2009 and 2010 were derived from the internal unaudited financial statements for such periods. The financial data for the six months ended December 31, 2009 and 2010 include all adjustments management of Wellmont considers necessary to present such information in conformity with accounting principles generally accepted in the United States of America on a basis consistent with that of the audited financial statements for the fiscal year ended June 30, 2010. The results of operations and changes in net assets for the six months ended December 31, 2010 are not necessarily indicative of the operating results to be expected for the entire fiscal year ending June 30, 2011.

Wellmont Health System and Affiliates
Combined Statements of Operations and Changes in Net Assets
(Dollars in Thousands)

	Fiscal Years ended June 30,			6 months ended December 31,	
	2008	2009	2010	2009	2010
				<i>Unaudited</i>	<i>Unaudited</i>
Revenue:					
Net patient revenue	\$679,874	\$680,056	\$692,920	\$342,363	\$375,374
Other revenue	27,211	27,842	31,472	15,968	14,488
Total revenue	<u>707,085</u>	<u>707,898</u>	<u>724,392</u>	<u>358,331</u>	<u>389,862</u>
Expenses:					
Salaries and benefits	314,034	323,801	310,667	152,813	170,104
Medical supplies and drugs	134,304	141,044	150,143	74,499	80,131
Purchased services	81,824	81,031	74,922	36,342	39,455
Interest	14,279	16,013	20,110	8,933	10,819
Provision for bad debts	57,794	33,402	35,293	17,888	18,258
Depreciation and amortization	39,421	42,957	43,711	20,981	23,201
Other	63,038	62,604	66,734	31,445	43,514
Total expenses	<u>704,694</u>	<u>700,852</u>	<u>701,580</u>	<u>342,901</u>	<u>385,482</u>
Income from operations	<u>\$2,391</u>	<u>\$7,046</u>	<u>\$22,812</u>	<u>\$15,430</u>	<u>\$4,380</u>
Nonoperating gains (losses)(1):					
Investment income	31,580	4,181	1,012	5,153	6,960
Derivative valuation adjustments	(4,539)	(5,747)	(2,693)	2,584	1,685
Other, net	(42)	293	(805)	-	(611)
Nonoperating (losses) gains, net	<u>26,999</u>	<u>(1,273)</u>	<u>(2,486)</u>	<u>7,737</u>	<u>8,034</u>
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	\$29,390	\$5,773	\$20,326	\$23,167	\$12,414
Discontinued operations	(6,976)	(4,455)	(1,109)	(878)	86
Revenues and gains in excess of expenses and losses	<u>\$22,414</u>	<u>\$1,318</u>	<u>\$19,217</u>	<u>\$22,289</u>	<u>\$12,500</u>
Income attributable to noncontrolling interests	<u>(177)</u>	<u>(918)</u>	<u>(1,065)</u>	<u>(531)</u>	<u>(779)</u>
Revenues and gains in excess of expenses and losses attributable to WHS	\$22,237	\$400	\$18,152	\$21,758	\$11,721
Other changes in unrestricted net assets (1):					
Change in net unrealized gains (losses) on investments	(40,398)	(60,663)	22,312	26,400	31,982
Net assets released from restrictions for additions to land, buildings and equipment	2,124	2,758	1,555	386	1,156
Transfer to/from permanently restricted net assets	-	-	-	79	-
Change in the funded status of benefit plans and other	(1,536)	(13,568)	(3,429)	(843)	14
Increase (decrease) in unrestricted net assets	<u>(17,573)</u>	<u>(71,073)</u>	<u>38,590</u>	<u>47,780</u>	<u>44,873</u>
Changes in temporarily restricted net assets:					
Contributions	3,539	1,944	2,934	1,132	1,280
Net assets released from temporary restrictions	(2,124)	(3,154)	(1,972)	(482)	(1,372)
Increase (decrease) in temporarily restricted net assets	<u>1,415</u>	<u>(1,210)</u>	<u>962</u>	<u>650</u>	<u>(92)</u>
Changes in permanently restricted net assets:					
Transfer to/from unrestricted net assets	-	-	-	(79)	-
Permanently restricted contributions and investment income	10	645	(77)	1	2
Increase (decrease) in permanently restricted net assets	<u>10</u>	<u>645</u>	<u>(77)</u>	<u>(78)</u>	<u>2</u>
Changes in noncontrolling interests (1):					
Adjustment to noncontrolling interest from the adoption of authoritative guidance	1,142	-	-	-	-
Income attributable to non-controlling interests	177	918	1,065	531	871
Distributions to noncontrolling interests	-	(426)	(711)	(537)	(671)
Changes in noncontrolling percentages	-	243	(21)	-	(92)
Increase (decrease) in noncontrolling interests	<u>1,319</u>	<u>735</u>	<u>333</u>	<u>(6)</u>	<u>108</u>
Change in net assets (1)	<u>(14,829)</u>	<u>(70,903)</u>	<u>39,808</u>	<u>48,346</u>	<u>44,891</u>
Net assets, beginning of period (1)	412,650	397,821	326,918	326,918	366,726
Net assets, end of period (1)	<u>\$397,821</u>	<u>\$326,918</u>	<u>\$366,726</u>	<u>\$375,264</u>	<u>\$411,617</u>

(1) Reflects change from "minority interests" to "noncontrolling interests" from the adoption of authoritative guidance and reflects Medical Mall Pharmacy as discontinued operations for all periods.

Wellmont Health System and Affiliates
Consolidated Balance Sheets
(Dollars in Thousands)

	June 30,			December 31,	
	2008	2009	2010	2009 Unaudited	2010 Unaudited
Current assets:					
Cash and cash equivalents	\$ 13,787	\$ 60,889	\$ 35,711	\$ 55,608	\$ 50,068
Assets limited as to use	2,235	2,201	1,815	-	-
Patient accounts receivable	109,514	98,071	94,057	90,510	104,374
Other receivables	12,714	11,173	10,919	10,994	9,953
Inventories	16,816	17,169	18,294	17,911	18,050
Prepaid expenses & other current assets	6,008	6,040	7,003	6,840	9,017
Total current assets	<u>161,074</u>	<u>195,543</u>	<u>167,799</u>	<u>181,863</u>	<u>191,462</u>
AWUIL, net of current portion	<u>346,414</u>	<u>245,600</u>	<u>301,807</u>	<u>268,298</u>	<u>297,211</u>
Land, buildings and equipment, net	<u>406,214</u>	<u>442,610</u>	<u>450,205</u>	<u>449,736</u>	<u>446,569</u>
Other assets:					
Long-term investments	35,571	31,974	32,391	34,707	35,324
Investments in affiliates	29,155	31,976	32,019	32,180	31,084
Deferred debt expense, net	5,062	4,824	4,644	4,728	4,709
Goodwill, net	9,641	9,509	9,501	9,496	16,628
Other	7,059	798	730	713	2,304
	<u>86,488</u>	<u>79,081</u>	<u>79,285</u>	<u>81,824</u>	<u>90,049</u>
Total assets	<u>\$ 1,000,190</u>	<u>\$ 962,834</u>	<u>\$ 999,096</u>	<u>\$ 981,721</u>	<u>\$ 1,025,291</u>
Current liabilities:					
Current portion of long-term debt	\$ 10,237	\$ 13,197	\$ 11,958	\$ 11,846	\$ 9,858
Line of credit/Short-term notes	17,932	15,811	14,000	14,000	14,000
Accounts payable and accrued expenses	76,958	77,139	74,679	62,536	67,316
Estimated third-party payor settlements	2,086	12,441	11,672	9,300	13,820
Current portion of other LT liabilities	4,915	6,352	7,251	6,802	8,380
Total current liabilities	<u>112,128</u>	<u>124,940</u>	<u>119,560</u>	<u>104,484</u>	<u>113,374</u>
Long-term debt, less current portion	469,321	474,608	467,833	466,841	456,086
Other long-term liabilities, less current(1)	20,920	36,368	44,977	35,132	44,214
Total liabilities	<u>602,369</u>	<u>635,916</u>	<u>632,370</u>	<u>606,457</u>	<u>613,674</u>
Net assets:					
Unrestricted	391,103	320,030	358,620	367,731	403,491
Temporarily restricted	4,799	3,589	4,551	4,239	4,460
Permanently restricted	600	1,245	1,168	1,246	1,170
Noncontrolling interests (1)	1,319	2,054	2,387	2,048	2,496
Total net assets	<u>397,821</u>	<u>326,918</u>	<u>366,726</u>	<u>375,264</u>	<u>411,617</u>
Total liabilities and net assets	<u>\$ 1,000,190</u>	<u>\$ 962,834</u>	<u>\$ 999,096</u>	<u>\$ 981,721</u>	<u>\$ 1,025,291</u>

(1) Reflects change from "minority interests" to "noncontrolling interests" from the adoption of authoritative guidance.

Sources of Patient Service Revenue

The following table shows the percentage of gross patient service revenue by payor for the fiscal years ended June 30, 2008, 2009 and 2010, and the six months ended December 31, 2010.

	Sources of Revenue			December 31, 2010
	June 30, 2008	June 30, 2009	June 30, 2010	
Medicare	34.5%	33.6%	32.5%	32.7%
Medicaid	13.5%	13.5%	13.5%	12.9%
Self Pay	6.1%	6.2%	6.5%	6.7%
Medicare Managed Care	14.7%	17.0%	18.4%	18.8%
Managed Care	25.8%	25.1%	25.0%	25.3%
Other	5.4%	4.7%	4.2%	3.5%
	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>

Source: Wellmont management

Approximately 49 percent of Wellmont's revenue sources are under managed care contracts – 6% in TennCare, 19% in Medicare Managed Care and 25% in Managed Care. The Medicare and TennCare contracts cover 127,000 lives in our service area. Wellmont Health System has contracts with 29 different managed care companies. Approximately 87 percent of our managed care revenues are concentrated with four different payors. Our contracts are normally reimbursed on a case basis with a percent of charge applied to most outpatient business.

Capitalization

The following table sets forth the capitalization ratios for Wellmont and Affiliates as of June 30, 2008, 2009 and 2010 and as of December 31, 2010.

		June 30			December 31
		2008	2009	2010	2010
(dollars in thousands)					
Capitalization					
Current portion of long-term debt		\$ 10,237	\$ 13,197	\$ 11,958	\$ 9,858
Lines of credit/short-term notes payable		17,932	15,811	14,000	14,000
Long-term debt, less current portion	A	469,321	474,608	467,833	456,086
Total debt		<u>497,490</u>	<u>503,616</u>	<u>493,791</u>	<u>479,944</u>
Unrestricted net assets	B	391,103	320,030	358,620	403,491
Other net assets		6,718	6,888	8,106	8,126
Total net assets		<u>397,821</u>	<u>326,918</u>	<u>366,726</u>	<u>411,617</u>
Long-term debt plus Unrestricted net assets	A+B	<u>\$ 860,424</u>	<u>\$ 794,638</u>	<u>\$ 826,453</u>	<u>\$ 859,577</u>
Long-term debt to Capitalization	A/(A+B)	0.545	0.597	0.566	0.531

Estimated Days Cash on Hand

The following table sets forth, for Wellmont and Affiliates, on a consolidated basis, the annual days cash on hand ratios for the fiscal years ended June 30, 2008, 2009 and 2010, and twelve months ended December 31, 2010.

	June 30			December 31
	2008	2009	2010	2010
	(dollars in thousands)			
Days Cash on Hand				
Unrestricted cash	\$ 13,787	\$ 60,889	\$ 35,711	\$ 50,068
Unrestricted investments:				
Capital improvements	200,469	157,467	247,674	244,120
Long-term investments	35,571	31,974	32,391	35,324
Less illiquid investments	(40,803)	(34,682)	(35,003)	(36,253)
	209,024	215,648	280,773	293,259
Operating expenses (12 months)	704,694	700,852	701,580	744,161
Less depreciation and amortization	(39,421)	(42,957)	(43,711)	(45,931)
Total cash expenses	665,273	657,895	657,869	698,230
Number of days in the period	366	365	365	365
Daily cash operating expenses	\$ 1,818	\$ 1,802	\$ 1,802	\$ 1,913
Days cash on hand	114.99	119.64	155.78	153.30

Historical Annual Debt Service Coverage

The following table sets forth, for Wellmont and Affiliates, on a consolidated basis, the actual historical annual debt service coverage ratio calculated in accordance with the Master Indenture for the fiscal years ended June 30, 2008, 2009 and 2010, and twelve months ended December 31, 2010.

	June 30			December 31
	2008	2009	2010	2010
	(dollars in thousands)			
Debt Service Coverage				
Revenue and gains in excess of expenses and losses (12 months)	\$ 22,414	\$ 1,318	\$ 19,217	\$ 9,428
Add back:				
Depreciation and amortization (12 months)	39,421	42,957	43,711	45,931
Interest expense (12 months)	14,279	16,013	20,110	21,996
Loss from discontinued operations (12 months)	6,976	4,455	1,109	145
Total income available for debt service per Master Trust Indenture C	83,090	64,743	84,147	77,500
Maximum annual debt service D	\$ 38,050	\$ 38,050	\$ 38,050	\$ 37,810
Debt Service Coverage Ratio per Master Trust Indenture C/D	2.18	1.70	2.21	2.05

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL INFORMATION

Accounting Policies and Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the

consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates include: the carrying amounts for goodwill, and property, plant, and equipment; valuation allowances for receivables; and liabilities for claims incurred but not reported under self-insured programs. Actual results could differ from those estimates.

For more information regarding Wellmont's accounting policies, see the notes to the audited consolidated financial statements that appear in APPENDIX B.

Historical Performance

Fiscal Year Ended June 30, 2009 vs. 2008

Net patient collections (defined as net patient revenues less bad debt) increased by \$24.6 million or 4.0 percent for the fiscal year ended June 30, 2009 compared to the same period in 2008. Patients in a bed, excluding newborns, were 50,650, which represented an increase of 2,276 (4.7 percent). Gross revenues increased by \$69.0 million resulting from utilization increases as additional operations came on line. Contractual adjustments and bad debt were higher by \$40.0 million, reflective of modest payor mix changes. Charity care increased by \$4.5 million versus 2008, reflective of the overall utilization increases. The increase is net of the effect of reclassification of certain accounts as charity care versus bad debt due to a policy change.

Salaries, benefits and purchased services increased by \$9.0 million or 2.3 percent. Rate of pay and benefits increases provided to employees caused the increase. Supply costs increased by \$6.7 million or 5.0 percent as a result of volume along with increases in price and mix of services provided. Other direct expenses decreased slightly (\$0.4 million or 0.7 percent) over the same period last year. This was caused by increases in lease, rental, repair and maintenance offset by consulting and discretionary spending control.

Bad debt expense reflects a significant decrease due to a change in policy resulting in a reclassification of accounts as charity versus bad debt in FY 2009. The slight net increase associated with volume and shift to Medicare Managed Care is reflected in the net collections discussed above.

Interest, depreciation and amortization increased by \$5.3 million or 9.8 percent related to purchases and Project Platinum coming on line.

Operating income was a \$7.1 million or a 1.0 percent margin compared to \$2.4 million or a .30 percent margin for fiscal year 2008.

Investment income was lower in fiscal year 2009 than in fiscal year 2008 given greater investment market volatility. Discontinued operations included the impact of Jenkins Community Hospital and Medical Mall Pharmacy over the two periods.

Excess of Revenues over Expenses was \$1.3 million in fiscal year 2009 compared to \$22.4 million for fiscal year 2008.

Fiscal Year Ended June 30, 2010 vs. 2009

Net patient collections increased by \$11.0 million or 1.7 percent for the fiscal year ended June 30, 2010 compared to the same period in 2009. Patients in a bed, excluding newborns, were 50,910, which represented an increase of 260 (.5 percent). Gross revenues decreased by \$19.2 million resulting from overall volume and utilization decreases. Contractual adjustments and bad debt were lower by \$27.1

million, reflective of utilization changes and improvements in reimbursement and contracted rates. Charity care decreased by \$2.9 million versus 2009, reflective of the utilization changes combined with slight payor mix changes.

Salaries, benefits and purchased services expenses decreased year over year by \$19.2 million or 4.8 percent. This decrease was driven by a reduction of full time equivalents and contractual obligation negotiations to reduce costs and right size operations. Supply expense was higher year over year by \$9.1 million or 6.5 percent. \$4 million of the supply increase is directly related to the increase in blood products. Drug costs drove another \$3.8 million of the increase primarily related to oncology drug costs. Other operating expense increased by \$4.1 million or 6.6 percent as a result of fees and other changes in expense structure associated with the right-sizing.

Bad debt expense increased by \$1.9 million or 5.7 percent because employers and payors shifted a larger amount of expenses to co-payments and deductibles.

Interest, depreciation and amortization increased by \$4.8 million or 8.2 percent related to Project Platinum coming on line and additional debt-related expenses.

Operating income was \$22.8 million or a 3.2 percent margin in fiscal year 2010, compared to \$7.1 million or a 1.0 percent margin in fiscal year 2009.

Investment income was lower in FY 2010 as a result of continued volatility in the market and the recognition of other than temporary losses. Discontinued operations were driven by the recognition of the sale of the Medical Mall Pharmacy operation.

Excess of Revenues over Expenses was \$19.2 million compared to \$1.3 million in the prior fiscal year.

Interim Six-Months Ended December 31, 2010 vs. 2009

Net patient revenue has grown 2.0% or \$6.9 million over the previous six month period last year. This excludes the additional revenue of \$16.6 million reported as a result of the merger of the cardiology practice in May 2010 and \$9.5 million related to the TennCare fee assessment. The \$9.5 million of fee assessment is offset in other expenses. Other revenue shows a decrease as a result of poor performance related to the Takoma joint venture.

Salaries and benefits for the six month period has increased over last year-to-date by \$1.9 million or 1.2% , net of cardiology practice expenses of \$15.4 million, driven by the 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 \$4.6 million or 6.1%, net of cardiology practice expenses of \$1.1 million, driven by higher drug costs, particularly in oncology, and utilization as well as volume.

Other expenses increased in the period over the same period last year by \$0.7 million as a result of increases in rental to support new operations and increases in maintenance for software systems.

Interest and depreciation increases are related to the completion of Project Platinum

Year-to-date, growth in expenses has out-stripped the growth in revenues resulting in a 1.1% operating margin.

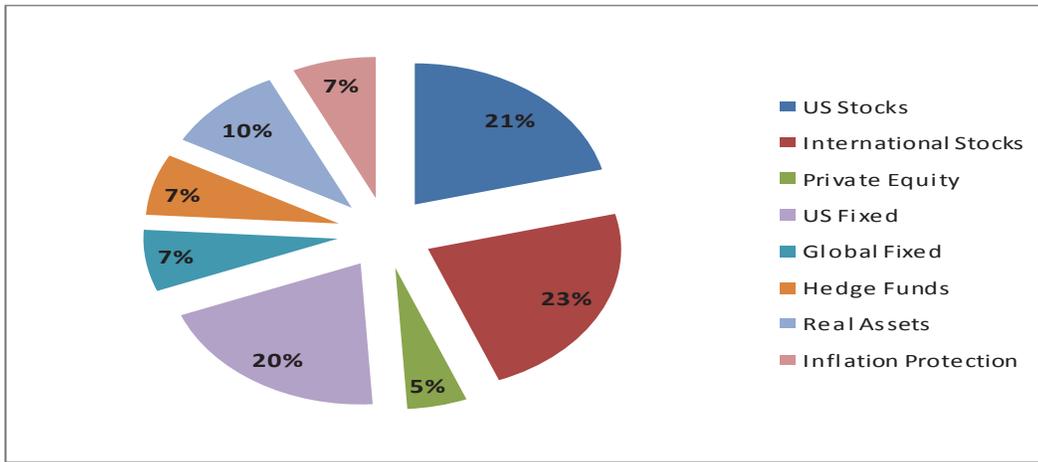
Investments are performing well with the rebound in the market while the mark-to-market on our derivatives is not as volatile as last year.

Discontinued operations include changes related to the valuation of the Jenkins' accounts receivable where last year also includes the Medical Mall Pharmacy operations.

Excess of Revenues over Expenses was \$12.5 million compared to \$22.3 million in the prior fiscal year.

Liquidity and Investment Policy

At December 31, 2010, Wellmont Health System had approximately \$293.3 million of unrestricted cash and cash equivalents and investments. The following chart sets forth the asset allocation of those funds.



Board-designated investments are invested pursuant to an investment policy approved by the Board (the "Investment Policy"). The policy specifies allowable investments, liquidity needs, performance benchmarks and asset allocation guidelines. The Board has delegated the implementation of this policy to the Finance and Investment Committee, which consists of members of the Board and other appointed members.

At the beginning of 2010, Wellmont completed a revision to the Investment Policy and implemented an asset allocation study for the investment portfolio. Wellmont relied on an external investment consultant to conduct a study that reviewed the existing investment pool and associated allocations and the efficiency of the investment pool's performance to date. The investment advisor, at the direction of Wellmont management, considered the operating characteristics, including time horizon, liquidity requirements, return expectations and risk tolerance, as well as the overall objective for the investment pool for incorporation into its investment policy and asset allocations recommendation. The allocation targets for the investment pool were adopted as follows: 28% fixed income (risk reduction assets), 21% domestic equity, 21% international equity, 3% emerging market, 5% private equity/special purposes, 6% hedge funds and 16% in inflation protection assets. These target allocations are based upon a long-term outlook. Performance is monitored regularly and adjustments are made if necessary. Actual allocations may differ from target allocations in the short-term or during periods of significant market fluctuations, and there can be no assurance that Wellmont will always rebalance the investment portfolios.

The investment policies are subject to revision from time to time by the Finance and Investment Committee. There can be no assurance that Wellmont will achieve its investment objectives or that it will receive any return on their investments. Investment performance may be volatile, and Wellmont may lose a significant portion of its investment portfolio. Adverse economic and market conditions or other events could result in substantial or total loss in respect of some or all investments.

Achievement of investment income is subject to significant risks and Wellmont can give no assurance that its investments will generate any particular level of return. See “BONDHOLDERS’ RISKS” in the forepart of this Official Statement. If Wellmont suffers investment losses, their business plans and financial results could be materially impacted.

Retirement Plan

Wellmont sponsors a retirement program and defined contribution retirement plan (Retirement Plan) that covers substantially all employees. This program and the related Retirement Plan were created from amendments, restatements, and mergers of existing defined contribution plans at Holston Valley and Bristol Regional. Wellmont makes annual contributions to the Retirement Plan in an amount equal to three percent of each participant’s base wages and contributes an additional amount, based on each participant’s voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Service Code, up to three percent of each participant’s wages.

In addition, there is a legacy Wellmont Health System Defined Benefit Plan that includes grandfathered employees at Holston Valley and Lonesome Pine Hospitals. The Defined Benefit Plan is frozen and no further benefits accrue. The plan is actuarially valued annually and Wellmont recognizes the funded status as an asset or liability in its consolidated balance sheets and recognizes changes in funded status in the year in which the change occurs as a change in unrestricted net assets.

Certain Indebtedness and Liabilities

Wellmont’s current and projected debt profiles (refinancing the 2006A Bonds with fixed rate debt with the same maturity to 2032 and replacing the letter of credit issued by Bank of America, N.A. securing the Series 2005 Bonds with a letter of credit issued by JP Morgan Chase Bank, N.A.) are shown in the schedules below:

Current Debt Profile:

Series	Par Outstanding	Structure	Credit Enhancement	Swaps	Maturity
2003	36,665,000	Fixed Rate	Radian		2019
2005	59,580,000	VRDBs	LOC (BAML)	Fixed Payer	2032
2006A	76,595,000	Index Floating Rate		TRS/Fixed Payer	2032
2006C	200,000,000	Fixed Rate			2036
2007A	55,000,000	Fixed Rate			2037
Capital Leases	19,270,174	Fixed Rate			Various
Notes Payable	5,944,842	Fixed Rate			Various
Line of Credit	14,000,000				2011
Series 2010 BQ	30,000,000	Index Floating Rate			2026
	<u>497,055,016</u>				

As of December 31, 2010

SWAP Profile:

Series	Notional	Related Bonds	Maturity	Receive	Pay	MTM
Basis Swap	62,730,000	Series 2002 (defeased)	2032	73.8% LIBOR	SIFMA	(2,267,701)
Total Return Swap	76,595,000	Series 2006A	2011	Bond Rate+1.10%	SIFMA	1,099,184
Fixed Payer	59,580,000	Series 2005	2016	67% 1M LIBOR	3.548%	(6,145,511)
Fixed Payer	35,342,000	Series 2006A	2021	67% 1M LIBOR	3.613%	(3,944,601)
TOTAL	234,247,000					(11,258,629)

As of December 31, 2010

Proposed Debt Profile:

Series	Par Outstanding	Structure	Credit Enhancement	Swaps	Maturity
2003	36,665,000	Fixed Rate	Radian		2019
2005	59,580,000	VRDBs	LOC (JPM)	Fixed Payer	2032
2011	76,165,000	Fixed Rate		Total Return Swap	2032
2006C	200,000,000	Fixed Rate			2036
2007A	55,000,000	Fixed Rate			2037
Capital Leases	19,270,174	Fixed Rate			Various
Notes Payable	5,944,842	Fixed Rate			Various
Line of Credit *	7,000,000				2011
Series 2010 BQ	30,000,000	Index Floating Rate			2026
	489,625,016				

After Issuance

* Paid \$7M in January 2011

Capital Improvement Plans

Overview of 2011 Capital Budget. The 2011 capital budget is approximately \$44.0 million. Management expects that \$10.0 million will be spent on strategic items with the majority being spent on the purchase of the Southwest Virginia Cancer Center building and land. Before any individual project is commenced or significant capital costs are incurred, the project is evaluated by management to determine financial feasibility and is submitted for approval to the Board. Management expects that the sources of funding for the capital projects approved will be cash from operations and philanthropic donations. Management closely monitors the progress of each project, including oversight of the schedule and the budget, and regularly reports such progress to the Board.

CORPORATE GOVERNANCE

Wellmont Board of Directors

Wellmont is governed by the Board, which is composed of community members. The role of the Board is to establish policy, promote performance improvement and provide for necessary resources and organizational management and planning.

Each trustee is elected for a four-year term and may serve a maximum of two terms, which then must be followed by one year off the Board before being elected to serve again. The bylaws of Wellmont require that there be at least 13 and not more than 15 voting trustees, four of whom must be physicians. There are seven at large members, one member as designated by the Lonesome Pine Advisory Board, one member designated by the Hawkins County Advisory Board. In addition there are two ex-officio

members by virtue of their positions of chairs of the Bristol and Holston Valley Advisory Boards. The chief executive officer of Wellmont serves on the Board as an *ex-officio* non-voting member.

The Directors serve on a voluntary basis and receive no compensation for their services. The names of the current Directors, their occupations and years of service are as follows:

Name/Title	Term Expires	Eligible for Another Term	Occupation
R. David Crockett Sr., chairman	06/30/2013	Yes - Through 6/30/2017	Consultant
T. Arthur Scott Jr., vice chairman	06/30/2014	Yes - Through 6/30/2018	Attorney
Julie Bennett, secretary	06/30/2013	Yes - Through 6/30/2017	Attorney
E. Wayne Kirk, treasurer/assistant secretary	06/30/2011	No	Certified Valuation Analyst and Certified Public Accountant
Robert Burgin	06/30/2013	Yes - Through 6/30/2017	Retired Hospital Administrator
Dr. Marvin Cameron	06/30/2012	ex-officio	Consultant
Denny DeNarvaez		by virtue of office	President and CEO
Dr. Pierre Istfan	06/30/2013	Yes - Through 6/30/2017	Cardiologist
Wayne Kennedy	06/30/2011	ex-officio	Retired Executive - Bristol Compressors
Ravan Krickbaum	06/30/2014	No	Retired - Superintendent of Rogersville City Schools
Roger Leonard	06/30/2013	Yes - Through 6/30/2017	Consultant
Roger K. Mowen Jr.	06/30/2012	Yes - Through 6/30/2016	Retired Executive Eastman Chemical Company
Dr. Thomas Pugh	06/30/2012	No	Radiologist
Glen "Skip" Skinner	06/30/2012	Yes - Through 6/30/2016	Administrator Wise County
Dr. Douglas Springer	06/30/2014	Yes - Through 6/30/2018	Gastroenterologist
Dr. David Thompson	06/30/2011	No	Internal Medicine Physician
John Williams	06/30/2014	Yes - Through 6/30/2018	CEO, Regional Eye Center

The Board delegates certain of its functions to several committees. Currently, the bylaws provide for five standing committees: Audit and Compliance; Governance; Human Resources; Finance and Investment; and Quality/Safety/Service. In addition to the five standing committees, the Board may appoint other committees from time to time. The committee responsible for oversight of Wellmont's financial operations is the Finance and Investment Committee. The Finance and Investment Committee is comprised of at least three trustees, and its purpose is to develop and monitor oversight of the operating and capital budgets and the investment portfolio of Wellmont. The Audit and Compliance Committee is responsible for oversight of Wellmont's financial reporting. Oversight responsibility of the Audit and Compliance Committee includes, but is not limited to: the integrity of financial statements, the financial reporting process, the systems of internal accounting and financial controls; the performance of a coordinated internal audit function; the performance of independent auditors; compliance with ethics policies; and compliance with legal and regulatory requirements.

Relationships with Board Members

Wellmont is permitted to enter into transactions from time to time with business organizations with which one or more of Wellmont's officers or Directors are affiliated. Pursuant to existing policy of the Board, such transactions or affiliations are permitted only after full disclosure of potential conflicts of interest to the Board and approval by a majority of the disinterested Directors. Interested Directors are not permitted to vote or to use personal influence on the matter and such Director is not counted in determining the quorum for a meeting when Board action is to be taken on the matter. The minutes of the meeting must reflect that a disclosure was made, the abstention from voting and the quorum satisfaction. There are currently no conflicts of interest with Directors relating to the Series 2011 Bonds.

Executive Management

Brief biographies of the executive management of Wellmont are set out below.

Margaret “Denny” DeNarvaez is president and CEO of Wellmont Health System. An accomplished executive with nearly 30 years of healthcare experience, DeNarvaez previously served as CEO of St. John’s Mercy Health Care, which includes hospitals in both St. Louis and Washington, Mo. DeNarvaez also provided 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 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 was 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. 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.

Elizabeth “Beth” Ward is executive vice president and chief financial officer of Wellmont Health System. She was appointed to this role in 2010. Ms. Ward was previously employed as CFO and treasurer of Moses Cone Health System in Greensboro, N.C., a position she had held since 2001. She joined Moses Cone in 1996 as the first corporate controller and previously worked in leadership roles at the University of North Carolina at Chapel Hill’s Division of Health Affairs and the University of North Carolina Hospitals. Ms. Ward is a graduate of Radford University in Virginia, where she received a bachelor’s degree in business finance and insurance. She earned a master’s degree in business administration from the University of North Carolina at Greensboro. She is a member of the Health Management Academy and the American Institute of Certified Public Accountants, as well as an advanced member of the Healthcare Financial Management Association. She is a certified public accountant in North Carolina and Tennessee and holds a leadership certification from the University of Michigan Business School in Ann Arber. She was named Business Woman of the Year by the Triad Business Journal in 2007 and CFO of the Year for Extra Large Organizations by the Triad Business Journal in August, 2009.

Tracey Moffatt is chief operating officer for Wellmont Health System. Moffatt, who has more than 25 years’ experience as a clinical and operations leader, joined Wellmont in January, 2011. As COO, Moffatt provides strategic leadership across the health system in areas of clinical service delivery, performance and quality management and decision support. She previously was senior vice president of consulting for Navvis and Company, a national healthcare consulting firm. Previously, Moffatt was employed for nearly two decades by the Sisters of Mercy Health System in St. Louis. She held positions of increasing responsibility during her tenure there, culminating in her service as executive vice president of clinical performance/chief nurse executive for St. John’s Mercy Health Care. Moffatt received her bachelor’s degree in nursing from Louisiana State University Medical Center in New Orleans. She earned a master’s degree in healthcare administration from Trinity University in San Antonio. She is a member of Sigma Theta Tau and in 2009 received the Missouri Hospital Association’s Distinguished Quality Professional Award.

Patrick Kane, an Emmy-nominated producer with nearly 25 years’ experience in advertising, marketing and communications, is senior vice president of marketing communications for Wellmont Health System. Before joining Wellmont in 2005, Mr. Kane served as director of marketing

communications for Conemaugh Health System in Johnstown, Pa. Prior to joining Conemaugh in 1997; he served as vice president and treasurer of Kane and Company Advertising Inc. in Johnstown. Mr. Kane is a graduate of Saint Joseph's College in Rensselaer, Ind., where he received a bachelor's degree in communications and theater arts, and King College in Bristol, Tenn., where he earned a master's degree in business administration.

Hamlin Wilson, senior vice president of human resources, joined the Wellmont Health System executive leadership staff in 2003. He has 22 years experience in health care, directing human resources functions for healthcare organizations in Tennessee and Mississippi. Mr. Wilson received his bachelor's degree at Southern Illinois University in Carbondale, Ill., and earned his master's degree at the University of Southern Mississippi in Hattiesburg, Miss. He holds advanced certification as a senior professional in human resources from the Society for Human Resource Management. He is a past president of the Tennessee Healthcare Human Resources Association and was honored by the American Society of Healthcare Human Resources Association when he received the Paul Guy Mentorship Award in 2003.

John Howard, an accomplished healthcare executive who holds doctorate and law degrees, serves as Wellmont Health System's general counsel and will help guide the organization's medical practice operations as of April 1, 2011. Mr. Howard worked for St. John's Mercy Health Care in St. Louis from 2001 to 2011. Most recently, he served as executive vice president and chief development officer. He was previously senior vice president, general counsel and assistant secretary. He also served as director of corporate compliance and privacy officer. Mr. Howard received a Bachelor of Arts degree in liberal studies from Concordia Lutheran College in Austin, Texas; a master's degree in English and philosophy from the University of Texas at Austin; a doctorate degree in English from St. Louis University; and a law degree from St. Louis University.

Todd Norris is executive director of the Wellmont Foundation and Wellmont Health System's senior vice president of institutional advancement. Mr. Norris is a graduate of East Tennessee State University, where he received his bachelor's and master's degrees. He has completed certificate programs through the Institute for Charitable Giving and Wharton's Institute for Higher Education Research. He is a member of the Council for Advancement and Support of Education, the Institute for Charitable Giving and the Association for Healthcare Philanthropy.

Virginia Frank is president of Holston Valley Medical Center. Ms. Frank previously served as administrator of the Heart and Vascular Hospital, a 96-bed facility that is part of St. John's Mercy Medical Center in St. Louis. She also served as vice president of operations for St. John's Mercy Medical Center. She previously worked as vice president of operations for Abbott Northwestern Hospital in Minneapolis and as chief information officer for Florida Medical Center Hospital in Fort Lauderdale, Fla. She earned a bachelor's degree in business administration from Florida Atlantic University in Boca Raton, Fla. She has also participated in the Global Leadership Development Program of the University of Michigan Business School.

Bart Hove, president of Bristol Regional Medical Center, is a graduate of Georgia Institute of Technology in Atlanta and the University of Alabama in Birmingham, where he received a master's degree in hospital administration. Before joining Bristol Regional in 2000, Mr. Hove was previously employed as chief executive officer of Delta Regional Medical Center in Greenville, Miss., CEO and president of Good Samaritan Hospital in Lexington, Ky., CEO of Crestwood Hospital in Huntsville, Ala., and administrator of Beaches Hospital in Jacksonville, Fla. He is a member of the American College of Hospital Administrators and the American Hospital Association.

David Brash serves as president of Lonesome Pine Hospital and regional vice president of Wellmont Health System hospitals in Southwest Virginia. Mr. Brash earned his bachelor's degree in

healthcare administration from West Virginia Institute of Technology and received his master's degree in healthcare administration from West Virginia College in Charleston. Prior to joining Mountain View, Brash served as the chief executive officer at Harlan Appalachian Regional Hospital in Kentucky, Russell County Medical Center in Lebanon, Va., and Plateau Medical Center in Oak Hill, W.Va. He has achieved fellow status with the American College of Healthcare Executives and is a member of the Virginia Hospital and Healthcare Association.

Fred Pelle, president of Hawkins County Memorial Hospital since 2005 and president of Hancock County Hospital since 2008, began his healthcare career in 1982 and has served in executive positions at hospitals in Alabama, Kentucky, Georgia and Virginia. Most recently, he served as CEO of Buchanan General Hospital in Grundy, Va. He is a graduate of Athens State College, where he earned a bachelor's degree in accounting, and Troy State University, where he received a master's degree in business administration. He is a fellow of the American College of Healthcare Executives and an advanced member of the Healthcare Financial Management Association.

Daniel Wolcott is president of Takoma Regional Hospital. Mr. Wolcott previously served as vice president of Florida Hospital Ormond Memorial and as administrator of Florida Hospital Oceanside, 205-bed and 119-bed hospitals, respectively, in Ormond Beach, Fla. He also previously served as director of patient financial services at Florida Hospital Ormond Memorial, and held the same title at Emory-Adventist Hospital in Smyrna, Ga. Mr. Wolcott received a master's degree in business administration with an emphasis in finance from Georgia State University. He earned a bachelor's degree in business administration/marketing from Southern Adventist University.

Tim Attebery is Senior Vice President of Cardiology Services for Wellmont Health System. Mr. Attebery has 26 years of healthcare consulting and senior management experience focused on cardiovascular services. From 1992 until 2010, he served as CEO at three different large cardiovascular group practices. Mr. Attebery managed the integration of Cardiovascular Associates and Wellmont Health System in 2010. He started CVI3, a national cardiovascular services consulting and training company in 2004 and sold that company in 2008. Mr. Attebery served on the Executive Committee and as President of the Cardiology Leadership Alliance, a national network of premier cardiology groups now known as MedAxiom. He organized the founding of the Society of Cardiovascular CT, which currently has over 5,000 international members and is recognized by the American College of Cardiology and the American Heart Association as the definitive, scientific organization for all cardiac CT matters.

MEDICAL STAFF

General. As of March 31, 2011, the combined medical staff of the Wellmont Health System consisted of 1,044 physicians with 932 or 89 percent being board certified. The average age of the medical staff was approximately 50 years.

	Active			Associate			Consulting			Courtesy			Affiliate			TOTAL		
	Avg Age	Bd Cert	Total	Avg Age	Bd Cert	Total	Avg Age	Bd Cert	Total	Avg Age	Bd Cert	Total	Avg Age	Bd Cert	Total	Avg Age	Bd Cert	Total
Bristol Regional Medical Center	51	169	190	38	26	32	50	30	31	52	47	51	51	42	49	50	314	353
Holston Valley Medical Center	50	243	246	42	60	60	49	56	56	49	40	41	54	40	41	49	439	444
Mountain View Regional Medical Center	52	15	31							51	40	53				52	55	84
Lee Regional Medical Center	49	8	15				58	1	1	53	25	32				52	34	48
Lonesome Pine Hospital	56	14	21				49	40	41	51	50	63				51	104	125
Hawkins County Memorial Hospital/Hancock	47	21	24	46	6	6	51	21	21	50	52	64				49	100	115
TOTAL (Excludes Duplicates)	51	423	475	41	81	90	49	121	123	51	226	267	53	81	89	50	932	1,044

Discharges by Specialty. The following table lists Wellmont's discharges for fiscal years 2009 and 2010 by Specialty.

	FY 2009 Discharges	FY 2010 Discharges
Medical Services		
Cardiology	1,477	1,104
Dermatology	1	-
Endocrinology	2	2
General Medicine	12,899	11,583
Gastroenterology	145	109
Neurology	114	93
Nephrology	735	592
Oncology/Hematology	232	183
Pulmonary	392	307
Rheumatology	-	1
Subtotal	15,997	13,974
Surgical Services:		
Cardiovascular	847	877
General Surgery	3,295	2,808
Gynecology	186	212
Neurosurgery	892	854
Ophthalmology	-	1
Orthopedics	2,150	2,240
Otolaryngology	75	67
Plastic/Reconstructive	17	38
Urology	171	138
Thoracic	107	96
Trauma	601	649
Vascular	23	23
Subtotal	8,364	8,003
Hospitalist's Services	14,525	15,836
Women's & Pediatrics Services	3,657	3,556
Psychiatric Service	15	11
Totals	42,558	41,380

OTHER INFORMATION

Employees

Wellmont employs over 6,369 persons or 5,278 full time equivalents. Of these 113 are physicians. There are 389 part time employees or 251 full time equivalents. None of Wellmont's employees are represented by a labor union, nor is management aware of any union-organizing activities among its employees. Employee relations are considered to be excellent.

Insurance Coverage and Litigation

Wellmont maintains a self-insurance program that includes general and professional liability coverage for its entire operations. The insurance provides coverage in amounts consistent with those normally maintained by similar health care facilities.

Wellmont maintains a risk management program to avert and mitigate potential losses through early reporting and intervention. Claims are managed cooperatively between Wellmont's risk manager and Wellmont's primary insurance carrier.

Currently, there are no known claims against Wellmont with the potential of exceeding the limits of coverage available under the insurance plan.

Wellmont is involved in various liability disputes, governmental and regulatory inspections, inquiries, investigations, proceedings and litigation matters that arise from time to time in the ordinary course of business. Wellmont is self-insured with respect to professional liability, medical, dental and workers compensation claims and comprehensive general liability risks, subject to certain limitations. Professional and comprehensive general healthcare liability risks in excess of \$1 million per occurrence are reinsured with major independent insurance companies up to an aggregate liability of \$50 million.

Philanthropy

The Foundation seeks charitable donations from individuals, corporations, foundations and other organizations on behalf of Wellmont. The Foundation has established programs in major gifts, planned giving, annual gifts, tribute and memorial gifts, and in-kind gifts.

Licenses, Accreditation and Approvals

The Health System's hospitals are licensed by the respective States in which they operate and are accredited by The Joint Commission. The Joint Commission's accreditation process seeks to help organizations identify and correct problems to improve the safety and quality of care and services provided. The process focuses on systems critical to the safety and quality of care, treatment and services.

The Health System's laboratories hold medical test site licenses issued by the respective States in which they operate and are accredited by the College of American Pathologists.

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APPENDIX B.

FINANCIAL STATEMENTS OF THE CORPORATION

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WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2010 and 2009

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

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

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

We have audited the accompanying consolidated balance sheets of Wellmont Health System and affiliates (Wellmont) as of June 30, 2010 and 2009, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended. These consolidated financial statements are the responsibility of Wellmont's management. 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 financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Wellmont's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Wellmont Health System and affiliates as of June 30, 2010 and 2009, and the consolidated results of their operations and changes in net assets, and cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

KPMG LLP

October 28, 2010

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2010 and 2009

(Dollars in thousands)

Assets	2010	2009
	<u> </u>	<u> </u>
Current assets:		
Cash and cash equivalents	\$ 35,711	60,889
Assets limited as to use, required for current liabilities	1,815	2,201
Patient accounts receivable, less allowance for uncollectible accounts of approximately \$25,113 and \$27,890 in 2010 and 2009, respectively	94,057	98,071
Other receivables	10,919	11,173
Inventories	18,294	17,169
Prepaid expenses and other current assets	<u>7,003</u>	<u>6,040</u>
Total current assets	<u>167,799</u>	<u>195,543</u>
Assets limited as to use, net of current portion	<u>301,807</u>	<u>245,600</u>
Land, buildings, and equipment, net	<u>450,205</u>	<u>442,610</u>
Other assets:		
Long-term investments	32,391	31,974
Investments in affiliates	32,019	31,976
Deferred debt expense, net	4,644	4,824
Goodwill, net	9,501	9,509
Other	<u>730</u>	<u>798</u>
Total assets	<u>\$ 999,096</u>	<u>962,834</u>
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term debt	\$ 11,958	13,197
Lines of credit/short-term note 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	<u>7,251</u>	<u>6,352</u>
Total current liabilities	119,560	124,940
Long-term debt, less current portion	467,833	474,608
Other long-term liabilities, less current portion	<u>47,364</u>	<u>38,422</u>
Total liabilities	<u>634,757</u>	<u>637,970</u>
Net assets:		
Unrestricted	358,620	320,030
Temporarily restricted	4,551	3,589
Permanently restricted	<u>1,168</u>	<u>1,245</u>
Total net assets	364,339	324,864
Commitments and contingencies		
Total liabilities and net assets	<u>\$ 999,096</u>	<u>962,834</u>

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES
Consolidated Statements of Operations and Changes in Net Assets
Years ended June 30, 2010 and 2009
(Dollars in thousands)

	2010	2009
Revenue:		
Net patient service revenue	\$ 692,920	680,056
Other revenues	31,472	27,842
Total revenue	724,392	707,898
Expenses:		
Salaries and benefits	310,667	323,801
Medical supplies and drugs	150,143	141,044
Purchased services	74,922	81,031
Interest	20,110	16,013
Provision for bad debts	35,293	33,402
Depreciation and amortization	43,711	42,957
Other	66,734	62,604
Total expenses	701,580	700,852
Income from operations	22,812	7,046
Nonoperating gains (losses):		
Investment income	1,012	4,181
Derivative valuation adjustments	(2,693)	(5,747)
Other, net	(1,870)	(625)
Nonoperating losses, net	(3,551)	(2,191)
Revenue and gains in excess of expenses and losses before discontinued operations	19,261	4,855
Discontinued operations	(1,109)	(4,455)
Revenue and gains in excess of expenses and losses	18,152	400
Other changes in unrestricted net assets:		
Change in net unrealized gains (losses) on investments	22,312	(60,663)
Net assets released from restrictions for additions to land, buildings, and equipment	1,555	2,758
Change in the funded status of benefit plans and other	(3,429)	(13,568)
Increase (decrease) in unrestricted net assets	38,590	(71,073)
Changes in temporarily restricted net assets:		
Contributions	2,934	1,944
Net assets released from temporary restrictions	(1,972)	(3,154)
Increase (decrease) in temporarily restricted net assets	962	(1,210)
Changes in permanently restricted net assets – investment (loss) income	(77)	645
Change in net assets	39,475	(71,638)
Net assets, beginning of year	324,864	396,502
Net assets, end of year	\$ 364,339	324,864

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2010 and 2009

(Dollars in thousands)

	<u>2010</u>	<u>2009</u>
Cash flows from operating activities:		
Change in net assets	\$ 39,475	(71,638)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	43,755	43,393
Loss on disposal of land, buildings, and equipment	1,282	659
Equity in gain of affiliated organizations	(6,773)	(5,549)
Amortization of deferred financing costs	180	238
Net realized and unrealized (gains) losses on investments, other than trading	(17,994)	66,199
Provision for bad debts	35,950	33,821
Change in fair value of derivative instruments	2,693	5,747
Changes in assets and liabilities:		
Patient accounts receivable	(31,936)	(22,378)
Other current assets	(2,088)	(385)
Other assets	322	3,735
Accounts payable and accrued expenses	2,722	(5,796)
Estimated third-party payor settlements	(769)	10,355
Other current liabilities	899	1,437
Other liabilities	7,933	11,101
Net cash provided by operating activities	<u>75,651</u>	<u>70,939</u>
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	88,887	67,580
Purchase of investments	(127,131)	(25,207)
Purchase of land, buildings, and equipment	(55,684)	(86,623)
Proceeds from the sale of buildings and equipment	4,357	31,251
Cash paid for acquisitions	(2,421)	—
Investment in affiliated organizations	—	(4,453)
Distributions from affiliated organizations	6,730	7,181
Distributions to affiliated organizations	(1,684)	(924)
Net cash used in investing activities	<u>(86,946)</u>	<u>(11,195)</u>
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	14,000	484
Payments on long-term debt	(12,083)	(11,005)
Payments on line of credit	(15,800)	(2,121)
Net cash used in financing activities	<u>(13,883)</u>	<u>(12,642)</u>
Net (decrease) increase in cash and cash equivalents	(25,178)	47,102
Cash and cash equivalents, beginning of year	60,889	13,787
Cash and cash equivalents, end of year	\$ <u>35,711</u>	<u>60,889</u>
Supplemental disclosures of noncash items:		
Wellmont entered into capital lease obligations for buildings and equipment in the amount of \$1,290 and \$18,050 in 2010 and 2009, respectively.		
Additions to property and equipment financed through current liabilities of \$5,182 and \$5,977 in 2010 and 2009, respectively.		

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

(1) Operations and Basis of Presentation

Wellmont Health System (Wellmont) was formed to assume operations of Bristol Regional Medical Center (BRMC) and Holston Valley Health Care, Inc. (HVHC), including Holston Valley Medical Center, Inc. (HVMC), and to act as sole corporate member of its consolidated foundations. Effective July 1, 1996, under terms of an agreement and plan of consolidation and merger, BRMC and HVHC, including HVMC, were merged and consolidated into Wellmont. Effective January 1, 1997, Lonesome Pine Hospital (LPH), a Virginia corporation, was merged into Wellmont under terms of a plan of merger and merger agreement. Effective July 1, 2000, Hawkins County Memorial Hospital (HCMH) transferred its operations and operating assets to Wellmont Hawkins County Memorial Hospital (WHCMH), a tax-exempt organization that is wholly owned and controlled by Wellmont. Hancock County Hospital (HCH), a critical access hospital, was opened in March 2005 to help provide for the immediate healthcare needs of the residents of Sneedville and the surrounding counties. As of July 16, 2007, Wellmont acquired Jenkins Community Hospital (Jenkins) in Kentucky. As of August 1, 2007, Wellmont acquired two hospitals in Virginia, Lee Regional Medical Center in Pennington Gap and Mountain View Regional Medical Center in Norton. On May 30, 2008, Wellmont acquired the Holston Valley Cath Lab, an outpatient lab. On May 1, 2010, Wellmont acquired Cardiovascular Associates.

As of April 30, 2009, Wellmont closed Jenkins, sold the majority of the facility's property and equipment to Appalachian Regional Healthcare, Inc for \$1,000 and recorded a loss on sale of approximately \$256. The consolidated financial statements for the years ended June 30, 2010 and 2009 present Jenkins as a discontinued operation. The operating losses of \$474 and \$3,659 for the years ended June 30, 2010 and 2009, respectively, and the impairment are included in the classification of discontinued operations.

As of June 30, 2010, it was announced that Wellmont will sell the majority of Medical Mall Pharmacy's assets to a national pharmacy company for \$1,300 plus inventory value. The consolidated financial statements for the years ended June 30, 2010 and 2009 present Medical Mall Pharmacy as a discontinued operation. The operating losses of \$635 and \$540 for the years ended June 30, 2010 and 2009, respectively, are included in the classification of discontinued operations. The sale was completed on September 23, 2010.

All acute care operations remain separately licensed and are treated as operating divisions within Wellmont. Wellmont's operations consist primarily of the delivery of healthcare services in northeast Tennessee and southwest Virginia.

The consolidated financial statements include the acute care operations of the above entities along with:

- Wellmont Foundation (the Foundation), which was created from the merger of Bristol Regional Medical Center Foundation and Holston Valley Health Care Foundation, Inc. The Foundation conducts fund-raising activities for the benefit of Wellmont.
- Wellmont, Inc., a wholly owned taxable subsidiary of Wellmont, formed as the holding company of various other taxable subsidiaries that provide medical collection and medical laundry services, operate a pharmacy and physician practices, provide other healthcare-related services, and invest in affiliates and other activities.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

- The Alzheimer's Center of East Tennessee was merged into Wellmont and changed its name to Wellmont Madison House effective September 1, 1997. Wellmont is the sole corporate member and the consolidated financial statements include the operations of this entity.

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

(2) Significant Accounting Policies

A summary of significant accounting policies follows:

(a) *Use of Estimates*

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

(b) *Cash and Cash Equivalents*

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

(c) *Investments*

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

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

On July 1, 2008, Wellmont adopted new guidance issued by the Financial Accounting Standards Board (FASB), which defines fair value, establishes a framework for the measurement of fair value, and enhances disclosures about fair value measurements now codified into Accounting Standards Codification (ASC) 850. ASC 850 statement does not require any new fair value measures and did not have a material impact on Wellmont's consolidated financial statements for the year ended June 30, 2009, however, expanded fair value disclosures have been provided in note 19.

(d) *Assets Limited as to Use*

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

(e) *Inventories*

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

(f) *Land, Buildings, and Equipment*

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

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

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expected to be generated by the asset. When such assets are considered to be impaired, the impairment loss recognized is measured by the amount by which the carrying value of the asset exceeds the fair value of the asset.

(g) Goodwill

Goodwill represents the difference between the cost of net assets acquired and estimated fair value at purchase date, and is being amortized using the straight-line method over periods of 5 to 15 years. For goodwill acquired by its taxable entities, the FASB has implemented a nonamortization approach to goodwill. However, the effective date for not-for-profit entities is not effective until fiscal year 2011 for Wellmont and, as such, Wellmont continues to amortize the goodwill associated with its tax-exempt entities. Wellmont assesses the recoverability and the amortization period of goodwill for not-for-profit entities by determining whether the amount can be recovered through undiscounted cash flows of the business acquired, excluding interest and amortization, over the remaining amortization period. If impairment is indicated by this analysis, measurement of the impairment recognized is based on the difference between the fair value and the carrying amount of the asset. Management considers external factors relating to each acquired business, including local market developments, regional and national trends, regulatory developments, and other pertinent factors in making its assessment. Goodwill for Wellmont's for-profit/taxable entities is reviewed for impairment at least annually in accordance with the provisions of FASB ASC 350, *Intangibles – Goodwill and Other* (Statement No. 142, *Goodwill and Other Intangible Assets*). The goodwill impairment test is a two-step test. Under the first step, the fair value of the reporting unit is compared with its carrying value (including goodwill). If the fair value of the reporting unit is less than its carrying value, an indication of goodwill impairment exists for the reporting unit and the enterprise must perform step two of the impairment test. Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step two does not need to be performed. A summary of goodwill and related amortization for the years ended June 30 follows:

	<u>2009</u>	<u>Additions</u>	<u>Decreases</u>	<u>2010</u>
Goodwill	\$ 12,604	—	—	12,604
Amortization	(3,095)	(8)	—	(3,103)
	<u>\$ 9,509</u>	<u>(8)</u>	<u>—</u>	<u>9,501</u>

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	<u>2008</u>	<u>Additions</u>	<u>Decreases</u>	<u>2009</u>
Goodwill	\$ 12,771	—	(167)	12,604
Amortization	(3,130)	(30)	65	(3,095)
	<u>\$ 9,641</u>	<u>(30)</u>	<u>(102)</u>	<u>9,509</u>

(h) *Deferred Debt Expense*

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

(i) *Derivative Financial Instruments*

As further described in note 12, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

(j) *Asset Retirement Obligations*

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

(k) *Temporarily and Permanently Restricted Net Assets*

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

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

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Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2010 and 2009 primarily included amounts related to the purchase of buildings and equipment for pediatrics, cancer, and other healthcare operations.

(l) Net Patient Service Revenue and Accounts Receivable

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the period related services are rendered and adjusted in future periods as final and other settlements are determined. Wellmont provides care to patients who meet criteria under its charity care policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

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

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

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

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

(n) Contributed Resources

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

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donor stipulations about how long those long-lived assets must be maintained, expiration of donor restrictions is reported when the donated or acquired long-lived assets are placed in service.

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

(o) Federal Income Taxes

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

On July 1, 2007, Wellmont adopted new guidance issued by on the accounting for uncertainty in income tax positions now codified into ASC 740. It also provides guidance on when tax positions are recognized in an entity's financial statements and how the values of these positions are determined. There was no impact on Wellmont's consolidated financial statements as a result of the adoption of the new guidance.

(p) New Accounting Pronouncements

Effective July 1, 2008, Wellmont adopted new guidance issued by FASB, which provides guidance on the net asset classification of donor-restricted endowment funds for a tax-exempt organization that is subject to an enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA) now codified into ASC 958, *Not-for-Profit Entities*. Effective July 1, 2007, the State of Tennessee adopted legislation that incorporates the provisions outlined in UPMIFA. Wellmont's endowments consist solely of donor-restricted endowment funds. Wellmont's endowments consist of four individual funds established for a variety of purposes.

Wellmont has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Wellmont classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are approved for expenditure by the organization in a

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manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Wellmont considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the organization and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the organization; and (7) the investment policies of the organization.

On June 30, 2009, Wellmont adopted guidance issued by the FASB for subsequent events, now codified into ASC 855, *Subsequent Events*. ASC 855 defines the period after the balance sheet date during which management shall evaluate events or transactions that may occur for potential recognition or disclosure, the circumstances under which an organization shall recognize events occurring after the balance sheet date and the disclosures that an organization shall make about those events or transactions. ASC 855 defines two types of subsequent events. The first type consists of events or transactions that provide additional evidence about conditions that existed at the date of the balance sheet, including the estimates inherent to the process of preparing financial statements (i.e., recognized subsequent events). The second type consists of events that provide evidence about conditions that did not exist at the date of the balance sheet but arose after the date (i.e., nonrecognized event).

Management evaluated all events and transactions that occurred through October 28, 2010. Other than described in note 11, Wellmont did not have any material subsequent events during this period.

On July 1, 2009, the FASB issued Statement No. 168, *The FASB Accounting Standards Codification™ and the Hierarchy of Generally Accepted Accounting Principles* (Statement 168). Statement 168 is the single source of authoritative nongovernmental GAAP, superseding existing FASB, American Institute of Certified Public Accountants, Emerging Issues Task Force, and related accounting literature. Statement 168 reorganizes the thousands of pages of GAAP pronouncements into roughly 90 accounting topics and displays them using a consistent structure. Also included is relevant Securities and Exchange Commission guidance organized using the same topical structure in separate sections. Statement 168 is effective for interim and annual periods ending after September 15, 2009. The adoption of Statement 168 had no significant effect on the Wellmont's consolidated financial statements.

(q) *Reclassifications*

Certain 2009 amounts have been reclassified to conform to the 2010 consolidated financial statement presentation.

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(3) Net Patient Service Revenue

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

	<u>2010</u>	<u>2009</u>
Gross patient service charges	\$ 2,158,847	2,178,018
Less:		
Contractual adjustments and other discounts	(1,411,435)	(1,440,519)
Charity care	(54,492)	(57,443)
	<u>(1,465,927)</u>	<u>(1,497,962)</u>
Net patient service revenue	<u>\$ 692,920</u>	<u>680,056</u>

(4) Third-Party Reimbursement Arrangements

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

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

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

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Net patient service revenue in 2010 and 2009 related to Medicare, TennCare, and Virginia Medicaid and net patient accounts receivable at June 30, 2010 and 2009 from Medicare, TennCare, and Virginia Medicaid were as follows:

	<u>2010</u>	<u>2009</u>
Net patient service revenue:		
Medicare	\$ 277,372	272,259
TennCare	22,918	22,509
Virginia Medicaid	23,536	19,036
Net patient accounts receivable:		
Medicare	\$ 41,125	39,852
TennCare	2,206	4,072
Virginia Medicaid	3,739	3,172

Wellmont has filed cost reports with Medicare and Virginia Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Virginia Medicaid cost reports have been audited by the intermediary through June 30, 2006.

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

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased (decreased) approximately \$863 and \$(2,600) in 2010 and 2009, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of final settlements, and years that are not longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2010 could differ materially from actual settlements based on the results of third-party audits.

(5) Charity Care and Community Services

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

Wellmont maintains records to identify and monitor the level of charity care it provides. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and the equivalent percentage of charity care patients to all patients serviced were \$54,492, \$15,567, and

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2.52%, respectively, for the year ended June 30, 2010 and \$57,443, \$16,203, and 2.63%, respectively, for the year ended June 30, 2009.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and State indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont's cost of providing care to those patients totaled \$55,461 and \$57,212 for the years ended June 30, 2010 and 2009, respectively.

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

(6) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include hospital, home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in net income of affiliates was approximately \$6,773 and \$5,549 for the years ended June 30, 2010 and 2009, respectively, and is included in other operating revenue in the consolidated financial statements. Wellmont made additional contributions of \$0 and \$4,453 during 2010 and 2009, respectively, to affiliates, which increased Wellmont's overall investment in affiliates. Wellmont received distributions of \$6,730 and \$7,181 during 2010 and 2009, respectively, which reduced Wellmont's overall investment in the affiliates.

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

	<u>2010</u>	<u>2009</u>
Total assets	\$ 129,720	137,737
Total liabilities	13,943	39,913
Total net assets	<u>\$ 115,777</u>	<u>97,824</u>
Net revenues	\$ 166,815	178,253
Expenses	142,534	159,004
Revenues in excess of expenses	<u>\$ 24,281</u>	<u>19,249</u>

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Wellmont's equity investment in these affiliates and its ownership percentage as of June 30, 2010 and 2009 are as follows:

	Amount		Percentage	
	2010	2009	2010	2009
Takoma Regional Hospital	\$ 12,645	12,302	60%	60%
Holston Valley Imaging Center (HVIC)	8,048	9,047	75	75
Advanced Home Care (AHC)	6,092	6,092	6	6
Spectrum Tennessee Network	3,850	3,462	20	20
Others	1,384	1,073	4% – 50%	4% – 50%
	<u>\$ 32,019</u>	<u>31,976</u>		

Wellmont provided billing and management services to the affiliates. Income recognized by Wellmont for the services was \$1,766 in 2010 and \$1,501 in 2009 and is included in other revenues.

Included in other receivables are \$124 and \$135 as of June 30, 2010 and 2009, respectively, of amounts due to Wellmont from these entities.

Although Wellmont's ownership percentage in Takoma Regional Hospital and HVIC is greater than 50%, Wellmont does not consolidate these entities because Wellmont only has a 50% representation on each respective board and does not have control over these entities.

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(7) Investments

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

	<u>2010</u>	<u>2009</u>
Assets limited as to use by Board for capital improvements:		
Stock mutual funds	\$ 109,629	108,036
Bond mutual funds	71,698	5,910
Cash and money market funds	1,474	2,517
Real estate funds	7,468	5,419
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):		
Liquid	33,915	12,415
Illiquid	23,490	23,171
	<u>247,674</u>	<u>157,468</u>
Assets limited as to use under self-insurance agreements:		
Corporate bonds	6,867	7,464
Cash and money market funds	558	643
	<u>7,425</u>	<u>8,107</u>
Assets limited as to use under bond indenture agreements:		
Cash and money market funds	48,523	82,226
Less assets limited as to use that are required for current liabilities	<u>1,815</u>	<u>2,201</u>
Assets limited as to use, net of current portion	\$ <u>301,807</u>	<u>245,600</u>
Long-term investments:		
Stock mutual funds	\$ 9,279	8,631
Bond mutual funds	7,599	3,648
Preferred equity investment and related options	11,512	11,512
Cash, money market funds, and certificates of deposit	287	5,202
Real estate funds	1,722	1,255
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):		
Liquid	1,992	1,726
Total long-term investments	\$ <u>32,391</u>	<u>31,974</u>

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately \$12,112 as of June 30, 2010 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which \$417 was paid subsequent to June 30, 2010.

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Wellmont has invested \$10,000 in the preferred equity of a regional managed services organization and \$1,512 on a right of first refusal related to any future sale of this organization. This equity has a guaranteed annual return of at least 6.5% of the outstanding preferred equity balance.

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

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, the Company recognized other-than-temporary impairment losses of \$8,233 and \$4,654 on investments as of June 30, 2010 and 2009, respectively. The unrealized losses on these mutual funds were primarily caused by the overall decline in the world's economy in 2009 and 2010. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2010 and 2009, were as follows:

		June 30, 2010					
		Less than 12 months		12 months or more		Total	
		Unrealized		Unrealized		Unrealized	
		losses	Fair value	losses	Fair value	losses	Fair value
Alternative investments	\$	—	—	910	4,219	910	4,219
Stock mutual funds		2,184	29,658	24,817	83,713	27,001	113,371
	\$	<u>2,184</u>	<u>29,658</u>	<u>25,727</u>	<u>87,932</u>	<u>27,911</u>	<u>117,590</u>
		June 30, 2009					
		Less than 12 months		12 months or more		Total	
		Unrealized		Unrealized		Unrealized	
		losses	Fair value	losses	Fair value	losses	Fair value
Bond mutual funds	\$	191	4,112	—	—	191	4,112
Alternative investments		5,525	16,227	4,144	7,120	9,669	23,347
Stock mutual funds		22,243	74,147	17,460	35,983	39,703	110,130
	\$	<u>27,959</u>	<u>94,486</u>	<u>21,604</u>	<u>43,103</u>	<u>49,563</u>	<u>137,589</u>

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

	<u>2010</u>	<u>2009</u>
Interest and dividends, net of amounts capitalized	\$ 5,330	9,717
Realized losses on investments, including \$8,233 and \$4,654 recognized losses related to other-than-temporary impairments in 2010 and 2009, respectively.	<u>(4,318)</u>	<u>(5,536)</u>
Investment income, net	<u>\$ 1,012</u>	<u>4,181</u>
Change in net unrealized gains (losses) on investments	<u>\$ 22,312</u>	<u>(60,663)</u>

(8) Land, Buildings, and Equipment

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

	<u>2010</u>	<u>2009</u>
Land	\$ 41,210	44,149
Buildings and improvements	488,285	392,593
Equipment	327,896	303,805
Buildings and equipment under capital lease obligations	<u>39,591</u>	<u>38,734</u>
	896,982	779,281
Less accumulated depreciation	<u>(459,935)</u>	<u>(418,399)</u>
	437,047	360,882
Construction in progress	<u>13,158</u>	<u>81,728</u>
Land, buildings, and equipment	<u>\$ 450,205</u>	<u>442,610</u>

Depreciation expense for the years ended June 30, 2010 and 2009 was \$43,755 and \$43,393, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was \$13,266 and \$9,109 as of June 30, 2010 and 2009, respectively.

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(9) Other Long-Term Liabilities

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

	<u>2010</u>	<u>2009</u>
Workers' compensation liability	\$ 6,606	5,706
Professional and general liability	11,183	9,494
Postretirement benefit obligation	5,861	5,653
Asset retirement obligation	3,710	3,621
Deferred gain on sale of assets	1,382	2,136
Derivative liability	12,943	10,250
Pension benefit liability	10,018	6,709
Other	2,912	1,205
	<u>54,615</u>	<u>44,774</u>
Less current portion	<u>(7,251)</u>	<u>(6,352)</u>
Total other long-term liabilities	<u>\$ 47,364</u>	<u>38,422</u>

(10) Lines of Credit/Notes Payable

During 2008, Wellmont entered into three lines of credit for \$15,000, \$1,800, and \$10,000. The \$15,000 line of credit had a variable interest rate based upon LIBOR plus 1% and a termination date of August 2009; at June 30, 2009, \$14,000 was outstanding on this line. During 2010, the \$15,000 line of credit was paid in full with a \$14,000 note payable, which was initiated with one bank to pay off the line of credit. The \$14,000 note payable has a variable interest rate based upon LIBOR plus 2% and a termination date of December 2010. At June 30, 2010, \$14,000 was outstanding on this note. During 2008, a \$1,800 line of credit was initiated with one bank and was paid in full with the funds from the \$10,000 line of credit from another bank, which had variable interest rate based upon LIBOR plus 0.95% and a termination date of August 31, 2009; at June 30, 2010 and 2009, \$0 and \$1,811, respectively, was outstanding on this line. The \$10,000 line of credit was paid in full in 2010.

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(11) Debt

(a) Long-Term Debt

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

	<u>2010</u>	<u>2009</u>
Hospital Revenue Bonds, Series 2007A	\$ 55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	200,000	200,000
Hospital Revenue Refunding Bonds, Series 2006A and 2006B	93,405	95,205
Hospital Revenue Refunding Bonds, Series 2005	61,810	63,940
Hospital Revenue Bonds, Series 2003	36,666	40,145
Notes payable	6,429	4,399
Capital lease obligations	19,698	22,388
Other	358	71
	<u>473,366</u>	<u>481,148</u>
Unamortized premium	7,538	7,800
Unamortized discount	<u>(1,113)</u>	<u>(1,143)</u>
	479,791	487,805
Less current maturities	<u>(11,958)</u>	<u>(13,197)</u>
	<u>\$ 467,833</u>	<u>474,608</u>

(b) Series 2007 Bonds

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

Principal on outstanding Series 2007A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from \$360 to \$2,460 commencing on September 1, 2017 through September 1, 2036, with a balloon payment of \$29,245 due on September 1, 2037. The outstanding bonds accrue interest at rates ranging from 5.125% to 5.25%.

(c) Series 2006C

On October 26, 2006, The Health, Educational and Housing Facilities Board of the County of Sullivan Tennessee issued, on behalf of Wellmont, \$200,000 of Hospital Revenue Bonds, Series 2006C. The Series 2006C Bonds were used to: finance the costs of acquisition of land for expansion, construction, expansion, equipping, and renovation of HVMC, including the construction of a new patient tower (collectively known as Project Platinum); finance the costs of the

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construction, expansion, equipping, and renovation of the emergency department at BRMC (the Bristol Emergency Department Project); and finance the costs of construction, expansion, renovation, and equipping of an operating room and related facilities at HCMH.

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

(d) Series 2006 A and B

On June 23, 2006, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee issued, on behalf of Wellmont, \$98,475 of Hospital Revenue Refunding Bonds, Series 2006. This bond issuance consists of Series A tax-exempt and Series B taxable bonds of \$76,595 and \$21,880, respectively. The Series 2006 Bonds together with other available funds were used to advance refund all the previously issued Hospital Revenue Bonds, Series 1993, to reimburse Wellmont for payments made on other taxable borrowings and to pay certain expenses incurred in connection with the issuance of the Series 2006 Bonds. Upon this refunding, a trust was established to pay all future bond payments related to the Series 1993 Bonds. Wellmont was deemed to have paid the Series 1993 Bonds and these Bonds are no longer deemed to be outstanding for purposes of the Series 1993 Trust Indenture.

Principal on outstanding Series 2006A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from \$875 to \$6,400 commencing on September 1, 2013 through September 1, 2032; and the outstanding bonds accrue interest on a variable rate, which is reset monthly based upon the AAA-insured Municipal Market Data Index, plus 85 basis points. Principal on outstanding Series 2006B Bonds is payable through maturity in annual amounts ranging from \$1,600 to \$2,930 commencing on September 1, 2007 through September 1, 2016, and the outstanding bonds accrue interest at a fixed rate of 6.95%.

Outstanding Series 2006A Bonds are subject to redemption prior to maturity at the option of The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%–102% of the principal amount of the Series 2006A Bonds being redeemed, plus accrued interest thereon to the redemption date.

On October 1, 2010, the Series 2006B Bonds were called and paid in full at par value of \$14,880.

(e) Series 2005

On December 8, 2005, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, \$70,620 of Hospital Revenue Refunding Bonds, Series 2005. The Series 2005 Bonds together with other available funds were used to advance refund the previously issued Hospital Revenue Bonds, Series 2002, and to pay certain expenses incurred in connection with the issuance of the Series 2005 Bonds.

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Principal on outstanding Series 2005 Bonds is payable through maturity or scheduled mandatory sinking fund redemption in annual amounts ranging from \$1,945 to \$3,390 commencing on September 1, 2007 through September 1, 2032. The terms of the bonds provide that bondholders may redeem or put the bonds to the remarketing agent on dates that approximate a weekly basis. The remarketing agent is obligated to remarket the redeemed bonds on a “best efforts” basis. Redeemed bonds are repaid to bondholders from the proceeds of the remarketing effort or, in the event of an inability to remarket the bonds, from a letter of credit. Subsequent to year-end, Wellmont amended its letter of credit to cover an amount equal to the principal and up to 40 days’ interest on the bonds at a maximum interest rate of 12% per annum, and is effective through July 1, 2011. This letter secures the bonds in the event of a failed remarketing or liquidity issue. In the event of a liquidity drawing under the letter of credit, Wellmont shall pay the Base Rate for the first 90 days equal to the greater of (i) the Prime Rate plus 1.50% per annum, ii) the Federal Funds Rate plus 3.00% per annum, or iii) 7.50% per annum. ; the Base Rate plus 0.50% for days 91 through 366 and the Base Rate plus 1.00% thereafter until the amount is paid in full.

Outstanding Series 2005 Bonds are subject to redemption prior to maturity at the option of The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%–102% of the principal amount of the Series 2005 Bonds being redeemed, plus accrued interest thereon to the redemption date.

(f) Series 2003

On June 1, 2003, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee issued, on behalf of Wellmont, \$59,100 of Hospital Revenue Bonds, Series 2003. The bonds were issued to provide funds necessary to refund Wellmont’s Hospital Revenue Bonds, Series 1993 (HVHC), to fund a debt service reserve fund and to pay certain expenses incurred in connection with the issuance of the Series 2003 Bonds.

The Wellmont Series 2003 Bonds consist of \$27,460 in fixed rate serial bonds and \$19,280 in fixed rate term bonds payable through maturity or mandatory sinking fund redemption maturing in annual amounts ranging from \$3,230 on September 1, 2007 to \$4,140 on September 1, 2019, and carrying interest rates ranging from 2.5% to 5.00%.

(g) Master Trust Indenture

The master trust indenture and loan agreements for the 2007, 2006, 2005, and 2003 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their

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obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

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

(h) Notes Payable

During 2007, Wellmont entered into a five-year \$3,000 note payable, which has a fixed interest rate of 7.25% and a termination date of July 2011; at June 30, 2010 and 2009, \$2,062 and \$2,319, respectively, was outstanding on this note.

During 2008, Wellmont entered into a five-year \$2,400 term note payable, which has a fixed interest rate of 7.25% and a termination date of August 2012; at June 30, 2010 and 2009, \$1,600 and \$2,080, respectively, was outstanding on this note.

During 2010, Wellmont entered into a \$2,767 note payable to finance the purchase of Cardiovascular Associates. The note payable has a fixed interest rate of 5.5% and a termination date of May 2013. At June 30, 2010, \$2,767 was outstanding on this note.

(i) Capital Lease Obligations

Wellmont has entered into leases for certain equipment under agreements classified as capital leases that expire over periods through 2011. Assets under capital leases are included in property and equipment and have a net carrying value of \$26,325 and \$29,625 as of June 30, 2010 and 2009, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 4.3% to 6.0%.

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(j) Long-term Debt Maturities Schedule

Bond maturities in accordance with the original terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2010 are as follows:

2011	\$	11,958
2012		13,329
2013		12,935
2014		12,193
2015		12,415
Thereafter		410,536
	\$	<u>473,366</u>

The following table reflects the required repayment terms for the years ended June 30 of Wellmont's debt obligations in the event that the put options associated with the 2005 bonds were exercised, but not successfully remarketed.

2011	\$	11,958
2012		30,859
2013		30,365
2014		29,508
2015		9,755
Thereafter		360,921
	\$	<u>473,366</u>

Interest paid for the years ended June 30, 2010 and 2009 was \$20,792 and \$21,564, respectively, net of amounts capitalized. Interest costs of \$2,776 and \$3,421, net of interest income of \$683 and \$3,293 in 2010 and 2009, respectively, were capitalized.

(12) Derivative Transactions

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

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Wellmont's bond rating. As of June 30, 2010 and 2009, Wellmont was not required to postcollateral related to its swaps.

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

In September and October 2008, the counterparty and credit support provider to the swaps filed bankruptcy. Subsequent to the bankruptcy filings, no payments have been made by Wellmont or the counterparty to each other. As of June 30, 2010, the net amounts due to Wellmont for this period are less than \$100 and have been fully reserved. The bankruptcy process is underway and the outcome cannot be determined at this time.

Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its debt structure using LIBOR. The fair value as of June 30, 2010 and 2009 of approximately \$(12,943) and \$(10,250), respectively, is included in other liabilities in the consolidated balance sheets. The change in the fair value of the derivative instruments was approximately \$(2,693) and \$(5,747), respectively, in 2010 and 2009 and is included in nonoperating losses, net in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. The net amounts have been recorded pending the outcome of any bankruptcy proceedings. The following is a summary of the interest rate swap information as of June 30, 2010:

<u>Type of interest swap</u>	<u>Debt hedging</u>	<u>Notional amount</u>	<u>Effective date</u>	<u>Maturity date</u>	<u>Rate paid</u>	<u>Rate received</u>	<u>Swap fair value asset (liability)</u>
Total return swap	Series 2006A	\$ 76,595	June 29, 2006	September 1, 2011	1.103%	5.440%	\$ 1,101
Pay fixed interest rate swap	Series 2005	65,975	December 13, 2005	September 1, 2016	3.548	0.217	(6,810)
Basis swap	Series 2002	67,965	September 1, 2002	September 1, 2032	0.253	0.198	(2,710)
Pay fixed interest rate swap	Series 2006A	35,342	October 24, 2003	September 1, 2021	3.613	0.162	(4,524)
							<u>\$ (12,943)</u>

The following is a summary of the interest rate swap information as of June 30, 2009:

<u>Type of interest swap</u>	<u>Debt hedging</u>	<u>Notional amount</u>	<u>Effective date</u>	<u>Maturity date</u>	<u>Rate paid</u>	<u>Rate received</u>	<u>Swap fair value asset (liability)</u>
Total return swap	Series 2006A	\$ 76,595	June 29, 2006	September 1, 2011	2.744%	5.884%	\$ 1,075
Pay fixed interest rate swap	Series 2005	65,975	December 13, 2005	September 1, 2016	3.548	0.309	(5,197)
Basis swap	Series 2002	67,965	September 1, 2002	September 1, 2032	1.894	1.728	(2,708)
Pay fixed interest rate swap	Series 2006A	35,342	October 24, 2003	September 1, 2021	3.613	1.184	(3,420)
							<u>\$ (10,250)</u>

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(13) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined contribution retirement plan (Retirement Plan) that covers substantially all employees. This program and the related Retirement Plan were created from amendments, restatements, and mergers of existing defined contribution plans at BRMC and HVMC. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 3% of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Code, up to 3% of each participant's wages. The total pension expense related to the Retirement Plan was \$9,990 and \$9,937 for the years ended June 30, 2010 and 2009, respectively.

HVMC sponsored a noncontributory, defined benefit pension plan covering substantially all its employees. However, effective June 30, 1996, this plan was frozen and no further benefits accrue. LPH also sponsors a defined benefit pension plan covering substantially all its employees.

HVMC's defined pension benefits are actuarially determined based on a formula taking into consideration an employee's compensation and years of service. HVMC's funding policy is to make annual contributions to the plan based upon the funding standard developed by the plan actuary. This standard uses the projected unit credit actuarial cost method, including the amortization of prior service costs, over a 20-year period. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. The LPH plan contains similar funding and actuarial policies.

On June 30, 2007, the HVMC plan merged into LPH plan and the plan name changed to Wellmont Health System Defined Benefit Plan. At the end of 2008, only a single defined pension plan exists. Collectively, the two defined benefit plans are referred to as the "Plans."

Wellmont recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined benefit pension plans as an asset or liability in its consolidated balance sheets and recognizes changes in that funded status in the year in which the changes occur as a change in unrestricted net assets. All defined benefit pension plans use a June 30 measurement date.

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

	<u>2010</u>	<u>2009</u>
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 40,035	37,212
Service cost	230	234
Interest cost	2,432	2,441
Actuarial losses	4,008	2,132
Benefits paid	<u>(2,140)</u>	<u>(1,984)</u>
Benefit obligation at end of year	\$ <u>44,565</u>	<u>40,035</u>
Change in plan assets:		
Fair value of plan assets at beginning of year	33,326	43,420
Actual return on plan assets	3,361	(8,110)
Benefits paid	<u>(2,140)</u>	<u>(1,984)</u>
Fair value of plan assets at end of year	<u>34,547</u>	<u>33,326</u>
Funded status	\$ <u>(10,018)</u>	<u>(6,709)</u>
Amounts recognized in the accompanying consolidated balance sheets:		
Pension liability – other long-term liability	\$ (10,018)	(6,709)

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	<u>2010</u>	<u>2009</u>
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:		
Unrecognized actuarial loss	\$ 13,158	10,851
Unrecognized prior service cost	<u>2</u>	<u>2</u>
Net amounts included as an accumulated charge to unrestricted net assets	\$ <u>13,160</u>	<u>10,853</u>
Calculation of change in unrestricted net assets:		
Accumulated charge to unrestricted net assets, end of year	\$ 13,160	10,853
Reversal of accumulated credit to unrestricted net assets, prior year	<u>(10,853)</u>	<u>2,357</u>
Change in unrestricted net assets	\$ <u>2,307</u>	<u>13,210</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Actuarial loss arising during the year	\$ 2,907	13,210
Amortization of actuarial gain or loss	(600)	—
Amortization of prior service cost	<u>—</u>	<u>—</u>
Net amounts recognized as a charge to unrestricted net assets	\$ <u>2,307</u>	<u>13,210</u>

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	<u>2010</u>	<u>2009</u>
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2011:		
Amortization of net loss	\$ 791	—
Amortization of prior service cost	—	2
Estimated future benefit payments:		
Fiscal 2011	2,211	2,150
Fiscal 2012	2,220	2,189
Fiscal 2013	2,337	2,314
Fiscal 2014	2,472	2,456
Fiscal 2015 (FY09 fiscal 2015 – 2019)	2,578	13,769
Fiscal 2016 – 2020	14,278	
Weighted average assumptions used to determine benefit obligations:		
Settlement (discount) rate	5.50%	6.25%
Weighted average rate of increase in future compensation levels	3.00	3.00
Components of net periodic benefit cost (benefit):		
Service cost	\$ 230	234
Interest cost	2,432	2,441
Expected return on plan assets	(2,259)	(2,968)
Amortization of unrecognized net loss	600	—
Amortization of unrecognized prior service cost	—	0
Net periodic benefit cost (benefit)	<u>\$ 1,003</u>	<u>(293)</u>
Weighted average assumptions used to determine net periodic benefit cost:		
Settlement (discount) rate	6.25%	6.75%
Expected long-term return on plan assets (HVMC)	7.00	7.00
Expected long-term return on plan assets (LPH)	7.00	7.00
Weighted average rate of increase in future compensation levels	3.00	3.00

Wellmont's overall expected long-term rate of return on assets is 7.00%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

Wellmont does not expect to make any contributions to the Plans during 2011.

Wellmont has developed a plan investment policy, which is reviewed and approved by the board of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a target asset allocation and an allowable range for such

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categories based on quarterly investment fluctuations. Investments are managed by independent advisers who are monitored by management and the board of directors.

The table below shows the target allocation and actual asset allocations as of June 30, 2010 and 2009:

Asset	Target allocation	June 30,	
		2010	2009
Equity securities	65%	56%	53%
Fixed income	28	27	29
Cash	5% – 15%	1	3
Other	5 – 15	16	15

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

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

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

	<u>2010</u>	<u>2009</u>
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 5,653	5,637
Interest cost	320	355
Plan participants contributions	73	36
Actuarial losses	197	23
Benefits paid	<u>(382)</u>	<u>(398)</u>
Benefit obligation at end of year	<u>5,861</u>	<u>5,653</u>
Change in plan assets:		
Fair value of plan assets at beginning of year	—	—
Employer contribution	309	362
Plan participants contributions	73	36
Benefits paid	<u>(382)</u>	<u>(398)</u>
Fair value of plan assets at end of year	<u>—</u>	<u>—</u>
Funded status	\$ <u>(5,861)</u>	<u>(5,653)</u>
Amounts recognized in the consolidated balance sheets consist of:		
Noncurrent liabilities	\$ (5,861)	(5,653)
Accumulated credit to unrestricted net assets	<u>3,560</u>	<u>4,076</u>
	\$ <u>(2,301)</u>	<u>(1,577)</u>

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

	<u>Postretirement benefits</u>	
	<u>2010</u>	<u>2009</u>
Net actuarial gain	\$ 3,560	4,076

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Net periodic benefit cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2010 and 2009 were:

	Postretirement benefits	
	2010	2009
Net periodic benefit cost:		
Interest cost	\$ 320	355
Amortization of net gain	(319)	(335)
Net periodic benefit cost recognized	<u>1</u>	<u>20</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	197	23
Amortization of net gain	319	335
Total recognized as a charge to unrestricted net assets	<u>516</u>	<u>358</u>
Total recognized in net periodic benefit cost and unrestricted net assets	<u>\$ 517</u>	<u>378</u>

The net gain and prior service credit for the defined benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are \$(261) and \$0, respectively. Weighted average assumptions used to determine benefit obligations for 2010 and 2009 were as follows:

	Postretirement benefits	
	2010	2009
Discount rate	5.00%	6.00%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2010 and 2009 were as follows:

	Postretirement benefits	
	2010	2009
Discount rate	6.00%	6.75%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00%	5.00%

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

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For measurement purposes, a 5% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2010.

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

	<u>2010</u>	<u>2009</u>
Effect of one-percentage-point increase in healthcare cost trend on:		
Service and interest cost	\$ 20	22
Accumulated pension benefit obligation	330	326
Effect of one-percentage-point decrease in healthcare cost trend on:		
Service and interest cost	(18)	(20)
Accumulated pension benefit obligation	(294)	(291)

The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2010 and 2009, respectively, were as follows:

Fair value measurement at June 30, 2010				
pension benefits – plan assets				
		Quoted prices		
<u>Asset category</u>	<u>Total</u>	<u>in active</u>	<u>Significant</u>	<u>Significant</u>
		<u>markets for</u>	<u>other</u>	<u>unobservable</u>
		<u>identical</u>	<u>observable</u>	<u>inputs</u>
		<u>assets</u>	<u>inputs</u>	<u>inputs</u>
		<u>(Level 1)</u>	<u>(Level 2)</u>	<u>(Level 3)</u>
Stock mutual funds	\$ 28,803	19,412	9,391	—
Cash and money market funds	244	244	—	—
Alternative investments	5,500	—	—	5,500
Total	\$ 34,547	19,656	9,391	5,500

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Fair value measurement at June 30, 2009				
pension benefits – plan assets				
Asset category	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Stock mutual funds	\$ 27,444	17,710	9,734	—
Cash and money market funds	749	749	—	—
Alternative investments	5,133	—	—	5,133
Total	\$ 33,326	18,459	9,734	5,133

The following tables presents Wellmont’s activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2010 and 2009:

	Alternative investments
Balance at June 30, 2008	\$ 7,960
Net change in value	(4,464)
Purchases, issuances, and settlements	1,637
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2009	5,133
Net change in value	254
Purchases, issuances, and settlements	113
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2010	\$ 5,500

(14) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers’ compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont has established revocable self-insurance trust funds to provide for professional and general liability claims and workers’ compensation claims and related expenses. Wellmont’s contributions to the self-insurance trusts are based upon actuarial determinations by an independent service company. The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers’ compensation program is supplemented for Tennessee and Virginia by excess workers’ compensation policies, with a commercial carrier for statutory limits per occurrence. Wellmont does not

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

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(Dollars in thousands)

qualify as a self-insurer in Kentucky and hence purchases a separate policy for its operation in Kentucky. Provisions based on actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Insurance expense under these programs amounted to approximately \$3,414 and \$5,658 for the years ended June 30, 2010 and 2009, respectively, and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2010 and 2009, Wellmont was involved in litigation relating to medical malpractice and workers' compensation claims arising in the ordinary course of business. There are also known incidents that occurred through June 30, 2010 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2010 are adequate to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

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

(15) Commitments and Contingencies

Construction in progress at June 30, 2010 and 2009 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately \$11,920 at June 30, 2010. Wellmont has entered into contracts of approximately \$11,920 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was \$16,857 and 16,441 for the years ended June 30, 2010 and 2009, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2010 are as follows:

2011	\$	14,227
2012		12,318
2013		8,149
2014		3,763
2015		3,383
Thereafter		20,699
	\$	<u>62,539</u>

The HCHM lease to WHCMH is for 20 years and can be automatically extended for two additional terms of 10 years each. Should WHCMH generate annual net excess revenue over expenses, 50% shall be transferred to a designated fund in the Foundation for the purpose of healthcare projects. No transfers were required for the years ended June 30, 2010 and 2009.

WELLMONT HEALTH SYSTEM AND AFFILIATES

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(Dollars in thousands)

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

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

(16) Functional Expense Disclosure

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

	<u>2010</u>	<u>2009</u>
Professional care of patients	\$ 583,222	597,951
Administrative and general	117,123	101,641
Fund-raising	1,235	1,260
	<u>\$ 701,580</u>	<u>700,852</u>

(17) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate company state income tax returns. These companies have combined net operating loss carryforwards for federal income tax purposes of approximately \$52,000 at June 30, 2010, which begin expiring in fiscal 2016 and expire through 2030. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont files a Form 990-T with the Internal Revenue Service to report such activity. Wellmont has net operating loss carryforwards for federal income tax purposes of approximately \$975 for unrelated business activities. Management believes that it is not more likely than not that deferred tax assets arising from net operating loss carryforwards will be realizable. Accordingly, these are fully reserved at June 30, 2010 and 2009.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

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(Dollars in thousands)

(18) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2010 and 2009 was as follows:

	<u>2010</u>	<u>2009</u>
Medicare	46%	45%
TennCare	4	4
Medicaid	8	8
Other third-party payors	31	31
Patients	11	12
	<u>100%</u>	<u>100%</u>

(19) Disclosures about Fair Value of Financial Instruments

(a) *Fair Value of Financial Instruments*

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

Cash and Cash Equivalents

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

Patient Accounts and Other Receivables

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

Investments and Assets Limited as to Use

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

Accounts Payable and Accrued Expenses

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

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

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

Long-Term Debt

The fair value of revenue bonds, using current market rates, was estimated at \$422,290 and \$344,863 for the years ended June 30, 2010 and 2009, respectively.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

(b) *Fair Value Hierarchy*

On July 1, 2008, Wellmont adopted new guidance issued by FASB for fair value measurement of financial assets and financial liabilities and for fair value measurement of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis now codified into ASC 820, *Fair Value Measurements and Disclosures*. ASC 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted market prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted market prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date.
- Level 2 inputs are inputs other than quoted market prices including within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.
- Level 3 inputs are unobservable inputs for the asset or liability.

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

In conjunction with the adoption of the new guidance, Wellmont elected to early adopt the measurement provisions of Accounting Standards Update No. 2009-12 to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. This guidance amends the previous guidance and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value, in many instances may not equal fair value that would be calculated pursuant to ASC 820. The fair value of these investments was \$56,972 and \$37,312 at June 30, 2010 and 2009, respectively.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2010:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 35,711	—	—	35,711
Assets limited as to use:				
Stock mutual funds	109,629	—	—	109,629
Bond mutual funds	71,698	—	—	71,698
Cash and money market funds	50,555	—	—	50,555
Real estate funds	7,468	—	—	7,468
Alternative investments		18,043	39,362	57,405
Corporate bonds	6,867	—	—	6,867
	<u>246,217</u>	<u>18,043</u>	<u>39,362</u>	<u>303,622</u>
Long-term investments:				
Stock mutual funds	9,279	—	—	9,279
Bond mutual funds	7,599	—	—	7,599
Cash and money market funds	287	—	—	287
Real estate funds	1,722	—	—	1,722
Alternative investments	—	1,992	—	1,992
	<u>18,887</u>	<u>1,992</u>	<u>—</u>	<u>20,879</u>
Total assets	\$ <u>300,815</u>	<u>20,035</u>	<u>39,362</u>	<u>360,212</u>
Liabilities:				
Interest rate derivatives liability	\$ —	12,943	—	12,943
Total liability	\$ —	<u>12,943</u>	<u>—</u>	<u>12,943</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

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(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2009:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 60,889	—	—	60,889
Assets limited as to use:				
Stock mutual funds	108,036	—	—	108,036
Bond mutual funds	5,910	—	—	5,910
Cash and money market funds	85,386	—	—	85,386
Real estate funds	5,419	—	—	5,419
Alternative investments	—	2,295	33,291	35,586
Corporate bonds	7,464	—	—	7,464
	<u>212,215</u>	<u>2,295</u>	<u>33,291</u>	<u>247,801</u>
Long-term investments:				
Stock mutual funds	8,631	—	—	8,631
Bond mutual funds	3,648	—	—	3,648
Cash and money market funds	5,202	—	—	5,202
Real estate funds	1,255	—	—	1,255
Alternative investments	—	1,726	—	1,726
	<u>18,736</u>	<u>1,726</u>	<u>—</u>	<u>20,462</u>
Total assets	\$ <u>291,840</u>	<u>4,021</u>	<u>33,291</u>	<u>329,152</u>
Liabilities:				
Interest rate derivatives liability	\$ —	10,250	—	10,250
Total liability	\$ —	<u>10,250</u>	<u>—</u>	<u>10,250</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

The following table presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2010 and 2009:

	Alternative investments
Balance at June 30, 2008:	\$ 51,661
Total realized and unrealized gains (losses):	
Included in revenues and gains in excess of expenses and losses	—
Included in changes in net assets	(3,574)
Purchases, issuances, and settlements	(14,796)
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2009:	\$ 33,291
Total realized and unrealized gains (losses):	
Included in revenues and gains in excess of expenses and losses	—
Included in changes in net assets	469
Purchases, issuances, and settlements	5,602
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2010	\$ <u>39,362</u>

APPENDIX C.

SUMMARY OF THE FINANCING DOCUMENTS

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SUMMARY OF THE FINANCING DOCUMENTS

Brief descriptions of the Master Indenture, the 2011 Bond Indenture and the Loan Agreement are included hereafter in this Appendix C to the Official Statement. Such descriptions do not purport to be comprehensive or definitive. All references herein to the Master Indenture, the 2011 Bond Indenture and the Loan Agreement are qualified in their entirety by reference to each such document, copies of which are available for review at the offices of the Corporation and the Bond Trustee. All references to the Series 2011 Bonds are qualified in their entirety by reference to the definitive forms thereof and the information with respect thereto included in the 2011 Bond Indenture.

DEFINITIONS OF CERTAIN TERMS

The following are definitions of certain terms used in the Master Indenture, the 2011 Bond Indenture, the Loan Agreement and the Official Statement. Certain definitions used below may have been modified so long as the Series 2011 Obligation is outstanding. See "Summary of Certain Provisions of the Master Indenture - Provisions Applicable as Long as Series 2011 Obligation Outstanding."

"Accountant" means any Person who or which is appointed (a) by any member of the Combined Group for the purpose of examining and reporting on or passing on questions relating to the financial statements of such member or (b) by the Obligated Group Agent for the purpose of examining and reporting on or passing on questions relating to the financial statements of two or more members of the Combined Group or the entire Combined Group, has all certifications necessary for the performance of such services, and, in the good faith opinion of the person making the appointment, has a favorable reputation for skill and experience in performing similar services in respect of entities of a comparable size and nature. If any Accountant's report or opinion is required to be given with respect to matters partly within and partly without the expertise of such Accountant, such Accountant may rely upon the report or opinion of another Accountant, which other Accountant shall be reasonably satisfactory to the relying Accountant and the Obligated Group Agent.

"Act" means Sections 48-101-301 to 48-101-318, Tennessee Code Annotated, as from time to time amended.

"Act of Bankruptcy" means the filing of a petition in bankruptcy (or any other commencement of a bankruptcy or similar proceeding) by or against the Corporation or any affiliate of the Corporation under any applicable bankruptcy, insolvency, reorganization or similar law, now or hereafter in effect.

"Additional Indebtedness" means any Indebtedness (including all Obligations, other than the Series 2003 Obligation, the Series 2005 Obligations, the Series 2006C Obligation, the Series 2007A Obligation, the Series 2010 Obligation, the Series 2011 Obligation and Series 2011 Swap Obligation) incurred by any Obligated Issuer, subsequent to its becoming an Obligated Issuer.

"Affiliate" of any specified Person means any other Person directly or indirectly controlling or controlled by or under direct or indirect common control with such specified Person. For purposes of this definition, (i) "control" when used with respect to any specified Person means the power to direct the management and policies of such Person, directly or indirectly, whether through the power to appoint and remove its directors, the ownership of voting securities, by contract, membership or otherwise; and (ii) the terms "controlling" and "controlled" have meanings correlative to the foregoing.

"Architect" means a Person who or which is appointed by any member of the Combined Group for the purpose of passing on questions relating to the design and construction of Facilities, has all licenses and certifications necessary for the performance of such services, and, in the good faith opinion of the Person making the appointment, has a favorable reputation for skill and experience in performing similar service in respect of Facilities of a comparable size and nature.

"Balloon Indebtedness" means (a) Long-Term Indebtedness as to which, when issued, 25% or more of the debt service thereon is due in a single year, or (b) Long-Term Indebtedness as to which, when issued, 25% or more of the original principal amount thereof may, at the option of the Holder or registered owner thereof, be redeemed or repurchased at one time, which portion of the principal is not required by the documents pursuant to which such Indebtedness is issued to be amortized by redemption prior to such date, or (c) any Guaranty of Long-Term Indebtedness that is Balloon Indebtedness.

"Bankruptcy Law" means the United States Bankruptcy Code, 11 U.S.C. §§ 101 et seq. or any similar statute.

"Bond Counsel" means a firm of nationally recognized standing in the field of municipal finance law whose opinions are generally accepted by purchasers of public obligations and who is acceptable to the Bond Trustee.

"Bond Fund" means the fund by that name created pursuant to the provisions of the 2011 Bond Indenture.

"Bond Index" means (i) in respect of any Outstanding Indebtedness, the average interest rate on such Indebtedness for the twelve (12) months immediately preceding the month prior to such calculation, or if such Indebtedness shall have had a variable rate for less than a twelve (12) month period, the average interest rate on such Indebtedness for such lesser period; and (ii) in respect of any proposed Indebtedness, at the option of the Obligated Group Agent, the initial rate established or reasonably expected to be established for such Indebtedness, as determined by an Officer's Certificate.

"Bond Trustee" means The Bank of New York Mellon Trust Company, N.A., a national banking association organized and existing under the laws of the United States, and its successors and any corporation resulting from or surviving any consolidation or merger to which it or its successors may be a party and any successor Bond Trustee at the time serving as successor Bond Trustee under the 2011 Bond Indenture.

"Book Entry System" means the system maintained by the Securities Depository as provided in the 2011 Bond Indenture.

"Book Value", when used in connection with Property of any member of the Combined Group, means the cost of such Property, net of accumulated depreciation, calculated in conformity with generally accepted accounting principles, and when used in connection with Property of the Combined Group, means the aggregate of the values so determined with respect to such Property of all members of the Combined Group determined in such a manner that no portion of such value of Property of any member of the Combined Group is included more than once.

"Business Day" means any day other than (a) a Saturday or Sunday, (b) a day on which the Bond Trustee is required or permitted by law to close, and (c) a day on which the New York Stock Exchange is closed.

"Capitalization" means the principal amount of all outstanding Long-Term Indebtedness of the Combined Group, plus the equity accounts of the Combined Group (i.e., unrestricted fund balances, including any shareholder equity or partnership equity).

"Code" means the Internal Revenue Code of 1986, as amended from time to time, and any successor thereto.

"Combined Group" means the Obligated Group and all Restricted Affiliates.

"Commitment Indebtedness" means the obligation of any Person to repay amounts disbursed pursuant to a credit facility to pay when due such Person's obligations under Indebtedness incurred in accordance with the provisions of the Master Indenture.

"Completion Indebtedness" means any Long-Term Indebtedness (a) incurred by any Person for the purpose of financing the completion of constructing or equipping Facilities with respect to which Long-Term Indebtedness was theretofore incurred in accordance with the provisions of the Master Indenture, and (b) with a principal amount

not in excess of the amount required (1) to provide a completed and equipped Facility of substantially the type and scope contemplated at the time such prior Long-Term Indebtedness was incurred, (2) to provide for capitalized interest during the period of construction, (3) to capitalize a reserve with respect to such Completion Indebtedness and (4) to pay the costs and expenses of issuing such Completion Indebtedness.

"Construction Index" means the health care component of the implicit price deflator for the gross national product as most recently reported prior to the date in question by the United States Department of Commerce or its successor agency, or, if such index is no longer published, such other index which is certified to be comparable and appropriate by the Obligated Group Agent in an Officer's Certificate delivered to the Master Trustee.

"Consultant" means a Person who or which is appointed by the Obligated Group Agent for the purpose of passing on questions relating to the financial affairs, management or operations of one or more members of the Combined Group or the entire Combined Group and, in the good faith opinion of the Obligated Group Agent, has a favorable reputation for skill and experience in performing similar services in respect of entities engaged in reasonably comparable endeavors. If any Consultant's report or opinion is required to be given with respect to matters partly within and partly without the expertise of such Consultant, such Consultant may rely upon the report or opinion of another Consultant, which other Consultant shall be reasonably satisfactory to the relying Consultant and the Obligated Group Agent.

"Corporation" means Wellmont Health System, a Tennessee nonprofit corporation, and its successors and assigns and any surviving, resulting or transferee entity as provided in the Agreement.

"Corporation Representative" means the person or persons at the time designated to act on behalf of the Corporation by written certificate furnished to the Issuer and the Bond Trustee containing the specimen signatures of such person or persons and signed on behalf of the Corporation by its President or Vice President. Such certificate may designate an alternate or alternates.

"Costs of Issuance" means the fees, costs, expenses and other charges incurred in connection with the issuance of the Series 2011 Bonds, including, but not limited to, the following: (a) counsel fees (including but not limited to Bond Counsel, Issuer's counsel, Trustee's counsel, Corporation's counsel, and underwriter's counsel); (b) underwriter's discount and financial advisor fees incurred in connection with the issuance of the Series 2011 Bonds; (c) initial Trustee acceptance and set-up fees and expenses incurred in connection with the issuance of the Series 2011 Bonds; (d) Trustee and authenticating agent fees and expenses related to issuance of the Series 2011 Bonds; and (e) printing costs for any offering materials.

"Costs of Issuance Fund" means the fund by that name created pursuant to the provisions of the 2011 Bond Indenture.

"Counsel" means a lawyer duly admitted to practice law before the highest court of any state in the United States of America or the District of Columbia, or any law firm, who or which, as the case may be, is not unsatisfactory to any recipient of the opinion to be rendered by such Counsel.

"Cross Guarantee" means the obligations of each Obligated Issuer pursuant to Section 2.3 of the Master Indenture.

"Debt Service Requirement" of any Person means, for any period of time, the amounts payable or the payments required to be made by such Person in respect of principal and interest on Outstanding Long-Term Indebtedness during such period (calculated in such a manner that no portion of Long-Term Indebtedness is included more than once), taking into account (for purposes of calculating any projected debt service requirements) (a) that any Indebtedness represented by a Guaranty shall be deemed payable on the dates and in the amounts contemplated in Section 4.3 of the Master Indenture (concerning the assumptions to be used in including debt service requirements of the guaranteed obligations), (b) that any payments to be made in respect of Balloon Indebtedness and Variable Rate Indebtedness shall be calculated in accordance with the provisions of Section 4.4 of the Master Indenture, (c) that, with respect to Indebtedness refunded or refinanced during such period, only an amount of principal and interest equal to the principal and interest not payable from the proceeds of Indebtedness

shall be taken into account during such period, and (d) any amounts payable from funds available under an Escrow Deposit (other than amounts so payable solely by reason of the obligor's failure to make payments from other sources), or funded from the proceeds of such Long-Term Indebtedness (i.e., accrued and capitalized interest), shall be excluded from the determination of the Debt Service Requirement.

"Eighth Supplemental Master Indenture" means the Eighth Supplemental Master Indenture, dated as of November 1, 2006, among the Corporation (as successor to Bristol Memorial Hospital), Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc., Wellmont Foundation and the Master Trustee pursuant to which the Series 2006C Obligation was issued.

"Eleventh Supplemental Master Indenture" means the Eleventh Supplemental Master Indenture dated as of May 1, 2011 among the Corporation (as the successor to Bristol Memorial Hospital), Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc., Wellmont Foundation and the Master Trustee pursuant to which the Series 2011 Obligation is issued.

"Escrow Deposit" means a segregated escrow fund or other similar fund, account or deposit in trust of cash in an amount (or Investment Securities the principal of and interest on which will be in an amount), and under terms, sufficient to pay all or a portion of the principal of, and premium, if any, and interest on, the indebtedness secured by such escrow fund or other similar fund, account or deposit as the same shall become due or payable upon redemption.

"Facilities" means all land, leasehold interests and buildings and all fixtures and equipment of a Person.

"Fair Value Net Worth" of a Person as of any date means:

(a) the fair value or fair saleable value (as the case may be, determined in accordance with applicable federal and state laws affecting creditors rights and governing determinations of insolvency of debtors) of such Person's assets (including such person's rights to contribution and subrogation under Sections 2.3(d) and (f) of the Master Indenture or in respect of any other guarantee) as of such date, minus

(b) the amount of all liabilities of such Person (determined in accordance with such laws) as of such date, excluding (x) such Person's Cross Guarantee and (y) any liabilities subordinated in right of payment to such Cross Guarantee, minus

(c) \$1.00.

"Fifth Supplemental Master Indenture" means the Fifth Supplemental Master Indenture, dated as of February 1, 2003, among the Corporation (as successor to Bristol Memorial Hospital) as a member of the Obligated Group, Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc., Wellmont Foundation and the Master Trustee pursuant to which the Series 2003 Obligation was issued.

"Financial Advisor" means an investment banking or financial advisory firm, commercial bank or any other qualified Person who or which is appointed by the Obligated Group Agent for the purpose of passing on questions relating to the availability and terms of specified types of Indebtedness for any member of the Combined Group and is actively engaged in and, in the good faith opinion of the Obligated Group Agent, has a favorable reputation for skill and experience in underwriting or providing financial advisory services in respect of similar types of Indebtedness incurred by entities engaged in reasonably comparable endeavors.

"Fiscal Year" means a period of twelve consecutive months ending on June 30 or on such other date as may be specified in an Officer's Certificate of the Obligated Group Agent executed and delivered to the Master Trustee.

"Fitch" means Fitch Ratings, Inc., its successors and their assigns, and, if such corporation is dissolved or liquidated or no longer performs the functions of a securities rating agency, "Fitch" will be deemed to refer to any other nationally recognized securities rating agency designated by the Corporation by written notice to the Bond Trustee.

"Governing Body" means, when used with respect to any Person, its board of directors, board of trustees, or other board, committee or group of individuals in which the powers of a board of directors or board of trustees is vested generally or for the specific matters under consideration.

"Government Issuer" means any federal, state or municipal corporation or political subdivision thereof or any instrumentality of any of the foregoing empowered to issue obligations on behalf thereof.

"Government Obligations" as used in the Master Indenture means (i) direct obligations of, or obligations the principal of and interest on which are unconditionally guaranteed by, the United States of America, including evidences of a direct ownership interest in future interest or principal payments on obligations issued or guaranteed by the United States of America, which obligations are held in a custody account by a custodian pursuant to the terms of a custody agreement, and (ii) obligations issued by any state of the United States of America or any political subdivision, public instrumentality or public authority of any state of the United States of America, provision for the full and timely payment of the principal or premium of and interest on which shall have been made by deposit with a trustee or escrow agent, pursuant to an irrevocable security agreement, of obligations described in clause (i) above.

"Government Obligations" as used in the 2011 Bond Indenture means direct general obligation of, or obligations the payment of the principal of and interest on which are unconditionally guaranteed as to full and timely payment by, the United States of America, which obligations are noncallable.

"Gross Receipts" means all receipts, revenues, income, gifts, donations, contributions, grants, bequests, pledges, chattel paper and instruments and other moneys received by or on behalf of the Obligated Group, including, but without limiting the generality of the foregoing, (a) revenues derived from the ownership or operation of Property, including insurance and condemnation proceeds with respect to Property or any portion thereof, and (b) all rights to receive the same, whether in the form of accounts, accounts receivable, contract rights or other rights and the proceeds of such rights, whether now owned, or held or hereafter coming into existence; provided however that (i) gifts, donations, contributions, grants (including Hill-Burton grants), bequests and pledges heretofore or hereafter made and designated as specified by the granting authority, donor or maker thereof as being for specified purposes (inconsistent with the payment of debt service on Indebtedness) and income derived therefrom to the extent required by such designation or specification, and (ii) revenues, receipts and income derived from the ownership and operation of Property which secures Non-Recourse Indebtedness shall be excluded from Gross Receipts.

"Guaranty" means any obligation of a Combined Group member guaranteeing any obligation of any other Person other than a Combined Group member, whether or not issued under the Master Indenture as an Indenture Guaranty, which obligation would, if such other Person were a member of the Combined Group, constitute Indebtedness thereunder.

"Historical Debt Service Coverage Ratio" means, for any period of time, the ratio determined by dividing Total Income Available for Debt Service for such period by the Debt Service Requirement of the Combined Group for such period.

"Historical Maximum Annual Debt Service Coverage Ratio" means, for any period of time, the ratio determined by dividing Total Income Available for Debt Service for such period by the Maximum Annual Debt Service of the Combined Group.

"Historical Pro Forma Debt Service Coverage Ratio" means for any period of time, the ratio determined by dividing Total Income Available for Debt Service for such period by the Maximum Annual Debt Service of the Combined Group for all Long-Term Indebtedness then Outstanding and the Long-Term Indebtedness then proposed to be issued.

"Holder" means, as the context requires, the registered owner of any Note, the beneficiary of any Indenture Guaranty in whose name an Indenture Guaranty is issued or the holder or beneficiary of any other type of Obligation. In the case of an Obligation issued to a trustee or other fiduciary acting on behalf of the holders of any bonds, notes or other similar obligations which are secured by such Obligation, including any registered securities

depository then in the business of holding (for the benefit of beneficial owners whose interests may be evidenced by book-entry registration) substantial amounts of obligations of types comprising the Obligations, the term Holder means the trustee or other fiduciary or, if so provided in the Related Financing Documents, the holders of the Related Bonds in proportion to their respective interests therein, including any registered securities depository then in the business of holding (for the benefit of beneficial owners whose interests may be evidenced by book-entry registration) substantial amounts of obligations of types comprising the Obligations.

"Income Available For Debt Service" of a Person means, with respect to any period of time, the excess of revenues over expenses, or, in the case of for-profit entities, net income after tax, as determined in accordance with generally accepted accounting principles, to which shall be added, in either case, (a) depreciation, (b) amortization, and (c) interest expense on Indebtedness, and from which shall be excluded any extraordinary items, any gain or loss resulting from either the extinguishment of indebtedness or the sale, exchange or other disposition of assets not made in the ordinary course of business and any revenues or expenses of any Person which is not a member of the Combined Group.

"Indebtedness" of a Person means (a) all Notes and Guaranties, (b) all liabilities (exclusive of reserves) recorded as indebtedness on the audited financial statements of such Person as of the end of the most recent Fiscal Year for which financial statements reported upon by an Accountant are available, and (c) all other obligations for borrowed money; provided that Indebtedness shall not include (1) Subordinated Indebtedness, (2) Interest Rate Swap Obligations, (3) any other Indebtedness of any member of the Combined Group to any other member of the Combined Group, (4) rentals payable under leases which are not properly capitalized under generally accepted accounting principles, or (5) any other obligation which does not constitute indebtedness under generally accepted accounting principles.

"Indenture Guaranty" means any Guaranty issued under the Master Indenture by an Obligated Issuer.

"Insurance Consultant" means a Person, who or which is appointed by any member of the Combined Group for the purpose of reviewing and recommending insurance coverage for the Facilities and operations of one or more members of the Combined Group or the entire Combined Group and, in the good faith opinion of the person making the appointment, has a favorable reputation for skill and experience in performing such services in respect of Facilities and operations of a comparable size and nature. If an Insurance Consultant's report or opinion is required to be given with respect to matters partly within and partly without the expertise of such Insurance Consultant, such Insurance Consultant may rely upon the report or opinion of another Insurance Consultant or other expert, which other Insurance Consultant or other expert shall be reasonably satisfactory to the relying Insurance Consultant and the Obligated Group Agent.

"Interest Payment Date" means each March 1 and September 1, commencing September 1, 2011.

"Investment Securities" means and includes the following:

- (a) Government Obligations;
- (b) debt obligations issued by any of the following agencies or such other like governmental or government-sponsored agencies which may be hereafter created; Bank for Cooperatives; Federal Intermediate Credit Banks; Federal Financing Bank; Federal Home Loan Bank System; Federal National Mortgage Association; Export-Import Bank of the United States; Farmers Home Administration; Small Business Administration; Inter-American Development Bank; International Bank for Reconstruction and Development; Federal Land Banks; Government National Mortgage Association; or Resolution Funding Corporation;
- (c) long-term debt obligations of any state or political subdivision thereof or any agency or instrumentality of such a state or political subdivision or of any corporation, provided that such obligations are rated by S&P or Moody's in any of the three highest rating categories (without reference to sub-categories) assigned by S&P or Moody's;

(d) rights to receive the principal of or the interest on obligations of states, political subdivisions, agencies or instrumentalities meeting the requirements set forth in subparagraph (c) above, whether through

(1) direct ownership as evidenced by physical possession of such obligations or unmatured interest coupons or by registration as to ownership on the books of the issuer or its duly authorized paying agent or transfer agent, or

(2) purchase of certificates or other instruments evidencing an undivided ownership interest in payments of the principal of or interest on such obligations;

(e) negotiable and non-negotiable certificates of deposit, time deposits or other similar banking arrangements which are issued by banks, trust companies or savings and loan associations, provided that, unless issued by a Qualified Financial Corporation, any such certificate, deposit or other arrangement shall be continuously secured as to principal in the manner and to the extent provided in the last paragraph of this definition;

(f) repurchase agreements for Investment Securities described in subparagraph (a) or (b) above with a Qualified Financial Corporation or with dealers in government bonds which report to, trade with and are recognized as primary dealers by a Federal Reserve Bank or are members of the Securities Investors Protection Corporation, provided that the repurchase price payable under any such agreement shall be continuously secured in the manner and to the extent provided in the last paragraph of this definition;

(g) investment agreements with Qualified Financial Corporations;

(h) commercial paper rated in the highest rating category (without reference to sub-categories) by S&P or Moody's;

(i) shares or certificates in any short-term investment fund which short-term investment fund invests solely in obligations described in subparagraph (a), (b), (c) or (h) above; or

(j) debt obligations of any foreign government or political subdivision thereof or any agency or instrumentality of such foreign government or political subdivision provided that such obligations are rated by S&P or Moody's (without reference to subcategories) in the highest rating category assigned by S&P or Moody's.

Any security required to be maintained for Investment Securities in the form of certificates of deposit, time deposits, other similar banking arrangements and repurchase agreements described in subparagraphs (e) and (f) above shall be subject to the following:

(1) the collateral shall be in the form of obligations described in subparagraphs (a) or (b) above, except that the security for certificates of deposit, time deposits or other similar banking arrangements may include other marketable securities which are eligible as security for trust funds under applicable regulations of the Comptroller of the Currency of the United States of America or under applicable state laws and regulations.

(2) the collateral shall have an aggregate market value, calculated not less frequently than monthly, at least equal to the principal amount (less any portion insured by the Federal Deposit Insurance Corporation or any comparable insurance corporation chartered by the United States of America) or the repurchase price secured thereby, as the case may be. The instruments governing the issuance of and security for the Investment Securities shall designate the Person responsible for making the foregoing calculations; provided that the Master Trustee shall make such calculations if they are not made by the Person so designated.

"Issuer" means The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee.

"Lien" means any mortgage or pledge of, security interest in or lien or encumbrance on any Property of any member of the Combined Group in favor of, or which secures any Indebtedness or any other obligation of any member of the Combined Group to any Person other than another member of the Combined Group, but specifically excluding subordination arrangements among creditors.

"Limited Obligor" means any Person, other than a member of the Combined Group, on whose account any Obligated Issuer has issued a Guaranty as consideration for such Person's execution and delivery to such Obligated Issuer of a Pledged Note.

"Long-Term Indebtedness" means (a) all Indebtedness which, at the time of incurrence or issuance, has a final maturity or term greater than one year or which is renewable at the option of the obligor thereof for a term greater than one year from the date of original incurrence or issuance; and (b) Short-Term Indebtedness which is incurred as interim financing and which is intended to be repaid out of the proceeds of other Long-Term Indebtedness, provided that any one of the applicable conditions described in Section 4.2 of the Master Indenture are met with respect to such Short-Term Indebtedness on the date of incurrence, assuming for purposes of compliance therewith that such Short-Term Indebtedness is Long-Term Indebtedness characterized as Balloon Indebtedness for purposes of meeting any of the applicable conditions in Section 4.2 of the Master Indenture; provided, that, Long-Term Indebtedness shall not include (1) Non-Recourse Indebtedness or Subordinated Indebtedness; (2) current obligations payable out of current revenues, including current payments for the funding of pension plans and contributions to self insurance programs; (3) obligations under contracts for supplies, services or pensions, allocated to the current operating expenses of future years in which the supplies are to be furnished, the services rendered or the pensions paid; and (4) rentals payable under leases which are not properly capitalized under generally accepted accounting principles.

"Master Indenture" means the Master Trust Indenture, dated as of May 1, 1991, between the Corporation's predecessor, Bristol Memorial Hospital, and the Master Trustee, as supplemented prior to the date hereof, and as further supplemented by the Eleventh Supplemental Master Indenture and Twelfth Supplemental Master Indenture and as it may from time to time be amended or supplemented in accordance with the terms thereof.

"Master Trustee" means U.S. Bank National Association (as successor to Wachovia Bank, National Association, First Union National Bank and Dominion Bank of Middle Tennessee), or any successor master trustee under the Master Indenture.

"Maximum Annual Debt Service" of the Combined Group means the highest annual Debt Service Requirement of the Combined Group for the current or any succeeding Fiscal Year during the remaining term of all Outstanding Obligations.

"Maximum Guaranty Liability" of a Person as of any date means the greater of (i) or (ii) below:

(i) The greater of (A) or (B) as of such date:

(A) the outstanding amount of all Obligations issued by such Person or

(B) the fair market value of all property acquired, in whole or in part, with the proceeds of such Obligations by such Person.

(ii) The greatest of the Fair Value Net Worth of such Person as of the latest fiscal year-end of such Person, each fiscal year-end of such Person thereafter occurring on or prior to the date of the determination of Maximum Guaranty Liability, the date on which enforcement of the pertinent Cross Guarantee is sought, and the date on which a case under the U.S. Bankruptcy Code is commenced with respect to any Obligated Issuer.

"Moody's" means Moody's Investors Service, Inc., a corporation organized and existing under the laws of the State of Delaware, its successors and assigns, and, if such corporation is dissolved or liquidated or no longer performs the functions of a securities rating agency, "Moody's" will be deemed to refer to any other nationally recognized securities rating agency designated by the Corporation by written notice to the Bond Trustee.

"Net Operating Revenues" of a Person means, with respect to any period of time, operating revenues less contractual allowances, free care, discounts and allowances for bad debts, all determined in accordance with generally accepted accounting principles.

"Ninth Supplemental Master Indenture" means the Ninth Supplemental Master Indenture dated as of July 1, 2007 among the Corporation (as the successor to Bristol Memorial Hospital), Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc., Wellmont Foundation and the Master Trustee, pursuant to which the Series 2007A Obligation is issued.

"Non-Arbitrage Certificate" means the Non-Arbitrage Certificate dated the date of delivery of the Series 2011 Bonds and executed by the Issuer.

"Non-Recourse Indebtedness" means any Indebtedness secured by a Lien on any real property, fixtures and tangible personal property, which Indebtedness is not a general obligation of the Obligated Group or any Obligated Issuer, and the liability for which Indebtedness is effectively limited to the property subject to such Lien (and the revenues derived therefrom), with no recourse, directly or indirectly, to any other property.

"Note" means any note issued under the Master Indenture by an Obligated Issuer to evidence Long-Term Indebtedness or Short-Term Indebtedness incurred pursuant to the terms thereof.

"Obligated Group" means the Corporation, Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc., Wellmont Foundation and each other Person who becomes a member of the Obligated Group in accordance with the Master Indenture.

"Obligated Group Agent" means the Corporation and any successor Obligated Group Agent appointed pursuant to the Master Indenture.

"Obligated Issuer" means (a) the Corporation, Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc. and Wellmont Foundation and each other Person which becomes an Obligated Issuer in accordance with the provisions of Article Three of the Master Indenture, whether or not such Person has issued any Obligations thereunder, and which has not withdrawn from the Obligated Group pursuant to Article Three thereof, and (b) when used in respect of any particular Obligation or other Indebtedness, means the obligor thereunder.

"Obligations" means all Notes and Indenture Guaranties issued under the Master Indenture, any lease, contractual agreement to pay money or other obligations of any Obligated Group Member issued under the Master Indenture and any additional forms of Obligations created pursuant to Section 9.1 of the Master Indenture.

"Officer's Certificate" means a certificate signed, in the case of a corporation, by the Chairman, Vice Chairman, President or Chief Financial Officer or, in the case of a certificate delivered by any other Person, the chief executive or chief financial officer of such Person, in either case whose authority to execute such certificate shall be evidenced to the satisfaction of the Master Trustee. When an Officer's Certificate is required to set forth matters relating to one or more Obligated Issuers, such Officer's Certificate may be given in reliance upon another certificate, or other certificates, and supporting materials, if any, provided by any duly authorized officer of the applicable Obligated Issuer.

"Opinion of Bond Counsel" means an opinion in writing signed by an attorney or firm of attorneys experienced in the field of municipal bonds whose opinions are generally accepted by purchasers of municipal bonds.

"Outstanding" (a) when used with reference to Notes, means, as of any date of determination, all Notes theretofore issued or incurred and not paid and discharged other than (1) Notes theretofore cancelled by the Master Trustee or delivered to the Master Trustee for cancellation, (2) Notes deemed paid and no longer Outstanding as provided in Article XI of the Master Indenture or for which an Escrow Deposit has been established, (3) Notes in lieu of which other Notes have been authenticated and delivered or have been paid pursuant to the provisions of the Master Indenture regarding mutilated, destroyed, lost or stolen Notes unless proof satisfactory to the Master Trustee has been received that any such Note is held by a bona fide purchaser for value without notice, and (4) any Note held by any Obligated Issuer; or, (b) all Indenture Guaranties unless the Master Trustee has received from the Holder thereof a written release of all claims thereof against the Obligated Issuer thereunder and all other Obligated Issuers; or, (c) when referring to Indebtedness other than Notes and Indenture Guaranties, means, as of any date of determination, all Indebtedness theretofore issued or incurred other than (1) Indebtedness which has been paid, (2) Indebtedness for which an opinion of Counsel stating that such Indebtedness has been discharged has been provided to the Master Trustee, (3) evidence of Indebtedness for which new evidence has been substituted in a manner analogous to clause (a)(3) above, and (4) any evidence of Indebtedness held by any Obligated Issuer, provided that Obligations or evidences of Indebtedness held by any Obligated Issuer may be deemed by such Obligated Issuer to be continuously Outstanding if such Obligations or evidences of Indebtedness were acquired with an intent that they only be held temporarily in connection with an effort to remarket them to Persons other than the Obligated Issuer.

"Outstanding" or "Bonds Outstanding" means all Series 2011 Bonds which have been authenticated and delivered by the Bond Trustee under the 2011 Bond Indenture, except:

- (a) Series 2011 Bonds canceled after purchase in the open market or because of payment at, or redemption prior to, maturity;
- (b) Series 2011 Bonds paid or deemed paid pursuant to the 2011 Bond Indenture;
- (c) Series 2011 Bonds in lieu of which others have been authenticated under the provisions of the 2011 Bond Indenture; and
- (d) Series 2011 Bonds deemed tendered under the 2011 Bond Indenture and for which another Series 2011 Bond has been issued.

"Owner" means the person or persons in whose name or names a Series 2011 Bond is registered on the books of the Issuer kept by the Bond Trustee for that purpose in accordance with provisions of the 2011 Bond Indenture.

"Participant" means one of the entities which is a member of the Securities Depository and deposits securities, directly or indirectly, in the Book Entry System.

"Permitted Liens" means the Master Indenture, all Related Financing Documents and, as of any particular time:

- (a) Any judgment lien or notice of pending action against any member of the Combined Group so long as (1) such judgment or pending action is being contested and execution thereon has been stayed or the period for responsive pleading or appeal has not lapsed, or (2) in the absence of such contest, neither the pledge and security interest of the Master Indenture nor any Property of any member of the Combined Group will be materially impaired or subject to material loss or forfeiture;
- (b) (1) Rights reserved to or vested in any municipality or public authority by the terms of any right, power, franchise, grant, license, permit or provision of law affecting any Property, to (i) terminate such right, power, franchise, grant, license or permit, provided that the exercise of such right would not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof, or (ii) purchase, condemn, appropriate or recapture, or designate a purchaser of, such Property; (2) any liens (or deposits to obtain the release of such liens) on any

Property for taxes, assessments, levies, fees, water and sewer charges, and other governmental and similar charges and any liens of mechanics, materialmen, laborers, suppliers or vendors for work or services performed or materials furnished in connection with such Property, which are not due and payable or which are not delinquent or which, or the amount or validity of which, are being contested and execution thereon is stayed; (3) easements, rights-of-way, servitudes, restrictions and other minor defects, encumbrances, and irregularities in the title to any Property which do not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof; (4) rights reserved to or vested in any municipality or public authority to control or regulate any Property or to use such Property in any manner, which rights do not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof; and (5) to the extent that it affects title to any Property, the Master Indenture;

(c) Any lease which relates to Property of the Combined Group which is of a type that is customarily the subject of such leases, including but not limited to any leasehold interest required under any Related Financing Documents, leases with respect to office space for physicians and educational institutions, food service facilities, gift shops and radiology or other hospital-based specialty services, pharmacy and similar departments and statutory landlord's liens with respect to such leases;

(d) Any Lien securing Indebtedness provided such Lien also secures all Obligations (other than Obligations representing Subordinated Indebtedness or Non-Recourse Indebtedness) on a parity basis;

(e) Any Lien arising by reason of good faith deposits in connection with leases of real estate, bids or contracts (other than contracts for the payment of money), deposits by any member of the Combined Group to secure public or statutory obligations, or to secure, or in lieu of, surety, stay or appeal bonds, and deposits as security for the payment of taxes or assessments or other similar charges;

(f) Any Lien arising by reason of deposits with, or the giving of any form of security to, any governmental agency or any body created or approved by law or government regulation for any purpose at any time as required by law or governmental regulation as a condition to the transaction of any business or the exercise of any privilege or license, or to enable any member of the Combined Group to maintain self insurance or to participate in any funds established to cover any insurance risks or in connection with workers compensation, unemployment insurance, pension or profit sharing plans or other similar social security plans, or to share in the privileges or benefits required for companies participating in such arrangements;

(g) Any Lien arising by reason of an Escrow Deposit;

(h) (1) Any Lien in favor of a trustee or the holder of a Note on the proceeds of Indebtedness or cash or investments deposited with such trustee and acquired with such proceeds prior to the application of such proceeds or cash or investments and (2) Liens in favor of a trustee, including the Master Trustee, to secure obligations to compensate, reimburse or indemnify such trustees;

(i) Any Lien on moneys deposited by patients or others with any member of the Combined Group as security for or as prepayment for the cost of patient care;

(j) Any Lien on Property received by any member of the Combined Group through gifts, grants or bequests, such Lien being due to restrictions on such gifts, grants or bequests of property or the income thereon;

(k) Statutory rights of the United States of America by reason of federal funds made available under 42 U.S.C. §§ 291 et seq. and similar rights under other federal and state statutes;

(l) Liens existing at the time of a Consolidation or Merger pursuant to Section 6.4 of the Master Indenture, on the date of acquisition of any Property or at the time a Person becomes an Obligated

Issuer pursuant to "-Persons Becoming Obligated Issuers" below or a Restricted Affiliate pursuant to "-Conditions for Designation of Restricted Affiliates" below;

(m) Liens existing at the time of any consolidation, merger, sale or conveyance pursuant to Section 6.4 of the Master Indenture, on the date of acquisition of any Property or at the time a Person becomes an Obligated Issuer pursuant to "-Persons Becoming Obligated Issuers" below or a Restricted Affiliate pursuant to "-Conditions for Designation of Restricted Affiliates" below; provided that

(1) No lien so described may be extended or renewed, nor may it be modified, to apply to any Property or any member of the Obligated Group not subject to such lien on the effective date, unless the lien as so extended, renewed or modified, or the replacement lien, otherwise qualified as a Permitted Encumbrance;

(2) No Additional Indebtedness may be thereafter incurred that is secured by such lien;

(3) No such lien was created in order to avoid the limitations contained herein on the imposition of liens on the property of the Obligated Group; and

(4) Such indebtedness does not become part of the Indebtedness of the Obligated Group.

(n) Any Lien described in Exhibit A to the Master Indenture which is existing on the date of authentication and delivery of the Initial Obligation provided that no such Lien (or the amount of indebtedness secured thereby) may be increased, extended, renewed or modified to apply to any Property of any member of the Combined Group not subject to such Lien on such date, unless such Lien as so extended, renewed or modified otherwise qualifies as a Permitted Lien thereunder;

(o) A security interest in any funds or accounts established pursuant to the provisions of any Related Financing Documents;

(p) Liens in the form of purchase money security interests in Property financed with the proceeds of Indebtedness secured thereby;

(q) Deposits of cash or cash equivalents to secure obligations under letters of credit incurred in the ordinary course of business of any member of the Combined Group.

"Person" means an individual, a corporation, a partnership, an association, a joint stock company, a joint venture, a trust, an unincorporated organization, a governmental unit or an agency, political subdivision or instrumentality thereof or any other group or organization of individuals.

"Pledged Note" means a promissory note executed by a Limited Obligor, as maker, in favor of an Obligated Issuer, as payee, evidencing a sum certain liability of such maker to such payee, which is assigned by such payee to the Master Trustee pursuant to Section 2.3 of the Master Indenture.

"Principal Office" of the Bond Trustee means the address specified in the 2011 Bond Indenture or such other address as may be designated in writing to the Issuer and the Corporation.

"Projected Debt Service Coverage Ratio" means for any future period of time, the ratio determined by dividing projected Total Income Available for Debt Service for such period by Maximum Annual Debt Service of the Combined Group.

"Property" means any and all land, leasehold interests, building, machinery, equipment, hardware, and inventory of each Obligated Issuer wherever located and whether now or hereafter acquired, and any and all rights,

title and interest in and to any and all property whether real or personal, tangible or intangible and wherever situated and whether now or hereafter acquired.

"Property, Plant and Equipment" means all Property which is classified as property, plant and equipment under generally accepted accounting principles.

"Qualified Financial Corporation" means a bank, trust company, national banking association, insurance company or other financial services company whose unsecured long-term debt obligations (in the case of a bank, trust company, national banking association or other financial services company) or whose claims paying abilities (in the case of an insurance company) are rated in any of the three highest rating categories (without reference to sub-categories) by S&P or Moody's. For purposes hereof, the term "financial services company" shall include any investment banking firm or any affiliate or division thereof which may be legally authorized to enter into the transactions described in the Master Indenture pertaining, applicable or limited to a Qualified Financial Corporation.

"Rating Agency" means, severally or collectively, if applicable (a) S&P and any successor thereto, if it has assigned a rating to any Obligation issued and Outstanding under the Master Indenture or any Related Bonds issued and Outstanding pursuant to any Related Financing Documents, (b) Moody's and any successor thereto, if it has assigned a rating to any Obligation issued and Outstanding under the Master Indenture or any Related Bonds issued and Outstanding pursuant to any Related Financing Documents, and (c) Fitch and any successor thereto, if it has assigned a rating to any Obligation issued and Outstanding pursuant to any Related Financing Documents. If any such Rating Agency shall no longer perform the functions of a securities rating service for whatever reason, the term "Rating Agency" shall thereafter be deemed to refer to the others, but if both of the others shall no longer perform the functions of a securities rating service for whatever reason, the term "Rating Agency" shall thereafter be deemed to refer to any other nationally recognized rating service or services as shall be designated in writing by the Obligated Group Agent to the Master Trustee; provided that such designee shall not be unsatisfactory to the Master Trustee.

"Rebate Fund" means the fund by that name created pursuant to the provisions of the 2011 Bond Indenture.

"Related Bond Indenture" means any indenture, bond resolution or other comparable instrument pursuant to which a series of Related Bonds is issued.

"Related Bond Issuer" means the Government Issuer of any issue of Related Bonds.

"Related Bond Trustee" means the trustee and its successors in the trust created under any Related Bond Indenture, and if there is no such trustee, means the Related Bond Issuer.

"Related Bonds" means the revenue bonds, notes, other evidences of indebtedness or any other obligations issued by a Government Issuer, pursuant to a single Related Bond Indenture, the proceeds of which are loaned or otherwise made available to an Obligated Issuer in consideration of the execution, authentication and delivery of a Note to or for the order of such Government Issuer.

"Related Financing Documents" means:

(a) in the case of any Note, (1) all documents, including any Related Bond Indenture, pursuant to which the proceeds of the Note are made available to an Obligated Issuer, the payment obligations evidenced by the Note are created and any security for the Note (if permitted under the Master Indenture) is granted, and (2) all documents creating any additional payment or other obligations on the part of an Obligated Issuer which are executed in favor of the Holder in consideration of the Note proceeds being loaned or otherwise made available to the Obligated Issuer;

(b) in the case of any Indenture Guaranty, all documents creating the indebtedness being guaranteed pursuant to the Indenture Guaranty and providing for the loan or other disposition of the proceeds of the indebtedness and all documents pursuant to which any security for the Indenture Guaranty (if permitted under the Master Indenture) is granted; and

(c) in the case of Indebtedness other than Notes and Indenture Guaranties, all documents relating thereto which are of the same nature and for the same purpose as the documents described in clauses (a) and (b) above.

"Reserved Rights" means amounts payable to the Issuer pursuant to the Loan Agreement as described under "Summary of Certain Provisions of the Loan Agreement - Obligation Payments; Fund Deposits; Prepayments and Other Payments - Additional Payments," "- Particular Covenants of the Corporation - Indemnity" and "- Defaults and Remedies - Agreement to Pay Attorneys' Fees, Costs and Expenses" below, and the right of the Issuer to receive notices.

"Responsible Officer" when used with respect to the Bond Trustee, means any officer within the corporate trust administrative department of the Bond Trustee, including any vice president, any assistant vice president, any trust officer, or any other officer of the Bond Trustee customarily performing functions similar to those performed by any of the above designated officers and also means, with respect to a particular corporate trust matter, any other officer to whom such matter is referred because of his or her knowledge of and familiarity with the particular subject.

"Restricted Affiliate" means any Affiliate of a member of the Obligated Group that:

(a) is either (1) a non-stock membership corporation of which one or more members of the Combined Group are the sole members, or (2) a non-stock, non-membership corporation or a trust of which the sole beneficiaries or controlling Persons are one or more members of the Combined Group, or (3) a stock corporation all of the outstanding shares of stock of which are owned by one or more members of the Combined Group, and

(b) if such Affiliate is a non-stock corporation or a trust,

(1) has the legal power, with approval of a majority of its Governing Body but without the consent of any other Person, to transfer to any Obligated Issuer (or to another Restricted Affiliate that possesses the power to transfer to any Obligated Issuer) money required for the payment of Indebtedness of any Obligated Issuer, and

(2) one or more members of the Combined Group have the sole right to elect or appoint and to remove, with or without cause, a majority of the members of the Governing Body thereof, and

(3) has the ability under applicable law and its organizational documents, with approval of a majority of the members of its Governing Body, to transfer all assets of such Affiliate remaining after payment of its debts to any Obligated Issuer or to another Restricted Affiliate whose remaining assets may be so transferred, provided that if such Affiliate is an organization described in Section 501(c)(3) of the Code, then for so long as the applicable Obligated Issuer is an organization described in Section 501(c)(3) of the Code, the organizational documents of such Affiliate and applicable law may (i) provide for the naming of another member of the Combined Group as a substitute beneficiary if the then current beneficiary ceases to be an organization described in Section 501(c)(3) of the Code and (ii) prohibit transfers to organizations not described in Section 501(c)(3) of the Code, and

(c) has satisfied (or a predecessor has satisfied) the requirements set forth in the Master Indenture for becoming a Restricted Affiliate and has not thereafter ceased to satisfy the requirements of clauses (a) and (b) above or satisfied the requirements set forth in the Master Indenture for ceasing to be a Restricted Affiliate.

The fact that one or more specified elements described above is not satisfied shall not disqualify a Person as a Restricted Affiliate if, in the written opinion of Counsel to such Restricted Affiliate delivered to the Master Trustee, substantially all of the indicia described above relating to the power to transfer Property of, and control, the

applicable Affiliate of a member of the Combined Group, is vested in one or more members of the Combined Group.

"Securities Depository" means The Depository Trust Corporation, New York, New York, or its nominee, and its successors and assigns.

"Series 2003 Bonds" means the Issuer's Hospital Revenue Refunding Bonds (Wellmont Health System Project) Series 2003 issued in the original aggregate principal amount of \$59,100,000 pursuant to the terms and conditions of the Bond Trust Indenture dated as of February 1, 2003 between the Issuer and BNY Trust Company of Missouri, as bond trustee thereunder.

"Series 2003 Obligation" means the \$59,100,000 principal amount Wellmont Health System Note (The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee), Refunding Series 2003, issued pursuant to the Fifth Supplemental Master Indenture

"Series 2005 Bonds" means the Issuer's Hospital Revenue Refunding Bonds (Wellmont Health System Project) Series 2005 issued in the original aggregate principal amount of \$70,620,000 pursuant to the terms and conditions of the Bond Trust Indenture dated as of December 1, 2005 between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee thereunder.

"Series 2005 Obligations" means the \$70,620,000 principal amount Wellmont Health System Note (The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee), Refunding Series 2005, and the \$71,548,702 principal amount Standby Note (2005 Master Note) of the Obligated Group, Reimbursement Obligation, each issued pursuant to the Sixth Supplemental Master Indenture.

"Series 2006C Bonds" means the Issuer's Hospital Revenue Bonds (Wellmont Health System Project) Series 2006C issued in the original aggregate principal amount of \$200,000,000 pursuant to the terms and conditions of the Bond Trust Indenture dated as of November 1, 2006 between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee thereunder.

"Series 2006C Obligation" means the \$200,000,000 principal amount Wellmont Health System Note (The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee), Series 2006C, issued pursuant to the Eighth Supplemental Master Indenture.

"Series 2007A Bonds" means the Virginia Small Business Financing Authority's Hospital Revenue Bonds (Wellmont Health System Project), Series 2007A issued in the original aggregate principal amount of \$55,000,000 pursuant to the terms and conditions of the Bond Trust Indenture dated as of July 1, 2007 between the Virginia Small Business Financing Authority and The Bank of New York Mellon Trust Company, N.A., as bond trustee thereunder.

"Series 2007A Obligation" means the \$55,000,000 principal amount Wellmont Health System Note (Virginia Small Business Financing Authority), Series 2007A, issued pursuant to the Ninth Supplemental Master Indenture.

"Series 2010 Bond" means the Issuer's Hospital Revenue Bond (Wellmont Health System Project), Series 2010 (Bank Qualified) issued in the original aggregate principal amount of \$30,000,000 pursuant to the terms and conditions of the Bond Purchase Agreement dated as of November 1, 2010 between the Issuer and First Tennessee Bank National Association, a national banking association, as purchaser.

"Series 2010 Obligation" means the \$30,000,000 principal amount Wellmont Health System Note (The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee), Series 2010, issued pursuant to the Tenth Supplemental Master Indenture.

"Series 2011 Bonds" means the Issuer's Hospital Revenue Refunding Bonds (Wellmont Health System Project), Series 2011 issued in the original aggregate principal amount of \$76,165,000 pursuant to the terms and

conditions of the Bond Trust Indenture dated as of May 1, 2011 between The Bank of New York Mellon Trust Company, N.A., as bond trustee thereunder.

"Series 2011 Obligation" means the \$76,165,000 principal amount Wellmont Health System Note (The Health Educational and Housing Facilities Board of the County of Sullivan, Tennessee), Series 2011, issued pursuant to the Eleventh Supplemental Master Indenture.

"Series 2011 Swap Obligation" means the Wellmont Health System Promissory Note Constituting Series 2011 Swap Obligation, issued pursuant to the Twelfth Supplemental Master Indenture.

"Short-Term Indebtedness" means all Indebtedness other than Long-Term Indebtedness.

"Sixth Supplemental Master Indenture" means the Sixth Supplemental Master Indenture dated as of December 1, 2005 among the Corporation (as the successor to Bristol Memorial Hospital), Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc., Wellmont Foundation and the Master Trustee, pursuant to which the Series 2005 Obligations were issued.

"S&P" means Standard & Poor's Ratings Services, a Division of The McGraw-Hill Companies, Inc., a corporation organized and existing under the laws of the State of New York, its successors and assigns, and, if such corporation is dissolved or liquidated or no longer performs the functions of a securities rating agency, "S&P" will be deemed to refer to any other nationally recognized securities rating agency designated by the Corporation by written notice to the Bond Trustee.

"State" means the State of Tennessee.

"Subordinated Indebtedness" means any promissory note, guaranty, lease, contractual agreement to pay money or other obligation of any Obligated Issuer which is expressly made subordinate and junior in right of payment of principal of, redemption premium, if any, and interest on, (a) all Obligations issued pursuant to the Master Indenture, and (b) all other obligations of the Obligated Group thereunder, on terms and conditions which substantially require that (1) no payment on account of principal of, redemption premium, if any, or interest on such Subordinated Indebtedness shall be made, nor shall any property or assets be applied to the purchase or other acquisition or retirement of such Subordinated Indebtedness, unless full payment of all amounts when due and payable upon maturity of Obligations issued under the Master Indenture have been made or duly provided for in accordance with the terms of such Obligations; (2) no payment on account of principal of, redemption premium, if any, or interest on such Subordinated Indebtedness shall be made, nor shall any property or assets be applied to the purchase or other acquisition or retirement of such Subordinated Indebtedness if, at the time of such payment or application, or immediately after giving effect thereto, (i) there shall exist a default in the payment of the principal of, redemption premium, if any, or interest on any Obligations (whether at maturity or upon mandatory redemption), or (ii) there shall have occurred an "event of default" with respect to any Obligations, as defined therein and in the Master Indenture, and such "event of default" shall not have been cured or waived or shall not have ceased to exist; and (c) in the event that any Subordinated Indebtedness is declared or otherwise becomes due and payable because of the occurrence of an "event of default" with respect thereto, (x) the Holders at such time shall be entitled to receive payment in full thereon before the holders of the Subordinated Indebtedness shall be entitled to receive any payment on account of such Subordinated Indebtedness as a result of such "event of default", and (y) no holder of Subordinated Indebtedness, or a trustee acting on such holder's behalf, shall be entitled to exercise any control over proceedings to enforce the terms and conditions of the Master Indenture.

"Supplemental Indenture" means an indenture supplemental to, and authorized and executed pursuant to, the terms of the Master Indenture.

"Tax Compliance Agreement" means the Tax Compliance Agreement dated as of May 1, 2011 between the Issuer and the Corporation.

"Tax-Exempt Organization" means a Person organized under the laws of the United States of America or any state thereof which is an organization described in Section 501(c)(3) of the Code, which is exempt from federal

income taxes under Section 501(a) of the Code, and which is not a "private foundation" within the meaning of Section 509(a) of the Code, or corresponding provisions of federal income tax laws from time to time in effect.

"Tenth Supplemental Master Indenture" means the Tenth Supplemental Master Indenture dated as of November 1, 2010 among the Corporation (as the successor to Bristol Memorial Hospital), Wellmont Hawkins County Memorial Hospital, Inc., Wellmont Inc., Wellmont Foundation and the Master Trustee pursuant to which the Series 2010 Obligation was issued.

"Total Income Available for Debt Service" means, as to any period, (a) the aggregate of Income Available for Debt Service of each member of the Combined Group for such period, determined in such a manner that no portion of Income Available for Debt Service of any member of the Combined Group is included more than once, plus (b) the Income Available For Debt Service of each Limited Obligor up to an amount equal to the amount of such Limited Obligor's Debt Service Requirement for such period with respect to the Indebtedness of such Limited Obligor guaranteed by a member of the Combined Group.

"Total Net Operating Revenues" means, as to any period, the aggregate of Net Operating Revenues of each member of the Combined Group for such period, determined in such a manner that no portion of Net Operating Revenues of any member of the Combined Group is included more than once.

"Trust Estate" means the property conveyed to the Bond Trustee pursuant to the Granting Clauses of the 2011 Bond Indenture.

"Twelfth Supplemental Master Indenture" means the Twelfth Supplemental Master Indenture dated as of May 1, 2011 among the Corporation (as the successor to Bristol Memorial Hospital), Wellmont Hawkins County Memorial Hospital, Inc., Wellmont Inc., Wellmont Foundation and the Master Trustee pursuant to which the Series 2011 Swap Obligation was issued.

"Unrelated Trade or Business" means an activity which constitutes an "unrelated trade or business" within the meaning of Section 513(a) of the Code without regard to whether such activity results in unrelated trade or business income subject to taxation under Section 512(a) of the Code.

"Value", when used in connection with any Property, means either (a) Book Value, or (b) at the election of the Obligated Group Agent evidenced by an Officer's Certificate delivered to the Master Trustee, the aggregate fair market value of such Property, as reflected in the most recent written report of an appraiser selected by the Obligated Group Agent and, in the case of real property, who or which is a member of the American Institute of Real Estate Appraisers (MAI), delivered to the Master Trustee (which report shall be dated not more than three years prior to the date as of which value is to be calculated) (1) increased or decreased by the cost of any Property acquired, or the fair market value of any Property disposed of, since the date of such report and (2) increased or decreased by a percentage equal to the aggregate percentage increase or decrease in the Construction Index from the date of such report to the date as of which value is to be calculated.

"Written Request" means with reference to the Issuer, a request in writing signed by the Chairman, Vice-Chairman or Secretary of the Issuer and with reference to the Corporation means a request in writing signed by the President or a Vice President of the Corporation, or any other officers designated by the Issuer or the Corporation, as the case may be.

SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE

The following is a summary of certain provisions of the Master Indenture, to which reference is made for a full and complete statement of its provisions.

Obligations

Each Obligation will be issued pursuant to the Master Indenture and will entitle each Holder thereof to the protection of the covenants, restrictions and other obligations imposed upon the Corporation and each Obligated Issuer by the Master Indenture. Such Obligations will be secured equally and ratably by the assignment and pledge to the Master Trustee of a security interest in all money and Investment Securities, if any, held from time to time by the Master Trustee in the funds and accounts established under the Master Indenture and in all Pledged Notes

Accounting Principles

Where the character or amount of any asset or liability or item of income or expense is required to be determined or any consolidation, combination or other accounting computation is required to be made for the purposes of the Master Indenture or any agreement, document or certificate executed and delivered in connection with or pursuant to the Master Indenture, such determination or computation shall be done in accordance with generally accepted accounting principles in effect on (a) the date of the delivery of the Master Indenture, or (b) at the election of the Obligated Group Agent, as specified in an Officer's Certificate delivered to the Master Trustee, the date such determination or computation is made for any purpose of the Master Indenture, such accounting principles, to the extent applicable, consistently applied; provided that intercompany balances and liabilities among the Obligated Issuers shall be disregarded and that the requirements set forth in this paragraph shall prevail, if inconsistent with generally accepted accounting principles. In the event that the fiscal year of any Obligated Issuer ends on a date other than the last day of a Fiscal Year, the character or amount of any asset or liability or item of income or expense of such Obligated Issuer for its fiscal year ending within any Fiscal Year under consideration shall be deemed to be the character or amount of the appropriate asset or liability or item of income or expense for such Fiscal Year. For purposes of calculating Total Income Available for Debt Service and Total Net Operating Revenues for any period, if any Obligated Issuer shall have become a member of the Combined Group during such period, such calculations shall be made assuming that such Obligated Issuer became a member of the Combined Group at the beginning of such period.

Master Indenture Obligations

Each Obligated Issuer is permitted to issue one or more series of Obligations under the Master Indenture on which all Obligated Issuers will be jointly and severally liable. The terms of each Obligation shall be set forth in a Supplemental Indenture.

The principal of, premium, if any, and interest on the Obligations shall be payable in any currency of the United States of America which is legal tender for the payment of public and private debts. Such payment shall be made at the principal corporate trust office of the Master Trustee or, if an Obligated Issuer so elects, by check, draft or wire transfer to such Holder. In the case of all payments made directly to a Holder, the Obligated Issuer shall give notice of such payment to the Master Trustee concurrently with the making thereof.

Each Obligated Issuer, jointly and severally, unconditionally guarantees to the Holders of the Obligations and to the Master Trustee the due and punctual payment of the principal of, and interest on, the Obligations and all other amounts due and payable under the Master Indenture. Further, each Obligated Issuer shall cause, to the extent permitted by law, its Restricted Affiliates to transfer to the Obligated Group such of their property as shall be necessary to enable the Obligated Group to meet all of its joint and several liability (determined without regard to the aggregate Maximum Guaranty Liability of the Obligated Issuers) in respect of all Outstanding Obligations, in the maximum amount permissible under the applicable fraudulent conveyance or similar laws.

Each Obligated Issuer shall be subrogated to all rights of the Holders of the Obligations and the Master Trustee against the other Obligated Issuers in respect of any amounts paid by such Obligated Issuer pursuant to the Master Indenture; provided, however, that no Obligated Issuer shall be entitled to enforce or receive any payments arising out of, or based upon such right of subrogation until all Obligations shall have been paid in full and discharged.

If any person ceases to be an Obligated Issuer, such person shall cease to be a "Cross Guarantor" under the Master Indenture, and its obligations as such shall be terminated and released; provided, however, that the foregoing provision is inapplicable (a) if such Person ceases to be an Obligated Issuer as a result of a transaction which is prohibited by the terms of the Master Indenture or (b) if, at the time such Person would otherwise have been released under the provisions of this paragraph, there has occurred and is continuing a default in the payment of principal of or interest on any Obligation (in which event this clause (b) shall cease to apply to such person at such time as such default shall be cured).

If an Obligated Issuer is called upon to make a payment under its Cross Guarantee, each of the Obligated Issuers will contribute to such paying Obligated Issuer their pro rata share, determined pursuant to the Master Indenture, of the amount of such payment.

The Master Trustee shall maintain at its principal corporate trust office a registration book relating to Obligations of the Obligated Group. These registration books shall contain (a) the names and addresses of Holders of Obligations, and (b) any other information which may be necessary for the proper discharge of the Master Trustee's duties under the Master Indenture. The Obligations of any series may be transferred or exchanged in the manner specified in the Supplemental Indenture providing for the issuance thereof.

The Master Trustee shall establish and maintain a revenue or similar debt service fund for the purpose of accumulating and paying amounts due on Outstanding Obligations (a) if the applicable Supplemental Indenture provides for the making of deposits directly with the Master Trustee in respect of an Obligation, or (b) upon the occurrence of an "event of default" under the Master Indenture and the exercise of any remedies by the Master Trustee for the benefit of all Holders of Outstanding Obligations.

All money held in any fund established under the Master Indenture, in the case of (a) above, shall, upon written request and direction of the Obligated Group Agent, be invested in Investment Securities, and any money realized by the Master Trustee in the case of (b) above, shall be invested by the Master Trustee, without need of any further authorization or direction, only in Government Obligations with maturities not in excess of ninety days, unless the Master Trustee is otherwise directed by Holders as provided in the Master Indenture. The Master Trustee shall not be liable or responsible for any loss resulting from any such investment.

Any Obligated Issuer and the Master Trustee may enter into a Supplemental Indenture to create an Obligation issued under the Master Indenture. The Supplemental Indenture shall (a) with respect to Obligations created thereby, set forth the date thereof, and the date or dates on which principal of, premium, if any, and interest on such Obligations shall be payable, and (b) provide for the form of such Obligations and shall contain such other terms and provisions as shall not be inconsistent with the provisions of the Master Indenture.

Simultaneously with or prior to the execution, authentication and delivery of the Obligations pursuant to the Master Indenture:

(a) All requirements and conditions to the issuance of such Obligations, if any, set forth in the Master Indenture and the Supplemental Indenture shall have been complied with and satisfied, as evidenced by an opinion of Counsel to that effect delivered to the Master Trustee;

(b) The applicable Obligated Issuer or the Obligated Group Agent shall have delivered to the Master Trustee such opinions, certificates, proceedings, instruments and other documents as the Master Trustee or the Related Bond Issuer, if any, may reasonably request;

(c) The requirements of the Master Indenture with respect to the incurrence of Additional Indebtedness shall have been satisfied if such Obligations constitute Indebtedness;

(d) Each Supplemental Indenture shall specify the purpose or purposes for which such Obligations are being issued, which may be any purpose within the corporate power of the applicable Obligated Issuer; and

(e) The Obligated Group Agent shall have delivered to the Master Trustee an opinion of counsel, regarding the Securities Act of 1933 and the Trust Indenture Act of 1939, as required pursuant to the Master Indenture.

Persons Becoming Obligated Issuers

The Master Indenture permits Persons other than the Corporation to become members of the Obligated Group subject to the satisfaction of certain conditions. These conditions include the following:

First, such Person must execute and deliver to the Master Trustee an appropriate instrument, satisfactory to the Obligated Group Agent, containing (a) the agreement of such Person to become an Obligated Issuer under the Master Indenture and thereby to become subject to compliance with all provisions of the Master Indenture pertaining to an Obligated Issuer, including the performance and observance of all covenants and obligations of an Obligated Issuer under the Master Indenture; (b) the agreement of such Person to consult with each other member of the Obligated Group prior to incurring any Obligations; and (c) such other restrictions on the ability of such Person to incur Obligations as may be imposed by the Obligated Group.

Second, each instrument executed and delivered to the Master Trustee as described in the preceding paragraph must be accompanied by an Officer's Certificate from the Obligated Group Agent to the effect that the Obligated Group Agent consents to such Person becoming an Obligated Issuer and an opinion of Counsel to the effect that (a) the conditions contained in the Master Indenture relating to such Person's membership in the Obligated Group have been satisfied; (b) under then existing law, such Person becoming an Obligated Issuer will not subject any Obligation to the registration provisions of the Securities Act of 1933, as amended, or that such Obligation has been so registered if so required, or the qualification of the Master Indenture pursuant to the Trust Indenture Act of 1939, as amended, or that the Master Indenture has been so qualified if qualification is required; and (c) each instrument delivered by the Person seeking to become a member of the Obligated Group has been duly authorized, executed and delivered by such Person and constitutes a legal, valid and binding agreement of such Person, enforceable in accordance with its terms, except as limited by then existing laws relating to bankruptcy and insolvency and other standard and customary legal exceptions.

If all amounts due or to become due on any Outstanding Related Bond which bears interest that is not includable in gross income under the Code has not been paid to the holder thereof (or provision for such payment has not been made in such manner as to have resulted in the defeasance of the Related Financing Documents), the Master Trustee must receive an Opinion of Bond Counsel to the effect that under then existing law such Person becoming an Obligated Issuer would not adversely affect the validity of such Related Bond or cause the interest payable on such Related Bond to become includable in gross income under the Code.

As a further condition to a Person becoming a member of the Obligated Group, the Master Trustee must receive:

An Officer's Certificate from the Obligated Group Agent to the effect that (i) no "event of default" then exists under the Master Indenture, nor to such officer's knowledge, does there then exist any event which, with the passage of time or giving of notice or both, would or might become an "event of default" under the Master Indenture, and (ii) either (A) if one dollar of Additional Indebtedness were incurred immediately following such Person's admission, the Combined Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to the Master Indenture and described in (a)(1) or (2) under "- Additional Long Term Indebtedness" below (assuming, for purposes of such certificate, that the Income Available for Debt Service and Indebtedness of such Person were Income Available for Debt Service and Indebtedness of an Obligated Issuer), or (B) such Person becoming a member of the Obligated Group will cure any "event of default" then in existence under the Master Indenture, or (C) by reason of such membership, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years following such entry into the Obligated Group will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such entry into the Obligated Group not occurred.

Withdrawal from Obligated Group

No Obligated Issuer may withdraw from the Obligated Group unless:

(a) If the Obligated Issuer is other than the Obligated Group Agent, the Obligated Group Agent consents to the withdrawal;

(b) If all amounts due on any Outstanding Related Bond which bears interest that is not includable in gross income under the Code have not been paid to the holder thereof (or provision for such payments has not been made in such manner as to have resulted in the defeasance of the Related Financing Documents), the Master Trustee receives an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law such Obligated Issuer's withdrawal from the Obligated Group would not adversely affect the validity of such Related Bond or cause the interest payable on such Related Bond to become includable in gross income under the Code;

(c) The Master Trustee receives an Officer's Certificate from the Obligated Group Agent to the effect that either (1) after giving effect to such withdrawal, if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to the Master Indenture, or (2) such Person's withdrawal from the Obligated Group will cure any "event of default" then in existence under the Master Indenture, or (3) by reason of such withdrawal, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years immediately following withdrawal of such Obligated Issuer from the Obligated Group will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such withdrawal not occurred;

(d) The Master Trustee receives an Officer's Certificate from the Obligated Group Agent to the effect that, immediately after the withdrawal of such Person from the Obligated Group, no "event of default" then exists under the Master Indenture, nor to such officer's knowledge, does there then exist any event which, with the passage of time or giving of notice or both, would or might become an "event of default" thereunder; and

(e) The Obligated Group Agent receives an opinion of Counsel to such Person to the effect that following such Person's withdrawal from the Obligated Group no member of the Obligated Group will have any liability for the payment of any indebtedness of such Person.

Upon compliance with the above conditions, the Master Trustee will execute any documents reasonably requested by the withdrawing Obligated Issuer to evidence the termination of such Issuer's obligations under the Master Indenture, under any Supplemental Indenture and under all Obligations.

Conditions for Designation of Restricted Affiliates

Any Affiliate of an Obligated Issuer that satisfies the definition of "Restricted Affiliate" will become a Restricted Affiliate upon delivery to the Master Trustee of the following documents:

(a) an Officer's Certificate from the Obligated Group Agent to the effect that the Obligated Group Agent consents to such Person becoming a Restricted Affiliate;

(b) a written undertaking for the benefit of the Master Trustee duly authorized and executed by such Affiliate evidencing the agreement of such Affiliate (1) to observe and perform the obligations that the Obligated Group has covenanted to cause Restricted Affiliates to observe and perform under the Master Indenture, and (2) subject to any applicable legal restrictions relating to dispositions of assets by organizations described in Section 501(c)(3) of the Code, that upon the liquidation or dissolution of such Affiliate, all remaining assets thereof shall be transferred to an Obligated Issuer, a specified Obligated Issuer, or another Restricted Affiliate;

(c) evidence of appropriate action of the Governing Body of such Affiliate authorizing such undertaking;

(d) an opinion of Counsel to the effect that the conditions contained in the Master Indenture relating to designation of a Restricted Affiliate have been satisfied and an opinion of Counsel to the effect that the instrument described in subparagraph (b) above has been duly authorized, executed and delivered by such Person and constitutes a legal, valid and binding agreement of such Person, enforceable in accordance with its terms, subject only to and limited by the then existing law relating to bankruptcy and insolvency and other standard and customary legal exceptions; and

(e) an Officer's Certificate of the Obligated Group Agent to the effect that (1) no "event of default" then exists under the Master Indenture, nor to such officer's knowledge, does there then exist any event which, with the passage of time or giving of notice or both, would or might become an "event of default" under the Master Indenture, and (2) either (i) if one dollar of Additional Indebtedness were incurred immediately following the designation of such Affiliate, the Combined Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to the Master Indenture and described in (a)(1) or (2) under "- Additional Long Term Indebtedness" below, or (ii) such Person becoming a Restricted Affiliate will cure any "event of default" then in existence under the Master Indenture, or (iii) by reason of such status, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years following such designation as a Restricted Affiliate will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such designation of such Person as a Restricted Affiliate not occurred.

Release of Restricted Affiliates

Any Person shall be released from its obligations and status as a Restricted Affiliate only upon the following conditions:

(a) The Master Trustee receives an Officer's Certificate from the Obligated Group Agent consenting to the release of such Person from its status as a Restricted Affiliate and certifying that either (1) if one dollar of Additional Indebtedness were incurred after giving effect to such release, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to the Master Indenture and described in (a)(1) or (2) under "- Additional Long Term Indebtedness" below or (2) such release will cure any "event of default" then in existence under the Master Indenture, or (3) by reason of such release, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years following such release will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such release not occurred.

(b) The Master Trustee receives an Officer's Certificate of the Person requesting such release stating that all conditions precedent provided for under the Master Indenture relating to the release of such Person as a Restricted Affiliate have been complied with and that, were such Person released as a Restricted Affiliate on the date of such Officer's Certificate, no "event of default" would then exist under the Master Indenture, nor to such officer's knowledge, would there then exist any event which, with the passage of time or giving of notice, or both, would or might become an "event of default" thereunder.

(c) Upon compliance with the conditions described in subparagraphs (a) and (b) above, the Master Trustee will execute any documents reasonably requested by the released Person to evidence the termination of such Person's status as a Restricted Affiliate.

Short-Term Indebtedness

Each Obligated Issuer has agreed that it will not incur, nor permit any of its Restricted Affiliates to incur, any Additional Indebtedness constituting Short-Term Indebtedness unless immediately after the incurrence of such Short-Term Indebtedness.

(a) (1) the principal amount of all Short-Term Indebtedness of the Combined Group then Outstanding does not exceed 25% of the Total Net Operating Revenues for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available, or

(2) any such Short-Term Indebtedness could be incurred under the tests set forth in the Master Indenture relating to Long-Term Indebtedness treating such Short-Term Indebtedness as Long-Term Indebtedness, and

(b) For a period of not fewer than 15 consecutive days within each Fiscal Year commencing July 1, 1991, the Combined Group reduces the aggregate principal amount of all Outstanding Short-Term Indebtedness described in (a)(1) above to less than 5% of the Total Net Operating Revenues for the immediately preceding Fiscal Year.

Additional Long-Term Indebtedness

Each Obligated Issuer has agreed that it will not incur, nor permit any of its Restricted Affiliates to incur, any Additional Indebtedness constituting Long-Term Indebtedness unless such Long-Term Indebtedness consists of one or more of the following:

(a) Long-Term Indebtedness of any member of the Combined Group, if prior to the incurrence thereof, there is delivered to the Master Trustee:

(1) an Officer's Certificate of the Obligated Group Agent demonstrating that the Historical Pro Forma Debt Service Coverage Ratio for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available was not less than 1.20; or

(2) (i) an Officer's Certificate of the Obligated Group Agent demonstrating that the Historical Debt Service Coverage Ratio for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available was not less than 1.10, and (ii) a Consultant's report (or, in lieu thereof, an Officer's Certificate of the Obligated Group Agent if the Projected Debt Service Coverage Ratio described in this clause (ii) is 1.75 or greater) to the effect that the Projected Debt Service Coverage Ratio, taking the proposed Additional Indebtedness into account, (x) in the case of Additional Indebtedness (other than a Guaranty) to finance capital improvements, for each of the two Fiscal Years succeeding the date on which such capital improvements are expected to be in operation, or (y) in the case of Long-Term Indebtedness not financing capital improvements or in the case of a Guaranty, for each of the two Fiscal Years succeeding the date on which the Indebtedness or Guaranty is incurred, is not less than 1.20.

The requirements described in (a)(2)(i) and (ii) above will be deemed satisfied if (A) a Consultant's report filed with the Master Trustee states that applicable laws or regulations have prevented or will prevent the achievement of such debt service coverage ratios, and (B) the Combined Group has generated Total Income Available for Debt Service in an amount which, in the opinion of such Consultant, the Combined Group could reasonably have generated given such laws and regulations during the period affected thereby.

(b) Completion Indebtedness of any member of the Combined Group without limit if there is delivered to the Master Trustee: (1) an Officer's Certificate of the applicable member of the Combined Group stating that at the time the original Long-Term Indebtedness for the Facilities to be completed was incurred, such Combined Group member had reason to believe that the proceeds of such Long-Term Indebtedness, together with other moneys then expected to be available, would provide sufficient moneys for the completion of such Facilities; (2) a statement of an Architect setting forth the amount estimated to be needed to complete the Facilities, and (3) an Officer's Certificate of such member of the Combined Group stating that the proceeds of such Completion Indebtedness to be applied to the completion of the Facilities, together with a reasonable estimate of investment income to be earned on such proceeds and the amount of moneys, if any, committed to such completion by such Combined Group member or through enumerated bank loans (including letters or lines of credit) or through federal or state grants, will be in an amount not less than the amount set forth in the statement of an Architect or other expert referred to in (2).

(c) Commitment Indebtedness of any member of the Combined Group or any Guaranty of any Commitment Indebtedness of any member of the Obligated Group without limit;

(d) Long-Term Indebtedness of any member of the Combined Group incurred for the purpose of refunding, repurchasing or refinancing (whether in advance or otherwise) any outstanding Long-Term Indebtedness;

(e) The conversion without limit of Long-Term Indebtedness of any member of the Combined Group that is convertible from one interest or payment mode to another interest or payment mode (e.g., weekly to monthly or to a fixed rate) from one mode to another pursuant to the terms of the documentation authorizing such Long-Term Indebtedness;

(f) Subordinated Indebtedness without limit of any member of the Combined Group or Non-Recourse Indebtedness without limit of any member of the Combined Group;

(g) Indebtedness incurred in connection with a sale of accounts receivable with recourse by any member of the Combined Group consisting of an obligation to repurchase all or a portion of such accounts receivable upon certain conditions, provided that the principal amount of such Indebtedness permitted may not exceed the aggregate sales price of such accounts receivable received by such Combined Group member;

(h) Long-Term Indebtedness of any member of the Combined Group, the principal amount of which at the time incurred, together with the aggregate principal amount of all other Long-Term Indebtedness of the Combined Group then Outstanding, does not exceed 25% of the Total Net Operating Revenues for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available;

(i) Long-Term Indebtedness of any member of the Combined Group if prior to the incurrence thereof an Officer's Certificate of the Obligated Group Agent is delivered to the Master Trustee certifying that, immediately following the incurrence of such Long-Term Indebtedness, the total Outstanding Long-Term Indebtedness of the Combined Group will not exceed 66-2/3% of the Capitalization.

Guaranties

(a) Each Obligated Issuer has agreed that it will not enter into, or become liable in respect of, or permit any Restricted Affiliate to enter into, or become liable in respect of, any Guaranty dated after the date of the Master Indenture unless the principal amount of the Indebtedness being guaranteed could then be incurred as Indebtedness described under the heading "- Additional Long-Term Indebtedness", taking into account the assumptions as to calculating the aggregate annual principal and interest payments on, and

the principal amount of, the Indebtedness being guaranteed, contained in the immediately succeeding paragraph.

(b) In the case of Guaranties of indebtedness that would, if such indebtedness were incurred by a member of the Combined Group, constitute Long-Term Indebtedness, the aggregate annual principal and interest payments on, and the principal amount of, the Guaranty will be deemed to be equal to 20% of the principal and interest payments which would be payable on the Indebtedness being guaranteed as if such indebtedness were Long-Term Indebtedness of the Guarantor. If at any time the Guaranty becomes due and payable, the aggregate annual principal and interest payments on, and the principal amount of, the Guaranty will, for purposes of this paragraph, be deemed to equal 100% of the principal and interest payable on, and the principal amount of, the Indebtedness being guaranteed for the Fiscal Year in which payment is made.

Limited Obligor

(a) Any Person may become a Limited Obligor upon delivery to the Master Trustee of the following:

(1) An Officer's Certificate from the Obligated Group Agent to the effect that the Obligated Group Agent consents to such Person becoming a Limited Obligor;

(2) An opinion of Counsel to the effect that the Pledged Note (i) has been duly authorized, executed and delivered by the Limited Obligor and (ii) constitutes the legal, valid and binding obligation of the Limited Obligor, enforceable in accordance with its terms, subject only to and limited by the then existing law relating to bankruptcy and insolvency and other customary and standard legal exceptions, and an opinion of Counsel to the applicable Obligated Issuer to the effect that the Pledged Note has been validly assigned by the applicable Obligated Issuer to the Master Trustee; and

(3) The duly executed Pledged Note made by such Person.

(b) Any Person may be released from its obligations and status as a Limited Obligor upon the following conditions:

(1) The Master Trustee receives an Officer's Certificate from the Obligated Group Agent consenting to the release of such Person from its status as a Limited Obligor and certifying that immediately after the release of such Person, no "event of default" then exists under the Master Indenture, nor to such officer's knowledge, would there then exist any event which, with the passage of time or giving of notice or both, would or might become an "event of default" thereunder; and

(2) The Master Trustee receives an Officer's Certificate from the Obligated Group Agent to the effect that either (i) after giving effect to such release, if one dollar of Additional Indebtedness were incurred, the Combined Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to Section 4.2(a)(i) or (ii) of the Master Indenture, or (ii) by reason of such release, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years immediately following such release will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such release not occurred, or (iii) such Person has become a member of the Combined Group.

(c) Upon compliance with the conditions described in subparagraph (b) above, the Master Trustee will surrender the Pledged Note to the released Person, duly marked "cancelled" and will execute such other documents reasonably requested by such Person to evidence the termination of such Person's status as a Limited Obligor.

Debt Service on Balloon Indebtedness and Variable Rate Indebtedness

For purposes of the covenants and computations required or permitted pursuant to the Master Indenture, it will be assumed, at the discretion of the Obligated Group Agent, as the case may be, that (a) the interest rate on Variable Rate Indebtedness is equal to that rate derived from the Bond Index and (b) the principal of Balloon Indebtedness is amortized:

- (1) from the date of calculation thereof over a term of thirty (30) years with level annual debt service payments at an assumed interest rate equal to the Bond Index; or
- (2) during the term to the maturity thereof by deposits made to a sinking fund therefor pursuant to the terms of such Balloon Indebtedness or in accordance with a sinking fund schedule established by resolution of the Governing Body of the applicable Obligated Issuer adopted at or subsequent to the time of incurrence of such Balloon Indebtedness, as certified in an Officer's Certificate, provided that, at the time of such calculation, all deposits required to have been made prior to such date shall have been made; or
- (3) the principal of Balloon Indebtedness is due and payable on the specified due date or due dates thereof; or
- (4) with respect to Balloon Indebtedness for which there exists a Credit Facility, the principal of such Balloon Indebtedness is due and payable in the amounts and at the times specified in the Credit Facility.

Insurance

Each Obligated Issuer have covenanted that it will maintain, or cause to be maintained, and will require each of its Restricted Affiliates to maintain or cause to be maintained, insurance covering such risks and in such amounts as, in its reasonable judgment, is adequate to protect it and its Property and operations, including (to the extent that such Obligated Issuer or Restricted Affiliate is a health care institution) professional liability or medical malpractice insurance. The Obligated Group Agent shall retain an Insurance Consultant who will prepare and file with the Master Trustee a report showing the adequacy of such insurance once every three years (such report to be filed as soon as practicable but in no event later than five months after the end of the applicable third Fiscal Year). Each Obligated Issuer will follow, and will require each of its Restricted Affiliates to follow, any recommendations of the Insurance Consultant to the extent feasible in the opinion of the Obligated Group Agent.

In lieu of maintaining the insurance policies described above, the Combined Group, or any member thereof, may self-insure any of the required coverages (or a portion thereof), provided the Master Trustee receives a report (as soon as practicable but in no event later than five months after the end of each Fiscal Year) of an Insurance Consultant to the effect that such self insurance is consistent with proper management and insurance practices. If any member of the Combined Group elects to self-insure in lieu of maintaining medical liability and malpractice insurance, a report of an Insurance Consultant must be filed with the Master Trustee annually stating that such Insurance Consultant has reviewed the self-insurance program and that the self-insured Combined Group Member has available the estimated amount required for the payment of claims and associated claims expenses with respect to such Fiscal Year.

In the event of damage to or destruction of all or any part of the Facilities of the Combined Group with a Value in excess of five percent (5%) of the Value of all Property of the Combined Group, the affected Combined Group member or the Obligated Group Agent will exercise its best efforts to recover any applicable insurance. Such proceeds will be paid to the Obligated Group Agent for the payment or reimbursement of reasonable expenses of obtaining the recovery. The Obligated Group Agent will then give notice to the Master Trustee of such expenses and of the amount of the remaining proceeds (herein called the "Net Proceeds").

Subject to the provisions of any Related Financing Document pertaining to a Permitted Lien, the affected Combined Group member will apply the Net Proceeds for any lawful corporate purpose as such Combined Group member determines, if the Obligated Group Agent first delivers to the Master Trustee an Officer's Certificate stating that the Projected Debt Service Coverage Ratio for each of the next two full succeeding Fiscal Years immediately following the date of such certificate(s), taking into account such damage or destruction and the proposed use of the Net Proceeds is at least 1.10. If the Obligated Group Agent is unable to deliver such an Officer's Certificate, the affected Combined Group member must apply the Net Proceeds or so much thereof as may be needed to the repair, replacement, restoration or reconstruction of the affected Facilities or, at the option of the applicable Combined Group member, to any other capital project of equivalent value and utility, to the acquisition of any Property or to the repayment in whole or in part of any Outstanding Obligations in such order of maturity or maturities or proportions as the Obligated Group Agent determines.

Any Net Proceeds remaining after compliance by the affected Combined Group member and the Obligated Group Agent with the provisions of the Master Indenture described in the immediately preceding paragraph will be transferred by the Obligated Group Agent to the Master Trustee and applied to the redemption of the Outstanding Obligations in such order of maturity or maturities or proportions as the Obligated Group Agent determines.

In the event of a taking by eminent domain of all or any part of the Facilities of the Combined Group with a Value in excess of five percent (5%) of the Value of all Property of the Combined Group, the affected Combined Group member or the Obligated Group Agent will exercise its best efforts to recover any applicable proceeds. Such proceeds shall be paid to the Obligated Group Agent. The Obligated Group Agent will make appropriate deductions from such proceeds and give notice to the Master Trustee of such deductions and of the amount of the remaining proceeds (also, "Net Proceeds"). The Net Proceeds shall be applied in the same manner as insurance proceeds are applied as described in the two immediately preceding paragraphs.

Certain Covenants of the Obligated Issuers

Each Obligated Issuer has covenanted (and will cause each of its Restricted Affiliates to comply with such covenants), among other things, to maintain its corporate or other separate legal existence and to be qualified to do business where such qualification is necessary, to maintain and keep its Facilities in good repair, to conduct its affairs in compliance with all applicable laws and regulations, to pay all lawful taxes and governmental charges and assessments levied or assessed upon or against it or its Property (except that each Obligated Issuer or Restricted Affiliate thereof may withhold such payments where the validity of such taxes and assessments is being contested in good faith), to comply with any covenants and provisions of any Liens upon its Property or securing any of its Indebtedness, to procure and maintain all necessary licenses and permits, to maintain accreditation of its health care Facilities and its status as a provider of health care services eligible for reimbursement under government programs (subject to certain exceptions set forth in the Master Indenture), and not to discriminate on any legally impermissible basis.

In addition, each Obligated Issuer has covenanted not to merge with or consolidate with any other Person not a member of the Combined Group or sell or convey all or substantially all of its assets to any Person not a member of the Combined Group unless: (a) the successor corporation (if other than the Obligated Issuer) is a Person organized and existing under the laws of the United States of America or a state thereof and such Person becomes an Obligated Issuer and expressly assumes the due and punctual payment of the principal of, premium, if any, and interest on all Outstanding Obligations according to their tenor, and the due and punctual performance and observance of all of the covenants and conditions of the Master Indenture by a Supplemental Indenture satisfactory to the Master Trustee, executed and delivered to the Master Trustee by such Person; (b) if all amounts due or to become due on any Outstanding Related Bonds which bear interest that is not includable in gross income under the Code have not been fully paid to the holders thereof (or provision for such payment has not been made in such manner as will result in the defeasance of the Related Financing Documents), the Master Trustee must receive an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law the consummation of such merger, consolidation, sale or conveyance, whether or not contemplated on the date of the delivery of any such Related Bonds, would not cause the interest payable on such Related Bonds to become includable in gross income under the Code or adversely affect the validity of such Related Bonds; and (c) there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent to the effect that

immediately following such transaction, (i) no "event of default" then exists nor, to such officer's knowledge, does there exist any event which, with the passage of time or the giving of notice or both, would or might become an "event of default" under the Master Indenture, and (ii) either (A) if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the tests providing for the incurrence of Long-Term Indebtedness described in Section 4.2(a)(i) or (ii) of the Master Indenture (assuming for purposes of such Certificate that the Income Available for Debt Service and Indebtedness of such Person were Income Available for Debt Service and Indebtedness of an Obligated Issuer), or (B) such transaction will cure any "event of default" then in existence under the Master Indenture, or (3) by reason of such transaction, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years following such release will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such transaction not occurred.

In case of any such consolidation, merger, sale or conveyance and upon any such assumption by the successor corporation, such successor corporation will succeed to and be substituted for its predecessor.

In case of any such consolidation, merger, sale or conveyance, such changes in phraseology and form (but not in substance) may be made in Obligations thereafter to be issued as may be appropriate.

Permitted Encumbrances

No Obligated Issuer may create or suffer to be created or to exist (or permit any Restricted Affiliate to create or suffer to be created or to exist) any Lien upon any of their Property including, without limitation, all proceeds thereof, whether cash or non-cash, now owned or after acquired by any of them, other than Permitted Liens.

Disposition of Property

Each Obligated Issuer has agreed that it will not, nor will it permit any of its Restricted Affiliates to, sell, lease or otherwise dispose of any Property, except for sales, leases or other dispositions of Property:

(a) To another member of the Combined Group;

(b) To any Person if prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate stating that, in the judgment of the officer executing such certificate, such Property has become, or within the next succeeding 24 calendar months is reasonably expected to become, inadequate, obsolete, worn out, unsuitable, unprofitable, undesirable or unnecessary and the sale, lease, removal or other disposition thereof will not impair the structural soundness, efficiency or economic value of the remaining Property;

(c) To any Person provided that prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent certifying that Property transferred as described in this subparagraph (c) in the then-current Fiscal Year by all Obligated Issuers and Restricted Affiliates does not exceed 10% of the Value of all Property of the Combined Group for the immediately preceding Fiscal Year;

(d) To any Person provided that prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent, to the effect that immediately after the transfer in question, either (1) if one dollar of Additional Indebtedness were incurred, the Combined Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to Section 4.2(a)(i) or (ii) of the Master Indenture or (2) such disposition will increase the Projected Debt Service Coverage Ratio in the Fiscal Year immediately following such disposition over what such ratio would have been in such Fiscal Year had such disposition not occurred;

(e) As part of a merger, consolidation, sale or conveyance permitted by the Master Indenture;

- (f) In the ordinary course of business;
- (g) To any Person in connection with an operating lease of Property to such Person;
- (h) Upon fair and reasonable terms no less favorable than would be obtained in a comparable arm's-length transaction;
- (i) To any Person if the transfer involves any Property received as restricted gifts, grants, bequests or other similar sums or the income thereon, to the extent that such sums may not be pledged or applied to the payment of any Debt Service Requirement or operating expenses generally as a result of restrictions or designations imposed by the donor or maker of the gift, grant, bequest or other sums in question; or
- (j) Certain Property specified in the Master Indenture, which Property may be transferred at any time, at the option of the Obligated Group Agent, notwithstanding anything to the contrary contained in the Master Indenture as described above.

Disposition of Restricted Affiliates

No Obligated Group Member may:

(a) Permit any of its Restricted Affiliates to issue or sell any shares of stock of such Restricted Affiliate to any Person (other than members of the Combined Group and except for director's qualifying shares), except for the purpose of paying a common stock dividend on, or splitting the common stock of such Restricted Affiliate; or

(b) Sell, transfer, or otherwise dispose of any shares of stock (except to members of the Combined Group) of any Restricted Affiliates or permit any of its Restricted Affiliates to sell, transfer, or otherwise dispose of (except to members of the Combined Group) any shares of stock of any other Restricted Affiliate, unless all shares of stock of such Restricted Affiliate owned by the members of the Combined Group are sold, transferred or disposed of and either (1) after giving effect to such disposition if one dollar of Additional Indebtedness were incurred, the Combined Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to Section 4.2(a)(i) or (ii) of the Master Indenture, or (2) the Projected Debt Service Coverage Ratio for each of the two Fiscal Years immediately following such disposition will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such disposition not occurred; or

(c) Permit any of the Restricted Affiliates to consolidate with or merge into any other corporation or to transfer all or substantially all of its assets as an entirety to another Person, unless the successor formed by such consolidation or into which the Restricted Affiliate is merged or the Person which acquires by conveyance or transfer the assets of the Restricted Affiliate substantially as an entirety is a member of the Combined Group or, if such successor or the transferee is not a member of the Combined Group, either (1) after giving effect to such consolidation, merger or transfer if one dollar of additional Indebtedness were incurred, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to Section 4.2(a)(i) or (ii) of the Master Indenture, or (2) the Projected Debt Service Coverage Ratio for each of the two Fiscal Years immediately following such consolidation, merger or transfer will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such consolidation, merger or transfer not occurred.

Filing of Financial Statements, Certificate of No Default, Other Information

The Obligated Group Agent has covenanted that it will:

(a) As soon as practicable but in no event later than five months after the end of each Fiscal Year, file, or cause to be filed, with the Master Trustee and, if such Persons are then providing a rating with respect to Obligations or any Related Bonds, with each Rating Agency, (1) a combined or consolidated revenue and expense statement of the Corporation, each other Obligated Issuer and each Restricted Affiliate, for such Fiscal Year and (2) a combined or consolidated balance sheet of the Corporation, each other Obligated Issuer and each Restricted Affiliate as of the end of such Fiscal Year, each accompanied by the required report of an Accountant.

(b) As soon as practicable but in no event later than five months after the end of each Fiscal Year, file with the Master Trustee (1) a written statement of the Accountant whose report accompanies the financial statements referred to in (a) above stating the Historical Debt Service Coverage Ratio and the Historical Maximum Annual Debt Service Coverage Ratio for such Fiscal Year, and (2) an Officer's Certificate of the Obligated Group Agent stating that all insurance required under the Master Indenture has been obtained and is in full force and effect, and stating whether or not, to the best knowledge of the signers, any Obligated Issuer is in default in the performance of any covenant contained in the Master Indenture, and, if so, specifying each such default of which the signers may have knowledge.

(c) If an "event of default" has occurred and is continuing under the Master Indenture, (1) file with the Master Trustee such other financial statements and information concerning its operations and financial affairs (or of any consolidated group of companies of which it is a member) as the Master Trustee may from time to time reasonably request, excluding specifically donor records, patient records and personnel records and (2) provide access to its Facilities for the purpose of inspection by the Master Trustee during regular business hours or at such other times as the Master Trustee may reasonably request.

(d) Within 10 days after its receipt thereof, file with the Master Trustee a copy of each report which any provision of the Master Indenture requires to be prepared by a Consultant or an Insurance Consultant.

Rates and Charges

Each Obligated Issuer has covenanted and agreed that it will, and cause each of its Restricted Affiliated to, operate on a revenue producing basis and charge such fees and rates for its Facilities and services and exercise such skill and diligence as to provide income from its Property together with other available funds sufficient to pay promptly all payments of principal and interest on its Indebtedness, all expenses of operation, maintenance and repair of its Property and all other payments required to be made by it under the Master Indenture to the extent permitted by law, and to use its best efforts to maintain in each Fiscal Year a ratio of Total Income Available For Debt Service to Maximum Annual Debt Service at least equal to 1.10:1. Each Obligated Issuer has further covenanted and agreed that it will from time to time as often as necessary and to the extent permitted by law, revise, and cause each of its Restricted Affiliates to revise, its rates, fees and charges in such manner as may be necessary or proper to comply with the provisions of the Master Indenture described herein.

If in any Fiscal Year the Historical Maximum Annual Debt Service Coverage Ratio of the Combined Group is less than 1.10:1, the Master Trustee will require the Obligated Group, at the expense of the Obligated Group, to retain a Consultant to make recommendations with respect to the rates, fees and charges of the Combined Group and its methods of operation and other factors affecting its financial condition in order to increase such Historical Maximum Annual Debt Service Coverage Ratio to at least 1.10:1.

A copy of the Consultant's report and recommendations, if any, will be filed with each Obligated Issuer, the Master Trustee, each Related Issuer and each Related Bond Trustee. Each Obligated Issuer must follow, and cause each of its Restricted Affiliates to follow, each recommendation of the Consultant applicable to it to the extent feasible (as determined by the Governing Body of such Obligated Issuer) and permitted by law. The provision of the Master Indenture herein described will not be construed to prohibit any Obligated Issuer or Restricted Affiliate from serving indigent patients to the extent required for such Obligated Issuer or Restricted Affiliate to continue its qualification as a Tax-Exempt Organization or from serving any other class or classes of patients without charge or at reduced rates, so long as such service does not prevent the Combined Group from satisfying the other

requirements of the Master Indenture herein described. So long as the Obligated Group retains a Consultant and follows such Consultant's recommendations to the extent permitted by law, the provisions of the Master Indenture herein described will be deemed to have been complied with even if such ratio for any subsequent Fiscal Year is below 1:10:1; provided, however, that in no event may the Historical Maximum Annual Debt Service Coverage Ratio for any year be less than 1:00:1.

The foregoing provisions of the Master Indenture notwithstanding, if in any Fiscal Year the Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group is less than 1.10:1, the Master Trustee will not be obligated to require the Obligated Group to retain a Consultant to make such recommendations if: (a) (1) there is filed with the Master Trustee (who will provide a copy to each Related Bond Trustee and Related Issuer) a written report addressed to them of a Consultant (which Consultant and report, including without limitation the scope, form, substance and other aspects of such report, are acceptable to the Master Trustee) which contains an opinion of such Consultant that applicable laws or regulations have prevented the Combined Group from generating Income Available for Debt Service during such Fiscal Year in an amount sufficient to attain a Historical Maximum Annual Debt Service Coverage Ratio of at least 1.10:1 and, if requested by the Master Trustee, such report is accompanied by a concurring opinion of Counsel (which Counsel and opinion, including without limitation the scope, form, substance and other aspects thereof, are acceptable to the Master Trustee) as to any conclusions of law supporting the opinion of such Consultant; and (2) the report of such Consultant indicates that the rates charged by the Obligated Group are such that, in the opinion of the Consultant, the Obligated Group has generated the maximum amount of revenues reasonably practicable given such laws or regulations; or (b) there is filed with the Master Trustee (who will provide a copy to each Related Bond Trustee and Related Issuer) an Officer's Certificate of the Obligated Group Agent stating that a Consultant's report described in the second paragraph under the heading "- Rates and Charges" has been filed previously, the facts and assumptions therein have not materially changed and the Obligated Group is continuing to use its best efforts to implement the Consultant's recommendations.

Defaults and Remedies

The following events are "events of default" under the Master Indenture:

(a) failure of any Obligated Issuer to make any payment of principal, redemption price or interest when due under the terms of any Obligation and such failure continues to exist as of the end of any applicable grace period; or

(b) failure of any Obligated Issuer to observe or perform any covenant or agreement contained in the Master Indenture or any Related Financing Documents for any Obligations for a period of 30 days after written notice of such failure, requiring the same to be remedied, has been given by the Master Trustee to each of the Obligated Issuers, the giving of which notice will be at the discretion of the Master Trustee unless the Master Trustee is requested in writing to do so by the Holders of at least 25% in aggregate principal amount of all Outstanding Obligations, in which event such notice must be given; provided, however, that if such observance or performance requires work to be done, actions to be taken, or conditions to be remedied, which by their nature cannot reasonably be done, taken or remedied, within such 30-day period, no "event of default" will be deemed to have occurred or to exist if, and so long as, the defaulting Obligated Issuer commences such observance or performance within such 30-day period and diligently and continuously prosecutes the same to completion; or

(c) (1) default of any Obligated Issuer in the payment of any Indebtedness (other than Obligations issued and Outstanding under the Master Indenture), the principal amount of which in the aggregate exceeds 5% of the Book Value of all Property of the Combined Group for the immediately preceding Fiscal Year, whether such Indebtedness now exists or is created after the date of the Master Indenture and any grace period with respect thereto expires, or (2) any "event of default" as defined in any Related Financing Documents under which any such Indebtedness may be issued, secured or evidenced occurs, which default in payment or "event of default" results in such Indebtedness becoming or being declared due and payable, unless within the time allowed for service of a responsive pleading in any proceeding to enforce payment of the Indebtedness under the laws governing such proceeding (1) the Obligated Issuer commences proceedings to contest the existence or payment of such Indebtedness, and (2)

in the absence of such contest, neither the pledge and security interest created under the Master Indenture nor any Property of the Combined Group will be materially impaired or subject to material loss or forfeiture; or

(d) bankruptcy, dissolution, liquidation or reorganization in bankruptcy of any Obligated Issuer or other similar events as provided in the Master Indenture.

Upon the occurrence of an "event of default" under the Master Indenture, the Master Trustee may, by notice in writing to the Obligated Issuers, declare the principal of all (but not less than all) Outstanding Obligations to be immediately due and payable, provided that the Master Trustee will be required to make such a declaration (1) if an "event of default" has occurred as described in subparagraph (a) above, (2) if an "event of default" has occurred as described in subparagraph (b) above as a result of a default under the Related Financing Documents for any Obligations, if the Related Financing Documents permit the Holders of such Obligations to declare (or to request the Master Trustee to declare) such Obligations to be immediately due and payable and if the Master Trustee is requested to make such a declaration by the Holders of not less than 25% in aggregate principal amount of such Obligations then Outstanding or such greater percentage as may be required under the Related Financing Documents, or (3) if the Master Trustee is requested to make such a declaration by the Holders of not less than 25% in aggregate principal amount of all Outstanding Obligations.

Any acceleration of the principal of the Obligations as described in the preceding paragraph will be subject to the condition that if, at any time after the principal of all Outstanding Obligations has been accelerated, and before any judgment or decree for the payment of the moneys due has been obtained or entered: (a) one or more Obligated Issuers deposits with the Master Trustee an aggregate sum sufficient to pay (1) all matured installments of interest upon all Outstanding Notes and the principal and premium, if any, of all Outstanding Notes due otherwise than by acceleration (with interest on overdue installments of interest, to the extent permitted by law and on such principal and premium, if any, at the respective rates borne by such Notes to the date of such deposit) and any other amounts required to be paid pursuant to such Notes, (2) all amounts due under each Indenture Guaranty other than by reason of acceleration, (3) all sums due under any Obligations other than Notes and Indenture Guaranties, other than by reason of acceleration, and (4) the expenses and fees of the Master Trustee; and (b) any and all "events of default" under the Master Indenture, other than the nonpayment of principal of and accrued interest on Outstanding Obligations that have become due by acceleration, are remedied, then and in every such case, the Master Trustee will, if requested by the Holders of 25% in aggregate principal amount of all Obligations then Outstanding, waive all "events of default" under the Master Indenture and rescind and annul such declaration and its consequences, but no such waiver or rescission and annulment will extend to or effect any subsequent "event of default" under the Master Indenture.

Upon the occurrence of an "event of default", as described in the Master Indenture, and upon demand of the Master Trustee, each Obligated Issuer will pay to the Master Trustee, for the benefit of the Holders of all Outstanding Obligations, (a) the whole amount then due and payable on all Obligations for principal or interest, or both, and such other amounts as may be required to be paid on all such Obligations, with interest on the overdue principal and installments of interest (to the extent permitted by law) at the respective rates of interest borne by such Obligations or as is provided in the applicable Supplemental Indenture, and (b) such further amounts sufficient to cover the cost and expenses of collection, including a reasonable compensation to the Master Trustee, its agents, attorneys and counsel, and any expenses incurred by the Master Trustee other than as a result of its gross negligence or bad faith.

The Master Trustee may institute any actions or proceedings at law or in equity for the collection of the sums due and may collect such sums in the manner provided by law out of the Property of the Obligated Group wherever situated.

If there are pending proceedings for the bankruptcy or for the reorganization of any Obligated Issuer, or if a receiver or trustee is appointed for its Property, the Master Trustee will be entitled and empowered, by intervention in such proceedings or otherwise, to file and prove a claim or claims for the whole amount of principal, premium, if any, interest and any other amounts owing and unpaid in respect of Obligations, and, in case of any judicial proceedings, to file such proofs of claim and other papers as may be necessary or advisable in order to have the claims of the Master Trustee and of the Holders of the Obligations allowed in such judicial proceedings relative to

such member of the Obligated Group, its creditors or its Property, and to collect and receive any moneys or other Property payable or deliverable on any such claim and to distribute the same after the deduction of its charges and expenses.

All rights of action and rights to assert claims under any Obligation may be enforced by the Master Trustee without the possession of such Obligation. In any proceedings brought by the Master Trustee (and also any proceedings involving the interpretation of any provision of the Master Indenture to which the Master Trustee is a party) the Master Trustee will be held to represent all the Holders of Obligations, and it will not be necessary to make any Holders of Obligations parties to such proceedings.

Application of Moneys Collected

Any amounts collected by the Master Trustee in connection with the exercise of any rights and remedies following an "event of default" under the Master Indenture and, except as otherwise provided in the Master Indenture, all money and Investment Securities on deposit in any funds which the Master Trustee may establish under the Master Indenture from time to time shall be applied for the equal and ratable benefit of the Holders of Obligations in the following order at the date or dates fixed by the Master Trustee for the distribution of such moneys, upon presentment of such Obligations, and stamping thereon the payment, if only partially paid, and upon surrender thereof if fully paid:

(a) to the payment of costs and expenses of collection, including fees of Counsel and reasonable compensation to the Master Trustee; and thereafter

(b) whether or not the principal of all Outstanding Obligations has become or has been declared due and payable, to Holders of the Outstanding Obligations for amounts due and unpaid on the Obligations, ratably, without preference or priority of any kind, according to the amounts due and payable on the Obligations; provided that for the purpose of determining the unpaid amount of any Obligation, there will be deducted the amount, if any, which has been realized by the Holder by exercise of its rights as a secured party with respect to any Liens permitted pursuant to the Master Indenture or is on deposit in any fund established pursuant to any Related Financing Documents for such Obligations (other than amounts consisting of payments of principal and interest previously made and credited against the payments due under such Obligations) as of the date of payment by the Master Trustee as described in this subparagraph (b), all as certified to the Master Trustee by the Holder; and

(c) to the payment of the remainder, if any, to the Obligated Group Agent, its successors or assigns, or to whomsoever may be lawfully entitled to receive the same, or as a court of competent jurisdiction may direct.

Actions by Holders

(a) No Holder of an Obligation has any right by virtue of or by availing of any provision of the Master Indenture to institute any suit, action or proceeding in equity or at law upon or under or with respect to the Master Indenture or for the appointment of a receiver or trustee, or any other remedy, unless the Holders of not less than 25% in aggregate principal amount of Obligations then Outstanding have made written request upon the Master Trustee to institute such action, suit or proceeding in its own name as Master Trustee and have offered to the Master Trustee such reasonable indemnity as it may require against the costs, expenses and liabilities which may be incurred therein or thereby, and the Master Trustee, for 30 days after its receipt of such notice, request and offer of indemnity, neglects or refuses to institute any such action, suit or proceeding and no direction inconsistent with such written request has been given to the Master Trustee; it being understood and intended, and being expressly covenanted by the Holder of an Obligation and the Master Trustee, that no one or more Holders of Obligations will have any right in any manner whatever by virtue of or by availing of any provision of the Master Indenture to affect, disturb or prejudice the rights of any other Holder of an Obligation or to obtain or seek to obtain priority over or

preference to any other such Holder, or to enforce any right under the Master Indenture, except in the manner therein provided and for the equal, ratable and common benefit of all Holders of Obligations. For the protection and enforcement of these provisions, each and every Holder of an Obligation and the Master Trustee will be entitled to such relief as can be given either at law or in equity.

(b) The Holder of an Obligation instituting a suit, action or proceeding in compliance with the provisions outlined in the Master Indenture and more fully set forth therein will be entitled in such suit, action or proceeding to such amounts as may be sufficient to cover the costs and expenses of collection, including to the extent permitted by applicable law, a reasonable compensation to its Counsel.

(c) Notwithstanding any other provision of the Master Indenture, the right of a Holder of an Obligation to receive payment of the principal of and interest on any Obligation and any other amounts payable thereunder, on or after the respective due dates expressed in such Obligation, or to institute suit for the enforcement of any such payment on or after such respective dates, may not be impaired or affected without the consent of such Holder, provided that any moneys collected through the exercise of rights and remedies of any Holder against any Obligated Issuer pursuant to the Related Financing Documents for an Obligation (other than rights and remedies relating to Liens permitted pursuant to the Master Indenture or to funds and accounts established under such Related Financing Documents) will be paid over to the Master Trustee or, with the consent of the Holder, collected directly by the Master Trustee.

Direction of Proceedings by Holders

The Holders of a majority in aggregate principal amount of Obligations then Outstanding have the right to direct the time, method, and place of conducting any proceeding for any remedy available to the Master Trustee, or exercising any trust or power conferred on the Master Trustee; provided, however, that, subject to its right to be indemnified in the Master Indenture, the Master Trustee has the right to decline to follow any such direction if the Master Trustee, being advised by Counsel, determines that the action so directed may not lawfully be taken, or if the Master Trustee in good faith, by a responsible officer or officers of the Master Trustee, determines that the proceedings so directed would be illegal or involve it in personal liability, and provided further that nothing in the Master Indenture will impair the right of the Master Trustee in its discretion to take any action deemed proper by the Master Trustee and which is not inconsistent with such direction by the Holders. The Master Trustee may require, at its option, that prior to taking any action under the Master Indenture, it be provided indemnity with respect to the taking of such action satisfactory to the Master Trustee.

Notice of Default

The Master Trustee will, within 10 days after the occurrence of an "event of default" under the Master Indenture known to the Master Trustee, mail to all Holders of Obligations, as the names and addresses of such Holders appear upon the books maintained by the Master Trustee, notice of such "event of default" under the Master Indenture known to the Master Trustee, unless such "event of default" has been cured before the giving of such notice; provided that, except in the case of a payment default on any Obligation, the Master Trustee will be protected in withholding such notice if and so long as the Master Trustee in good faith determines that the withholding of such notice is in the interest of the Holders of the Obligations. For purposes of the Master Indenture, matters will not be considered to be known to the Master Trustee unless an officer of its corporate trust department located at its principal corporate trust office has actual knowledge thereof.

Concerning the Master Trustee

Prior to the occurrence of an "event of default" under the Master Indenture and after the curing or waiving of all such "events of default" which may have occurred, the Master Trustee has undertaken to perform only those duties specifically set forth in the Master Indenture. If such an "event of default" occurs and is not cured or waived, the Master Trustee will exercise the rights and powers vested in it by the Master Indenture, and use the same degree

of care and skill in their exercise as a prudent man would exercise or use under the circumstances in the conduct of his own affairs.

No provision of the Master Indenture will be construed to relieve the Master Trustee from liability for its own grossly negligent action, its own grossly negligent failure to act, or its own willful misconduct; provided, however, that:

(1) the Master Trustee will not be liable for any error of judgment made in good faith by a responsible officer or officers of the Master Trustee, unless it is proved that the Master Trustee was grossly negligent in ascertaining the pertinent facts, other than facts which the Master Trustee is not required to investigate as provided in the Master Indenture; and

(2) the Master Trustee will not be liable with respect to any action taken or admitted to be taken by it in good faith in accordance with the direction of the Holders of the majority in aggregate principal amount of Obligations then Outstanding relating to the time, method and place of conducting any proceeding for any remedy available to the Master Trustee, or exercising any trust or power conferred upon the Master Trustee, under the Master Indenture.

Except as otherwise described in the immediately preceding paragraphs:

(a) The Master Trustee may rely and will be protected in acting or refraining from acting upon various papers or documents believed by it in good faith to be genuine and to have been signed or presented by the proper party or parties.

(b) An Officer's Certificate (unless otherwise specifically prescribed) will be sufficient evidence of any request, direction, order or demand of any Obligated Issuer mentioned under the Master Indenture. Any resolution of the Governing Body of an Obligated Issuer may be evidenced to the Master Trustee by copy thereof, certified by the Secretary or an Assistant Secretary of such Obligated Issuer.

(c) The Master Trustee may consult with Counsel, and the advice of such Counsel will be full and complete authorization and protection. The Master Trustee will be relieved of liability to the Holders of the Obligations and to the Obligated Issuers in respect of any action taken, suffered or omitted by it under the Master Indenture in good faith and in accordance with Counsel's advice.

(d) Prior to the occurrence of an "event of default" under the Master Indenture and after the curing of all "events of default", the Master Trustee is not bound to make any investigation into facts or matters stated in various papers or documents, unless requested in writing to do so by the Holders of a majority in aggregate principal amount of Obligations then Outstanding. As a condition to proceeding with the requested investigation, the Master Trustee, in accordance with the terms of the Master Indenture, may require indemnity against various costs, expenses or liabilities.

(e) The Master Trustee may execute any of the trusts or powers under the Master Indenture or perform any duties under the Master Indenture either directly or by or through agents or attorneys.

(f) The Master Trustee is under no responsibility for the approval by it in good faith by an expert or other skilled person for any of the purposes expressed in the Master Indenture.

The recitals contained in the Master Indenture and in the Obligations (other than the certificate of authentication on such Obligations) will be taken as the statements of the Obligated Issuers, and the Master Trustee assumes no responsibility for the correctness thereof. Further, the Master Trustee makes no representations as to the validity or sufficiency of the Master Indenture or the liens and security created thereunder or of the Obligations. The Master Trustee is not accountable for the use or application by any Obligated Issuer of any of the Notes or the proceeds of such Obligations, any moneys paid over by the Master Trustee, or any moneys received by any paying agent other than the Master Trustee.

The Master Trustee, in its individual or any other capacity, may become the owner or pledgee of Obligations with the same rights it would have if it were not the Master Trustee under the Master Indenture.

Further, the Master Indenture does not prohibit the Master Trustee from serving as trustee under any Related Financing Documents or for maintaining a banking relationship with any Obligated Issuer; provided that if the Master Trustee determines that there is a conflict with its duties under the Master Indenture, it will eliminate the conflict or resign as Master Trustee.

Each Obligated Issuer will pay, and will be jointly and severally liable to pay, to the Master Trustee reasonable compensation and reimbursement for all reasonable expenses, disbursement and advances incurred or made by the Master Trustee in connection with the acceptance or administration of its trusts under the Master Indenture. Each Obligated Issuer will indemnify, defend and will be jointly and severally liable to indemnify, the Master Trustee and its officers, directors, employees and agents for, and to hold them harmless against, any loss, liability or expense incurred without gross negligence or willful misconduct on the part of the Master Trustee and arising out of or in connection with the acceptance or administration of such trusts, including the costs and expenses of defending itself against any claim of liability in the premises. The Obligated Issuers' joint and several obligations described herein will survive the satisfaction and discharge of the Master Indenture and the resignation, removal and succession of the Master Trustee. Subject only to the rights of any Holder, the Master Trustee will have an express first and prior lien on any moneys or Investment Securities on deposit in any funds established under the Master Indenture as security for the payment of all such obligations.

Subject to the provisions of the Master Indenture described in the first paragraph under "- Concerning the Master Trustee", any matter may be conclusively proved and established by an Officer's Certificate delivered to the Master Trustee. In the absence of willful misconduct or gross negligence on the part of the Master Trustee, any such Officer's Certificate will be full ratification of any action taken, suffered or omitted by the Master Trustee under the provisions of the Master Indenture upon the faith thereof, and the Master Trustee will not be obligated to make any investigation into the facts stated therein.

The Master Trustee may resign at any time without cause by giving notice as provided in the Master Indenture. Further, the Master Trustee may be removed (a) with cause at the direction of the Holders of not less than 66-2/3% in aggregate principal amount of Obligations then Outstanding, delivered to the Obligated Group and the Master Trustee and such other notice required by the Master Indenture, or (b) for any reason at the direction of the Obligation Group Agent if no "event of default" then exists under the Master Indenture. The Master Trustee will promptly give notice of any removal as described in the previous sentence in writing to each Holder of an Obligation then Outstanding. In the case of the resignation and removal of the Master Trustee, a successor Master Trustee may be appointed by the Obligated Group unless an "event of default" exists under the Master Indenture. If an "event of default" exists under the Master Indenture, or if the Obligated Group otherwise fails to appoint a successor in accordance with the terms of the Master Indenture, a successor may be appointed at the direction of the Holders of not less than 66-2/3% in aggregate principal amount of Obligations then Outstanding.

Any successor Master Trustee, however appointed, in accordance with the terms of the Master Indenture, must accept such appointment in writing, and, without further act, will become vested with all the estates, properties, rights, powers and duties of its predecessor under the Master Indenture as if originally named the Master Trustee. The successor Master Trustee may, however, request that its predecessor execute and deliver an instrument transferring the above and assigning, transferring, delivering and paying over to such successor Master Trustee all moneys or other property then held by the predecessor under the Master Indenture.

Any successor Master Trustee, however appointed, must be a bank or trust company having together with its Affiliates a combined capital and surplus on a consolidated basis of at least \$50,000,000.

Any corporation into which the Master Trustee may be merged or converted or with which it may be consolidated, or any corporation resulting from any merger, conversion or consolidation to which the Master Trustee is a party, or any corporation to which substantially all the business of the Master Trustee may be transferred, will, subject to the provisions of the Master Indenture described in the immediately preceding paragraph, be the Master Trustee under the Master Indenture without further act.

Subject to the terms and conditions set forth in the Master Indenture, the Master Trustee will have the power to appoint one or more Persons not unsatisfactory to the Obligated Group Agent to act as Co-Master Trustee as provided in the Master Indenture.

Modifications

Each Obligated Issuer, when authorized by a resolution of its Governing Body, and the Master Trustee may, without the consent of the Holders of the Obligations then Outstanding, enter into a Supplemental Indenture to the Master Indenture to (a) provide for the issuance of any Obligations under the Master Indenture, (b) evidence the addition of an Obligated Issuer or the succession of another corporation to any Obligated Issuer, (c) add additional covenants for the protection of the Holders of Obligations, (d) cure any ambiguity or defective provision of the Master Indenture or any Supplemental Indenture in such manner as is not inconsistent with and does not impair the security of the Master Indenture or adversely affect the Holders of any particular Obligations or series of Obligations issued under the Master Indenture, (e) qualify the Master Indenture under the Trust Indenture Act of 1939 or under any similar federal statute hereafter enacted, (f) provide for the establishment of additional funds and accounts, (g) permit the issuance of additional forms of Obligations, provided such Obligations are equally and ratably secured with all other Obligations issued under the Master Indenture (except as otherwise provided therein), (h) reflect a change in applicable law, and (i) modify, amend, change or remove any covenant, agreement, term or provision of the Master Indenture (other than a modification of the type described in the immediately following paragraph hereof requiring the unanimous written consent of the Holders), provided that either of the following conditions is satisfied prior to the effective date of such Supplemental Indenture: (x) if at the time of the proposed amendment, the Obligations or any series of Related Bonds are rated by one or more Rating Agencies, written notice of the substance of such proposed amendment is given to such Rating Agencies by the Obligated Group Agent not fewer than 30 days prior to the date such amendment is to take effect, and the Obligated Group Agent provides evidence satisfactory to the Master Trustee that the ratings on the Obligations or any series of Related Bonds will not be lowered or withdrawn by such Rating Agencies as a result of such proposed amendment; or (y) a Consultant's report is delivered to the Master Trustee prior to the date such amendment is to take effect, to the effect that the proposed amendment is consistent with then current industry standards for comparable institutions and demonstrating either that (1) the Projected Debt Service Coverage Ratio for the full Fiscal Year immediately after the effective date of such proposed amendment is not less than 1.20, assuming the maximum implementation (or such lower implementation certified to the Master Trustee by the Obligated Group Agent as being a reasonable basis for assumption) by the Obligated Group of the proposed amendment; or (2) if the proposed amendment is to a provision of the Master Indenture that contains a quantitative restriction or covenant, the average of the Projected Debt Service Coverage Ratio for the two full Fiscal Years immediately after the effective date of such proposed amendment or supplement will be greater than the average of the Debt Service Coverage Ratio for such period had the proposed amendment not been implemented, assuming the maximum implementation (or such lower implementation certified to the Master Trustee by the Obligated Group Agent as being a reasonable basis for assumption) of the proposed amendment; or (3) (A) the average of the Projected Debt Service Coverage Ratio for the two full Fiscal Years immediately after the effective date of such proposed amendment will not be less than 1.10, and (B) the average of the Projected Debt Service Coverage Ratios for the two full Fiscal Years immediately after the effective date of such proposed amendment will not be more than 35% lower than the average of the Debt Service Coverage Ratios had the proposed amendment not been implemented, assuming with respect to the projections made under (A) and (B) the maximum implementation (or such lower implementation certified to the Master Trustee by the Obligated Group Agent as being a reasonable basis for assumption) of the proposed amendment if the proposed amendment is to a provision of the Master Indenture that contains a quantitative restriction or covenant.

Each Obligated Issuer, when authorized by its Governing Body, and the Master Trustee may, with the consent of the Holders of a majority in aggregate principal amount of Obligations then Outstanding, otherwise amend or supplement the Master Indenture, subject to the provisions contained in the Master Indenture; provided, however, that (a) without the consent of the Holders of all Obligations whose Obligations are proposed to be modified, no such Supplemental Indenture may effect a change in the times, amounts or currency of payment of the principal of, premium, if any, or interest on any Obligation or a reduction in the principal amount or redemption price of any Obligation or the rate of interest thereon or permit the preference or priority of any Obligation or Obligations over any other Obligation or Obligations, and (b) without the consent of the Holders of all Obligations

then Outstanding, no such Supplemental Indenture may reduce the aforesaid percentage or affected class of Obligations, the Holders of which are required to consent to any such Supplemental Indenture.

Effect of Supplemental Indenture

Upon the execution of any Supplemental Indenture, the Master Indenture will be modified and amended in accordance therewith, and the respective rights, limitation of rights, obligations, duties, and immunities under the Master Indenture of the Master Trustee, each Obligated Issuer and the Holders of Obligations issued under the Master Indenture will thereafter be determined, exercised and enforced under the Master Indenture subject in all respects to such modifications and amendments, and all the terms and conditions of any such Supplemental Indenture will be deemed to be part of the terms and conditions of the Master Indenture.

Immunity of Incorporators, Members, Officers and Members of Governing Body

No recourse under or upon any obligation, covenant or agreement of the Master Indenture, or of any Obligations issued under the Master Indenture, or for any claim based thereon or otherwise in respect thereof, may be had against any incorporator, member, officer or member of the Governing Body, as such, past, present or future, of any Obligated Issuer or of any successor corporation, either directly or through such Obligated Issuer, whether by virtue of any constitution, statute or rule of law, or by the enforcement of any assessment or penalty or otherwise.

Immunity of Officers, Employees and Directors of the Master Trustee

No recourse may be had by the Obligated Group, the Issuer or any Holder for any claim based upon the Master Indenture or any Obligation issued thereunder against any director, officer or employee of the Master Trustee unless such claim is based on bad faith, fraud, deceit or other willful misconduct of such Person or the gross negligence of such Person.

Satisfaction and Discharge of Indenture

If the Master Trustee receives: (a) an amount which is (1) in the form of (i) cash, or (ii) Government Obligations, and (2) in a principal amount sufficient, as determined in the sole and absolute discretion of the Master Trustee, together with the interest thereon and any funds on deposit under the Master Indenture and available for such purpose, to provide for the payment of the principal of and premium, if any, and interest on all Outstanding Obligations to and including the maturity date or prior redemption or prepayment date thereof; (b) irrevocable instructions to redeem all Obligations to be redeemed prior to maturity and to notify the Holders of each such redemption; (c) an amount sufficient, as determined in the sole and absolute discretion of the Master Trustee, to pay or provide for the payment of all other sums payable under the Master Indenture by the Obligated Issuers or any thereof; and (d) a verification report of an independent nationally recognized certified public accounting firm that the principal and interest becoming due on Government Obligations held by the Master Trustee after such transaction and any other moneys available therefor will provide the Master Trustee with moneys which at all times will be sufficient to pay the principal, premium, if any, and interest on the outstanding Obligations, then the Master Indenture will cease to be of further effect, and the Master Trustee, on demand of the Obligated Group Agent, will execute all such instruments acknowledging satisfaction of and discharging the Master Indenture as requested by the Obligated Group Agent.

Similarly, the Obligated Issuer of any particular Obligation may provide for the payment thereof (or a portion thereof) at or prior to maturity, and the Obligation (or portion thereof) so provided for will thereupon cease to be Outstanding under the Master Indenture.

In lieu of the foregoing, the Obligated Issuer of any particular Obligation may deliver to the Holder thereof the amount required under the Related Financing Documents to provide for the payment of the principal, premium,

if any, and interest due or to become due in respect of such Obligation and such Obligation will, upon surrender to the Master Trustee for cancellation, no longer be deemed Outstanding under the Master Indenture.

**Fifth Supplemental Master Indenture, Sixth Supplemental Master Indenture;
and Eighth Supplemental Master Indenture**

The Fifth Supplemental Master Indenture, the Sixth Supplemental Master Indenture and Eighth Supplemental Master Indenture contain terms and provisions in addition to those described above that apply only so long as the Series 2003 Obligation, the Series 2005 Obligations and the Series 2006C Obligation, respectively, remain Outstanding.

SUMMARY OF CERTAIN PROVISIONS OF THE 2011 BOND INDENTURE

The 2011 Bond Indenture contains various covenants, security provisions, terms and conditions, certain of which are summarized below. Reference is made to the 2011 Bond Indenture for a full and complete statement of its provisions.

Payment of Principal, Premium, if any, and Interest

The Issuer has covenanted that it will promptly pay or cause to be paid the principal of, premium, if any, and interest on every Series 2011 Bond issued under the 2011 Bond Indenture at the place, on the dates, and in the manner provided therein and in said Series 2011 Bonds according to the true intent and meaning thereof, but solely from the amounts pledged therefor. Neither the Issuer, the State, nor any political subdivision of the State will in any event be liable for the payment of the principal of, premium, if any, or interest on any of the Series 2011 Bonds or for the performance of any pledge, obligation or agreement undertaken by the Issuer except to the extent that the moneys pledged in the 2011 Bond Indenture are sufficient therefor. No Owner of any Series 2011 Bond has the right to compel any exercise of taxing power of the State or any political subdivision thereof to pay the Series 2011 Bonds or the interest thereon, and the Series 2011 Bonds do not constitute an indebtedness of the Issuer, the State or any political subdivision of the State, or a loan of credit of any of the foregoing within the meaning of any constitutional or statutory provision.

Revenues and Funds

Bond Fund. The 2011 Bond Indenture creates and establishes with the Bond Trustee a trust fund to be designated "The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee - Bond Fund, Wellmont Health System," which will be used to pay when due the principal of, premium, if any, and interest on the Series 2011 Bonds. The Bond Trustee will make a deposit from the proceeds of the Series 2011 Bonds representing accrued interest on the Series 2011 Bonds in the Costs of Issuance Fund on the date of issuance of the Series 2011 Bonds, as described under "Sources and Uses of Funds" in this Official Statement. There will be deposited into the Bond Fund from time to time, all moneys received by the Bond Trustee under and pursuant to any of the provisions of the 2011 Bond Indenture, the Loan Agreement, the Series 2011 Obligation or otherwise which are required to be or which are accompanied by directions that such moneys are to be paid into the Bond Fund. Except as otherwise specifically provided in the 2011 Bond Indenture, moneys in the Bond Fund will be used solely for the payment of the principal of, premium, if any, and interest on the Series 2011 Bonds and for the redemption of the Series 2011 Bonds prior to maturity.

Costs of Issuance Fund. The Trustee will make a deposit from the proceeds of the Series 2011 Bonds in the Costs of Issuance Fund on the date of issuance of the Series 2011 Bonds. Amounts in the Costs of Issuance Fund will be disbursed by the Bond Trustee to pay Costs of Issuance upon receipt of a Written Request by the Corporation which states the amount to be paid, the payee and the purpose for such payment. Upon the receipt of Written Request from the Corporation or the date that is 120 days following the date of issuance of the Series 2011 Bonds,

whichever date is sooner, the Bond Trustee will transfer amounts remaining in the Costs of Issuance Fund to the Bond Fund to be applied as provided in the 2011 Bond Indenture.

Nonpresentment of Bonds. If any Series 2011 Bond is not presented for payment when the principal thereof becomes due, either at maturity, or at the date fixed for redemption thereof, or otherwise, if moneys sufficient to pay any such Series 2011 Bond have been deposited with the Bond Trustee for the benefit of the Owner thereof, all liability of the Issuer to the Owner thereof for the payment of such Series 2011 Bond will forthwith cease, determine and be completely discharged, and thereupon it will be the duty of the Bond Trustee to hold such funds, uninvested or invested in Government Obligations maturing overnight, but in any event without liability for interest thereon, for the benefit of the Owner of such Series 2011 Bond, to which funds the Owner will thereafter be restricted exclusively for any claim of whatever nature on its part under the 2011 Bond Indenture with respect to such Series 2011 Bond.

Any moneys so deposited with and held by the Bond Trustee not so applied to the payment of Series 2011 Bonds within two years after the date on which the same became due will be repaid by the Bond Trustee to the Corporation upon written direction of a Corporation Representative, and thereafter Owners of Series 2011 Bonds will be entitled to look only to the Corporation for payment, and then to the extent of the amount so repaid, and all liability of the Bond Trustee with respect to such money will thereupon cease, and the Corporation will not be liable for any interest thereon and will not be regarded as a trustee of such money.

Moneys to be Held in Trust. All moneys required to be deposited with or paid to the Bond Trustee for the account of any fund or account referred to in any provision of the 2011 Bond Indenture or the Loan Agreement will be held by the Bond Trustee in trust, and, while held by the Bond Trustee, will constitute part of the Trust Estate and be subject to the lien and security interest created thereby, except as otherwise specifically provided in the 2011 Bond Indenture.

Rebate Fund. The 2011 Bond Indenture creates and establishes with the Bond Trustee a trust fund to be held in trust to be designated "The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee Rebate Fund Wellmont Health System." The Bond Trustee will make information regarding the Series 2011 Bonds and the investments under the 2011 Bond Indenture available to the Corporation upon written request, will make deposits to and disbursements from the Rebate Fund in accordance with the directions received from the Corporation or the Corporation Representative, will invest moneys in the Rebate Fund pursuant to said directions and will deposit income from such investments pursuant to said directions, and will make payments to the United States of America in accordance with directions received from the Corporation.

Notwithstanding any provision of the 2011 Bond Indenture to the contrary, the Bond Trustee will not be liable or responsible for any calculation or determination which may be required in connection with or for the purpose of complying with Section 148 of the Code or any applicable Treasury regulation (the "Arbitrage Rules"), including, without limitation, the calculation of amounts required to be paid to the United States under the provisions of the Arbitrage Rules, the maximum amount which may be invested in "nonpurpose obligations" as defined in the Code and the fair market value of any investment made thereunder, it being understood and agreed that the sole obligation of the Bond Trustee with respect to investments of funds under the 2011 Bond Indenture will be to invest the moneys received by the Bond Trustee pursuant to the written instructions of the Corporation Representative given in accordance with the 2011 Bond Indenture and as described under "- Investment of Moneys" below. The Bond Trustee will have no responsibility for determining whether or not the investments made pursuant to the direction of the Corporation Representative or any of the instructions received by the Bond Trustee as described herein comply with the requirements of the Arbitrage Rules and will have no responsibility for monitoring the obligations of the Corporation or the Issuer for compliance with the provisions of the 2011 Bond Indenture with respect to the Arbitrage Rules.

Investment of Moneys

Any moneys held as a part of the Costs of Issuance Fund, upon a Written Request of the Corporation, will be invested or reinvested by the Bond Trustee in Investment Securities maturing at such time or times so that the Bond Trustee will be able to pay the costs of issuance of the Bonds from time to time upon the Written Request of

the Corporation. The Bond Trustee will not be obligated to invest any moneys held by it in the Costs of Issuance Fund except as directed in writing by the Corporation, but will inform the Corporation as soon as practicable of any amounts that remain uninvested but are eligible for investment in Investment Securities.

Any moneys held as a part of the Bond Fund or the Rebate Fund will be invested or reinvested by the Bond Trustee in Government Obligations with such maturities as required in order to assure full and timely payment of amounts required to be paid from such funds, which maturities, in the case of the Bond Fund, may extend no more than 30 days from the date of acquisition thereof.

The Bond Trustee will sell or present for redemption any investments so purchased whenever necessary to provide moneys to meet any payment pursuant to the Bond Indenture and the Bond Trustee will not be liable or responsible for any loss resulting from such investments. The Bond Trustee will not be responsible for any reduction of the value of any investments made in accordance with the Written Request of the Corporation or any losses incurred in the sale of such investments.

The Bond Trustee may make any and all such investments through its own bond or investment department or the bond or investment department of any bank or trust company under common control with the Bond Trustee, and may charge and collect its and/or pay its customary fees and expenses in connection therewith. The Bond Trustee will not be liable for any depreciation in the value of any investment made pursuant to the 2011 Bond Indenture or for any loss arising from any such investment, or any determination that the Series 2011 Bonds are "arbitrage bonds" as a result of any such investments. All such investments will at all times be a part of the fund or account from which the moneys used to acquire such investments have come and all income and profits on such investments will be credited to, and losses thereon will be charged against, such fund. All investments under the 2011 Bond Indenture will be registered in the name of the Bond Trustee, as Bond Trustee under the 2011 Bond Indenture, and will be held by or under the control of the Bond Trustee. The Bond Trustee may conclusively rely upon the Corporation's written instructions as to both the suitability and legality of all directed investments under the Bond Indenture. Ratings of investment shall be determined at the time of purchase of such investments and without regard to ratings subcategories. The Bond Trustee shall have no responsibility to monitor the ratings of investments after the initial purchase of such investments. In the absence of written investment instructions from the Corporation, the Bond Trustee shall not be responsible or liable for keeping the moneys held by it under the Bond Indenture fully invested. Confirmations of investments are not required to be issued by the Bond Trustee for each month in which a monthly statement is rendered.

Notwithstanding any other provisions of the 2011 Bond Indenture described herein, all investment earnings will be subject to the provisions of the Tax Compliance Agreement and Non-Arbitrage Certificate. The Issuer has covenanted and certified to and for the benefit of the Owners of the Series 2011 Bonds from time to time Outstanding that so long as any of the Series 2011 Bonds remain Outstanding, the Issuer will not direct that moneys on deposit in any fund or account in connection with the Series 2011 Bonds (whether or not such moneys were derived from the proceeds of the sale of the Series 2011 Bonds or from any other sources), be used in a manner which will cause the Series 2011 Bonds to be classified as "arbitrage bonds" within the meaning of Section 148 of the Code. Pursuant to such covenants, the Issuer has obligated itself to comply throughout the term of the Series 2011 Bonds with any request of the Corporation regarding the requirements of Section 148 of the Code, and any regulations promulgated thereunder. Notwithstanding any provision of the 2011 Bond Indenture to the contrary, the Bond Trustee will not be liable or responsible for any calculation or determination which may be required in connection with or for the purpose of complying with Section 148 of the Code including, without limitation, the calculation of amounts required to be paid to the United States under the provisions of such Section 148 of the Code, and will be entitled to rely on the directions or the absence of directions of the Corporation and any rebate analyst.

Discharge of Indenture

If the Issuer pays or causes to be paid, in accordance with the provisions of the 2011 Bond Indenture, to the Owners of the Series 2011 Bonds, the principal of, premium, if any, and interest due or to become due thereon at the times and in the manner stipulated therein, and if the Issuer is not then in default in any of the other covenants and promises in the Series 2011 Bonds and in the 2011 Bond Indenture expressed as to be kept, performed and observed by it or on its part, and if the Issuer pays or causes to be paid to the Bond Trustee all sums of money due or to

become due according to the provisions thereof, then the presents and the estate and rights granted by the 2011 Bond Indenture will cease, determine and be void, whereupon the Bond Trustee will cancel and discharge the lien of the 2011 Bond Indenture, and execute and deliver to the Issuer such instruments in writing as are required to release the lien thereof and re-convey, release, assign and deliver to the Issuer any and all of the estate, right, title and interest in and to any and all rights or property conveyed, assigned or pledged to the Bond Trustee or otherwise subject to the lien of the 2011 Bond Indenture, except (i) cash held by the Bond Trustee for the payment of the principal of, premium, if any, or interest on particular Series 2011 Bonds and (ii) amounts in the Rebate Fund required to be paid to the United States.

Defeasance of Bonds

Any Series 2011 Bond will be deemed to be paid within the meaning of the 2011 Bond Indenture and for all purposes thereof when (a) payment of the principal of and premium, if any, on such Series 2011 Bond, plus interest thereon to the due date thereof (whether such due date is by reason of maturity or upon redemption) either (i) have been made or caused to be made in accordance with the terms thereof, or (ii) have been provided for by irrevocably depositing with the Bond Trustee, in trust and irrevocably set aside exclusively for such payment, (1) moneys sufficient to make such payment or (2) Government Obligations maturing as to principal and interest in such amounts and at such times as will insure, without further investment or reinvestment thereof, in the opinion of an independent certified public accounting firm of national reputation (a copy of which opinion must be furnished to the rating agency then providing the rating borne by the Series 2011 Bonds, if any), the availability of sufficient moneys to make such payment, and (b) all necessary and proper fees, compensation and expenses of the Bond Trustee and the Issuer pertaining to the Series 2011 Bonds with respect to which such deposit is made, have been paid or the payment thereof provided for to the satisfaction of the Bond Trustee. At such time as a Series 2011 Bond is deemed to be paid under the 2011 Bond Indenture, as aforesaid, such Series 2011 Bond will no longer be secured by or entitled to the benefits of the 2011 Bond Indenture, except for the purposes of any such payment from such moneys or Government Obligations.

Notwithstanding the foregoing, no deposit described in clause (a)(ii) of the immediately preceding paragraph will be deemed payment of such Series 2011 Bonds as aforesaid until (a) proper notice of redemption of such Series 2011 Bonds has been previously given in accordance with the 2011 Bond Indenture, or if said Series 2011 Bonds are not by their terms subject to redemption within the next 60 days, until the Corporation has given the Bond Trustee, in form satisfactory to the Bond Trustee, irrevocable instructions to notify, as soon as practicable, the Owners of the Series 2011 Bonds that the deposit described in such clause (a)(ii) above has been made with the Bond Trustee and that said Series 2011 Bonds are deemed to have been paid in accordance with the 2011 Bond Indenture and stating the maturity or redemption date upon which moneys are to be available for the payment of the principal of and the applicable redemption premium, if any, on said Series 2011 Bonds, plus interest thereon to the due date thereof; or (b) the maturity of such Series 2011 Bonds.

Before accepting or using any moneys to be deposited as described herein, the Bond Trustee may require that the Corporation furnish to it (i) an opinion of Bond Counsel to the effect that such deposit will not adversely affect the exclusion from gross income for federal income tax purposes of interest on the Series 2011 Bonds and that all conditions of the 2011 Bond Indenture described herein have been satisfied, and (ii) a certificate of an independent certified public accountant to the effect that such deposit will be sufficient to defease the Series 2011 Bonds as provided in the 2011 Bond Indenture. The Bond Trustee will be fully protected in relying upon such Bond Counsel opinion and/or accountant's certificate in accepting or using any moneys deposited as described herein.

All moneys so deposited with the Bond Trustee may also be invested and reinvested, at the written direction of the Corporation, in noncallable Government Obligations, maturing in the amounts and times as hereinbefore set forth, and all income from all Government Obligations in the hands of the Bond Trustee as described herein which is not required for the payment of the Series 2011 Bonds and interest and premium, if any, thereon with respect to which such moneys have been so deposited will be deposited in the Bond Fund as and when realized and collected for use and application as are other moneys deposited in the Bond Fund; provided that unless the opinion of Bond Counsel specifically permits any such reinvestment, the Corporation will furnish to the Bond Trustee an opinion of Bond Counsel to the effect that such reinvestment will not adversely affect the exclusion from gross income for federal income tax purposes of interest on the Series 2011 Bonds.

The Issuer has covenanted in the 2011 Bond Indenture that no deposit will knowingly be made or accepted and no use knowingly made of any such deposit which would cause the Series 2011 Bonds to be treated as arbitrage bonds within the meaning of Section 148 of the Code.

Notwithstanding any provision of any other article of the 2011 Bond Indenture which may be contrary to the provisions described herein, all moneys or Government Obligations so set aside and held in trust for the payment of Series 2011 Bonds (including interest and premium thereon, if any) will be applied to and used solely for the payment of the particular Series 2011 Bonds (including the interest and premium thereon, if any) with respect to which such moneys or Government Obligations have been so set aside in trust.

Defaults and Remedies

Defaults. The occurrence of any of the following events constitutes a "Default" under the 2011 Bond Indenture:

- (a) Default in the due and punctual payment of interest on any Series 2011 Bond;
- (b) Default in the due and punctual payment of the principal of or premium, if any, on any Series 2011 Bond, whether at the stated maturity thereof, or upon proceedings for redemption thereof, or upon the maturity thereof by declaration;
- (c) The occurrence of a Default under the Loan Agreement;
- (d) An event of default as described in subparagraph (a) under "Summary of Certain Provisions of the Master Indenture - Defaults and Remedies" above occurs and is continuing from and after the date on which the Master Trustee is entitled under the Master Indenture to declare any Obligation immediately due and payable, or the Master Trustee declares any Obligation immediately due and payable; and
- (e) Default in the performance or observance of any other of the covenants, agreements or conditions on the part of the Issuer contained in the 2011 Bond Indenture or in the Series 2011 Bonds contained and failure to remedy the same after notice thereof pursuant to the provisions of the 2011 Bond Indenture.

Acceleration. Upon the occurrence of any Default, the Bond Trustee may, and at the written request of the Owners of at least a majority in aggregate principal amount of Outstanding Series 2011 Bonds must, by notice in writing delivered to the Issuer and the Corporation (or, if the Book Entry System is in effect, the Securities Depository), declare the principal of all Series 2011 Bonds and the interest accrued thereon to the date of such acceleration immediately due and payable. Upon any declaration of acceleration as described herein, the Bond Trustee will immediately declare all payments required to be made by the Corporation under the Loan Agreement to be immediately due and payable. Interest will cease to accrue on the Series 2011 Bonds on the date of declaration of acceleration as so described.

Other Remedies; Rights of Owners of Bonds. Subject to the provisions of the 2011 Bond Indenture described under "- Acceleration" above and with respect to indemnification of the Bond Trustee, upon the occurrence of a Default, the Bond Trustee may pursue any available remedy at law or in equity to enforce the payment of the principal of, premium, if any, and interest on the Outstanding Series 2011 Bonds.

Subject to the provisions of the 2011 Bond Indenture described under "- Acceleration" above, if a Default has occurred and is continuing and if requested so to do by the Owners of at least a majority in aggregate principal amount of Outstanding Series 2011 Bonds and provided the Bond Trustee is indemnified as provided in the 2011 Bond Indenture, the Bond Trustee will be obligated to exercise such one or more of the rights and powers conferred by the 2011 Bond Indenture, as the Bond Trustee, being advised by counsel, deems most expedient in the interests of the Owners of Series 2011 Bonds.

Subject to the provisions of the 2011 Bond Indenture described under "- Acceleration" above, no remedy by the terms of the 2011 Bond Indenture conferred upon or reserved to the Bond Trustee (or to the Owners of Series 2011 Bonds) is intended to be exclusive of any other remedy, but each and every such remedy will be cumulative and in addition to any other remedy given to the Bond Trustee or to the Owners of Series 2011 Bonds under the 2011 Bond Indenture or now or hereafter existing at law or in equity.

No delay or omission to exercise any right or power accruing upon any Default will impair any such right or power or be construed to be a waiver of any such Default or acquiescence therein; such right or power may be exercised from time to time as often as may be deemed expedient.

No waiver of any Default under the 2011 Bond Indenture, whether by the Bond Trustee or by the Owners of Series 2011 Bonds, will extend to or affect any subsequent Default or impair any rights or remedies consequent thereon.

Right of Owners of Series 2011 Bonds to Direct Proceedings. Subject to the provisions of the 2011 Bond Indenture described under "- Acceleration" above, anything in the 2011 Bond Indenture to the contrary notwithstanding, the Owners of at least a majority in aggregate principal amount of the Outstanding Series 2011 Bonds will have the right, at any time, by an instrument or instruments in writing executed and delivered to the Bond Trustee, to direct the method and place of conducting all proceedings to be taken in connection with the enforcement of the terms and conditions of the 2011 Bond Indenture, or for the appointment of a receiver or any other proceedings thereunder provided that such direction may not be otherwise than in accordance with the provisions of law and of the 2011 Bond Indenture.

Appointment of Receivers. Upon the occurrence of a Default, and upon the filing of a suit or other commencement of judicial proceedings to enforce the rights of the Bond Trustee and of the Owners of Series 2011 Bonds under the 2011 Bond Indenture, the Bond Trustee will be entitled, as a matter of right, to the appointment of a receiver or receivers of the Trust Estate and of the revenues, earnings, income, products and profits thereof, pending such proceedings, with such powers as the court making such appointment confers.

Waiver. Upon the occurrence of a Default, to the extent that such rights may then lawfully be waived, neither the Issuer nor anyone claiming through or under it, will set up, claim or seek to take advantage of any appraisal, valuation, stay, extension or redemption laws of any jurisdiction now or hereafter in force, in order to prevent or hinder the enforcement of the 2011 Bond Indenture, and the Issuer, for itself and all who may claim through or under it, has waived, to the extent that it lawfully may do so, the benefit of all such laws.

Application of Moneys. All moneys received by the Bond Trustee pursuant to any right given or action taken under the provisions of the 2011 Bond Indenture (other than moneys deposited with the Bond Trustee and held in accordance with the provisions of the 2011 Bond Indenture as described under "- Revenues and Funds - Nonpresentment of Bonds" above) will, after payment of the costs and expenses of the proceedings resulting in the collection of such moneys and of the fees, expenses, liabilities and advances owing to or incurred or made by the Bond Trustee and the creation of a reasonable reserve for anticipated fees, costs and expenses, be deposited in the Bond Fund and applied as follows:

(a) Unless the principal of all the Series 2011 Bonds has become or has been declared due and payable, all such moneys will be applied:

FIRST – To the payment to the persons entitled thereto of all installments of interest then due on the Series 2011 Bonds, in the order of the maturity of the installments of such interest (with interest on overdue installments of such interest, to the extent permitted by law, at the rate of interest borne by the Series 2011 Bonds) and, if the amount available are not sufficient to pay in full any particular installment, then to the payment ratably, according to the amounts due on such installment, to the persons entitled thereto, without any discrimination or privilege; and

SECOND – To the payment to the persons entitled thereto of the unpaid principal of and premium, if any, on any of the Series 2011 Bonds which have become due (other than Series 2011 Bonds matured or called for redemption for the payment of which moneys are held pursuant to the

provisions of the 2011 Bond Indenture), (with interest on overdue installments of principal and premium, if any, to the extent permitted by law, at the rate of interest borne by the Series 2011 Bonds) and, if the amount available are not sufficient to pay in full all Series 2011 Bonds due on any particular date, then to the payment ratably according to the amount of principal due on such date, to the persons entitled thereto without any discrimination or privilege; and

THIRD – To the payment to the persons entitled thereto as the same become due of the principal of and premium, if any, and interest on the Series 2011 Bonds which may thereafter become due and, if the amount available are not sufficient to pay in full Series 2011 Bonds due on any particular date, together with interest and premium, if any, then due and owing thereon, payment will be made ratably according to the amount of interest, principal and premium, if any, due on such date to the persons entitled thereto without any discrimination or privilege.

(b) If the principal of all the Series 2011 Bonds has become due or has been declared due and payable, all such moneys will be applied to the payment of the principal and interest then due and unpaid upon the Series 2011 Bonds, without preference or priority of principal over interest or of interest over principal, or of any installment of interest over any other installment of interest, or of any Series 2011 Bond over any other Series 2011 Bond, ratably, according to the amounts due, respectively, for principal and interest, to the persons entitled thereto without any discrimination or privilege, with interest on overdue installments of interest or principal, to the extent permitted by law, at the rate of interest borne by the Series 2011 Bonds.

(c) If the principal of all the Series 2011 Bonds has been declared due and payable and if such declaration thereafter has been rescinded and annulled as provided in the 2011 Bond Indenture, then, subject to the provisions of the 2011 Bond Indenture described in subparagraph (b) above, if the principal of all the Series 2011 Bonds later becomes due or be declared due and payable, the moneys will be applied in accordance with the provisions of the 2011 Bond Indenture described in subparagraph (a) above.

Whenever moneys are to be applied as described herein, such moneys will be applied at such times, and from time to time, as the Bond Trustee determines, having due regard to the amount of such moneys available for application and the likelihood of additional moneys becoming available for such application in the future. Whenever the Bond Trustee applies such funds, it will fix the date (which must be an Interest Payment Date unless it deems another date more suitable) upon which such application is to be made and upon such date interest on the amounts of principal to be paid on such dates will cease to accrue; provided that upon an acceleration of Series 2011 Bonds as described under "- Acceleration" above, interest will cease to accrue on the Series 2011 Bonds on and after the date of such acceleration. The Bond Trustee will give such notice as it may deem appropriate of the deposit with it of any such moneys and of the fixing of any such date, and will not be required to make payment to the Owner of any Series 2011 Bond until such Series 2011 Bond is presented to the Bond Trustee for appropriate endorsement or for cancellation if fully paid.

Whenever the principal of, premium, if any, and interest on all Series 2011 Bonds have been paid as provided in the 2011 Bond Indenture and all expenses and charges of the Bond Trustee have been paid, any balance remaining in the Bond Fund will be paid to the Corporation as described under "- Revenues and Funds --Bond Fund" above.

Rights and Remedies of Owners of Bonds. No Owner of any Series 2011 Bond will have any right to institute any suit, action or proceeding at law or in equity for the enforcement of the 2011 Bond Indenture or for the execution of any trust thereof or for the appointment of a receiver or any other remedy thereunder, unless (subject to the provisions of the 2011 Bond Indenture described under "- Acceleration" above) (i) a Default has occurred of which the Bond Trustee has been notified as provided in the 2011 Bond Indenture, or of which it is deemed to have notice, (ii) the Owners of at least a majority in aggregate principal amount of Outstanding Series 2011 Bonds have made written request to the Bond Trustee and have offered it reasonable opportunity either to proceed to exercise the powers granted by the 2011 Bond Indenture or to institute such action, suit or proceeding and have offered to the Bond Trustee indemnity as provided in the 2011 Bond Indenture, and (iii) the Bond Trustee thereafter fails or refuses to exercise the powers granted by the 2011 Bond Indenture, or to institute such action, suit or proceeding. Such notification, request and offer of indemnity are in every case at the option of the Bond Trustee conditions

precedent to the execution of the powers and trusts of the 2011 Bond Indenture, and to any action or cause of action for the enforcement of the 2011 Bond Indenture, or for the appointment of a receiver or for any other remedy thereunder; it being understood and intended that no one or more Owners of the Series 2011 Bonds have any right in any manner whatsoever to affect, disturb or prejudice the lien of the 2011 Bond Indenture by their action or to enforce any right thereunder except in the manner provided therein, and that all proceedings at law or equity must be instituted, had and maintained in the manner therein provided and for the equal and ratable benefit of the Owners of all Outstanding Series 2011 Bonds. However, nothing contained in the 2011 Bond Indenture will affect or impair the right of any Owner of Series 2011 Bonds to enforce the payment of the principal of, premium, if any, and interest on any Series 2011 Bond at and after the maturity thereof, or the obligation of the Issuer to pay the principal of, premium, if any, and interest on each of the Series 2011 Bonds issued under the 2011 Bond Indenture to the respective Owners thereof at the time and place, from the source and in the manner in the Series 2011 Bonds expressed.

Waivers of Default. The Bond Trustee will waive any Default under the 2011 Bond Indenture and its consequences and rescind any declaration of acceleration of principal upon the written request of the Owners of (1) at least a majority in aggregate principal amount of all Outstanding Series 2011 Bonds in respect of which default in the payment of principal or interest, or both, exists or (2) at least a majority in aggregate principal amount of Outstanding Series 2011 Bonds in the case of any other Default; provided that there may not be waived any Default as described in subparagraphs (a) or (b) under "- Defaults" above unless prior to such waiver or rescission, the Corporation has caused to be paid to the Bond Trustee (i) all arrears of principal and interest (other than principal of or interest on the Series 2011 Bonds which became due and payable by declaration of acceleration), with interest at the rate then borne by the Series 2011 Bonds on overdue installments, to the extent permitted by law, and (ii) all fees and expenses of the Bond Trustee in connection with such Default. In case of any waiver or rescission described above, or in case any proceeding taken by the Bond Trustee on account of any such Default has been discontinued or concluded or determined adversely, then and in every such case the Issuer, the Bond Trustee and the Owners of Series 2011 Bonds will be restored to their former positions and rights under the 2011 Bond Indenture, respectively, but no such waiver or rescission will extend to any subsequent or other Default, or impair any right consequent thereon.

Notice of Certain Defaults; Opportunity to Cure Such Defaults. Anything in the 2011 Bond Indenture to the contrary notwithstanding, no Default under the 2011 Bond Indenture as described in subparagraphs (c) or (d) under "- Defaults" above will be deemed a Default until notice of such Default has been given to the Issuer and the Corporation by the Bond Trustee or by the Owners of at least a majority in aggregate principal amount of all Outstanding Series 2011 Bonds, and the Issuer and the Corporation have had 30 days after receipt of such notice to correct said Default or to cause said Default to be corrected and have not corrected said Default or caused said Default to be corrected within the applicable period; provided that if said Default is such that it cannot be corrected within the applicable period, it will not constitute a Default if corrective action is instituted by the Issuer or the Corporation within the applicable period and diligently pursued until the Default is corrected.

With regard to any Default concerning which notice is given to the Issuer and the Corporation as described above, the Issuer has granted the Corporation full authority for the account of the Issuer to perform any covenant or obligation alleged in said notice to constitute a Default, in the name and stead of the Issuer with full power to do any and all things and acts to the same extent that the Issuer could do and perform any such things and acts and with power of substitution.

Bond Trustee

Acceptance of Trusts. The Bond Trustee has accepted the trusts imposed upon it by the 2011 Bond Indenture, and has agreed to perform said trusts, but only upon and subject to the terms and conditions set forth in the 2011 Bond Indenture.

Notice to Owners of Bonds if Default Occurs. If a Default occurs of which the Bond Trustee has been notified or of which it is deemed to have notice, as provided in the 2011 Bond Indenture, then the Bond Trustee will promptly give notice thereof to the Owner of each Series 2011 Bond.

Successor Bond Trustee. Any corporation or association into which the Bond Trustee may be converted or merged, or with which it may be consolidated, or to which it may sell or transfer its corporate trust business and assets as a whole or substantially as a whole, or any corporation or association resulting from any such conversion, sale, merger, consolidation or transfer to which it is a party, will be and become successor Bond Trustee under the 2011 Bond Indenture and vested with all of the title to the Trust Estate and all the trusts, powers, discretions, immunities, privileges and all other matters as was its predecessor, without the execution or filing of any instrument or any further act, deed or conveyance on the part of any of the parties to the 2011 Bond Indenture, anything therein to the contrary notwithstanding.

Resignation by the Bond Trustee. The Bond Trustee and any successor Bond Trustee may at any time resign from the trusts created by the 2011 Bond Indenture by giving 30 days' notice to the Issuer, the Corporation, and the Owner of each Series 2011 Bond. Such resignation will not take effect until the appointment of a successor Bond Trustee or temporary Bond Trustee. Upon such resignation, the resigning Bond Trustee shall be entitled to prompt payment in full of all fees and expenses and other amounts payable to the Bond Trustee pursuant to the 2011 Bond Indenture or the Loan Agreement.

Removal of the Bond Trustee. The Bond Trustee may be removed at any time by an instrument or concurrent instruments in writing delivered to the Bond Trustee and to the Issuer and signed by the Owners of at least a majority in aggregate principal amount of Outstanding Series 2011 Bonds. Such removal will not take effect until (i) the appointment of a successor Bond Trustee or temporary Bond Trustee and the transfer to said successor or temporary Bond Trustee of the Credit Facility and (ii) payment in full of all fees and expenses and other amounts payable to the Bond Trustee pursuant thereto or to the Loan Agreement.

Appointment of Successor Bond Trustee by Owners of Bonds. If the Bond Trustee resigns or is removed, or is dissolved, or is in the course of dissolution or liquidation, or otherwise becomes incapable of acting under the 2011 Bond Indenture, or if it is taken under the control of any public officer or officers, or of a receiver appointed by a court, a successor may be appointed by the Owners of at least a majority in aggregate principal amount of Outstanding Series 2011 Bonds by an instrument or concurrent instruments in writing signed by such Owners, or by their attorneys in fact duly authorized, a copy of which will be delivered personally or sent by registered mail to the Issuer and the Corporation. In case of any such vacancy, the Issuer, by an instrument executed by its official who executed the Series 2011 Bonds or his successor in office, may appoint a temporary successor Bond Trustee to fill such vacancy until a successor Bond Trustee may be appointed by the Owners of Series 2011 Bonds in the manner above described; and such temporary successor Bond Trustee so appointed by the Issuer will immediately and without further act be superseded by the Bond Trustee appointed by the Owners of Series 2011 Bonds. If no successor Bond Trustee has accepted appointment in the manner described in the immediately following paragraph within 60 days after the Bond Trustee has given notice of resignation to the Issuer and the Owner of each Series 2011 Bond, the Bond Trustee may petition any court of competent jurisdiction for the appointment of a temporary successor Bond Trustee; provided that any Bond Trustee so appointed will immediately and without further act be superseded by a Bond Trustee appointed by the Issuer or the Owners of Series 2011 Bonds as described herein. Every successor Bond Trustee appointed pursuant to the provisions of the 2011 Bond Indenture described herein, if there be such an institution willing, must be qualified and able to accept the trust upon customary terms, a bank or trust company within or without the State, in good standing and having reported capital and surplus of not less than \$50,000,000 and rated Baa3/Prime-3 or better by Moody's (or a substantially equivalent rating by such other rating agency then providing the rating borne by the Series 2011 Bonds).

Acceptance by Successor Bond Trustee. Every successor Bond Trustee appointed under the 2011 Bond Indenture will execute, acknowledge and deliver to its or his predecessor and also to the Issuer and the Corporation an instrument in writing accepting such appointment and thereupon such successor, without any further act, deed or conveyance, will become fully vested with all the estates, properties, rights, powers, trusts, duties and obligations of its predecessor; but its predecessor will, nevertheless, on the written request of the Issuer, or of its successor, execute and deliver an instrument transferring to such successor all the estates, properties, rights, powers and trusts of such predecessor under the 2011 Bond Indenture; and every predecessor Bond Trustee will deliver all securities and moneys held by it as Bond Trustee under the 2011 Bond Indenture to its successor. Should any instrument in writing from the Issuer be required by any successor Bond Trustee for more fully and certainly vesting in such successor the estate, rights, powers and duties vested by the 2011 Bond Indenture or intended to be vested in the

predecessor, any and all such instruments in writing will, on request, be executed, acknowledged and delivered by the Issuer.

Supplemental Indentures

Supplemental Indentures Not Requiring Consent of Owners of Bonds. The Issuer and the Bond Trustee may, upon receipt of an opinion of Bond Counsel to the effect that the proposed supplemental indenture will not adversely affect the excludability of interest on the Series 2011 Bonds from gross income for federal income tax purposes and is authorized by the 2011 Bond Indenture, and without consent of, or notice to, any of the Owners of Series 2011 Bonds, enter into an indenture or indentures supplemental to the 2011 Bond Indenture for any one or more of the following purposes:

- (a) To cure any ambiguity or formal defect or omission in the 2011 Bond Indenture;
- (b) To grant to or confer upon the Bond Trustee for the benefit of the Owners of Series 2011 Bonds any additional rights, remedies, powers or authorities that may lawfully be granted to or conferred upon the Owners of Series 2011 Bonds or the Bond Trustee;
- (c) To subject to the 2011 Bond Indenture additional revenues, properties or collateral;
- (d) To modify, amend or supplement the 2011 Bond Indenture or any indenture supplemental thereof in such manner as to permit the qualification thereof under the Trust Indenture Act of 1939, as amended, or any similar federal statute hereafter in effect or to permit the qualification of the Series 2011 Bonds for sale under the securities laws of any of the states of the United States of America;
- (e) To evidence the appointment of a separate or Co-Bond Trustee or the succession of a new Bond Trustee;
- (f) To correct any description of, or to reflect changes in, any of the properties comprising the Trust Estate;
- (g) To make any revisions of the 2011 Bond Indenture required by Fitch, Moody's or S&P in order to obtain or maintain an investment grade rating on the Series 2011 Bonds;
- (h) To provide for an uncertificated system of registering the Series 2011 Bonds or to provide for changes to or from the Book Entry System; or
- (i) To effect any other change in the 2011 Bond Indenture which is not to the material prejudice of the Bond Trustee or the Owners of Series 2011 Bonds.

If Fitch, S&P and/or Moody's, as the case may be, has issued a rating of any of the Series 2011 Bonds, the Bond Trustee will provide written notice of the proposed amendment to such rating agencies, but such notice will not be a condition of the effectiveness of such amendment.

Supplemental Indentures Requiring Consent of Owners of Bonds. Exclusive of supplemental indentures described under "- Supplemental Indentures Not Requiring Consent of Owners of Bonds" above, and subject to the terms and provisions contained in the 2011 Bond Indenture and not otherwise, the Owners of not less than a majority in aggregate principal amount of the Outstanding Series 2011 Bonds have the right, from time to time, anything contained in the 2011 Bond Indenture to the contrary notwithstanding, to consent to and approve the execution by the Issuer and the Bond Trustee of such other indenture or indentures supplemental to the 2011 Bond Indenture as deemed necessary and desirable for the purpose of modifying, altering, amending, adding to or rescinding, in any particular, any of the terms or provisions contained in the 2011 Bond Indenture or in any supplemental indenture; provided that nothing contained in the 2011 Bond Indenture will permit, or be construed as permitting, without the consent of the Owners of all Series 2011 Bonds Outstanding, (a) an extension of the maturity

of the principal of, or the interest on, any bond issued under the 2011 Bond Indenture, or (b) a reduction in the principal amount of, or redemption premium on, any Series 2011 Bond or the rate of interest thereon, or (c) a privilege or priority of any Series 2011 Bond or Series 2011 Bonds over any other Series 2011 Bond or Series 2011 Bonds, or (d) a reduction in the aggregate principal amount of the Series 2011 Bonds required for consent to such supplemental indentures or any modifications or waivers of the provisions of the 2011 Bond Indenture or the Loan Agreement, or (e) the creation of any lien ranking prior to or on a parity with the lien of the 2011 Bond Indenture on the Trust Estate or any part thereof, except as hereinbefore expressly described, or (f) the deprivation of the Owner of any Outstanding Series 2011 Bond of the lien created by the 2011 Bond Indenture on the Trust Estate.

If at any time the Issuer requests the Bond Trustee to enter into any such supplemental indenture for any of the purposes described in the preceding paragraph, the Bond Trustee will, upon being satisfactorily indemnified with respect to expenses, cause notice of the proposed execution of such supplemental indenture to be given to the Owners of the Series 2011 Bonds as provided in the 2011 Bond Indenture; provided that prior to the delivery of such notice, the Bond Trustee may require that an opinion of Bond Counsel be furnished to the effect that the supplemental indenture complies with the provisions of the 2011 Bond Indenture and will not adversely affect the excludability of interest on the Series 2011 Bonds from gross income for federal income tax purposes. Such notice will briefly set forth the nature of the proposed supplemental indenture and state that copies thereof are on file at the Principal Office of the Bond Trustee for inspection by all Owners of Series 2011 Bonds. If, within 60 days or such longer period as prescribed by the Issuer following such notice, the Owners of not less than a majority in aggregate principal amount of the Series 2011 Bonds Outstanding (except for those supplemental indentures requiring the consent of the Owners of all Series 2011 Bonds Outstanding as described above) at the time of the execution of any such supplemental indenture have consented to and approved the execution thereof as described herein, no Owner of any Series 2011 Bond will have any right to object to any of the terms and provisions contained therein, or the operation thereof, or in any manner to question the propriety of the execution thereof, or to enjoin or restrain the Bond Trustee or the Issuer from executing the same or from taking any action pursuant to the provisions thereof. Upon the execution of any such supplemental indenture as permitted by the 2011 Bond Indenture, the 2011 Bond Indenture will be and be deemed to be modified and amended in accordance therewith.

If Fitch, S&P and/or Moody's, as the case may be, has issued a rating of any of the Series 2011 Bonds, the Bond Trustee will provide written notice of the proposed amendment to such rating agencies, but such notice will not be a condition of the effectiveness of such amendment.

Consent of the Corporation. Anything in the 2011 Bond Indenture to the contrary notwithstanding, a supplemental indenture as described above will not become effective unless and until the Corporation has consented to the execution and delivery of such supplemental indenture. In this regard, the Bond Trustee will cause notice of the proposed execution of any such supplemental indenture, together with a copy of the proposed supplemental indenture, to be mailed to the Corporation at least 15 Business Days prior to the proposed date of execution and delivery of any such supplemental indenture.

Amendment without Consent of Issuer. If the Issuer is unable to enter into any supplemental indenture permitted by the 2011 Bond Indenture as described above, the Bond Trustee may, without the consent of the Issuer, amend or supplement the 2011 Bond Indenture in any manner otherwise permitted by the 2011 Bond Indenture so long as such supplemental indenture does not adversely affect the rights of the Issuer.

Execution of Amendments and Supplements by Bond Trustee. The Bond Trustee will not be obligated to sign any amendment or supplement to the 2011 Bond Indenture or the Series 2011 Bonds if the amendment or supplement, in the judgment of the Bond Trustee, could adversely affect the rights, duties, liabilities, protections, privileges, indemnities or immunities of the Bond Trustee. In signing an amendment or supplement, the Bond Trustee will be entitled to receive, and to be fully protected in conclusively relying on, an opinion of Bond Counsel stating that such amendment or supplement is authorized by the 2011 Bond Indenture, and will not adversely affect the exclusion of interest on the Series 2011 Bonds from gross income for federal income tax purposes.

Amendment of Loan Agreement

Amendments to Loan Agreement Not Requiring Consent of Owners of Bonds. The Issuer and the Bond Trustee may, upon receipt of an opinion of Bond Counsel to the effect that the proposed amendment will not adversely affect the excludability of interest on the Series 2011 Bonds from gross income for federal income tax purposes and is authorized by the 2011 Bond Indenture, and without the consent of or notice to the Owners of Series 2011 Bonds, consent to any amendment, change or modification of the Loan Agreement as may be required (i) by the provisions of the Loan Agreement, (ii) for the purpose of curing any ambiguity or formal defect or omission in the Loan Agreement, (iii) to enter into an indenture or indentures supplemental to the 2011 Bond Indenture as described under "- Supplemental Indentures - Supplemental Indentures Not Requiring Consent of Owners of Bonds" above; (iv) to make any revisions required by Fitch, Moody's and/or S&P in order to obtain or maintain an investment grade rating on the Series 2011 Bonds, (v) in connection with any other change therein which is not to the prejudice of the Bond Trustee or the Owners of Series 2011 Bonds or (vi) to make revisions thereto which will be effective only upon, and in connection with, the remarketing of all of the Series 2011 Bonds then Outstanding.

Amendments to Loan Agreement Requiring Consent of Owners of Bonds. Except for amendments, changes or modifications as described in the immediately preceding paragraph, neither the Issuer nor the Bond Trustee may consent to any other amendment, change or modification of the Loan Agreement without mailing of notice and the written approval or consent of the Owners of a majority in aggregate principal amount of the Outstanding Series 2011 Bonds, provided that the consent of the Owners of all Series 2011 Bonds Outstanding is required for any amendment, change or modification of the Loan Agreement that would permit the termination or cancellation of the Loan Agreement or a reduction in or postponement of the payments under the Loan Agreement or any change in the provisions relating to payment thereunder. If at any time the Issuer and the Corporation request the consent of the Bond Trustee to any such proposed amendment, change or modification of the Loan Agreement, the Bond Trustee, upon being satisfactorily indemnified with respect to expenses, will cause notice of such proposed amendment, change or modification to be given as provided in the 2011 Bond Indenture; provided that prior to the delivery of such notice or request, the Bond Trustee and the Issuer may require that an opinion of Bond Counsel be furnished to the effect that such amendment, change or modification complies with the provisions of the 2011 Bond Indenture and will not adversely affect the excludability of interest on the Series 2011 Bonds from gross income for federal income tax purposes.

The Bond Trustee will not be obligated to sign any amendment or supplement to the Loan Agreement if such amendment or supplement, in the judgment of the Bond Trustee, might adversely affect the rights, duties, liabilities, protections, indemnities or immunities of the Bond Trustee. In signing any such amendment or supplement, the Bond Trustee will be entitled to receive, and will be fully protected in conclusively relying upon, an opinion of Bond Counsel stating that such amendment or supplement is authorized by the 2011 Bond Indenture and will not impair the exclusion of the interest on any Series 2011 Bonds from the gross income of the Owners thereof for federal income tax purposes.

Payments Due on Saturdays, Sundays and Holidays

In any case where the date of maturity of interest on or principal of the Series 2011 Bonds or the date fixed for purchase or redemption of any Series 2011 Bonds is not be Business Day, then payment of principal, premium, if any, or interest need not be made on such date but may be made on the next Business Day with the same force and effect as if made on the date of maturity or the date fixed for purchase or redemption.

No Personal Liability

Notwithstanding anything to the contrary contained in the 2011 Bond Indenture or in any of the Series 2011 Bonds or the Loan Agreement, or in any other instrument or document executed by or on behalf of the Issuer in connection therewith, no stipulation, covenant, agreement or obligation contained therein may be deemed or construed to be a stipulation, covenant, agreement or obligation of any present or future member, commissioner, director, trustee, officer, employee or agent of the Issuer, or of any incorporator, member, commissioner, director,

trustee, officer, employee or agent of any successor to the Issuer, in any such person's individual capacity, and no such person, in his individual capacity, will be liable personally for any breach or non observance of or for any failure to perform, fulfill or comply with any such stipulations, covenants, agreements or obligations, nor may any recourse be had for the payment of the principal of, premium, if any, or interest on any of the Series 2011 Bonds or for any claim based thereon or on any such stipulation, covenant, agreement or obligation, against any such person, in his individual capacity, either directly or through the Issuer or any successor to the Issuer, under any rule of law or equity, statute or constitution or by the enforcement of any assessment or penalty or otherwise, and all such liability of any such person, in his individual capacity, has been expressly waived and released in the 2011 Bond Indenture.

SUMMARY OF CERTAIN PROVISIONS OF THE LOAN AGREEMENT

The following is a summary of certain provisions of the Loan Agreement between the Corporation and the Issuer, to which reference is made for a full and complete statement of its provisions.

Loan of Series 2011 Bond Proceeds

Pursuant to the Loan Agreement, the Issuer will lend the proceeds from the sale of the Series 2011 Bonds to the Corporation. The Series 2011 Obligation will be delivered to the Issuer and assigned to the Bond Trustee to evidence such loan and the obligation of the Obligated Group to repay the same. The Series 2011 Obligation will be issued in a principal amount equal to the aggregate principal amount of the Series 2011 Bonds, and will provide for payment of principal, premium, if any, and interest thereon, sufficient to permit the Issuer to make payments of principal, premium, if any, and interest on the Series 2011 Bonds.

Payment of Series 2011 Bonds

The Corporation has agreed that the principal of, premium, if any, and interest on the Series 2011 Bonds will be payable in accordance with the provisions of the 2011 Bond Indenture and the Loan Agreement. The Corporation has further agreed that the Loan Agreement, the Series 2011 Obligation and any additional Obligation delivered to the Issuer to evidence loans made by the Issuer pursuant to the Loan Agreement from the proceeds of Additional Bonds and payments to be made thereunder and thereon (excluding Reserved Rights) will be assigned and pledged to the Bond Trustee to secure the payment of the Series 2011 Bonds. The foregoing notwithstanding, the Corporation has agreed that the moneys and securities, if any, on deposit in the Rebate Fund created under the 2011 Bond Indenture are not part of the Trust Estate and are not available to make payments of principal and interest on the Series 2011 Bonds.

Obligation Payments; Fund Deposits; Prepayments And Other Payments

Payment of Principal, Premium, if any, and Interest. The Corporation has covenanted that it will duly and punctually pay the principal of, premium, if any, and interest on the Series 2011 Bonds at the dates and the places and in the manner mentioned in the Series 2011 Bonds according to the true intent and meaning thereof.

Payments in Respect of the Series 2011 Obligation. The Corporation has covenanted and agreed to make the following payments in respect of the Series 2011 Obligation directly to the Bond Trustee for application under the 2011 Bond Indenture on the following dates:

- (a) Interest: On or prior to each Interest Payment Date for the Series 2011 Bonds, an amount which is not less than the interest to become due on the next Interest Payment Date of the Series 2011 Bonds; provided that the Corporation will be entitled to certain credits on such payments as permitted by the Loan Agreement and described under "- Credits on Obligation" below.

(b) Principal: On or prior to each date on which principal of the Series 2011 Bonds is due and payable, an amount which is not less than the next installment of principal coming due on the Series 2011 Bonds by maturity or mandatory sinking fund redemption; provided that the Corporation will be entitled to certain credits on such payments as permitted by the Loan Agreement and described under "- Credits on Obligation" below.

Credits on Obligation. Notwithstanding any provision contained in the Loan Agreement or in the 2011 Bond Indenture to the contrary, in addition to any credits on the Series 2011 Obligation or any additional Obligation pledged under the 2011 Bond Indenture resulting from the payment or prepayment thereof from other sources:

(a) any moneys deposited by the Bond Trustee or the Corporation in the Bond Fund maintained under the 2011 Bond Indenture will be credited against the obligation of the Corporation to pay the principal of and interest on the Obligation pledged under the 2011 Bond Indenture as the same become due and in the order of maturity to the same extent as payments are applied upon the principal of and interest on, respectively, the Series 2011 Bonds through the Bond Fund; and

(b) the principal amount of Series 2011 Bonds of any series and maturity purchased by the Corporation and delivered to the Bond Trustee, or purchased by the Bond Trustee and cancelled, will be credited against the obligation of the Corporation to pay the principal of the Obligation (including installment payments corresponding to mandatory sinking fund payments on such Series 2011 Bonds) related to such series of Series 2011 Bonds so purchased; provided that deposit of a Series 2011 Bond of one maturity may not be credited against an Obligation which would be used, in the normal course, to retire a Series 2011 Bond of another maturity.

Additional Payments. The Corporation has agreed to pay directly all costs incurred by or on behalf of the Issuer or the Corporation in connection with or incident to the issuance and sale of the Series 2011 Bonds which exceed the amount on deposit in the Costs of Issuance Fund established under the 2011 Bond Indenture. The Corporation has also agreed to pay the following items to the following persons as additional payments under the Loan Agreement:

(a) To the Bond Trustee, within 30 days of receipt of written demand therefor, all reasonable fees and expenses of the Bond Trustee for services rendered under the 2011 Bond Indenture and all reasonable fees and charges of any Paying Agent, registrars, counsel, accountants, consultants, engineers and other persons incurred in the performance of services under the 2011 Bond Indenture, on request of the Bond Trustee for which the Bond Trustee and such other persons are entitled to payment or reimbursement;

(b) To the Issuer, upon demand, all fees and expenses incurred by the Issuer in relation to the Series 2011 Obligation pledged under the 2011 Bond Indenture or the Series 2011 Bonds which are not otherwise required to be paid by the Corporation under the terms of the Loan Agreement, and all fees, expenses, taxes and assessments of the Issuer as provided for under the Act; and

(c) To the Master Trustee or the Bond Trustee, as the case may be, the amount of all advances of funds made by either of them under the provisions of the Master Indenture or the 2011 Bond Indenture, with interest thereon from the date of each such advance at the lesser of (i) Master Trustee's or Bond Trustee's (or the Bond Trustee's affiliated bank's), as the case may be, announced prime rate per annum from time to time in effect or (ii) the highest amount then allowed by law.

(d) If the Corporation fails to make any of the payments required by the Loan Agreement as described herein, the item or installment so in default will continue as an obligation of the Corporation until the amount in default has been fully paid, and the Corporation has agreed to pay the same with interest thereon, to the extent permitted by law, from the date when such payment was due, at the rate of interest borne by the Series 2011 Bonds.

Obligation of Corporation Unconditional. The obligations of the Corporation to make the payments described above and to perform and observe the other agreements contained in the Loan Agreement are absolute and

unconditional will not be subject to any defense or any right of setoff, counterclaim or recoupment arising out of any breach by the Issuer or the Bond Trustee of any obligation to the Corporation, whether under the Loan Agreement or otherwise, or out of any indebtedness or liability at any time owing to the Corporation by the Issuer or the Bond Trustee, and, until such time as the principal of, premium, if any, and interest on the Series 2011 Bonds have been fully paid or provision for the payment thereof has been made in accordance with the 2011 Bond Indenture, the Corporation has agreed that it (i) will not suspend or discontinue any payments provided for in the Loan Agreement as described above, (ii) will perform and observe all other agreements contained in the Loan Agreement and (iii) except as otherwise provided in the Loan Agreement, will not terminate the Term of Agreement for any cause, including, without limiting the generality of the foregoing, any change in the tax or other laws of the United States of America or of the State or any political subdivision of either thereof or any failure of the Issuer or the Bond Trustee to perform and observe any agreement, whether express or implied, or any duty, liability or obligation arising out of or connected with the Loan Agreement. Nothing contained in the Loan Agreement as herein described will be construed to release the Issuer from the performance of any of the agreements on its part contained in the Loan Agreement, and if the Issuer or the Bond Trustee fails to perform any such agreement on its part, the Corporation may institute such action against the Issuer or the Bond Trustee as the Corporation deems necessary to compel performance so long as such action does not abrogate the obligations of the Corporation described in the first sentence of this paragraph.

Prepayment and Redemption

Prepayment Generally. The Corporation will have the option to prepay its obligations under the Loan Agreement at the times and in the amounts as necessary to exercise its option to prepay to cause the Series 2011 Bonds to be redeemed as set forth in the 2011 Bond Indenture and in the Series 2011 Bonds. If such prepayment is made, the Issuer agrees to accept prepayment of the Series 2011 Obligation pledged under the 2011 Bond Indenture to the extent required to provide for a permitted prepayment or redemption of the Series 2011 Bonds. No other prepayment of the Series 2011 Obligation pledged under the 2011 Bond Indenture will be permitted.

Amortization Schedules. On the date of any partial prepayment of any Obligation pledged under the 2011 Bond Indenture, the Corporation, upon consultation with the Bond Trustee, will deliver to the Issuer two copies of an amortization schedule with respect to the Series 2011 Obligation then outstanding setting forth the amount of the installments to be paid on the Series 2011 Obligation after the date of such partial prepayment and the unpaid principal balance of the Series 2011 Obligation after payment of each such installment.

Covenants Relating to Use and Operation of Corporation's Property

Use of the Corporation's Property. The Corporation will use its health care Facilities primarily as and for a general hospital and related activities and only in furtherance of the lawful corporate purposes of the Corporation.

The Corporation has agreed that it will not permit any of the Property for which it or the Issuer is or was reimbursed or which is or has been acquired, constructed or equipped, in whole or in part, out of (a) the loan of proceeds of the Series 2011 Bonds or (b) the proceeds of any loan refinanced or for the refinancing of which the Corporation or the Issuer is or has been reimbursed, in whole or in part, whether directly or indirectly, from the proceeds of the Series 2011 Bonds, to be used (i) by any Person in an Unrelated Trade or Business of the Corporation, or (ii) by any Person who is not a Tax-Exempt Organization, in either case in such manner or to such extent as would result in the loss of tax exemption of interest on the Series 2011 Bonds or the Series 2011 Bonds or any other such tax-exempt bonds otherwise afforded under Section 103(a) of the Code.

The Corporation has further agreed that it will not use or permit to be used any of the Property for which it is reimbursed or which is acquired, constructed or equipped, in whole or in part, out of (a) the loan of proceeds of the Prior Bonds or (b) the proceeds of any loans refinanced or for the refinancing of which the Corporation is reimbursed, in whole or in part, whether directly or indirectly, from the proceeds of the Series 2011 Bonds (i) primarily for sectarian instruction or study or as a place of devotional activities or religious worship or as a facility used primarily in connection with any part of the program of a school or department of divinity for any

religious denomination or the training of ministers, priests, rabbis or other similar persons in the field of religion, or (ii) in a manner which is prohibited by the Establishment of Religion Clause of the First Amendment to the Constitution of the United States of America and the decisions of the United States Supreme Court interpreting the same or by any comparable provisions of the Constitution of the State and the decisions in the Supreme Court of the State interpreting the same.

The Corporation will permit the Issuer and the Bond Trustee to make inspections of any of its Property to determine compliance with the provisions of the Loan Agreement described in the two preceding paragraphs. The provisions of the Loan Agreement described in this paragraph and the immediately preceding paragraph will remain in full force and effect notwithstanding the payment of the Series 2011 Bonds and the Series 2011 Obligation and the termination of the 2011 Bond Indenture and the Loan Agreement.

Rates and Charges. The Corporation has covenanted and agreed to operate its existing health care Facilities primarily as a revenue producing hospital or as facilities related thereto, and to operate all its Property on a nondiscriminatory basis, to charge such fees and rates for its Facilities and services and to exercise such skill and diligence as to provide income from its Property together with other available funds sufficient to pay promptly all expenses of operation, maintenance and repair of its Property, all amounts owing under the 2011 Bond Indenture and all other payments required to be made by the Corporation under the Loan Agreement to the extent permitted by law. The Corporation has further covenanted and agreed that it will, from time to time as often as necessary, to the extent permitted by law, revise its rates, fees and charges in such manner as may be necessary or proper to comply with the provisions of the Loan Agreement described herein. The provisions of the Loan Agreement described in this paragraph may not be construed to prohibit the Corporation from serving indigent patients to the extent required for it to continue its qualification as a Tax-Exempt Organization or from serving any other class or classes of patients without charge at or reduced rates so long as such service does not prevent the Corporation from satisfying the other requirements of the Loan Agreement described herein.

Particular Corporation Covenants

Maintenance of Corporate Existence and Status. The Corporation has agreed that, except as permitted by the Master Indenture, it will at all times maintain its existence as a Tennessee nonprofit corporation and that it will neither take any action nor suffer any action to be taken by others which will alter, change or destroy its status as a nonprofit corporation or its status as a Tax-Exempt Organization. The Corporation has further covenanted and agreed that, as long as any Series 2011 Bonds remain Outstanding, it or any successor thereto into which it is merged or consolidated under the terms of the Master Indenture will remain a member of the Obligated Group. The Corporation has further agreed that it will not act or fail to act in any other manner which would adversely affect the exemptions from federal income tax of the interest earned by the owners of the Series 2011 Bonds to which such Series 2011 Bonds would otherwise be entitled.

Maintenance; Recording. The Corporation will, at its expense, take all necessary action to maintain and preserve the Loan Agreement so long as the Series 2011 Obligation or any additional Obligation pledged under the 2011 Bond Indenture is Outstanding. The Corporation will, forthwith after the execution and delivery of the Loan Agreement and thereafter from time to time, cause the Loan Agreement and all documents securing the Loan Agreement or any document securing the Series 2011 Obligation pledged under the 2011 Bond Indenture (including any amendments and supplements thereof) and any financing statements in respect thereof to be filed, registered and recorded in such manner and in such places as may be required by law in order to publish notice thereof and fully to perfect and protect the lien of the 2011 Bond Indenture upon the trust estate referred to therein or any part thereof and, from time to time, will perform or cause to be performed any other act as provided by law and will execute or cause to be executed any and all continuation statements and further instruments that may be requested by the Issuer or the Bond Trustee for such publication, perfection and protection. The Corporation will provide copies to the Bond Trustee of any such filings or registrations. Except to the extent it is exempt therefrom, the Corporation will pay or cause to be paid all filing and registration and recording fees incident to such filing and registration and recording, and all expenses incident to the preparation, execution and acknowledgment of such instruments of further assurance and all federal or state fees and other similar fees, duties, imposts, assessments and charges arising out of or in connection with the execution and delivery of the Loan Agreement, the Series 2011 Obligation and such instruments of further assurance.

Financial Statements. The Corporation has covenanted that it will keep proper books of records and accounts in which full, true and correct entries will be made of all dealings or transactions of, or in relation to, the business and affairs of the Corporation in accordance with generally accepted principles of accounting consistently applied and will furnish the materials and notice required to be delivered to the Master Trustee pursuant to the Master Indenture. In addition, the Corporation covenants that it will prepare unaudited consolidated financial statements, including balance sheets, income statements and cash flow for the three-month periods ending September 30, December 31 and March 31 of each year and will file the same with the Municipal Securities Rulemaking Board's Electronic Municipal Market Access system within 45 days following the end of each such three-month period.

Indemnity. The Corporation has agreed that it will pay, protect, indemnify and save the Issuer and the Bond Trustee harmless from and against any and all liabilities, losses, damages, costs and expenses (including reasonable attorneys' fees, costs and expenses of the Issuer and the Bond Trustee), causes of action, suits, claims, demands and judgments of whatsoever kind and nature (including those arising or resulting from any injury to or death of any person or damage to property) arising from or in any manner directly or indirectly growing out of or connected with the following:

- (a) the use, non-use, condition or occupancy of any of the Corporation's Property, any repairs, construction, alterations, renovation, relocation, remodeling and equipping thereof or thereto or the condition of any of such Property including adjoining sidewalks, streets or alleys and any equipment or Facilities at any time located on such Property or used in connection therewith but which are not the result of the negligence of the Issuer or the Bond Trustee;
- (b) violation of any agreement, warranty, covenant or condition of the Loan Agreement, except by the Issuer;
- (c) violation of any contract, agreement, or restriction by the Corporation relating to its Property;
- (d) violation of any law, ordinance, regulation or court order affecting any of the Corporation's Property or the ownership, occupancy or use thereof;
- (e) any statement or information concerning the Corporation or any other Obligated Issuer, any of its or their officers and members or its or their Property, contained in any official statement furnished to the Issuer or the purchaser of any Series 2011 Bonds, that is untrue or incorrect in any material respect, and any omission from such official statement of any statement or information which should be contained therein for the purpose for which the same is to be used or which is necessary to make the statements therein concerning the Corporation or any other Obligated Issuer, any of its or their officers and members and its or their Property not misleading in any material respect, provided that such official statement has been approved by the Corporation or the Obligated Group Agent and the indemnified party did not have knowledge of the omission or misstatement or did not use such official statement with reckless disregard of or gross negligence in regard to the accuracy or completeness of such official statement; and
- (f) the performance by the Bond Trustee of its duties under the 2011 Bond Indenture, but only to the extent that the Bond Trustee is not negligent in such performance.

For purposes of the provisions of the Loan Agreement described under "- Indemnity," Property will be deemed to include property otherwise excluded from the definition of "Property" as described in subparagraph (j) "Summary of Certain Provisions of the Master Indenture - Disposition of Property" above.

Such indemnity will extend to each person, if any, who "controls" the Issuer or the Bond Trustee, as the case may be, as that term is defined in Section 15 of the Securities Act of 1933, as amended, and to any officer, director or employee of the Issuer or the Bond Trustee.

In the event of settlement of any litigation commenced or threatened, such indemnity will be limited to the aggregate amount paid under a settlement effected with the written consent of the Corporation or the Obligated Group Agent.

The Issuer and the Bond Trustee will promptly notify the Corporation and the Obligated Group Agent in writing of any claim or action brought against the Issuer, the Bond Trustee or any controlling person, as the case may be, in respect of which indemnity may be sought against the Corporation, setting forth the particulars of such claim or action, and the Corporation will assume the defense thereof, including the employment of counsel satisfactory to the Issuer, the Bond Trustee or such controlling person, as the case may be, and the payment of all reasonable expenses. The Issuer, the Bond Trustee or any such controlling person, as the case may be, may employ separate counsel in any such action and participate in the defense thereof, but the fees and expenses of such counsel will not be payable by the Corporation unless such employment has been specifically authorized in writing by the Corporation.

All amounts payable to or with respect to the Issuer as herein described will be deemed to be fees and expenses of the Issuer for the purposes of the provisions of the Loan Agreement and of the 2011 Bond Indenture dealing with assignment of the Issuer's rights under the loan Agreement. The indemnification provided in the Loan Agreement shall survive the termination of the Loan Agreement, the payment in full of the Series 2011 Bonds or the sooner resignation or removal of the Bond Trustee and shall inure to the benefit of the Bond Trustee's successor and assigns.

Accreditation and Licensure. The Corporation has warranted that its hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations and that its health care Facilities have all state and local licenses required for the operation thereof. The Corporation has covenanted that it will obtain and maintain all such licenses required for its operations and the operation of its health care Facilities and will use its best efforts to obtain and maintain such accreditation, so long as it is in the best interests of the Corporation and the Bondholders.

Government Grants. The Corporation has covenanted to comply with all of the terms and provisions of any government grants it receives, including those made by the State and the federal government, and the laws and regulations under which they are made.

Transfer of Assets. The Corporation has covenanted and agreed that it will not sell, lease or otherwise dispose of any of its Property except as permitted by the Master Indenture. The provisions of the Master Indenture notwithstanding, the Corporation has further covenanted and agreed that it will not sell, lease or otherwise dispose (including without limitation any involuntary disposition) of in excess of 2% in the aggregate of the Property financed or refinanced with the proceeds of the Series 2011 Bonds (which percentage will be reduced to the extent Property financed or refinanced with the proceeds of the Series 2011 Bonds is being used in an Unrelated Trade or Business of the Corporation) unless (a) prior to such sale, lease or other disposition the Corporation delivers to the Bond Trustee and the Issuer a written Opinion of Bond Counsel (which counsel and opinion are acceptable to the Bond Trustee) to the effect that any such disposition will not adversely affect the validity of the Series 2011 Bonds or the exemption from federal income taxation of the interest paid on the Series 2011 Bonds or any other such tax-exempt bonds under Section 103(a) of the Code, or (b) prior to such sale, lease or other disposition there is delivered to the Bond Trustee an Officer's Certificate of the Corporation stating that, in the judgment of such officer, such Property has become inadequate, obsolete or worn out and that any amounts received by the Corporation upon such disposition must be applied by the Corporation to acquire additional Property constituting a "project" under the Act. The Corporation has agreed to apply the proceeds of any disposition referred to in a certificate of the type described in clause (b) above as described in such clause and has agreed that any property acquired with such proceeds will be deemed to be Property financed or refinanced with the proceeds of the Series 2011 Bonds for the purposes of applying the provisions of the Loan Agreement. The amount of Property disposed of will be calculated in accordance with the provisions of the Master Indenture.

The provisions of the Master Indenture notwithstanding, the Corporation has further covenanted and agreed that it will not sell, lease or otherwise dispose (including without limitation any involuntary disposition) of any Property pursuant to the provisions of the Master Indenture described in subparagraph (c) under "Summary of Certain Provisions of the Master Indenture - Disposition of Property" above unless, prior to the sale, lease or other disposition, the Corporation delivers to the Master Trustee and the Bond Trustee an Officer's Certificate certifying

that Property so transferred in the then-current Fiscal Year by all Obligated Issuers and Restricted Affiliates does not exceed the lesser of (i) 10% of the Value of all Property of the Combined Group for the immediately preceding Fiscal Year or (ii) 5% of the aggregate of "gross patient revenues" of each member of the Combined Group for the immediately preceding Fiscal Year.

The provisions of the Master Indenture notwithstanding, the Corporation has further covenanted and agreed that it will not sell, lease or otherwise dispose (including without limitation any involuntary disposition) of any Property pursuant to the provisions of the Master Indenture described under "Summary of Certain Provisions of the Master Indenture - Disposition of Property" above unless, prior to the sale, lease or other disposition, the Corporation delivers to the Master Trustee and the Bond Trustee an Officer's Certificate certifying that, after such sale, lease or other disposition, the Corporation will have Unrestricted Cash and Investments in an amount equal to at least 100 Days of Operating Expenses, calculated as of the end of the most recently audited fiscal year and as if the sale, lease or other disposition had occurred at the beginning of such fiscal year. For purposes of this paragraph, "Unrestricted Cash and Investments" means the sum of cash, cash equivalents and unrestricted/unencumbered long term marketable or liquid investments less trustee held funds, reserves, deposits or set asides including debt service funds, construction funds, reserve funds, malpractice funds, litigation reserves, self insurance or captive insurer funds, and pension or retirement funds, adjusted to exclude any short term indebtedness, and "100 Days of Operating Expenses" means operating expenses minus depreciation and amortization expense for the applicable fiscal year divided by 365 or 366, as appropriate, then multiplied by 100.

Maintenance of Status as a Member of the Obligated Group. The Corporation has covenanted and agreed that as long as any Series 2011 Bonds remain Outstanding, it will remain a member of the Obligated Group.

Defaults and Remedies

Defaults Defined. The following are "Defaults" under the Loan Agreement and the term "Default" means, whenever it is used in the Loan Agreement, any one or more of the following events:

(a) Failure by the Corporation to pay any amount required to be paid as described under "- Obligation Payments; Fund Deposits; Prepayments and Other Payments - Payments in Respect of the Series 2011 Obligation."

(b) Failure by the Corporation to observe and perform any covenant, condition or agreement on its part to be observed or performed, other than as described in subparagraph (a) above, for a period of 30 days after written notice specifying such failure and requesting that it be remedied has been given to the Corporation by the Issuer or the Bond Trustee, unless the Issuer and the Bond Trustee agree in writing to an extension of such time prior to its expiration; provided that if the failure stated in the notice cannot be corrected within the applicable period, the Issuer and the Bond Trustee will not unreasonably withhold their consent to an extension of such time if corrective action is instituted by the Corporation within the applicable period and diligently pursued until such failure is corrected.

(c) The dissolution or liquidation of the Corporation, except as authorized by the Loan Agreement or the Master Indenture, or the voluntary initiation by the Corporation of any proceeding under any federal or state law relating to bankruptcy, insolvency, arrangement, reorganization, readjustment of debt or any other form of debtor relief, or the initiation against the Corporation of any such proceeding which remain undismissed for 60 days, or failure by the Corporation to promptly have discharged any execution, garnishment or attachment of such consequence as would impair the ability of the Corporation to carry on its operations at the Facilities, or assignment by the Corporation for the benefit of creditors, or the entry by the Corporation into an agreement of composition with its creditors or the failure generally by the Corporation to pay its debts as they become due.

(d) The occurrence of a Default under the 2011 Bond Indenture.

The provisions of the Loan Agreement described in subparagraph (b) above are subject to the following limitation: if by reason of force majeure the Corporation is unable in whole or in part to carry out any of its agreements contained herein (other than its obligations as described under "- Obligation Payments; Fund Deposits; Prepayments And Other Payments" above), the Corporation will not be deemed in Default during the continuance of such inability. The term "force majeure" as used herein means, without limitation, the following: acts of God; strikes or other industrial disturbances; acts of public enemies; orders or restraints of any kind of the government of the United States of America, or of the State or of any of their departments, agencies or officials, or of any civil or military authority; insurrections; riots; landslides; earthquakes; fires; storms; droughts; floods; explosions; breakage or accident to machinery, transmission pipes or canals; and any other cause or event not reasonably within the control of the Corporation. The Corporation has agreed, however, to remedy with all reasonable dispatch the cause or causes preventing the Corporation from carrying out its agreement, provided that the settlement of strikes and other industrial disturbances will be entirely within the discretion of the Corporation and the Corporation will not be required to settle strikes, lockouts and other industrial disturbances by acceding to the demands of the opposing party or parties when such course is in the judgment of the Corporation unfavorable to the Corporation.

Remedies on Default. Whenever any Default described under "- Defaults Defined" above has happened and is continuing, the Bond Trustee, or the Issuer with the written consent of the Bond Trustee, may take one or any combination of the following remedial steps:

(a) If the Bond Trustee has declared the Series 2011 Bonds immediately due and payable pursuant to the acceleration provisions of the 2011 Bond Indenture, by written notice to the Corporation, declare an amount equal to all amounts then due and payable on the Series 2011 Bonds, whether by acceleration of maturity (as provided in the 2011 Bond Indenture) or otherwise, to be immediately due and payable as liquidated damages under the Loan Agreement and not as a penalty, whereupon the same will become immediately due and payable;

(b) Have reasonable access to and inspect, examine and make copies of the books and records and any and all accounts, data and income tax and other tax returns of the Corporation during regular business hours of the Corporation if reasonably necessary in the opinion of the Bond Trustee; or

(c) Take whatever action at law or in equity may appear necessary or desirable to collect the amounts then due and thereafter to become due, or to enforce performance and observance of any obligation, agreement or covenant of the Corporation under the Loan Agreement.

Any amounts collected pursuant to action taken as herein described will be paid into the Bond Fund and applied in accordance with the provisions of the 2011 Bond Indenture.

No Remedy Exclusive. Subject to the acceleration provisions of the 2011 Bond Indenture, no remedy in the Loan Agreement conferred upon or reserved to the Issuer or the Bond Trustee is intended to be exclusive of any other available remedy or remedies, but each and every such remedy will be cumulative and be in addition to every other remedy given under the Loan Agreement or now or hereafter existing at law or in equity. No delay or omission to exercise any right or power accruing upon any Default will impair any such right or power or be construed to be a waiver thereof, but any such right or power may be exercised from time to time and as often as may be deemed expedient. In order to entitle the Issuer or the Bond Trustee to exercise any remedy reserved to it as described herein, it will not be necessary to give any notice other than such notice as may be required by the Loan Agreement. Such rights and remedies as are given the Issuer under the Loan Agreement will also extend to the Bond Trustee, and the Bond Trustee and the Owners of the Series 2011 Bonds, subject to the provisions of the 2011 Bond Indenture, will be entitled to the benefit of all covenants and agreements contained in the Loan Agreement.

Agreement to Pay Attorneys' Fees, Costs and Expenses. If the Corporation defaults under any of the provisions of the Loan Agreement and the Issuer or the Bond Trustee employs attorneys or incurs other costs or expenses for the collection of payments required thereunder or the enforcement of performance or observance of any obligation or agreement on the part of the Corporation contained therein, the Corporation has agreed that it will on demand therefor pay to the Issuer or the Bond Trustee, as applicable, the reasonable fees, costs and expenses of such attorneys and such other costs or expenses so incurred by the Issuer or the Bond Trustee, as applicable.

No Additional Waiver Implied by One Waiver. If any agreement contained in the Loan Agreement is breached by either party and thereafter waived by the other party, such waiver will be limited to the particular breach so waived and may not be deemed to waive any other breach thereunder.

Term of Agreement

The Loan Agreement will remain in full force and effect from its date to and including September 1, 2032 or until such time as all of the Series 2011 Bonds and the fees and expenses of the Issuer and the Bond Trustee have been fully paid or provision made for such payments, whichever is later; provided that the Loan Agreement may be terminated prior to such date as provided in the Loan Agreement, but in no event before all of the obligations and duties of the Corporation thereunder have been fully performed, including, without limitation, the payments of all costs and fees mandated thereunder.

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APPENDIX D.

FORM OF APPROVING OPINION OF BOND COUNSEL

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May __, 2011

The Health, Educational and Housing Facilities Board
of the County of Sullivan, Tennessee
Sullivan, Tennessee

\$76,165,000
The Health, Educational and Housing Facilities Board
of the County of Sullivan, Tennessee
Hospital Revenue Refunding Bonds
(Wellmont Health System Project)
Series 2011

Ladies and Gentlemen:

We have served as Bond Counsel in connection with the issuance by The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee (the "Board") of the Board's \$76,165,000 Hospital Revenue Refunding Bonds (Wellmont Health System Project), Series 2011 (the "Bonds"). The Bonds have been issued pursuant to the terms of a Bond Trust Indenture dated as of May 1, 2011 (the "Indenture"), between the Board and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Trustee"). Unless otherwise defined, each capitalized term used in this opinion shall have the meaning given it in Article I of the Indenture.

The proceeds of the Bonds are to be loaned by the Board to Wellmont Health System (the "Borrower") pursuant to the terms of a Loan Agreement dated as of May 1, 2011 (the "Loan Agreement"), between the Board and the Borrower.

The Bonds will be dated their date of delivery. The Bonds are payable solely from the revenues, receipts and payments pledged pursuant to the Indenture. We refer you to the Bonds, the Indenture and the Loan Agreement for a description of the purposes for which the Bonds are issued and the security for them.

We have examined the Constitution of the State of Tennessee (the "State") and the laws of both the United States and the State, including, without limitation, the Internal Revenue Code of 1986, as amended (the "Code"), and the Act, and such certified proceedings and other documents of the Board as we deem necessary to render this opinion, including the resolution adopted by the Board on April 14, 2011 authorizing the issuance of the Bonds.

As to questions of fact material to our opinion, we have relied upon (a) representations of and compliance with covenants by the Borrower and the Board contained in the Indenture, the Loan Agreement and the Tax Compliance Agreement, (b) certificates of public officials furnished to us, (c) computations provided by Merrill Lynch, Pierce, Fenner & Smith Incorporated (the "Underwriter"), relating to the yield on the Bonds, and (d) certificates of representatives of the Borrower, the Board, the Trustee and other parties, including, without limitation, representations, covenants and certifications as to the use of the proceeds of the Bonds and the property financed or refinanced thereby, compliance with the arbitrage yield restriction and rebate requirements, the average reasonably expected economic life of the property being financed with the Bonds and other factual matters which are relevant to the opinions expressed in paragraph 5, in each case without undertaking any independent verification. We have assumed that all signatures on documents, certificates and instruments examined by us are genuine, all documents, certificates and instruments submitted to us as originals are authentic and all documents, certificates and instruments submitted to us as copies conform to the originals. In addition, we have assumed that all documents, certificates and instruments relating to this financing have been duly authorized, executed and delivered by all of their parties other than the Board, and we have further assumed the due organization, existence and powers of such other parties other than the Board.

Reference is made to the opinion, of even date hereof, of Hunter, Smith & Davis, LLP as counsel to the Borrower, with respect to the organization of the Borrower, the status of the Borrower as an organization described in Section 501(c)(3) of the Code, the power of the Borrower to enter into and perform its obligations under the Corporation Documents (as defined in the Loan Agreement), and other related documents to which the Borrower is a party, and the authorization, execution, delivery and enforceability of the Corporation Documents and the other documents by and against the Borrower.

Based on the foregoing, we are of the opinion that, under current law:

1. The Bonds have been duly authorized and issued in accordance with the Act and the Indenture and, subject to paragraph 4 below, constitute valid, binding and enforceable limited obligations of the Board, payable as to principal, premium, if any, and interest solely from the revenues, receipts and payments pledged to such purpose under the Indenture. The Bonds do not constitute a debt of the Board within the meaning of any constitutional or statutory limitation and is not in any respect a general obligation of the Board nor are the Bonds payable in any manner by taxation.

2. The Indenture and the Loan Agreement have been duly authorized, executed and delivered by the Board and, subject to paragraph 4 below, constitute valid and binding agreements of the Board, enforceable against the Board in accordance with their terms.

3. The Board's right, title and interest in the Loan Agreement (except for Authority's rights to payment of costs and expenses, indemnification and exemption from liability thereunder and Authority's right to receive notices) and in Series 2011 Obligation have been assigned to the

Trustee and, subject to paragraph 4 below, such assignment constitutes a valid and binding assignment by the Board, enforceable against the Board in accordance with its terms.

4. The enforceability of the obligations of the parties under the Bonds, the Indenture and the Loan Agreement and the Board's assignment of the Loan Agreement and the Series 2011 Obligation to the Trustee, is subject to the provisions of applicable bankruptcy, insolvency, reorganization, moratorium and similar laws, now or hereafter in effect, relating to or affecting the enforcement of creditors' rights. The enforceability of such obligations is also subject to usual equitable principles, which may limit the specific enforcement of certain remedies but which do not affect the validity of such documents. Certain indemnity provisions may be unenforceable pursuant to court decisions invalidating such indemnity agreements on grounds of public policy.

5. Interest on the Bonds is excludable from gross income for federal income tax purposes and is not a specific item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations. Further, for purposes of alternative minimum tax imposed on corporations (as defined for federal income tax purposes under Section 56 of the Code), interest on the Bonds must be included in the calculation of adjusted current earnings. We express no opinion regarding other federal tax consequences arising with respect to the Bonds.

In providing the opinions set forth in this paragraph, we are assuming continuing compliance with the Covenants (as hereinafter defined) by the Board and the Borrower. The Code and the regulations promulgated thereunder contain a number of requirements that must be satisfied after the issuance of the Bonds in order for interest on the Bonds to be and remain excludable from gross income for purposes of federal income taxation. These requirements include, by way of example and not limitation, the requirement that the Borrower maintain its status as an organization described in Section 501 (c)(3) of the Code, restrictions on the use, expenditure and investment of the proceeds of the Bonds and the use of the property financed or refinanced by the Bonds, limitations on the source of the payment of and the security for the Bonds, and the obligation to rebate certain excess earnings on the gross proceeds of the Bonds to the United States Treasury. The Indenture, the Loan Agreement and the Tax Compliance Agreement contain covenants (the "Covenants") under which the Board and the Borrower have agreed to comply with such requirements. Failure by the Board or the Borrower to comply with their respective Covenants could cause interest on the Bonds to become includable in gross income for federal income tax purposes retroactively to their date of issue. In the event of noncompliance with the Covenants, the available enforcement remedies may be limited by applicable provisions of law and, therefore, may not be adequate to prevent interest on the Bonds from becoming includable in gross income for federal income tax purposes. Compliance by the Board with its respective Covenants does not require the Board to make any financial contribution for which it does not receive funds from the Borrower.

This opinion speaks as of its date, is based on current legal authority and precedent, covers certain matters not directly addressed by such authority and precedent, and represents our judgment as to the proper treatment of interest on the Bonds for federal income tax purposes.

The Health, Educational and Housing Facilities Board
of the County of Sullivan, Tennessee
May __, 2011
Page 4

This opinion does not contain or provide any opinion or assurance regarding the future activities of the Board or the Borrower or about the effect of future changes in the Code, the applicable regulations, the interpretation thereof or the enforcement thereof by the Internal Revenue Service. The Board and the Borrower have covenanted, however, to comply with the requirements of the Code.

Certain requirements and procedures contained, incorporated or referred to in the Indenture, the Loan Agreement and the Tax Compliance Agreement, including the Covenants, may be changed and certain actions may be taken or omitted under the circumstances and subject to the terms and conditions set forth in such documents.

6. The Bonds and the interest thereon are exempt from all state, county and municipal taxation in the State, except for inheritance, transfer and estate taxes and except to the extent that the Bonds and the interest thereon are included within the measure of certain privilege and excise taxes imposed under State law. We express no opinion regarding (i) other State tax consequences arising with respect to the Bonds or (ii) any consequences arising with respect to the Bonds under the tax laws of any state or local jurisdiction other than the State. Prospective purchasers of the Bonds should consult its own tax advisors regarding state and local tax issues not covered by this opinion, including the tax status of interest on the Bonds in a particular state or local jurisdiction other than the State.

Our services as Bond Counsel to the Board have been limited to rendering the foregoing opinions based on our review of such legal proceedings and other documents as we deem necessary to approve the validity of the Bonds and tax-exempt status of the interest on them and the enforceability of the Indenture and the Loan Agreement. The foregoing opinions are in no respect an opinion as to the business or financial resources of the Board or the Borrower or the ability of the Board or the Borrower to provide for the payment of the Bonds or the accuracy or completeness of any information, including the Board's Preliminary Official Statement dated April 28, 2011, and Official Statement dated May 2, 2011, that anyone may have relied upon in making the decision to purchase the Bonds.

This opinion is given as of the date hereof, and we assume no obligation to revise or supplement this opinion to reflect any facts or circumstances that may hereafter come to our attention, or any changes in law that may hereafter occur.

Very truly yours,

APPENDIX E.

SUMMARY OF THE CONTINUING DISCLOSURE AGREEMENT

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SUMMARY OF THE CONTINUING DISCLOSURE AGREEMENT

The Continuing Disclosure Agreement will be entered into by the Corporation, Wellmont, Inc., Wellmont Foundation and Wellmont Hawkins County Memorial Hospital, Inc. The following is a summary of the proposed form of the Continuing Disclosure Agreement. It is expected that the executed Continuing Disclosure Agreement will conform to this summary in all material respects; however, in the event of conflict between the executed version of the Continuing Disclosure Agreement and this summary, the executed version will control.

This summary is being provided in the form of excerpts from the proposed Continuing Disclosure Agreement. Section references in these excerpts correspond to the sections of the proposed form of the Continuing Disclosure Agreement.

Excerpts from the proposed form of Continuing Disclosure Agreement:

Section 1. Definitions

Capitalized terms not otherwise defined in this Agreement shall have the meaning assigned in the Indenture. In addition, the terms set forth below shall have the meaning assigned unless the context clearly otherwise requires:

“**Bonds**” means the \$76,165,000 Hospital Revenue Refunding Bonds (Wellmont Health System Project), Series 2011, issued by the Issuer.

“**Corporation**” means Wellmont Health System, a Tennessee nonprofit corporation and a 501(c)(3) organization under the Internal Revenue Code.

“**EMMA**” means the MSRB’s Electronic Municipal Market Access System (EMMA) established pursuant to the Rule.

“**Indenture**” means the Bond Trust Indenture dated as of May 1, 2011 between the Issuer and the Trustee.

“**Issuer**” means The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, a Tennessee public corporation.

“**MSRB**” means the Municipal Securities Rulemaking Board.

“**Obligors**” means the Corporation and the other Obligors described in the opening paragraph of this Agreement.

“**Official Statement**” means the Official Statement dated May 2, 2011 with respect to the Bonds.

“**Rule**” means Rule 15c2-12 adopted by the Securities and Exchange Commission, as the same may be amended from time to time.

“**Trustee**” means The Bank of New York Mellon Trust Company, N.A., as trustee under the Indenture.

Section 2. Purpose and Beneficiaries of this Agreement

This Agreement is entered into by the Obligors for the benefit of the holders of the Bonds in order to assist the underwriter or underwriters for the Bonds in complying with the requirements of the Rule.

Section 3. Annual Financial Information

(a) Within 150 days after the end of each fiscal year, the Obligors shall file with the MSRB the following information:

(1) **Operating data.** Information about operating statistics for such fiscal year, and comparative information for the prior fiscal year, but not partial year information, substantially in the form included in APPENDIX A to the Official Statement under the following heading:

“FACILITIES—Historical Utilization”

(2) **Financial information.** Information about financial performance for such fiscal year, and comparative information for the prior fiscal year, but not partial year information, substantially in the form included in APPENDIX A to the Official Statement under the following headings:

“HISTORICAL FINANCIAL INFORMATION—Summary Financial Information”

“HISTORICAL FINANCIAL INFORMATION—Sources of Patient Service Revenue”

“HISTORICAL FINANCIAL INFORMATION—Estimated Days Cash on Hand”

“HISTORICAL FINANCIAL INFORMATION—Historical Annual Debt Service Coverage”

(b) The Obligors may omit or modify any part of the annual information required by this section if the operations to which it relates have been discontinued or materially changed. The Obligors will include an explanation to that effect as part of the annual information for the year in which such event first occurs.

(c) If any amendment is made to this Agreement, the annual information for the year in which such amendment is made shall contain a description of the reasons for such amendment and its impact on the type of information being provided.

Section 4. Audited Financial Statements

(a) Within 30 days after receipt by the Obligors, but in no event more than 150 days after the end of each fiscal year, the Obligors shall file with the MSRB audited financial statements of the Corporation and its affiliates. The audited financial statements shall be prepared on a basis consistent with the accounting principles and auditing standards used to prepare the financial statements attached as APPENDIX B to the Official Statement, as such standards may be modified from time to time under generally accepted accounting principles and auditing standards applicable to the Obligors.

(b) The Obligors operate acute care hospitals and related healthcare facilities that are part of a healthcare delivery system that is managed and supervised by the Corporation. The Corporation serves as the parent organization for the Obligors. The annual audited financial statements of the Corporation are consolidated statements that provide financial information with respect to the Corporation and its affiliates described in the audit report, including the other Obligors. The Obligors do not have audited financial statements prepared for the Obligors alone. The Obligors intend to comply with their continuing disclosure obligations under this Agreement by providing consolidated annual audited financial information for the Corporation and its affiliates that will include information about the Obligors substantially in the form included in APPENDIX B to the Official Statement.

Section 5. Quarterly Financial Information

(a) Within 45 days after the end of each of the first three quarters of the fiscal year, the Obligors shall file with the MSRB the following information:

(1) **Operating data.** Information about operating statistics for the period ending on the last day of such quarter, together with comparative information for the corresponding period of the prior fiscal

year, substantially in the form included in APPENDIX A to the Official Statement under the following heading:

“FACILITIES—Historical Utilization”

(2) **Financial information.** Information about financial performance for the period ending on the last day of such quarter, together with comparative information for the corresponding period of the prior fiscal year, substantially in the form included in APPENDIX A to the Official Statement under the following headings:

“HISTORICAL FINANCIAL INFORMATION—Summary Financial Information”

“HISTORICAL FINANCIAL INFORMATION—Sources of Patient Service Revenue”

“HISTORICAL FINANCIAL INFORMATION—Estimated Days Cash on Hand”

“HISTORICAL FINANCIAL INFORMATION—Historical Annual Debt Service Coverage”

(b) The Obligors may omit or modify any part of the quarterly information required by this section if the operations to which it relates have been discontinued or materially changed. The Obligors will include an explanation to that effect as part of the quarterly information for the quarter in which such event first occurs (or, if such event occurs in the last quarter of the fiscal year, as part of the annual financial information provided by Section 4).

Section 6. Event Disclosure

(a) In a timely manner not in excess of 10 business days after the occurrence of the event, the Obligors shall file with the MSRB notice of the occurrence of any of the following events affecting the Bonds:

- (1) principal and interest payment delinquencies;
- (2) non-payment related defaults, if material;
- (3) unscheduled draws on debt service reserves reflecting financial difficulties;
- (4) unscheduled draws on credit enhancements reflecting financial difficulties;
- (5) substitution of credit or liquidity providers, or their failure to perform;
- (6) adverse tax opinions, the issuance by the Internal Revenue Service of proposed or final determinations of taxability, Notice of Proposed Issue (IRS Form 5701-TEB), or other material notices or determinations with respect to the tax status of the Bonds, or other material events affecting the tax status of the Bonds;
- (7) modifications to rights of the holders of the Bonds, if material;
- (8) Bond calls, if material, and tender offers;
- (9) defeasances;
- (10) release, substitution or sale of property securing repayment of the Bonds, if material;
- (11) rating changes;
- (12) bankruptcy, insolvency, receivership or similar events affecting an Obligor;
- (13) the consummation of a merger, consolidation, or acquisition involving an Obligor or the sale of all or substantially all of the assets of an Obligor, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; and
- (14) appointment of a successor or additional trustee or the change of name of a trustee, if material.

(b) In a timely manner the Obligors shall file with the MSRB notice of failure to make a filing, on or before the date specified in this Agreement, of annual information required by Section 3 or Section 4 of this Agreement.

Section 7. Consequences of Failure to File

If the Obligors fail to comply with any provision of this Agreement, the holder of any Bond may seek mandamus or specific performance by court order, to cause the Obligors to comply with their obligations under this Agreement. A default under this Agreement shall not be deemed an event of default under the Indenture or any other financing document related to the issuance of the Bonds, including without limitation the Loan Agreement and the Master Indenture referred to in the Indenture. The sole remedy under this Agreement shall be an action to compel performance.

Section 8. Amendment

This Agreement may be amended by the Obligors if the amendment is required by, or consistent with, changes to, or interpretations of, the Rule made by governmental authority after the Bonds are issued.

Section 9. Termination

(a) This Agreement shall terminate when (i) all Bonds have been paid or defeased in accordance with the terms of the Indenture or (ii) the continuing disclosure obligation of the Rule is no longer applicable to the Bonds.

(b) Any Obligor may terminate its obligations under this Agreement if and when such Obligor no longer remains an obligated person with respect to the Bonds.

Section 10. Filing

(a) The Obligors shall make the information filings required or permitted by this Agreement with the MSRB through the MSRB's Electronic Municipal Market Access System (EMMA).

(b) All documents provided to the MSRB pursuant to this Agreement shall be filed in electronic format as prescribed by the MSRB and shall be accompanied by identifying information as prescribed by the MSRB.

(c) Information about the filing system and requirements of EMMA is available at www.emma.msrb.org.

Section 11. Additional Information

The Obligors may, in their sole discretion, file with the MSRB additional notices with information not required by this Agreement or the Rule. Such additional filings may be discontinued by the Obligors at any time in their sole discretion.

Section 12. No Indirect Beneficiaries

This Agreement is for the benefit of the underwriter or underwriters for the Bonds and the holders of the Bonds and shall not create rights or benefits for any other person or entity.

Section 13. Agent for Filings

The Obligors may appoint an agent for purposes of making the filings required or permitted by this Agreement, but no such appointment, or failure of such agent to perform, shall relieve the Obligors of their responsibilities under this Agreement.

Section 14. Governing Law

This Agreement shall be governed by the laws of the State of Tennessee.

Dated: _____.

[Execution by Obligor]

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APPENDIX F.

THE DTC BOOK ENTRY SYSTEM

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The DTC Book Entry System

1. The Depository Trust Company (“DTC”), New York, New York, will act as securities depository for the Bonds (the “Securities”). The Securities will be issued as fully-registered securities registered in the name of Cede & Co. (DTC’s partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered Security certificate will be issued for each maturity of the Securities, in the aggregate principal amount of such maturity, and will be deposited with DTC.

2. DTC, the world’s largest depository, is a limited-purpose trust company organized under the New York Banking Law, a “banking organization” within the meaning of the New York Banking Law, a member of the Federal Reserve System, a “clearing corporation” within the meaning of the New York Uniform Commercial Code, and a “clearing agency” registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.5 million issues of U.S. and non-U.S. equity, corporate and municipal debt issues, and money market instrument from over 100 countries that DTC’s participants (“Direct Participants”) deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions in deposited securities through electronic computerized book-entry transfers and pledges between Direct Participants’ accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations, and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation (“DTCC”). DTCC is the holding company for DTC, National Securities Clearing Corporation, and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly (“Indirect Participants”). DTC has Standard & Poor’s highest rating: AAA. The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com and www.dtc.org.

3. Purchases of Securities under the DTC system must be made by or through Direct Participants, which will receive a credit for the Securities on DTC’s records. The ownership interest of each actual purchaser of each Security (“Beneficial Owner”) is in turn to be recorded on the Direct and Indirect Participants’ records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners are, however, expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Securities are to be accomplished by entries made on the books of Direct and Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their ownership interests in Securities, except in the event that use of the book-entry system for the Securities is discontinued.

4. To facilitate subsequent transfers, all Securities deposited by Direct Participants with DTC are registered in the name of DTC’s partnership nominee, Cede & Co. or such other name as may be requested by an authorized representative of DTC. The deposit of Securities with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Securities; DTC’s records reflect only the identity of the Direct Participants to whose accounts such Securities are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

5. Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time. Beneficial Owners of Securities may wish to take certain steps to augment the transmission to them of notices of significant events with respect to the Securities, such as redemptions, tenders, defaults, and proposed amendments to the Security documents. For example, Beneficial Owners of Securities may wish to ascertain that the nominee holding the Securities for their benefit has agreed to obtain and transmit notices to Beneficial Owners.

In the alternative, Beneficial Owners may wish to provide their names and addresses to the registrar and request that copies of notices be provided directly to them.

6. Redemption notices shall be sent to DTC. If less than all of the Securities within one issue are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such issue to be redeemed.

7. Neither DTC nor Cede & Co. (nor such other DTC nominee) will consent or vote with respect to the Securities unless authorized by a Direct Participant in accordance with DTC's MMI Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to the Issuer as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts the Securities are credited on the record date (identified in a listing attached to the Omnibus Proxy).

8. Redemption proceeds, distributions and dividend payments on the Securities will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding detail information from the Issuer or Trustee on the payable date in accordance with their respective holdings shown on DTC's records. Payments by Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Participant and not of DTC, the Issuer, or the Trustee, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of redemption proceeds, distributions and dividend payments to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Issuer and Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

9. A Beneficial Owner shall give notice to elect to have its Securities purchased or tendered, through its Participant, to the Trustee, and shall effect delivery of such Securities by causing the Direct Participant to transfer the Participant's interest in the Securities, on DTC's records, to the Trustee. The requirement for physical delivery of Securities in connection with an optional tender or a mandatory purchase will be deemed satisfied when the ownership rights in the Securities are transferred by Direct Participants on DTC's records and followed by a book-entry credit of tendered Securities to the Trustee's DTC account.

10. DTC may discontinue providing its services as depository with respect to the Securities at any time by giving reasonable notice to the Issuer or Trustee. Under such circumstances, in the event that a successor securities depository is not obtained, Security certificates are required to be printed and delivered.

11. The Issuer may decide to discontinue use of the system of book-entry-only transfers through DTC (or a successor securities depository). In that event, Security certificates will be printed and delivered to DTC.

12. The information in this section concerning DTC and DTC's book-entry system has been obtained from sources that the Issuer and the Corporation believe to be reliable, but neither the Issuer nor the Corporation takes responsibility for the accuracy thereof.

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Exhibit 11.5

Attachment B

Wellmont Audits - External Audited Financial Statements for 2011 to 2014



WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2010 and 2009

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

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

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

We have audited the accompanying consolidated balance sheets of Wellmont Health System and affiliates (Wellmont) as of June 30, 2010 and 2009, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended. These consolidated financial statements are the responsibility of Wellmont's management. 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 financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Wellmont's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Wellmont Health System and affiliates as of June 30, 2010 and 2009, and the consolidated results of their operations and changes in net assets, and cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

KPMG LLP

October 28, 2010

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2010 and 2009

(Dollars in thousands)

Assets	2010	2009
	<hr/>	<hr/>
Current assets:		
Cash and cash equivalents	\$ 35,711	60,889
Assets limited as to use, required for current liabilities	1,815	2,201
Patient accounts receivable, less allowance for uncollectible accounts of approximately \$25,113 and \$27,890 in 2010 and 2009, respectively	94,057	98,071
Other receivables	10,919	11,173
Inventories	18,294	17,169
Prepaid expenses and other current assets	7,003	6,040
Total current assets	<hr/>	<hr/>
	167,799	195,543
Assets limited as to use, net of current portion	<hr/>	<hr/>
	301,807	245,600
Land, buildings, and equipment, net	<hr/>	<hr/>
	450,205	442,610
Other assets:		
Long-term investments	32,391	31,974
Investments in affiliates	32,019	31,976
Deferred debt expense, net	4,644	4,824
Goodwill, net	9,501	9,509
Other	730	798
	<hr/>	<hr/>
	79,285	79,081
Total assets	<hr/>	<hr/>
	\$ 999,096	962,834
	<hr/>	<hr/>
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term debt	\$ 11,958	13,197
Lines of credit/short-term note 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
	<hr/>	<hr/>
Total current liabilities	119,560	124,940
Long-term debt, less current portion	467,833	474,608
Other long-term liabilities, less current portion	<hr/>	<hr/>
	47,364	38,422
Total liabilities	<hr/>	<hr/>
	634,757	637,970
Net assets:		
Unrestricted	358,620	320,030
Temporarily restricted	4,551	3,589
Permanently restricted	1,168	1,245
	<hr/>	<hr/>
Total net assets	364,339	324,864
Commitments and contingencies		
Total liabilities and net assets	<hr/>	<hr/>
	\$ 999,096	962,834
	<hr/>	<hr/>

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES
Consolidated Statements of Operations and Changes in Net Assets
Years ended June 30, 2010 and 2009
(Dollars in thousands)

	<u>2010</u>	<u>2009</u>
Revenue:		
Net patient service revenue	\$ 692,920	680,056
Other revenues	31,472	27,842
Total revenue	<u>724,392</u>	<u>707,898</u>
Expenses:		
Salaries and benefits	310,667	323,801
Medical supplies and drugs	150,143	141,044
Purchased services	74,922	81,031
Interest	20,110	16,013
Provision for bad debts	35,293	33,402
Depreciation and amortization	43,711	42,957
Other	66,734	62,604
Total expenses	<u>701,580</u>	<u>700,852</u>
Income from operations	<u>22,812</u>	<u>7,046</u>
Nonoperating gains (losses):		
Investment income	1,012	4,181
Derivative valuation adjustments	(2,693)	(5,747)
Other, net	(1,870)	(625)
Nonoperating losses, net	<u>(3,551)</u>	<u>(2,191)</u>
Revenue and gains in excess of expenses and losses before discontinued operations	19,261	4,855
Discontinued operations	<u>(1,109)</u>	<u>(4,455)</u>
Revenue and gains in excess of expenses and losses	18,152	400
Other changes in unrestricted net assets:		
Change in net unrealized gains (losses) on investments	22,312	(60,663)
Net assets released from restrictions for additions to land, buildings, and equipment	1,555	2,758
Change in the funded status of benefit plans and other	(3,429)	(13,568)
Increase (decrease) in unrestricted net assets	<u>38,590</u>	<u>(71,073)</u>
Changes in temporarily restricted net assets:		
Contributions	2,934	1,944
Net assets released from temporary restrictions	(1,972)	(3,154)
Increase (decrease) in temporarily restricted net assets	<u>962</u>	<u>(1,210)</u>
Changes in permanently restricted net assets – investment (loss) income	<u>(77)</u>	<u>645</u>
Change in net assets	39,475	(71,638)
Net assets, beginning of year	<u>324,864</u>	<u>396,502</u>
Net assets, end of year	<u>\$ 364,339</u>	<u>324,864</u>

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2010 and 2009

(Dollars in thousands)

	<u>2010</u>	<u>2009</u>
Cash flows from operating activities:		
Change in net assets	\$ 39,475	(71,638)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	43,755	43,393
Loss on disposal of land, buildings, and equipment	1,282	659
Equity in gain of affiliated organizations	(6,773)	(5,549)
Amortization of deferred financing costs	180	238
Net realized and unrealized (gains) losses on investments, other than trading	(17,994)	66,199
Provision for bad debts	35,950	33,821
Change in fair value of derivative instruments	2,693	5,747
Changes in assets and liabilities:		
Patient accounts receivable	(31,936)	(22,378)
Other current assets	(2,088)	(385)
Other assets	322	3,735
Accounts payable and accrued expenses	2,722	(5,796)
Estimated third-party payor settlements	(769)	10,355
Other current liabilities	899	1,437
Other liabilities	7,933	11,101
Net cash provided by operating activities	<u>75,651</u>	<u>70,939</u>
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	88,887	67,580
Purchase of investments	(127,131)	(25,207)
Purchase of land, buildings, and equipment	(55,684)	(86,623)
Proceeds from the sale of buildings and equipment	4,357	31,251
Cash paid for acquisitions	(2,421)	—
Investment in affiliated organizations	—	(4,453)
Distributions from affiliated organizations	6,730	7,181
Distributions to affiliated organizations	(1,684)	(924)
Net cash used in investing activities	<u>(86,946)</u>	<u>(11,195)</u>
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	14,000	484
Payments on long-term debt	(12,083)	(11,005)
Payments on line of credit	(15,800)	(2,121)
Net cash used in financing activities	<u>(13,883)</u>	<u>(12,642)</u>
Net (decrease) increase in cash and cash equivalents	(25,178)	47,102
Cash and cash equivalents, beginning of year	60,889	13,787
Cash and cash equivalents, end of year	\$ <u>35,711</u>	<u>60,889</u>

Supplemental disclosures of noncash items:

Wellmont entered into capital lease obligations for buildings and equipment in the amount of \$1,290 and \$18,050 in 2010 and 2009, respectively.

Additions to property and equipment financed through current liabilities of \$5,182 and \$5,977 in 2010 and 2009, respectively.

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

(1) Operations and Basis of Presentation

Wellmont Health System (Wellmont) was formed to assume operations of Bristol Regional Medical Center (BRMC) and Holston Valley Health Care, Inc. (HVHC), including Holston Valley Medical Center, Inc. (HVMC), and to act as sole corporate member of its consolidated foundations. Effective July 1, 1996, under terms of an agreement and plan of consolidation and merger, BRMC and HVHC, including HVMC, were merged and consolidated into Wellmont. Effective January 1, 1997, Lonesome Pine Hospital (LPH), a Virginia corporation, was merged into Wellmont under terms of a plan of merger and merger agreement. Effective July 1, 2000, Hawkins County Memorial Hospital (HCMH) transferred its operations and operating assets to Wellmont Hawkins County Memorial Hospital (WHCMH), a tax-exempt organization that is wholly owned and controlled by Wellmont. Hancock County Hospital (HCH), a critical access hospital, was opened in March 2005 to help provide for the immediate healthcare needs of the residents of Sneedville and the surrounding counties. As of July 16, 2007, Wellmont acquired Jenkins Community Hospital (Jenkins) in Kentucky. As of August 1, 2007, Wellmont acquired two hospitals in Virginia, Lee Regional Medical Center in Pennington Gap and Mountain View Regional Medical Center in Norton. On May 30, 2008, Wellmont acquired the Holston Valley Cath Lab, an outpatient lab. On May 1, 2010, Wellmont acquired Cardiovascular Associates.

As of April 30, 2009, Wellmont closed Jenkins, sold the majority of the facility's property and equipment to Appalachian Regional Healthcare, Inc for \$1,000 and recorded a loss on sale of approximately \$256. The consolidated financial statements for the years ended June 30, 2010 and 2009 present Jenkins as a discontinued operation. The operating losses of \$474 and \$3,659 for the years ended June 30, 2010 and 2009, respectively, and the impairment are included in the classification of discontinued operations.

As of June 30, 2010, it was announced that Wellmont will sell the majority of Medical Mall Pharmacy's assets to a national pharmacy company for \$1,300 plus inventory value. The consolidated financial statements for the years ended June 30, 2010 and 2009 present Medical Mall Pharmacy as a discontinued operation. The operating losses of \$635 and \$540 for the years ended June 30, 2010 and 2009, respectively, are included in the classification of discontinued operations. The sale was completed on September 23, 2010.

All acute care operations remain separately licensed and are treated as operating divisions within Wellmont. Wellmont's operations consist primarily of the delivery of healthcare services in northeast Tennessee and southwest Virginia.

The consolidated financial statements include the acute care operations of the above entities along with:

- Wellmont Foundation (the Foundation), which was created from the merger of Bristol Regional Medical Center Foundation and Holston Valley Health Care Foundation, Inc. The Foundation conducts fund-raising activities for the benefit of Wellmont.
- Wellmont, Inc., a wholly owned taxable subsidiary of Wellmont, formed as the holding company of various other taxable subsidiaries that provide medical collection and medical laundry services, operate a pharmacy and physician practices, provide other healthcare-related services, and invest in affiliates and other activities.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

- The Alzheimer's Center of East Tennessee was merged into Wellmont and changed its name to Wellmont Madison House effective September 1, 1997. Wellmont is the sole corporate member and the consolidated financial statements include the operations of this entity.

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

(2) Significant Accounting Policies

A summary of significant accounting policies follows:

(a) Use of Estimates

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

(b) Cash and Cash Equivalents

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

(c) Investments

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

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(Dollars in thousands)

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

On July 1, 2008, Wellmont adopted new guidance issued by the Financial Accounting Standards Board (FASB), which defines fair value, establishes a framework for the measurement of fair value, and enhances disclosures about fair value measurements now codified into Accounting Standards Codification (ASC) 850. ASC 850 statement does not require any new fair value measures and did not have a material impact on Wellmont's consolidated financial statements for the year ended June 30, 2009, however, expanded fair value disclosures have been provided in note 19.

(d) *Assets Limited as to Use*

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

(e) *Inventories*

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

(f) *Land, Buildings, and Equipment*

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

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

expected to be generated by the asset. When such assets are considered to be impaired, the impairment loss recognized is measured by the amount by which the carrying value of the asset exceeds the fair value of the asset.

(g) Goodwill

Goodwill represents the difference between the cost of net assets acquired and estimated fair value at purchase date, and is being amortized using the straight-line method over periods of 5 to 15 years. For goodwill acquired by its taxable entities, the FASB has implemented a nonamortization approach to goodwill. However, the effective date for not-for-profit entities is not effective until fiscal year 2011 for Wellmont and, as such, Wellmont continues to amortize the goodwill associated with its tax-exempt entities. Wellmont assesses the recoverability and the amortization period of goodwill for not-for-profit entities by determining whether the amount can be recovered through undiscounted cash flows of the business acquired, excluding interest and amortization, over the remaining amortization period. If impairment is indicated by this analysis, measurement of the impairment recognized is based on the difference between the fair value and the carrying amount of the asset. Management considers external factors relating to each acquired business, including local market developments, regional and national trends, regulatory developments, and other pertinent factors in making its assessment. Goodwill for Wellmont's for-profit/taxable entities is reviewed for impairment at least annually in accordance with the provisions of FASB ASC 350, *Intangibles – Goodwill and Other* (Statement No. 142, *Goodwill and Other Intangible Assets*). The goodwill impairment test is a two-step test. Under the first step, the fair value of the reporting unit is compared with its carrying value (including goodwill). If the fair value of the reporting unit is less than its carrying value, an indication of goodwill impairment exists for the reporting unit and the enterprise must perform step two of the impairment test. Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step two does not need to be performed. A summary of goodwill and related amortization for the years ended June 30 follows:

	<u>2009</u>	<u>Additions</u>	<u>Decreases</u>	<u>2010</u>
Goodwill	\$ 12,604	—	—	12,604
Amortization	(3,095)	(8)	—	(3,103)
	<u>\$ 9,509</u>	<u>(8)</u>	<u>—</u>	<u>9,501</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

	<u>2008</u>	<u>Additions</u>	<u>Decreases</u>	<u>2009</u>
Goodwill	\$ 12,771	—	(167)	12,604
Amortization	(3,130)	(30)	65	(3,095)
	<u>\$ 9,641</u>	<u>(30)</u>	<u>(102)</u>	<u>9,509</u>

(h) Deferred Debt Expense

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

(i) Derivative Financial Instruments

As further described in note 12, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

(j) Asset Retirement Obligations

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

(k) Temporarily and Permanently Restricted Net Assets

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

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2010 and 2009 primarily included amounts related to the purchase of buildings and equipment for pediatrics, cancer, and other healthcare operations.

(l) Net Patient Service Revenue and Accounts Receivable

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the period related services are rendered and adjusted in future periods as final and other settlements are determined. Wellmont provides care to patients who meet criteria under its charity care policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

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

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

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

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

(n) Contributed Resources

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

donor stipulations about how long those long-lived assets must be maintained, expiration of donor restrictions is reported when the donated or acquired long-lived assets are placed in service.

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

(o) Federal Income Taxes

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

On July 1, 2007, Wellmont adopted new guidance issued by on the accounting for uncertainty in income tax positions now codified into ASC 740. It also provides guidance on when tax positions are recognized in an entity's financial statements and how the values of these positions are determined. There was no impact on Wellmont's consolidated financial statements as a result of the adoption of the new guidance.

(p) New Accounting Pronouncements

Effective July 1, 2008, Wellmont adopted new guidance issued by FASB, which provides guidance on the net asset classification of donor-restricted endowment funds for a tax-exempt organization that is subject to an enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA) now codified into ASC 958, *Not-for-Profit Entities*. Effective July 1, 2007, the State of Tennessee adopted legislation that incorporates the provisions outlined in UPMIFA. Wellmont's endowments consist solely of donor-restricted endowment funds. Wellmont's endowments consist of four individual funds established for a variety of purposes.

Wellmont has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Wellmont classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are approved for expenditure by the organization in a

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manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Wellmont considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the organization and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the organization; and (7) the investment policies of the organization.

On June 30, 2009, Wellmont adopted guidance issued by the FASB for subsequent events, now codified into ASC 855, *Subsequent Events*. ASC 855 defines the period after the balance sheet date during which management shall evaluate events or transactions that may occur for potential recognition or disclosure, the circumstances under which an organization shall recognize events occurring after the balance sheet date and the disclosures that an organization shall make about those events or transactions. ASC 855 defines two types of subsequent events. The first type consists of events or transactions that provide additional evidence about conditions that existed at the date of the balance sheet, including the estimates inherent to the process of preparing financial statements (i.e., recognized subsequent events). The second type consists of events that provide evidence about conditions that did not exist at the date of the balance sheet but arose after the date (i.e., nonrecognized event).

Management evaluated all events and transactions that occurred through October 28, 2010. Other than described in note 11, Wellmont did not have any material subsequent events during this period.

On July 1, 2009, the FASB issued Statement No. 168, *The FASB Accounting Standards Codification™ and the Hierarchy of Generally Accepted Accounting Principles* (Statement 168). Statement 168 is the single source of authoritative nongovernmental GAAP, superseding existing FASB, American Institute of Certified Public Accountants, Emerging Issues Task Force, and related accounting literature. Statement 168 reorganizes the thousands of pages of GAAP pronouncements into roughly 90 accounting topics and displays them using a consistent structure. Also included is relevant Securities and Exchange Commission guidance organized using the same topical structure in separate sections. Statement 168 is effective for interim and annual periods ending after September 15, 2009. The adoption of Statement 168 had no significant effect on the Wellmont's consolidated financial statements.

(q) Reclassifications

Certain 2009 amounts have been reclassified to conform to the 2010 consolidated financial statement presentation.

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(3) Net Patient Service Revenue

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

	<u>2010</u>	<u>2009</u>
Gross patient service charges	\$ 2,158,847	2,178,018
Less:		
Contractual adjustments and other discounts	(1,411,435)	(1,440,519)
Charity care	<u>(54,492)</u>	<u>(57,443)</u>
	<u>(1,465,927)</u>	<u>(1,497,962)</u>
Net patient service revenue	\$ <u>692,920</u>	<u>680,056</u>

(4) Third-Party Reimbursement Arrangements

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

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

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

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Net patient service revenue in 2010 and 2009 related to Medicare, TennCare, and Virginia Medicaid and net patient accounts receivable at June 30, 2010 and 2009 from Medicare, TennCare, and Virginia Medicaid were as follows:

	<u>2010</u>	<u>2009</u>
Net patient service revenue:		
Medicare	\$ 277,372	272,259
TennCare	22,918	22,509
Virginia Medicaid	23,536	19,036
Net patient accounts receivable:		
Medicare	\$ 41,125	39,852
TennCare	2,206	4,072
Virginia Medicaid	3,739	3,172

Wellmont has filed cost reports with Medicare and Virginia Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Virginia Medicaid cost reports have been audited by the intermediary through June 30, 2006.

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

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased (decreased) approximately \$863 and \$(2,600) in 2010 and 2009, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of final settlements, and years that are not longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2010 could differ materially from actual settlements based on the results of third-party audits.

(5) Charity Care and Community Services

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

Wellmont maintains records to identify and monitor the level of charity care it provides. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and the equivalent percentage of charity care patients to all patients serviced were \$54,492, \$15,567, and

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2.52%, respectively, for the year ended June 30, 2010 and \$57,443, \$16,203, and 2.63%, respectively, for the year ended June 30, 2009.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and State indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont's cost of providing care to those patients totaled \$55,461 and \$57,212 for the years ended June 30, 2010 and 2009, respectively.

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

(6) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include hospital, home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in net income of affiliates was approximately \$6,773 and \$5,549 for the years ended June 30, 2010 and 2009, respectively, and is included in other operating revenue in the consolidated financial statements. Wellmont made additional contributions of \$0 and \$4,453 during 2010 and 2009, respectively, to affiliates, which increased Wellmont's overall investment in affiliates. Wellmont received distributions of \$6,730 and \$7,181 during 2010 and 2009, respectively, which reduced Wellmont's overall investment in the affiliates.

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

	<u>2010</u>	<u>2009</u>
Total assets	\$ 129,720	137,737
Total liabilities	13,943	39,913
Total net assets	<u>\$ 115,777</u>	<u>97,824</u>
Net revenues	\$ 166,815	178,253
Expenses	142,534	159,004
Revenues in excess of expenses	<u>\$ 24,281</u>	<u>19,249</u>

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Wellmont's equity investment in these affiliates and its ownership percentage as of June 30, 2010 and 2009 are as follows:

	Amount		Percentage	
	2010	2009	2010	2009
Takoma Regional Hospital	\$ 12,645	12,302	60%	60%
Holston Valley Imaging Center (HVIC)	8,048	9,047	75	75
Advanced Home Care (AHC)	6,092	6,092	6	6
Spectrum Tennessee Network	3,850	3,462	20	20
Others	1,384	1,073	4% – 50%	4% – 50%
	<u>\$ 32,019</u>	<u>31,976</u>		

Wellmont provided billing and management services to the affiliates. Income recognized by Wellmont for the services was \$1,766 in 2010 and \$1,501 in 2009 and is included in other revenues.

Included in other receivables are \$124 and \$135 as of June 30, 2010 and 2009, respectively, of amounts due to Wellmont from these entities.

Although Wellmont's ownership percentage in Takoma Regional Hospital and HVIC is greater than 50%, Wellmont does not consolidate these entities because Wellmont only has a 50% representation on each respective board and does not have control over these entities.

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(7) Investments

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

	<u>2010</u>	<u>2009</u>
Assets limited as to use by Board for capital improvements:		
Stock mutual funds	\$ 109,629	108,036
Bond mutual funds	71,698	5,910
Cash and money market funds	1,474	2,517
Real estate funds	7,468	5,419
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):		
Liquid	33,915	12,415
Illiquid	23,490	23,171
	<u>247,674</u>	<u>157,468</u>
Assets limited as to use under self-insurance agreements:		
Corporate bonds	6,867	7,464
Cash and money market funds	558	643
	<u>7,425</u>	<u>8,107</u>
Assets limited as to use under bond indenture agreements:		
Cash and money market funds	48,523	82,226
Less assets limited as to use that are required for current liabilities	<u>1,815</u>	<u>2,201</u>
Assets limited as to use, net of current portion	\$ <u>301,807</u>	<u>245,600</u>
Long-term investments:		
Stock mutual funds	\$ 9,279	8,631
Bond mutual funds	7,599	3,648
Preferred equity investment and related options	11,512	11,512
Cash, money market funds, and certificates of deposit	287	5,202
Real estate funds	1,722	1,255
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):		
Liquid	1,992	1,726
Total long-term investments	\$ <u>32,391</u>	<u>31,974</u>

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately \$12,112 as of June 30, 2010 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which \$417 was paid subsequent to June 30, 2010.

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Wellmont has invested \$10,000 in the preferred equity of a regional managed services organization and \$1,512 on a right of first refusal related to any future sale of this organization. This equity has a guaranteed annual return of at least 6.5% of the outstanding preferred equity balance.

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

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, the Company recognized other-than-temporary impairment losses of \$8,233 and \$4,654 on investments as of June 30, 2010 and 2009, respectively. The unrealized losses on these mutual funds were primarily caused by the overall decline in the world's economy in 2009 and 2010. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2010 and 2009, were as follows:

		June 30, 2010					
		Less than 12 months		12 months or more		Total	
		Unrealized		Unrealized		Unrealized	
		losses	Fair value	losses	Fair value	losses	Fair value
Alternative investments	\$	—	—	910	4,219	910	4,219
Stock mutual funds		2,184	29,658	24,817	83,713	27,001	113,371
	\$	<u>2,184</u>	<u>29,658</u>	<u>25,727</u>	<u>87,932</u>	<u>27,911</u>	<u>117,590</u>
		June 30, 2009					
		Less than 12 months		12 months or more		Total	
		Unrealized		Unrealized		Unrealized	
		losses	Fair value	losses	Fair value	losses	Fair value
Bond mutual funds	\$	191	4,112	—	—	191	4,112
Alternative investments		5,525	16,227	4,144	7,120	9,669	23,347
Stock mutual funds		22,243	74,147	17,460	35,983	39,703	110,130
	\$	<u>27,959</u>	<u>94,486</u>	<u>21,604</u>	<u>43,103</u>	<u>49,563</u>	<u>137,589</u>

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

	<u>2010</u>	<u>2009</u>
Interest and dividends, net of amounts capitalized	\$ 5,330	9,717
Realized losses on investments, including \$8,233 and \$4,654 recognized losses related to other-than-temporary impairments in 2010 and 2009, respectively.	<u>(4,318)</u>	<u>(5,536)</u>
Investment income, net	<u>\$ 1,012</u>	<u>4,181</u>
Change in net unrealized gains (losses) on investments	<u>\$ 22,312</u>	<u>(60,663)</u>

(8) Land, Buildings, and Equipment

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

	<u>2010</u>	<u>2009</u>
Land	\$ 41,210	44,149
Buildings and improvements	488,285	392,593
Equipment	327,896	303,805
Buildings and equipment under capital lease obligations	<u>39,591</u>	<u>38,734</u>
	896,982	779,281
Less accumulated depreciation	<u>(459,935)</u>	<u>(418,399)</u>
	437,047	360,882
Construction in progress	<u>13,158</u>	<u>81,728</u>
Land, buildings, and equipment	<u>\$ 450,205</u>	<u>442,610</u>

Depreciation expense for the years ended June 30, 2010 and 2009 was \$43,755 and \$43,393, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was \$13,266 and \$9,109 as of June 30, 2010 and 2009, respectively.

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(9) Other Long-Term Liabilities

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

	<u>2010</u>	<u>2009</u>
Workers' compensation liability	\$ 6,606	5,706
Professional and general liability	11,183	9,494
Postretirement benefit obligation	5,861	5,653
Asset retirement obligation	3,710	3,621
Deferred gain on sale of assets	1,382	2,136
Derivative liability	12,943	10,250
Pension benefit liability	10,018	6,709
Other	<u>2,912</u>	<u>1,205</u>
	54,615	44,774
Less current portion	<u>(7,251)</u>	<u>(6,352)</u>
Total other long-term liabilities	<u>\$ 47,364</u>	<u>38,422</u>

(10) Lines of Credit/Notes Payable

During 2008, Wellmont entered into three lines of credit for \$15,000, \$1,800, and \$10,000. The \$15,000 line of credit had a variable interest rate based upon LIBOR plus 1% and a termination date of August 2009; at June 30, 2009, \$14,000 was outstanding on this line. During 2010, the \$15,000 line of credit was paid in full with a \$14,000 note payable, which was initiated with one bank to pay off the line of credit. The \$14,000 note payable has a variable interest rate based upon LIBOR plus 2% and a termination date of December 2010. At June 30, 2010, \$14,000 was outstanding on this note. During 2008, a \$1,800 line of credit was initiated with one bank and was paid in full with the funds from the \$10,000 line of credit from another bank, which had variable interest rate based upon LIBOR plus 0.95% and a termination date of August 31, 2009; at June 30, 2010 and 2009, \$0 and \$1,811, respectively, was outstanding on this line. The \$10,000 line of credit was paid in full in 2010.

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(11) Debt

(a) Long-Term Debt

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

	<u>2010</u>	<u>2009</u>
Hospital Revenue Bonds, Series 2007A	\$ 55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	200,000	200,000
Hospital Revenue Refunding Bonds, Series 2006A and 2006B	93,405	95,205
Hospital Revenue Refunding Bonds, Series 2005	61,810	63,940
Hospital Revenue Bonds, Series 2003	36,666	40,145
Notes payable	6,429	4,399
Capital lease obligations	19,698	22,388
Other	358	71
	<u>473,366</u>	<u>481,148</u>
Unamortized premium	7,538	7,800
Unamortized discount	<u>(1,113)</u>	<u>(1,143)</u>
	479,791	487,805
Less current maturities	<u>(11,958)</u>	<u>(13,197)</u>
	<u>\$ 467,833</u>	<u>474,608</u>

(b) Series 2007 Bonds

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

Principal on outstanding Series 2007A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from \$360 to \$2,460 commencing on September 1, 2017 through September 1, 2036, with a balloon payment of \$29,245 due on September 1, 2037. The outstanding bonds accrue interest at rates ranging from 5.125% to 5.25%.

(c) Series 2006C

On October 26, 2006, The Health, Educational and Housing Facilities Board of the County of Sullivan Tennessee issued, on behalf of Wellmont, \$200,000 of Hospital Revenue Bonds, Series 2006C. The Series 2006C Bonds were used to: finance the costs of acquisition of land for expansion, construction, expansion, equipping, and renovation of HVMC, including the construction of a new patient tower (collectively known as Project Platinum); finance the costs of the

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construction, expansion, equipping, and renovation of the emergency department at BRMC (the Bristol Emergency Department Project); and finance the costs of construction, expansion, renovation, and equipping of an operating room and related facilities at HCMH.

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

(d) Series 2006 A and B

On June 23, 2006, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee issued, on behalf of Wellmont, \$98,475 of Hospital Revenue Refunding Bonds, Series 2006. This bond issuance consists of Series A tax-exempt and Series B taxable bonds of \$76,595 and \$21,880, respectively. The Series 2006 Bonds together with other available funds were used to advance refund all the previously issued Hospital Revenue Bonds, Series 1993, to reimburse Wellmont for payments made on other taxable borrowings and to pay certain expenses incurred in connection with the issuance of the Series 2006 Bonds. Upon this refunding, a trust was established to pay all future bond payments related to the Series 1993 Bonds. Wellmont was deemed to have paid the Series 1993 Bonds and these Bonds are no longer deemed to be outstanding for purposes of the Series 1993 Trust Indenture.

Principal on outstanding Series 2006A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from \$875 to \$6,400 commencing on September 1, 2013 through September 1, 2032; and the outstanding bonds accrue interest on a variable rate, which is reset monthly based upon the AAA-insured Municipal Market Data Index, plus 85 basis points. Principal on outstanding Series 2006B Bonds is payable through maturity in annual amounts ranging from \$1,600 to \$2,930 commencing on September 1, 2007 through September 1, 2016, and the outstanding bonds accrue interest at a fixed rate of 6.95%.

Outstanding Series 2006A Bonds are subject to redemption prior to maturity at the option of The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%–102% of the principal amount of the Series 2006A Bonds being redeemed, plus accrued interest thereon to the redemption date.

On October 1, 2010, the Series 2006B Bonds were called and paid in full at par value of \$14,880.

(e) Series 2005

On December 8, 2005, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, \$70,620 of Hospital Revenue Refunding Bonds, Series 2005. The Series 2005 Bonds together with other available funds were used to advance refund the previously issued Hospital Revenue Bonds, Series 2002, and to pay certain expenses incurred in connection with the issuance of the Series 2005 Bonds.

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Principal on outstanding Series 2005 Bonds is payable through maturity or scheduled mandatory sinking fund redemption in annual amounts ranging from \$1,945 to \$3,390 commencing on September 1, 2007 through September 1, 2032. The terms of the bonds provide that bondholders may redeem or put the bonds to the remarketing agent on dates that approximate a weekly basis. The remarketing agent is obligated to remarket the redeemed bonds on a “best efforts” basis. Redeemed bonds are repaid to bondholders from the proceeds of the remarketing effort or, in the event of an inability to remarket the bonds, from a letter of credit. Subsequent to year-end, Wellmont amended its letter of credit to cover an amount equal to the principal and up to 40 days’ interest on the bonds at a maximum interest rate of 12% per annum, and is effective through July 1, 2011. This letter secures the bonds in the event of a failed remarketing or liquidity issue. In the event of a liquidity drawing under the letter of credit, Wellmont shall pay the Base Rate for the first 90 days equal to the greater of (i) the Prime Rate plus 1.50% per annum, ii) the Federal Funds Rate plus 3.00% per annum, or iii) 7.50% per annum. ; the Base Rate plus 0.50% for days 91 through 366 and the Base Rate plus 1.00% thereafter until the amount is paid in full.

Outstanding Series 2005 Bonds are subject to redemption prior to maturity at the option of The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%–102% of the principal amount of the Series 2005 Bonds being redeemed, plus accrued interest thereon to the redemption date.

(f) Series 2003

On June 1, 2003, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee issued, on behalf of Wellmont, \$59,100 of Hospital Revenue Bonds, Series 2003. The bonds were issued to provide funds necessary to refund Wellmont’s Hospital Revenue Bonds, Series 1993 (HVHC), to fund a debt service reserve fund and to pay certain expenses incurred in connection with the issuance of the Series 2003 Bonds.

The Wellmont Series 2003 Bonds consist of \$27,460 in fixed rate serial bonds and \$19,280 in fixed rate term bonds payable through maturity or mandatory sinking fund redemption maturing in annual amounts ranging from \$3,230 on September 1, 2007 to \$4,140 on September 1, 2019, and carrying interest rates ranging from 2.5% to 5.00%.

(g) Master Trust Indenture

The master trust indenture and loan agreements for the 2007, 2006, 2005, and 2003 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their

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obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

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

(h) Notes Payable

During 2007, Wellmont entered into a five-year \$3,000 note payable, which has a fixed interest rate of 7.25% and a termination date of July 2011; at June 30, 2010 and 2009, \$2,062 and \$2,319, respectively, was outstanding on this note.

During 2008, Wellmont entered into a five-year \$2,400 term note payable, which has a fixed interest rate of 7.25% and a termination date of August 2012; at June 30, 2010 and 2009, \$1,600 and \$2,080, respectively, was outstanding on this note.

During 2010, Wellmont entered into a \$2,767 note payable to finance the purchase of Cardiovascular Associates. The note payable has a fixed interest rate of 5.5% and a termination date of May 2013. At June 30, 2010, \$2,767 was outstanding on this note.

(i) Capital Lease Obligations

Wellmont has entered into leases for certain equipment under agreements classified as capital leases that expire over periods through 2011. Assets under capital leases are included in property and equipment and have a net carrying value of \$26,325 and \$29,625 as of June 30, 2010 and 2009, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 4.3% to 6.0%.

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(j) Long-term Debt Maturities Schedule

Bond maturities in accordance with the original terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2010 are as follows:

2011	\$	11,958
2012		13,329
2013		12,935
2014		12,193
2015		12,415
Thereafter		410,536
	\$	<u>473,366</u>

The following table reflects the required repayment terms for the years ended June 30 of Wellmont's debt obligations in the event that the put options associated with the 2005 bonds were exercised, but not successfully remarketed.

2011	\$	11,958
2012		30,859
2013		30,365
2014		29,508
2015		9,755
Thereafter		360,921
	\$	<u>473,366</u>

Interest paid for the years ended June 30, 2010 and 2009 was \$20,792 and \$21,564, respectively, net of amounts capitalized. Interest costs of \$2,776 and \$3,421, net of interest income of \$683 and \$3,293 in 2010 and 2009, respectively, were capitalized.

(12) Derivative Transactions

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

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Wellmont's bond rating. As of June 30, 2010 and 2009, Wellmont was not required to postcollateral related to its swaps.

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

In September and October 2008, the counterparty and credit support provider to the swaps filed bankruptcy. Subsequent to the bankruptcy filings, no payments have been made by Wellmont or the counterparty to each other. As of June 30, 2010, the net amounts due to Wellmont for this period are less than \$100 and have been fully reserved. The bankruptcy process is underway and the outcome cannot be determined at this time.

Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its debt structure using LIBOR. The fair value as of June 30, 2010 and 2009 of approximately \$(12,943) and \$(10,250), respectively, is included in other liabilities in the consolidated balance sheets. The change in the fair value of the derivative instruments was approximately \$(2,693) and \$(5,747), respectively, in 2010 and 2009 and is included in nonoperating losses, net in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. The net amounts have been recorded pending the outcome of any bankruptcy proceedings. The following is a summary of the interest rate swap information as of June 30, 2010:

<u>Type of interest swap</u>	<u>Debt hedging</u>	<u>Notional amount</u>	<u>Effective date</u>	<u>Maturity date</u>	<u>Rate paid</u>	<u>Rate received</u>	<u>Swap fair value asset (liability)</u>
Total return swap	Series 2006A	\$ 76,595	June 29, 2006	September 1, 2011	1.103%	5.440%	\$ 1,101
Pay fixed interest rate swap	Series 2005	65,975	December 13, 2005	September 1, 2016	3.548	0.217	(6,810)
Basis swap	Series 2002	67,965	September 1, 2002	September 1, 2032	0.253	0.198	(2,710)
Pay fixed interest rate swap	Series 2006A	35,342	October 24, 2003	September 1, 2021	3.613	0.162	(4,524)
							<u>\$ (12,943)</u>

The following is a summary of the interest rate swap information as of June 30, 2009:

<u>Type of interest swap</u>	<u>Debt hedging</u>	<u>Notional amount</u>	<u>Effective date</u>	<u>Maturity date</u>	<u>Rate paid</u>	<u>Rate received</u>	<u>Swap fair value asset (liability)</u>
Total return swap	Series 2006A	\$ 76,595	June 29, 2006	September 1, 2011	2.744%	5.884%	\$ 1,075
Pay fixed interest rate swap	Series 2005	65,975	December 13, 2005	September 1, 2016	3.548	0.309	(5,197)
Basis swap	Series 2002	67,965	September 1, 2002	September 1, 2032	1.894	1.728	(2,708)
Pay fixed interest rate swap	Series 2006A	35,342	October 24, 2003	September 1, 2021	3.613	1.184	(3,420)
							<u>\$ (10,250)</u>

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(13) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined contribution retirement plan (Retirement Plan) that covers substantially all employees. This program and the related Retirement Plan were created from amendments, restatements, and mergers of existing defined contribution plans at BRMC and HVMC. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 3% of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Code, up to 3% of each participant's wages. The total pension expense related to the Retirement Plan was \$9,990 and \$9,937 for the years ended June 30, 2010 and 2009, respectively.

HVMC sponsored a noncontributory, defined benefit pension plan covering substantially all its employees. However, effective June 30, 1996, this plan was frozen and no further benefits accrue. LPH also sponsors a defined benefit pension plan covering substantially all its employees.

HVMC's defined pension benefits are actuarially determined based on a formula taking into consideration an employee's compensation and years of service. HVMC's funding policy is to make annual contributions to the plan based upon the funding standard developed by the plan actuary. This standard uses the projected unit credit actuarial cost method, including the amortization of prior service costs, over a 20-year period. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. The LPH plan contains similar funding and actuarial policies.

On June 30, 2007, the HVMC plan merged into LPH plan and the plan name changed to Wellmont Health System Defined Benefit Plan. At the end of 2008, only a single defined pension plan exists. Collectively, the two defined benefit plans are referred to as the "Plans."

Wellmont recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined benefit pension plans as an asset or liability in its consolidated balance sheets and recognizes changes in that funded status in the year in which the changes occur as a change in unrestricted net assets. All defined benefit pension plans use a June 30 measurement date.

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

	<u>2010</u>	<u>2009</u>
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 40,035	37,212
Service cost	230	234
Interest cost	2,432	2,441
Actuarial losses	4,008	2,132
Benefits paid	<u>(2,140)</u>	<u>(1,984)</u>
Benefit obligation at end of year	\$ <u>44,565</u>	<u>40,035</u>
Change in plan assets:		
Fair value of plan assets at beginning of year	33,326	43,420
Actual return on plan assets	3,361	(8,110)
Benefits paid	<u>(2,140)</u>	<u>(1,984)</u>
Fair value of plan assets at end of year	<u>34,547</u>	<u>33,326</u>
Funded status	\$ <u><u>(10,018)</u></u>	<u><u>(6,709)</u></u>
Amounts recognized in the accompanying consolidated balance sheets:		
Pension liability – other long-term liability	\$ (10,018)	(6,709)

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	<u>2010</u>	<u>2009</u>
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:		
Unrecognized actuarial loss	\$ 13,158	10,851
Unrecognized prior service cost	<u>2</u>	<u>2</u>
Net amounts included as an accumulated charge to unrestricted net assets	\$ <u>13,160</u>	<u>10,853</u>
Calculation of change in unrestricted net assets:		
Accumulated charge to unrestricted net assets, end of year	\$ 13,160	10,853
Reversal of accumulated credit to unrestricted net assets, prior year	<u>(10,853)</u>	<u>2,357</u>
Change in unrestricted net assets	\$ <u>2,307</u>	<u>13,210</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Actuarial loss arising during the year	\$ 2,907	13,210
Amortization of actuarial gain or loss	(600)	—
Amortization of prior service cost	<u>—</u>	<u>—</u>
Net amounts recognized as a charge to unrestricted net assets	\$ <u>2,307</u>	<u>13,210</u>

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	<u>2010</u>	<u>2009</u>
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2011:		
Amortization of net loss	\$ 791	—
Amortization of prior service cost	—	2
Estimated future benefit payments:		
Fiscal 2011	2,211	2,150
Fiscal 2012	2,220	2,189
Fiscal 2013	2,337	2,314
Fiscal 2014	2,472	2,456
Fiscal 2015 (FY09 fiscal 2015 – 2019)	2,578	13,769
Fiscal 2016 – 2020	14,278	
Weighted average assumptions used to determine benefit obligations:		
Settlement (discount) rate	5.50%	6.25%
Weighted average rate of increase in future compensation levels	3.00	3.00
Components of net periodic benefit cost (benefit):		
Service cost	\$ 230	234
Interest cost	2,432	2,441
Expected return on plan assets	(2,259)	(2,968)
Amortization of unrecognized net loss	600	—
Amortization of unrecognized prior service cost	—	0
Net periodic benefit cost (benefit)	<u>\$ 1,003</u>	<u>(293)</u>
Weighted average assumptions used to determine net periodic benefit cost:		
Settlement (discount) rate	6.25%	6.75%
Expected long-term return on plan assets (HVMC)	7.00	7.00
Expected long-term return on plan assets (LPH)	7.00	7.00
Weighted average rate of increase in future compensation levels	3.00	3.00

Wellmont's overall expected long-term rate of return on assets is 7.00%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

Wellmont does not expect to make any contributions to the Plans during 2011.

Wellmont has developed a plan investment policy, which is reviewed and approved by the board of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a target asset allocation and an allowable range for such

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categories based on quarterly investment fluctuations. Investments are managed by independent advisers who are monitored by management and the board of directors.

The table below shows the target allocation and actual asset allocations as of June 30, 2010 and 2009:

<u>Asset</u>	<u>Target allocation</u>	<u>June 30,</u>	
		<u>2010</u>	<u>2009</u>
Equity securities	65%	56%	53%
Fixed income	28	27	29
Cash	5% – 15%	1	3
Other	5 – 15	16	15

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

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

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

	<u>2010</u>	<u>2009</u>
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 5,653	5,637
Interest cost	320	355
Plan participants contributions	73	36
Actuarial losses	197	23
Benefits paid	<u>(382)</u>	<u>(398)</u>
Benefit obligation at end of year	<u>5,861</u>	<u>5,653</u>
Change in plan assets:		
Fair value of plan assets at beginning of year	—	—
Employer contribution	309	362
Plan participants contributions	73	36
Benefits paid	<u>(382)</u>	<u>(398)</u>
Fair value of plan assets at end of year	<u>—</u>	<u>—</u>
Funded status	\$ <u>(5,861)</u>	<u>(5,653)</u>
Amounts recognized in the consolidated balance sheets consist of:		
Noncurrent liabilities	\$ (5,861)	(5,653)
Accumulated credit to unrestricted net assets	<u>3,560</u>	<u>4,076</u>
	\$ <u>(2,301)</u>	<u>(1,577)</u>

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

	<u>Postretirement benefits</u>	
	<u>2010</u>	<u>2009</u>
Net actuarial gain	\$ 3,560	4,076

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Net periodic benefit cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2010 and 2009 were:

	Postretirement benefits	
	2010	2009
Net periodic benefit cost:		
Interest cost	\$ 320	355
Amortization of net gain	(319)	(335)
Net periodic benefit cost recognized	<u>1</u>	<u>20</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	197	23
Amortization of net gain	319	335
Total recognized as a charge to unrestricted net assets	<u>516</u>	<u>358</u>
Total recognized in net periodic benefit cost and unrestricted net assets	<u>\$ 517</u>	<u>378</u>

The net gain and prior service credit for the defined benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are \$(261) and \$0, respectively. Weighted average assumptions used to determine benefit obligations for 2010 and 2009 were as follows:

	Postretirement benefits	
	2010	2009
Discount rate	5.00%	6.00%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2010 and 2009 were as follows:

	Postretirement benefits	
	2010	2009
Discount rate	6.00%	6.75%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00%	5.00%

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

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For measurement purposes, a 5% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2010.

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

	<u>2010</u>	<u>2009</u>
Effect of one-percentage-point increase in healthcare cost trend on:		
Service and interest cost	\$ 20	22
Accumulated pension benefit obligation	330	326
Effect of one-percentage-point decrease in healthcare cost trend on:		
Service and interest cost	(18)	(20)
Accumulated pension benefit obligation	(294)	(291)

The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2010 and 2009, respectively, were as follows:

Fair value measurement at June 30, 2010				
pension benefits – plan assets				
		Quoted prices		
<u>Asset category</u>	<u>Total</u>	in active	Significant	Significant
		markets for	other	unobservable
		identical	observable	inputs
		assets	inputs	inputs
		(Level 1)	(Level 2)	(Level 3)
Stock mutual funds	\$ 28,803	19,412	9,391	—
Cash and money market funds	244	244	—	—
Alternative investments	5,500	—	—	5,500
Total	\$ 34,547	19,656	9,391	5,500

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Fair value measurement at June 30, 2009				
pension benefits – plan assets				
Asset category	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Stock mutual funds	\$ 27,444	17,710	9,734	—
Cash and money market funds	749	749	—	—
Alternative investments	5,133	—	—	5,133
Total	\$ 33,326	18,459	9,734	5,133

The following tables presents Wellmont’s activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2010 and 2009:

	Alternative investments
Balance at June 30, 2008	\$ 7,960
Net change in value	(4,464)
Purchases, issuances, and settlements	1,637
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2009	5,133
Net change in value	254
Purchases, issuances, and settlements	113
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2010	\$ 5,500

(14) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers’ compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont has established revocable self-insurance trust funds to provide for professional and general liability claims and workers’ compensation claims and related expenses. Wellmont’s contributions to the self-insurance trusts are based upon actuarial determinations by an independent service company. The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers’ compensation program is supplemented for Tennessee and Virginia by excess workers’ compensation policies, with a commercial carrier for statutory limits per occurrence. Wellmont does not

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qualify as a self-insurer in Kentucky and hence purchases a separate policy for its operation in Kentucky. Provisions based on actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Insurance expense under these programs amounted to approximately \$3,414 and \$5,658 for the years ended June 30, 2010 and 2009, respectively, and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2010 and 2009, Wellmont was involved in litigation relating to medical malpractice and workers' compensation claims arising in the ordinary course of business. There are also known incidents that occurred through June 30, 2010 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2010 are adequate to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

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

(15) Commitments and Contingencies

Construction in progress at June 30, 2010 and 2009 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately \$11,920 at June 30, 2010. Wellmont has entered into contracts of approximately \$11,920 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was \$16,857 and 16,441 for the years ended June 30, 2010 and 2009, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2010 are as follows:

2011	\$	14,227
2012		12,318
2013		8,149
2014		3,763
2015		3,383
Thereafter		20,699
	\$	<u>62,539</u>

The HCHM lease to WHCMH is for 20 years and can be automatically extended for two additional terms of 10 years each. Should WHCMH generate annual net excess revenue over expenses, 50% shall be transferred to a designated fund in the Foundation for the purpose of healthcare projects. No transfers were required for the years ended June 30, 2010 and 2009.

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

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

(16) Functional Expense Disclosure

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

	<u>2010</u>	<u>2009</u>
Professional care of patients	\$ 605,360	617,198
Administrative and general	117,123	101,641
Fund-raising	1,235	1,260
	<u>\$ 723,718</u>	<u>720,099</u>

(17) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate company state income tax returns. These companies have combined net operating loss carryforwards for federal income tax purposes of approximately \$52,000 at June 30, 2010, which begin expiring in fiscal 2016 and expire through 2030. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont files a Form 990-T with the Internal Revenue Service to report such activity. Wellmont has net operating loss carryforwards for federal income tax purposes of approximately \$975 for unrelated business activities. Management believes that it is not more likely than not that deferred tax assets arising from net operating loss carryforwards will be realizable. Accordingly, these are fully reserved at June 30, 2010 and 2009.

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(18) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2010 and 2009 was as follows:

	<u>2010</u>	<u>2009</u>
Medicare	46%	45%
TennCare	4	4
Medicaid	8	8
Other third-party payors	31	31
Patients	11	12
	<u>100%</u>	<u>100%</u>

(19) Disclosures about Fair Value of Financial Instruments

(a) Fair Value of Financial Instruments

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

Cash and Cash Equivalents

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

Patient Accounts and Other Receivables

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

Investments and Assets Limited as to Use

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

Accounts Payable and Accrued Expenses

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

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

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

Long-Term Debt

The fair value of revenue bonds, using current market rates, was estimated at \$422,290 and \$344,863 for the years ended June 30, 2010 and 2009, respectively.

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(b) Fair Value Hierarchy

On July 1, 2008, Wellmont adopted new guidance issued by FASB for fair value measurement of financial assets and financial liabilities and for fair value measurement of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis now codified into ASC 820, *Fair Value Measurements and Disclosures*. ASC 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted market prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted market prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date.
- Level 2 inputs are inputs other than quoted market prices including within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.
- Level 3 inputs are unobservable inputs for the asset or liability.

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

In conjunction with the adoption of the new guidance, Wellmont elected to early adopt the measurement provisions of Accounting Standards Update No. 2009-12 to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. This guidance amends the previous guidance and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value, in many instances may not equal fair value that would be calculated pursuant to ASC 820. The fair value of these investments was \$56,972 and \$37,312 at June 30, 2010 and 2009, respectively.

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(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2010:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 35,711	—	—	35,711
Assets limited as to use:				
Stock mutual funds	109,629	—	—	109,629
Bond mutual funds	71,698	—	—	71,698
Cash and money market funds	50,555	—	—	50,555
Real estate funds	7,468	—	—	7,468
Alternative investments	—	18,043	39,362	57,405
Corporate bonds	6,867	—	—	6,867
	<u>246,217</u>	<u>18,043</u>	<u>39,362</u>	<u>303,622</u>
Long-term investments:				
Stock mutual funds	9,279	—	—	9,279
Bond mutual funds	7,599	—	—	7,599
Cash and money market funds	287	—	—	287
Real estate funds	1,722	—	—	1,722
Alternative investments	—	1,992	—	1,992
	<u>18,887</u>	<u>1,992</u>	<u>—</u>	<u>20,879</u>
Total assets	\$ <u>300,815</u>	<u>20,035</u>	<u>39,362</u>	<u>360,212</u>
Liabilities:				
Interest rate derivatives liability	\$ —	12,943	—	12,943
Total liability	\$ —	<u>12,943</u>	<u>—</u>	<u>12,943</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2009:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 60,889	—	—	60,889
Assets limited as to use:				
Stock mutual funds	108,036	—	—	108,036
Bond mutual funds	5,910	—	—	5,910
Cash and money market funds	85,386	—	—	85,386
Real estate funds	5,419	—	—	5,419
Alternative investments	—	2,295	33,291	35,586
Corporate bonds	7,464	—	—	7,464
	<u>212,215</u>	<u>2,295</u>	<u>33,291</u>	<u>247,801</u>
Long-term investments:				
Stock mutual funds	8,631	—	—	8,631
Bond mutual funds	3,648	—	—	3,648
Cash and money market funds	5,202	—	—	5,202
Real estate funds	1,255	—	—	1,255
Alternative investments	—	1,726	—	1,726
	<u>18,736</u>	<u>1,726</u>	<u>—</u>	<u>20,462</u>
Total assets	\$ <u>291,840</u>	<u>4,021</u>	<u>33,291</u>	<u>329,152</u>
Liabilities:				
Interest rate derivatives liability	\$ —	10,250	—	10,250
Total liability	\$ —	<u>10,250</u>	<u>—</u>	<u>10,250</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2010 and 2009

(Dollars in thousands)

The following table presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2010 and 2009:

	Alternative investments
Balance at June 30, 2008:	\$ 51,661
Total realized and unrealized gains (losses):	
Included in revenues and gains in excess of expenses and losses	—
Included in changes in net assets	(3,574)
Purchases, issuances, and settlements	(14,796)
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2009:	\$ 33,291
Total realized and unrealized gains (losses):	
Included in revenues and gains in excess of expenses and losses	—
Included in changes in net assets	469
Purchases, issuances, and settlements	5,602
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2010	\$ <u>39,362</u>



WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2011 and 2010

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

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

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

We have audited the accompanying consolidated balance sheets of Wellmont Health System and affiliates (Wellmont) as of June 30, 2011 and 2010, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended. These consolidated financial statements are the responsibility of Wellmont's management. 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 financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Wellmont's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Wellmont Health System and affiliates as of June 30, 2011 and 2010, and the consolidated results of their operations and changes in net assets, and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

KPMG LLP

October 27, 2011

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2011 and 2010

(Dollars in thousands)

Assets	2011	2010
Current assets:		
Cash and cash equivalents	\$ 36,558	35,711
Assets limited as to use, required for current liabilities	1,902	1,815
Patient accounts receivable, less allowance for uncollectible accounts of approximately \$24,246 and \$25,113 in 2011 and 2010, respectively	101,565	94,057
Other receivables	9,904	10,919
Inventories	17,830	18,294
Prepaid expenses and other current assets	7,163	7,003
Total current assets	174,922	167,799
Assets limited as to use, net of current portion	319,387	301,807
Land, buildings, and equipment, net	454,937	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	16,721	9,501
Other	1,875	730
	92,057	79,285
Total assets	\$ 1,041,303	999,096
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term debt	\$ 9,273	11,958
Short-term note payable	—	14,000
Accounts payable and accrued expenses	70,943	74,679
Estimated third-party payor settlements	9,533	11,672
Current portion of other long-term liabilities	8,527	7,251
Total current liabilities	98,276	119,560
Long-term debt, less current portion	459,260	467,833
Other long-term liabilities, less current portion	42,006	44,976
Total liabilities	599,542	632,369
Net assets:		
Unrestricted	434,661	358,620
Temporarily restricted	3,570	4,551
Permanently restricted	1,174	1,168
Total net assets attributable to Wellmont	439,405	364,339
Noncontrolling interests	2,356	2,388
Total net assets	441,761	366,727
Commitments and contingencies		
Total liabilities and net assets	\$ 1,041,303	999,096

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES
Consolidated Statements of Operations and Changes in Net Assets
Years ended June 30, 2011 and 2010
(Dollars in thousands)

	2011	2010
Revenue:		
Net patient service revenue	\$ 767,450	692,920
Other revenues	29,799	31,472
Total revenue	797,249	724,392
Expenses:		
Salaries and benefits	347,185	310,667
Medical supplies and drugs	160,565	150,143
Purchased services	80,348	74,922
Interest	20,750	20,110
Provision for bad debts	37,858	35,293
Depreciation and amortization	46,059	43,711
Other	87,319	66,734
Total expenses	780,084	701,580
Income from operations	17,165	22,812
Nonoperating gains (losses):		
Investment income	10,383	1,012
Derivative valuation adjustments	1,355	(2,693)
Other, net	(519)	(805)
Gain on refinancing	1,042	—
Nonoperating gains (losses), net	12,261	(2,486)
Revenue and gains in excess of expenses and losses before discontinued operations	29,426	20,326
Discontinued operations	44	(1,109)
Revenue and gains in excess of expenses and losses	29,470	19,217
Income attributable to noncontrolling interests	(1,238)	(1,062)
Revenues and gains in excess of expenses and losses attributable to Wellmont	28,232	18,155
Other changes in unrestricted net assets:		
Change in net unrealized gains on investments	42,186	22,312
Net assets released from restrictions for additions to land, buildings, and equipment	2,852	1,555
Change in the funded status of benefit plans and other	2,771	(3,428)
Increase in unrestricted net assets	76,041	38,594
Changes in temporarily restricted net assets:		
Contributions	2,566	2,934
Net assets released from temporary restrictions	(3,547)	(1,972)
(Decrease) increase in temporarily restricted net assets	(981)	962
Changes in permanently restricted net assets – investment income (loss)	6	(77)
Changes in noncontrolling interests:		
Adjustment due to adoption of authoritative guidance	—	2,054
Income attributable to noncontrolling interests	1,238	1,062
Distributions to noncontrolling interests	(1,178)	(711)
Change in noncontrolling percentages	(92)	(21)
(Decrease) increase in noncontrolling interests	(32)	2,384
Change in net assets	75,034	41,863
Net assets, beginning of year	366,727	324,864
Net assets, end of year	\$ 441,761	366,727

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2011 and 2010

(Dollars in thousands)

	<u>2011</u>	<u>2010</u>
Cash flows from operating activities:		
Change in net assets	\$ 75,034	41,863
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	46,070	43,755
(Gain) loss on disposal of land, buildings, and equipment	(864)	1,282
Equity in earnings of affiliated organizations	(4,478)	(6,773)
Distributions from affiliated organizations	5,320	6,730
Amortization of deferred financing costs	158	180
Net realized and unrealized gains on investments	(43,162)	(17,994)
Provision for bad debts	37,893	35,950
Change in fair value of derivative instruments	(1,355)	2,693
Gain on refinancing	(1,042)	—
Changes in assets and liabilities:		
Patient accounts receivable	(45,402)	(31,936)
Other current assets	303	(2,088)
Other assets	(538)	322
Accounts payable and accrued expenses	(6,729)	2,722
Estimated third-party payor settlements	(2,139)	(769)
Other current liabilities	1,276	899
Other liabilities	(63)	5,545
Net cash provided by operating activities	<u>60,282</u>	<u>82,381</u>
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	186,085	88,887
Purchase of investments	(164,635)	(127,131)
Purchase of land, buildings, and equipment	(42,352)	(55,684)
Proceeds from the sale of buildings and equipment	244	4,357
Cash paid for acquisitions	(7,826)	(2,421)
Distributions to affiliated organizations	—	(1,684)
Net cash used in investing activities	<u>(28,484)</u>	<u>(93,676)</u>
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	91,133	14,000
Payments on long-term debt	(106,069)	(12,083)
Payment of debt issuance costs	(2,015)	—
Payments on line of credit	(14,000)	(15,800)
Net cash used in financing activities	<u>(30,951)</u>	<u>(13,883)</u>
Net increase (decrease) in cash and cash equivalents	847	(25,178)
Cash and cash equivalents, beginning of year	<u>35,711</u>	<u>60,889</u>
Cash and cash equivalents, end of year	\$ <u><u>36,558</u></u>	\$ <u><u>35,711</u></u>

Supplemental disclosures of noncash items:

Wellmont entered into capital lease obligations for buildings and equipment in the amount of \$5,785 and \$1,290 in 2011 and 2010, respectively.

Additions to property and equipment financed through current liabilities of \$2,933 and \$5,182 in 2011 and 2010, respectively.

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2011 and 2010

(Dollars in thousands)

(1) Operations and Basis of Presentation

Wellmont Health System (Wellmont) was formed to assume operations of Bristol Regional Medical Center (BRMC) and Holston Valley Health Care, Inc. (HVHC), including Holston Valley Medical Center, Inc. (HVMC), and to act as sole corporate member of its consolidated foundations. Effective July 1, 1996, under terms of an agreement and plan of consolidation and merger, BRMC and HVHC, including HVMC, were merged and consolidated into Wellmont. Effective January 1, 1997, Lonesome Pine Hospital (LPH), a Virginia corporation, was merged into Wellmont under terms of a plan of merger and merger agreement. Effective July 1, 2000, Hawkins County Memorial Hospital (HCMH) transferred its operations and operating assets to Wellmont Hawkins County Memorial Hospital (WHCMH), a tax-exempt organization that is wholly owned and controlled by Wellmont. Hancock County Hospital (HCH), a critical access hospital, was opened in March 2005 to help provide for the immediate healthcare needs of the residents of Sneedville and the surrounding counties. As of July 16, 2007, Wellmont acquired Jenkins Community Hospital in Kentucky. As of August 1, 2007, Wellmont acquired two hospitals in Virginia, Lee Regional Medical Center in Pennington Gap and Mountain View Regional Medical Center in Norton. On May 30, 2008, Wellmont acquired the Holston Valley Cath Lab, an outpatient lab. On May 1, 2010, Wellmont acquired Cardiovascular Associates. On January 1, 2011 Wellmont acquired Pulmonary Associates of Kingsport.

As of April 30, 2009, Wellmont closed Jenkins. The consolidated financial statements for the years ended June 30, 2011 and 2010 present Jenkins as a discontinued operation. Losses of \$120 and \$474 for the years ended June 30, 2011 and June 30, 2010, respectively, are included in discontinued operations.

As of September 23, 2010 Wellmont sold the majority of Medical Mall Pharmacy's assets to a national pharmacy company for \$1,300 plus inventory value and recorded a gain of approximately \$517 at June 30, 2011. The consolidated financial statements for the years ended June 30, 2011 and 2010 present Medical Mall Pharmacy as a discontinued operation. Losses of \$353 and \$635 for the years ended June 30, 2011 and June 30, 2010, respectively, are included in discontinued operations.

All acute care operations remain separately licensed and are treated as operating divisions within Wellmont. Wellmont's continuing operations consist primarily of the delivery of healthcare services in northeast Tennessee, and southwest Virginia.

The consolidated financial statements include the acute care operations of the above entities along with:

- Wellmont Foundation (the Foundation), which was created from the merger of Bristol Regional Medical Center Foundation and Holston Valley Health Care Foundation, Inc. The Foundation conducts fund-raising activities for the benefit of Wellmont.
- Wellmont, Inc., a wholly owned taxable subsidiary of Wellmont, formed as the holding company of various other taxable subsidiaries that provide medical collection and medical laundry services, operate physician practices, provide other healthcare-related services, and invest in affiliates and other activities.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

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(Dollars in thousands)

- The Alzheimer's Center of East Tennessee was merged into Wellmont and changed its name to Wellmont Madison House effective September 1, 1997. Wellmont is the sole corporate member and the consolidated financial statements include the operations of this entity.

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

(2) Significant Accounting Policies

A summary of significant accounting policies follows:

(a) *Use of Estimates*

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

(b) *Cash and Cash Equivalents*

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

(c) *Investments*

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

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(Dollars in thousands)

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

(d) *Assets Limited as to Use*

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

(e) *Inventories*

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

(f) *Land, Buildings, and Equipment*

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

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

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(g) Goodwill

Effective July 1, 2010, Wellmont adopted ASU 2010-07 which in part requires healthcare entities to follow ASC Topic 350-20-35, *Intangibles – Goodwill and Other*. ASC Topic 350-20-35 requires goodwill of not-for-profit entities to be evaluated for impairment at least annually. The goodwill impairment test is a two-step test. Under the first step, the fair value of each reporting unit is compared with its carrying value (including goodwill). If the fair value of a reporting unit is less than its carrying value, an indication of goodwill impairment exists for the reporting unit and the entity must perform step two of the impairment test (measurement). Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit’s goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step two does not need to be performed. Wellmont has determined that the appropriate reporting unit for goodwill is the consolidated Wellmont entity and the annual impairment test is performed as of June 30. A summary of goodwill and related amortization for the year ended June 30 follows:

	<u>2010</u>	<u>Additions</u>	<u>Decreases</u>	<u>2011</u>
Goodwill	\$ 9,501	7,220	—	16,721
	<u>2009</u>	<u>Additions</u>	<u>Decreases</u>	<u>2010</u>
Goodwill	\$ 12,604	—	—	12,604
Amortization	(3,095)	(8)	—	(3,103)
	\$ 9,509	(8)	—	9,501

(h) Deferred Debt Expense

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

(i) Derivative Financial Instruments

As further described in note 12, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations

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(Dollars in thousands)

and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

(j) *Asset Retirement Obligations*

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

(k) *Temporarily and Permanently Restricted Net Assets*

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

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

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2011 and 2010 primarily included amounts related to the purchase of buildings and equipment for pediatrics, cancer, and other healthcare operations.

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

Wellmont has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Wellmont classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are approved for expenditure by the organization in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Wellmont considers the following factors in making a determination to appropriate or

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(Dollars in thousands)

accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the organization and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the organization; and (7) the investment policies of the organization.

(l) *Net Patient Service Revenue and Accounts Receivable*

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the period related services are rendered and adjusted in future periods as final and other settlements are determined. Wellmont provides care to patients who meet criteria under its charity care policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

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

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

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

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

(n) *Contributed Resources*

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted contributions, and are excluded from revenue and gains in excess of expenses and losses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets

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Notes to Consolidated Financial Statements

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(Dollars in thousands)

with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expiration of donor restrictions is reported when the donated or acquired long-lived assets are placed in service.

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

(o) Federal Income Taxes

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

On July 1, 2007, Wellmont adopted new guidance issued on the accounting for uncertainty in income tax positions now codified into ASC 740. It also provides guidance on when tax positions are recognized in an entity's financial statements and how the values of these positions are determined. There was no impact on Wellmont's consolidated financial statements as a result of the adoption of the new guidance.

(p) New Accounting Pronouncements

Effective July 1, 2010, Wellmont adopted the new provisions of ASC 810-10-65-1 regarding noncontrolling interests in consolidated financial statements. This guidance requires Wellmont to clearly identify and present ownership interest in subsidiaries held by parties other than Wellmont in the consolidated financial statements within the net assets section. It also requires the amounts of consolidated revenues and gains in excess of expenses and losses attributable to Wellmont and to the noncontrolling interest to be clearly identified and presented on the face of the consolidated statements of operations. Upon adoption, Wellmont recorded a reclassification of \$2,054 to reclass noncontrolling interest to net assets as of July 1, 2009.

In January 2010, the Financial Accounting Standards Board issued ASU 2010-06, *Improving Disclosures about Fair Value Measurements* (ASU 2010-06). ASU 2010-06 amends ASC Subtopic 820-10, Fair Value Measurements and Disclosures, to provide additional disclosure requirements for transfers into and out of Levels 1 and 2 and for activity in Level 3 and to clarify

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other existing disclosure requirements. WHS implemented ASU 2010-06 for the period ended June 30, 2011.

In January 2010, the Financial Accounting Standards Board issued ASU 2010-07, *Not-for-Profit Entities: Mergers and Acquisitions* (ASU 2010-07). ASU 2010-07 provides guidance on a transaction or other event in which a not-for-profit entity that is a reporting entity combines with one or more other not-for-profit, businesses or nonprofit activities in a transaction that meets the definition of a merger of not-for-profit entities or an acquisition by a not-for-profit entity. In addition the ASU provides transitional guidance on existing goodwill at the time this ASU is adopted. WHS adopted ASU 2010-07 effective July 1, 2010.

In August 2010, the Financial Accounting Standards Board issued ASU 2010-23, *Measuring Charity Care for Disclosure* (ASU 2010-23). ASU 2010-23 requires that cost be used as the measurement basis for charity care disclosures purposes and that cost can be identified as direct and indirect costs of providing charity care. The adoption of ASU 2010-23 will be effective for WHS beginning in fiscal year 2012.

In August 2010, the Financial Accounting Standards Board issued ASU 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries* (ASU 2010-24). ASU 2010-24 clarifies that healthcare entities should not net insurance recoveries against the related claim liability and that the claim liability amount should be determined without consideration of insurance recoveries. The adoption of ASU 2010-24 will be effective for WHS beginning in fiscal year 2012.

In July 2011, the Financial Accounting Standards Board issued ASU 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07). ASU 2011-07 will change WHS' presentation of provision for bad debts in the consolidated statements of operations and changes in net assets to a deduction from net patient service revenue. In addition there are enhanced disclosures about the entities policies for recognizing revenue and assessing bad debts. The ASU also requires disclosures of patient service revenue as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. The adoption of ASU 2011-07 will be effective for WHS beginning in fiscal year 2013 with early adoption permitted.

(q) Reclassifications

Certain 2010 amounts have been reclassified to conform to the 2011 consolidated financial statement presentation. The reclassifications had no impact on total assets or changes in net assets.

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(3) Net Patient Service Revenue

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

	<u>2011</u>	<u>2010</u>
Gross patient service charges	\$ 2,260,489	2,158,847
Less:		
Contractual adjustments and other discounts	(1,431,215)	(1,411,435)
Charity care	(61,824)	(54,492)
	<u>(1,493,039)</u>	<u>(1,465,927)</u>
Net patient service revenue	<u>\$ 767,450</u>	<u>692,920</u>

(4) Third-Party Reimbursement Arrangements

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

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

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

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Net patient service revenue in 2011 and 2010 related to Medicare, TennCare and Virginia Medicaid and net patient accounts receivable at June 30, 2011 and 2010 from Medicare, TennCare, and Virginia Medicaid were as follows:

	<u>2011</u>	<u>2010</u>
Net patient service revenue:		
Medicare	\$ 286,977	277,372
TennCare	23,575	22,918
Virginia Medicaid	22,555	23,536
Net patient accounts receivable:		
Medicare	\$ 34,671	41,125
TennCare	2,798	2,206
Virginia Medicaid	3,427	3,739

Wellmont has filed cost reports with Medicare and Virginia Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Virginia Medicaid cost reports have been audited and final settled by the intermediary through June 30, 2006 and audit adjustments have been received and considered for certain hospital and year-ends through June 30, 2010.

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

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased approximately \$2,319 and \$863 in 2011 and 2010, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of audits and final settlements, and years that are no longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2011 could differ materially from actual settlements based on the results of third-party audits.

(5) Charity Care and Community Services

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

Wellmont maintains records to identify and monitor the level of charity care it provides. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and

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the equivalent percentage of charity care patients to all patients serviced were \$61,824, \$18,080, and 2.73%, respectively, for the year ended June 30, 2011 and \$54,492, \$15,567, and 2.52%, respectively, for the year ended June 30, 2010.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and State indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont's cost of providing care to those patients totaled \$56,658 and \$55,461 for the years ended June 30, 2011 and 2010, respectively.

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

(6) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include hospital, home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in earnings of affiliates was approximately \$4,478 and \$6,773 for the years ended June 30, 2011 and 2010, respectively, and is included in other operating revenue in the consolidated financial statements. During FY2011, Wellmont Health Services, Inc. 20% membership interest in Spectrum Tennessee Network, LLC was exchanged through a capital contribution for a 1.19% membership interest in Lab Group Holdings, LLC. Wellmont received distributions of \$5,320 and \$6,730 during 2011 and 2010, respectively, which reduced Wellmont's overall investment in the affiliates.

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

	<u>2011</u>	<u>2010</u>
Total assets	\$ 127,545	129,720
Total liabilities	31,326	13,943
Total net assets	<u>\$ 96,219</u>	<u>115,777</u>
Net revenues	\$ 184,648	166,815
Expenses	171,070	142,534
Revenues in excess of expenses	<u>\$ 13,578</u>	<u>24,281</u>

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Wellmont's equity investment in these affiliates and its ownership percentage as of June 30, 2011 and 2010 are as follows:

	Amount		Percentage	
	2011	2010	2011	2010
Takoma Regional Hospital	\$ 11,161	12,645	60%	60%
Holston Valley Imaging Center (HVIC)	8,689	8,048	75	75
Advanced Home Care (AHC)	6,092	6,092	6	6
Spectrum Tennessee Network	—	3,850	—	20
Lab Group Holdings LLC	3,500	—	1	—
Others	1,735	1,384	4% – 50%	4% – 50%
	\$ 31,177	32,019		

Wellmont provided billing, management, and professional services to the affiliates. Income recognized by Wellmont for the services was \$943 in 2011 and \$1,766 in 2010 and is included in other revenues.

Included in other receivables are \$0 and \$124 as of June 30, 2011 and 2010, respectively, of amounts due to Wellmont from these entities.

Although Wellmont's ownership percentage in Takoma Regional Hospital and HVIC is greater than 50%, Wellmont does not consolidate these entities because Wellmont only has a 50% representation on each respective board and does not have control over these entities.

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(7) Investments

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

	<u>2011</u>	<u>2010</u>
Assets limited as to use by Board for capital improvements:		
Stock mutual funds	\$ 88,073	109,629
Bond mutual funds	112,176	71,698
Cash and money market funds	904	1,474
Real estate funds	8,475	7,468
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds)		
Liquid	37,421	33,915
Illiquid	<u>26,837</u>	<u>23,490</u>
	<u>273,886</u>	<u>247,674</u>
Assets limited as to use under self-insurance agreements:		
Corporate bonds	7,877	6,867
Cash and money market funds	<u>652</u>	<u>558</u>
	<u>8,529</u>	<u>7,425</u>
Assets limited as to use under bond indenture agreements:		
Cash and money market funds	37,659	47,286
U.S. Treasury bonds	1,215	1,237
Less assets limited as to use that are required for current liabilities	<u>1,902</u>	<u>1,815</u>
Assets limited as to use, net of current portion	<u>\$ 319,387</u>	<u>301,807</u>
Long-term investments:		
Stock mutual funds	\$ 12,198	9,279
Bond mutual funds	9,433	7,599
Preferred equity investment and related options	11,512	11,512
Cash, money market funds, and certificates of deposit	191	287
Real estate funds	832	1,722
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds)	<u>2,271</u>	<u>1,992</u>
Total long-term investments	<u>\$ 36,437</u>	<u>32,391</u>

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately \$8,805 as of June 30, 2011 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which \$353 was paid subsequent to June 30, 2011.

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Wellmont has invested \$10,000 in the preferred equity of a regional managed services organization and \$1,512 on a right of first refusal related to any future sale of this organization. This equity has a guaranteed annual return of at least 6.5% of the outstanding preferred equity balance.

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

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, the Company recognized other-than-temporary impairment losses of \$610 and \$8,233 on investments as of June 30, 2011 and 2010, respectively. The unrealized losses on these mutual funds were primarily caused by the overall decline in the world's economy. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2011 and 2010, were as follows:

	Less than 12 months		12 months or more		Total	
	Unrealized Losses	Fair value	Unrealized Losses	Fair value	Unrealized Losses	Fair value
2011:						
Alternative investments	\$ —	—	402	5,421	402	5,421
Stock mutual funds	616	75,091	9	158	625	75,249
	<u>\$ 616</u>	<u>75,091</u>	<u>411</u>	<u>5,579</u>	<u>1,027</u>	<u>80,670</u>
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2010:						
Alternative investments	\$ —	—	910	4,219	910	4,219
Stock mutual funds	2,184	29,658	24,817	83,713	27,001	113,371
	<u>\$ 2,184</u>	<u>29,658</u>	<u>25,727</u>	<u>87,932</u>	<u>27,911</u>	<u>117,590</u>

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

	<u>2011</u>	<u>2010</u>
Interest and dividends net of amounts capitalized	\$ 9,407	5,330
Realized gains (losses) on investments	976	(4,318)
Investment income, net	<u>\$ 10,383</u>	<u>1,012</u>
Change in net unrealized gains on investments	<u>\$ 42,186</u>	<u>22,312</u>

(8) Land, Buildings, and Equipment

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

	<u>2011</u>	<u>2010</u>
Land	\$ 49,060	41,210
Buildings and improvements	509,382	488,285
Equipment	328,604	327,896
Buildings and equipment under capital lease obligations	39,661	39,591
	<u>926,707</u>	<u>896,982</u>
Less accumulated depreciation	<u>(484,187)</u>	<u>(459,935)</u>
	442,520	437,047
Construction in progress	12,417	13,158
Land, buildings, and equipment	<u>\$ 454,937</u>	<u>450,205</u>

Depreciation expense for the years ended June 30, 2011 and 2010 was \$46,070 and \$43,755, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was \$15,336 and \$13,266 as of June 30, 2011 and 2010, respectively.

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(9) Other Long-Term Liabilities

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

	<u>2011</u>	<u>2010</u>
Workers' compensation liability	\$ 7,812	6,606
Professional and general liability	12,830	11,183
Postretirement benefit obligation	7,763	5,861
Asset retirement obligation	2,912	3,710
Deferred gain on sale of assets	628	1,382
Derivative liability	11,588	12,943
Pension benefit liability	6,526	10,018
Other	474	524
	<u>50,533</u>	<u>52,227</u>
Less current portion	<u>(8,527)</u>	<u>(7,251)</u>
Total other long-term liabilities	<u>\$ 42,006</u>	<u>44,976</u>

(10) Short-Term Note Payable

At June 30, 2010, WHS had a \$14,000 note payable with a variable interest rate based upon LIBOR plus 2% and a termination date of December, 2010. During 2011, the \$14,000 note payable was paid in full.

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(11) Debt

(a) Long-Term Debt

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

	<u>2011</u>	<u>2010</u>
Hospital Revenue Refunding Bonds, Series 2011	\$ 76,165	—
Hospital Revenue Bonds, Series 2010 (Bank Qualified)	14,968	—
Hospital Revenue Bonds, Series 2007A	55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	200,000	200,000
Hospital Revenue Refunding Bonds, Series 2006A and 2006B	—	93,405
Hospital Revenue Refunding Bonds, Series 2005	59,580	61,810
Hospital Revenue Bonds, Series 2003	33,035	36,666
Notes payable	4,749	6,429
Capital lease obligations	16,889	19,698
Other	1,237	358
	<u>461,623</u>	<u>473,366</u>
Unamortized premium	7,287	7,538
Unamortized discount	<u>(377)</u>	<u>(1,113)</u>
	468,533	479,791
Less current maturities	<u>(9,273)</u>	<u>(11,958)</u>
	<u>\$ 459,260</u>	<u>467,833</u>

(b) Series 2011 Bonds

On May 5, 2011, Wellmont refunded the Revenue Bonds, Series 2006A, with the proceeds of the Revenue Bonds, Series 2011. The Series 2011 Bonds were issued by Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2006A and to pay the costs of issuing the Series 2011 Bonds.

In order to refund the Series 2006A Bonds, Wellmont made a tender offer to the holders of the Series 2006A Bonds. The holders of all outstanding Series 2006A Bonds agreed to tender their Series 2006A Bonds to Wellmont. Proceeds of the Series 2011 Bonds were used to pay the purchase price of Series 2006A Bonds tendered for purchase. All outstanding Series 2006A Bonds were purchased by the Wellmont on the date of issuance of the Bonds and were immediately surrendered to the trustee for the Series 2006A Bonds for retirement and cancellation.

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The Series 2011 Bonds were issued with two maturities of \$42,385 and \$33,780 for 2026 and 2032, respectively. The Series 2011 Bonds maturing September 1, 2026 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates starting on September 1, 2013 and ending on September 1, 2026 in annual amounts ranging from \$865 to \$4,680. The Series 2011 Bonds maturing September 1, 2032 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates starting on September 1, 2027 and ending on September 1, 2032 in annual amounts ranging from \$4,980 to \$6,300. The Series 2011 Bonds were issued as fixed rate obligations at 6.0% and 6.5% for the two maturities (2026 and 2032, respectively).

(c) *Series 2010 Bank Qualified Bonds*

On November 1, 2010, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee (the Board) issued \$30,000 Hospital Revenue Bonds, Series 2010 (Bank Qualified). The Series 2010 Bonds were issued and sold pursuant to the Bond Purchase Agreement dated as of November 1, 2010, between the Board and First Tennessee Bank National Association. As of June 30, 2011, Wellmont has received advances on the bonds in the amount of \$14,968.

Commencing on January 1, 2011, and continuing on the first day of each fiscal quarter thereafter, WHS shall pay accrued interest on the outstanding balance of the loan. Commencing on October 1, 2011 and continuing on the first day of each fiscal quarter thereafter, WHS shall also make principal payments equal to \$500,000. The outstanding bonds accrue interest at a rate equal to the product of 65% of the sum of LIBOR plus the applicable margin which at June 30, 2011 was set at 1.95%.

(d) *Series 2007 Bonds*

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

Principal on outstanding Series 2007A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from \$360 to \$2,460 commencing on September 1, 2017 through September 1, 2036, with a balloon payment of \$29,245 due on September 1, 2037. The outstanding bonds accrue interest at rates ranging from 5.125% to 5.25%.

(e) *Series 2006 C*

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

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

(f) Series 2006 A and B

On June 23, 2006, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, \$98,475 of Hospital Revenue Refunding Bonds, Series 2006. This bond issuance consisted of Series A tax-exempt and Series B taxable bonds of \$76,595 and \$21,880, respectively. The Series 2006 Bonds together with other available funds were used to advance refund all the previously issued Hospital Revenue Bonds, Series 1993, to reimburse Wellmont for payments made on other taxable borrowings and to pay certain expenses incurred in connection with the issuance of the Series 2006 Bonds. Upon this refunding, a trust was established to pay all future bond payments related to the Series 1993 Bonds. Wellmont was deemed to have paid the Series 1993 Bonds and these Bonds are no longer deemed to be outstanding for purposes of the Series 1993 Trust Indenture.

Principal on outstanding Series 2006A Bonds was payable through maturity or mandatory sinking fund redemption in annual amounts ranging from \$875 to \$6,400 commencing on September 1, 2013 through September 1, 2032; and the outstanding bonds accrued interest on a variable rate, which was reset monthly based upon the AAA-insured Municipal Market Data Index, plus 85 basis points. Principal on outstanding Series 2006B Bonds was payable through maturity in annual amounts ranging from \$1,600 to \$2,930 commencing on September 1, 2007 through September 1, 2016, and the outstanding bonds accrued interest at a fixed rate of 6.95%.

Outstanding Series 2006A Bonds were subject to redemption prior to maturity at the option of The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%-102% of the principal amount of the Series 2006A Bonds being redeemed, plus accrued interest thereon to the redemption date.

On October 1, 2010, the Series 2006B Bonds were called and paid in full at par value of \$14,880.

On May 5, 2011, the Series 2006A Bonds were refunded with the proceeds of the Revenue Bonds, Series 2011.

(g) Series 2005

On December 8, 2005, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, \$70,620 of Hospital Revenue Refunding Bonds, Series 2005. The Series 2005 Bonds together with other available funds were used to advance refund the previously issued Hospital Revenue Bonds, Series 2002, and to pay certain expenses incurred in connection with the issuance of the Series 2005 Bonds.

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Principal on outstanding Series 2005 Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from \$1,945 to \$3,390 commencing on September 1, 2007 through September 1, 2032. The terms of the bonds provide that bondholders may redeem or put the bonds to the remarketing agent on dates that approximate a weekly basis. The remarketing agent is obligated to remarket the redeemed bonds on a “best efforts” basis. Redeemed bonds are repaid to bondholders from the proceeds of the remarketing effort or, in the event of an inability to remarket the bonds, from a letter of credit. This letter secures the bonds in the event of a failed remarketing or liquidity issue. In the event of a liquidity drawing under the letter of credit, Wellmont shall pay the Base Rate equal to the greater of (i) the Prime Rate plus 1.5% per annum, (ii) LIBOR plus 2.5% per annum, or (iii) 7.50% per annum. Wellmont shall repay the liquidity drawing amount in twelve equal quarterly installments, with the first such installment due on the first anniversary of the related liquidity drawing.

Outstanding Series 2005 Bonds are subject to redemption prior to maturity at the option of The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%-102% of the principal amount of the Series 2005 Bonds being redeemed, plus accrued interest thereon to the redemption date.

(h) Series 2003

On June 1, 2003, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, \$59,100 of Hospital Revenue Bonds, Series 2003. The bonds were issued to provide funds necessary to refund Wellmont’s Hospital Revenue Bonds, Series 1993 (HVHC), to fund a debt service reserve fund and to pay certain expenses incurred in connection with the issuance of the Series 2003 Bonds.

The Wellmont Series 2003 Bonds consist of \$27,460 in fixed-rate serial bonds and \$19,280 in fixed-rate term bonds payable through maturity or mandatory sinking fund redemption maturing in annual amounts ranging from \$3,230 on September 1, 2007 to \$4,140 on September 1, 2019, and carrying interest rates ranging from 2.5% to 5.00%.

(i) Master Trust Indenture

The master trust indentures and loan agreements for the 2011, 2010, 2007, 2006, 2005, and 2003 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

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

(j) Notes Payable

During 2007, Wellmont entered into a five-year \$3,000 note payable, which has a fixed interest rate of 7.25% and a termination date of July 2011. At June 30, 2011 and 2010, \$1,784 and \$2,062, respectively, was outstanding on this note.

During 2008, Wellmont entered into a five-year \$2,400 term note payable, which has a fixed interest rate of 7.25% and a termination date of August 2012. At June 30, 2011 and 2010, \$1,120 and \$1,600, respectively, was outstanding on this note.

During 2010, Wellmont entered into a \$2,767 note payable to finance the purchase of Cardiovascular Associates. The note payable has a fixed interest rate of 5.5% and a termination date of May, 2013. At June 30, 2011 and 2010, \$1,845 and \$2,767, respectively, was outstanding on this note.

(k) Capital Lease Obligations

Wellmont has entered into leases for certain equipment under agreements classified as capital leases that expire over periods through 2011. Assets under capital leases are included in property and equipment and have a net carrying value of \$24,325 and \$26,325 as of June 30, 2011 and 2010, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 4.3% to 12%.

(l) Long-term Debt Maturities Schedule

Bond maturities in accordance with the original terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2011 are as follows:

2012	\$	9,273
2013		13,454
2014		9,572
2015		9,608
2016		9,896
Thereafter		409,820
	\$	<u>461,623</u>

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The following table reflects the required repayment terms for the years ended June 30 of Wellmont's debt obligations in the event that the put options associated with the 2005 bonds were exercised, but not successfully remarketed.

2012	\$	9,273
2013		25,337
2014		26,110
2015		26,032
2016		11,887
Thereafter		<u>362,984</u>
	\$	<u>461,623</u>

Interest paid for the years ended June 30, 2011 and 2010 was \$20,750 and \$20,792, respectively, net of amounts capitalized. Interest costs of \$590 and \$2,776, net of interest income of \$49 and \$683 in 2011 and 2010, respectively, were capitalized.

(12) Derivative Transactions

Wellmont is a party to a number of interest rate swap agreements. Such swaps have not been designated as hedges and are valued at estimated fair value in the accompanying consolidated balance sheets. By using derivative financial instruments to hedge exposures to changes in interest rates, Wellmont exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes Wellmont, which creates credit risk for Wellmont. When the fair value of a derivative contract is negative, Wellmont owes the counterparty, and therefore, Wellmont is not exposed to the counterparty's credit risk in those circumstances. Pursuant to the terms of its interest rate swap agreements, Wellmont is required to post collateral with its counterparties under certain specified conditions. Collateral posting requirements are based on the amount of Wellmont's derivative liability and Wellmont's bond rating. As of June 30, 2011, and 2010, Wellmont was not required to post collateral related to its swaps.

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

In September and October, 2008, the counterparty and credit support provider, for four of the swaps held at June 30, 2010, filed bankruptcy. Subsequent to the bankruptcy filings and into 2011, no payments were made by Wellmont or the counterparty to each other. During 2011, Wellmont and the counterparty agreed to settle all amounts due on the swaps for net cash flow receivables or payables. The bankruptcy process is underway and the ultimate outcome regarding any final settlement cannot be determined at this time.

Wellmont has a Total Return Swap on the Series 2011 Bonds with a new counterparty.

Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its variable rate debt structure using LIBOR rates. The fair value as of June 30, 2011 and

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2010 of approximately \$(11,588) and \$(12,943), respectively, is included in other liabilities in the consolidated balance sheets. The change in the fair value of the derivative instruments was approximately \$1,355 and \$(2,693), respectively, in 2011 and 2010 and is included in nonoperating gains (losses), net in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. The following is a summary of the interest rate swap information as of June 30, 2011:

<u>Type of interest swap</u>	<u>Debt hedging</u>	<u>Notional amount</u>	<u>Effective date</u>	<u>Maturity date</u>	<u>Rate paid</u>	<u>Rate received</u>	<u>Swap fair value asset (liability)</u>
Total return swap	Series 2011	\$ 76,165	May 5, 2011	September 1, 2032	1.440%	6.200%	\$ (377)
Pay fixed interest rate swap	Series 2005	59,580	December 13, 2005	September 1, 2016	3.548	0.309	(5,954)
Basis swap	Series 2002	62,730	September 1, 2002	September 1, 2032	0.090	0.124	(1,715)
Pay fixed interest rate swap	*	35,342	October 24, 2003	September 1, 2021	3.613	0.124	(3,542)
							<u>\$ (11,588)</u>

* Previously designated bond series has been refinanced.

The following is a schedule detailing the swap information as of June 30, 2010:

<u>Type of interest swap</u>	<u>Debt hedging</u>	<u>Notional amount</u>	<u>Effective date</u>	<u>Maturity date</u>	<u>Rate paid</u>	<u>Rate received</u>	<u>Swap fair value asset (liability)</u>
Total return swap	Series 2006A	\$ 76,595	June 29, 2006	September 1, 2011	1.103%	5.440%	\$ 1,101
Pay fixed interest rate swap	Series 2005	65,975	December 13, 2005	September 1, 2016	3.548	0.217	(6,810)
Basis swap	Series 2002	67,965	September 1, 2002	September 1, 2032	0.253	0.198	(2,710)
Pay fixed interest rate swap	Series 2006A	35,342	October 24, 2003	September 1, 2021	3.613	0.162	(4,524)
							<u>\$ (12,943)</u>

(13) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined contribution retirement plan (Retirement Plan) that covers substantially all employees. This program and the related Retirement Plan were created from amendments, restatements, and mergers of existing defined contribution plans at BRMC and HVMC. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 3% of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Code, up to 3% of each participant's wages. The total pension expense related to the Retirement Plan was \$10,344 and \$9,990 for the years ended June 30, 2011 and 2010, respectively.

HVMC sponsored a noncontributory, defined benefit pension plan covering substantially all its employees. However, effective June 30, 1996, this plan was frozen and no further benefits accrue. LPH also sponsors a defined benefit pension plan covering substantially all its employees.

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HVMC's defined pension benefits are actuarially determined based on a formula taking into consideration an employee's compensation and years of service. HVMC's funding policy is to make annual contributions to the plan based upon the funding standard developed by the plan actuary. This standard uses the projected unit credit actuarial cost method, including the amortization of prior service costs, over a 20-year period. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. The LPH plan contains similar funding and actuarial policies.

On June 30, 2007, the HVMC plan merged into LPH plan and the plan name changed to Wellmont Health System Defined Benefit Plan. At the end of 2008, only a single defined pension plan exists. Collectively, the two defined benefit plans are referred to as the "Plans." Effective June 30, 2010, the plan was frozen for all Lonesome Pine Hospital employees and no further benefits will be accrued.

Wellmont recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined benefit pension plans as an asset or liability in its consolidated balance sheet and recognizes changes in that funded status in the year in which the changes occur as a change in unrestricted net assets. All defined benefit pension plans use a June 30 measurement date.

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

	<u>2011</u>	<u>2010</u>
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 44,565	40,035
Service cost	220	230
Interest cost	2,390	2,432
Actuarial losses	896	4,008
Benefits paid	(2,239)	(2,140)
Curtailments *	(495)	—
	<u>45,337</u>	<u>44,565</u>
Change in plan assets:		
Fair value of plan assets at beginning of year	34,547	33,326
Actual return on plan assets	6,503	3,361
Benefits paid	(2,239)	(2,140)
	<u>38,811</u>	<u>34,547</u>
Funded status	\$ <u>(6,526)</u>	<u>(10,018)</u>
Amounts recognized in the accompanying consolidated balance sheets:		
Pension benefit liability (other long-term liabilities)	\$ (6,526)	(10,018)

* Reflects frozen benefit accruals for Lonesome Pine participants as of June 30, 2011.

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	<u>2011</u>	<u>2010</u>
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:		
Unrecognized actuarial loss	\$ 8,565	13,158
Unrecognized prior service cost	<u>—</u>	<u>2</u>
Net amounts included as an accumulated charge to unrestricted net assets	<u>\$ 8,565</u>	<u>13,160</u>
Calculation of change in unrestricted net assets:		
Accumulated charge to unrestricted net assets, end of year	\$ 8,565	13,160
Reversal of accumulated charge to unrestricted net assets, prior year	<u>(13,160)</u>	<u>(10,853)</u>
Change in unrestricted net assets	<u>\$ (4,595)</u>	<u>2,307</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Prior service credit adjustment for curtailment	\$ (1)	—
Actuarial (gain) loss arising during the year	(3,763)	2,907
Amortization of actuarial loss	(831)	(600)
Amortization of prior service cost	<u>—</u>	<u>—</u>
Net amounts recognized as a charge to unrestricted net assets	<u>\$ (4,595)</u>	<u>2,307</u>

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	<u>2011</u>	<u>2010</u>
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2012:		
Amortization of net loss	\$ 382	791
Amortization of prior service cost	—	—
Estimated future benefit payments:		
Fiscal 2012	2,276	2,220
Fiscal 2013	2,369	2,337
Fiscal 2014	2,492	2,472
Fiscal 2015	2,596	2,578
Fiscal 2016 (FY10 fiscal 2016 – 2020)	2,671	14,278
Fiscal 2017 – 2021	14,819	
Weighted average assumptions used to determine benefit obligations:		
Settlement (discount) rate	5.50%	5.50%
Weighted average rate of increase in future compensation levels	3.00	3.00
Components of net periodic benefit cost (benefit):		
Service cost	\$ 220	230
Interest cost	2,390	2,432
Expected return on plan assets	(2,340)	(2,259)
Amortization of net loss	831	600
Amortization of unrecognized prior service cost curtailments	1	—
Net periodic benefit cost	<u>\$ 1,102</u>	<u>1,003</u>
Weighted average assumptions used to determine net periodic benefit cost:		
Settlement (discount) rate	5.50%	6.25%
Expected long-term return on plan assets (HVMC)	7.00	7.00
Expected long-term return on plan assets (LPH)	7.00	7.00
Weighted average rate of increase in future compensation levels	3.00	3.00

Wellmont's overall expected long-term rate of return on assets is 7.00%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

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

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The table below shows the target allocation and actual asset allocations as of June 30, 2011 and 2010:

Asset	Target allocation	2011	2010
Equity securities	65%	46%	56%
Fixed income	28	35	27
Cash	5 – 15%	2	1
Other	5 – 15%	17	16

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

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

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

	Postretirement benefits	
	2011	2010
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 5,861	5,653
Interest cost	365	320
Plan participants contributions	79	73
Actuarial losses	1,686	197
Benefits Paid	<u>(228)</u>	<u>(382)</u>
Benefit obligation at end of year	<u>7,763</u>	<u>5,861</u>
Change in plan assets:		
Fair value of plan assets at beginning of year	—	—
Employer contribution	149	309
Plan participants contributions	79	73
Benefits paid	<u>(228)</u>	<u>(382)</u>
Fair value of plan assets at end of year	<u>—</u>	<u>—</u>
Funded Status	<u>\$ 7,763</u>	<u>5,861</u>
Amounts recognized in the consolidated balance sheets consist of:		
Noncurrent assets	\$ —	—
Current liabilities	(271)	(499)
Noncurrent liabilities	(7,492)	(5,362)
Accumulated charge to unrestricted net assets	<u>1,755</u>	<u>3,560</u>
	<u>\$ (6,008)</u>	<u>(2,301)</u>

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

	2011	2010
Net actuarial gain	\$ 1,755	3,560

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Net periodic benefit cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2011 and 2010 were:

	Postretirement benefits	
	2011	2010
Net periodic benefit cost		
Interest cost	\$ 365	320
Amortization of net gain	(119)	(319)
Net periodic benefit cost recognized	<u>246</u>	<u>1</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	1,686	197
Amortization of net gain	119	319
Total recognized as a charge to unrestricted net assets	<u>1,805</u>	<u>516</u>
Total recognized in net periodic benefit cost and unrestricted net assets	<u>\$ 2,051</u>	<u>517</u>

The net gain and prior service credit for the defined benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are \$(88) and \$(261), respectively. Weighted average assumptions used to determine benefit obligations for 2011 and 2010 were as follows:

	2011	2010
Discount rate	5.00%	5.00%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2011 and 2010 were as follows:

	Postretirement benefits	
	2011	2010
Discount rate	5.00%	6.00%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00	5.00

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Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

For measurement purposes, a 5% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2011.

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

	<u>2011</u>	<u>2010</u>
Effect of one-percentage point increase in healthcare cost trend on:		
Service and interest cost	\$ 27	20
Accumulated pension benefit obligation	545	330
Effect of one-percentage point decrease in healthcare cost trend on:		
Service and interest cost	(24)	(18)
Accumulated pension benefit obligation	(486)	(294)

The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2011 and 2010, respectively, were as follows:

Fair Value measurement at June 30, 2011				
Pension benefits – plan assets				
	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Stock mutual funds	\$ 31,311	31,311	—	—
Cash and money market funds	764	764	—	—
Alternative funds	6,868	—	3,280	3,588
Total	\$ 38,943	32,075	3,280	3,588

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Fair Value measurement at June 30, 2010				
Pension benefits - plan assets				
	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Stock mutual funds	\$ 28,803	19,412	9,391	—
Cash and money market funds	244	244	—	—
Alternative funds	5,500	—	—	5,500
Total	\$ 34,547	19,656	9,391	5,500

The following table presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (level 3) as defined in ASC 820 for the years ended June 30, 2011 and 2010:

	Alternative investments
Balance at June 30, 2009	\$ 5,133
Net change in value	254
Purchases, issuances, and settlements	113
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2010	5,500
Net change in value	1,349
Purchases, issuances, and settlements	19
Transfers in and/or out of Level 3 (net)	(3,280)
Balance at June 30, 2011	\$ 3,588

(14) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers' compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont has established revocable self-insurance trust funds to provide for professional and general liability claims and workers' compensation claims and related expenses. Wellmont's contributions to the self-insurance trusts are based upon actuarial determinations by an independent service company. The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers' compensation program is supplemented for Tennessee and Virginia by excess workers' compensation policies, with a commercial carrier for statutory limits per occurrence. Provisions based on

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actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Insurance expense under these programs amounted to approximately \$4,692 and \$3,414 for the years ended June 30, 2011 and 2010, respectively, and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2011 and 2010, Wellmont was involved in litigation relating to medical malpractice and workers' compensation claims arising in the ordinary course of business. There are also known incidents which occurred through June 30, 2011 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2011 are adequate to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

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

(15) Commitments and Contingencies

Construction in progress at June 30, 2011 and 2010 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately \$12,448 at June 30, 2011. Wellmont has entered into contracts of \$12,448 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was \$18,179 and \$16,857 for the years ended June 30, 2011 and 2010, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2011 are as follows:

2012	\$	13,168
2013		10,071
2014		6,269
2015		5,491
2016		4,190
Thereafter		28,904
	\$	<u>68,093</u>

Wellmont has entered into contractual employment relationships with physicians to provide services to Wellmont physician practices that are intended to qualify under the employee safe harbor of the Anti-Kickback Statute and the employee exception of the Physician Self-Referral Law. These contracts

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have terms of varying lengths, guarantee certain base payments, and may provide for additional incentives based upon productivity.

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

(16) Functional Expense Disclosure

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

	<u>2011</u>	<u>2010</u>
Professional care of patients	\$ 636,403	583,222
Administrative and general	142,768	117,123
Fund-raising	913	1,235
	<u>\$ 780,084</u>	<u>701,580</u>

(17) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate company state income tax returns. These companies have combined net operating loss carry forwards for federal income tax purposes of approximately \$67,000 at June 30, 2011, which begin expiring in fiscal 2018 and expire through 2032. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont Health System participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont Health System files a Form 990-T with the IRS to report such activity. Wellmont Health System has net operating loss carry forwards for federal income tax purposes of approximately \$1,766 for unrelated business activities. Management believes that it is not more likely than not that deferred tax assets arising from net operating loss carry forwards will be realizable. Accordingly, these are fully reserved at June 30, 2011 and 2010.

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(18) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2011 and 2010, was as follows:

	2011	2010
Medicare	42%	46%
TennCare	4	4
Medicaid	9	8
Other third-party payors	35	31
Patients	10	11
	100%	100%

(19) Disclosures about Fair Value of Financial Instruments

(a) Fair Value of Financial Instruments

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

- *Cash and Cash Equivalents*

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

- *Patient Accounts and Other Receivables*

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

- *Investments and Assets Limited as to Use*

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

- *Accounts Payable and Accrued Expenses*

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

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

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

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- *Long-Term Debt*

The fair value of revenue bonds, using current market rates, was estimated at \$419,960 and \$422,290 for the years ended June 30, 2011 and 2010, respectively.

(b) *Fair Value Hierarchy*

On July 1, 2008, Wellmont adopted new guidance issued by FASB for fair value measurement of financial assets and financial liabilities and for fair value measurement of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis now codified into ASC 820, *Fair Value Measurements and Disclosures*. ASC 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted market prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted market prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date.
- Level 2 inputs are inputs other than quoted market prices including within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.
- Level 3 inputs are unobservable inputs for the asset or liability.

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

In conjunction with the adoption of the new guidance, Wellmont elected to early adopt the measurement provisions of Accounting Standards Update No. 2009-12 to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. This guidance amends the previous guidance and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value, in many instances may not equal fair value that would be calculated pursuant to ASC 820. The fair value of these investments was \$66,529 and \$59,397 at June 30, 2011 and 2010, respectively.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2011 and 2010

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2011:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 36,558	—	—	36,558
Assets limited as to use:				
Stock mutual funds	88,073	—	—	88,073
Bond mutual funds	112,176	—	—	112,176
Cash and money market funds	39,215	—	—	39,215
Real estate funds	8,475	—	—	8,475
Alternative investments	—	26,480	37,778	64,258
Corporate bonds	7,877	—	—	7,877
U.S. Treasury bonds	1,215	—	—	1,215
Subtotal	<u>293,589</u>	<u>26,480</u>	<u>37,778</u>	<u>357,847</u>
Long-term investments:				
Stock mutual funds	12,198	—	—	12,198
Bond mutual funds	9,433	—	—	9,433
Cash and money market funds	191	—	—	191
Real estate funds	832	—	—	832
Alternative investments	—	2,271	—	2,271
Subtotal	<u>22,654</u>	<u>2,271</u>	<u>—</u>	<u>24,925</u>
	<u>\$ 316,243</u>	<u>28,751</u>	<u>37,778</u>	<u>382,772</u>
Liabilities:				
Derivatives liability	\$ —	11,588	—	11,588
Total	\$ —	<u>11,588</u>	<u>—</u>	<u>11,588</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2011 and 2010

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2010:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 35,711	—	—	35,711
Assets limited as to use:				
Stock mutual funds	109,629	—	—	109,629
Bond mutual funds	71,698	—	—	71,698
Cash and money market funds	49,318	—	—	49,318
Real estate funds	7,468	—	—	7,468
Alternative investments	—	18,043	39,362	57,405
Corporate bonds	6,867	—	—	6,867
U.S. Treasury bonds	1,237	—	—	1,237
Subtotal	<u>281,928</u>	<u>18,043</u>	<u>39,362</u>	<u>339,333</u>
Long-term investments:				
Stock mutual funds	9,279	—	—	9,279
Bond mutual funds	7,599	—	—	7,599
Cash and money market funds	287	—	—	287
Real estate funds	1,722	—	—	1,722
Alternative investments	—	1,992	—	1,992
Subtotal	<u>18,887</u>	<u>1,992</u>	<u>—</u>	<u>20,879</u>
	<u>\$ 300,815</u>	<u>20,035</u>	<u>39,362</u>	<u>360,212</u>
Liabilities:				
Derivatives liability	\$ —	12,943	—	12,943
Total	\$ —	<u>12,943</u>	<u>—</u>	<u>12,943</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2011 and 2010

(Dollars in thousands)

The following table presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2011 and 2010:

	Alternative investments
Balance at June 30, 2009:	\$ 33,291
Total realized and unrealized gains (losses)	
Included in revenues and gains in excess of expenses and losses	—
Included in changes in net assets	469
Purchases, issuances and settlements	5,602
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2010	39,362
Total realized and unrealized gains (losses)	
Included in revenues and gains in excess of expenses and losses	
Included in changes in net assets	(3,401)
Purchases, issuances and settlements	1,817
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2011	\$ <u><u>37,778</u></u>

(20) Subsequent Events

WHS has evaluated subsequent events from the balance sheet date through October 27, 2011, the date at which the financial statements were available to be issued. No material subsequent events were identified for recognition.



WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2012 and 2011

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

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

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

We have audited the accompanying consolidated balance sheets of Wellmont Health System and affiliates (Wellmont) as of June 30, 2012 and 2011, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended. These consolidated financial statements are the responsibility of Wellmont's management. 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 financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Wellmont's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Wellmont Health System and affiliates as of June 30, 2012 and 2011, and the consolidated results of their operations and changes in their net assets, and their cash flows for the years then ended, in conformity with U.S. generally accepted accounting principles.

As discussed in note 2 to the consolidated financial statements, Wellmont changed its presentation of provision for bad debts as a result of the adoption of Accounting Standards Update No. 2011-07, *Health Care Entities: Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*.

KPMG LLP

October 24, 2012

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2012 and 2011

(Dollars in thousands)

Assets	2012	2011
Current assets:		
Cash and cash equivalents	\$ 44,930	36,558
Assets limited as to use, required for current liabilities	4,372	1,902
Patient accounts receivable, less allowance for uncollectible accounts of approximately \$25,656 and \$24,246 in 2012 and 2011, respectively	108,265	101,565
Other receivables	23,805	9,904
Inventories	17,862	17,830
Prepaid expenses and other current assets	7,462	7,163
Total current assets	<u>206,696</u>	<u>174,922</u>
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	17,090	16,721
Other	651	1,875
	<u>92,439</u>	<u>92,057</u>
Total assets	<u>\$ 1,096,213</u>	<u>1,041,303</u>
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	<u>114,473</u>	<u>98,276</u>
Long-term debt, less current portion	459,654	458,882
Other long-term liabilities, less current portion	54,060	42,384
Total liabilities	<u>628,187</u>	<u>599,542</u>
Net assets:		
Unrestricted	458,218	434,661
Temporarily restricted	5,739	3,570
Permanently restricted	1,304	1,174
Total net assets attributable to Wellmont	<u>465,261</u>	<u>439,405</u>
Noncontrolling interests	2,765	2,356
Total net assets	<u>468,026</u>	<u>441,761</u>
Commitments and contingencies		
Total liabilities and net assets	<u>\$ 1,096,213</u>	<u>1,041,303</u>

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES
Consolidated Statements of Operations and Changes in Net Assets
Years ended June 30, 2012 and 2011
(Dollars in thousands)

	<u>2012</u>	<u>2011</u>
Revenue:		
Patient service revenue	\$ 813,229	767,450
Provision for bad debt	(71,407)	(37,858)
Net patient revenue less provision for bad debt	<u>741,822</u>	<u>729,592</u>
Other revenues	47,904	29,799
Total revenue	<u>789,726</u>	<u>759,391</u>
Expenses:		
Salaries and benefits	368,772	347,185
Medical supplies and drugs	164,397	160,565
Purchased services	79,509	80,348
Interest	21,677	20,750
Depreciation and amortization	46,403	46,059
Other	86,645	87,319
Total expenses	<u>767,403</u>	<u>742,226</u>
Income from operations	<u>22,323</u>	<u>17,165</u>
Nonoperating gains (losses):		
Investment income	17,272	10,383
Derivative valuation adjustments	1,807	1,355
Other, net	—	(519)
Gain on refinancing	—	1,042
Nonoperating gains, net	<u>19,079</u>	<u>12,261</u>
Revenue and gains in excess of expenses and losses before discontinued operations	<u>41,402</u>	<u>29,426</u>
Discontinued operations	88	44
Revenue and gains in excess of expenses and losses	<u>41,490</u>	<u>29,470</u>
Income attributable to noncontrolling interests	(1,670)	(1,238)
Revenues and gains in excess of expenses and losses attributable to Wellmont	<u>39,820</u>	<u>28,232</u>
Other changes in unrestricted net assets:		
Change in net unrealized gains on investments	(9,534)	42,186
Net assets released from restrictions for additions to land, buildings, and equipment	3,766	2,852
Change in the funded status of benefit plans and other	(10,495)	2,771
Increase in unrestricted net assets	<u>23,557</u>	<u>76,041</u>
Changes in temporarily restricted net assets:		
Contributions	6,661	2,566
Net assets released from temporary restrictions	(4,492)	(3,547)
Increase (decrease) in temporarily restricted net assets	<u>2,169</u>	<u>(981)</u>
Changes in permanently restricted net assets – investment income	130	6
Changes in noncontrolling interests:		
Income attributable to noncontrolling interests	1,670	1,238
Distributions to noncontrolling interests	(1,261)	(1,178)
Change in noncontrolling percentages	—	(92)
Increase (decrease) in noncontrolling interests	<u>409</u>	<u>(32)</u>
Change in net assets	<u>26,265</u>	<u>75,034</u>
Net assets, beginning of year	<u>441,761</u>	<u>366,727</u>
Net assets, end of year	<u>\$ 468,026</u>	<u>441,761</u>

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2012 and 2011

(Dollars in thousands)

	<u>2012</u>	<u>2011</u>
Cash flows from operating activities:		
Change in net assets	\$ 26,265	75,034
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	46,403	46,070
Gain on disposal of land, buildings, and equipment	(458)	(864)
Equity in earnings of affiliated organizations	(7,233)	(4,478)
Distributions from affiliated organizations	5,764	5,320
Amortization of deferred financing costs	428	158
Net realized and unrealized loss (gain) on investments	2,633	(43,162)
Provision for bad debts	71,407	37,893
Change in fair value of derivative instruments	(1,807)	(1,355)
Gain on refinancing	—	(1,042)
Changes in assets and liabilities:		
Patient accounts receivable	(78,107)	(45,402)
Other current assets	(331)	303
Other assets	(13,920)	(538)
Accounts payable and accrued expenses	10,230	(6,729)
Estimated third-party payor settlements	6,002	(2,139)
Other current liabilities	(2,745)	1,276
Other liabilities	13,672	(63)
Net cash provided by operating activities	<u>78,203</u>	<u>60,282</u>
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	149,087	186,085
Purchase of investments	(174,029)	(164,635)
Purchase of land, buildings, and equipment	(46,026)	(42,352)
Proceeds from the sale of buildings and equipment	1,721	244
Cash paid for acquisitions	(813)	(7,826)
Net cash used in investing activities	<u>(70,060)</u>	<u>(28,484)</u>
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	11,368	91,133
Payments on long-term debt	(11,139)	(106,069)
Payment of debt issuance costs	—	(2,015)
Payments on line of credit	—	(14,000)
Net cash provided by (used in) financing activities	<u>229</u>	<u>(30,951)</u>
Net increase in cash and cash equivalents	8,372	847
Cash and cash equivalents, beginning of year	<u>36,558</u>	<u>35,711</u>
Cash and cash equivalents, end of year	\$ <u>44,930</u>	\$ <u>36,558</u>

Supplemental disclosures of noncash items:

Wellmont entered into capital lease obligations for buildings and equipment in the amount of \$3,281 and \$5,785 in 2012 and 2011, respectively.

Additions to property and equipment financed through current liabilities of \$2,487 and \$2,933 in 2012 and 2011, respectively.

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Dollars in thousands)

(1) Operations and Basis of Presentation

Wellmont Health System (Wellmont) was formed to assume operations of Bristol Regional Medical Center (BRMC) and Holston Valley Health Care, Inc. (HVHC), including Holston Valley Medical Center, Inc. (HVMC), and to act as sole corporate member of its consolidated foundation. Effective July 1, 1996, under terms of an agreement and plan of consolidation and merger, BRMC and HVHC, including HVMC, were merged and consolidated into Wellmont. Effective January 1, 1997, Lonesome Pine Hospital (LPH), a Virginia corporation, was merged into Wellmont under terms of a plan of merger and merger agreement. Effective July 1, 2000, Hawkins County Memorial Hospital (HCMH) transferred its operations and operating assets to Wellmont Hawkins County Memorial Hospital (WHCMH), a tax-exempt organization that is wholly owned and controlled by Wellmont. Hancock County Hospital (HCH), a critical access hospital, was opened in March 2005 to help provide for the immediate healthcare needs of the residents of Sneedville and the surrounding counties. As of July 16, 2007, Wellmont acquired Jenkins Community Hospital in Kentucky. As of August 1, 2007, Wellmont acquired two hospitals in Virginia, Lee Regional Medical Center in Pennington Gap and Mountain View Regional Medical Center in Norton. On May 30, 2008, Wellmont acquired the Holston Valley Cath Lab, an outpatient lab. On May 1, 2010, Wellmont acquired Cardiovascular Associates. On January 1, 2011, Wellmont acquired Pulmonary Associates of Kingsport.

As of April 30, 2009, Wellmont closed Jenkins. The consolidated financial statements for the years ended June 30, 2012 and 2011 present Jenkins as a discontinued operation. Losses of \$4 and \$120 for the years ended June 30, 2012 and June 30, 2011, respectively, are included in discontinued operations.

As of September 23, 2010 Wellmont sold the majority of Medical Mall Pharmacy's assets to a national pharmacy company for \$1,300 plus inventory value and recorded a gain of approximately \$517 at June 30, 2011. The consolidated financial statements for the years ended June 30, 2012 and 2011 present Medical Mall Pharmacy as a discontinued operation. The gains (losses) of \$92 and \$(353) for the years ended June 30, 2012 and June 30, 2011, respectively, are included in discontinued operations.

All acute care operations remain separately licensed and are treated as operating divisions within Wellmont. Wellmont's continuing operations consist primarily of the delivery of healthcare services in northeast Tennessee and southwest Virginia.

The consolidated financial statements include the acute care operations of the above entities along with:

- Wellmont Foundation (the Foundation), which was created from the merger of Bristol Regional Medical Center Foundation and Holston Valley Health Care Foundation, Inc. The Foundation conducts fund-raising activities for the benefit of Wellmont.
- Wellmont, Inc., a wholly owned taxable subsidiary of Wellmont, formed as the holding company of various other taxable subsidiaries that provide medical collection and medical laundry services, operate physician practices, provide other healthcare-related services, and invest in affiliates and other activities.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Dollars in thousands)

- The Alzheimer's Center of East Tennessee was merged into Wellmont and changed its name to Wellmont Madison House effective September 1, 1997. Wellmont is the sole corporate member and the consolidated financial statements include the operations of this entity.

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

(2) Significant Accounting Policies

A summary of significant accounting policies is as follows:

(a) *Use of Estimates*

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

(b) *Cash and Cash Equivalents*

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

(c) *Investments*

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Dollars in thousands)

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

(d) *Assets Limited as to Use*

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

(e) *Inventories*

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

(f) *Land, Buildings, and Equipment*

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

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Dollars in thousands)

(g) Goodwill

Effective July 1, 2010, Wellmont adopted Accounting Standards Update (ASU) No. 2010-07, *Not for Profit Entities: Mergers and Acquisitions* which in part requires healthcare entities to follow Accounting Standards Codification (ASC) Topic 350-20-35, *Intangibles – Goodwill and Other*. ASC Topic 350-20-35 requires goodwill of not-for-profit entities to be evaluated for impairment at least annually. The goodwill impairment test is a two-step test. Under the first step, the fair value of each reporting unit is compared with its carrying value (including goodwill). If the fair value of a reporting unit is less than its carrying value, an indication of goodwill impairment exists for the reporting unit and the entity must perform step two of the impairment test (measurement). Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step two does not need to be performed. The annual impairment test is performed as of June 30. A summary of goodwill and related amortization for the years ended June 30 follows:

	<u>2011</u>	<u>Additions</u>	<u>Decreases</u>	<u>2012</u>
Goodwill	\$ 16,721	369	—	17,090
	<u>2010</u>	<u>Additions</u>	<u>Decreases</u>	<u>2011</u>
Goodwill	\$ 9,501	7,220	—	16,721

(h) Deferred Debt Expense

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

(i) Derivative Financial Instruments

As further described in note 12, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Dollars in thousands)

(j) *Asset Retirement Obligations*

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

(k) *Temporarily and Permanently Restricted Net Assets*

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

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

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2012 and 2011 primarily included amounts related to the purchase of equipment for pediatrics, cancer, and other healthcare operations.

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Dollars in thousands)

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

(l) *Net Patient Service Revenue and Accounts Receivable*

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

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

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

The consolidated statements of operations and changes in net assets include revenue and gains in excess of expenses and losses. Changes in unrestricted net assets that are excluded from revenue and gains in excess of expenses and losses, consistent with industry practice, include changes in net

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unrealized gains (losses) on investments other than trading securities, changes in the funded status of Wellmont's defined-benefit plan, contributions of long-lived assets, including assets acquired using contributions that, by donor restriction, were to be used for the purposes of acquiring such assets, and cumulative effects of changes in accounting principles.

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

(n) Contributed Resources

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

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

(o) Federal Income Taxes

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

On July 1, 2007, Wellmont adopted new guidance issued on the accounting for uncertainty in income tax positions now codified into ASC 740. It also provides guidance on when tax positions are recognized in an entity's financial statements and how the values of these positions are determined. There was no impact on Wellmont's consolidated financial statements as a result of the adoption of the new guidance.

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(p) New Accounting Pronouncements

In August 2010, the Financial Accounting Standards Board issued ASU No. 2010-23, *Measuring Charity Care for Disclosure* (ASU 2010-23). ASU 2010-23 requires that cost be used as the measurement basis for charity care disclosures purposes and that cost can be identified as direct and indirect costs of providing charity care. The adoption of ASU 2010-23 as of July 1, 2011 had no impact on the consolidated financial statements. In August 2010, the Financial Accounting Standards Board issued ASU No. 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries* (ASU 2010-24). ASU 2010-24 clarifies that healthcare entities should not net insurance recoveries against the related claim liability and that the claim liability amount should be determined without consideration of insurance recoveries. The adoption of ASU 2010-24 as of July 1, 2011 had no impact on the consolidated financial statements.

In July 2011, the Financial Accounting Standards Board issued ASU No. 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07). Wellmont adopted ASU 2011-07 on July 1, 2011 and applied it retrospectively to fiscal year 2011. Wellmont's presentation of provision for bad debts in the consolidated statements of operations and changes in net assets is now shown as a deduction from net patient service revenue. In addition, there are enhanced disclosures about the entities policies for recognizing revenue and assessing bad debts. The ASU also requires disclosures of patient service revenue as well as qualitative and quantitative information about changes in the allowance for doubtful accounts.

The Financial Accounting Standards Board issued ASU No. 2011-08, *Intangibles – Goodwill and Other (Topic 350): Testing Goodwill for Impairment* (ASU 2011-08) in September 2011. ASU 2011-08 allows entities to assess qualitative factors first to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If the initial determination is negative, then the entity does not need to perform the two-step impairment test. If the conclusion is otherwise, then the entity must perform the first step of the two-step impairment test. The adoption of ASU 2011-08 will be effective for Wellmont beginning in fiscal year 2013.

The Financial Accounting Standards Board issued ASU No. 2011-11, *Balance Sheet (Topic 210): Disclosures about Offsetting Assets and Liabilities* (ASU 2011-11) in December 2011. This ASU requires improved disclosures about financial instruments and derivative instruments that are offset in accordance with Section 210-20-45 or Section 815-10-45 or subject to an enforceable master netting arrangement or similar agreement. The adoption of ASU 2011-11 will be effective for Wellmont beginning in fiscal year 2014.

(q) Reclassifications

Certain 2011 amounts have been reclassified to conform to the 2012 consolidated financial statement presentation. The reclassifications had no impact on total assets or changes in net assets.

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(3) Net Patient Service Revenue

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

	<u>2012</u>	<u>2011</u>
Gross patient service revenue	\$ 2,398,999	2,260,489
Less:		
Contractual adjustments and other discounts	(1,524,110)	(1,431,215)
Charity care	<u>(61,660)</u>	<u>(61,824)</u>
Net patient service revenue before provision for bad debts	813,229	767,450
Less provision for bad debts	<u>(71,407)</u>	<u>(37,858)</u>
Net patient service revenue	<u>\$ 741,822</u>	<u>729,592</u>

Wellmont's allowance for doubtful accounts is predominantly for self-pay patients and patient balances remaining after third-party payments. The provision for bad debts increased \$33,549 from fiscal 2011 to fiscal 2012 and the net write-offs increased \$31,272 from fiscal 2011 to fiscal 2012. Both increases were the result of negative trends experienced in the collection of amounts from patients in fiscal year 2012 as a result of the economic conditions and due to the increased proportion of patient financial responsibility for those patients with health insurance. Wellmont has not changed its charity care or uninsured discount policies during fiscal 2012. Wellmont does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

(4) Third-Party Reimbursement Arrangements

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

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

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

Net patient service revenue in 2012 and 2011 related to Medicare, TennCare, and Medicaid and net patient accounts receivable at June 30, 2012 and 2011 from Medicare, TennCare, and Medicaid were as follows:

	<u>2012</u>	<u>2011</u>
Net patient service revenue:		
Medicare	\$ 312,202	285,821
TennCare	28,548	23,791
Medicaid	19,541	22,336
Net patient accounts receivable:		
Medicare	\$ 41,883	34,671
TennCare	2,957	2,798
Medicaid	5,244	3,427

Wellmont has filed cost reports with Medicare and Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Medicaid cost reports have been audited and final settled by the intermediary through June 30, 2006 and audit adjustments have been received and considered for certain hospitals and year-ends through June 30, 2010.

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

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased approximately \$3,575 and \$2,319 in 2012 and 2011, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of audits and final settlements, and years that are no longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2012 could differ materially from actual settlements based on the results of third-party audits.

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(5) Meaningful Use Incentives

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

During the fiscal year ended June 30, 2012, Wellmont recorded \$13.1 million in other operating revenue related to the EHR and meaningful use incentives. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria.

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

(6) Charity Care and Community Services

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

Wellmont maintains records to identify and monitor the level of charity care it provides. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and the equivalent percentage of charity care patients to all patients serviced were \$61,660, \$16,144, and 2.57%, respectively, for the year ended June 30, 2012 and \$61,824, \$16,982, and 2.73%, respectively, for the year ended June 30, 2011.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and State indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont’s cost of providing care to those patients totaled \$44,432 and \$49,180, for the years ended June 30, 2012 and 2011, respectively.

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

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(7) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include hospital, home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in earnings of affiliates was approximately \$7,233 and \$4,478 for the years ended June 30, 2012 and 2011, respectively, and is included in other operating revenue in the consolidated financial statements. Wellmont received distributions of \$5,764 and \$5,320 during 2012 and 2011, respectively, which reduced Wellmont's overall investment in the affiliates.

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

		<u>2012</u>	<u>2011</u>
Total assets	\$	127,206	127,545
Total liabilities		<u>27,732</u>	<u>31,326</u>
Total net assets	\$	<u>99,474</u>	<u>96,219</u>
Net revenues	\$	228,644	184,648
Expenses		<u>207,806</u>	<u>171,070</u>
Revenues in excess of expenses	\$	<u>20,838</u>	<u>13,578</u>

Wellmont's equity investment in these affiliates and its ownership percentage as of June 30, 2012 and 2011 is as follows:

		<u>Amount</u>		<u>Percentage</u>	
		<u>2012</u>	<u>2011</u>	<u>2012</u>	<u>2011</u>
Takoma Regional Hospital	\$	12,350	11,161	60%	60%
Holston Valley Imaging Center (HVIC)		8,818	8,689	75	75
Advanced Home Care (AHC)		6,092	6,092	6	6
Lab Group Holdings LLC		3,500	3,500	1	1
Others		<u>1,886</u>	<u>1,735</u>	4% – 50%	4% – 50%
	\$	<u>32,646</u>	<u>31,177</u>		

Although Wellmont's ownership percentage in Takoma Regional Hospital and HVIC is greater than 50%, Wellmont does not consolidate these entities because Wellmont only has a 50% representation on each respective board and does not have control over these entities.

Wellmont provided billing, management, and professional services to some of the affiliates. Income recognized by Wellmont for the services was \$929 in 2012 and \$943 in 2011 and is included in other revenues.

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During the fiscal year ended June 30, 2012, Takoma Regional Hospital recorded \$3.2 million in net revenue related to the EHR and meaningful use incentives of which \$1.9 million is included as income in affiliates in Wellmont's consolidated financial statements. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria.

Included in other receivables are \$374 and \$320 as of June 30, 2012 and 2011, respectively, of amounts due to Wellmont from these entities.

(8) Investments

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

	<u>2012</u>	<u>2011</u>
Assets limited as to use by Board for capital improvements:		
Stock mutual funds	\$ 88,942	80,413
Bond mutual funds	163,401	119,836
Cash and money market funds	1,492	904
Real estate funds	7,157	8,475
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):		
Liquid	9,616	37,421
Illiquid	<u>27,373</u>	<u>26,837</u>
	<u>297,981</u>	<u>273,886</u>
Assets limited as to use under self-insurance agreements:		
Corporate bonds	2,673	7,877
Cash and money market funds	<u>32</u>	<u>652</u>
	<u>2,705</u>	<u>8,529</u>
Assets limited as to use under bond indenture agreements:		
Cash and money market funds	42,716	37,659
U.S. Treasury bonds	—	1,215
Less assets limited as to use that are required for current liabilities	<u>4,372</u>	<u>1,902</u>
Assets limited as to use, net of current portion	<u>\$ 339,030</u>	<u>319,387</u>

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	<u>2012</u>	<u>2011</u>
Long-term investments:		
Stock mutual funds	\$ 10,321	10,897
Bond mutual funds	13,926	10,734
Preferred equity investment and related option	11,512	11,512
Cash, money market funds, and certificates of deposit	189	191
Real estate funds	685	832
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds)	—	2,271
Total long-term investments	<u>\$ 36,633</u>	<u>36,437</u>

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately \$6,705 as of June 30, 2012 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which \$157 was paid subsequent to June 30, 2012.

Wellmont has invested \$10,000 in the preferred equity of a regional managed services organization and \$1,512 on a right of first refusal related to any future sale of this organization. This equity has a guaranteed annual return of at least 6.5% of the outstanding preferred equity balance.

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

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, Wellmont recognized other-than-temporary impairment losses of \$265 and \$610 on investments as of June 30, 2012 and 2011, respectively. The unrealized losses on these mutual funds were primarily caused by the overall decline in the world's economy. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

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Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2012 and 2011, were as follows:

	<u>Less than 12 months</u>		<u>12 months or more</u>		<u>Total</u>	
	<u>Unrealized losses</u>	<u>Fair value</u>	<u>Unrealized losses</u>	<u>Fair value</u>	<u>Unrealized losses</u>	<u>Fair value</u>
2012:						
Alternative investments	\$ 129	52	—	—	129	52
Mutual funds	2,692	55,142	2,903	15,407	5,595	70,549
	<u>\$ 2,821</u>	<u>55,194</u>	<u>2,903</u>	<u>15,407</u>	<u>5,724</u>	<u>70,601</u>
2011:						
Alternative investments	\$ —	—	402	5,421	402	5,421
Mutual funds	616	75,091	9	158	625	75,249
	<u>\$ 616</u>	<u>75,091</u>	<u>411</u>	<u>5,579</u>	<u>1,027</u>	<u>80,670</u>

Investment income comprises the following for the years ended June 30:

	<u>2012</u>	<u>2011</u>
Interest and dividends net of amounts capitalized	\$ 10,371	9,407
Realized gains on investments	6,901	976
Investment income, net	<u>\$ 17,272</u>	<u>10,383</u>
Change in net unrealized (losses) gains on investments	\$ (9,534)	42,186

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(9) Land, Buildings, and Equipment

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

	<u>2012</u>	<u>2011</u>
Land	\$ 49,397	49,060
Buildings and improvements	526,243	509,382
Equipment	364,973	328,604
Buildings and equipment under capital lease obligations	42,404	39,661
	<u>983,017</u>	<u>926,707</u>
Less accumulated depreciation	<u>(527,828)</u>	<u>(484,187)</u>
	455,189	442,520
Construction in progress	<u>2,859</u>	<u>12,417</u>
Land, buildings, and equipment	<u>\$ 458,048</u>	<u>454,937</u>

Depreciation expense for the years ended June 30, 2012 and 2011 was \$46,359 and \$46,070, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was \$17,234 and \$15,336 as of June 30, 2012 and 2011, respectively.

(10) Other Long-Term Liabilities

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

	<u>2012</u>	<u>2011</u>
Workers' compensation liability	\$ 9,097	7,812
Professional and general liability	12,535	12,830
Postretirement benefit obligation	7,039	7,763
Asset retirement obligation	2,994	2,912
Deferred gain on sale of assets	439	628
Derivative liability	9,781	11,588
Pension benefit liability	17,290	6,526
Other	667	852
	<u>59,842</u>	<u>50,911</u>
Less current portion	<u>(5,782)</u>	<u>(8,527)</u>
Total other long-term liabilities	<u>\$ 54,060</u>	<u>42,384</u>

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(11) Debt

(a) Long-Term Debt

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

	2012	2011
Hospital Revenue Refunding Bonds, Series 2011	\$ 76,165	76,165
Hospital Revenue Bonds, Series 2010 (Bank Qualified)	24,836	14,968
Hospital Revenue Bonds, Series 2007A	55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	200,000	200,000
Hospital Revenue Refunding Bonds, Series 2005	57,250	59,580
Hospital Revenue Bonds, Series 2003	29,230	33,035
Notes payable	3,102	4,749
Capital lease obligations	18,514	16,889
Other	826	859
	464,923	461,245
Unamortized premium	7,005	7,287
Unamortized discount	(361)	(377)
	471,567	468,155
Less current maturities	(11,913)	(9,273)
	\$ 459,654	458,882

(b) Series 2011 Bonds

On May 5, 2011, Wellmont refunded the Revenue Bonds, Series 2006A, with the proceeds of the Revenue Bonds, Series 2011. The Series 2011 Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2006A and to pay the costs of issuing the Series 2011 Bonds.

In order to refund the Series 2006A Bonds, Wellmont made a tender offer to the holders of the Series 2006A Bonds. The holders of all outstanding Series 2006A Bonds agreed to tender their Series 2006A Bonds to Wellmont. Proceeds of the Series 2011 Bonds were used to pay the purchase price of Series 2006A Bonds tendered for purchase. All outstanding Series 2006A Bonds were purchased by the Wellmont on the date of issuance of the Bonds and were immediately surrendered to the trustee for the Series 2006A Bonds for retirement and cancellation.

The Series 2011 Bonds were issued with two maturities of \$42,385 and \$33,780 for 2026 and 2032, respectively. The Series 2011 Bonds maturing September 1, 2026 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2013 and ending on September 1, 2026 in annual

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amounts ranging from \$865 to \$4,680. The Series 2011 Bonds maturing September 1, 2032 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2027 and ending on September 1, 2032 in annual amounts ranging from \$4,980 to \$6,300. The Series 2011 Bonds were issued as fixed-rate obligations at 6.0% and 6.5% for the two maturities (2026 and 2032, respectively).

(c) Series 2010 Bank Qualified Bonds

On November 1, 2010, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee (the Board) issued \$30,000 Hospital Revenue Bonds, Series 2010 (Bank Qualified). The Series 2010 Bonds were issued and sold pursuant to the Bond Purchase Agreement dated as of November 1, 2010, between the Board and First Tennessee Bank National Association. During the fiscal year ended June 30, 2012 and 2011, Wellmont has received advances on the bonds in the amounts of \$11,368 and \$14,968, respectively.

Commencing on January 1, 2011, and continuing on the first day of each fiscal quarter thereafter, Wellmont shall pay accrued interest on the outstanding balance of the loan. Commencing on October 1, 2011 and continuing on the first day of each fiscal quarter thereafter, Wellmont shall also make principal payments equal to \$500. The outstanding bonds accrue interest at a rate equal to the product of 65% of the sum of LIBOR plus the applicable margin, which at June 30, 2012 was set at 1.95%.

(d) Series 2007 Bonds

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

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

(e) Series 2006 C

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

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

(f) Series 2006 A and B

On June 23, 2006, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, \$98,475 of Hospital Revenue Refunding Bonds, Series 2006. This bond issuance consisted of Series A tax-exempt and Series B taxable bonds of \$76,595 and \$21,880, respectively. The Series 2006 Bonds together with other available funds were used to advance refund all the previously issued Hospital Revenue Bonds, Series 1993, to reimburse Wellmont for payments made on other taxable borrowings and to pay certain expenses incurred in connection with the issuance of the Series 2006 Bonds. Upon this refunding, a trust was established to pay all future bond payments related to the Series 1993 Bonds. Wellmont was deemed to have paid the Series 1993 Bonds and these Bonds are no longer deemed to be outstanding for purposes of the Series 1993 Trust Indenture.

Principal on outstanding Series 2006A Bonds was payable through maturity or mandatory sinking fund redemption in annual amounts ranging from \$875 to \$6,400 commencing on September 1, 2013 through September 1, 2032; and the outstanding bonds accrued interest on a variable rate, which was reset monthly based upon the AAA-insured Municipal Market Data Index, plus 85 basis points. Principal on outstanding Series 2006B Bonds was payable through maturity in annual amounts ranging from \$1,600 to \$2,930 commencing on September 1, 2007 through September 1, 2016, and the outstanding bonds accrued interest at a fixed rate of 6.95%.

Outstanding Series 2006A Bonds were subject to redemption prior to maturity at the option of The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100% – 102% of the principal amount of the Series 2006A Bonds being redeemed, plus accrued interest thereon to the redemption date.

On October 1, 2010, the Series 2006B Bonds were called and paid in full at par value of \$14,880.

On May 5, 2011, the Series 2006A Bonds were refunded with the proceeds of the Revenue Bonds, Series 2011.

(g) Series 2005

On December 8, 2005, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, \$70,620 of Hospital Revenue Refunding Bonds, Series 2005. The Series 2005 Bonds together with other available funds were used to advance refund the previously issued Hospital Revenue Bonds, Series 2002, and to pay certain expenses incurred in connection with the issuance of the Series 2005 Bonds.

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Principal on outstanding Series 2005 Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from \$1,945 to \$3,390 commencing on September 1, 2007 through September 1, 2032. The terms of the bonds provide that bondholders may redeem or put the bonds to the remarketing agent on dates that approximate a weekly basis. The remarketing agent is obligated to remarket the redeemed bonds on a “best efforts” basis. Redeemed bonds are repaid to bondholders from the proceeds of the remarketing effort or, in the event of an inability to remarket the bonds, from a letter of credit. This letter secures the bonds in the event of a failed remarketing or liquidity issue. In the event of a liquidity drawing under the letter of credit, Wellmont shall pay the Base Rate equal to the greater of (i) the Prime Rate plus 1.50% per annum, (ii) LIBOR plus 2.50% per annum, or (iii) 7.50% per annum. Wellmont shall repay the liquidity drawing amount in 12 equal quarterly installments, with the first such installment due on the first anniversary of the related liquidity drawing.

Outstanding Series 2005 Bonds are subject to redemption prior to maturity at the option of The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100% – 102% of the principal amount of the Series 2005 Bonds being redeemed, plus accrued interest thereon to the redemption date.

(h) Series 2003

On June 1, 2003, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, \$59,100 of Hospital Revenue Bonds, Series 2003. The bonds were issued to provide funds necessary to refund Wellmont’s Hospital Revenue Bonds, Series 1993 (HVHC), to fund a debt service reserve fund and to pay certain expenses incurred in connection with the issuance of the Series 2003 Bonds.

The Wellmont Series 2003 Bonds consist of \$27,460 in fixed-rate serial bonds and \$19,280 in fixed-rate term bonds payable through maturity or mandatory sinking fund redemption maturing in annual amounts ranging from \$3,230 on September 1, 2007 to \$4,140 on September 1, 2019, and carrying interest rates ranging from 2.5% to 5.00%.

(i) Master Trust Indenture

The master trust indentures and loan agreements for the 2011, 2010, 2007, 2006, 2005, and 2003 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

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

(j) Notes Payable

During 2007, Wellmont entered into a five-year \$3,000 note payable, which has a fixed interest rate of 7.25% and a termination date of July 2011. In August 2011, Wellmont renewed this note agreement in the amount of \$1,760 with a variable interest rate indexed to the Wall Street Journal U.S. Prime Rate with a ceiling of 7.75% and a floor of 4.00% and a maturity date of August 2016. At June 30, 2012 and 2011, \$1,540 and \$1,784, respectively, was outstanding on this note.

During 2009, Wellmont entered into a five-year \$2,400 term note payable with a variable interest rate indexed to the Wall Street Journal U.S. Prime Rate and a maturity date of October 2013. At June 30, 2012 and 2011, \$640 and \$1,120, respectively, was outstanding on this note.

During 2010, Wellmont entered into a \$2,767 note payable to finance the purchase of Cardiovascular Associates. The note payable has a fixed interest rate of 5.5% and a termination date of May, 2013. At June 30, 2012 and 2011, \$922 and \$1,845, respectively, was outstanding on this note.

(k) Capital Lease Obligations

Assets under capital leases are included in property and equipment and have a net carrying value of \$25,170 and \$24,325 as of June 30, 2012 and 2011, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 4.3% to 12.0%.

(l) Long-Term Debt Maturities Schedule

Bond maturities in accordance with the original terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2012 are as follows:

2013	\$	11,913
2014		10,230
2015		10,294
2016		10,610
2017		11,253
Thereafter		410,623
	\$	<u>464,923</u>

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The following table reflects the required repayment terms for the years ended June 30 of Wellmont's debt obligations in the event that the put options associated with the 2005 bonds were exercised, but not successfully remarketed.

2013	\$	11,913
2014		21,390
2015		25,907
2016		26,103
2017		12,916
Thereafter		<u>366,694</u>
	\$	<u>464,923</u>

Interest paid for the years ended June 30, 2012 and 2011 was \$22,216 and \$21,957, respectively, net of amounts capitalized. Interest costs of \$0 and \$590, net of interest income of \$0 and \$49 in 2012 and 2011, respectively, were capitalized.

(12) Derivative Transactions

Wellmont is a party to a number of interest rate swap agreements. Such swaps have not been designated as hedges and are valued at estimated fair value in the accompanying consolidated balance sheets. By using derivative financial instruments to hedge exposures to changes in interest rates, Wellmont exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes Wellmont, which creates credit risk for Wellmont. When the fair value of a derivative contract is negative, Wellmont owes the counterparty, and therefore, Wellmont is not exposed to the counterparty's credit risk in those circumstances. Pursuant to the terms of its interest rate swap agreements, Wellmont is required to post collateral with its counterparties under certain specified conditions. Collateral posting requirements are based on the amount of Wellmont's derivative liability and Wellmont's bond rating. As of June 30, 2012 and 2011, Wellmont was not required to post collateral related to its swaps.

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

In September and October, 2008, the counterparty and credit support provider, for four of the swaps held at June 30, 2010, filed bankruptcy. Subsequent to the bankruptcy filings and into 2011, no payments were made by Wellmont or the counterparty to each other. During 2011, Wellmont and the counterparty agreed to settle all amounts due on the swaps for net cash flow receivables or payables. The bankruptcy process is underway and the ultimate outcome regarding any final settlement cannot be determined at this time.

Wellmont has a Total Return Swap on the Series 2011 Bonds with a new counterparty.

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Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its variable rate debt structure using LIBOR rates. The fair value as of June 30, 2012 and 2011 of approximately \$(9,781) and \$(11,588), respectively, is included in other long-term liabilities in the consolidated balance sheets. The change in the fair value of the derivative instruments was approximately \$1,807 and \$1,355, respectively, in 2012 and 2011 and is included in nonoperating gains (losses), net in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. The following is a summary of the interest rate swap information as of June 30, 2012:

<u>Type of interest swap</u>	<u>Debt hedging</u>	<u>Notional amount</u>	<u>Effective date</u>	<u>Maturity date</u>	<u>Rate paid</u>	<u>Rate received</u>	<u>Swap fair value asset (liability)</u>
Total return swap Pay fixed interest	Series 2011	\$ 76,165	May 5, 2011	September 1, 2032	1.530%	6.200%	\$ 2,888
rate swap	Series 2005	57,250	December 13, 2005	September 1, 2016	3.548	0.165	(6,471)
Basis swap	Series 2002	60,765	September 1, 2002	September 1, 2032	0.180	0.339	(1,662)
Pay fixed interest rate swap	*	32,880	October 24, 2003	September 1, 2021	3.613	0.165	<u>(4,536)</u>
							<u>\$ (9,781)</u>

* Previously designated bond series has been refinanced.

The following is a schedule detailing the swap information as of June 30, 2011:

<u>Type of interest swap</u>	<u>Debt hedging</u>	<u>Notional amount</u>	<u>Effective date</u>	<u>Maturity date</u>	<u>Rate paid</u>	<u>Rate received</u>	<u>Swap fair value asset (liability)</u>
Total return swap Pay fixed interest	Series 2011	\$ 76,165	May 5, 2011	September 1, 2032	1.440%	6.200%	\$ (377)
rate swap	Series 2005	59,580	December 13, 2005	September 1, 2016	3.548	0.124	(5,954)
Basis swap	Series 2002	62,730	September 1, 2002	September 1, 2032	0.090	0.181	(1,715)
Pay fixed interest rate swap	*	35,342	October 24, 2003	September 1, 2021	3.613	0.124	<u>(3,542)</u>
							<u>\$ (11,588)</u>

* Previously designated bond series has been refinanced.

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(13) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined-contribution retirement plan (Retirement Plan) that covers substantially all employees. This program and the related Retirement Plan were created from amendments, restatements, and mergers of existing defined-contribution plans at BRMC and HVMC. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 3% of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Code, up to 3% of each participant's wages. The total pension expense related to the Retirement Plan was \$10,346 and \$10,344 for the years ended June 30, 2012 and 2011, respectively.

HVMC sponsored a noncontributory, defined-benefit pension plan covering substantially all its employees. However, effective June 30, 1996, this plan was frozen and no further benefits accrue. LPH also sponsors a defined-benefit pension plan covering substantially all its employees.

HVMC's defined-pension benefits are actuarially determined based on a formula taking into consideration an employee's compensation and years of service. HVMC's funding policy is to make annual contributions to the plan based upon the funding standard developed by the plan actuary. This standard uses the projected unit credit actuarial cost method, including the amortization of prior service costs, over a 20-year period. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. The LPH plan contains similar funding and actuarial policies.

On June 30, 2007, the HVMC plan merged into LPH plan and the plan name changed to Wellmont Health System Defined Benefit Plan. At the end of 2008, only a single defined-pension plan exists. Collectively, the two defined-benefit plans are referred to as the "Plans." Effective June 30, 2010, the plan was frozen for all Lonesome Pine Hospital employees and no further benefits will be accrued.

Wellmont recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined-benefit pension plans as an asset or liability in its consolidated balance sheet and recognizes changes in that funded status in the year in which the changes occur as a change in unrestricted net assets. All defined-benefit pension plans use a June 30 measurement date.

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

	<u>2012</u>	<u>2011</u>
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 45,337	44,565
Service cost	—	220
Interest cost	2,422	2,390
Actuarial losses	8,614	896
Benefits paid	(2,292)	(2,239)
Curtailments *	—	(495)
	<u>54,081</u>	<u>45,337</u>
Benefit obligation at end of year		
Change in plan assets:		
Fair value of plan assets at beginning of year	38,811	34,547
Actual return on plan assets	(304)	6,503
Employer contribution	576	—
Benefits paid	(2,292)	(2,239)
	<u>36,791</u>	<u>38,811</u>
Fair value of plan assets at end of year		
Funded status	\$ <u>(17,290)</u>	<u>(6,526)</u>
Amounts recognized in the accompanying consolidated balance sheets:		
Pension benefit liability (other long-term liabilities)	\$ (17,290)	(6,526)

* Reflects frozen benefit accruals for Lonesome Pine participants as of June 30, 2011.

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	<u>2012</u>	<u>2011</u>
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:		
Unrecognized actuarial loss	\$ 19,773	8,565
Unrecognized prior service cost	<u>—</u>	<u>—</u>
Net amounts included as an accumulated charge to unrestricted net assets	\$ <u>19,773</u>	<u>8,565</u>
Calculation of change in unrestricted net assets:		
Accumulated charge to unrestricted net assets, end of year	\$ 19,773	8,565
Reversal of accumulated charge to unrestricted net assets, prior year	<u>(8,565)</u>	<u>(13,160)</u>
Change in unrestricted net assets	\$ <u>11,208</u>	<u>(4,595)</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Prior service credit adjustment for curtailment	\$ —	(1)
Actuarial loss (gain) arising during the year	11,577	(3,763)
Amortization of actuarial loss	(369)	(831)
Amortization of prior service cost	<u>—</u>	<u>—</u>
Net amounts recognized in unrestricted net assets	\$ <u>11,208</u>	<u>(4,595)</u>

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	<u>2012</u>	<u>2011</u>
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2012:		
Amortization of net loss	\$ 2,186	382
Amortization of prior service cost	—	—
Estimated future benefit payments:		
Fiscal 2012	—	2,276
Fiscal 2013	2,609	2,369
Fiscal 2014	2,732	2,492
Fiscal 2015	2,821	2,596
Fiscal 2016	2,996	2,671
Fiscal 2017 – 2021	16,054	14,819
Weighted average assumptions used to determine benefit obligations:		
Settlement (discount) rate	4.00%	5.50%
Weighted average rate of increase in future compensation levels	N/A	N/A
Components of net periodic benefit cost (benefit):		
Service cost	\$ —	220
Interest cost	2,422	2,390
Expected return on plan assets	(2,658)	(2,340)
Amortization of net loss	369	831
Amortization of unrecognized prior service cost curtailments	—	1
Net periodic benefit cost	<u>\$ 133</u>	<u>1,102</u>
Weighted average assumptions used to determine net periodic benefit cost:		
Settlement (discount) rate	5.50%	5.50%
Expected long-term return on plan assets (HVMC)	7.00	7.00
Expected long-term return on plan assets (LPH)	7.00	7.00
Weighted average rate of increase in future compensation levels	N/A	3.00

Wellmont's overall expected long-term rate of return on assets is 7.00%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

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

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The table below shows the target allocation and actual asset allocations as of June 30, 2012 and 2011:

Asset	Target allocation	2012	2011
Equity securities	65%	47%	46%
Fixed income	28	32	35
Cash	5 – 15%	2	2
Other	5 – 15%	19	17

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

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

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

	Postretirement benefits	
	2012	2011
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 7,763	5,861
Interest cost	298	365
Plan participants contributions	34	79
Actuarial losses	(975)	1,686
Benefits paid	(81)	(228)
Benefit obligation at end of year	7,039	7,763
Change in plan assets:		
Fair value of plan assets at beginning of year	—	—
Employer contribution	47	149
Plan participants contributions	34	79
Benefits paid	(81)	(228)
Fair value of plan assets at end of year	—	—
Funded status	\$ 7,039	7,763

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	Postretirement benefits	
	2012	2011
Amounts recognized in the consolidated balance sheets consist of:		
Noncurrent assets	\$ —	—
Current liabilities	(245)	(271)
Noncurrent liabilities	(6,794)	(7,492)
Accumulated charge to unrestricted net assets	2,469	1,755
	<u>\$ (4,570)</u>	<u>(6,008)</u>

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

	2012	2011
Net actuarial gain	\$ 2,469	1,755

Net periodic benefit cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2012 and 2011 were:

	Postretirement benefits	
	2012	2011
Net periodic benefit cost:		
Interest cost	\$ 299	365
Amortization of net gain	(262)	(119)
Net periodic benefit cost recognized	<u>37</u>	<u>246</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	(975)	1,686
Amortization of net gain	262	119
Total recognized in unrestricted net assets	<u>(713)</u>	<u>1,805</u>
Total recognized in net periodic benefit cost and unrestricted net assets	<u>\$ (676)</u>	<u>2,051</u>

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The net gain and prior service credit for the defined-benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are \$(168) and \$(88), respectively. Weighted average assumptions used to determine benefit obligations for 2012 and 2011 were as follows:

	<u>2012</u>	<u>2011</u>
Discount rate	3.50%	5.00%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2012 and 2011 were as follows:

	<u>Postretirement benefits</u>	
	<u>2012</u>	<u>2011</u>
Discount rate	5.00%	5.00%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00	5.00

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

For measurement purposes, a 5% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2012.

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

	<u>2012</u>	<u>2011</u>
Effect of one-percentage-point increase in healthcare cost trend on:		
Service and interest cost	\$ 21	27
Accumulated pension benefit obligation	533	545
Effect of one-percentage-point decrease in healthcare cost trend on:		
Service and interest cost	\$ (19)	(24)
Accumulated pension benefit obligation	(473)	(486)

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The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2012 and 2011, respectively, were as follows:

Fair value measurement at June 30, 2012				
pension benefits – plan assets				
	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Stock mutual funds	\$ 29,223	29,223	—	—
Cash and money market funds	578	578	—	—
Alternative funds	6,990	—	3,443	3,547
Total	<u>\$ 36,791</u>	<u>29,801</u>	<u>3,443</u>	<u>3,547</u>
Fair value measurement at June 30, 2011				
pension benefits – plan assets				
	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Stock mutual funds	\$ 31,311	31,311	—	—
Cash and money market funds	632	632	—	—
Alternative funds	6,868	—	3,280	3,588
Total	<u>\$ 38,811</u>	<u>31,943</u>	<u>3,280</u>	<u>3,588</u>

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The following table presents Wellmont’s activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2012 and 2011:

	Alternative investments
Balance at June 30, 2010	\$ 5,500
Net change in value	1,349
Purchases, issuances, and settlements	19
Transfers in and/or out of Level 3 (net)	(3,280)
Balance at June 30, 2011	3,588
Net change in value	(29)
Purchases, issuances, and settlements	(12)
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2012	\$ 3,547

(14) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers’ compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont has established revocable self-insurance trust funds to provide for professional and general liability claims and workers’ compensation claims and related expenses. Wellmont’s contributions to the self-insurance trusts are based upon actuarial determinations by an independent service company. The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers’ compensation program is supplemented for Tennessee and Virginia by excess workers’ compensation policies, with a commercial carrier for statutory limits per occurrence. Provisions based on actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Workers’ compensation expense under these programs amounted to approximately \$4,100 and \$4,056 for the years ended June 30, 2012 and 2011, respectively, and are included in salaries and benefits expense in the accompanying consolidated statements of operations and changes in net assets. All other self-insurance expense under these programs amounted to approximately \$2,763 and \$3,097 for the years ended June 30, 2012 and 2011, respectively, and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2012 and 2011, Wellmont was involved in litigation relating to medical malpractice and workers’ compensation claims arising in the ordinary course of business. There are also known incidents that occurred through June 30, 2012 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2012 are adequate

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to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

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

(15) Commitments and Contingencies

Construction in progress at June 30, 2012 and 2011 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately \$2,768 at June 30, 2012. Wellmont has entered into contracts of \$2,768 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was \$19,391 and \$18,179 for the years ended June 30, 2012 and 2011, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2012 are as follows:

2013	\$	13,473
2014		7,613
2015		6,564
2016		4,527
2017		4,364
Thereafter		19,713
	\$	<u>56,254</u>

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

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Dollars in thousands)

(16) Functional Expense Disclosure

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

	<u>2012</u>	<u>2011</u>
Professional care of patients	\$ 619,560	598,545
Administrative and general	146,740	142,768
Fund-raising	1,103	913
	<u>\$ 767,403</u>	<u>742,226</u>

(17) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate company state income tax returns. These companies have combined net operating loss carryforwards for federal income tax purposes of approximately \$84,000 at June 30, 2012, which begin expiring in fiscal 2018 and expire through 2032. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont Health System participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont Health System files a Form 990-T with the IRS to report such activity. Wellmont Health System has net operating loss carry forwards for federal income tax purposes of approximately \$1,800 for unrelated business activities. Management believes that it is not more likely than not that deferred tax assets arising from net operating loss carry forwards will be realizable. Accordingly, these are fully reserved at June 30, 2012 and 2011.

(18) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2012 and 2011, was as follows:

	<u>2012</u>	<u>2011</u>
Medicare	50%	42%
TennCare	5	4
Medicaid	7	9
Other third-party payors	31	35
Patients	7	10
	<u>100%</u>	<u>100%</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Dollars in thousands)

(19) Disclosures about Fair Value of Financial Instruments

(a) Fair Value of Financial Instruments

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

- *Cash and Cash Equivalents*

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

- *Patient Accounts and Other Receivables*

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

- *Investments and Assets Limited as to Use*

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

- *Accounts Payable and Accrued Expenses*

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

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

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

- *Long-Term Debt*

The fair value of revenue bonds, using current market rates, was estimated at \$436,634 and \$419,960 for the years ended June 30, 2012 and 2011, respectively.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Dollars in thousands)

(b) Fair Value Hierarchy

On July 1, 2008, Wellmont adopted new guidance issued by FASB for fair value measurement of financial assets and financial liabilities and for fair value measurement of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis now codified into ASC 820, *Fair Value Measurement*. ASC 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted market prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted market prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date.
- Level 2 inputs are inputs other than quoted market prices including within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.
- Level 3 inputs are unobservable inputs for the asset or liability.

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

Wellmont also applies the measurement provisions of ASU No. 2009-12 to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. This guidance amends the previous guidance and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value, in many instances may not equal fair value that would be calculated pursuant to ASC 820. The fair value of these investments was \$36,989 and \$66,529 at June 30, 2012 and 2011, respectively.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2012:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 44,930	—	—	44,930
Assets limited as to use:				
Stock mutual funds	88,942	—	—	88,942
Bond mutual funds	163,401	—	—	163,401
Cash and money market funds	44,240	—	—	44,240
Real estate funds	7,157	—	—	7,157
Alternative investments	—	—	36,989	36,989
Corporate bonds	2,673	—	—	2,673
U.S. Treasury bonds	—	—	—	—
Subtotal	<u>351,343</u>	<u>—</u>	<u>36,989</u>	<u>388,332</u>
Long-term investments:				
Stock mutual funds	10,321	—	—	10,321
Bond mutual funds	13,926	—	—	13,926
Cash and money market funds	189	—	—	189
Real estate funds	685	—	—	685
Alternative investments	—	—	—	—
Subtotal	<u>25,121</u>	<u>—</u>	<u>—</u>	<u>25,121</u>
	<u>\$ 376,464</u>	<u>—</u>	<u>36,989</u>	<u>413,453</u>
Liabilities:				
Derivatives liability	\$ —	9,781	—	9,781
Total	\$ —	<u>9,781</u>	<u>—</u>	<u>9,781</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2011:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 36,558	—	—	36,558
Assets limited as to use:				
Stock mutual funds	80,413	—	—	80,413
Bond mutual funds	119,836	—	—	119,836
Cash and money market funds	39,215	—	—	39,215
Real estate funds	8,475	—	—	8,475
Alternative investments	—	26,480	37,778	64,258
Corporate bonds	7,877	—	—	7,877
U.S. Treasury bonds	1,215	—	—	1,215
Subtotal	<u>293,589</u>	<u>26,480</u>	<u>37,778</u>	<u>357,847</u>
Long-term investments:				
Stock mutual funds	10,890	—	—	10,890
Bond mutual funds	10,741	—	—	10,741
Cash and money market funds	191	—	—	191
Real estate funds	832	—	—	832
Alternative investments	—	2,271	—	2,271
Subtotal	<u>22,654</u>	<u>2,271</u>	<u>—</u>	<u>24,925</u>
	<u>\$ 316,243</u>	<u>28,751</u>	<u>37,778</u>	<u>382,772</u>
Liabilities:				
Derivatives liability	\$ —	11,588	—	11,588
Total	\$ —	<u>11,588</u>	<u>—</u>	<u>11,588</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Dollars in thousands)

The following table presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2012 and 2011:

	Alternative investments
Balance at June 30, 2010	\$ 39,362
Total realized and unrealized gains (losses):	
Included in revenues and gains in excess of expenses and losses	—
Included in changes in net assets	(3,401)
Purchases, issuances, and settlements	1,817
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2011	37,778
Total realized and unrealized gains (losses):	
Included in revenues and gains in excess of expenses and losses	264
Included in changes in net assets	(420)
Purchases, issuances, and settlements	(633)
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2012	\$ <u>36,989</u>

(20) Subsequent Events

On September 7, 2012, Wellmont entered into a \$55 million contract with a major information systems service provider to replace its clinical information systems. Wellmont expects to spend approximately \$100 million on the project.

Wellmont has evaluated subsequent events from the balance sheet date through October 24, 2012, the date at which the financial statements were available to be issued. No other material subsequent events were identified for recognition.



WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2013 and 2012

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

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

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Wellmont Health System and affiliates, which comprise the consolidated balance sheets as of June 30, 2013 and 2012, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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



Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Wellmont Health System and affiliates as of June 30, 2013 and 2012, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Nashville, Tennessee
October 23, 2013

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2013 and 2012

(Dollars in thousands)

Assets	2013	2012
Current assets:		
Cash and cash equivalents	\$ 55,958	44,930
Assets limited as to use, required for current liabilities	5,061	4,372
Patient accounts receivable, less allowance for uncollectible accounts of approximately \$26,209 and \$25,656 in 2013 and 2012, respectively	107,029	108,265
Other receivables	17,995	23,805
Inventories	18,361	17,862
Prepaid expenses and other current assets	8,949	7,462
Total current assets	<u>213,353</u>	<u>206,696</u>
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	15,096	17,090
Other	547	651
Total assets	<u>\$ 1,145,115</u>	<u>1,096,213</u>
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	<u>112,657</u>	<u>114,473</u>
Long-term debt, less current portion	475,946	459,654
Other long-term liabilities, less current portion	41,567	54,060
Total liabilities	<u>630,170</u>	<u>628,187</u>
Net assets:		
Unrestricted	503,934	458,218
Temporarily restricted	6,927	5,739
Permanently restricted	1,311	1,304
Total net assets attributable to Wellmont	<u>512,172</u>	<u>465,261</u>
Noncontrolling interests	2,773	2,765
Total net assets	<u>514,945</u>	<u>468,026</u>
Commitments and contingencies		
Total liabilities and net assets	<u>\$ 1,145,115</u>	<u>1,096,213</u>

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES
Consolidated Statements of Operations and Changes in Net Assets
Years ended June 30, 2013 and 2012
(Dollars in thousands)

	<u>2013</u>	<u>2012</u>
Revenue:		
Patient service revenue	\$ 809,517	811,882
Provision for bad debt	(55,029)	(71,407)
Net patient revenue less provision for bad debt	<u>754,488</u>	<u>740,475</u>
Other revenues	43,735	47,904
Total revenue	<u>798,223</u>	<u>788,379</u>
Expenses:		
Salaries and benefits	381,210	368,287
Medical supplies and drugs	163,922	164,350
Purchased services	80,179	78,732
Interest	21,833	21,677
Depreciation and amortization	51,319	46,369
Other	86,816	86,501
Total expenses	<u>785,279</u>	<u>765,916</u>
Income from operations	<u>12,944</u>	<u>22,463</u>
Nonoperating gains:		
Investment income	19,467	17,272
Derivative valuation adjustments	2,356	1,807
Nonoperating gains, net	<u>21,823</u>	<u>19,079</u>
Revenue and gains in excess of expenses and losses before discontinued operations	34,767	41,542
Discontinued operations	<u>(2,167)</u>	<u>(52)</u>
Revenue and gains in excess of expenses and losses	32,600	41,490
Income attributable to noncontrolling interests	<u>(1,228)</u>	<u>(1,670)</u>
Revenues and gains in excess of expenses and losses attributable to Wellmont	31,372	39,820
Other changes in unrestricted net assets:		
Change in net unrealized gains (losses) on investments	6,157	(9,534)
Net assets released from restrictions for additions to land, buildings, and equipment	828	3,766
Change in the funded status of benefit plans and other	7,359	(10,495)
Increase in unrestricted net assets	<u>45,716</u>	<u>23,557</u>
Changes in temporarily restricted net assets:		
Contributions	2,977	6,661
Net assets released from temporary restrictions	(1,789)	(4,492)
Increase in temporarily restricted net assets	<u>1,188</u>	<u>2,169</u>
Changes in permanently restricted net assets – investment income	<u>7</u>	<u>130</u>
Changes in noncontrolling interests:		
Income attributable to noncontrolling interests	1,228	1,670
Distributions to noncontrolling interests	(1,220)	(1,261)
Increase in noncontrolling interests	<u>8</u>	<u>409</u>
Change in net assets	46,919	26,265
Net assets, beginning of year	<u>468,026</u>	<u>441,761</u>
Net assets, end of year	<u>\$ 514,945</u>	<u>468,026</u>

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2013 and 2012

(Dollars in thousands)

	<u>2013</u>	<u>2012</u>
Cash flows from operating activities:		
Change in net assets	\$ 46,919	26,265
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	51,392	46,403
Loss (gain) on disposal of land, buildings, and equipment	211	(458)
Equity in earnings of affiliated organizations	(4,594)	(7,233)
Distributions from affiliated organizations	5,366	5,764
Amortization of deferred financing costs	486	428
Net realized and unrealized (gain) loss on investments	(9,580)	2,633
Provision for bad debts	55,029	71,407
Change in fair value of derivative instruments	(2,356)	(1,807)
Impairment of goodwill	2,007	—
Changes in assets and liabilities:		
Patient accounts receivable	(53,793)	(78,107)
Other current assets	(1,986)	(331)
Other assets	5,872	(13,920)
Accounts payable and accrued expenses	(2,532)	10,230
Estimated third-party payor settlements	(8,378)	6,002
Other current liabilities	416	(2,745)
Other liabilities	(10,137)	13,672
Net cash provided by operating activities	<u>74,342</u>	<u>78,203</u>
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	115,439	149,087
Purchase of investments	(135,222)	(174,029)
Purchase of land, buildings, and equipment	(57,747)	(46,026)
Proceeds from the sale of buildings and equipment	355	1,721
Cash paid for acquisitions	(13)	(813)
Net cash used in investing activities	<u>(77,188)</u>	<u>(70,060)</u>
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	28,908	11,368
Payments on long-term debt	(14,789)	(11,139)
Payment of debt issuance costs	(245)	—
Net cash provided by financing activities	<u>13,874</u>	<u>229</u>
Net increase in cash and cash equivalents	11,028	8,372
Cash and cash equivalents, beginning of year	<u>44,930</u>	<u>36,558</u>
Cash and cash equivalents, end of year	\$ <u>55,958</u>	\$ <u>44,930</u>

Supplemental disclosures of noncash items:

Wellmont entered into capital lease obligations for buildings and equipment in the amount of \$5,262 and \$3,281 in 2013 and 2012, respectively.

Additions to property and equipment financed through current liabilities of \$5,589 and \$2,487 in 2013 and 2012, respectively.

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2013 and 2012

(Dollars in thousands)

(1) Operations and Basis of Presentation

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

Wellmont also operates physician organizations and practices that are organized within Wellmont Medical Associates and Wellmont Cardiology Services.

As of May 17, 2013, a subsidiary of Wellmont ceased operating its sleep labs, which were managed by a third party. The consolidated financial statements for the year ended June 30, 2013 present the sleep labs as discontinued operations. The losses of \$2,302, including an impairment loss of \$2,007, and \$140 for the years ended June 30, 2013 and 2012, respectively, are included in discontinued operations.

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

The consolidated financial statements include the operations of the above entities along with:

- Wellmont Foundation (the Foundation), which conducts fund-raising activities for the benefit of Wellmont
- Wellmont, Inc., a wholly owned taxable subsidiary of Wellmont, formed as the holding company of various other taxable subsidiaries that provide medical collection and medical laundry services, operate physician practices, provide other healthcare-related services, and invest in affiliates and other activities.

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

(2) Significant Accounting Policies

A summary of significant accounting policies is as follows:

(a) Use of Estimates

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2013 and 2012

(Dollars in thousands)

(b) Cash and Cash Equivalents

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

(c) Investments

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

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

(d) Assets Limited as to Use

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

(e) Inventories

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

(f) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost, if purchased, or fair value at date of donation. Depreciation is computed using the straight-line method based on the estimated useful life of the

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2013 and 2012

(Dollars in thousands)

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

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

(g) Goodwill

Wellmont adopted ASU No. 2010-07, *Not for Profit Entities: Mergers and Acquisitions*, which in part requires healthcare entities to follow Accounting Standards Codification (ASC) Topic 350-20-35, *Intangibles – Goodwill and Other* along with ASU 2011-08, *Testing Goodwill for Impairment*, effective July 1, 2012. ASC Topic 350-20-35 requires goodwill of not-for-profit entities to be evaluated for impairment at least annually. An entity has the option to first assess qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If, after assessing the totality of events or circumstances, an entity determines it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step impairment test is unnecessary. The more-likely than-not threshold is defined as having a likelihood of more than 50 percent. However, if an entity concludes otherwise, then it is required to perform the first step of the two-step impairment test by calculating the fair value of the reporting unit and comparing the fair value with the carrying amount (including goodwill) of the reporting unit. If the carrying amount of a reporting unit exceeds its fair value, then the entity is required to perform the second step of the goodwill impairment test to measure the amount of the impairment loss. Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2013 and 2012

(Dollars in thousands)

two does not need to be performed. The annual impairment test is performed as of June 30. A summary of goodwill for the years ended June 30 is as follows:

	<u>2012</u>	<u>Additions</u>	<u>Decreases</u>	<u>2013</u>
Goodwill	\$ 17,090	13	(2,007)	15,096

	<u>2011</u>	<u>Additions</u>	<u>Decreases</u>	<u>2012</u>
Goodwill	\$ 16,721	369	—	17,090

(h) *Deferred Debt Expense*

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

(i) *Derivative Financial Instruments*

As further described in note 12, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

(j) *Asset Retirement Obligations*

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

(k) *Temporarily and Permanently Restricted Net Assets*

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

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

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2013 and 2012 primarily included amounts related to the purchase of equipment for pediatrics, cancer, and other healthcare operations.

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

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

(l) Net Patient Service Revenue and Accounts Receivable

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the period related services are rendered and adjusted in future periods as final and other settlements are determined. On the basis of historical experience, a significant portion of Wellmont's uninsured patients will be unable or unwilling to pay for the services provided. Therefore, Wellmont records a significant provision for bad debts related to uninsured patients in the period the services are provided. This provision for bad debts is presented on the statement of operations as a component of net patient revenue. Wellmont provides care to patients who meet criteria under its charity care

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policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

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

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

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

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

(n) Contributed Resources

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

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

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(o) Federal Income Taxes

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

On July 1, 2007, Wellmont adopted new guidance issued on the accounting for uncertainty in income tax positions now codified into ASC 740. It also provides guidance on when tax positions are recognized in an entity's financial statements and how the values of these positions are determined. There was no impact on Wellmont's consolidated financial statements as a result of the adoption of the new guidance.

(p) Recently Adopted Accounting Standards

The FASB issued ASU No. 2011-04, *Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRSs*, in May 2011. This ASU requires the reason for the fair value measurement to be disclosed, a description of the valuation techniques, and descriptions of the inputs used for all Level 2 and Level 3 fair value measurements. It also requires all transfers between levels of the fair value hierarchy to be separately reported and described. Wellmont adopted ASU 2011-04 as of July 1, 2012.

(q) Reclassifications

Certain 2012 amounts have been reclassified to conform to the 2013 consolidated financial statement presentation. The reclassifications had no impact on total assets or changes in net assets.

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(3) Net Patient Service Revenue

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

	<u>2013</u>	<u>2012</u>
Gross patient service revenue	\$ 2,517,774	2,396,167
Less:		
Contractual adjustments and other discounts	(1,646,455)	(1,522,625)
Charity care	<u>(61,802)</u>	<u>(61,660)</u>
Net patient service revenue before provision for bad debts	809,517	811,882
Less provision for bad debts	<u>(55,029)</u>	<u>(71,407)</u>
Net patient service revenue	\$ <u><u>754,488</u></u>	<u><u>740,475</u></u>

Wellmont's allowance for doubtful accounts is predominantly for self-pay patients and patient balances remaining after third-party payments. The provision for bad debts decreased \$16,378 from fiscal 2012 to fiscal 2013 and the net write-offs decreased \$15,521 from fiscal 2012 to fiscal 2013. Both decreases were the result of significant decreases in inpatient and emergency room volumes, which are the primary source of patients with bad debt. Wellmont has not changed its charity care or uninsured discount policies during fiscal 2013. Wellmont does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

(4) Third-Party Reimbursement Arrangements

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

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

The Medicare program pays for the costs of inpatient services on a prospective basis. Payments are based upon diagnostic-related group assignments, which are determined by the patient's clinical diagnosis and

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medical procedures utilized. Wellmont receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid-eligible and other low-income patients. Outpatient services are also reimbursed primarily on a prospectively determined basis.

Net patient service revenue in 2013 and 2012 related to Medicare, TennCare, and Medicaid and net patient accounts receivable at June 30, 2013 and 2012 from Medicare, TennCare, and Medicaid were as follows:

	<u>2013</u>	<u>2012</u>
Net patient service revenue:		
Medicare	\$ 303,694	312,202
TennCare	28,749	28,548
Medicaid	30,413	19,541
Net patient accounts receivable:		
Medicare	\$ 44,702	41,883
TennCare	3,298	2,957
Medicaid	6,980	5,244

Wellmont has filed cost reports with Medicare and Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Medicaid cost reports have been audited and final settled by the intermediary through June 30, 2007 and audit adjustments have been received and considered for certain hospitals and year-ends through June 30, 2011.

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

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased approximately \$6,605 and \$3,575 in 2013 and 2012, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of audits and final settlements, and years that are no longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2013 could differ materially from actual settlements based on the results of third-party audits.

(5) Meaningful Use Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record (EHR) technology. The Medicare incentive payments are paid out to qualifying

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hospitals and physician groups over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals, and physician groups must meet EHR “meaningful use” criteria that become more stringent over three stages as determined by Centers for Medicare & Medicaid Services (CMS). Medicaid programs and payment schedules vary from state to state.

For fiscal years ending June 30, 2013 and 2012, Wellmont recorded \$13,707 and \$13,177, respectively, in other operating revenue related to the EHR and meaningful use incentives. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria.

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

(6) Charity Care and Community Services

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

Wellmont maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone and estimated costs incurred for services and supplies furnished under its charity care policy. Costs incurred are estimated based on the ratio of total operating expenses to gross charges applied to charity care charges. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and the equivalent percentage of charity care patients to all patients serviced were \$61,802, \$15,536, and 2.45%, respectively, for the year ended June 30, 2013 and \$61,660, \$16,144, and 2.57%, respectively, for the year ended June 30, 2012.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and State indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont’s cost of providing care to those patients totaled \$37,999 and \$44,432, for the years ended June 30, 2013 and 2012, respectively.

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

(7) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include hospital, home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in earnings of affiliates was approximately \$4,594 and \$7,233 for the years ended June 30, 2013 and 2012, respectively, and is included in other operating

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revenue in the consolidated financial statements. Wellmont received distributions of \$5,366 and \$5,764 during 2013 and 2012, respectively, which reduced Wellmont's overall investment in the affiliates.

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

	<u>2013</u>	<u>2012</u>
Total assets	\$ 135,802	127,206
Total liabilities	<u>40,617</u>	<u>27,732</u>
Total net assets	\$ <u>95,185</u>	<u>99,474</u>
Net revenues	\$ 200,765	228,644
Expenses	<u>186,394</u>	<u>207,806</u>
Revenues in excess of expenses	\$ <u>14,371</u>	<u>20,838</u>

Wellmont's investment in these affiliates and its ownership percentage as of June 30, 2013 and 2012 is as follows:

	<u>Amount</u>		<u>Percentage</u>	
	<u>2013</u>	<u>2012</u>	<u>2013</u>	<u>2012</u>
Takoma Regional Hospital	\$ 11,983	12,350	60%	60%
Holston Valley Imaging Center (HVIC)	8,336	8,818	75	75
Advanced Home Care (AHC)	6,092	6,092	6	6
Lab Group Holdings LLC	3,500	3,500	1	1
Others	<u>1,963</u>	<u>1,886</u>	4%–50%	4%–50%
	\$ <u>31,874</u>	<u>32,646</u>		

Although Wellmont's ownership percentage in Takoma Regional Hospital and HVIC is greater than 50%, Wellmont does not consolidate these entities because Wellmont only has a 50% representation on each respective board and does not have control over these entities.

Wellmont provided billing, management, and professional services to some of the affiliates. Income recognized by Wellmont for the services was \$971 in 2013 and \$929 in 2012 and is included in other revenues.

Included in other receivables are \$406 and \$374 as of June 30, 2013 and 2012, respectively, of amounts due to Wellmont from these entities.

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(8) Investments

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

	<u>2013</u>	<u>2012</u>
Assets limited as to use by Board for capital improvements:		
Stock mutual funds	\$ 109,356	88,942
Bond mutual funds	175,594	163,401
Cash and money market funds	3,749	1,492
Real estate funds	16,377	7,157
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):		
Liquid	10,504	9,616
Illiquid	26,016	27,373
	<u>341,596</u>	<u>297,981</u>
Assets limited as to use under self-insurance agreements:		
Corporate bonds	—	2,673
Cash and money market funds	—	32
	<u>—</u>	<u>2,705</u>
Assets limited as to use under bond indenture agreements:		
Cash and money market funds	39,174	42,716
Less assets limited as to use that are required for current liabilities	<u>5,061</u>	<u>4,372</u>
Assets limited as to use, net of current portion	<u>\$ 375,709</u>	<u>339,030</u>
Long-term investments:		
Stock mutual funds	\$ 12,228	10,321
Bond mutual funds	13,478	13,926
Preferred equity investment and related options	1,512	11,512
Cash, money market funds, and certificates of deposit	190	189
Real estate funds	1,220	685
Total long-term investments	<u>\$ 28,628</u>	<u>36,633</u>

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately \$5,229 as of June 30, 2013 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which \$117 was paid subsequent to June 30, 2013.

Effective June 27, 2013, Wellmont redeemed its \$10,000 in the preferred equity of a regional managed services organization; however, retained its \$1,512 on a right of first refusal related to any future sale of

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this organization. This equity had a guaranteed annual return of at least 6.5% of the outstanding preferred equity balance.

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

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, Wellmont recognized other-than-temporary impairment losses of \$131 and \$265 on investments as of June 30, 2013 and 2012, respectively. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2013 and 2012 were as follows:

	<u>Less than 12 months</u>		<u>12 months or more</u>		<u>Total</u>	
	<u>Unrealized losses</u>	<u>Fair value</u>	<u>Unrealized losses</u>	<u>Fair value</u>	<u>Unrealized losses</u>	<u>Fair value</u>
2013:						
Alternative investments	\$ 478	3,243	—	—	478	3,243
Mutual funds	7,304	181,780	371	3,185	7,675	184,965
	<u>\$ 7,782</u>	<u>185,023</u>	<u>371</u>	<u>3,185</u>	<u>8,153</u>	<u>188,208</u>
	<u>Less than 12 months</u>	<u>12 months or more</u>	<u>Total</u>			
	<u>Unrealized losses</u>	<u>Fair value</u>	<u>Unrealized losses</u>	<u>Fair value</u>	<u>Unrealized losses</u>	<u>Fair value</u>
2012:						
Alternative investments	\$ 129	52	—	—	129	52
Mutual funds	2,692	55,142	2,903	15,407	5,595	70,549
	<u>\$ 2,821</u>	<u>55,194</u>	<u>2,903</u>	<u>15,407</u>	<u>5,724</u>	<u>70,601</u>

Investment income comprises the following for the years ended June 30:

	<u>2013</u>	<u>2012</u>
Interest and dividends, net of amounts capitalized	\$ 16,044	10,371
Realized gains on investments, net	3,423	6,901
Investment income, net	<u>\$ 19,467</u>	<u>17,272</u>
Change in net unrealized gains (losses) on investments	\$ 6,157	(9,534)

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(9) Land, Buildings, and Equipment

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

	<u>2013</u>	<u>2012</u>
Land	\$ 49,758	49,397
Buildings and improvements	536,758	526,243
Equipment	384,747	364,973
Buildings and equipment under capital lease obligations	<u>45,102</u>	<u>42,404</u>
	1,016,365	983,017
Less accumulated depreciation	<u>(576,210)</u>	<u>(527,828)</u>
	440,155	455,189
Construction in progress	<u>34,575</u>	<u>2,859</u>
Land, buildings, and equipment	<u>\$ 474,730</u>	<u>458,048</u>

Depreciation expense for the years ended June 30, 2013 and 2012 was \$51,350 and \$46,393, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was \$18,408 and \$17,234 as of June 30, 2013 and 2012, respectively.

(10) Other Long-Term Liabilities

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

	<u>2013</u>	<u>2012</u>
Workers' compensation liability	\$ 9,882	9,097
Professional and general liability	11,492	12,535
Postretirement benefit obligation	4,582	7,039
Asset retirement obligation	2,969	2,994
Deferred gain on sale of assets	439	439
Derivative liability	7,425	9,781
Pension benefit liability	10,393	17,290
Other	<u>583</u>	<u>667</u>
	47,765	59,842
Less current portion	<u>(6,198)</u>	<u>(5,782)</u>
Total other long-term liabilities	<u>\$ 41,567</u>	<u>54,060</u>

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(11) Debt

(a) Long-Term Debt

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

	<u>2013</u>	<u>2012</u>
Hospital Revenue Refunding Bonds, Series 2011	\$ 76,165	76,165
Hospital Revenue Bonds, Series 2010 (Bank Qualified)	22,836	24,836
Hospital Revenue Bonds, Series 2007A	55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	200,000	200,000
Hospital Revenue Refunding Bonds, Series 2005	54,820	57,250
Hospital Revenue Bonds, Series 2003	25,225	29,230
Project Odyssey 2012 Tax-Exempt Master Lease/Sublease	16,150	—
Notes payable	11,968	3,102
Capital lease obligations	21,601	18,514
Other	847	826
	<u>484,612</u>	<u>464,923</u>
Unamortized premium	6,679	7,005
Unamortized discount	<u>(343)</u>	<u>(361)</u>
	490,948	471,567
Less current maturities	<u>(15,002)</u>	<u>(11,913)</u>
	<u>\$ 475,946</u>	<u>459,654</u>

(b) Series 2011 Bonds

On May 5, 2011, Wellmont refunded the Revenue Bonds, Series 2006A, with the proceeds of the Revenue Bonds, Series 2011. The Series 2011 Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2006A and to pay the costs of issuing the Series 2011 Bonds.

In order to refund the Series 2006A Bonds, Wellmont made a tender offer to the holders of the Series 2006A Bonds. The holders of all outstanding Series 2006A Bonds agreed to tender their Series 2006A Bonds to Wellmont. Proceeds of the Series 2011 Bonds were used to pay the purchase price of Series 2006A Bonds tendered for purchase. All outstanding Series 2006A Bonds were purchased by the Wellmont on the date of issuance of the Bonds and were immediately surrendered to the trustee for the Series 2006A Bonds for retirement and cancellation.

The Series 2011 Bonds were issued with two maturities of \$42,385 and \$33,780 for 2026 and 2032, respectively. The Series 2011 Bonds maturing September 1, 2026 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the

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redemption dates beginning on September 1, 2013 and ending on September 1, 2026 in annual amounts ranging from \$865 to \$4,680. The Series 2011 Bonds maturing September 1, 2032 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2027 and ending on September 1, 2032 in annual amounts ranging from \$4,980 to \$6,300. The Series 2011 Bonds were issued as fixed-rate obligations at 6.0% and 6.5% for the two maturities (2026 and 2032, respectively).

(c) Series 2010 Bank Qualified Bonds

On November 1, 2010, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee (the Board) issued \$30,000 Hospital Revenue Bonds, Series 2010 (Bank Qualified). The Series 2010 Bonds were issued and sold pursuant to the Bond Purchase Agreement dated as of November 1, 2010, between the Board and First Tennessee Bank National Association. During the fiscal years ended June 30, 2013 and 2012, Wellmont has received advances on the bonds in the amounts of \$0 and \$11,368, respectively.

Commencing on January 1, 2011, and continuing on the first day of each fiscal quarter thereafter, Wellmont shall pay accrued interest on the outstanding balance of the loan. Commencing on October 1, 2011 and continuing on the first day of each fiscal quarter thereafter, Wellmont shall also make principal payments equal to \$500. The outstanding bonds accrue interest at a rate equal to the product of 65% of the sum of LIBOR plus the applicable margin, which at June 30, 2013 was set at 1.95%.

(d) Series 2007 Bonds

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

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

(e) Series 2006 C

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

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

(f) Series 2005

On December 8, 2005, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, \$70,620 of Hospital Revenue Refunding Bonds, Series 2005. The Series 2005 Bonds together with other available funds were used to advance refund the previously issued Hospital Revenue Bonds, Series 2002, and to pay certain expenses incurred in connection with the issuance of the Series 2005 Bonds.

Principal on outstanding Series 2005 Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from \$1,945 to \$3,390 commencing on September 1, 2007 through September 1, 2032. The terms of the bonds provide that bondholders may redeem or put the bonds to the remarketing agent on dates that approximate a weekly basis. The remarketing agent is obligated to remarket the redeemed bonds on a "best efforts" basis. Redeemed bonds are repaid to bondholders from the proceeds of the remarketing effort or, in the event of an inability to remarket the bonds, from a letter of credit. This letter secures the bonds in the event of a failed remarketing or liquidity issue. In the event of a liquidity drawing under the letter of credit, Wellmont shall pay the Base Rate equal to the greater of (i) the Prime Rate plus 1.50% per annum, (ii) LIBOR plus 2.50% per annum, or (iii) 7.50% per annum. Wellmont shall repay the liquidity drawing amount in 12 equal quarterly installments, with the first such installment due on the first anniversary of the related liquidity drawing.

Outstanding Series 2005 Bonds are subject to redemption prior to maturity at the option of The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%-102% of the principal amount of the Series 2005 Bonds being redeemed, plus accrued interest thereon to the redemption date.

(g) Series 2003

On June 1, 2003, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, \$59,100 of Hospital Revenue Bonds, Series 2003. The bonds were issued to provide funds necessary to refund Wellmont's Hospital Revenue Bonds, Series 1993 (HVHC), to fund a debt service reserve fund and to pay certain expenses incurred in connection with the issuance of the Series 2003 Bonds.

The Wellmont Series 2003 Bonds consist of \$27,460 in fixed-rate serial bonds and \$19,280 in fixed-rate term bonds payable through maturity or mandatory sinking fund redemption maturing in annual amounts ranging from \$3,230 on September 1, 2007 to \$4,140 on September 1, 2019, and carrying interest rates ranging from 2.5% to 5.00%.

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(h) Master Trust Indenture

The master trust indentures and loan agreements for the 2011, 2010, 2007, 2006, 2005, and 2003 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

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

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

On December 1, 2012, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee (as Lessee) and Wellmont (as Sub-Lessee) entered into a Master Equipment Lease and Sublease Agreement with Banc of America Public Capital Corp (the Lessor). The proceeds of this Master Lease are being used to finance an electronic medical records system consisting of an EpicCare Inpatient Clinical System and an EpicCare Ambulatory Electronic Medical Records System inclusive of hardware, software, and implementation services subject to a License and Support agreement between Epic Systems Corporate and Sub-lessees dated September 19, 2012. The Sub-Lessee has authorized the Lessor to take a security interest in the entire System although only certain components of the System are to be funded under this Master Lease with the rest to be funded by Bank of America N.A. and Sub-Lessee. During the fiscal year ended June 30, 2013, Wellmont has received two advances totaling \$16,150.

Each Lease Term shall commence and interest shall begin to accrue on the date any funds are advanced by the Lessor. The Lease payments shall be payable on a monthly basis. The first six lease payments under each agreement shall consist only of an interest component and the remaining 78 lease payments shall consist of a principal component and an interest component. Commencing on June 30, 2013, and continuing on the first day of each fiscal quarter thereafter, Wellmont shall pay accrued interest on the outstanding balance of the loan. Each agreement will have an interest component based on a fixed-rate of interest and payable with respect to the amount of funds that the Lessor has advanced. The Leases issued during the fiscal year ended June 30, 2013 as fixed-rate obligations calculated at 0.65% if the Average Life Swap Rate, United States Treasury Swap as of

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the Request date plus 1.0635% based on Lessor's credit evaluation of Wellmont, which resulted in 1.45% and 1.82% for the two maturities in 2020.

(j) Notes Payable

During 2007, Wellmont entered into a five-year \$3,000 note payable, which has a fixed interest rate of 7.25% and a termination date of July 2011. In August 2011, Wellmont renewed this note agreement in the amount of \$1,760 with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate with a ceiling of 7.75% and a floor of 4.00% and a maturity date of August 2016. At June 30, 2013 and 2012, \$1,199 and \$1,540, respectively, were outstanding on this note.

During 2009, Wellmont entered into a five-year \$2,400 term note payable with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate and a maturity date of October 2013. At June 30, 2013 and 2012, \$379 and \$640, respectively, were outstanding on this note.

During 2010, Wellmont entered into a \$2,767 note payable to finance the purchase of Cardiovascular Associates. The note payable had a fixed interest rate of 5.5% and a termination date of May 2013. At June 30, 2013 and 2012, \$0 and \$922, respectively, were outstanding on this note.

On October 17, 2012, Wellmont entered into a ten-year \$12,500 term note payable with Bank of America, N.A. The proceeds were used for the EpicCare system and its implementation, among other general corporate purposes. The note payable has a fixed interest rate of 3.27% and a maturity date of December 13, 2022. At June 30, 2013, \$10,390 was outstanding on this note.

(k) Capital Lease Obligations

Assets under capital leases are included in property and equipment and have a net carrying value of \$26,695 and \$25,170 as of June 30, 2013 and 2012, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 2.03% to 12.0%.

(l) Long-Term Debt Maturities Schedule

Bond maturities in accordance with the original terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2013 are as follows:

2014	\$	15,002
2015		14,450
2016		14,124
2017		13,677
2018		16,182
Thereafter		411,177
	\$	<u>484,612</u>

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The following table reflects the required repayment terms for the years ended June 30 of Wellmont's debt obligations in the event that the put options associated with the 2005 bonds were exercised, but not successfully remarketed.

2014	\$	12,457
2015		30,064
2016		29,617
2017		29,045
2018		12,766
Thereafter		<u>370,663</u>
	\$	<u>484,612</u>

Interest paid for the years ended June 30, 2013 and 2012 was \$21,163 and \$22,216, respectively, net of amounts capitalized. Interest costs of \$299 and \$0, net of interest income of \$0 and \$0 in 2013 and 2012, respectively, were capitalized.

(12) Derivative Transactions

Wellmont is a party to a number of interest rate swap agreements. Such swaps have not been designated as hedges and are valued at estimated fair value in the accompanying consolidated balance sheets. By using derivative financial instruments to hedge exposures to changes in interest rates, Wellmont exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes Wellmont, which creates credit risk for Wellmont. When the fair value of a derivative contract is negative, Wellmont owes the counterparty, and therefore, Wellmont is not exposed to the counterparty's credit risk in those circumstances. Pursuant to the terms of its interest rate swap agreements, Wellmont is required to post collateral with its counterparties under certain specified conditions. Collateral posting requirements are based on the amount of Wellmont's derivative liability and Wellmont's bond rating. As of June 30, 2013 and 2012, Wellmont was not required to post collateral related to its swaps.

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

Wellmont has a Total Return Swap on the Series 2011 Bonds with a new counterparty.

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Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its variable rate debt structure using LIBOR rates. The fair value as of June 30, 2013 and 2012 of approximately \$(7,425) and \$(9,781), respectively, is included in other long-term liabilities in the consolidated balance sheets. The change in the fair value of the derivative instruments was approximately \$2,356 and \$1,807, respectively, in 2013 and 2012 and is included in nonoperating gains in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. The following is a summary of the interest rate swap information as of June 30, 2013:

<u>Type of interest swap</u>	<u>Debt hedging</u>	<u>Notional amount</u>	<u>Effective date</u>	<u>Maturity date</u>	<u>Rate paid</u>	<u>Rate received</u>	<u>Swap fair value asset (liability)</u>
Total return swap Pay fixed interest	Series 2011	\$ 76,165	May 5, 2011	September 1, 2032	1.400%	6.222%	\$ 1,792
rate swap	Series 2005	54,820	December 13, 2005	September 1, 2016	3.548	0.082	(4,738)
Basis swap	Series 2002	58,680	September 1, 2002	September 1, 2032	0.050	0.163	(1,245)
Pay fixed interest rate swap	*	30,295	October 24, 2003	September 1, 2021	3.613	0.082	<u>(3,234)</u>
							<u>\$ (7,425)</u>

* Previously designated bond series has been refinanced.

The following is a schedule detailing the swap information as of June 30, 2012:

<u>Type of interest swap</u>	<u>Debt hedging</u>	<u>Notional amount</u>	<u>Effective date</u>	<u>Maturity date</u>	<u>Rate paid</u>	<u>Rate received</u>	<u>Swap fair value asset (liability)</u>
Total return swap Pay fixed interest	Series 2011	\$ 76,165	May 5, 2011	September 1, 2032	1.530%	6.200%	\$ 2,888
rate swap	Series 2005	57,250	December 13, 2005	September 1, 2016	3.548	0.165	(6,471)
Basis swap	Series 2002	60,765	September 1, 2002	September 1, 2032	0.180	0.339	(1,662)
Pay fixed interest rate swap	*	32,880	October 24, 2003	September 1, 2021	3.613	0.165	<u>(4,536)</u>
							<u>\$ (9,781)</u>

* Previously designated bond series has been refinanced.

In September and October 2008, the counterparty and credit support provider, for four of the swaps held at that time, filed bankruptcy. The bankruptcy process is underway and the ultimate outcome regarding any final settlement cannot be determined at this time.

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(13) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined-contribution retirement plan (Retirement Plan) that covers substantially all employees. This program and the related Retirement Plan were created from amendments, restatements, and mergers of existing defined-contribution plans at BRMC and HVMC. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 3% of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Code, up to 3% of each participant's wages. The total pension expense related to the Retirement Plan was \$13,020 and \$10,346 for the years ended June 30, 2013 and 2012, respectively.

HVMC sponsored a noncontributory, defined-benefit pension plan covering substantially all its employees. However, effective June 30, 1996, this plan was frozen and no further benefits accrue. LPH also sponsors a defined-benefit pension plan covering substantially all its employees.

HVMC's defined-pension benefits are actuarially determined based on a formula taking into consideration an employee's compensation and years of service. HVMC's funding policy is to make annual contributions to the plan based upon the funding standard developed by the plan actuary. This standard uses the projected unit credit actuarial cost method, including the amortization of prior service costs, over a 20-year period. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. The LPH plan contains similar funding and actuarial policies.

On June 30, 2007, the HVMC plan merged into LPH plan and the plan name changed to Wellmont Health System Defined Benefit Plan. At the end of 2008, only a single defined-pension plan exists. Collectively, the two defined-benefit plans are referred to as the "Plans." Effective June 30, 2010, the plan was frozen for all Lonesome Pine Hospital employees and no further benefits will be accrued.

Wellmont recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined-benefit pension plans as an asset or liability in its consolidated balance sheet and recognizes changes in that funded status in the year in which the changes occur as a change in unrestricted net assets. All defined-benefit pension plans use a June 30 measurement date.

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

	<u>2013</u>	<u>2012</u>
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 54,081	45,337
Service cost	—	—
Interest cost	2,102	2,422
Actuarial losses	(3,062)	8,614
Benefits paid	<u>(2,372)</u>	<u>(2,292)</u>
Benefit obligation at end of year	<u>50,749</u>	<u>54,081</u>
Change in plan assets:		
Fair value of plan assets at beginning of year	36,791	38,811
Actual return on plan assets	2,521	(304)
Employer contribution	3,417	576
Benefits paid	<u>(2,372)</u>	<u>(2,292)</u>
Fair value of plan assets at end of year	<u>40,357</u>	<u>36,791</u>
Funded status	\$ <u>(10,393)</u>	<u>(17,290)</u>
Amounts recognized in the accompanying consolidated balance sheets:		
Pension benefit liability (other long-term liabilities)	\$ (10,393)	(17,290)

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	<u>2013</u>	<u>2012</u>
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:		
Unrecognized actuarial loss	\$ 14,552	19,773
Unrecognized prior service cost	<u>—</u>	<u>—</u>
Net amounts included as an accumulated charge to unrestricted net assets	<u>\$ 14,552</u>	<u>19,773</u>
Calculation of change in unrestricted net assets:		
Accumulated charge to unrestricted net assets, end of year	\$ 14,552	19,773
Reversal of accumulated charge to unrestricted net assets, prior year	<u>(19,773)</u>	<u>(8,565)</u>
Change in unrestricted net assets	<u>\$ (5,221)</u>	<u>11,208</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Actuarial loss (gain) arising during the year	\$ (3,003)	11,577
Amortization of actuarial loss	(2,218)	(369)
Amortization of prior service cost	<u>—</u>	<u>—</u>
Net amounts recognized in unrestricted net assets	<u>\$ (5,221)</u>	<u>11,208</u>

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	<u>2013</u>	<u>2012</u>
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2013:		
Amortization of net loss	\$ 1,467	2,186
Amortization of prior service cost	—	—
Estimated future benefit payments:		
Fiscal 2013	\$ —	2,609
Fiscal 2014	2,590	2,732
Fiscal 2015	2,658	2,821
Fiscal 2016	2,741	2,897
Fiscal 2017	2,828	2,996
Fiscal 2018–2022	18,643	16,054
Weighted average assumptions used to determine benefit obligations:		
Settlement (discount) rate	4.50%	4.00%
Weighted average rate of increase in future compensation levels	N/A	N/A
Components of net periodic benefit cost (benefit):		
Service cost	\$ —	—
Interest cost	2,102	2,422
Expected return on plan assets	(2,581)	(2,658)
Amortization of net loss	2,218	369
Net periodic benefit cost	<u>\$ 1,739</u>	<u>133</u>
Weighted average assumptions used to determine net periodic benefit cost:		
Settlement (discount) rate	4.00%	5.50%
Expected long-term return on plan assets (HVMC)	7.00	7.00
Expected long-term return on plan assets (LPH)	7.00	7.00
Weighted average rate of increase in future compensation levels	N/A	N/A

Wellmont’s overall expected long-term rate of return on assets is 7.00%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

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

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The table below shows the target allocation and actual asset allocations as of June 30, 2013 and 2012:

Asset	Target allocation	2013	2012
Equity securities	65%	48%	47%
Fixed income	28	33	32
Cash	5%–15%	1	2
Other	5%– 5%	18	19

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

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

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

	Postretirement benefits	
	2013	2012
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 7,039	7,763
Interest cost	163	298
Plan participants contributions	19	34
Actuarial losses	(2,554)	(975)
Benefits paid	(85)	(81)
Benefit obligation at end of year	4,582	7,039
Change in plan assets:		
Fair value of plan assets at beginning of year	—	—
Employer contribution	66	47
Plan participants contributions	19	34
Benefits paid	(85)	(81)
Fair value of plan assets at end of year	—	—
Funded status	\$ 4,582	7,039

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	Postretirement benefits	
	2013	2012
Amounts recognized in the consolidated balance sheets consist of:		
Noncurrent assets	\$ —	—
Current liabilities	—	—
Noncurrent liabilities	(4,582)	(7,039)
Accumulated charge to unrestricted net assets	4,608	2,469
	<u>\$ 26</u>	<u>(4,570)</u>

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

	2013	2012
Net actuarial gain	\$ 4,608	2,469

Net periodic benefit cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2013 and 2012 were as follows:

	Postretirement benefits	
	2013	2012
Net periodic benefit cost:		
Interest cost	\$ 163	299
Amortization of net gain	(416)	(262)
Net periodic benefit cost recognized	<u>(253)</u>	<u>37</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	(2,554)	(975)
Amortization of net gain	416	262
Total recognized in unrestricted net assets	<u>(2,138)</u>	<u>(713)</u>
Total recognized in net periodic benefit cost and unrestricted net assets	<u>\$ (2,391)</u>	<u>(676)</u>

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The net gain and prior service credit for the defined-benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are \$(405) and \$(168), respectively. Weighted average assumptions used to determine benefit obligations for 2013 and 2012 were as follows:

	<u>2013</u>	<u>2012</u>
Discount rate	4.00%	3.50%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2013 and 2012 were as follows:

	<u>Postretirement benefits</u>	
	<u>2013</u>	<u>2012</u>
Discount rate	3.50%	5.00%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00	5.00

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

For measurement purposes, a 6.50% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2013.

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

	<u>2013</u>	<u>2012</u>
Effect of one-percentage-point increase in healthcare cost trend on:		
Service and interest cost	\$ 10	21
Accumulated pension benefit obligation	271	533
Effect of one-percentage-point decrease in healthcare cost trend on:		
Service and interest cost	\$ (9)	(19)
Accumulated pension benefit obligation	(242)	(473)

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The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2013 and 2012, respectively, were as follows:

Fair value measurement at June 30, 2013				
pension benefits – plan assets				
	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Stock mutual funds	\$ 32,750	32,750	—	—
Cash and money market funds	543	543	—	—
Alternative funds	7,064	—	3,674	3,390
Total	<u>\$ 40,357</u>	<u>33,293</u>	<u>3,674</u>	<u>3,390</u>
Fair value measurement at June 30, 2012				
pension benefits – plan assets				
	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Stock mutual funds	\$ 29,223	29,223	—	—
Cash and money market funds	578	578	—	—
Alternative funds	6,990	—	3,443	3,547
Total	<u>\$ 36,791</u>	<u>29,801</u>	<u>3,443</u>	<u>3,547</u>

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The following table presents Wellmont’s activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2013 and 2012:

		Alternative investments
Balance at June 30, 2011	\$	3,588
Net change in value		(29)
Purchases, issuances, and settlements		(12)
Transfers into and/or out of Level 3 (net)		<u>—</u>
Balance at June 30, 2012		3,547
Net change in value		(61)
Purchases, issuances, and settlements		(96)
Transfers into and/or out of Level 3 (net)		<u>—</u>
Balance at June 30, 2013	\$	<u><u>3,390</u></u>

There were no transfers between any levels during the years ended June 30, 2013 and 2012.

(14) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers’ compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont had established revocable self-insurance trust funds to provide for professional and general liability claims and workers’ compensation claims and related expenses. Wellmont’s contributions to the self-insurance trusts were based upon actuarial determinations by an independent service company. The trust fund requirement for professional and general liability was eliminated in 2013. The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers’ compensation program is supplemented for Tennessee and Virginia by excess workers’ compensation policies, with a commercial carrier for statutory limits per occurrence. Provisions based on actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Workers’ compensation expense under these programs amounted to approximately \$3,681 and \$4,100 for the years ended June 30, 2013 and 2012, respectively, and are included in salaries and benefits expense in the accompanying consolidated statements of operations and changes in net assets. All other self-insurance expense under these programs amounted to approximately \$2,229 and \$2,763 for the years ended June 30, 2013 and 2012, respectively, and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2013 and 2012, Wellmont was involved in litigation relating to medical malpractice and workers’ compensation claims arising in the ordinary course of business. There are also known incidents that occurred through June 30, 2013 that may result in the assertion of additional claims, and other claims

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2013 and 2012

(Dollars in thousands)

may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2013 are adequate to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

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

(15) Commitments and Contingencies

Construction in progress at June 30, 2013 and 2012 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately \$15,403 at June 30, 2013. Wellmont has entered into contracts of \$15,403 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was \$18,240 and \$19,269 for the years ended June 30, 2013 and 2012, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2013 are as follows:

2014	\$	9,076
2015		8,164
2016		5,749
2017		4,898
2018		4,377
Thereafter		15,251
	\$	<u>47,515</u>

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2013 and 2012

(Dollars in thousands)

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

(16) Functional Expense Disclosure

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

	<u>2013</u>	<u>2012</u>
Professional care of patients	\$ 655,152	612,639
Administrative and general	128,955	152,171
Fund-raising	1,172	1,106
	<u>\$ 785,279</u>	<u>765,916</u>

(17) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate-company state income tax returns. These companies have combined net operating loss carryforwards for federal income tax purposes of approximately \$107,000 at June 30, 2013, which begin expiring in fiscal 2018 and expire through 2032. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont files a Form 990-T with the Internal Revenue Service to report such activity. Wellmont has net operating loss carryforwards for federal income tax purposes of approximately \$1,780 for unrelated business activities. Management believes that it is more likely than not that deferred tax assets arising from net operating loss carryforwards will not be realizable. Accordingly, these are fully reserved at June 30, 2013 and 2012.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2013 and 2012

(Dollars in thousands)

(18) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2013 and 2012 was as follows:

	2013	2012
Medicare	53%	50%
TennCare	6	5
Medicaid	9	7
Other third-party payors	26	31
Patients	6	7
	100%	100%

(19) Disclosures about Fair Value of Financial Instruments

The fair value of a financial instrument is the amount that would be received to sell an asset or paid to transfer or settle a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820, *Fair Value Measurements and Disclosures*, establishes a three-level fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The classification of an investment within the hierarchy is based upon the pricing transparency or ability to redeem the investment and does not necessarily correspond to the perceived risk of that investment. Inputs are used in applying various valuation techniques that are assumptions, which market participants use to make valuation decisions, including assumptions about risk. Inputs may include price information, volatility statistics, operating statistics, specific and broad credit data, liquidity statistics, recent transactions, earnings forecasts, future cash flows, market multiples, discount rates and other factors.

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

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

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

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2013 and 2012

(Dollars in thousands)

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

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2013:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 55,958	—	—	55,958
Assets limited as to use:				
Stock mutual funds	109,356	—	—	109,356
Bond mutual funds	175,594	—	—	175,594
Cash and money market funds	42,923	—	—	42,923
Real estate funds	16,377	—	—	16,377
Alternative investments	—	—	36,520	36,520
Subtotal	<u>400,208</u>	<u>—</u>	<u>36,520</u>	<u>436,728</u>
Long-term investments:				
Stock mutual funds	12,228	—	—	12,228
Bond mutual funds	13,478	—	—	13,478
Cash and money market funds	190	—	—	190
Real estate funds	1,220	—	—	1,220
Subtotal	<u>27,116</u>	<u>—</u>	<u>—</u>	<u>27,116</u>
	<u>\$ 427,324</u>	<u>—</u>	<u>36,520</u>	<u>463,844</u>
Liabilities:				
Derivatives liability	\$ —	7,425	—	7,425
Total	<u>\$ —</u>	<u>7,425</u>	<u>—</u>	<u>7,425</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2013 and 2012

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2012:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 44,930	—	—	44,930
Assets limited as to use:				
Stock mutual funds	88,942	—	—	88,942
Bond mutual funds	163,401	—	—	163,401
Cash and money market funds	44,240	—	—	44,240
Real estate funds	7,157	—	—	7,157
Alternative investments	—	—	36,989	36,989
Corporate bonds	2,673	—	—	2,673
U.S. Treasury bonds	—	—	—	—
Subtotal	<u>351,343</u>	<u>—</u>	<u>36,989</u>	<u>388,332</u>
Long-term investments:				
Stock mutual funds	10,321	—	—	10,321
Bond mutual funds	13,926	—	—	13,926
Cash and money market funds	189	—	—	189
Real estate funds	685	—	—	685
Alternative investments	—	—	—	—
Subtotal	<u>25,121</u>	<u>—</u>	<u>—</u>	<u>25,121</u>
	<u>\$ 376,464</u>	<u>—</u>	<u>36,989</u>	<u>413,453</u>
Liabilities:				
Derivatives liability	\$ —	9,781	—	9,781
Total	\$ —	9,781	—	9,781

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

- *Cash and Cash Equivalents*

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

- *Patient Accounts and Other Receivables*

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2013 and 2012

(Dollars in thousands)

- *Investments and Assets Limited as to Use*

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

Wellmont also applies the measurement provisions of ASU No. 2009-12 to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. This guidance amends the previous guidance and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value, in many instances may not equal fair value that would be calculated pursuant to ASC 820. The fair value of these investments was \$36,520 and \$36,989 at June 30, 2013 and 2012, respectively.

- *Accounts Payable and Accrued Expenses*

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

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

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

- *Long-Term Debt*

The carrying amount of indebtedness with variable interest rates approximates its fair value because the variable rates reflect current market rates for indebtedness with similar maturities and credit quality. The fair value of indebtedness with fixed interest rates is based on rates assumed to be currently available for indebtedness with similar terms and average maturities. Fair value measurements of indebtedness are based on observable interest rates and maturity schedules that fall within Level 2 of the hierarchy of fair value inputs. The estimated fair value of revenue bonds, using current market rates, was estimated at \$436,832 and \$436,634 for the years ended June 30, 2013 and 2012, respectively. The carrying amount of other long-term debt reported in Note 11 and on the consolidated balance sheet approximates the related fair value.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2013 and 2012

(Dollars in thousands)

The following table presents additional information about Level 3 assets measured at fair value. Both observable and unobservable inputs may be used to determine the fair value of positions that the Health System has classified within the Level 3 category. As a result, the unrealized gains and losses for assets within the Level 3 category in the table below may include changes in fair value that were attributable to both observable and unobservable inputs.

	<u>Alternative investments</u>
Balance at June 30, 2011	\$ 37,778
Total realized and unrealized gains (losses):	
Included in revenues and gains in excess of expenses and losses	264
Included in changes in net assets	(420)
Purchases, issuances, and settlements	(633)
Transfers into and/or out of Level 3 (net)	<u>—</u>
Balance at June 30, 2012	36,989
Total realized and unrealized gains (losses):	
Included in revenues and gains in excess of expenses and losses	(69)
Included in changes in net assets	1,113
Purchases, issuances, and settlements	(1,513)
Transfers into and/or out of Level 3 (net)	<u>—</u>
Balance at June 30, 2013	\$ <u><u>36,520</u></u>

There were no transfers between any of the levels during the years ended June 30, 2013 and 2012.

(20) Subsequent Events

Effective October 1, 2013, Wellmont closed Lee Regional Medical Center in Pennington Gap, Virginia.

Wellmont has evaluated subsequent events from the balance sheet date through October 23, 2013, the date at which the consolidated financial statements were issued. No other material subsequent events were identified for recognition.



WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

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

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Wellmont Health System and affiliates, which comprise the consolidated balance sheets as of June 30, 2014 and 2013, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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



Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Wellmont Health System and affiliates as of June 30, 2014 and 2013, and the results of their operations and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Nashville, Tennessee
October 24, 2014

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2014 and 2013

(Dollars in thousands)

Assets	2014	2013
Current assets:		
Cash and cash equivalents	\$ 30,674	55,958
Assets limited as to use, required for current liabilities	3,233	5,061
Patient accounts receivable, less allowance for uncollectible accounts of approximately \$38,007 and \$25,991 in 2014 and 2013, respectively	117,265	107,029
Other receivables	14,685	17,995
Inventories	18,684	18,361
Prepaid expenses and 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	51,649	15,096
Other	520	547
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	—
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
Total net assets attributable to Wellmont	548,140	512,172
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

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES
Consolidated Statements of Operations and Changes in Net Assets
Years ended June 30, 2014 and 2013
(Dollars in thousands)

	<u>2014</u>	<u>2013</u>
Revenue:		
Patient service revenue	\$ 788,910	791,230
Provision for bad debt	(45,644)	(53,251)
Net patient revenue less provision for bad debt	<u>743,266</u>	<u>737,979</u>
Other revenues	<u>29,441</u>	<u>42,127</u>
Total revenue	<u>772,707</u>	<u>780,106</u>
Expenses:		
Salaries and benefits	374,309	373,150
Medical supplies and drugs	166,676	162,604
Purchased services	73,674	77,716
Interest	18,350	20,292
Depreciation and amortization	50,058	49,465
Maintenance and utilities	36,978	36,830
Lease and rental	15,506	17,892
Other	<u>32,312</u>	<u>26,745</u>
Total expenses	<u>767,863</u>	<u>764,694</u>
Income from operations	<u>4,844</u>	<u>15,412</u>
Nonoperating gains:		
Investment income	14,749	19,316
Derivative valuation adjustments	1,307	2,356
Loss on refinancing	(1,133)	—
Gain on revaluation of equity method investment	<u>14,744</u>	<u>—</u>
Nonoperating gains, net	<u>29,667</u>	<u>21,672</u>
Revenue and gains in excess of expenses and losses before discontinued operations	<u>34,511</u>	<u>37,084</u>
Discontinued operations	<u>(26,639)</u>	<u>(4,484)</u>
Revenue and gains in excess of expenses and losses	<u>7,872</u>	<u>32,600</u>
Income attributable to noncontrolling interests	<u>(1,540)</u>	<u>(1,228)</u>
Revenues and gains in excess of expenses and losses attributable to Wellmont	<u>6,332</u>	<u>31,372</u>
Other changes in unrestricted net assets:		
Change in net unrealized gains (losses) on investments	28,333	6,157
Net assets released from restrictions for additions to land, buildings, and equipment	901	828
Change in the funded status of benefit plans and other	<u>(893)</u>	<u>7,359</u>
Increase in unrestricted net assets	<u>34,673</u>	<u>45,716</u>
Changes in temporarily restricted net assets:		
Contributions	2,707	2,977
Net assets released from temporary restrictions	<u>(1,420)</u>	<u>(1,789)</u>
Increase in temporarily restricted net assets	<u>1,287</u>	<u>1,188</u>
Changes in permanently restricted net assets – investment income	<u>8</u>	<u>7</u>
Changes in noncontrolling interests:		
Income attributable to noncontrolling interests	1,540	1,228
Distributions to noncontrolling interests	<u>(1,623)</u>	<u>(1,220)</u>
Change in noncontrolling interests	<u>(83)</u>	<u>8</u>
Change in net assets	<u>35,885</u>	<u>46,919</u>
Net assets, beginning of year	<u>514,945</u>	<u>468,026</u>
Net assets, end of year	<u>\$ 550,830</u>	<u>514,945</u>

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2014 and 2013

(Dollars in thousands)

	<u>2014</u>	<u>2013</u>
Cash flows from operating activities:		
Change in net assets	\$ 35,885	46,919
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	50,526	51,392
(Gain) loss on disposal of land, buildings, and equipment	(78)	211
Equity in earnings of affiliated organizations	(1,764)	(4,594)
Distributions from affiliated organizations	3,484	5,366
Amortization of deferred financing costs	426	486
Net realized and unrealized gain on investments	(31,302)	(9,580)
Provision for bad debts	40,237	55,029
Change in fair value of derivative instruments	(1,307)	(2,356)
Loss on refinancing	1,133	—
Gain on revaluation of equity method investment	(14,744)	—
Loss on impairment	22,456	2,007
Changes in assets and liabilities, net of acquisitions:		
Patient accounts receivable	(44,839)	(53,793)
Other current assets	(1,711)	(1,986)
Other assets	3,297	5,872
Accounts payable and accrued expenses	5,474	(2,532)
Estimated third-party payor settlements	1,268	(8,378)
Other current liabilities	11,358	416
Other liabilities	2,998	(10,137)
Net cash provided by operating activities	<u>82,797</u>	<u>74,342</u>
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	123,193	115,439
Purchase of investments	(141,095)	(135,222)
Purchase of land, buildings, and equipment	(86,879)	(57,747)
Proceeds from the sale of buildings and equipment	2,434	355
Cash paid for acquisitions	<u>(22,637)</u>	<u>(13)</u>
Net cash used in investing activities	<u>(124,984)</u>	<u>(77,188)</u>
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	128,623	28,908
Payments on long-term debt	(111,092)	(14,789)
Payment of debt issuance costs	<u>(628)</u>	<u>(245)</u>
Net cash provided by financing activities	<u>16,903</u>	<u>13,874</u>
Net (decrease) increase in cash and cash equivalents	<u>(25,284)</u>	<u>11,028</u>
Cash and cash equivalents, beginning of year	<u>55,958</u>	<u>44,930</u>
Cash and cash equivalents, end of year	\$ <u>30,674</u>	\$ <u>55,958</u>

Supplemental disclosures of noncash items:

Wellmont entered into capital lease obligations for buildings and equipment in the amount of \$1,345 and \$5,262 in 2014 and 2013, respectively.

Additions to property and equipment financed through current liabilities of \$3,770 and \$5,589 in 2014 and 2013, respectively.

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2014 and 2013

(Dollars in thousands)

(1) Operations and Basis of Presentation

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

The consolidated financial statements also include the operations of:

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

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

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

The following are included in discontinued operations:

- As of October 1, 2013, Wellmont closed Lee Regional Medical Center in Pennington Gap, Virginia. The losses of \$26,091 and \$2,317, including an impairment loss of \$22,456 and \$0, for the years ended June 30, 2014 and 2013, respectively, are included in discontinued operations
- As of May 17, 2013, a subsidiary of Wellmont ceased operating its sleep labs, which were managed by a third party. The losses of \$292 and \$2,302, including an impairment loss of \$0 and \$2,007, for the years ended June 30, 2014 and 2013, respectively, are included in discontinued operations.
- As of September 23, 2010, Wellmont sold the majority of its retail pharmacy's assets to a national pharmacy company. The gains (losses) of \$45 and (\$131) for the years ended June 30, 2014 and 2013, respectively, are included in discontinued operations.
- As of April 30, 2009, Wellmont closed Jenkins Community Hospital in Jenkins, Kentucky. The gains (losses) of (\$301) and \$266 for the years ended June 30, 2014 and 2013, respectively, are included in discontinued operations.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2014 and 2013

(Dollars in thousands)

(2) Significant Accounting Policies

A summary of significant accounting policies is as follows:

(a) Use of Estimates

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

(b) Cash and Cash Equivalents

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

(c) Investments

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

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

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(d) *Assets Limited as to Use*

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

(e) *Inventories*

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

(f) *Land, Buildings, and Equipment*

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

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

(g) *Goodwill*

Wellmont adopted ASU No. 2010-07, *Not for Profit Entities: Mergers and Acquisitions*, which in part requires healthcare entities to follow Accounting Standards Codification (ASC) Topic 350-20-35, *Intangibles – Goodwill and Other* along with ASU 2011-08, *Testing Goodwill for Impairment*, effective July 1, 2012. ASC Topic 350-20-35 requires goodwill of not-for-profit entities to be evaluated for impairment at least annually. An entity has the option to first assess qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its

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carrying amount. If, after assessing the totality of events or circumstances, an entity determines it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step impairment test is unnecessary. The more-likely than-not threshold is defined as having a likelihood of more than 50%. However, if an entity concludes otherwise, then it is required to perform the first step of the two-step impairment test by calculating the fair value of the reporting unit and comparing the fair value with the carrying amount (including goodwill) of the reporting unit. If the carrying amount of a reporting unit exceeds its fair value, then the entity is required to perform the second step of the goodwill impairment test to measure the amount of the impairment loss. Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step two does not need to be performed. The annual impairment test is performed as of June 30.

(h) *Deferred Debt Expense*

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

(i) *Derivative Financial Instruments*

As further described in note 12, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

(j) *Asset Retirement Obligations*

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

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(k) *Temporarily and Permanently Restricted Net Assets*

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

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

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2014 and 2013 primarily included amounts related to the purchase of equipment for pediatrics, cancer, and other healthcare operations.

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

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

(l) *Net Patient Service Revenue and Accounts Receivable*

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the

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period related services are rendered and adjusted in future periods as final and other settlements are determined. On the basis of historical experience, a significant portion of Wellmont's uninsured patients will be unable or unwilling to pay for the services provided. Therefore, Wellmont records a significant provision for bad debts related to uninsured patients in the period the services are provided. This provision for bad debts is presented on the statements of operations as a component of net patient revenue. Wellmont provides care to patients who meet criteria under its charity care policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

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

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

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

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

(n) Contributed Resources

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

Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. Gifts are reported as either a temporarily or permanently restricted contribution if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished,

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temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions. Unrestricted contributions are included in other revenues.

(o) Federal Income Taxes

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

(p) Recently Adopted Accounting Standards

The FASB issued ASU No. 2011-04, *Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRSs*, in May 2011. This ASU requires the reason for the fair value measurement to be disclosed, a description of the valuation techniques, and descriptions of the inputs used for all Level 2 and Level 3 fair value measurements. It also requires all transfers between levels of the fair value hierarchy to be separately reported and described. Wellmont adopted ASU 2011-04 as of July 1, 2012.

(q) Reclassifications

Certain 2013 amounts have been reclassified to conform to the 2014 consolidated financial statement presentation. The reclassifications had no impact on total assets or changes in net assets.

(3) Business Combinations and Goodwill

On November 30, 2013, Wellmont purchased 100% of the membership interest in Wexford House from Residential Healthcare Affiliates. Wexford House is a skilled nursing facility, which serves residents of Sullivan County, Tennessee and the surrounding communities. The facility provides short- and long-term medical and rehabilitation care. In addition, on March 31, 2014, Wellmont purchased the remaining 25% interest in Holston Valley Imaging Center (HVIC), which included the remaining 50% governance interest from Blue Ridge Radiology Investment. The assets acquired and liabilities assumed under each acquisition were recorded at their estimated fair value in accordance with ASC 805.

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The following table summarizes the consideration paid and the estimated fair value of the assets acquired and liabilities assumed at the business combination date:

	<u>Wexford</u>	<u>HVIC</u>
Consideration:		
Cash	\$ 14,770	7,867
Fair value of Wellmont's equity interest in HVIC held before acquisition	—	23,601
	<u>\$ 14,770</u>	<u>31,468</u>
Recognized amounts of identifiable assets acquired and liabilities assumed:		
Current assets	\$ 2,976	2,474
Other assets	5,277	241
Current liabilities	(564)	(863)
Long-term liabilities	(608)	—
Total identifiable net assets	<u>7,081</u>	<u>1,852</u>
Goodwill	<u>7,689</u>	<u>29,616</u>
	<u>\$ 14,770</u>	<u>31,468</u>

Wellmont recognized a gain of \$14,744 as a result of remeasuring to fair value its 75% equity interest in HVIC held before the business combination. The gain is included in nonoperating gains (losses) on the consolidated statement of operations for the year ended June 30, 2014.

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

	<u>2013</u>	<u>Additions</u>	<u>Decreases</u>	<u>2014</u>
Goodwill	\$ 15,096	37,305	(752)	51,649
	<u>2012</u>	<u>Additions</u>	<u>Decreases</u>	<u>2013</u>
Goodwill	\$ 17,090	13	(2,007)	15,096

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(4) Net Patient Service Revenue

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

	<u>2014</u>	<u>2013</u>
Gross patient service revenue	\$ 2,683,891	2,452,561
Less:		
Contractual adjustments and other discounts	(1,838,900)	(1,605,045)
Charity care	<u>(56,081)</u>	<u>(56,286)</u>
Net patient service revenue before provision for bad debts	788,910	791,230
Less provision for bad debts	<u>(45,644)</u>	<u>(53,251)</u>
Net patient service revenue	<u>\$ 743,266</u>	<u>737,979</u>

Wellmont's allowance for doubtful accounts is predominantly for self-pay patients and patient balances remaining after third-party payments. The provision for bad debts decreased \$7,607 from fiscal 2013 to fiscal 2014 and the net write-offs decreased \$19,262 from fiscal 2013 to fiscal 2014. The decrease in the provision for bad debts was primarily offset by an increase of \$6,594 in self-pay discounts. The decrease in write-offs was due to the above item and the implementation of a new billing system in the last quarter of the fiscal year. Wellmont has not changed its charity care or uninsured discount policies during fiscal 2014. Wellmont does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

(5) Third-Party Reimbursement Arrangements

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

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

The Medicare program pays for the costs of inpatient services on a prospective basis. Payments are based upon diagnostic-related group assignments, which are determined by the patient's clinical diagnosis and

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medical procedures utilized. Wellmont receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid-eligible and other low-income patients. Outpatient services are also reimbursed primarily on a prospectively determined basis.

Net patient service revenue in 2014 and 2013 related to Medicare and TennCare/Medicaid and net patient accounts receivable at June 30, 2014 and 2013 from Medicare and TennCare/Medicaid were as follows:

	<u>2014</u>	<u>2013</u>
Net patient service revenue:		
Medicare	\$ 304,713	313,429
TennCare/Medicaid	37,216	39,515
Net patient accounts receivable:		
Medicare	\$ 44,480	38,102
TennCare/Medicaid	6,817	6,146

Wellmont has filed cost reports with Medicare and Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Medicaid cost reports have been audited and final settled by the intermediary through June 30, 2010 and audit adjustments have been received and considered for certain hospitals and year-ends through June 30, 2012.

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

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased approximately \$3,334 and \$6,605 in 2014 and 2013, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of audits and final settlements, and years that are no longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2014 could differ materially from actual settlements based on the results of third-party audits.

(6) Meaningful Use Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record (EHR) technology. The Medicare incentive payments are paid out to qualifying hospitals and physician groups over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals, and physician groups must meet EHR “meaningful use” criteria that

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become more stringent over three stages as determined by Centers for Medicare & Medicaid Services (CMS). Medicaid programs and payment schedules vary from state to state.

For fiscal years ended June 30, 2014 and 2013, Wellmont recorded \$7,211 and \$12,267, respectively, in other operating revenue related to the EHR and meaningful use incentives. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria.

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

(7) Charity Care and Community Services

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

Wellmont maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone and estimated costs incurred for services and supplies furnished under its charity care policy. Costs incurred are estimated based on the ratio of total operating expenses to gross charges applied to charity care charges. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and the equivalent percentage of charity care patients to all patients serviced were \$56,081, \$14,567, and 2.39%, respectively, for the year ended June 30, 2014 and \$56,286, \$15,735, and 2.57%, respectively, for the year ended June 30, 2013.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and state indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont's cost of providing care to those patients totaled \$37,432 and \$45,056 for the years ended June 30, 2014 and 2013, respectively.

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

(8) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include hospital, home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in earnings of affiliates was approximately \$1,764 and \$4,594 for the years ended June 30, 2014 and 2013, respectively, and is included in other operating revenue in the consolidated financial statements. Wellmont received distributions of \$3,484 and \$5,366 during 2014 and 2013, respectively, which reduced Wellmont's overall investment in the affiliates.

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

	<u>2014</u>	<u>2013</u>
Total assets	\$ 136,824	135,802
Total liabilities	<u>38,396</u>	<u>40,617</u>
Total net assets	\$ <u>98,428</u>	<u>95,185</u>
Net revenues	\$ 201,639	200,765
Expenses	<u>191,023</u>	<u>186,394</u>
Revenues in excess of expenses	\$ <u>10,616</u>	<u>14,371</u>

Wellmont's investment in these affiliates and its ownership percentage as of June 30, 2014 and 2013 is as follows:

	<u>Amount</u>		<u>Percentages</u>	
	<u>2014</u>	<u>2013</u>	<u>2014</u>	<u>2013</u>
Takoma Regional Hospital	\$ 10,763	11,983	60%	60%
Holston Valley Imaging Center (HVIC)	—	8,336	—	75
Advanced Home Care (AHO)	6,092	6,092	6	6
Lab Group Holdings, LLC	—	3,500	—	1
Others	<u>1,366</u>	<u>1,963</u>	25%–50%	25%–50%
	\$ <u>18,221</u>	<u>31,874</u>		

As of March 31, 2014, Wellmont purchased the remaining 25% interest in HVIC and included HVIC in the consolidated financial statements from that date.

Prior to this transaction and although Wellmont's ownership percentage in Takoma Regional Hospital and HVIC was greater than 50%, Wellmont did not consolidate these entities because Wellmont only had a 50% representation on each respective board and did not have control over these entities. Also, during the fiscal year ended June 30, 2014, Lab Group Holdings, LLC was purchased by another entity, which also purchased all of Wellmont's share in this entity.

Wellmont provided billing, management, and professional services to some of the affiliates. Income recognized by Wellmont for the services was \$173 in 2014 and \$971 in 2013 and is included in other revenues. Included in other receivables are \$242 and \$406 as of June 30, 2014 and 2013, respectively, of amounts due to Wellmont from these entities.

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(9) Investments

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

	2014	2013
Assets limited as to use by Board for capital improvements:		
Stock mutual funds	\$ 148,453	109,356
Bond mutual funds	167,156	175,594
Cash and money market funds	5,904	3,749
Real estate funds	21,381	16,377
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):		
Liquid	14,215	10,504
Illiquid	26,852	26,016
	383,961	341,596
Assets limited as to use under self-insurance agreements:		
Cash and money market funds	16,051	—
Assets limited as to use under bond indenture agreements:		
Cash and money market funds	28,961	39,174
Less assets limited as to use that are required for current liabilities	3,233	5,061
Assets limited as to use, net of current portion	\$ 425,740	375,709
Long-term investments:		
Stock mutual funds	\$ 17,741	12,228
Bond mutual funds	11,420	13,478
Preferred equity investment and related options	1,512	1,512
Cash, money market funds, and certificates of deposit	230	190
Real estate funds	1,618	1,220
Total long-term investments	\$ 32,521	28,628

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately \$10,162 as of June 30, 2014 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which \$567 was paid subsequent to June 30, 2014.

Effective June 27, 2013, Wellmont redeemed its \$10,000 in the preferred equity of a regional managed services organization; however, retained its \$1,512 on a right of first refusal related to any future sale of this organization. This equity had a guaranteed annual return of at least 6.5% of the outstanding preferred equity balance.

Wellmont's investments are concentrated in stock and bond mutual funds. In the event of a downward trend in the stock and bond markets, Wellmont's overall market value of net assets could be adversely

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affected by a material amount. Investments in alternative investments are generally illiquid investments whose value is determined by the general partner such as hedge funds, private equity, commingled funds, and real estate funds. Distributions are only at the discretion of a voting majority of the general partners.

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, Wellmont recognized other-than-temporary impairment losses of \$0 and \$131 on investments as of June 30, 2014 and 2013, respectively. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2014 and 2013 were as follows:

	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2014:						
Alternative investments	\$ —	—	647	878	647	878
Mutual funds	16	1,655	3,632	119,716	3,648	121,371
	<u>\$ 16</u>	<u>1,655</u>	<u>4,279</u>	<u>120,594</u>	<u>4,295</u>	<u>122,249</u>
	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2013:						
Alternative investments	\$ 478	3,243	—	—	478	3,243
Mutual funds	7,304	181,780	371	3,185	7,675	184,965
	<u>\$ 7,782</u>	<u>185,023</u>	<u>371</u>	<u>3,185</u>	<u>8,153</u>	<u>188,208</u>

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

	2014	2013
Interest and dividends, net of amounts capitalized	\$ 11,780	15,893
Realized gains on investments, net	2,969	3,423
Investment income, net	<u>\$ 14,749</u>	<u>19,316</u>
Change in net unrealized gains on investment	\$ 28,333	6,157

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(Dollars in thousands)

(10) Land, Buildings, and Equipment

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

	<u>2014</u>	<u>2013</u>
Land	\$ 49,825	49,758
Buildings and improvements	523,069	536,758
Equipment	490,805	384,747
Buildings and equipment under capital lease obligations	<u>46,031</u>	<u>45,102</u>
	1,109,730	1,016,365
Less accumulated depreciation	<u>(623,930)</u>	<u>(576,210)</u>
	485,800	440,155
Construction in progress	<u>6,781</u>	<u>34,575</u>
Land, buildings, and equipment	<u>\$ 492,581</u>	<u>474,730</u>

Depreciation expense for the years ended June 30, 2014 and 2013 was \$50,058 and \$49,465, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was \$21,789 and \$18,408 as of June 30, 2014 and 2013, respectively.

(11) Other Long-Term Liabilities

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

	<u>2014</u>	<u>2013</u>
Workers' compensation liability	\$ 11,096	9,882
Professional and general liability	15,940	11,492
Postretirement benefit obligation	2,633	4,582
Asset retirement obligation	3,139	2,969
Deferred gain on sale of assets	409	439
Derivative liability	6,118	7,425
Pension benefit liability	11,041	10,393
Other	<u>—</u>	<u>583</u>
	50,376	47,765
Less current portion	<u>(6,510)</u>	<u>(6,198)</u>
Total other long-term liabilities	<u>\$ 43,866</u>	<u>41,567</u>

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(12) Debt

(a) Long-Term Debt

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

	<u>2014</u>	<u>2013</u>
Hospital Refunding Bonds, Series 2014A	\$ 14,242	—
Hospital Refunding Bonds, Series 2014B	52,275	—
Hospital Refunding Bonds, Series 2014C	20,836	—
Hospital Revenue Bonds, Series 2014D	13,575	—
Hospital Revenue Refunding Bonds, Series 2011	75,300	76,165
Hospital Revenue Bonds, Series 2010 (Bank Qualified)	—	22,836
Hospital Revenue Bonds, Series 2007A	55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	200,000	200,000
Hospital Revenue Refunding Bonds, Series 2005	—	54,820
Hospital Revenue Bonds, Series 2003	—	25,225
Project Odyssey 2012 Tax-Exempt Master Lease/Sublease Financing	40,589	16,150
Notes payable	10,232	11,968
Capital lease obligations	19,749	21,601
Other	674	847
	<u>502,472</u>	<u>484,612</u>
Unamortized premium	5,986	6,679
Unamortized discount	—	(343)
	<u>508,458</u>	<u>490,948</u>
Less current maturities	<u>(18,015)</u>	<u>(15,002)</u>
	<u>\$ 490,443</u>	<u>475,946</u>

(b) Series 2014 Bonds

On June 25, 2014, Wellmont (a) refunded the Revenue Bonds, Series 2003, the Revenue Refunding Bonds, Series 2005, and the Revenue Bonds, Series 2010 (Bank Qualified), with the proceeds of the Hospital Revenue Refunding Bonds, Series 2014A, Series 2014B, and Series 2014C and (b) issued Series 2014D. The Series 2014A through Series 2014D Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2003, the Revenue Refunding Bonds, Series 2005, and the Revenue Bonds, Series 2010 (Bank Qualified) and to issue new debt in the amount of \$13,575 to reimburse Wellmont for the purchase price of Wellmont Wexford House and to pay closing costs of issuing the Series 2014D Bonds. All of the Series 2014 Bonds were issued as tax-exempt and were issued in accordance with the Master Trust Indenture dated May 1, 1991.

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

Interest on the Series 2014 Bonds is 100% of LIBOR plus a quotient of applicable spread divided by 67%. Accrued interest is paid monthly in arrears. Interest rates on the 2014A, 2014B, 2014C, and 2014D Bonds were 0.92%, 1.02%, 0.85%, and 0.85%, respectively, as of June 30, 2014.

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

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

On December 1, 2012, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee (as Lessee) and Wellmont (as Sub-Lessee) entered into a Master Equipment Lease and Sublease Agreement with Banc of America Public Capital Corp (the Lessor). The proceeds of this Master Lease were used to finance an electronic medical records system consisting of an EpicCare Inpatient Clinical System and an EpicCare Ambulatory Electronic Medical Records System inclusive of hardware, software, and implementation services. The Sub-Lessee authorized the Lessor to take a security interest in the entire System although only certain components of the System were funded under this Master Lease with the rest funded by Bank of America N.A. and Sub-Lessee. During the fiscal year ended June 30, 2013, Wellmont received two draws totaling \$16,150. During the fiscal year ended June 30, 2014, Wellmont received two additional draws totaling \$26,349.

Each lease term shall commence and interest shall begin to accrue on the date any funds are advanced by Wellmont. The first six lease payments under each agreement consist only of an interest component and the remaining 78 lease payments consist of a principal component and an interest component. Commencing on June 30, 2013, and continuing on the first day of each fiscal quarter thereafter, Wellmont shall pay accrued interest on the outstanding balance of the loan. Each agreement will have an interest component based on a fixed rate of interest and payable with respect to the amount of funds that the Lessor has advanced. The rates of interest are 1.79% and 1.97% for the two draws in the fiscal year ended June 30, 2014 and 1.45% and 1.82% for the two draws in the fiscal year ended June 30, 2013.

(d) *Series 2011 Bonds*

On May 5, 2011, Wellmont refunded the Revenue Bonds, Series 2006A, with the proceeds of the Revenue Bonds, Series 2011. The Series 2011 Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2006A and to pay the costs of issuing the Series 2011 Bonds.

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In order to refund the Series 2006A Bonds, Wellmont made a tender offer to the holders of the Series 2006A Bonds. The holders of all outstanding Series 2006A Bonds agreed to tender their Series 2006A Bonds to Wellmont. Proceeds of the Series 2011 Bonds were used to pay the purchase price of Series 2006A Bonds tendered for purchase. All outstanding Series 2006A Bonds were purchased by the Wellmont on the date of issuance of the Bonds and were immediately surrendered to the trustee for the Series 2006A Bonds for retirement and cancellation.

The Series 2011 Bonds were issued with two maturities of \$42,385 and \$33,780 for 2026 and 2032, respectively. The Series 2011 Bonds maturing September 1, 2026 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2013 and ending on September 1, 2026 in annual amounts ranging from \$865 to \$4,680. The Series 2011 Bonds maturing September 1, 2032 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2027 and ending on September 1, 2032 in annual amounts ranging from \$4,980 to \$6,300. The Series 2011 Bonds were issued as fixed-rate obligations at 6.0% and 6.5% for the two maturities (2026 and 2032, respectively).

(e) *Series 2010 Bank Qualified Bonds*

On November 1, 2010, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee (the Board) issued \$30,000 Hospital Revenue Bonds, Series 2010 (Bank Qualified). The Series 2010 Bonds were issued and sold pursuant to the Bond Purchase Agreement dated as of November 1, 2010, between the Board and First Tennessee Bank National Association. Commencing on January 1, 2011, and continuing on the first day of each fiscal quarter thereafter, Wellmont shall pay accrued interest on the outstanding balance of the loan. Commencing on October 1, 2011 and continuing on the first day of each fiscal quarter thereafter, Wellmont shall also make principal payments equal to \$500. The outstanding bonds accrue interest at a rate equal to the product of 65% of the sum of LIBOR plus the applicable margin; however, the Series 2010 Bonds were redeemed upon the issuance of the Series 2014C Bonds.

(f) *Series 2007 Bonds*

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

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

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(g) Series 2006 C

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

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

(h) Series 2005

On December 8, 2005, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, \$70,620 of Hospital Revenue Refunding Bonds, Series 2005. The Series 2005 Bonds together with other available funds were used to advance refund the previously issued Hospital Revenue Bonds, Series 2002, and to pay certain expenses incurred in connection with the issuance of the Series 2005 Bonds. Principal on outstanding Series 2005 Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from \$1,945 to \$3,390 commencing on September 1, 2007 through September 1, 2032; however, the Series 2005 Bonds were redeemed upon the issuance of the Series 2014B Bonds.

(i) Series 2003

On June 1, 2003, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, \$59,100 of Hospital Revenue Bonds, Series 2003. The bonds were issued to provide funds necessary to refund Wellmont's Hospital Revenue Bonds, Series 1993 (HVHC), to fund a debt service reserve fund and to pay certain expenses incurred in connection with the issuance of the Series 2003 Bonds.

The Wellmont Series 2003 Bonds consist of \$27,460 in fixed-rate serial bonds and \$19,280 in fixed-rate term bonds payable through maturity or mandatory sinking fund redemption maturing in annual amounts ranging from \$3,230 on September 1, 2007 to \$4,140 on September 1, 2019; however, the Series 2003 Bonds were redeemed upon the issuance of the Series 2014A Bonds.

(j) Master Trust Indenture

The master trust indentures and loan agreements for the 2014, 2011, 2007, and 2006 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross

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receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

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

(k) Notes Payable

During 2007, Wellmont entered into a five-year \$3,000 note payable, which has a fixed interest rate of 7.25% and a termination date of July 2011. In August 2011, Wellmont renewed this note agreement in the amount of \$1,760 with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate with a ceiling of 7.75% and a floor of 4.00% and a maturity date of August 2016. At June 30, 2014 and 2013, \$828 and \$1,199, respectively, were outstanding on this note.

During 2009, Wellmont entered into a five-year \$2,400 term note payable with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate and a maturity date of October 2014. At June 30, 2014 and 2013, \$150 and \$379, respectively, were outstanding on this note.

On October 17, 2012, Wellmont entered into a 10-year \$12,500 term note payable with Bank of America, N.A. The proceeds were used for the EpicCare system and its implementation, among other general corporate purposes. The note payable has a fixed interest rate of 3.27% and a maturity date of December 13, 2022. At June 30, 2014, \$9,254 and \$10,390 was outstanding on this note.

(l) Capital Lease Obligations

Assets under capital leases are included in property and equipment and have a net carrying value of \$24,242 and \$26,695 as of June 30, 2014 and 2013, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 2.1% to 12.0%.

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(m) Long-Term Debt Maturities Schedule

Bond maturities in accordance with the original terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2014 are as follows:

2015	\$	18,015
2016		17,318
2017		16,405
2018		18,912
2019		19,638
Thereafter		412,184
	\$	<u>502,472</u>

Interest paid for the years ended June 30, 2014 and 2013 was \$18,899 and \$19,622, respectively, net of amounts capitalized. Interest costs of \$1,444 and \$299 were capitalized in 2014 and 2013, respectively.

(13) Derivative Transactions

Wellmont is a party to a number of interest rate swap agreements. Such swaps have not been designated as hedges and are valued at estimated fair value in the accompanying consolidated balance sheets. By using derivative financial instruments to hedge exposures to changes in interest rates, Wellmont exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes Wellmont, which creates credit risk for Wellmont. When the fair value of a derivative contract is negative, Wellmont owes the counterparty, and therefore, Wellmont is not exposed to the counterparty's credit risk in those circumstances. Pursuant to the terms of its interest rate swap agreements, Wellmont is required to postcollateral with its counterparties under certain specified conditions. Collateral posting requirements are based on the amount of Wellmont's derivative liability and Wellmont's bond rating. As of June 30, 2014 and 2013, Wellmont was not required to postcollateral related to its swaps.

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

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Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its variable rate debt structure using LIBOR rates. The fair value as of June 30, 2014 and 2013 of approximately \$(6,118) and \$(7,425), respectively, is included in other long-term liabilities in the consolidated balance sheets. The change in the fair value of the derivative instruments was approximately \$1,307 and \$2,356, respectively, in 2014 and 2013 and is included in nonoperating gains in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. The following is a summary of the interest rate swap information as of June 30, 2014:

<u>Type of interest swap</u>	<u>Debt hedging</u>	<u>Notional amount</u>	<u>Effective date</u>	<u>Maturity date</u>	<u>Rate paid</u>	<u>Rate received</u>	<u>Swap fair value asset (liability)</u>
Total return swap	Series 2011	\$ 75,300	May 5, 2011	September 1, 2032	1.410%	6.222%	\$ 987
Pay fixed interest rate swap	*	52,275	December 13, 2005	September 1, 2016	3.548	0.101	(3,323)
Basis swap	*	56,465	September 1, 2002	September 1, 2032	0.060	0.173	(1,127)
Pay fixed interest rate swap	*	27,575	October 24, 2003	September 1, 2021	3.613	0.104	(2,655)
							<u>\$ (6,118)</u>

* Previously designated bond series has been refinanced.

The following is a schedule detailing the swap information as of June 30, 2013:

<u>Type of interest swap</u>	<u>Debt hedging</u>	<u>Notional amount</u>	<u>Effective date</u>	<u>Maturity date</u>	<u>Rate paid</u>	<u>Rate received</u>	<u>Swap fair value asset (liability)</u>
Total return swap	Series 2011	\$ 76,165	May 5, 2011	September 1, 2032	1.400%	6.222%	\$ 1,792
Pay fixed interest rate swap	Series 2005	54,820	December 13, 2005	September 1, 2016	3.548	0.082	(4,738)
Basis swap	*	58,680	September 1, 2002	September 1, 2032	0.050	0.163	(1,245)
Pay fixed interest rate swap	*	30,295	October 24, 2003	September 1, 2021	3.613	0.082	(3,234)
							<u>\$ (7,425)</u>

* Previously designated bond series has been refinanced.

In September and October 2008, the counterparty and credit support provider, for four of the swaps held at that time, filed bankruptcy. The bankruptcy process is underway and the ultimate outcome regarding any final settlement cannot be determined at this time.

(14) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined-contribution retirement plan (Retirement Plan) that covers substantially all employees. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 2% (after October 1, 2013) and 3% (before October 1, 2013) of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which

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cannot exceed certain limits established in the Internal Revenue Code, up to 2.4% (after October 1, 2013) and 3% (before October 1, 2013) of each participant's wages. The total pension expense related to the Retirement Plan was \$10,687 and \$12,765 for the years ended June 30, 2014 and 2013, respectively.

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

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

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

	<u>2014</u>	<u>2013</u>
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 50,749	54,081
Service cost	—	—
Interest cost	2,196	2,102
Actuarial loss(gain)	5,815	(3,062)
Benefits paid	<u>(2,469)</u>	<u>(2,372)</u>
Benefit obligation at end of year	<u>56,291</u>	<u>50,749</u>
Change in plan assets:		
Fair value of plan assets at beginning of year	40,357	36,791
Actual return on plan assets	4,960	2,521
Employer contribution	2,402	3,417
Benefits paid	<u>(2,469)</u>	<u>(2,372)</u>
Fair value of plan assets at end of year	<u>45,250</u>	<u>40,357</u>
Funded status	\$ <u><u>(11,041)</u></u>	<u><u>(10,393)</u></u>
Amounts recognized in the accompanying consolidated balance sheets:		
Pension benefit liability (other long-term liabilities)	\$ (11,041)	(10,393)

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	<u>2014</u>	<u>2013</u>
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:		
Unrecognized actuarial loss	\$ 16,777	14,552
Unrecognized prior service cost	<u>—</u>	<u>—</u>
Net amounts included as an accumulated charge to unrestricted net assets	\$ <u>16,777</u>	<u>14,552</u>
Calculation of change in unrestricted net assets:		
Accumulated charge to unrestricted net assets, end of year	\$ 16,777	14,552
Reversal of accumulated charge to unrestricted net assets, prior year	<u>(14,552)</u>	<u>(19,773)</u>
Change in unrestricted net assets	\$ <u>2,225</u>	<u>(5,221)</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Actuarial loss (gain) arising during the year	\$ 3,665	(3,003)
Amortization of actuarial loss	(1,440)	(2,218)
Amortization of prior service cost	<u>—</u>	<u>—</u>
Net amounts recognized in unrestricted net assets	\$ <u>2,225</u>	<u>(5,221)</u>

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	<u>2014</u>	<u>2013</u>
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2013:		
Amortization of net loss	\$ 1,810	1,467
Amortization of prior service cost	—	—
Estimated future benefit payments:		
Fiscal 2014	\$ —	2,590
Fiscal 2015	2,804	2,658
Fiscal 2016	2,894	2,741
Fiscal 2017	3,004	2,828
Fiscal 2018	3,093	2,907
Fiscal 2019–2023	19,937	15,736
Weighted average assumptions used to determine benefit obligations:		
Settlement (discount) rate	4.00%	4.50%
Weighted average rate of increase in future compensation levels	N/A	N/A
Components of net periodic benefit cost (benefit):		
Service cost	\$ —	—
Interest cost	2,196	2,102
Expected return on plan assets	(2,810)	(2,581)
Amortization of net loss	1,440	2,218
Net periodic benefit cost	\$ <u>826</u>	<u>1,739</u>
Weighted average assumptions used to determine net periodic benefit cost:		
Settlement (discount) rate	4.50%	4.00%
Expected long-term return on plan assets (HVMC)	7.00	7.00
Expected long-term return on plan assets (LPH)	7.00	7.00
Weighted average rate of increase in future compensation levels	N/A	N/A

Wellmont’s overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

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

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The table below shows the target allocation and actual asset allocations as of June 30, 2014 and 2013:

Asset	Target allocation	2014	2013
Equity securities	47%	48%	48%
Fixed income	41	33	33
Cash	—	3	1
Other	12	16	18

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

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

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

	Postretirement benefits	
	2014	2013
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 4,582	7,039
Interest cost	96	163
Plan participants contributions	17	19
Actuarial losses	(1,978)	(2,554)
Benefits paid	(84)	(85)
Benefit obligation at end of year	2,633	4,582
Change in plan assets:		
Fair value of plan assets at beginning of year	—	—
Employer contribution	66	66
Plan participants contributions	17	19
Benefits paid	(83)	(85)
Fair value of plan assets at end of year	—	—
Funded status	\$ (2,633)	(4,582)

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	Postretirement benefits	
	2014	2013
Amounts recognized in the consolidated balance sheets consist of:		
Noncurrent assets	\$ —	—
Current liabilities	—	—
Noncurrent liabilities	(2,633)	(4,582)
Accumulated charge to unrestricted net assets	5,939	4,608
	<u>\$ 3,306</u>	<u>26</u>

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

	2014	2013
Net actuarial gain	\$ 5,939	4,608

Net periodic benefit cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2014 and 2013 were as follows:

	Postretirement benefits	
	2014	2013
Net periodic benefit cost:		
Interest cost	\$ 95	163
Amortization of net gain	(646)	(416)
Net periodic benefit recognized	<u>(551)</u>	<u>(253)</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	(1,978)	(2,554)
Amortization of net gain	646	416
Total recognized in unrestricted net assets	<u>(1,332)</u>	<u>(2,138)</u>
Total recognized in net periodic benefit cost and unrestricted net assets	<u>\$ (1,883)</u>	<u>(2,391)</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2014 and 2013

(Dollars in thousands)

The net gain and prior service credit for the defined-benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are \$(646) and \$(416), respectively. Weighted average assumptions used to determine benefit obligations for 2014 and 2013 were as follows:

	<u>2014</u>	<u>2013</u>
Discount rate	3.50%	4.00%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2014 and 2013 were as follows:

	<u>Postretirement benefits</u>	
	<u>2014</u>	<u>2013</u>
Discount rate	4.00%	4.00%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00	5.00

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

For measurement purposes, a 6.7% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2014.

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

	<u>2014</u>	<u>2013</u>
Effect of one-percentage-point increase in healthcare cost trend on:		
Service and interest cost	\$ 4	10
Accumulated pension benefit obligation	132	271
Effect of one-percentage-point decrease in healthcare cost trend on:		
Service and interest cost	\$ (3)	(9)
Accumulated pension benefit obligation	(116)	(242)

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2014 and 2013

(Dollars in thousands)

The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2014 and 2013, respectively, were as follows:

Fair value measurement at June 30, 2014				
pension benefits – plan assets				
	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Stock mutual funds	\$ 36,546	36,546	—	—
Cash and money market funds	1,416	1,416	—	—
Alternative funds	7,425	—	3,935	3,490
Total	\$ 45,387	37,962	3,935	3,490

Fair value measurement at June 30, 2013				
pension benefits – plan assets				
	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Stock mutual funds	\$ 32,750	32,750	—	—
Cash and money market funds	543	543	—	—
Alternative funds	7,064	—	3,674	3,390
Total	\$ 40,357	33,293	3,674	3,390

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2014 and 2013

(Dollars in thousands)

The following table presents Wellmont’s activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2014 and 2013:

	<u>Alternative investments</u>
Balance at June 30, 2012	\$ 3,547
Net change in value	(61)
Purchases, issuances, and settlements	(96)
Transfers into and/or out of Level 3 (net)	—
Balance at June 30, 2013	<u>3,390</u>
Net change in value	232
Purchases, issuances, and settlements	(132)
Transfers into and/or out of Level 3 (net)	—
Balance at June 30, 2014	\$ <u><u>3,490</u></u>

There were no transfers between any levels during the years ended June 30, 2014 and 2013.

(15) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers’ compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont had established revocable self-insurance trust funds to provide for professional and general liability claims and workers’ compensation claims and related expenses. Wellmont’s contributions to the self-insurance trusts were based upon actuarial determinations by an independent service company. The trust fund requirement for professional and general liability was eliminated in fiscal year 2013.

Wellmont Insurance Company SPC, Ltd (the captive) was formed in 2014 as a wholly owned captive insurance company in the Cayman Islands. The captive holds Wellmont’s self-insurance liabilities for professional and general liability and is funded by transfers from Wellmont Health System. These funds are included in assets limited as to use.

The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers’ compensation program is supplemented for Tennessee and Virginia by excess workers’ compensation policies, with a commercial carrier for statutory limits per occurrence. Provisions based on actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Workers’ compensation expense under these programs amounted to approximately \$3,695 and \$3,588 for the years ended June 30, 2014 and 2013, respectively, and are included in salaries and benefits expense in the accompanying consolidated statements of operations and changes in net assets. All other self-insurance expense under these programs amounted to approximately \$5,707 and \$2,229 for the years ended June 30, 2014 and 2013, respectively,

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2014 and 2013

(Dollars in thousands)

and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2014 and 2013, Wellmont was involved in litigation relating to medical malpractice and workers' compensation claims arising in the ordinary course of business. There are also known incidents that occurred through June 30, 2014 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2014 are adequate to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

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

(16) Commitments and Contingencies

Construction in progress at June 30, 2014 and 2013 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately \$24,685 at June 30, 2014. Wellmont has entered into contracts of \$24,685 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was \$15,506 and \$17,892 for the years ended June 30, 2014 and 2013, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2014 are as follows:

2015	\$	11,222
2016		8,117
2017		7,210
2018		6,439
2019		6,167
Thereafter		20,423
	\$	<u>59,578</u>

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2014 and 2013

(Dollars in thousands)

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

(17) Functional Expense Disclosure

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

	<u>2014</u>	<u>2013</u>
Professional care of patients	\$ 610,162	613,277
Administrative and general	156,647	150,245
Fund-raising	1,054	1,172
	<u>\$ 767,863</u>	<u>764,694</u>

(18) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate-company state income tax returns. These companies have combined net operating loss carryforwards for federal income tax purposes of approximately \$111,000 at June 30, 2014, which begin expiring in fiscal 2019 and expire through 2033. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont files a Form 990-T with the Internal Revenue Service to report such activity. Wellmont has net operating loss carryforwards for federal income tax purposes of approximately \$1,796 for unrelated business activities. Management believes that it is more likely than not that deferred tax assets arising from net operating loss carryforwards will not be realizable. Accordingly, these are fully reserved at June 30, 2014 and 2013.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2014 and 2013

(Dollars in thousands)

(19) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2014 and 2013 was as follows:

	2014	2013
Medicare	48%	53%
TennCare/Medicaid	13	14
Other third-party payors	31	27
Patients	8	6
	100%	100%

(20) Disclosures about Fair Value of Financial Instruments

The fair value of a financial instrument is the amount that would be received to sell an asset or paid to transfer or settle a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820, *Fair Value Measurements*, establishes a three-level fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The classification of an investment within the hierarchy is based upon the pricing transparency or ability to redeem the investment and does not necessarily correspond to the perceived risk of that investment. Inputs are used in applying various valuation techniques that are assumptions, which market participants use to make valuation decisions, including assumptions about risk. Inputs may include price information, volatility statistics, operating statistics, specific and broad credit data, liquidity statistics, recent transactions, earnings forecasts, future cash flows, market multiples, discount rates, and other factors.

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

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

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

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

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

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2014 and 2013

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2014:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 30,674	—	—	30,674
Assets limited as to use:				
Stock mutual funds	148,453	—	—	148,453
Bond mutual funds	167,156	—	—	167,156
Cash and money market funds	50,916	—	—	50,916
Real estate funds	21,381	—	—	21,381
Alternative investments	—	—	41,067	41,067
Subtotal	<u>418,580</u>	<u>—</u>	<u>41,067</u>	<u>459,647</u>
Long-term investments:				
Stock mutual funds	17,741	—	—	17,741
Bond mutual funds	11,420	—	—	11,420
Cash and money market funds	230	—	—	230
Real estate funds	1,618	—	—	1,618
Subtotal	<u>31,009</u>	<u>—</u>	<u>—</u>	<u>31,009</u>
	\$ <u>449,589</u>	<u>—</u>	<u>41,067</u>	<u>490,656</u>
Liabilities:				
Derivatives liability	\$ —	6,118	—	6,118
Total	\$ <u>—</u>	<u>6,118</u>	<u>—</u>	<u>6,118</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2014 and 2013

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2013:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 55,958	—	—	55,958
Assets limited as to use:				
Stock mutual funds	109,356	—	—	109,356
Bond mutual funds	175,594	—	—	175,594
Cash and money market funds	42,923	—	—	42,923
Real estate funds	16,377	—	—	16,377
Alternative investments	—	—	36,520	36,520
Subtotal	<u>400,208</u>	<u>—</u>	<u>36,520</u>	<u>436,728</u>
Long-term investments:				
Stock mutual funds	12,228	—	—	12,228
Bond mutual funds	13,478	—	—	13,478
Cash and money market funds	190	—	—	190
Real estate funds	1,220	—	—	1,220
Subtotal	<u>27,116</u>	<u>—</u>	<u>—</u>	<u>27,116</u>
	<u>\$ 427,324</u>	<u>—</u>	<u>36,520</u>	<u>463,844</u>
Liabilities:				
Derivatives liability	<u>—</u>	<u>7,425</u>	<u>—</u>	<u>7,425</u>
Total	<u>\$ —</u>	<u>7,425</u>	<u>—</u>	<u>7,425</u>

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

- *Cash and Cash Equivalents*
The carrying amount approximates fair value due to the short maturities of these instruments.
- *Patient Accounts and Other Receivables*
The net recorded carrying value approximates fair value due to the short maturities of these instruments.
- *Investments and Assets Limited as to Use*
The fair values of investments and assets limited as to use are based on quoted market prices and quotes obtained from security brokers or, in the case of the limited partnerships, by the general partner.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2014 and 2013

(Dollars in thousands)

Wellmont also applies the measurement provisions of ASU No. 2009-12 to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. This guidance amends the previous guidance and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value, in many instances may not equal fair value that would be calculated pursuant to ASC 820. The fair value of these investments was \$41,067 and \$36,520 at June 30, 2014 and 2013, respectively.

- *Accounts Payable and Accrued Expenses*

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

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

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

- *Long-Term Debt*

The carrying amount of indebtedness with variable interest rates approximates its fair value because the variable rates reflect current market rates for indebtedness with similar maturities and credit quality. The fair value of indebtedness with fixed interest rates is based on rates assumed to be currently available for indebtedness with similar terms and average maturities. Fair value measurements of indebtedness are based on observable interest rates and maturity schedules that fall within Level 2 of the hierarchy of fair value inputs. The estimated fair value of revenue bonds, using current market rates, was estimated at \$444,106 and \$436,832 for the years ended June 30, 2014 and 2013, respectively. The carrying amount of other long-term debt reported in note 11 and on the consolidated balance sheet approximates the related fair value.

The following table presents additional information about Level 3 assets measured at fair value. Both observable and unobservable inputs may be used to determine the fair value of positions that the Health System has classified within the Level 3 category. As a result, the unrealized gains and losses for assets within the Level 3 category in the table below may include changes in fair value that were attributable to both observable and unobservable inputs.

	Alternative investments
Balance at June 30, 2012	\$ 36,989
Total realized and unrealized gains (losses):	
Included in revenues and gains in excess of expenses and losses	(69)
Included in changes in net assets	1,113
Purchases, issuances, and settlements	(1,513)
Transfers into and/or out of Level 3 (net)	—
Balance at June 30, 2013	36,520

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2014 and 2013

(Dollars in thousands)

	<u>Alternative investments</u>
Total realized and unrealized gains (losses):	
Included in revenues and gains in excess of expenses and losses	\$ (3,161)
Included in changes in net assets	1,898
Purchases, issuances, and settlements	5,810
Transfers into and/or out of Level 3 (net)	—
Balance at June 30, 2014	<u>\$ 41,067</u>

There were no transfers between any of the levels during the years ended June 30, 2014 and 2013.

(21) Subsequent Events

On July 1, 2014, Wellmont sold its 60% interest in Takoma Regional Hospital to Adventist Health System (which also owned the other 40%). Cash in the amount of \$11,700 was received prior to July 1, 2014 and is included in current liabilities.

On September 24, 2014, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee issued, on behalf of Wellmont, \$21,335 of Hospital Revenue Refunding Bonds, Series 2014E. Under the terms of the bond indenture, the proceeds were used to establish a fund to advance refund \$19,580 of the Hospital Revenue Bonds, Series 2006C upon their call date in 2016. The Series 2014E Bonds were issued as tax-exempt and were issued in accordance with the Master Trust Indenture dated May 1, 1991. Upon the issuance of the Series 2014E Bonds, a new Master Trust Indenture was implemented and replaced the one dated May 1, 1991.

Wellmont has evaluated subsequent events from the balance sheet date through October 24, 2014, the date at which the consolidated financial statements were issued. No other material subsequent events were identified for recognition and disclosed.



WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2015 and 2014

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

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

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Wellmont Health System and affiliates, which comprise the consolidated balance sheets as of June 30, 2015 and 2014, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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



Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Wellmont Health System and affiliates as of June 30, 2015 and 2014, and the results of their operations and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Nashville, Tennessee
October 27, 2015

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2015 and 2014

(Dollars in thousands)

Assets	2015	2014
Current assets:		
Cash and cash equivalents	\$ 48,866	30,674
Assets limited as to use, required for current liabilities	3,651	4,066
Patient accounts receivable, less allowance for uncollectible accounts of approximately \$33,297 and \$38,007 in 2015 and 2014, respectively	112,299	117,265
Other receivables	11,238	14,685
Inventories	19,981	18,684
Prepaid expenses and other current assets	9,979	10,337
Total current assets	<u>206,014</u>	<u>195,711</u>
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	51,583	51,649
Other	525	520
Total other assets	<u>91,503</u>	<u>107,137</u>
Total assets	<u>\$ 1,206,950</u>	<u>1,220,336</u>
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	—	11,700
Total current liabilities	<u>141,144</u>	<u>135,197</u>
Long-term debt, less current portion	480,187	490,443
Other long-term liabilities, less current portion	39,097	43,866
Total liabilities	<u>660,428</u>	<u>669,506</u>
Net assets:		
Unrestricted	535,632	538,607
Temporarily restricted	6,960	8,214
Permanently restricted	1,323	1,319
Total net assets attributable to Wellmont	<u>543,915</u>	<u>548,140</u>
Noncontrolling interests	2,607	2,690
Total net assets	<u>546,522</u>	<u>550,830</u>
Commitments and contingencies		
Total liabilities and net assets	<u>\$ 1,206,950</u>	<u>1,220,336</u>

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES
Consolidated Statements of Operations and Changes in Net Assets
Years ended June 30, 2015 and 2014
(Dollars in thousands)

	2015	2014
Revenue:		
Patient service revenue	\$ 838,277	788,910
Provision for bad debts	(47,307)	(45,644)
Net patient revenue less provision for bad debts	790,970	743,266
Other revenues	21,759	29,441
Total revenue	812,729	772,707
Expenses:		
Salaries and benefits	399,955	374,309
Medical supplies and drugs	168,678	166,676
Purchased services	75,749	73,674
Interest	17,757	18,350
Depreciation and amortization	58,569	50,058
Maintenance and utilities	39,764	36,978
Lease and rental	15,435	15,506
Other	30,128	32,312
Total expenses	806,035	767,863
Income from operations	6,694	4,844
Nonoperating gains (losses):		
Investment income	14,207	14,749
Derivative valuation adjustments	(563)	1,307
Loss on refinancing	(1,389)	(1,133)
Gain on revaluation of equity method investmen	—	14,744
Nonoperating gains, net	12,255	29,667
Revenue and gains in excess of expenses and losses before discontinued operations	18,949	34,511
Discontinued operations	(2,720)	(26,639)
Revenue and gains in excess of expenses and losses	16,229	7,872
Income attributable to noncontrolling interests	(866)	(1,540)
Revenues and gains in excess of expenses and losses attributable to Wellmont	15,363	6,332
Other changes in unrestricted net assets:		
Change in net unrealized (losses) gains on investment:	(18,555)	28,333
Net assets released from restrictions for additions to land, buildings, and equipment	2,712	901
Change in the funded status of benefit plans	(2,495)	(893)
(Decrease) increase in unrestricted net assets	(2,975)	34,673
Changes in temporarily restricted net assets:		
Contributions	2,545	2,707
Net assets released from temporary restrictions	(3,799)	(1,420)
(Decrease) increase in temporarily restricted net assets	(1,254)	1,287
Changes in permanently restricted net assets— investment income	4	8
Changes in noncontrolling interests:		
Income attributable to noncontrolling interests:	866	1,540
Distributions to noncontrolling interests	(949)	(1,623)
Change in noncontrolling interests	(83)	(83)
Change in net assets	(4,308)	35,885
Net assets, beginning of year	550,830	514,945
Net assets, end of year	\$ 546,522	550,830

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2015 and 2014

(Dollars in thousands)

	<u>2015</u>	<u>2014</u>
Cash flows from operating activities:		
Change in net assets	\$ (4,308)	35,885
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	58,569	50,526
Gain on disposal of land, buildings, and equipment	(569)	(78)
Equity in earnings of affiliated organizations	(405)	(1,764)
Distributions from affiliated organizations	231	3,484
Amortization of deferred financing costs	534	426
Net realized and unrealized loss (gain) on investments	18,182	(31,302)
Provision for bad debts	47,307	40,237
Change in fair value of derivative instruments	1,637	(1,307)
Loss on refinancing	1,389	1,133
Gain on revaluation of equity method investment	—	(14,744)
Loss on impairment	66	22,456
Changes in assets and liabilities, net of acquisitions:		
Patient accounts receivable	(42,341)	(44,839)
Other current assets	(939)	(1,711)
Other assets	3,442	3,297
Accounts payable and accrued expenses	6,240	5,474
Estimated third-party payor settlements	4,562	1,268
Other current liabilities	(10,550)	11,358
Other liabilities	(6,925)	2,998
Net cash provided by operating activities	<u>76,122</u>	<u>82,797</u>
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	100,324	123,193
Purchase of investments	(101,791)	(141,095)
Purchase of land, buildings, and equipment	(39,044)	(86,879)
Proceeds from the sale of buildings and equipment	2,424	2,434
Cash paid for acquisitions	—	(22,637)
Net cash used in investing activities	<u>(38,087)</u>	<u>(124,984)</u>
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	21,335	128,623
Payments on long-term debt	(40,746)	(111,092)
Payment of debt issuance costs	(432)	(628)
Net cash (used in) provided by financing activities	<u>(19,843)</u>	<u>16,903</u>
Net increase (decrease) increase in cash and cash equivalents	18,192	(25,284)
Cash and cash equivalents, beginning of year	<u>30,674</u>	<u>55,958</u>
Cash and cash equivalents, end of year	<u>\$ 48,866</u>	<u>30,674</u>
Supplemental disclosures of noncash items:		
Wellmont entered into capital lease obligations for buildings and equipment in the amount of \$8,284 and \$1,345 in 2015 and 2014, respectively.		
Additions to property and equipment financed through current liabilities of \$5,084 and \$3,770 in 2015 and 2014, respectively.		

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

June 30, 2015 and 2014

(Dollars in thousands)

(1) Operations and Basis of Presentation

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

The consolidated financial statements also include the operations of:

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

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

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

The following are included in discontinued operations:

- As of October 1, 2013, Wellmont closed Lee Regional Medical Center in Pennington Gap, Virginia. The losses of \$2,717 and \$26,091, for the years ended June 30, 2015 and 2014, respectively, including an impairment loss of \$22,456, for the year ended June 30, 2014, are included in discontinued operations
- As of May 17, 2013, a subsidiary of Wellmont ceased operating its sleep labs, which were managed by a third party. The gains (losses) of \$3 and (\$292) for the years ended June 30, 2015 and 2014, respectively, are included in discontinued operations.
- As of September 23, 2010, Wellmont sold the majority of its retail pharmacy's assets to a national pharmacy company. The gains (losses) of (\$6) and \$45 for the years ended June 30, 2015 and 2014, respectively, are included in discontinued operations.
- As of April 30, 2009, Wellmont closed Jenkins Community Hospital in Jenkins, Kentucky. The gains (losses) of \$0 and (\$301) for the years ended June 30, 2015 and 2014, respectively, are included in discontinued operations.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

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(Dollars in thousands)

(2) Significant Accounting Policies

A summary of significant accounting policies is as follows:

(a) *Use of Estimates*

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

(b) *Cash and Cash Equivalents*

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

(c) *Investments*

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

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

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Notes to Consolidated Financial Statements

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(Dollars in thousands)

(d) *Assets Limited as to Use*

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

(e) *Inventories*

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

(f) *Land, Buildings, and Equipment*

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

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

(g) *Goodwill*

Wellmont follows ASU No. 2010-07, *Not for Profit Entities: Mergers and Acquisitions*, which in part requires healthcare entities to follow Accounting Standards Codification (ASC) Topic 350-20-35, *Intangibles – Goodwill and Other* along with ASU 2011-08, *Testing Goodwill for Impairment*. ASC Topic 350-20-35 requires goodwill of not-for-profit entities to be evaluated for impairment at least annually. An entity has the option to first assess qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If, after assessing the totality of events or circumstances, an entity determines it is not more likely than not that the fair value of a reporting unit

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

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(Dollars in thousands)

is less than its carrying amount, then performing the two-step impairment test is unnecessary. The more-likely than-not threshold is defined as having a likelihood of more than 50%. However, if an entity concludes otherwise, then it is required to perform the first step of the two-step impairment test by calculating the fair value of the reporting unit and comparing the fair value with the carrying amount (including goodwill) of the reporting unit. If the carrying amount of a reporting unit exceeds its fair value, then the entity is required to perform the second step of the goodwill impairment test to measure the amount of the impairment loss. Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step two does not need to be performed. The annual impairment test is performed as of June 30.

(h) *Deferred Debt Expense*

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

(i) *Derivative Financial Instruments*

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

(j) *Asset Retirement Obligations*

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

(k) *Temporarily and Permanently Restricted Net Assets*

Temporarily restricted net assets are those whose use by Wellmont has been limited by donors to a specific-time period or purpose. Permanently restricted net assets have been restricted by donors to be

WELLMONT HEALTH SYSTEM AND AFFILIATES

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maintained by Wellmont in perpetuity. Generally, donors of permanently restricted assets permit use of all or part of the income earned on related investments for general or specific purposes.

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

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2015 and 2014 primarily included amounts related to the purchase of equipment for pediatrics, cancer, and other healthcare operations.

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

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

(l) *Net Patient Service Revenue and Accounts Receivable*

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the period related services are rendered and adjusted in future periods as final and other settlements are determined. On the basis of historical experience, a significant portion of Wellmont's uninsured patients will be unable or unwilling to pay for the services provided. Therefore, Wellmont records a significant provision for bad debts related to uninsured patients in the period the services are provided. This provision for bad

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debts is presented on the statements of operations as a component of net patient revenue. Wellmont provides care to patients who meet criteria under its charity care policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

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

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

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

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

(n) Contributed Resources

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

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

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(Dollars in thousands)

(o) Federal Income Taxes

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

(p) Recently Adopted Accounting Standards

In May 2015, the FASB issued ASU No. 2015-07, *Disclosures for Investments in Certain Entities that Calculate Net Asset Value per Share (or Its Equivalent)*. This ASU removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the net asset value per share practical expedient. The amendments also remove the requirement to make certain disclosures for all investments that are eligible to be measured at fair value using the net asset value per share practical expedient. Rather, those disclosures are limited to investments for which the entity has elected to measure the fair value using the practical expedient. Adoption of this standard should be applied on a retrospective basis. Wellmont early implemented the provisions of ASU 2015-07 during fiscal year 2015, retrospectively effective July 1, 2014.

(q) Reclassifications

Certain 2014 amounts have been reclassified to conform to the 2015 consolidated financial statement presentation. The reclassifications had no impact on total assets or changes in net assets.

(3) Business Combinations and Goodwill

On November 30, 2013, Wellmont purchased 100% of the membership interest in Wexford House from Residential Healthcare Affiliates. Wexford House is a skilled nursing facility, which serves residents of Sullivan County, Tennessee and the surrounding communities. The facility provides short- and long-term medical and rehabilitation care. In addition, on March 31, 2014, Wellmont purchased the remaining 25% interest in Holston Valley Imaging Center (HVIC), which included the remaining 50% governance interest from Blue Ridge Radiology Investment. The assets acquired and liabilities assumed under each acquisition were recorded at their estimated fair value in accordance with ASC 805.

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(Dollars in thousands)

The following table summarizes the consideration paid and the estimated fair value of the assets acquired and liabilities assumed at the business combination date:

	<u>Wexford</u>	<u>HVIC</u>
Consideration:		
Cash	\$ 14,770	7,867
Fair value of Wellmont's equity interest in HVIC held before acquisition	—	23,601
	<u>\$ 14,770</u>	<u>31,468</u>
Recognized amounts of identifiable assets acquired and liabilities assumed:		
Current assets	\$ 2,976	2,474
Other assets	5,277	241
Current liabilities	(564)	(863)
Long-term liabilities	(608)	—
Total identifiable net assets	7,081	1,852
Goodwill	7,689	29,616
	<u>\$ 14,770</u>	<u>31,468</u>

Wellmont recognized a gain of \$14,744 as a result of remeasuring to fair value its 75% equity interest in HVIC held before the business combination. The gain is included in nonoperating gains (losses) on the consolidated statement of operations for the year ended June 30, 2014.

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

	<u>2014</u>	<u>Additions</u>	<u>Decreases</u>	<u>2015</u>
Goodwill	\$ 51,649		(66)	51,583
	<u>2013</u>	<u>Additions</u>	<u>Decreases</u>	<u>2014</u>
Goodwill	\$ 15,096	37,305	(752)	51,649

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(4) Net Patient Service Revenue

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

	<u>2015</u>	<u>2014</u>
Gross patient service revenue	\$ 2,973,219	2,683,891
Less:		
Contractual adjustments and other discounts	(2,069,377)	(1,838,900)
Charity care	<u>(65,565)</u>	<u>(56,081)</u>
Net patient service revenue before provision for bad debts	838,277	788,910
Less provision for bad debts	<u>(47,307)</u>	<u>(45,644)</u>
Net patient service revenue	<u>\$ 790,970</u>	<u>743,266</u>

Wellmont's allowance for doubtful accounts is predominantly for self-pay patients and patient balances remaining after third-party payments. The provision for bad debts increased \$1,663 from fiscal 2014 to fiscal 2015 and the net write-offs increased \$30,169 from fiscal 2014 to fiscal 2015. The increase in write-offs was due to the implementation of a new billing system in the last quarter of fiscal 2014, which then caused a catch up on write-offs in fiscal 2015. Wellmont has not changed its charity care or uninsured discount policies during fiscal 2015. Wellmont does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

(5) Third-Party Reimbursement Arrangements

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

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

The Medicare program pays for the costs of inpatient services on a prospective basis. Payments are based upon diagnostic-related group assignments, which are determined by the patient's clinical diagnosis and medical procedures utilized. Wellmont receives additional payments from Medicare based on the provision

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of services to a disproportionate share of Medicaid-eligible and other low-income patients. Outpatient services are also reimbursed primarily on a prospectively determined basis.

Net patient service revenue in 2015 and 2014 related to Medicare and TennCare/Medicaid and net patient accounts receivable at June 30, 2015 and 2014 from Medicare and TennCare/Medicaid were as follows:

	<u>2015</u>	<u>2014</u>
Net patient service revenue:		
Medicare	\$ 337,813	304,713
TennCare/Medicaid	49,883	37,216
Net patient accounts receivable:		
Medicare	\$ 33,101	44,480
TennCare/Medicaid	6,474	6,817

Wellmont has filed cost reports with Medicare and Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Medicaid cost reports have been audited and final settled by the intermediary through June 30, 2011 and audit adjustments have been received and considered for certain hospitals and year-ends through June 30, 2013.

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

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased approximately \$2,735 and \$3,334 in 2015 and 2014, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of audits and final settlements, and years that are no longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2015 could differ materially from actual settlements based on the results of third-party audits.

(6) Meaningful Use Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record (EHR) technology. The Medicare incentive payments are paid out to qualifying hospitals and physician groups over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals, and physician groups must meet EHR “meaningful use” criteria that become

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more stringent over three stages as determined by Centers for Medicare & Medicaid Services (CMS). Medicaid programs and payment schedules vary from state to state.

For fiscal years ended June 30, 2015 and 2014, Wellmont recorded \$3,233 and \$7,211, respectively, in other operating revenue related to the EHR and meaningful use incentives. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria.

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

(7) Charity Care and Community Services

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

Wellmont maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone and estimated costs incurred for services and supplies furnished under its charity care policy. Costs incurred are estimated based on the ratio of total operating expenses to gross charges applied to charity care charges. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and the equivalent percentage of charity care patients to all patients serviced were \$69,565 and \$17,254, and 2.66%, respectively, for the year ended June 30, 2015 and \$56,081, \$14,567, and 2.39%, respectively, for the year ended June 30, 2014.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and state indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont's cost of providing care to those patients totaled \$37,818 and \$37,432 for the years ended June 30, 2015 and 2014, respectively.

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

(8) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in earnings of affiliates was approximately \$405 and \$1,764 for the years ended June 30, 2015 and 2014, respectively, and is included in other operating revenue in the consolidated financial statements. Wellmont received distributions of \$231 and \$3,484 during 2015 and 2014, respectively, which reduced Wellmont's overall investment in the affiliates.

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

	<u>2015</u>	<u>2014</u>
Total assets	\$ 116,359	136,824
Total liabilities	<u>28,284</u>	<u>38,396</u>
Total net assets	\$ <u>88,075</u>	<u>98,428</u>
Net revenues	\$ 150,253	201,639
Expenses	<u>141,825</u>	<u>191,023</u>
Revenues in excess of expenses	\$ <u>8,428</u>	<u>10,616</u>

Wellmont's investment in these affiliates and its ownership percentage as of June 30, 2015 and 2014 is as follows:

	<u>Amount</u>		<u>Percentages</u>	
	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>
Takoma Regional Hospital	\$ —	10,763	0%	60%
Advanced Home Care (AHO)	6,092	6,092	6	6
Others	<u>1,122</u>	<u>1,366</u>	4%-50%	25%-50%
	\$ <u>7,214</u>	<u>18,221</u>		

As of July 1, 2014, Wellmont sold the 60% ownership in Takoma Regional Hospital. Prior to this transaction and although Wellmont's ownership percentage in Takoma Regional Hospital was greater than 50%, Wellmont did not consolidate this entity because Wellmont only had a 50% representation on the board and did not have control over the entity. Wellmont provides billing, management, and professional services to some of the affiliates. Income recognized by Wellmont for the services was \$173 in 2014 and is included in other revenues. Included in other receivables are \$86 and \$242 as of June 30, 2015 and 2014, respectively, of amounts due to Wellmont from these entities.

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(9) Investments

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

	<u>2015</u>	<u>2014</u>
Assets limited as to use by Board for capital improvements:		
Stock mutual funds	\$ 155,165	148,453
Bond mutual funds	157,091	167,156
Cash and money market funds	9,530	5,904
Real estate funds	17,967	21,381
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):		
Liquid	14,911	14,215
Illiquid	28,012	26,852
	<u>382,676</u>	<u>383,961</u>
Assets limited as to use under self-insurance agreements:		
Cash and money market funds	16,992	16,051
Assets limited as to use under bond indenture agreements:		
Cash and money market funds	28,847	28,961
Less assets limited as to use that are required for current liabilities	<u>3,651</u>	<u>4,066</u>
Assets limited as to use, net of current portion	<u>\$ 424,864</u>	<u>424,907</u>
Long-term investments:		
Stock mutual funds	\$ 15,627	17,741
Bond mutual funds	9,535	11,420
Right of first refusal	1,512	1,512
Cash, money market funds, and certificates of deposit	242	230
Real estate funds	1,048	1,618
Total long-term investments	<u>\$ 27,964</u>	<u>32,521</u>

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately \$15,917 as of June 30, 2015 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which \$1,053 was paid subsequent to June 30, 2015.

Wellmont's investments are concentrated in stock and bond mutual funds. In the event of a downward trend in the stock and bond markets, Wellmont's overall market value of net assets could be adversely affected by a material amount. Investments in alternative investments are generally illiquid investments whose value is

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determined by the general partner such as hedge funds, private equity, commingled funds, and real estate funds. Distributions are only at the discretion of a voting majority of the general partners.

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, Wellmont recognized other-than-temporary impairment losses of \$845 and \$0 on investments as of June 30, 2015 and 2014, respectively. Other-than-temporary impairment losses are considered as realized losses and are reported within “investment income” in the consolidated statements of operations and changes in net assets.

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2015 and 2014 were as follows:

	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2015:						
Alternative investments	\$ 396	2,975	12	459	408	3,434
Mutual funds	3,282	128,081	8,508	72,699	11,790	200,780
	<u>\$ 3,678</u>	<u>131,056</u>	<u>8,520</u>	<u>73,158</u>	<u>12,198</u>	<u>204,214</u>
	Less than 12 months	12 months or more	Total			
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2014:						
Alternative investments	\$ —	—	647	878	647	878
Mutual funds	16	1,655	3,632	119,716	3,648	121,371
	<u>\$ 16</u>	<u>1,655</u>	<u>4,279</u>	<u>120,594</u>	<u>4,295</u>	<u>122,249</u>

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

	<u>2015</u>	<u>2014</u>
Interest and dividends, net of amounts capitalized	\$ 13,677	11,780
Realized gains on investments, net	530	2,969
Investment income, net	<u>\$ 14,207</u>	<u>14,749</u>
Change in net unrealized gains on investment	<u>\$ (18,555)</u>	<u>28,333</u>

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(10) Land, Buildings, and Equipment

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

	<u>2015</u>	<u>2014</u>
Land	\$ 49,536	49,825
Buildings and improvements	530,904	523,069
Equipment	517,990	490,805
Buildings and equipment under capital lease obligations	54,316	46,031
	<u>1,152,746</u>	<u>1,109,730</u>
Less accumulated depreciation	<u>(674,587)</u>	<u>(623,930)</u>
	478,159	485,800
Construction in progress	<u>6,410</u>	<u>6,781</u>
Land, buildings, and equipment	<u>\$ 484,569</u>	<u>492,581</u>

Depreciation expense for the years ended June 30, 2015 and 2014 was \$58,569 and \$50,058, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was \$26,168 and \$21,789 as of June 30, 2015 and 2014, respectively.

(11) Other Long-Term Liabilities

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

	<u>2015</u>	<u>2014</u>
Workers' compensation liability	\$ 12,195	11,096
Professional and general liability	15,465	15,940
Postretirement benefit obligation	2,487	2,633
Asset retirement obligation	3,353	3,139
Deferred gain on sale of assets	1,327	409
Derivative liability	(90)	6,118
Pension benefit liability	12,020	11,041
	<u>46,757</u>	<u>50,376</u>
Less current portion	<u>(7,660)</u>	<u>(6,510)</u>
Total other long-term liabilities	<u>\$ 39,097</u>	<u>43,866</u>

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(12) Debt

(a) Long-Term Debt

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

	<u>2015</u>	<u>2014</u>
Hospital Refunding Bonds, Series 2014A	\$ 12,137	14,242
Hospital Refunding Bonds, Series 2014B	49,615	52,275
Hospital Refunding Bonds, Series 2014C	18,836	20,836
Hospital Revenue Bonds, Series 2014D	13,575	13,575
Hospital Revenue Bonds, Series 2014E	21,335	—
Hospital Revenue Refunding Bonds, Series 2011	74,410	75,300
Hospital Revenue Bonds, Series 2007A	55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	180,420	200,000
Project Odyssey 2012 Tax-Exempt Master Lease/Sublease Financing	34,341	40,589
Notes payable	9,771	10,232
Capital lease obligations	23,864	19,749
Other	308	674
	<u>493,612</u>	<u>502,472</u>
Unamortized premium	5,201	5,986
	498,813	508,458
Less current maturities	<u>(18,626)</u>	<u>(18,015)</u>
	<u>\$ 480,187</u>	<u>490,443</u>

(b) Series 2014 Bonds

On June 25, 2014, Wellmont (a) refunded the Revenue Bonds, Series 2003, the Revenue Refunding Bonds, Series 2005, and the Revenue Bonds, Series 2010 (Bank Qualified), with the proceeds of the Hospital Revenue Refunding Bonds, Series 2014A, Series 2014B, and Series 2014C and (b) issued Series 2014D. The Series 2014A through Series 2014E Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2003, the Revenue Refunding Bonds, Series 2005, a portion of the Revenue Refunding Bonds, Series 2006C, and the Revenue Bonds, Series 2010 (Bank Qualified) and to issue new debt in the amount of \$13,575 to reimburse Wellmont for the purchase price of Wellmont Wexford House and to pay closing costs of issuing the Series 2014D Bonds. On September 1, 2014, the 2014E Bonds were issued by The Health, Educational, and Housing Facilities board of the County of Sullivan, Tennessee

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on behalf of Wellmont. All of the Series 2014 Bonds were issued as tax-exempt and were issued in accordance with the Amended and Restated Master Trust Indenture dated September 1, 2014.

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

Interest on the Series 2014 Bonds is 100% of LIBOR plus a quotient of applicable spread divided by 67%. Accrued interest is paid monthly in arrears. Interest rates on the 2014A, 2014B, 2014C, 2014D and 2014E Bonds were .89%, .99%, .97%, .97% and .97%, respectively, as of June 30, 2015.

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

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

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

(d) *Series 2011 Bonds*

On May 5, 2011, Wellmont refunded the Revenue Bonds, Series 2006A, with the proceeds of the Revenue Bonds, Series 2011. The Series 2011 Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2006A and to pay the costs of issuing the Series 2011 Bonds.

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In order to refund the Series 2006A Bonds, Wellmont made a tender offer to the holders of the Series 2006A Bonds. The holders of all outstanding Series 2006A Bonds agreed to tender their Series 2006A Bonds to Wellmont. Proceeds of the Series 2011 Bonds were used to pay the purchase price of Series 2006A Bonds tendered for purchase. All outstanding Series 2006A Bonds were purchased by the Wellmont on the date of issuance of the Bonds and were immediately surrendered to the trustee for the Series 2006A Bonds for retirement and cancellation.

The Series 2011 Bonds were issued with two maturities of \$42,385 and \$33,780 for 2026 and 2032, respectively. The Series 2011 Bonds maturing September 1, 2026 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2013 and ending on September 1, 2026 in annual amounts ranging from \$865 to \$4,680. The Series 2011 Bonds maturing September 1, 2032 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2027 and ending on September 1, 2032 in annual amounts ranging from \$4,980 to \$6,300. The Series 2011 Bonds were issued as fixed-rate obligations at 6.0% and 6.5% for the two maturities (2026 and 2032, respectively).

(e) Series 2007 Bonds

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

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

(f) Series 2006 C

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

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

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(g) Master Trust Indenture

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

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

(h) Notes Payable

In August 2011, Wellmont entered into a note agreement in the amount of \$1,760 with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate with a ceiling of 7.75% and a floor of 4.00% and a maturity date of August 2016. At June 30, 2015 and 2014, \$446 and \$828, respectively, were outstanding on this note.

On October 17, 2012, Wellmont entered into a 10-year \$12,500 term note payable with Bank of America, N.A. The proceeds were used for the EpicCare system and its implementation, among other general corporate purposes. The note payable has a fixed interest rate of 3.27% and a maturity date of December 13, 2022. At June 30, 2015 and 2014, \$9,254 and \$9,254, respectively, were outstanding on this note.

On January 4, 2013, Wellmont entered into a three-year \$193 term note payable with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate and a maturity date of December 2015. At June 30, 2015 and 2014, \$45 and \$107, respectively, were outstanding on this note.

On March 25, 2013, Wellmont entered into a three-year \$47 term note payable with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate and a maturity date of August 2016. At June 30, 2015 and 2014, \$26 and \$43, respectively, were outstanding on this note.

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(i) Capital Lease Obligations

Assets under capital leases are included in property and equipment and have a net carrying value of \$28,148 and \$24,242 as of June 30, 2015 and 2014, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 2.1% to 12.0%.

(j) Long-Term Debt Maturities Schedule

Bond maturities in accordance with the terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2015 are as follows:

2016	\$	18,626
2017		17,722
2018		20,059
2019		20,027
2020		20,505
Thereafter		396,673
	\$	<u>493,612</u>

Interest paid for the years ended June 30, 2015 and 2014 was \$19,881 and \$18,899, respectively, net of amounts capitalized. Interest costs of \$210 and \$1,444 were capitalized in 2015 and 2014, respectively.

(13) Derivative Transactions

Wellmont is and has been a party to a number of interest rate swap agreements. Such swaps have not been designated as hedges and are valued at estimated fair value in the accompanying consolidated balance sheets. By using derivative financial instruments to hedge exposures to changes in interest rates, Wellmont exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes Wellmont, which creates credit risk for Wellmont. When the fair value of a derivative contract is negative, Wellmont owes the counterparty, and therefore, Wellmont is not exposed to the counterparty's credit risk in those circumstances. Pursuant to the terms of its interest rate swap agreements, Wellmont is required to postcollateral with its counterparties under certain specified conditions. Collateral posting requirements are based on the amount of Wellmont's derivative liability and Wellmont's bond rating. As of June 30, 2015 and 2014, Wellmont was not required to postcollateral related to its swaps.

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

Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its variable rate debt structure using LIBOR rates. The fair value as of June 30, 2015 and 2014 of approximately \$90 and \$(6,118), respectively, is included in other long-term liabilities in the

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consolidated balance sheets. The change in the fair value of the derivative instruments was approximately \$1,637 and \$1,307, respectively, in 2015 and 2014 and is included in nonoperating gains in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. Effective May 28, 2015, Wellmont terminated and settled three of the interest rate swaps resulting in a loss of \$2,200 included in Nonoperating gains (losses) in the consolidated statements of operations and changes in net assets. The following is a summary of the interest rate swap information as of June 30, 2015:

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

The following is a schedule detailing the swap information as of June 30, 2014:

<u>Type of interest swap</u>	<u>Debt hedging</u>	<u>Notional amount</u>	<u>Effective date</u>	<u>Maturity date</u>	<u>Rate paid</u>	<u>Rate received</u>	<u>Swap fair value asset (liability)</u>
Total return swap	Series 2011	\$ 75,300	May 5, 2011	September 1, 2032	1.410%	6.222%	\$ 987
Pay fixed interest rate swap	*	52,275	December 13, 2005	September 1, 2016	3.548	0.101	(3,323)
Basis swap	*	56,465	September 1, 2002	September 1, 2032	0.060	0.173	(1,127)
Pay fixed interest rate swap	*	27,575	October 24, 2003	September 1, 2021	3.613	0.104	(2,655)
							\$ (6,118)

* Previously designated bond series has been refinanced.

(14) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined-contribution retirement plan (Retirement Plan) that covers substantially all employees. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 2% (after October 1, 2013) and 3% (before October 1, 2013) of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Code, up to 2.4% (after October 1, 2013) and 3% (before October 1, 2013) of each participant's wages. The total pension expense related to the Retirement Plan was \$8,841 and \$10,687 for the years ended June 30, 2015 and 2014, respectively.

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

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

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

	<u>2015</u>	<u>2014</u>
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 56,291	50,749
Service cost	—	—
Interest cost	2,176	2,196
Actuarial loss(gain)	(886)	5,815
Benefits paid	<u>(2,501)</u>	<u>(2,469)</u>
Benefit obligation at end of year	<u>55,080</u>	<u>56,291</u>
Change in plan assets:		
Fair value of plan assets at beginning of year	45,250	40,357
Actual return on plan assets	(1,591)	4,960
Employer contribution	1,902	2,402
Benefits paid	<u>(2,501)</u>	<u>(2,469)</u>
Fair value of plan assets at end of year	<u>43,060</u>	<u>45,250</u>
Funded status	<u>\$ (12,020)</u>	<u>(11,041)</u>
Amounts recognized in the accompanying consolidated balance sheets:		
Pension benefit liability (other long-term liabilities)	\$ (12,020)	(11,041)

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	<u>2015</u>	<u>2014</u>
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:		
Unrecognized actuarial loss	\$ 18,901	16,777
Unrecognized prior service cost	<u>—</u>	<u>—</u>
Net amounts included as an accumulated charge to unrestricted net assets	\$ <u>18,901</u>	<u>16,777</u>
Calculation of change in unrestricted net assets:		
Accumulated charge to unrestricted net assets, end of year	\$ 18,901	16,777
Reversal of accumulated charge to unrestricted net assets, prior year	<u>(16,777)</u>	<u>(14,552)</u>
Change in unrestricted net assets	\$ <u>2,124</u>	<u>2,225</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Actuarial loss (gain) arising during the year	\$ 3,869	3,665
Amortization of actuarial loss	(1,745)	(1,440)
Amortization of prior service cost	<u>—</u>	<u>—</u>
Net amounts recognized in unrestricted net assets	\$ <u>2,124</u>	<u>2,225</u>

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	<u>2015</u>	<u>2014</u>
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2014:		
Amortization of net loss	\$ 2,200	1,810
Amortization of prior service cost	—	—
Estimated future benefit payments:		
Fiscal 2015	—	2,804
Fiscal 2016	2,882	2,894
Fiscal 2017	2,987	3,004
Fiscal 2018	3,079	3,093
Fiscal 2019	3,162	3,178
Fiscal 2020–2023	20,295	16,759
Weighted average assumptions used to determine benefit obligations:		
Settlement (discount) rate	4.25%	4.00%
Weighted average rate of increase in future compensation levels	N/A	N/A
Components of net periodic benefit cost (benefit):		
Service cost	\$ —	—
Interest cost	2,176	2,196
Expected return on plan assets	(3,164)	(2,810)
Amortization of net loss	1,745	1,440
Net periodic benefit cost	<u>\$ 757</u>	<u>826</u>
Weighted average assumptions used to determine net periodic benefit cost:		
Settlement (discount) rate	4.00%	4.50%
Expected long-term return on plan assets (HVMC)	7.00	7.00
Expected long-term return on plan assets (LPH)	7.00	7.00
Weighted average rate of increase in future compensation levels	N/A	N/A

Wellmont’s overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

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

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The table below shows the target allocation and actual asset allocations as of June 30, 2015 and 2014:

Asset	Target allocation	2015	2014
Equity securities	47%	47%	48%
Fixed income	41	33	33
Cash	—	3	3
Other	12	17	16

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

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

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

	Postretirement benefits	
	2015	2014
Change in benefit obligation:		
Benefit obligation at beginning of year	\$ 2,633	4,582
Interest cost	86	96
Plan participants contributions	16	17
Actuarial losses	(172)	(1,978)
Benefits paid	(76)	(84)
Benefit obligation at end of year	2,487	2,633
Change in plan assets:		
Fair value of plan assets at beginning of year	—	—
Employer contribution	60	66
Plan participants contributions	16	17
Benefits paid	(76)	(83)
Fair value of plan assets at end of year	—	—
Funded status	\$ (2,487)	(2,633)

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	Postretirement benefits	
	2015	2014
Amounts recognized in the consolidated balance sheets consist of:		
Noncurrent assets	\$ —	—
Current liabilities	(179)	—
Noncurrent liabilities	(2,308)	(2,633)
Accumulated charge to unrestricted net assets	5,568	5,939
	<u>\$ 3,081</u>	<u>3,306</u>

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

	2015	2014
Net actuarial gain	\$ 5,568	5,939

Net periodic benefit cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2015 and 2014 were as follows:

	Postretirement benefits	
	2015	2014
Net periodic benefit cost:		
Interest cost	\$ 86	95
Amortization of net gain	(544)	(646)
Net periodic benefit recognized	<u>(458)</u>	<u>(551)</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	(173)	(1,978)
Amortization of net gain	544	646
Total recognized in unrestricted net assets	<u>371</u>	<u>(1,332)</u>
Total recognized in net periodic benefit cost and unrestricted net assets	<u>\$ (87)</u>	<u>(1,883)</u>

The net gain and prior service credit for the defined-benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are \$(544) and \$(646),

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(Dollars in thousands)

respectively. Weighted average assumptions used to determine benefit obligations for 2015 and 2014 were as follows:

	<u>2015</u>	<u>2014</u>
Discount rate	3.75%	3.50%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2015 and 2014 were as follows:

	<u>Postretirement benefits</u>	
	<u>2015</u>	<u>2014</u>
Discount rate	3.50%	4.00%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00	5.00

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

For measurement purposes, a 7.25% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2015.

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

	<u>2015</u>	<u>2014</u>
Effect of one-percentage-point increase in healthcare cost trend on:		
Service and interest cost	\$ 5	4
Accumulated pension benefit obligation	143	132
Effect of one-percentage-point decrease in healthcare cost trend on:		
Service and interest cost	\$ (5)	(3)
Accumulated pension benefit obligation	(124)	(116)

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The asset allocations of Wellmont’s pension and postretirement benefits as of June 30, 2015 and 2014, respectively, were as follows:

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

Fair value measurement at June 30, 2014				
pension benefits – plan assets				
		Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
	Total			
Assets:				
Stock mutual funds	\$ 36,546	36,546	—	—
Cash and money market funds	1,279	1,279	—	—
Fixed income fund	3,935	—	3,935	—
	<u>41,760</u>	<u>37,825</u>	<u>3,935</u>	<u>—</u>
Alternative funds - recorded at net asset value	<u>3,490</u>			
Total	<u>\$ 45,250</u>			

WELLMONT HEALTH SYSTEM AND AFFILIATES

Notes to Consolidated Financial Statements

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(Dollars in thousands)

(15) Self-Insurance Programs

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

The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers' compensation program is supplemented for Tennessee and Virginia by excess workers' compensation policies, with a commercial carrier for statutory limits per occurrence. Provisions based on actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Workers' compensation expense under these programs amounted to approximately \$4,612 and \$3,695 for the years ended June 30, 2015 and 2014, respectively, and are included in salaries and benefits expense in the accompanying consolidated statements of operations and changes in net assets. All other self-insurance expense under these programs amounted to approximately \$1,568 and \$5,707 for the years ended June 30, 2015 and 2014, respectively, and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2015 and 2014, Wellmont was involved in litigation relating to medical malpractice, workers' compensation and other claims arising in the ordinary course of business. There are also known incidents that occurred through June 30, 2015 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2015 are adequate to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

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

(16) Commitments and Contingencies

Construction in progress at June 30, 2015 and 2014 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately \$5,191 at June 30, 2015. Wellmont has entered into contracts of \$5,191 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was \$15,453 and \$15,506 for the years ended June 30, 2015

WELLMONT HEALTH SYSTEM AND AFFILIATES

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June 30, 2015 and 2014

(Dollars in thousands)

and 2014, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2015 are as follows:

2016	\$	10,018
2017		8,046
2018		6,692
2019		5,908
2020		5,062
Thereafter		<u>13,822</u>
	\$	<u><u>49,548</u></u>

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

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

(17) Functional Expense Disclosure

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

	<u>2015</u>	<u>2014</u>
Professional care of patients	\$ 652,458	643,618
Administrative and general	152,549	123,191
Fund-raising	1,028	1,054
	<u>\$ 806,035</u>	<u>767,863</u>

WELLMONT HEALTH SYSTEM AND AFFILIATES

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(18) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate-company state income tax returns. These companies have combined net operating loss carryforwards for federal income tax purposes of approximately \$111,000 at June 30, 2015, which begin expiring in fiscal 2019 and expire through 2033. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont files a Form 990-T with the Internal Revenue Service to report such activity. Wellmont has net operating loss carryforwards for federal income tax purposes of approximately \$1,860 for unrelated business activities. Management believes that it is more likely than not that deferred tax assets arising from net operating loss carryforwards will not be realizable. Accordingly, these are fully reserved at June 30, 2015 and 2014.

(19) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2015 and 2014 was as follows:

	<u>2015</u>	<u>2014</u>
Medicare	43%	48%
TennCare/Medicaid	12	13
Other third-party payors	32	31
Patients	13	8
	<u>100%</u>	<u>100%</u>

(20) Disclosures about Fair Value of Financial Instruments

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

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practical expedient are not categorized within the fair value hierarchy, however, the amount measured is included to permit reconciliation of the fair value of investments included in the fair value hierarchy to the line items presented in the consolidated statement of operations and changes in net assets.

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

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

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

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

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

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

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 48,866	—	—	48,866
Assets limited as to use:				
Stock mutual funds	155,165	—	—	155,165
Bond mutual funds	157,091	—	—	157,091
Cash and money market funds	55,369	—	—	55,369
Real estate funds	17,967	—	—	17,967
	<u>434,458</u>	<u>—</u>	<u>—</u>	<u>434,458</u>
Alternative investments - recorded at net asset value				42,923
Subtotal				<u>477,381</u>
Long-term investments:				
Stock mutual funds	15,627	—	—	15,627
Bond mutual funds	9,535	—	—	9,535
Cash and money market funds	242	—	—	242
Real estate funds	1,049	—	—	1,049
Subtotal	<u>26,453</u>	<u>—</u>	<u>—</u>	<u>26,453</u>
	<u>\$ 460,911</u>	<u>—</u>	<u>—</u>	<u>503,834</u>
Liabilities:				
Derivatives asset	\$ —	90	—	90
Total	<u>\$ —</u>	<u>90</u>	<u>—</u>	<u>90</u>

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The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2014:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets:				
Cash and cash equivalents	\$ 30,674	—	—	30,674
Assets limited as to use:				
Stock mutual funds	148,453	—	—	148,453
Bond mutual funds	167,156	—	—	167,156
Cash and money market funds	50,916	—	—	50,916
Real estate funds	21,381	—	—	21,381
	<u>418,580</u>	<u>—</u>	<u>—</u>	<u>418,580</u>
Alternative investments - recorded at net asset value				<u>41,067</u>
Subtotal				<u>459,647</u>
Long-term investments:				
Stock mutual funds	17,741	—	—	17,741
Bond mutual funds	11,420	—	—	11,420
Cash and money market funds	230	—	—	230
Real estate funds	1,618	—	—	1,618
Subtotal	<u>31,009</u>	<u>—</u>	<u>—</u>	<u>31,009</u>
	<u>\$ 449,589</u>	<u>—</u>	<u>—</u>	<u>490,656</u>
Liabilities:				
Derivatives liability	\$ —	6,118	—	6,118
Total	<u>\$ —</u>	<u>6,118</u>	<u>—</u>	<u>6,118</u>

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

- *Cash and Cash Equivalents*
The carrying amount approximates fair value due to the short maturities of these instruments.
- *Patient Accounts and Other Receivables*
The net recorded carrying value approximates fair value due to the short maturities of these instruments.
- *Investments and Assets Limited as to Use*
The fair values of investments and assets limited as to use are based on quoted market prices and quotes obtained from security brokers or, in the case of the limited partnerships, by the general partner.

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

- *Accounts Payable and Accrued Expenses*

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

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

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

- *Long-Term Debt*

The carrying amount of indebtedness with variable interest rates approximates its fair value because the variable rates reflect current market rates for indebtedness with similar maturities and credit quality. The fair value of indebtedness with fixed interest rates is based on rates assumed to be currently available for indebtedness with similar terms and average maturities. Fair value measurements of indebtedness are based on observable interest rates and maturity schedules that fall within Level 2 of the hierarchy of fair value inputs. The estimated fair value of revenue bonds, using current market rates, was estimated at \$455,650 and \$444,106 for the years ended June 30, 2015 and 2014, respectively. The carrying amount of other long-term debt reported in note 12 and on the consolidated balance sheet approximates the related fair value.

(21) Subsequent Events

On July 1, 2014, Wellmont sold its 60% interest in Takoma Regional Hospital to Adventist Health System (which also owned the other 40%). Cash in the amount of \$11,700 was received prior to July 1, 2014 and is included in current liabilities as of June 30, 2014. Subsequently, during 2015, Adventist Health System and Wellmont have agreed in principle that Wellmont will repurchase Takoma in fiscal year 2016. Wellmont has evaluated subsequent events from the balance sheet date through October 27, 2015 the date at which the consolidated financial statements were issued. No other material subsequent events were identified for recognition or disclosure.

Exhibit 11.5

Attachment D

The Wellmont External Auditor Management Letters are considered confidential information and will be subsequently filed.

Exhibit 11.5

Attachment E

Wellmont - Rating Agencies Reports

August 24, 2009

Wellmont Health System, Tennessee; System

Primary Credit Analyst:

Karl Propst, Dallas (1) 214-871-1427; karl_propst@standardandpoors.com

Secondary Credit Analyst:

Liz Sweeney, New York (1) 212-438-2102; liz_sweeney@standardandpoors.com

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Wellmont Hlth Sys, Tennessee

Sullivan Cnty Hlth Ed & Hsg Fac Brd (Wellmont Health System)

<i>Long Term Rating</i>	BBB+/Stable	Outlook Revised
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Sullivan Cnty Hlth Ed & Hsg Fac Brd (Wellmont Health System)

<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Outlook Revised
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Virginia Small Business Fin Auth, Virginia

Wellmont Hlth Sys, Tennessee

Virginia Small Business Fin Auth (Wellmont Health System)

<i>Long Term Rating</i>	BBB+/Stable	Outlook Revised
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Many issues are enhanced by bond insurance.

Rationale

Standard & Poor's Ratings Services revised its rating outlook to stable from negative on bonds issued for Wellmont Health System, Tenn. by various issuers. At the same time, Standard & Poor's rating services affirmed its 'BBB+' long-term rating and 'BBB+' underlying ratings (SPUR) on the bonds.

The outlook revision reflects better-than-expected operating performance through the fiscal year ended June 30 (unaudited); the initial implementation of various expense and revenue cycle improvements expected to support improved performance on an ongoing basis; and the culmination of Wellmont's look-back into the previous management's historical accounting practices, which ultimately led to the restatement of fiscal 2007 audited results and a long delay in the release of the system's fiscal 2008 audit.

Wellmont's former CEO and its chief financial officer (CFO) left the organization in July 2008 and December 2008, respectively. After serving in an interim capacity since July 2008, Wellmont named Mike Snow permanent CEO in March 2009. Wellmont is currently operating with an experienced interim CFO while conducting the search for a permanent CFO.

The affirmed 'BBB+' rating reflects Wellmont's:

- Improving financial metrics, including positive (unaudited) fiscal 2009 operating income of \$6.5 million (a 0.9% margin), which compared with operating losses in the previous two years;
- Acceptable 2.1x maximum annual debt services (MADS) coverage (or 1.8x on an operating lease adjusted basis), which remained consistent with prior years, despite the significant decline of investment income and other nonoperating revenues in fiscal 2009;
- A stabilized, although still constrained, balance sheet due to Wellmont's acquisition activity over the past five years. Current balance sheet metrics are characterized by 131 days' cash on hand, a moderately high 58% long-term debt to total capitalization, and unrestricted cash to long-term debt of 54%; and
- The system's solid business position characterized by good market share in a demographically favorable region that is largely dominated by two health care systems that have recently become more collaborative.

Further supporting the rating are revenue cycle, staffing, expense, and other identified operating improvements that generated \$7 million of incremental operating income for fiscal 2009 and are budgeted to produce about \$15 million in improvements for fiscal 2010.

Offsetting factors include current uncertainty related to Wellmont's direct-pay letter of credit (LOC) agreement with Bank of America N.A. (BofA). Wellmont is currently out of compliance with its debt-to-capitalization covenant related to the BofA reimbursement agreement. Wellmont had been operating under a forbearance agreement with BofA and management is in discussions with the bank over debt covenants and the extension of a \$64 million direct-pay LOC related to Wellmont's series 2005 bonds. The LOC expires in December 2010. Management expects to reach a successful extension with BofA, but should an agreement not be reached, the level of puttable debt relative to unrestricted cash is manageable at 26%. Other potentially negative credit factors include the ultimate outcome of health care reform, which may result in a significant reduction in reimbursement to system hospitals, a decrease in current-year inpatient and surgical volumes relative to fiscal 2008 at Wellmont's two newest hospitals, Lee Regional and Mountain View Regional, which represent approximately 7% of Wellmont's net revenue, and additional competitive pressure facing Wellmont's Bristol Regional Medical Center, from a competitor's replacement hospital that is under construction in Abingdon, Va.

In connection with its year-end 2008 audit, Wellmont changed its outside auditing firm to KPMG. KPMG and the audit committee of Wellmont's board identified a number of accounting entries that it believed warranted further review and possible reclassification. That process resulted in a protracted delay in the release of 2008 audited results and the restatement of audited results for fiscal 2007.

Restated results

Although Wellmont's fiscal 2006 results were not restated, accounting errors related to 2006 were recorded as a negative \$15.1 million adjustment to beginning fiscal 2007 net assets. Had 2006 results been restated, reported operating income would have been revised to \$2.8 million. Fiscal 2007 restated results reflected a decrease in operating income to a negative \$6.5 million, as per Standard & Poor's calculation, which treated the \$8.5 million gain on sale of Wellmont's home-care affiliate as a nonoperating item. Management originally reported fiscal 2007 operating income as \$9.2 million, excluding the \$8.5 million gain. The accounting restatements related to numerous accounting entries including the reconciliation of cash, accounts receivable, third-party payor settlement liabilities, prepaid expenses, goodwill amortization, the capitalization and depreciation of buildings and equipment, accounts payable and accruals, as well as other assets and liabilities. There was no fraud or personal gain associated with any of the restatements.

A gross revenue pledge of the obligated group, and a mortgage on Wellmont's two largest hospitals, and the Lee Regional and Mountain View hospitals secure the bonds. The obligated group includes the parent, Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary, and the system's fundraising arm. Six of the system hospitals are included by virtue of operating as unincorporated divisions of the parent: Holston Valley Medical Center, Bristol Regional Medical Center, Lonesome Pine Hospital, and the three hospitals recently acquired. All of the systems entities are included in the analysis and all numbers cited in this report.

As of June 30, 2009, Wellmont had \$454.3 million of bonded debt. Based upon the increased counterparty risk associated with Lehman bankruptcy, Standard & Poor's revised its Debt Derivative Profile (DDP) on Wellmont to an overall score of '3' on a scale of '1' to '4' with '1' representing the lowest risk and '4' the highest. The overall score of '3' reflects Standard & Poor's view that the risks associated with Wellmont's derivatives portfolio are

moderate at this time.

As of June 30, Wellmont's swap liability was \$10.2 million; however, there was no required posted collateral. There have been no changes to Wellmont's swap portfolio since our last published report in January 2009.

Outlook

The return to a stable outlook reflects our increased comfort that Wellmont has identified and corrected the accounting issues that led to the restated 2007 results and the 2008 audit delay. Additionally, while current economic conditions, and the uncertainty whether limits on future Medicare, TennCare, and Virginia Medicaid reimbursement may constrain operations, we believe that management initiatives to reduce costs and improve Wellmont's revenue cycle will support a generally improving operating trend. In addition, as market conditions improve, Wellmont's liquidity metrics and cash flow coverage will improve. While we remain concerned about the system's balance sheet, particularly leverage, Wellmont's future capital spending plans are modest, as \$45 million remains in the 2006C Project Fund, and management has no current plans to issue additional long-term debt. Should the balance sheet or operations unexpectedly weaken, a downgrade or the return to a negative outlook would be likely. By contrast, significant improvement to the balance sheet over time would be cause for a positive outlook revision and possibly an upgrade.

System And Market Profile

Wellmont Health System, created in 1996 with the merger of Bristol Regional Medical Center and Holston Valley Medical Center, began a series of acquisitions that significantly expanded its geographic footprint. In 1997, the system added Lonesome Pine Hospital, a 60-bed facility in Big Stone Gap, Va. In 2000, the 50-bed Hawkins County Memorial Hospital, located in Rogersville, Tenn., joined the system. In 2005, Wellmont opened Hancock county Hospital a 10-bed, critical-access hospital. In 2007, Wellmont acquired Lee Regional Medical Center, an 80-bed facility, and Mountain View Regional Medical Center, a 133-bed facility. Both hospitals are located in relatively rural areas of southwest Virginia.

Also in 2007, Wellmont acquired a 60% interest in Takoma Regional Hospital from Adventist Health System Sunbelt ('A+'). The 108-bed hospital is located in Greene County, Tenn., southwest of Wellmont's core markets. Although Wellmont acquired a 60% equity stake, Adventist Health System Sunbelt is the manager of the facility so it is not consolidated but is accounted for as an equity investment.

On April 30, 2009, Wellmont closed Jenkins Community Hospital and sold the hospital's property plant and equipment for a \$1 million. Jenkins was a 25-bed critical-access hospital in Jenkins, Ky., about an hour and a half north of Kingsport. Jenkins, acquired in 2007, failed to meet management's financial targets -- having lost \$1.1 million from operations in fiscal 2008. The sale of Jenkins resulted in a fiscal 2008 impairment charge of \$6.3 million.

Other key components of the system include a cancer center in Norton Va., an assisted-living and adult day care center; a hospice; a wellness and fitness center; a fundraising foundation; and a number of relatively small for-profit subsidiaries, including a physician-hospital organization, a billing-and-collection service, two retail pharmacies, and a regional laundry.

The system currently consists of eight hospitals with about 1,286 licensed beds serving Tennessee and Virginia markets. Wellmont's primary service area (PSA) encompasses three Tennessee counties and six Virginia counties. The system's two largest hospitals, Bristol Regional Medical Center and Holston Valley Medical Center, are both in Tennessee but are very close to the Virginia border. Portions of Bristol's facility are across the border in Virginia. The Virginia side of the service area is more rural and has a lower population density than the Tennessee side but also less competition. Even though Wellmont has no hospitals located in some of its PSA counties that are in Virginia, the system draws sizable market share from those counties. For example, market share in Scott County, Va. is 68%. In its core county of Sullivan, Tenn., there are three hospitals: Bristol, Holston Valley, and Mountain State's Indian Path Medical Center. Wellmont draws a solid 59% market share in Sullivan County, while Mountain States Health Alliance (MSHA) garners a 36% market share. Overall, market share for the nine PSA counties is solid at 56% and continues to grow. County-by-county market share ranges from 28% to 85%.

Bristol Regional Medical Center was a brand-new hospital in 1994 and is an attractive facility with a sizable campus and a broad range of services. Holston Valley Medical Center is the core tertiary provider in the primary service area, with a very active cardiac program, a level-one trauma center, a neonatal program, and other programs typical of a tertiary center. Both hospitals should benefit from the "Project Platinum" expansion and renovation plans funded with series 2006C bond proceeds.

Although MSHA and Wellmont have historically been fiercely competitive, both have benefitted from regional population growth. With the change in leadership at Wellmont over the past year, there appears to be a desire for a more collaborative working relationship between the two systems.

Finances: Improved Financial Metrics

For the fiscal year ended June 30, 2009 (unaudited), Wellmont generated operating income of \$6.5 million (a 0.87% margin) on \$739 million of total net revenues. Operating results reflect an \$11.1 million positive swing from fiscal 2008, although 2008 was negatively affected by a \$6.3 million impairment charge related to the April 30, 2009 sale of Jenkins Community Hospital. Net operating income improved from Wellmont's implementation of revenue and expense cycle initiatives, which generated \$7.5 million of incremental income for fiscal 2009, and are expected to produce \$15 million of operational improvements in 2010. Wellmont's 2010 budgeted operating income is \$19.8 million.

Acute discharges were up slightly to 42,558 relative to fiscal 2008 inpatient volumes of 42,401. Combined inpatient and outpatient surgery volumes grew by 3.9% to 25,128. Emergency department visits declined 2% to 222,560 from 227,181 in 2008.

Wellmont's excess revenues, as per Standard & Poor's calculations, were \$10.3 million, which included \$8.4 million of realized investment income offset by discontinued operations and other nonoperating expenses. While positive, investment income was well short of budget and substantially below 2008 when Wellmont's investments generated realized income of \$31.6 million. Unrealized investment losses in fiscal 2009 were \$65 million. Wellmont also had a \$5.7 million unrealized loss on its swaps at year-end. Both unrealized investment and swap losses are treated as below the line for purposes of Standard & Poor's analysis.

Cash flow remains acceptable as evidenced by a 9% EBIDA margin, generating 2.2x coverage of Wellmont's \$30.6 million maximum debt service. Historically operating leases have been relatively modest in amount. However, as

Wellmont monetizes its medical office buildings, operating leases have become more material to its overall financial profile. Adjusted for the growing operating lease expense, MADS coverage is diluted by 0.42x to 1.8x .

Wellmont's balance sheet remains acceptable, although due to the decline in capitalization over the past couple of years, leverage metrics are now at a level where the system has very limited flexibility to issue more debt without a rating implication. However, there are currently no plans to issue new debt, and Wellmont has \$37 million of unspent series 2006C bond proceeds. which is adequate to complete its "Project Platinum," which includes a new surgical suite, intensive care unit, and emergency department projects that are currently underway at Holston Valley Medical Center.

Unrestricted cash and investments totaled \$248.8 million at year-end, equal to 131 days' cash on hand, and 54% of long-term debt. Cash was flat relative to last year. Wellmont's long-term debt to capitalization increased to 58%, from 54% in 2008, although the increase was strictly a function of a smaller denominator. Other than information-technology-related capital spending, Wellmont has limited capital spending plans that should support the continued growth of unrestricted cash and investments. The system's 2010 budget reflects an 18-day increase in day's cash on hand to 149 days, and 62% cash to debt.

About 85% of the system's cash and investment assets are liquid with maturities of less than one year. Less than 10% (\$23.2 million) are invested in real assets and private equity. Wellmont has a moderate level of future private equity capital funding commitments equal to \$15 million.

Debt Derivative Profile: '3.0'

Wellmont's overall DDP score has been revised to '3.0' on a scale of '1' to '4', whereby '1' represents the lowest risk and '4' is the highest. The overall score of '3.0' reflects Standard & Poor's view that Wellmont's swap exposure represents a moderate credit risk at this time.

The overall score of '3.0' includes the following factors:

- Above-average collateral posting risk due to the requirement that Wellmont post collateral when its rating falls to 'BBB-' or lower, a somewhat narrow spread for a 'BBB+' credit (there are no termination-rating triggers);
- High counterparty risk, based on the credit quality of the counterparty, Lehman Brothers Special Financing, guaranteed by Lehman Brothers Holdings (not rated), which filed for bankruptcy in September 2008;
- Low economic viability risk based on projected performance under stressful economic scenarios; and
- Strong management practices, including a written swap policy, thorough audit disclosure, frequent communication of swap performance to the board, and the use of independent financial advisors to assist in evaluating swap strategies and performance.

Wellmont has four swaps in place, all of which are with Lehman Brothers Special Financing. The swaps include a \$66.3 million notional basis swap that matures in 2032, under which Wellmont pays the Securities Industry and Financial Markets Municipal Assn. (SIFMA) swap index rate and receives 73.8% of LIBOR. In 2006, Wellmont executed a total return swap related to its series 2006A bonds, which it placed were privately. Under the total return structure, Wellmont synthetically converted its cost on the bonds to the SIFMA index rate plus 85 basis points from the index rate. The remaining two swaps synthetically fix \$99.3 million of variable-rate debt. They are traditional floating- to fixed-rate swaps using one-month LIBOR as the receive index. Variable-rate debt is 30.9% of the total,

but inclusive of the effects of the swaps, Wellmont's current net variable-rate exposure is 9.1%.

Related Research

- USPF Criteria: "Not-For-Profit Health Care," June 14, 2007
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009
- USPF Criteria: "Debt Derivative Profile Scores," March 27, 2006

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Sullivan County Health, Educational, and Housing Facilities Board, Tennessee Wellmont Health System; System

Credit Profile

Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee

Wellmont Hlth Sys, Tennessee

Sullivan Cnty Hlth Ed & Hsg Fac Brd (Wellmont Health System)

Long Term Rating

BBB+/Stable

Affirmed

Rationale

Standard & Poor's Ratings Services affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on bonds issued for Wellmont Health System, Tenn. by various issuers. The outlook is stable.

The rating affirmations and stable outlook reflect improved operating and financial metrics following management's implementation last year of various expense and revenue cycle improvements, which it expects to support Wellmont's improved performance on an ongoing basis.

More specifically the ratings reflect Wellmont's:

- Stronger financial metrics, including positive fiscal 2009 operating income of \$6.5 million (a 0.88% margin) and six-month year-to-date operating income of \$15.2 million as of Dec. 31;
- Acceptable 2.1x fiscal year-end maximum annual debt service (MADS) coverage (or 1.7x on an operating lease-adjusted basis), which remained consistent with prior years, despite the significant decline of investment income and other nonoperating revenues in fiscal 2009;
- Stabilized, although still constrained, balance sheet due to its acquisition activity over the past five years. Current (Dec. 31) balance sheet metrics are characterized by 146 days' cash on hand, a moderately high 56% long-term debt to total capitalization, and unrestricted cash to long-term debt of 55%; and
- Solid business position characterized by good market share in a demographically favorable region that is largely dominated by two health care systems.

Further supporting the ratings are revenue cycle, staffing, expense, and other operating improvements that generated \$7.5 million of incremental operating income for fiscal 2009 and are expected to produce about \$15 million in improvements for fiscal 2010. Additionally, accounting issues leading to the delayed release of the system's fiscal 2008 audit and the restatement of fiscal 2007 results have been resolved.

Wellmont recently hired a permanent CFO, Beth Ward, who was formerly CFO of Moses Cone Health System in Greensboro N.C. Also, Mike Snow, Wellmont's CEO, announced his resignation effective March 1, 2010. Bob Burgin, who serves on Wellmont's board and who had previously retired as Mission Health's (Asheville, N.C.) president and CEO in 2004, will take over as interim CEO for Wellmont while a search is conducted for his permanent replacement. During his tenure as interim CEO, Mr. Burgin has taken a leave of absence from Wellmont's board.

As of June 30, 2009, Wellmont had \$452.2 million of bonded debt. A gross revenue pledge of the obligated group and a mortgage on Wellmont's two largest hospitals, Lee Regional Hospital, and Mountain View Hospital secure the bonds. The obligated group includes the parent, Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary, and the system's fundraising arm. Six of the system hospitals are included by virtue of operating as unincorporated divisions of the parent: Holston Valley Medical Center, Bristol Regional Medical Center, Lonesome Pine Hospital, and three recently acquired hospitals. All of the system's entities are included for the purpose of our calculations in this report.

Wellmont's direct-pay letter of credit agreement with Bank of America N.A. (BoFA) expires in December 2010. Management expects to reach a successful extension with BoFA, but should an agreement not be reached, the level of puttable debt relative to unrestricted cash is manageable at about 26%. The system is currently in compliance with its bank and bond covenants.

Wellmont's overall Debt Derivative Profile (DDP) score is '3' on a scale of '1' to '4', with '1' representing the lowest risk. The overall score of '3' reflects Standard & Poor's view that the risks associated with Wellmont's derivatives portfolio are moderate at this time due to risks associated with the Lehman bankruptcy. As of Dec. 31, Wellmont's swap liability was \$7.7 million. There is no required collateral posting at this time. Additionally there have been no changes to Wellmont's swap portfolio since our last published report on Aug, 24, 2009.

Outlook

The stable outlook reflects our increased comfort that Wellmont has corrected the accounting issues that led to the restated fiscal 2007 results and the fiscal 2008 audit delay. Additionally, while reimbursement, competitive issues, or other factors may constrain Wellmont's operations in the future, we believe that management's initiatives to reduce costs and improve the revenue cycle will support a generally improving operating trend over the outlook period. In addition, we believe that as market conditions continue to improve, Wellmont's liquidity metrics and cash flow coverage will likewise improve. While we remain focused on certain credit weaknesses, including leverage, we understand that Wellmont's future capital spending plans are modest and management has no current plans to issue additional long-term debt. Should the balance sheet or operations unexpectedly weaken, a downgrade or the return to a negative outlook would be likely. By contrast, significant improvement to the balance sheet over time would be cause for a positive outlook revision and possibly an upgrade.

Finances

For the fiscal year ended June 30, 2009, Wellmont generated operating income of \$6.5 million (a 0.88% margin) on \$737 million of total net revenues. Operating results reflect an \$11.1 million positive swing from fiscal 2008, although 2008 was negatively affected by a \$6.3 million impairment charge related to the April 30, 2009, sale of Jenkins Community Hospital. Net operating income improved from Wellmont's implementation of revenue and expense cycle initiatives, which generated \$7.5 million of incremental income for fiscal 2009, and are expected to produce \$15 million of operational improvements in fiscal 2010. Wellmont's fiscal 2010 budgeted operating income is \$19.8 million.

Acute discharges rose slightly to 42,558 in fiscal 2009 from 42,401 in fiscal 2008. Combined inpatient and outpatient surgery volumes grew by 3.9% to 25,128. Emergency department visits declined 2% to 222,560 from

227,181 in fiscal 2008.

Wellmont's excess revenues, as per Standard & Poor's calculations, were \$6.1 million, which included \$8.8 million of realized investment income offset by discontinued operations and other nonoperating expenses. While positive, investment income was well short of budget and substantially below fiscal 2008's \$31.6 million. Unrealized investment losses in fiscal 2009 were \$60 million. Wellmont also had a \$5.7 million unrealized loss on its swaps at year-end. Both unrealized investment and swap losses are treated as below the line for purposes of Standard & Poor's analysis.

Cash flow remains acceptable as evidenced by a 9% EBIDA margin, generating 2.1x coverage of Wellmont's \$30.6 million MADS. Historically operating leases have been relatively modest in amount. However, as Wellmont monetizes its medical office buildings, operating leases have become more material to its overall financial profile. Adjusted for the growing operating lease expense, MADS coverage is diluted to 1.7x.

Wellmont's balance sheet remains acceptable, although due to the decline in capitalization over the past couple of years, leverage metrics are now at a level where the system has very limited flexibility to issue more debt without a rating implication. Wellmont recently completed its "Project Platinum," which includes a new surgical suite, intensive care unit, and emergency department project at Holston Valley Medical Center. We understand that management currently no plans to issue new debt.

Unrestricted cash and investments totaled \$250.3 million at year-end, equal to 133 days' cash on hand and 50% of long-term debt. Cash was flat relative to last year. Wellmont's long-term debt to capitalization rose to 60% from 55% in 2008, although the increase was strictly a function of a smaller denominator. Other than information-technology-related capital spending, Wellmont has limited capital spending plans that should support the continued growth of unrestricted cash and investments.

About 85% of the system's cash and investment assets are liquid with maturities of less than one year. Less than 10% (\$23.2 million) are invested in real assets and private equity. Wellmont has a moderate level of future private equity capital funding commitments equal to \$15 million.

Interim Financial Metrics

Through the first six months ended Dec. 31, 2009, Wellmont generated \$15.2 million of operating income (a 4.1% margin) on \$374.4 million of total operating revenues. Operations compared favorably with Wellmont's \$5.2 million loss for the first six months of last year. Excess income was \$19.8 million (a 5.2% margin) compared with an excess loss of \$627,000 in 2009, as per Standard & Poor's calculations, which treat unrealized derivative valuation adjustments as below the line items. Same-facility patient volumes were flat relative to the prior year. Management attributes improved fiscal 2010 operating performance to revenue and expense cycle initiatives implemented in late fiscal 2009.

Unrestricted cash and investments grew to \$270 million by Dec. 31, equal to 146 days of operating expenses and 55% of Wellmont's total debt outstanding. The system's debt to capitalization improved to 56%. All figures are based on Standard & Poor's calculations.

Debt Derivative Profile: '3'

Wellmont's overall DDP score has been revised to '3' on a scale of '1' to '4', whereby '1' represents the lowest risk. The overall score of '3' reflects Standard & Poor's view that Wellmont's swap exposure represents a moderate credit risk at this time.

The overall score of '3.0' includes the following factors:

- Above-average collateral posting risk due to the requirement that Wellmont post collateral when its rating falls to 'BBB-' or lower, a somewhat narrow spread for a 'BBB+' credit (there are no termination-rating triggers);
- High counterparty risk, based on the credit quality of the counterparty, Lehman Brothers Special Financing, guaranteed by Lehman Brothers Holdings (not rated), which filed for bankruptcy in September 2008;
- Low economic viability risk based on projected performance under stressful economic scenarios; and
- Strong management practices, including a written swap policy, thorough audit disclosure, regular communication of swap performance to the board and investors, and the use of independent financial advisors to assist in evaluating swap strategies and performance.

Wellmont has four swaps in place, all of which are with Lehman Brothers Special Financing. At Dec. 31 the swaps had a combined marked to market value of negative \$7.7 million. At that level of swap liability, no collateral posting is required. Variable-rate debt is about 31% of the total, but inclusive of the effects of the swaps, Wellmont's current net variable-rate exposure is about 9.0%.

Related Research

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- USPF Criteria: Debt Derivative Profile Scores, March 27, 2006
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009

Ratings Detail (As Of February 19, 2010)

Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee

Wellmont Hlth Sys, Tennessee

Sullivan Cnty Hlth Ed & Hsg Fac Brd (Wellmont Health System)

Unenhanced Rating

BBB+(SPUR)/Stable

Affirmed

Virginia Small Business Fin Auth, Virginia

Wellmont Hlth Sys, Tennessee

Virginia Small Business Fin Auth (Wellmont Health System)

Long Term Rating

BBB+/Stable

Affirmed

Many issues are enhanced by bond insurance.

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Related Criteria And Research

Sullivan County Health, Educational, and Housing Facilities Board, Tennessee Wellmont Health System; System

Credit Profile		
US\$76.265 mil hosp rev rfdg bnds (Wellmont Hlth Sys) ser 2011 dtd 05/03/2011 due 09/01/2032		
<i>Long Term Rating</i>	BBB+/Stable	New
Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee		
Wellmont Hlth Sys, Tennessee		
Sullivan Cnty Hlth Ed & Hsg Fac Brd (Wellmont Health System)		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed

Rationale

Standard & Poor's Ratings Services assigned its 'BBB+' long-term rating to Sullivan County Health, Educational, and Housing Facilities Board, Tenn.'s \$76.2 million series 2011 fixed-rate refunding bonds issued for Wellmont Health System. At the same time, Standard & Poor's affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on Wellmont's other rated bonds from various issuers. Standard & Poor's expects to assign an 'A-1+' short-term rating to Wellmont's series 2005 bonds based on the support of JP Morgan Chase Bank N.A. (AA-/A-1+), the replacement letter of credit provider. The outlook is stable.

The series 2011 bonds will fully refund Wellmont's series 2006A variable-rate obligations outstanding (not rated) with fixed-rate debt of the same maturity. For the series 2005 variable-rate demand bonds (not rated), Wellmont plans to obtain a replacement direct-pay letter of credit from JP Morgan Chase. The letter of credit is currently provided by Bank of America.

The ratings and stable outlook reflect our view of improved operating and financial metrics following management's implementation in 2009 of various expense and revenue cycle initiatives, which it expects to support Wellmont's improved performance on a sustained basis.

More specifically, the ratings reflect our opinion of Wellmont's:

- Solid financial metrics, including positive fiscal 2010 operating income of \$22.8 million (a 3.2% margin) and six-month year-to-date operating income of \$4.4 million as of December 31;
- Acceptable 2.8x fiscal year-end maximum annual debt service (MADS) coverage (or 2.1x on an operating lease-adjusted basis), which improved from prior years;
- Improved, although still constrained balance sheet due to its acquisition activity over the past several years. As of December 31, Wellmont had 193 days' cash on hand, moderately high 53% long-term debt to total capitalization, and unrestricted cash to long-term debt of 80%; and
- Solid business position characterized by good market share in a demographically favorable region that is largely dominated by two health care systems.

Further supporting the ratings is our view of revenue cycle, staffing, expense, and other operating improvements that

helped Wellmont generate net operating income of \$7.0 million in fiscal 2009 (a \$4.7 million improvement over fiscal 2008) and an operating profit of \$22.8 million in fiscal 2010. In addition, the system's major acquisition activities are completed, which will likely allow Wellmont to continue to build balance sheet strength.

In June 2010, Wellmont named Margaret "Denny" DeNarvaez president and CEO of the health system. She assumed the role in August 2010 from Bob Burgin, who served as Wellmont's interim CEO following the resignation of Mike Snow in March. Ms. DeNarvaez joined Wellmont from St. John's Mercy Healthcare in St. Louis, where she served as its CEO.

As of June 30, 2010, Wellmont had \$447 million of bonded debt. Gross revenues of the obligated group and a mortgage on Wellmont's two largest hospitals, Bristol Regional Medical Center and Holston Valley Medical Center, as well as two of its community hospitals, Lee Regional Medical Center and Mountain View Regional Medical Center, secure the bonds. The obligated group includes the parent, Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary, and the system's fundraising arm. Six of the system's hospitals are included by virtue of operating as unincorporated divisions of the parent: Holston Valley Medical Center, Bristol Regional Medical Center, Lonesome Pine Hospital, Hancock County Hospital, Lee Regional Medical Center, and Mountain View Regional Medical Center. All of the system's entities are included for the purpose of our calculations in this report.

Wellmont's direct-pay letter of credit agreement with Bank of America N.A. expires on July 1, 2011. As noted above, management plans to obtain a replacement letter of credit for its series 2005 variable-rate demand bonds from JP Morgan Chase. The level of puttable debt relative to unrestricted cash as of Dec. 31, 2010, is manageable, in our view, at about 16%. The system is currently in compliance with all bank and bond covenants.

Wellmont's overall Debt Derivative Profile (DDP) score is '3' on a scale of '1' to '4', with '1' representing the lowest risk. The overall score of '3' reflects Standard & Poor's view that the risks associated with Wellmont's derivatives portfolio are moderate at this time due to risks associated with the Lehman bankruptcy. As of March 31, 2011, Wellmont's swap liability was \$10.0 million. There is no required collateral posting at this time. In addition, there have been no changes to Wellmont's swap portfolio since our last published report on Feb. 19, 2010.

Outlook

The stable outlook reflects our view of management's initiatives to reduce costs and improve the revenue cycle. While we remain focused on certain credit weaknesses, including leverage, we understand that Wellmont's future capital spending plans are modest and that management has no current plans to issue additional long-term debt. Should the balance sheet or operations unexpectedly weaken, a downgrade or a negative outlook would become more likely. By contrast, significant improvement to the balance sheet over time, provided good operating performance is sustained, could be cause for a positive outlook revision and possibly an upgrade.

Finances

For the fiscal year ended June 30, 2010, Wellmont generated operating income of \$22.8 million (a 3.2% margin) on \$724 million of total net revenues. Operating results reflect a \$15.8 million improvement over fiscal 2009. Net operating income has materially improved over the past two years, principally due to Wellmont's implementation of revenue and expense cycle initiatives. Wellmont's fiscal 2011 budgeted operating income was \$24 million; however, operating results are more likely to be about half that amount, resulting in an operating margin of about 1.5%

(down from more than 3% last year). Wellmont attributes this year's decline mainly to weather-related volume decreases at its Virginia hospitals: due to harsh winter weather conditions, volumes in those hospitals declined by 6% to 10% and patient no-show rates exceeded 50%.

Acute discharges dipped 2.8% to 41,380 in fiscal 2010 from 42,558 in fiscal 2009, although with observation patients included, those patient volumes increased by 0.5% to 50,910 in fiscal 2010. Combined inpatient and outpatient surgery volumes declined by 6.0% to 36,559 while emergency department visits decreased 4.6% to 212,383 from 222,560 in fiscal 2009. According to management, those declines were attributed to economic weakness but also transportation problems due to winter weather conditions in 2010.

For the fiscal year, Wellmont's excess revenues, as per Standard & Poor's calculations, were \$20.8 million, which included \$1.0 million of realized investment income offset by discontinued operations and other nonoperating expenses. While positive, investment income was substantially lower than two previous fiscal years; however, unrealized investment gains in fiscal 2010 were \$22.3 million, compared to more than \$60 million of unrealized losses in 2009. Wellmont also had a \$2.7 million unrealized loss on its swaps at year-end. Both unrealized investment gains and the swap loss are treated as below the line for purposes of Standard & Poor's analysis.

Cash flow remains acceptable, in our view, as evidenced by an 11.7% EBIDA margin, generating 2.8x coverage of Wellmont's \$30.6 million MADS. Operating leases have historically been relatively modest in amount. However, as Wellmont monetizes its medical office buildings, operating leases have become more material to its overall financial profile. Adjusted for the growing operating lease expense, MADS coverage is diluted to 2.1x.

Wellmont's balance sheet remains acceptable, in our opinion, although due to the decline in capitalization over the past few years, leverage metrics are now at a level where the system has very limited flexibility to issue more debt at the current rating level. However, we understand that management has no current plans to issue any additional debt, other than for refunding purposes.

Unrestricted cash and investments totaled \$316 million at year-end, equal to 175 days' cash on hand and 64% of long-term debt, as per Standard & Poor's calculation methodology. Wellmont excludes the less liquid investments from the days' cash calculation, resulting in 156 days' cash at the fiscal year-end, compared with its minimum covenant level of 100 days. Robust cash flow and minimal capital spending needs allowed cash to grow by more than \$65 million relative to last year. Other than modest strategic, information technology, and equipment-related capital spending, Wellmont has limited spending plans that will likely support the continued growth of the system's liquidity.

About 85% of the system's cash and investment assets are liquid with maturities of less than one year. Less than 10% (\$23.5 million) are invested in real assets and private equity. Wellmont has a moderate level of future private equity capital funding commitments equal to \$12 million.

Interim Financial Metrics

Through the six months ended Dec. 31, 2010, Wellmont generated \$4.4 million of operating income (a 1.1% margin) on \$390 million of total operating revenues despite an increase in patient volumes. Operations compared unfavorably with Wellmont's \$15 million in operating revenue for last year principally due to expense increases related to drug costs, higher personnel, and other expenses and interest expense and depreciation associated with the

completion of Project Platinum. Excess income for the six months was \$10.7 million (a 2.7% margin), down from \$19.8 million (a 5.2% margin) for the same period in fiscal 2010.

Unrestricted cash and investments grew to \$383 million by December 31, equal to 193 days of operating expenses and 80% of Wellmont's total debt outstanding. The system's debt to capitalization improved to 53%. All figures are based on Standard & Poor's calculations.

Debt Derivative Profile

Wellmont's overall DDP score has been revised to '3' on a scale of '1' to '4', whereby '1' represents the lowest risk. The overall score of '3' reflects Standard & Poor's view that Wellmont's swap exposure represents a moderate credit risk at this time.

The overall score of '3.0' reflects our view of:

- Above-average collateral posting risk due to the requirement that Wellmont post collateral when its bond rating falls to 'BBB-' or lower, a somewhat narrow spread for a 'BBB+' credit (there are no termination-rating triggers);
- High counterparty risk, based on the credit quality of the counterparty, Lehman Brothers Special Financing, guaranteed by Lehman Brothers Holdings (not rated), which filed for bankruptcy in September 2008;
- Low economic viability risk based on projected performance under stressful economic scenarios; and
- Strong management practices, including a written swap policy, thorough audit disclosure, regular communication of swap performance to the board and investors, and the use of independent financial advisors to assist in evaluating swap strategies and performance.

Wellmont has four swaps in place, all of which are with Lehman Brothers Special Financing. At March 31, 2011, the swaps had a combined mark-to-market value of negative \$10 million. At that level of swap liability, no collateral posting is required. Variable-rate debt is about 34% of the total, but inclusive of the effects of the swaps, Wellmont's current net variable-rate exposure is about 15%

Related Criteria And Research

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009
- USPF Criteria: Debt Derivative Profile Scores, March 27, 2006

Ratings Detail (As Of April 29, 2011)		
Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee		
Wellmont Hlth Sys, Tennessee		
Sullivan Cnty Hlth Ed & Hsg Fac Brd (Wellmont Health System)		
<i>Unenhanced Rating</i>	BBB+(SPUR)/Stable	Affirmed
Virginia Small Business Fin Auth, Virginia		
Wellmont Hlth Sys, Tennessee		
Virginia Small Business Fin Auth (Wellmont Health System)		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Many issues are enhanced by bond insurance.		

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FITCH RATES WELLMONT HEALTH SYSTEM, TN'S 2011 REVS 'BBB+'; OUTLOOK STABLE

Fitch Ratings-New York-02 May 2011: Fitch Ratings assigns a 'BBB+' rating to the expected issuance of approximately \$76 million of Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee hospital revenue refunding bonds (Wellmont Health System Project), series 2011, issued on behalf of Wellmont Health System (Wellmont).

In addition, Fitch affirms the 'BBB+' rating on the following bonds:

- \$76,595,000 revenue refunding bonds, series 2006A;
- \$200,000,000 hospital revenue bonds, series 2006C;
- \$59,580,000 hospital revenue refunding bonds, series 2005;
- \$36,665,000 hospital revenue refunding bonds, series 2003;
- \$55,000,000 Virginia Small Business Financing Authority hospital revenue bonds, series 2007A.

The Rating Outlook is Stable.

Proceeds from the 2011 fixed rate bonds will be used to refinance the series 2006A bonds. In March 2011, Wellmont put out a tender notice for the 2006A bonds, which was accepted by all outstanding bondholders. The 2006A bonds were variable rate index bonds and redeemable in whole at any time. After issuance, Wellmont's long-term debt will total \$457.4 million, which includes a \$30 million variable-rate, bank qualified loan secured in 2010. After replacing the 2006A variable-rate bonds, Wellmont's debt structure will be comprised of 80% of fixed rate bonds, a relatively conservative debt portfolio. The 2011 bonds will be sold the week of May 4th.

RATING RATIONALE:

- Most of Wellmont's financial and capital metrics are consistent with the rating category.
- Wellmont benefits from a leading inpatient market share of 60% (2009) in its primary service area and a stable market share in its secondary markets.
- Operating margins are expected to be approximately 1.5% over the next few years as a new CEO and new senior management team implement strategic initiatives around quality, information technology, and physician alignment.
- Six month fiscal 2011 interim figures show an operating margin of 1.1%, which supports solid pro forma maximum annual debt service (MADS) coverage of 2.6 times (x).
- With no new debt issuance expected over the next two to three years, Fitch expects Wellmont's elevated leverage indicators to moderate.

KEY RATING DRIVERS

- A new senior management team implements its strategy over the medium term, bringing a measure of stability at the senior management level that has eluded Wellmont over the last few years and has been a credit concern.
- In spite of the strategic investments, Wellmont is able to maintain its current level of operations keeping its financial profile relatively stable.

SECURITY

Bonds are secured by gross receipts and mortgage pledge of the obligated group (OG). A fully funded debt service fund and a liquidity covenant provide additional security. For the fiscal year ended June 30, 2010, the OG accounted for 89.4% of the system's total net assets, 87.6% of its operating revenues and 64.7% of its operating income.

CREDIT SUMMARY

The 'BBB+' rating is supported Wellmont's overall financial profile that is consistent with most rating category medians and its leading inpatient market share in its primary service area (PSA).

Credit concerns include the continued turnover in senior management and a slightly elevated debt burden.

Wellmont finished fiscal 2010 (year end June 2010) with a 3.1% operating margin and pro forma MADS coverage of 2.5x, both solid for the 'BBB' category. Six-month interim results show an operating margin of 1.1% and MADS coverage of 2.6x. The lower operating margin is more in line with where Fitch expects Wellmont's operations to be over the next few years, given softer volumes and expenses related to strategic initiatives of the new management team. The former management team was more focused on expense management and efficiency, which contributed to the higher operating margin in fiscal 2010.

Senior management turnover at Wellmont has been a credit concern over the past few years; the new CEO has been in place nine months and has added new members to the management team. A key rating driver for Wellmont is maintaining stability at the senior management level, especially as the management team pursues critical strategic initiatives around quality, information technology, and physician alignment.

Liquidity is good for the rating category. As of Dec. 31, 2010, Wellmont had cash and unrestricted investments of \$315.5 million (adjusted for \$14 million line of credit), which equated to days cash on hand (DCOH) of 167.4, a cushion ratio of 9.2x, and cash to debt of 69.2%. DCOH and the cushion ratio were above their respective category medians, while cash to debt was below. In January 2011, Wellmont paid down \$7 million of the line of credit.

Wellmont's debt burden remains elevated for the rating level, as represented by MADS as a percentage of revenue of 4.4%, Debt-to-EBITDA of 5.1x, and debt to capitalization of 56.6% as of Dec. 31, 2010, all of which are above the category medians. Mitigating this concern is the expectation that Wellmont will be issuing no new debt over the next two to three years, which should help ease some of these ratios.

The Stable Outlook reflects Fitch's belief that Wellmont will maintain its current level of operating performance, which should continue to support solid debt service coverage. The service area remains fairly competitive with Mountain States Health Alliance (general revenue bonds rated 'BBB+' by Fitch) a formidable competitor. However, the competitive pressures have subsided in the past few years, and Wellmont's leading 60% market share in its PSA has been stable. Capital expenditures over the next two to three years are expected to be reasonable at approximately \$45 to \$50 million per year (representing just over 100% of depreciation). The biggest short-term outlay will be \$14 million for information technology. Wellmont expects to be ready for meaningful use within the next 18 months.

Wellmont has four swaps in place. Lehman is the counterparty for all the swaps and there are no collateral posting requirements at the current rating level. The aggregate mark to market as of March 31, 2011 was a negative \$10 million.

Wellmont Health System (WHS) is a large regional health care system with eight acute hospitals (856 staffed beds) and other related entities located in northeastern TN and southwestern VA. Wellmont had approximately \$724.4 million in total revenue in fiscal 2010. WHS covenants to provide audited financial statements to the Municipal Securities Rulemaking Board's Electronic Municipal Market Access system (EMMA), as well as quarterly unaudited statements.

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Applicable Criteria and Related Research:

--'Revenue-Supported Rating Criteria', dated Oct. 10, 2010;

--'Nonprofit Hospitals and Health Systems Rating Criteria', dated Dec. 29, 2009.

For information on Build America Bonds, visit 'www.fitchratings.com/BABs'.

Applicable Criteria and Related Research:

Revenue-Supported Rating Criteria

http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=564565

Nonprofit Hospitals and Health Systems Rating Criteria

http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=493186

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Related Criteria And Research

Sullivan County Health Educational & Housing Facilities Board, Tennessee

Wellmont Health System; System

Credit Profile

Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee

Wellmont Hlth Sys, Tennessee

Ser 2006C

Long Term Rating

BBB+/Stable

Affirmed

Rationale

Standard & Poor's Ratings Services affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on \$360.4 million in bonds, including series 2003, 2006C, 2007A, and 2011, issued for Wellmont Health System, Tenn. by various issuing authorities. The outlook is stable.

In addition, Standard & Poor's 'AA-/A-1+' long-term and short-term ratings on Wellmont's \$54.8 million series 2005 variable-rate demand obligations are based solely on the support of JP Morgan Chase Bank N.A. (AA-/A-1+), the letter of credit provider.

The affirmed ratings and stable outlook reflect our view of Wellmont's improving operating and financial metrics as well as its stable enterprise profile. We believe that Wellmont is well positioned for operational success with respect to its markets, competition, and changing reimbursement environment.

More specifically, the ratings reflect our opinion of Wellmont's:

- Solid financial metrics, including positive fiscal 2012 unaudited operating income of \$20.7 million (a 2.6% margin), as per Standard & Poor's calculations;
- Acceptable 3.0x fiscal year end maximum annual debt service (MADS) coverage, which continues to improve from prior years;
- Improved balance sheet highlighted by the system's 192 days' cash on hand, moderately elevated 50% long-term debt to total capitalization, and unrestricted cash to long-term debt of 83%, as per Standard & Poor's calculations; and
- Solid business position characterized by good market share in a demographically favorable region that is largely dominated by two health care systems.

Further supporting the ratings is our view of revenue cycle, staffing, expense, and other operating improvements that have helped Wellmont generate consistently robust operating results during the past three fiscal years. In addition, we anticipate that as the system's major acquisition activities are completed, Wellmont will likely be able to continue to build balance sheet strength over time.

Partially offsetting the above-noted strengths, in our opinion, is Wellmont's plan to issue roughly \$55 million of new

debt in fiscal 2013, as well as management's plan to transition the health system over to an Epic IT Platform, which during the next five years will involve about \$100 million of capital spending. While the transition to Epic could potentially involve some disruption to Wellmont's operations, management believes that it is very well prepared to undertake the implementation and had a very successful recent implementation of its electronic health record.

In addition, while we believe that major facilities acquisitions are done now that most of the desirable candidates in the markets served by Wellmont and its major competitor have been acquired, we continue to believe that competition for patient volumes between these two sizable systems remains intense.

As of June 30, 2012, Wellmont had \$459 million of bonded debt and capital leases. About \$82 million of Wellmont's outstanding debt is variable-rate obligations, including \$24.8 million in bank qualified directly placed index floating-rate bonds (not rated). The variable-rate obligations have tender provisions that may allow the bonds to be redeemed before maturity. In our opinion, the amount of puttable debt relative to unrestricted cash as of June 30, 2012 is manageable, at about 17%. In addition, Wellmont has more than adequate unrestricted liquidity available to cover these potential tender obligations by a ratio of 4.6x. We understand that Wellmont may issue approximately \$55 million of incremental debt in fiscal 2013, and, in our opinion, the system has capacity to issue some additional debt, including the amount contemplated, without negatively affecting the ratings.

Wellmont uses interest rate swaps to partially hedge its interest rate risk. Wellmont has three swaps totaling \$161 million notional principal; Lehman Brothers Special Financing is the counterparty. In our opinion, the risks associated with Wellmont's derivatives portfolio are moderate at this time. As of June 30, 2012, Wellmont's swap liability was \$16.7 million and there is no required collateral posting. In addition, there were no changes to Wellmont's swap portfolio since our last published report on April 29, 2011.

The system remains in compliance with all bank and bond covenants. Gross revenues of the obligated group and a mortgage on Wellmont's two largest hospitals, Bristol Regional Medical Center and Holston Valley Medical Center, as well as two of its community hospitals, Lee Regional Medical Center and Mountain View Regional Medical Center, secure the bonds. The obligated group includes the parent, Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary, and the system's fundraising arm. Six of the system's hospitals are included by virtue of operating as unincorporated divisions of the parent: Holston Valley Medical Center, Bristol Regional Medical Center, Lonesome Pine Hospital, Hancock County Hospital, Lee Regional Medical Center, and Mountain View Regional Medical Center. All of the system's entities are included for the purpose of our calculations in this report.

Outlook

The stable outlook reflects our view of management's initiatives to control expenses and increase incremental revenues through its ambulatory strategy and oncology and cardiology service line focus. We anticipate that balance sheet metrics will likely remain stable or improve during the two-year outlook period as most of Wellmont's major bricks-and-mortar capital spending initiatives have been completed -- although the system's transition to Epic for its clinical information system will represent a sizable level of spending during the next five years. We are aware that Wellmont plans to issue about \$55 million of new debt in fiscal 2013 and while the details are uncertain at this time,

the system maintains adequate capacity to support this level of incremental debt at the existing rating level, in our opinion.

Should the system's balance sheet or its operations unexpectedly weaken, such that Wellmont's MADS coverage declines and is sustained below 2.0x, or if unrestricted liquidity falls to fewer than 150 days or 70% of long-term debt, then a downgrade or a negative outlook would become more likely. By contrast, improvement to the balance sheet over time, provided operating performance remains good, could be cause for a positive outlook revision and possibly an upgrade.

Enterprise Profile

Wellmont is an eight-hospital system headquartered in Kingsport, Tenn. and is composed of 1,253 licensed (856 staffed including managed (not owned acute), psych, rehab, and skilled nursing facility) inpatient beds. The system's facilities are located in Tennessee and Virginia. Acute discharges totaled 40,121 in fiscal 2012, down 4.6% from fiscal 2011. Total bedded volumes, including observations, increased to 53,790, or by 1.7%, compared with the previous fiscal year. The system's outpatient registrations continue to grow, and totaled 236,437 in fiscal 2012, up 5.1% from fiscal 2011, partially driven by the system's acquisition of a cardiology practice earlier this year. Emergency department and combined surgery volumes were essentially flat.

Management remains focused on the system's ambulatory strategy, which includes the creation of a strategic infrastructure around oncology and cardiology centers of excellence. Pulmonology is also a service line that management considers a strategic focus. Although in the past several years Wellmont had been focused on the acquisition of hospitals and facilities, both in Tennessee and in Virginia, major facilities acquisition activity is completed as there are few desirable remaining hospital acquisition candidates in the system's service area that are not already affiliated with Wellmont or its major competitor. Management's current strategy is to maintain or develop outposts to draw patients from a larger geographic area without having to have a hospital located in those areas. In addition, management plans to capitalize on its strengths in core service lines supported by its new dyad leadership model, which appears to be creating favorable results through improved patient satisfaction scores.

Management

Wellmont named Alice Pope CFO of Wellmont in August 2012. Ms. Pope previously served as SVP finance managed care and revenue cycle for the system, and has served in various roles with the organization during the past 12 years.

Financial Profile

For the fiscal year ended June 30, 2012 (unaudited), Wellmont generated operating income of \$20.7 million (a 2.6% margin) on \$789.7 million of total net revenues. Commencing with these fiscal 2012 results, and this review, Standard & Poor's analysis conforms to accounting rule ASU 2011-07, which changes the classification of bad debt expense to a deduction from revenues. This change had the effect of elevating days' cash on hand and reflecting modestly higher operating and excess margins.

Operating results reflect a \$4.8 million improvement over fiscal 2011 principally due to Wellmont's implementation of revenue and expense cycle initiatives, including a narrow network agreement with Cigna for a major local employer and physician practice acquisitions, as well as a greater focus on documentation and coding, increasing its case mix, and reducing lengths of stay.

For the fiscal year, Wellmont's excess revenues, as per Standard & Poor's calculations, were \$38 million (or a 4.7% margin), which included \$17.3 million of realized investment income. Wellmont also had a \$5.1 million unrealized loss on its swaps at year end, and unrealized investment losses of \$9.5 million. Both unrealized investment losses and the swap loss are treated as below the line for purposes of Standard & Poor's analysis.

Cash flow remains acceptable, in our view, as evidenced by a 13.2% EBIDA margin, generating just over 3.0x coverage of Wellmont's \$35.2 million MADS. Operating leases have historically been relatively modest in amount; however, with the monetization of Wellmont's medical office buildings, operating leases have become more material to the system's overall financial profile. Adjusted for operating lease expense, MADS coverage is diluted to 2.3x.

Wellmont's fiscal 2013 budgeted operating income is \$15 million, resulting in an operating margin of about 1.9%, a level comparable to fiscal 2011 results, but below fiscal 2012. Wellmont expects to grow its operating margin over time, once the full Epic clinical information system has been implemented in 2014/2015.

Balance sheet

Wellmont's balance sheet remains acceptable, in our view, and although management plans to issue \$55 million of new debt in fiscal 2013, we believe that the system has some flexibility to issue additional debt at the existing rating level given its solid operating performance and improved capitalization during the past three years.

Unrestricted cash and investments totaled \$380 million at year end, equal to 192 days' cash on hand and 83% of long-term debt. As part of its methodology Wellmont excludes the less liquid investments from the days' cash calculation. By making that adjustment, days' cash declines to about 173 days at fiscal year end, which remains solid and in compliance with Wellmont's minimum covenant level of 100 days. Robust cash flow and minimal capital spending needs allowed cash to grow by more than \$32 million relative to last year.

Wellmont's systemwide combined routine and strategic capital budget is \$40 million for fiscal 2013, not including the system's budget for converting to a new Epic IT Platform, which will represent a \$100 million capital spend during the next five years (plus \$84 million of operating costs). Wellmont is budgeting for about \$45 million of meaningful use stimulus money, which will help to offset the cost of its Epic conversion. Other than modest strategic and equipment-related capital spending and the planned spending for its Epic IT Platform conversion, Wellmont has limited other capital spending plans. As a result, we anticipate that the system's liquidity will continue to grow.

Wellmont Health System

	Fiscal Year Ended June 30,			
	Fiscal Year Ended June 30, 2012 (Unaudited)	2011	2010	2009
Financial performance				
Net patient revenue (\$000s)	741,822	767,450	692,920	699,303
Total operating revenue (\$000s)	789,726	797,249	724,392	737,073

Wellmont Health System (cont.)				
Total operating expenses (\$000s)	769,074	781,322	701,580	730,567
Operating income (\$000s)	20,652	15,927	22,812	6,506
Operating margin (%)	2.62	2.00	3.15	0.88
Net nonoperating income (\$000s)	17,360	9,908	(1,967)	(359)
Excess income (\$000s)	38,012	25,835	20,845	6,147
Excess margin (%)	4.71	3.20	2.89	0.83
Operating EBIDA margin (%)	11.24	10.38	11.96	8.89
EBIDA margin (%)	13.15	11.48	11.72	8.84
Net available for debt service (\$000s)	106,092	92,644	84,666	65,148
Maximum annual debt service (\$000s)	35,157	35,157	35,157	35,157
Maximum annual debt service coverage (x)	3.02	2.64	2.41	1.85
Operating lease-adjusted coverage (x)	2.30	2.28	2.14	1.73
Liquidity and financial flexibility				
Unrestricted cash and investments (\$000s)	379,544	346,881	315,776	250,331
Unrestricted days' cash on hand	191.7	172.2	175.2	132.9
Unrestricted cash/total long-term debt (%)	82.6	75.5	67.5	52.7
Average age of plant (years)	11.4	10.5	10.5	9.7
Capital expenditures/depreciation and amortization (%)	103.6	92.0	127.4	201.5
Debt and liabilities				
Total long-term debt (\$000s)	459,654	459,260	467,833	474,608
Long-term debt/capitalization (%)	49.6	51.2	56.6	59.7
Debt burden (%)	4.36	4.35	4.85	4.74
Defined benefit plan funded status (%)	N.A.	85.61	77.52	83.24
Pro forma ratios				
Unrestricted days' cash on hand	191.70			
Unrestricted cash/total long-term debt (%)	73.75			
Long-term debt/capitalization (%)	52.44			
N.A.: Not available.				

Related Criteria And Research

- USPF Criteria: Assessing Construction Risk, June 22, 2007
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009
- USPF Criteria: Contingent Liquidity Risks, March 5, 2012

Ratings Detail (As Of September 25, 2012)

Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee

Wellmont Hlth Sys, Tennessee

Ser 2003

Unenhanced Rating

BBB+(SPUR)/Stable

Affirmed

Ser 2011

Ratings Detail (As Of September 25, 2012) (cont.)

<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Virginia Small Business Fin Auth, Virginia		
Wellmont Hlth Sys, Tennessee		
Ser 2007A		
<i>Long Term Rating</i>	BBB+/Stable	Affirmed
Many issues are enhanced by bond insurance.		

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McGRAW-HILL

FITCH AFFIRMS WELLMONT HEALTH SYSTEM, TN'S REVS AT 'BBB+'; OUTLOOK STABLE

Fitch Ratings-New York-22 April 2013: Fitch Ratings affirms the 'BBB+' rating on the following bonds issued on behalf of Wellmont Health System (Wellmont):

- \$76,165,000 The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee hospital revenue refunding bonds (Wellmont Health System Project), series 2011;
- \$55,000,000 Virginia Small Business Financing Authority hospital revenue bonds, series 2007A (Wellmont Health System Project);
- \$200,000,000 The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee hospital revenue bonds, series 2006C (Wellmont Health System Project);
- \$59,580,000 The Health, Educational and Housing Facilities Board of the County of Sullivan, TN hospital revenue refunding bonds, series 2005 (Wellmont Health System Project);
- \$33,035,000 The Health, Educational and Housing Facilities Board of the County of Sullivan, TN hospital revenue refunding bonds, series 2003 (Wellmont Health System Project).

The Rating Outlook is Stable.

SECURITY

The bonds are secured by gross receipts and mortgage pledge of the obligated group (OG). A fully funded debt service fund provides additional security. In addition, there is a liquidity covenant.

KEY RATING DRIVERS:

STRONG OPERATING EBITDA: Wellmont's operating EBITDA is consistently above Fitch's 'BBB' category medians, averaging 11.2% over the past four audited years and at 10.2% in the six month fiscal 2013 (June 30 year end) interim period.

CATEGORY CONSISTENT METRICS: Most of Wellmont's financial and capital metrics are consistent with the rating category, with liquidity strengthening over the last four audited years to above category medians.

LEADING MARKET SHARE: Wellmont maintains leading 55% inpatient market share in its defined primary service area. Although its market share has declined slightly in the past few years, it is not a credit concern.

ELEVATED DEBT BURDEN: Maximum annual debt service (MADS) as a percentage of revenue is high at 5.3% in the six month interim period relative to a Fitch's 'BBB' median of 3.3%. Wellmont is drawing down a \$42.5 million loan (\$3.1 million has been drawn to date) as part of its EPIC implementation (a separate \$12.5 million was closed and drawn upon last year for a total of \$55 million in additional debt for EPIC), all of which is factored into the MADS figure. With no other additional debt anticipated, Fitch expects Wellmont's debt burden to moderate over next few years.

RATING SENSITIVITIES:

OPERATING PRESSURE: Like many hospitals, Wellmont has seen inpatient volumes decline as services have shifted to an outpatient setting, with Wellmont's operating performance slightly weaker in the six month interim due, in part, to the reduction in inpatient services. Wellmont's ability to adjust to this volume shift and maintain its operating performance is key to the current rating. A weakening of its operating EBITDA would be a credit concern, given Wellmont's elevated debt burden.

CREDIT PROFILE:

The 'BBB+' rating is supported by an overall financial profile consistent with Fitch's 'BBB' rating category medians and Wellmont's leading inpatient market share in its primary service area (PSA). Wellmont finished fiscal 2013 with a 2.8% operating margin and MADS coverage of 2.6x, both solid for the 'BBB' category.

Six month fiscal 2012 interim figures show the operating margin sliding to 1.1%, which is off Wellmont's budget. Wellmont is adjusting its budget and expects to improve operations over the second half of the year, helped by an additional \$6.5 million in meaningful use funds.

Liquidity has strengthened materially over the last four years, with unrestricted cash and investments growing by approximately 45% over that time, and Wellmont's key liquidity ratios now exceeding Fitch's 'BBB' medians. At Dec. 31, 2012, Wellmont had cash and unrestricted investments of \$395.6 million (excluding \$38.4 million in illiquid investments), which equated to days cash on hand of 197.1, a pro forma cushion ratio of 9.5x, and pro forma cash to debt (assuming full draw down on \$45 million loan - only \$3.2 million has been drawn to date) of 76.1%.

Wellmont's debt burden remains elevated for the rating level, as represented by MADS as a percentage of revenue of 5.3% and debt-to-EBITDA of 4.6x, and debt to capitalization of 51.8% as of Dec. 31, 2012, all of which compare unfavorably to 'BBB' category medians. An additional credit concern is competitive service area with Mountain States Health Alliance (general revenue bonds rated 'BBB+'/Outlook Stable by Fitch) a formidable competitor.

The Stable Outlook reflects Fitch's belief that Wellmont will maintain a level of operating performance to support consistent debt service coverage. Capital expenditures over the next two to three years are expected to be reasonable at approximately \$40 million to \$50 million per year, excluding \$100 million EPIC implementation.

Wellmont's debt portfolio is relatively conservative with approximately 12% of its \$481 million of long-term debt in variable rate mode. However, Wellmont does have four swaps. Lehman is the counterparty for three of the swaps. There are no collateral posting requirements at the current rating level. The aggregate mark to market as of Dec. 31, 2012 was a negative \$8.5 million.

Wellmont Health System (WHS) is a large regional health care system with seven acute hospitals (816 staffed beds) and other related entities located in northeastern TN and southwestern VA. Wellmont had approximately \$790 million in total revenue in fiscal 2012. WHS covenants to provide audited financial statements to the Municipal Securities Rulemaking Board's Electronic Municipal Market Access system (EMMA), as well as quarterly unaudited statements.

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Applicable Criteria and Related Research:

- 'Revenue-Supported Rating Criteria', June 12, 2012;
- 'Nonprofit Hospitals and Health Systems Rating Criteria', July 23, 2012.

For information on Build America Bonds, visit 'www.fitchratings.com/BABs'.

Applicable Criteria and Related Research

Revenue-Supported Rating Criteria

http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=681015

Nonprofit Hospitals and Health Systems Rating Criteria

http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=683418

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Research

Sullivan County Health Educational & Housing Facilities Board, Tennessee Wellmont Health System; System

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Sullivan County Health Educational & Housing Facilities Board, Tennessee

Wellmont Health System; System

Credit Profile

Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee

Wellmont Hlth Sys, Tennessee

Ser 2006C

Long Term Rating

BBB+/Negative

Outlook Revised

Rationale

Standard & Poor's Ratings Services revised its outlook to negative from stable and affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on \$356.4 million in bonds, including series 2003, 2006C, 2007A, and 2011, issued for Wellmont Health System, Tenn. by various issuing authorities.

The long-term and short-term ratings on Wellmont's \$54.8 million series 2005 variable-rate demand obligations are 'A+/A-1' and are based solely on the support of JP Morgan Chase Bank N.A. (A+/A-1), the letter of credit provider.

The 'BBB+' rating is based on our view of Wellmont Health System's group credit profile and core status as the obligated group that includes Wellmont Health System (as parent); Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary; and the system's fundraising arm. Accordingly, the bonds are rated at the same level as the group credit profile. The negative outlook and affirmed 'BBB+' ratings reflect our view of Wellmont's operating and financial metrics, which while still adequate for the rating level have trended lower and are expected to weaken during fiscal 2014. The rating is supported by the system's stable enterprise profile. In addition, we believe that Wellmont is well positioned for operational success with respect to its markets, its competition, and the changing reimbursement environment.

More specifically, the ratings reflect our opinion of Wellmont's:

- Solid financial metrics, including positive fiscal 2013 operating income of \$11.7 million (a 1.5% margin), as per Standard & Poor's calculations;
- Acceptable 2.5x fiscal year-end maximum annual debt service (MADS) coverage;
- Improved balance sheet, highlighted by the system's 218 days' cash on hand, moderately elevated 48% long-term debt to total capitalization, and unrestricted cash to long-term debt of 90% as of Sept. 30, 2013, and as per Standard & Poor's calculations; and
- Solid business position characterized by good market share in a demographically favorable region that is largely dominated by two health care systems.

Further supporting the ratings is our view of revenue cycle, staffing, expense, and other operating improvements that have helped Wellmont generate favorable operating results during the past four years. In addition, we expect

Wellmont's balance sheet will remain robust, since it has limited capital spending needs for the foreseeable future.

Partially offsetting the above-noted strengths, in our opinion, is Wellmont's plan to issue roughly \$13.5 million of new debt in fiscal 2014, as well as management's ongoing Epic IT Platform implementation, which over last year and during the next four years will involve a total of about \$95 million to \$100 million of capital spending. While the transition to Epic could still potentially involve some disruption to Wellmont's operations, management believes that it is very well prepared to undertake the implementation and successfully implemented its electronic health record during the previous two years.

In addition, while we believe that major facilities acquisitions are done now that most of the desirable candidates in the markets served by Wellmont and its major competitor have been acquired, we continue to believe that competition for patient volumes between these two sizable systems remains intense.

As of June 30, 2013, Wellmont had \$476 million of bonded debt and capital leases. About \$78 million of Wellmont's outstanding debt is variable-rate obligations, including \$23 million in bank qualified directly placed index floating-rate bonds (not rated). The variable-rate obligations have tender provisions that may allow the bonds to be redeemed before maturity. In our opinion, the amount of puttable debt relative to unrestricted cash as of June 30, 2013, is negligible, at less than 10%. We understand that Wellmont may issue approximately \$13.5 million of incremental debt in fiscal 2014, and, in our opinion, the system has capacity to issue this level of additional debt without negatively affecting the ratings.

Wellmont uses interest rate swaps to partially hedge its interest rate risk. Wellmont has four swaps totaling \$220 million notional principal; Lehman Brothers Special Financing is the counterparty for three of the swaps, and Bank of America Merrill Lynch is the counterparty for a \$76.1 million total return swap entered into in 2011. In our opinion, the risks associated with Wellmont's derivatives portfolio are moderate at this time. Wellmont's swap liability was \$7.4 million at June 30, 2013, and there is no required collateral posting. The estate of Lehman Brothers recently filed suit seeking \$21 million of damages from Wellmont in disputed claims related to Wellmont's termination of a total return swap on its series 2006A bonds. Management believes that the suit is without merit and plans to vigorously defend itself.

The system remains in compliance with all bank and bond covenants. Gross revenues of the obligated group and a mortgage on Wellmont's two largest hospitals, Bristol Regional Medical Center and Holston Valley Medical Center, as well as a mortgage on Mountain View Regional Medical Center, a community hospital, secure the bonds. Gross revenues from Lee Regional Medical Center also formerly secured the bonds; however, the facility was recently closed. The obligated group includes the parent, Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary, and the system's fundraising arm. Six of the system's hospitals are included by virtue of operating as unincorporated divisions of the parent: Holston Valley Medical Center, Bristol Regional Medical Center, Lonesome Pine Hospital, Hancock County Hospital, Lee Regional Medical Center, and Mountain View Regional Medical Center. All of the system's entities are included for the purpose of our calculations in this report.

Outlook

The negative outlook reflects our view of Wellmont's weaker fiscal 2013 and year-to-date operating performance reflecting a decline in patient volumes, higher drug costs, and the step down in meaningful use funds (as expected) leading to more modest coverage at MADS. Management is also expecting a further downturn in operating income for fiscal 2014. While we believe that Wellmont's balance sheet remains robust enough to support current rating, we believe that operating results are likely to be challenged during the two-year outlook period by the changes being brought about by health reform, potentially leading to weaker balance sheet metrics and substandard coverage for the rating level. Should Wellmont's coverage at MADS fall to and be sustained below 2.0x or if unrestricted liquidity falls to fewer than 150 days or 70% of long-term debt, then a downgrade would become more likely. We do not expect to raise the ratings during the outlook period.

While most of Wellmont's major bricks-and-mortar capital spending initiatives have been completed, the system continues to incur capital spending for its Epic IT Platform. We are also aware that Wellmont plans to incur about \$13.5 million of new debt in fiscal 2014, and while the details are uncertain at this time, we believe that the system maintains adequate capacity to support this level of incremental debt at the existing rating level.

Enterprise Profile

Wellmont is a seven-hospital system headquartered in Kingsport, Tenn., and is composed of 781 staffed beds including managed (not owned acute), psych, rehab, and skilled nursing facility) inpatient beds. The system's facilities are located in Tennessee and Virginia. Acute discharges totaled 37,798 in fiscal 2013, down 5.8% from fiscal 2012 (which was down 4.6% from fiscal 2011). Total bedded volumes, including observations, declined to 51,539 from 53,790, or by 4.2%, compared with the previous fiscal year. The system's outpatient registrations continue to grow, and totaled 210,044 in fiscal 2013, up from 209,024 in fiscal 2012. Combined surgery volumes were essentially flat while emergency department volumes were lower (by 6.7%), reflecting the presence of three urgent-care centers that are treating patients in a lower-cost setting.

Management remains focused on the system's ambulatory strategy, which has included the creation of a strategic infrastructure around oncology and cardiology centers of excellence. Pulmonology is also a service line that management considers a strategic focus. Although in the past several years Wellmont had focused on the acquisition of hospitals and facilities, both in Tennessee and in Virginia, facilities acquisition activity is completed and there are very few desirable remaining acquisition candidates in the system's service area that are not already affiliated with Wellmont or its major competitor.

Management's current strategy is to maintain or develop outposts to draw patients from a larger geographic area without having to have a hospital located in those areas and to focus on its strategy regarding the continuum of care including the recently announced acquisition of Wexford House, a post-acute care facility. In addition, management plans to capitalize on its strengths in core service lines supported by its new dyad leadership model, which appears to be creating favorable results through improved patient satisfaction scores.

To address the decline in patient volumes and the resultant effect on operations, Wellmont has eliminated the duplicative administrative overhead at each hospital and consolidated most administrative functions to the system level. In addition, the system has closed inpatient units to improve occupancy and efficiency, established 24/7 case management coverage in its emergency departments, and opened dedicated observation units to better match the cost of care to revenues.

Management

We believe that Wellmont is led by a capable leadership team headed by Denny DeNarvaez, CEO, who joined Wellmont in 2010 following her service to St. John's Mercy Healthcare as CEO. In August 2012 Wellmont named Alice Pope CFO. Ms. Pope previously served as SVP finance managed care and revenue cycle for the system, and has served in various roles with the organization during the past 12 years.

Financial Profile

In accordance with the publication of our article, "New Bad Debt Accounting Rules Will Alter Some U.S. Not-for-Profit Health Care Ratios But Won't Affect Ratings," on Jan.

19, 2012, we have reflected Wellmont's 2012 and 2013 audited results and the year to date interims with the adoption of Financial Accounting Standards Board statement 954 in 2012, but not for prior periods. The new accounting treatment means that Wellmont's fiscal 2012 and subsequent financial statistics are not directly comparable to the results for 2011 and prior years, nor are they directly comparable to the 2011 median ratios. For an explanation of how each financial measure is affected by the change in accounting for bad debt, including the direction and size of the change, please see the above-mentioned article.

For the fiscal year ended June 30, 2013, Wellmont generated operating income of \$11.7 million (a 1.5% margin) on \$798 million of total net revenues. Results compared with \$20.7 million (a 2.6% margin) on \$789.7 million of total net revenues for fiscal 2012. The decline in operating results in fiscal 2013 and for the year to date ended Sept. 30, which saw net operating income of \$580,000 (a 0.3% margin), reflects weaker volumes, the more challenging reimbursement environment, and Wellmont's cost structure, which was too high given the declining revenues. Management is addressing its costs through reduced staffing and the efficiency initiatives noted earlier, including the opening of a dedicated observation units and the elimination of administrative overhead at individual system hospitals.

For the fiscal year, Wellmont's excess revenues, as per Standard & Poor's calculations, were \$29 million (or a 3.6% margin), which included \$19.4 million of realized investment income and gains. Wellmont also had a \$2.1 million loss from discontinued operations.

Cash flow remains acceptable, in our view, as evidenced by a 12.5% EBIDA margin, generating just under 2.5x coverage of Wellmont's \$41.3 million MADS. Operating leases have historically been relatively modest in amount; however, with the monetization of Wellmont's medical office buildings, operating leases have become more material to the system's overall financial profile. Adjusted for operating lease expense, MADS coverage is diluted to 2.0x.

Wellmont's fiscal 2014 budgeted operating income is \$3.9 million inclusive of almost \$9 million of meaningful use

stimulus funds, resulting in an operating margin of about 0.5%. According to management, however, recent reimbursement changes related to CMS's two-midnight rule could have a \$3 million to \$4 million negative impact on Wellmont's reimbursement, which was not known at the time the budget was prepared. In our view, operating performance is becoming more constrained and could be a key issue leading to a lower credit rating in the future.

Balance sheet

Wellmont's balance sheet remains acceptable, in our view, and although management plans to issue \$13.5 million of new debt in fiscal 2014, we believe that the system has some flexibility to issue additional debt at the existing rating level given its improved capitalization during the past four years.

Unrestricted cash and investments totaled \$434 million at Sept. 30, equal to 218 days' cash on hand and 90% of long-term debt, which we view as solid for the rating level. As part of its methodology Wellmont excludes the less liquid investments from the days' cash calculation. By making that adjustment, days' cash declines to about 202 days at Sept. 30, which remains solid and in compliance with Wellmont's minimum covenant level of 100 days. Robust cash flow and minimal capital spending needs allowed cash to grow by more than \$54 million relative to fiscal year-end 2012.

Wellmont's systemwide combined routine and strategic capital budget is \$41.5 million for fiscal 2014 inclusive of approximately \$6 million of funds not yet allocated. The spending budget does not include the remaining spending under the system's budget for converting to a new Epic IT Platform, which is expected to come in below the original \$100 million five-year budget. Wellmont is budgeting for about \$45 million of meaningful use stimulus money, which will help to offset the cost of its Epic conversion. Other than modest strategic and equipment-related capital spending and the planned spending for its Epic IT Platform conversion, Wellmont has limited other capital spending plans. As a result, we anticipate that the system's liquidity will continue to grow.

Wellmont Health System				
		<u>Fiscal Year Ended June 30,</u>		
	Three-Month Interim Ended Sept. 30, 2013	2013	2012	2011
Financial performance				
Net patient revenue (\$000s)	185,220	754,488	741,822	767,450
Total operating revenue (\$000s)	194,051	798,223	789,726	797,249
Total operating expenses (\$000s)	193,471	786,507	769,073	781,322
Operating income (\$000s)	580	11,716	20,653	15,927
Operating margin (%)	0.30	1.47	2.62	2.00
Net nonoperating income (\$000s)	1,807	17,300	17,360	9,908
Excess income (\$000s)	2,387	29,016	38,013	25,835
Excess margin (%)	1.22	3.56	4.71	3.20
Operating EBIDA margin (%)	9.40	10.63	11.24	10.38
EBIDA margin (%)	10.24	12.53	13.15	11.48
Net available for debt service (\$000s)	20,052	102,241	106,093	92,644
Maximum annual debt service (\$000s)	41,310	41,310	41,310	41,310
Maximum annual debt service coverage (x)	1.94	2.47	2.57	2.24
Operating lease-adjusted coverage (x)	N.A.	2.02	2.07	1.86

Wellmont Health System (cont.)

Liquidity and financial flexibility

Unrestricted cash and investments (\$000s)	433,634	426,182	379,544	346,881
Unrestricted days' cash on hand	218.5	211.6	191.7	172.2
Unrestricted cash/total long-term debt (%)	90.0	89.5	82.6	75.5
Capital expenditures/depreciation and amortization (%)	84.6	112.4	99.2	92.0

Debt and liabilities

Total long-term debt (\$000s)	481,710	475,946	459,654	459,260
Long-term debt/capitalization (%)	48.1	48.4	49.9	51.2
Debt burden (%)	5.27	5.05	5.12	5.11

N.A.: Not available.

Related Criteria And Research

Related Criteria

- USPF Criteria: Municipal Swaps, June 27, 2007
- USPF Criteria: Not-For-Profit Health Care, June 14, 2007

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- U.S. Not-For-Profit Health Care Sector Outlook: Providers Prove Adaptable But Face A Test In 2013 As Reform Looms, Jan. 4, 2013
- U.S. Not-For-Profit Health Care System Ratios: Metrics Remain Steady As Providers Navigate An Evolving Environment, Aug. 8, 2013
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013
- U.S. Not-For-Profit Health Care Providers Hone Their Strategies For Reform, May 16, 2011

Ratings Detail (As Of December 18, 2013)

Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee

Wellmont Hlth Sys, Tennessee

Ser 2003

Unenhanced Rating BBB+(SPUR)/Negative Outlook Revised

Ser 2011

Long Term Rating BBB+/Negative Outlook Revised

Virginia Small Business Fin Auth, Virginia

Wellmont Hlth Sys, Tennessee

Ser 2007A

Long Term Rating BBB+/Negative Outlook Revised

Many issues are enhanced by bond insurance.

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FITCH AFFIRMS WELLMONT HEALTH SYSTEM, TN REVS AT 'BBB+'; OUTLOOK STABLE

Fitch Ratings-New York-10 April 2014: Fitch Ratings affirms the 'BBB+' rating on the following Health, Education and Housing Facilities Board of the County of Sullivan, Tennessee bonds issued on behalf of Wellmont Health System (Wellmont):

- \$76,165,000, hospital revenue refunding bonds (Wellmont Health System Project), series 2011;
- \$200,000,000 hospital revenue bonds, series 2006C (Wellmont Health System Project);
- \$54,820,000 hospital revenue refunding bonds, series 2005 (Wellmont Health System Project);
- \$25,225,000 hospital revenue refunding bonds, series 2003 (Wellmont Health System Project).

In addition, Fitch affirms at 'BBB+' the following parity debt also issued on behalf of Wellmont:

- \$55,000,000 Virginia Small Business Financing Authority hospital revenue bonds, series 2007A (Wellmont Health System Project).

The Rating Outlook is Stable.

KEY RATING DRIVERS:

STRONG OPERATING EBITDA: Wellmont's operating EBITDA is consistently above Fitch's 'BBB' category median, averaging 11.5% over the past four audited years and at 9.9% in the six-month fiscal 2014 (June 30 year-end) interim period.

LIQUIDITY A CREDIT STRENGTH: Wellmont has \$419.6 million in unrestricted cash and investments (not including \$27 million in illiquid funds) at Dec. 31, 2013, a 6% year-over-year increase. Wellmont's key liquidity figures compare favorably to Fitch's 'BBB' medians.

ADEQUATE DEBT SERVICE: Most of Wellmont's financial and capital metrics are consistent with the rating category.

LEADING MARKET SHARE: Wellmont maintains a leading 56% inpatient market share in its defined primary service area (PSA). Although market share has declined slightly in the past few years, Fitch is not concerned, as Wellmont remains competitive in key strategic service lines.

ELEVATED DEBT BURDEN: Maximum annual debt service (MADS) as a percentage of revenue was high at 5.4% in the six-month interim period relative to a Fitch's 'BBB' median of 3.5%. However, after completing a large EPIC implementation at a cost of approximately \$100 million, for which it assumed additional debt, Wellmont's capital spending should slow, which should allow it to moderate its debt burden.

RATING SENSITIVITIES

SEEKING STRATEGIC PARTNER: Wellmont is in the process of evaluating potential strategic partnerships. The process of evaluating and choosing a potential partner is expected to be completed in the next 12 months. The effect of a strategic partnership on Wellmont is not factored into the rating. Fitch will continue to monitor the process and will evaluate a partnership once the process is completed. For the remaining fiscal year, Fitch expects Wellmont's performance to improve slightly as the expenses related to EPIC implementation have been fully absorbed.

Credit Profile

Wellmont Health System (WHS) is a large regional health care system with seven acute hospitals (816 staffed beds) and other related entities located in northeastern TN and southwestern VA. Wellmont had approximately \$798.2 million in total revenue in fiscal 2013.

Financial Summary

The 'BBB+' rating is supported by an overall financial profile consistent with Fitch's 'BBB' rating category medians and Wellmont's leading inpatient market share in its defined PSA. Wellmont finished fiscal 2013 with a 1.6% operating margin and MADS coverage of 2.6x, both adequate for the 'BBB' category, but below category medians. Wellmont's operating EBITDA was stronger at 10.8%, above the category median of 9%.

Operations were lower in the first six months of fiscal 2014 due largely to EPIC implementation costs, as Wellmont went live with its physicians in December 2013 and live in its hospitals in late March 2014. For fiscal 2014, Wellmont budgeted for \$13.5 million of implementation expenses that cannot be capitalized, with a portion of those expenses coming in the first half of the fiscal year. However, Wellmont did anticipate these expenses and is tracking ahead of budget for the first six months. In the first six months of fiscal 2014, Wellmont posted a 1.2% operating margin and 2.2x debt service coverage, compared to a 1.6% operating margin and 2.5x debt service coverage for the first six months of fiscal 2013. Wellmont's management reports that performance continues to be ahead of budget through February 2014, and Fitch expects Wellmont's operating performance to continue to improve through the end of the fiscal year.

Liquidity has continued to strengthen with unrestricted cash growing 6% in the year-over-year interim period and 49% from fiscal year-end 2010. At Dec. 31, 2013, Wellmont had cash and unrestricted investments of \$419.6 million (excluding \$27 million in illiquid investments), which equated to days cash on hand of 213.3, a cushion ratio of 10x, and cash-to-debt of 82.6%, which compare well to 'BBB' category medians of 144.7, 10.2, and 91.7, respectively.

Wellmont's debt burden remains elevated for the rating level, as represented by MADS as a percentage of revenue of 5.4% and debt-to-EBITDA of 5.5x. as of Dec. 31, 2013, both of which compare unfavorably to 'BBB' category medians. However, Fitch expects debt to moderate with the EPIC implementation completed. Wellmont is issuing bank debt to acquire a skilled nursing facility, Wexford House, but the facility is producing enough cash flow to cover the additional debt.

Fitch views the acquisition as credit neutral. The skilled nursing facility will build on Wellmont's efforts to prepare for population health management and other aspects of health care reform. Other initiatives in this effort include participating in an Accountable Care Organization, structuring shared savings contracts with select payors, and continuing to position the organization as the low-cost, high-quality provider for the region.

Potential Strategic Partnerships

Wellmont is actively exploring a strategic partnership through a formal RFP process.

Wellmont plans to evaluate the RFP responses, and Fitch expects a decision to be made within the next rating cycle. The financial arrangement of a potential partnership is not clear and could range from a loose affiliation to a full asset merger. Fitch views the potential partnership as credit neutral as much will depend on the outcome of the process and the final partner. However, Fitch notes positively that Wellmont is entering the process from a position of credit strength with a strong balance sheet, good market position, and consistent levels of operations and debt service coverage.

Debt Profile

Wellmont's debt portfolio is relatively conservative with approximately 15% of its \$508 million of long-term debt in variable-rate mode. However, Wellmont does have four swaps. Two are fixed payor swaps, one is a basis swap, and one is a total return swap.

There are no collateral posting requirements at the current rating level. The aggregate mark to market as of Dec. 31, 2013 was a negative \$7.2 million.

In addition, Wellmont is planning to restructure some of its debt in the next three months. Fitch expects that the covenants for that debt will remain consistent with the current covenants.

Disclosure

WHS covenants to provide audited financial statements to the Municipal Securities Rulemaking Board's Electronic Municipal Market Access system (EMMA), as well as quarterly unaudited statements.

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Applicable Criteria and Related Research:

--Rating Guidelines for Nonprofit Hospitals and Health Systems, May 20, 2013

For information on Build America Bonds, visit 'www.fitchratings.com/BABs'.

Applicable Criteria and Related Research:

Rating Guidelines for Nonprofit Continuing Care Retirement Communities
http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=40171

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Wellmont Health System, Tennessee; System

Credit Profile

Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee

Wellmont Hlth Sys, Tennessee

Ser 2006C

Long Term Rating

BBB+/Stable

Outlook Revised

Rationale

Standard & Poor's Ratings Services revised its outlook to stable from negative and affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on \$135 million in bonds, including series 2006C, 2007A, and 2011, issued for Wellmont Health System, Tenn. by various issuing authorities.

The 'BBB+' rating is based on our view of Wellmont Health System's group credit profile and core status as the obligated group, which includes Wellmont Health System (as parent); Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary; and the system's fundraising arm. Accordingly, the bonds are rated at the same level as the group credit profile. The stable outlook and affirmed 'BBB+' ratings reflect our view of Wellmont's operating and financial metrics, which were adequate for the rating level in fiscal 2014 and showed improvement during the first fiscal quarter of 2015. The rating is supported by the system's stable enterprise profile. While we understand that management is considering strategic options to strengthen the system's operational viability under health reform, we still believe that Wellmont is adequately positioned for operational success with respect to its markets, its competition, and the changing reimbursement environment.

More specifically, the ratings reflect our opinion of Wellmont's:

- Light but adequate financial metrics, including positive fiscal 2014 operating income of \$3.3 million (a 0.43% margin), as per Standard & Poor's calculations;
- Acceptable 2.0x fiscal year-end maximum annual debt service (MADS) coverage;
- Acceptable balance sheet, highlighted by the system's 212 days' cash on hand, moderately elevated 47% long-term debt to total capitalization, and unrestricted cash to long-term debt of 89% as of Sept. 30, 2014, and as per Standard & Poor's calculations; and
- Solid business position characterized by good market share in a demographically favorable region that is largely dominated by two health care systems.

Further supporting the ratings is our view of revenue cycle, staffing, expense, and other operating initiatives that will likely help Wellmont generate better operating results over time. In addition, we expect Wellmont's balance sheet will remain robust since Wellmont has limited capital spending needs for the foreseeable future.

Partly offsetting rating factors include Wellmont's reliance on supplemental reimbursement and meaningful-use stimulus funds to generate the system's positive net from operations during the past two to three years. In addition, we believe that competition for patient volumes between Wellmont and its main competitors remains intense.

As of Sept. 30, 2014, Wellmont had \$484 million of bonded debt and capital leases. About \$123 million of Wellmont's outstanding debt is variable-rate bank direct purchase obligations. The variable-rate obligations have tender provisions that may allow the bonds to be redeemed before maturity. In our opinion, unrestricted cash to puttable debt as of Sept. 30, 2014, was robust, at about 3.5x.

Wellmont uses interest rate swaps to partly hedge its interest rate risk. Wellmont has four swaps totaling \$260 million notional principal; Lehman Brothers Special Financing is the counterparty for three of the swaps, and Bank of America Merrill Lynch is the counterparty for a \$74.4 million total return swap entered into in 2011. In our opinion, the risks associated with Wellmont's derivatives portfolio are moderate at this time. Wellmont's swap liability was \$5.7 million at Dec. 31, 2014, and there is no required collateral posting.

The system remains in compliance with all bank and bond covenants. Gross revenues of the obligated group and a mortgage on Wellmont's two largest hospitals, Bristol Regional Medical Center and Holston Valley Medical Center, secure the bonds. The obligated group includes the parent, Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary, and the system's fundraising arm. All of the system's entities are included for the purpose of our calculations in this report.

Outlook

The stable outlook reflects our view of Wellmont's weak fiscal 2014, but improved fiscal 2015 year-to-date, results, supported by the service line expansions, the completion of Wellmont's Epic installation last year, and operational improvement initiatives. While we believe that Wellmont's balance sheet remains robust enough to support the current rating, we believe that operating results may continue to be challenged during the two-year outlook period by the changes being brought about by health reform, potentially leading to weaker balance sheet metrics and lower-than-desirable coverage relative to the rating level.

Downside scenario

Should Wellmont's fiscal 2015 results fall short of budgeted expectations, MADS coverage fall to and be sustained at below 2.0x, or unrestricted liquidity fall to fewer than 150 days or 70% of long-term debt, then a downgrade would become more likely.

Upside scenario

While we do not expect to raise the ratings during the outlook period, we could do so over time in response to, at a minimum, sustained improved operating performance, a moderation in Wellmont's leverage, and no material decline in the system's enterprise profile, which includes market share.

Enterprise Profile

Following the closure of Lee Regional in October 2013, Wellmont is a six-hospital system headquartered in Kingsport, Tenn., and is composed of 711 staffed beds, including acute, psych, rehab, and skilled nursing facility inpatient beds. The system's facilities are located in Tennessee and Virginia. Acute discharges totaled 34,917 in fiscal 2014, down 7.6% from fiscal 2013 (which was down 5.8% from fiscal 2012), although we note that patient volume declines have

not been adjusted for the closure of Lee Regional in October 2013. Inclusive of the same-store adjustment, inpatient volumes declined about 5.7%. Likewise, but also not adjusted on a same-store basis, equivalent inpatient admissions declined to 85,112 from 87,434, or by 2.7%. Combined surgery volumes were essentially flat while emergency department volumes were lower (by 7.1%), reflecting the presence of five urgent-care centers that are treating patients in a lower-cost setting.

Management remains focused on the system's ambulatory strategy, which has included the creation of a strategic infrastructure around oncology and cardiology centers of excellence. Orthopedics, neurology, and pulmonology are also service lines that management considers a strategic focus, along with post-acute and long-term care. Management plans to capitalize on its strengths in core service lines, supported by its dyad leadership model.

Also, in recognition of the challenging operating environment, Wellmont is exploring its strategic options around alignment with another health system. We understand that the system's board will likely reach a decision in early 2015. In our view, alignment with another strong provider will be a credit positive for the system.

Management

We believe that Wellmont is led by a capable leadership team headed by Bart Hove, CEO, who formerly served as the president of Wellmont's Bristol Regional Hospital and took over the system's CEO responsibilities in September 2014, following the departure of Denny DeNarvaez. Wellmont's CFO is Alice Pope, who has served in her current role since 2012 and has been with Wellmont for 15 years. Wellmont's COO is Eric Deaton, who recently rejoined the system after previously having worked for Wellmont for four years.

Financial Profile

For the fiscal year ended June 30, 2014, Wellmont generated operating income of \$3.3 million (a 0.4% margin), under Standard & Poor's methodology, on \$773 million of total net revenues. Results were down from \$11.7 million (a 1.5% margin) on \$798 million of total net revenues for fiscal 2013. The decline in operating results in fiscal 2014 reflects continued weaker volumes; the challenging reimbursement environment, including the effects of Medicare's two-midnight rule for observation patients; and operational inefficiencies. Management is addressing operational inefficiencies through supply chain, labor, and service line initiatives with a goal of reducing expenses by about \$25 million per year. Wellmont's excess revenues, as per Standard & Poor's calculations, were \$33 million (or a 4.1% margin), which included \$15 million of realized investment income and gains.

Cash flow remains acceptable, in our view, as evidenced by an 11% EBIDA margin, generating 2.0x coverage of Wellmont's \$42.8 million MADS. Operating leases have historically been relatively modest in amount; however, with the monetization of Wellmont's medical office buildings, operating leases have become more material to the system's overall financial profile. Adjusted for operating lease expense, MADS coverage is diluted to 1.8x.

Year-to-date results through September 2014 reflected an improvement in operating income of \$4.5 million (or a 2.2% margin) on \$205 million of operating revenues, producing 2.6x MADS coverage on an annualized basis. We understand that through six months Wellmont's consolidated results exceed budget and results for the same period last year.

Wellmont's fiscal 2015 budgeted operating income is just over break even, inclusive of \$4 million of meaningful-use stimulus funds, although results year to date point to a stronger-than-budgeted fiscal 2015. While the operating environment remains challenging, we believe that the Wellmont board's decision to consider an alignment with another system is positive strategic step to help Wellmont remain a healthy system over the long term.

Balance sheet

Wellmont's balance sheet remains acceptable, in our view. Unrestricted cash and investments totaled \$431 million at Sept. 30, equal to 212 days' cash on hand and 89% of long-term debt, which we view as solid for the rating level and in compliance with Wellmont's minimum covenant level of 100 days. We view the system's 47% leverage to be manageable and in line with the median for the rating level. We understand that management has no current plans to issue additional debt.

Wellmont's systemwide combined routine and strategic capital budget is \$35 million for fiscal 2015, inclusive of approximately \$3 million of funds not yet allocated. With the completion of the system's Epic implementation last year, capital spending needs are more limited and approximate about 70% of depreciation. As a result, we anticipate that the system's liquidity will continue to grow.

Wellmont Health System

	Fiscal year ended June 30,			Medians		
	Three-month interim ended Sept. 30, 2014	2014	2013	2012	Health care system BBB+ 2013	Health care system A- 2013
Selected financial statistics						
Inpatient admissions	8,347	34,917	37,798	40,121	MNR	MNR
Emergency visits	45,588	170,331	183,378	208,013	MNR	MNR
Inpatient surgeries	2,353	9,430	9,101	9,418	MNR	MNR
Outpatient surgeries	6,442	24,896	25,118	26,839	MNR	MNR
Based on net/gross revenues	Gross	Gross	Gross	Gross	MNR	MNR
Medicare %	54.4	54.3	53.2	52.9	MNR	MNR
Medicaid %	10.9	11.1	11.5	11.4	MNR	MNR
Commercial/blues %	28.7	27.7	24.8	25.3	MNR	MNR
Financial profile						
Financial performance						
Net patient revenue (\$000s)	198,716	743,266	754,488	741,822	1,049,981	1,567,503
Total operating revenue (\$000s)	204,521	772,707	798,223	789,726	MNR	MNR
Total operating expenses (\$000s)	200,040	769,403	786,507	769,073	MNR	MNR
Operating income (\$000s)	4,481	3,304	11,716	20,653	MNR	MNR
Operating margin (%)	2.19	0.43	1.47	2.62	0.90	1.50
Net nonoperating income (\$000s)	3,554	14,749	17,300	17,360	MNR	MNR
Excess income (\$000s)	8,035	18,053	29,016	38,013	MNR	MNR
Excess margin (%)	3.86	2.29	3.56	4.71	3.00	3.60
Operating EBIDA margin (%)	11.59	9.28	10.63	11.24	8.90	8.40
EBIDA margin (%)	13.10	10.98	12.53	13.15	10.20	9.50

Wellmont Health System (cont.)						
Net available for debt service (\$000s)	27,248	86,461	102,241	106,093	115,667	166,108
Maximum annual debt service (\$000s)	42,797	42,797	42,797	42,797	MNR	MNR
Maximum annual debt service coverage (x)	2.55	2.02	2.39	2.48	2.50	3.40
Operating lease-adjusted coverage (x)	2.55	1.75	1.97	2.02	2.10	2.60
Liquidity and financial flexibility						
Unrestricted reserves (\$000s)	430,895	447,156	426,182	379,544	574,523	761,463
Unrestricted days' cash on hand	211.8	226.9	211.6	191.7	144.60	163.90
Unrestricted reserves/total long-term debt (%)	89.3	91.2	89.5	82.6	106.70	119.60
Average age of plant (years)	N.A.	12.5	11.2	11.4	11.50	11.40
Capital expenditures/depreciation and amortization (%)	36.0	173.6	112.4	99.2	114.10	124.60
Debt and liabilities						
Total long-term debt (\$000s)	482,617	490,443	475,946	459,654	MNR	MNR
Long-term debt/capitalization (%)	47.2	47.5	48.4	49.9	46.20	42.50
Debt burden (%)	5.14	5.43	5.23	5.30	3.00	2.70
Defined benefit plan funded status (%)	N.A.	80.39	79.52	68.03	80.20	79.90

MNR: Median not reported. N.A.: Not available. Note: Fiscal 2012 and 2013 patient volumes include Lee Regional, which as of Oct. 1, 2013, became a discontinued operation.

Related Criteria And Research

Related Criteria

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- USPF Criteria: Commercial Paper, VRDO, And Self-Liquidity, July 3, 2007
- USPF Criteria: Contingent Liquidity Risks, March 5, 2012
- General Criteria: Methodology: Industry Risk, Nov. 20, 2013

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- U.S. Not-For-Profit Health Care Outlook Remains Negative Despite A Glimmer Of Relief , Dec. 17, 2014
- U.S. Not-For-Profit Health Care System Ratios: Operating Performance Weakened In 2013, Aug. 13, 2014
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013
- Standard & Poor's Assigns Industry Risk Assessments To 38 Nonfinancial Corporate Industries, Nov. 20, 2013
- Alternative Financing: Disclosure Is Critical To Credit Analysis In Public Finance, Feb. 18, 2014
- Health Care Organizations See Integration And Greater Transparency As Prescriptions For Success, May 19, 2014

Ratings Detail (As Of February 4, 2015)

Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee

Wellmont Hlth Sys, Tennessee

Ser 2011

Long Term Rating

BBB+/Stable

Outlook Revised

Ratings Detail (As Of February 4, 2015) (cont.)

Virginia Small Business Fin Auth, Virginia

Wellmont Hlth Sys, Tennessee

Ser 2007A

Long Term Rating

BBB+/Stable

Outlook Revised

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Research

Bulletin:

Mountain States Health Alliance-Wellmont Health System Merger Does Not Affect Ratings

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DALLAS (Standard & Poor's) April 2, 2015--Standard & Poor's Ratings Services said today that Mountain States Health Alliance's (BBB+/Stable) and Wellmont Health System's (BBB+/Stable) agreement of intent to merge has no immediate effect on ratings. The proposed merger will be a true merger, with equal representation of board members, under a new name for the combined organization to be agreed upon at a later date. We understand that Wellmont and Mountain States will enter into due diligence with anticipated finalization of an agreement by the end of August 2015, completion of regulatory review within 90 days after that, and closing of the merger not later than Dec. 31, 2015.

Mountain States is a 13-hospital system with facilities in Tennessee and Virginia and more than 1,300 staffed acute-care beds along with numerous outpatient facilities. Wellmont is a six-hospital system with facilities in Tennessee and Virginia and operates more than 700 acute-care beds.

While details of the merger remain to be addressed, we understand that the two entities will likely combine their balance sheets and that both organizations are committed to reducing debt. In our view, the merged organization will likely have opportunities for cost reduction and other operating synergies, but at this point detailed benefits of the merger cannot be fully evaluated.

Bulletin: Mountain States Health Alliance-Wellmont Health System Merger Does Not Affect Ratings

We believe that it is likely the two systems will successfully reach a final agreement to merge and that any regulatory issues will be addressed. We are not taking rating action at this time.

Standard & Poor's will review and evaluate the merger integration plan and wait on a final agreement between Mountain States and Wellmont before forming a rating opinion later this year.

For more information on Wellmont Health System, please see our report published Feb. 4, 2015, on RatingsDirect. For more information on Mountain States Health Alliance, please see our report published Jan. 9, 2015.

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Exhibit 11.6

The current annual budget for Mountain States is considered competitively sensitive information under federal antitrust laws and will be subsequently filed.

Exhibit 11.7

The current annual budget for Wellmont is considered competitively sensitive information under federal antitrust laws and will be subsequently filed.

Exhibit 11.8

Five Year Projected Budget for the New Health System

FTI Consulting ("FTI") was engaged by the Parties for the purpose of providing an independent and objective review focused on the identification and quantification of potential economies and efficiencies gained through the integration of Wellmont Health System (WHS) and Mountain States Health Alliance (MSHA). Through the development of a financial model (the "Financial Model"), FTI calculated baseline ("Baseline") financial statements for the combined New Health System. The "Baseline" financial statements served as the source for the creation of financial statements for the New Health System to demonstrate the expected impact of the identified synergies of the merger, the "Preliminary Efficiencies" financial statements.

The work completed by FTI was performed by members of FTI's Health Solutions Practice. This Practice consists of over 300 professionals including clinicians, healthcare executives, strategists, and functional specialists located in 27 offices across the United States. Many of FTI's Health Solutions executives have more than 25 years of experience leading health systems, hospitals, and physician organizations; designing and implementing enhanced performance programs; and performing complex healthcare operational and financial analyses. In performance of our work, FTI utilized processes, procedures and methodologies consistent with merger, affiliation and cost efficiency work that we have performed for other healthcare clients. The FTI Team included one member who was involved in the Memorial Mission Hospital/St. Joseph's Hospital COPA development in 1995. FTI created the Financial Model in accordance with Generally Accepted Accounting Principles ("GAAP").

Financial Model

Creation of the Financial Model. The "Baseline" Financial Model portrays the combined operations of the Parties primarily utilizing information contained within the audited financial statements as well as other publicly available data. This financial information is referred to as the "Baseline" financials or the (A + B = C) financial statements. Out of an abundance of caution, FTI worked under a Black Box agreement and established a "Black Box Team" in order to be able to review and take into consideration information that could be deemed proprietary and confidential in creating the assumptions that underpin the projections in our Financial Model.

The "Preliminary Efficiencies" financial statements for the New Health System in FTI's financial model reflect the impacts from the potential efficiency savings to be derived from the synergies identified as well as the expenditures related to the intended uses of efficiency savings for the public benefit as determined by the Parties. The "Preliminary Efficiencies" financial statements are built off of the "Baseline" financial statements. These statements are intended to represent the financial impacts to the New Health System as the result of achieving the identified efficiency savings and investing in the new public benefit initiatives.

In creating both the “Baseline” and “Preliminary Efficiencies” financial statements, the FTI “Clean Team” members considered, but did not directly incorporate in an identifiable way, specific financial information provided by each individual organization in their business plans, projections, or any other source of information that was deemed to be confidential or proprietary given the competitive environment in which the Parties currently operate. All assumptions related to projections in pricing, volume, costs, and other income and expenses are based on the Parties’ combined historical performance, adjusted by FTI’s understanding of the health care provider industry and experience in developing financial forecasting models. Certain financial line items have been consolidated, blended or otherwise adjusted to protect the confidentiality of proprietary information, where applicable.

Both the “Baseline” and “Preliminary Efficiencies” financials include an income statement, balance sheet, and a statement of cash flows. In addition to those schedules, FTI created (1) debt schedules, and (2) PP&E and Capital Expenditures schedules. These schedules calculate certain balance sheet accounts that are dependent on income statement accounts and other investing or financing activities that are not reflected on the face of the income statement.

Timing and Phases of Efficiency Assumptions. During discussions with the Parties’ Management teams, FTI validated “phase in” periods separately for each of the efficiencies savings from “Non-Labor”, “Labor” and “Clinical” work areas. No efficiency savings are projected to be implemented in whole or in part until the FYE 6/17, and timing varies based on the agreed upon ability to successfully implement each individual opportunity.

“Baseline Model” – Income Statement. In the points enumerated below, we delineate the key drivers and/or assumptions used in the Baseline Financial Model for the preparation of a combined New Health System Income Statement. The assumptions apply general industry expectations in accordance with historical performance, and do not include any known or anticipated changes in operations for the individual hospitals that would be deemed to be proprietary or confidential in a manner that would allow either Party’s proprietary or confidential information to be calculated.

- **Revenue.** The key drivers for this account are service volume and reimbursement rates, which are built into the model as percentage changes and applied to the prior year volume and reimbursement rates. Service volume is based on adjusted patient days (“APD”) and reimbursement rates utilize net patient service revenue (“NPSR”) per APD as the proxy for reimbursement rates. Revenue includes the revenue related to Joint Ventures (“JVs”) that are consolidated for financial reporting purposes. The net income attributable to the JVs is eliminated in the “Other non-operating items” line in the income statement. The service volume assumptions in the model account for an initial decrease in service volume related to changes in utilization based on industry trends. The later periods reflect consistent service volume based COPA commitments to maintain/expand locations and services currently available to the community. The model assumption for NPSR per APD includes an annual increase of 2.0%.

- **Other Revenues.** The model assumes other revenues remain flat each year over the 5-year forecasted period.
- **Salaries, Wages, & Benefits.** The key drivers for this expense are total paid full-time equivalents (“FTEs”) and average salaries, wages, & benefits (SW&B) per paid FTE. The total paid FTEs is a function of service volume, which is related to APDs; however, the assumption does not include a proportionate decline in paid FTEs and APDs. Since a portion of the staff is corporate overhead and would not necessarily increase or decrease with service volume, FTI reduced the change in FTE’s by 15% of the change in volume (e.g., if patient volume decreased by 2%, then paid FTEs would only decrease by 1.7%). Additionally, there is an independent assumption that applies a percentage change to the prior period average SW&B per paid FTE to calculate the current period SW&B per paid FTE. The total salaries, wages, & benefits is the product of the current period paid FTEs and the current period average SW&B per paid FTE. The model assumption for SW&B per paid FTE is an annual increase of 3.0%.
- **Medical Supplies & Drugs.** The key drivers for these expenses are service volume and product costs. The financial model calculates the average medical supplies & drugs cost per APD from the base period. Then the model incorporates a cost increase from prior period to the current period for the average medical supplies & drugs cost per APD. The total “medical supplies & drugs” expense is the product of the current period medical supplies & drugs cost per APD and the service volume (e.g., APD). The model assumption for the percentage change is an annual increase of 2.5%.
- **Purchased Services Assumption.** The model assumption applies a percentage change to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 3.0%.
- **Interest & Taxes.** The model uses a blended interest rate of 4.0% derived from the historical experience of the Parties. The outstanding long-term debt balance used in the model is described in the “Baseline Debt Schedule” of this document. The model does not include an input for taxes due to their immaterial nature to the Parties historically.
- **Depreciation & Amortization.** The key drivers are rate of depreciation & amortization, asset disposals, and capital expenditures. The primary assumptions that impact these expenses are capital expenditures and the useful life of property, plant, and equipment (“PP&E”). This represents a non-cash expense and is primarily a function of the PP&E on New Health System’s balance sheet.
- **Maintenance & Utilities.** The model applies a percentage change to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 3.0%.
- **Lease & Rental.** The model applies a percentage change to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 2.5%.

- **Other Expenses.** The model applies a percentage change to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 4.0%.
- **Investment Income.** The key drivers are the rate of return on investments and the long-term investments amount on the balance sheet. The total investment income is the product of the rate of return and the long-term investments balance. The model assumes that investment income is rolled into the long-term investment balance at the end of the fiscal year. The model assumption for the interest income is an annual increase of 2.0%.
- **Derivative Valuation Adjustments.** This expense represents an event driven scenario that would produce a non-cash expense. The user of the financial model may manually change this amount given such an event is known; however, the model, as constructed by FTI, does not contemplate such an event.
- **Loss on Refinancing.** This expense represents an event driven scenario that would produce a non-cash expense. The user of the financial model may manually change this amount given such an event is known; however, the model, as constructed by FTI, does not contemplate such an event.
- **Gain on Revaluation of Equity Method Investment.** This expense represents an event driven scenario that would produce a non-cash expense. The user of the financial model may manually change this amount given such an event is known; however, the model, as constructed by FTI, does not contemplate such an event.
- **Discontinued Operations.** This expense represents an event driven scenario that attempts to present financial statements net of the impact from discontinued segments of operations. The user of the financial model may manually change this amount given such an event is known or expected; however, the model, as constructed by FTI, does not contemplate such an event.
- **Income Attributable to Non-Controlling Interest.** MSHA owns a majority interest in three hospital facilities. The total amounts of revenues, expenses, gains, losses and net income attributed to these facilities is included in the “Income Statement” in the appropriate line item classification. The amount of income attributable to the non-controlling interest (minority interest) is reported as “Income attributable to non-controlling interest” in the “Other non-operating section” of the “Income Statement”.

“Baseline Model”– Balance Sheet. In the points enumerated below, FTI delineates the key drivers and/or assumptions used in the Baseline Financial Model for a combined New Health System Balance Sheet. These assumptions apply general health care industry assumptions to the Parties’ combined historical performance and do not include any known or anticipated changes in operations for the individual hospitals that would be deemed to be proprietary or confidential.

- **Cash & Cash Equivalents.** The balance for this asset account is a function of operations, changes in various balance sheet, etc. The “cash & cash equivalents” is calculated on the “Baseline Cash Flow Statement”.
- **Current Portion of Investments.** This asset account is subject to the duration and timing of when long-term investments reach the end of their stated investment period. Although this may vary significantly from period to period based on the New Health System’s investment strategy, FTI incorporated a model assumption that the current portion of investments remains flat each year over the 5-year forecasted period.
- **Patients Accounts Receivable, Net.** This asset account is a function of NPSR from the income statement and a model assumption that estimates average payor payment terms as days sales outstanding (“DSO”). The balance is the product of the average daily NPSR for the current period and the DSO assumption. The model assumption for the DSO is 55.0 each year over the 5-year forecasted period.
- **Other Receivables, Net.** The model applies an independent percentage change assumption to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 5.0%.
- **Inventories & Prepaid Expenses.** This asset account is a function of “medical supplies & drugs” from the income statement and a model assumption that estimates average inventory & prepaid carrying amount called days inventory outstanding (“DIO”). The balance is the product of the average daily “medical supplies & drugs” expense for the current period and the DIO assumption. The model assumption for the DIO is 65.0 each year over the 5-year forecasted period.
- **Long-Term Investments.** This asset account is dependent on the assumptions related to “Investment Income” on the income statement. The model assumption related to this account is that all “Investment Income” is reinvested. Thus, the current period balance in the model is the summation of the prior period account balance and the current period “Investment Income”. The model assumption for the interest income is an annual increase of 2.0%.
- **Property, Plant, & Equipment, Net.** This asset account is dependent on depreciation & amortization, asset disposals, and capital expenditures. The primary assumptions that impact these expenses are capital expenditures and the useful life of property, plant, and equipment (“PP&E”). The asset account is calculated on a separate schedule FTI prepared that includes our assumptions related to capital expenditures, asset disposals, and depreciation of assets.
- **Goodwill.** Changes in this account balance primarily relate to events such as acquisitions or impairment of prior acquisitions. The balance of this account may be changed manually, but the model, as constructed by FTI, assumes there are no changes in the goodwill balance.

- **Net Deferred Financing, Acquisition Costs & Other Charges.** The model applies an independent percentage change assumption to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual decrease of 5.0%.
- **Other Assets.** The model applies an independent percentage change assumption to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 3.0%.
- **Current Portion of Debt & Liabilities.** The model is built to be able to apply an independent percentage change assumption to the prior period amount to calculate the current period amount, if applicable. The model as built by FTI, however, assumes the current portion of debt and liabilities remains flat each year over the 5-year forecasted period.
- **Accounts Payable & Accrued Expenses.** This liability account is a function of certain operating expenses from the income statement and a model assumption that estimates average payment terms as days payables outstanding (“DPO”). The balance is the product of the average daily operating expense for the current period and the DPO assumption. The model assumption for the DPO is 60.0 each year over the 5-year forecasted period.
- **Estimated Third-Party Payor Settlements.** The model applies an independent percentage change assumption to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 2.0%.
- **Long-Term Debt & Liabilities.** The liability account is a function of the principal portion of debt service payments and any new financing or additional principal payments. The balance for this liability is calculated on the “Debt Schedule”, which is discussed later in this section.
- **Retention Bonus Liability.** Since this is an event driven liability and would not likely occur unless an actual merger went into effect, FTI has not included any balance in this liability account for the “Baseline Balance Sheet” in the Baseline model. However, the “Preliminary Efficiencies” balance sheet does include a \$5 million dollar liability for retention bonus liability at 6/30/17 related to the “Uses Expenses”. The liability and remaining portion of the “Uses Expenses” is expected to be paid before 6/30/18.
- **Other Long-Term Liabilities.** The model applies an independent percentage change assumption to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 2.0%.
- **Unrestricted (Net Assets).** This balance is a function of the prior period balance and the “Revenues & Gains in Excess of Expenses & Losses Attributable to the New Health System” on the income statement.

- **Temporarily Restricted (Net Assets).** Since this is an event driven allocation, FTI held this balance flat for each forecasted period and allocated the change in net assets from operations to the “Unrestricted” and the “Non-Controlling Interests” accounts.
- **Permanently Restricted (Net Assets).** Since this is an event driven allocation, FTI held this balance flat for each forecasted period and allocated the change in net assets from operations to the “Unrestricted” and the “Non-Controlling Interests” accounts.
- **Non-Controlling Interests (Net Assets).** MSHA owns a majority interest in three hospital facilities. The non-controlling interest (minority interest) is the portion of equity (net assets) not attributable directly to the majority owner. The non-controlling interest is shown as “Non-controlling interest” in the net assets section of the “Balance Sheet”.

“Preliminary Efficiencies Financial Model”– Functionality & Assumptions. The “Preliminary Efficiencies Financial Model” tabs include the assumptions and results from the “Baseline Income Statement & Balance Sheet” tabs and layers in the anticipated savings from: (1) Non-Labor Efficiencies; (2) Labor Efficiencies; and (3) Clinical Efficiencies. The estimated savings assumptions were presented to and discussed with Management from both Parties and with the Integration Council as well as the “Joint Board Task Force”. Additionally, the “Preliminary Efficiencies Financial Model” includes an additional line item for “Uses expenses related to COPA, excluding D&A expenses” (“Uses Expense”) which includes the estimated expenses related to combination of the hospital systems, COPA compliance costs, and costs associated with providing additional benefits and services to the community. The Uses Expenses were provided by the Integration Council. In FTI’s financial model, the “Preliminary Efficiencies Financial Model” tabs reflect the same assumptions and results as the “Baseline Income Statement & Balance Sheet” tabs previously described, unless modifications to certain assumptions are made by the user, such as the examples provided below.

- **PP&E and Capital Expenditures Schedule.** The “depreciation and amortization expense” and “capital expenditures” may differ from the “Baseline Financial Model” if the user modifies the assumptions within the “PP&E and CapEx schedules” on the “Preliminary Efficiencies” tabs to reflect different decisions or scenarios than those included in the “Baseline Financial Model”. Changes made directly to this schedule within the “Preliminary Efficiencies” model flow directly into the “Preliminary Efficiencies” financial statements, but not into the Baseline financial statements and vice versa, as the “Baseline” and “Preliminary Efficiencies” financial statements operate independently of one another.
- **Debt Schedule.** As is the case with the PP&E and Capital Expenditures Schedules, as described above, the interest expense for this schedule may differ from the “Baseline Income Statement” if certain assumptions within “Preliminary Efficiencies” tabs are modified, since the assumptions within the “Preliminary Efficiencies” financial statements are built and operate independently of the “Baseline” financial statements.

"Baseline" Financial Model Income Statement

Income Statement - NewCo Baseline \$'000s	Actuals			Forecasted				
	FYE 6/13	FYE 6/14	FYE 6/15	FYE 6/16	FYE 6/17	FYE 6/18	FYE 6/19	FYE 6/20
Net patient service revenue ("NPSR")	\$ 1,670,727	\$ 1,671,050	\$ 1,813,472	\$ 1,812,747	\$ 1,886,737	\$ 1,924,471	\$ 1,962,961	\$ 2,002,220
Other revenues:								
Other revenues	120,585	102,581	90,756	90,756	90,756	90,756	90,756	90,756
Total other revenues	120,585	102,581	90,756	90,756	90,756	90,756	90,756	90,756
Total revenue, gains, & support	1,791,312	1,773,631	1,904,228	1,903,502	1,977,492	2,015,227	2,053,716	2,092,976
Expenses:								
Salaries, wages, & benefits	881,530	865,989	925,061	936,615	948,313	960,157	972,150	984,292
Medical supplies & drugs	325,559	330,375	344,718	346,269	362,169	371,224	380,504	390,017
Purchased services	183,607	189,280	196,037	201,918	207,975	214,215	220,641	227,260
Interest & taxes	63,495	62,742	61,453	60,964	59,338	57,756	56,216	54,717
Depreciation & amortization	130,666	121,237	127,336	126,507	126,364	126,828	127,872	129,471
Maintenance & utilities	53,687	54,030	56,561	58,258	60,006	61,806	63,660	65,570
Lease & rental	17,892	15,506	15,435	15,821	16,216	16,622	17,037	17,463
Other	107,995	122,584	143,924	149,681	155,668	161,895	168,371	175,105
Total expenses & losses	1,764,431	1,761,743	1,870,524	1,896,033	1,936,050	1,970,502	2,006,451	2,043,895
Income from operations	26,881	11,888	33,704	7,470	41,442	44,724	47,266	49,080
Non-operating gains:								
Investment income	60,296	65,452	4,883	23,099	23,561	24,032	24,512	25,003
Derivative valuation adjustments	9,474	4,526	19,093	-	-	-	-	-
Loss on refinancing	-	(5,755)	(1,389)	-	-	-	-	-
Gain on revaluation of equity method investment	-	14,744	-	-	-	-	-	-
Non-operating gains, net	69,770	78,967	22,587	23,099	23,561	24,032	24,512	25,003
Revenues & gains in excess of expenses & losses	96,651	90,855	56,291	30,568	65,002	68,756	71,778	74,083
Other non-operating items:								
Discontinued operations	(4,484)	(26,639)	(2,720)	-	-	-	-	-
Income attributable to non-controlling interest	(7,728)	(9,826)	(15,046)	(14,459)	(14,975)	(15,031)	(15,077)	(15,111)
Total other non-operating operations	(12,212)	(36,465)	(17,765)	(14,459)	(14,975)	(15,031)	(15,077)	(15,111)
Revenues & gains in excess of expenses & losses attributable to NewCo	\$ 84,439	\$ 54,390	\$ 38,526	\$ 16,110	\$ 50,027	\$ 53,725	\$ 56,701	\$ 58,972

“Baseline” Financial Model Balance Sheet

Balance Sheet - NewCo Baseline								
\$'000s	Actuals			Forecasted				
	6/30/13	6/30/14	6/30/15	6/30/16	6/30/17	6/30/18	6/30/19	6/30/20
Current assets:								
Cash & cash equivalents	\$ 130,860	\$ 89,859	\$ 128,580	\$ 98,369	\$ 87,482	\$ 80,297	\$ 70,623	\$ 57,914
Current portion of investments	25,447	28,262	22,904	22,904	22,904	22,904	22,904	22,904
Patient accounts receivable, net	271,216	278,583	274,678	273,154	284,303	289,989	295,789	301,704
Other receivables, net	51,463	60,187	41,588	43,667	45,851	48,143	50,551	53,078
Inventories & prepaid expenses	58,383	59,859	63,930	61,664	64,496	66,108	67,761	69,455
Total current assets	537,370	516,750	531,680	499,758	505,035	507,442	507,628	505,056
Other non-current assets:								
Long-term investments	1,037,563	1,124,957	1,154,927	1,178,026	1,201,586	1,225,618	1,250,131	1,275,133
Property, plant, & equipment, net	1,359,023	1,374,010	1,331,657	1,330,150	1,335,035	1,346,020	1,362,851	1,385,318
Goodwill	169,487	208,262	208,179	208,179	208,179	208,179	208,179	208,179
Net deferred financing, acquisition costs & other charges	33,658	30,067	28,972	27,523	26,147	24,840	23,598	22,418
Other assets	47,091	48,870	53,567	55,174	56,830	58,534	60,290	62,099
Total other non-current assets	2,646,822	2,786,166	2,777,303	2,799,052	2,827,778	2,863,191	2,905,049	2,953,148
Total assets	3,184,192	3,302,916	3,308,983	3,298,811	3,332,813	3,370,633	3,412,676	3,458,204
Current liabilities:								
Current portion of debt & liabilities	75,323	73,791	84,731	84,731	84,731	84,731	84,731	84,731
Accounts payable & accrued expenses	242,267	261,554	270,782	268,682	275,199	280,683	286,301	292,056
Estimated third-party payor settlements	33,932	18,888	18,471	18,841	19,217	19,602	19,994	20,394
Total current liabilities	351,523	354,233	373,985	372,254	379,148	385,017	391,027	397,181
Non-current liabilities:								
Long-term debt & liabilities	1,566,294	1,565,512	1,524,098	1,483,455	1,443,897	1,405,393	1,367,915	1,331,438
Retention bonus liability	-	-	-	-	-	-	-	-
Other long-term liabilities	78,447	99,400	81,633	83,265	84,931	86,629	88,362	90,129
Total non-current liabilities	1,644,740	1,664,912	1,605,731	1,566,721	1,528,827	1,492,022	1,456,277	1,421,567
Total liabilities	1,996,263	2,019,145	1,979,715	1,938,975	1,907,975	1,877,038	1,847,304	1,818,748
Net assets:								
Unrestricted	994,348	1,080,586	1,112,232	1,128,342	1,178,369	1,232,094	1,288,796	1,347,767
Temporarily restricted	19,703	20,418	20,508	20,508	20,508	20,508	20,508	20,508
Permanently restricted	1,438	1,446	1,450	1,450	1,450	1,450	1,450	1,450
Noncontrolling interests	172,439	181,321	195,078	209,536	224,511	239,542	254,619	269,730
Total net assets	1,187,929	1,283,771	1,329,268	1,359,836	1,424,838	1,493,594	1,565,372	1,639,456
Total liabilities and net assets	\$ 3,184,192	\$ 3,302,916	\$ 3,308,983	\$ 3,298,811	\$ 3,332,813	\$ 3,370,633	\$ 3,412,676	\$ 3,458,204

“Baseline” Financial Model Statement of Cash Flows

Statement of Cash Flows - NewCo Baseline	Forecasted				
	\$'000s	6/30/16	6/30/17	6/30/18	6/30/19
Cash flows from operating activities:					
Income from operations	\$ 7,470	\$ 41,442	\$ 44,724	\$ 47,266	\$ 49,080
Adjustments to reconcile change in net assets to net cash provided by operating activities:					
Depreciation and amortization	126,507	126,364	126,828	127,872	129,471
Loss on extinguishment of debt	-	-	-	-	-
Change in estimated fair value of derivatives	-	-	-	-	-
Equity in net income of JVs, net	-	-	-	-	-
Loss/(Gain) on disposal of assets	-	-	-	-	-
Capital Appreciation Bond accretion and other	-	-	-	-	-
Restricted contributions	-	-	-	-	-
Pension and other defined benefit plan adjustments	-	-	-	-	-
Increase/(Decrease) in cash due to change in:					
Patient accounts receivable, net	1,524	(11,149)	(5,686)	(5,800)	(5,916)
Other receivables, net	(2,079)	(2,183)	(2,293)	(2,407)	(2,528)
Inventories & prepaid expenses	2,266	(2,832)	(1,612)	(1,653)	(1,694)
Net deferred financing, acquisition costs & other charges	1,449	1,376	1,307	1,242	1,180
Other assets	(1,607)	(1,655)	(1,705)	(1,756)	(1,809)
Current portion of debt & liabilities	-	-	-	-	-
Accounts payable & accrued expenses	(2,100)	6,517	5,485	5,618	5,755
Estimated third-party payor settlements	369	377	384	392	400
Other long-term liabilities	1,633	1,665	1,699	1,733	1,767
Total adjustments	127,962	118,480	124,407	125,241	126,627
Net cash provided by operating activities	135,432	159,922	169,132	172,506	175,707
Cash flows from investing activities:					
Purchases of property, plant, and equipment	(125,000)	(131,250)	(137,813)	(144,703)	(151,938)
Acquisitions, net of cash acquired	-	-	-	-	-
Non-operating gains, net	23,099	23,561	24,032	24,512	25,003
Purchases of held-to-maturity securities	(23,099)	(23,561)	(24,032)	(24,512)	(25,003)
Net distribution from JV's and unconsolidated affiliates	-	-	-	-	-
Proceeds from sale of plant, property, and equipment	-	-	-	-	-
Net cash used in investing activities	(125,000)	(131,250)	(137,813)	(144,703)	(151,938)
Cash flows from financing activities:					
Payments on LT debt and liabilities (net of interest)	(40,643)	(39,559)	(38,504)	(37,477)	(36,478)
Payment of acquisition and financing costs	-	-	-	-	-
Proceeds from issuance of LT debt & other financings	-	-	-	-	-
Net amounts received on interest rate swaps	-	-	-	-	-
Restricted contributions received	-	-	-	-	-
Net cash used by financing activities	(40,643)	(39,559)	(38,504)	(37,477)	(36,478)
Net increase/(decrease) in cash and cash equivalents	(30,211)	(10,887)	(7,185)	(9,674)	(12,709)
Cash and cash equivalents at beginning of year	128,580	98,369	87,482	80,297	70,623
Cash and cash equivalents at end of year	\$ 98,369	\$ 87,482	\$ 80,297	\$ 70,623	\$ 57,914

New Health System "Preliminary Efficiencies" Financial Model Income Statement

Income Statement - NewCo with Preliminary Efficiency Estimates								
\$'000s	Actuals			Forecasted				
	FYE 6/13	FYE 6/14	FYE 6/15	FYE 6/16	FYE 6/17	FYE 6/18	FYE 6/19	FYE 6/20
Net patient service revenue ("NPSR")	\$ 1,670,727	\$ 1,671,050	\$ 1,813,472	\$ 1,812,747	\$ 1,886,737	\$ 1,924,471	\$ 1,962,961	\$ 2,002,220
Other revenues:								
Other revenues	120,585	102,581	90,756	90,756	90,756	90,756	90,756	90,756
Total other revenues	120,585	102,581	90,756	90,756	90,756	90,756	90,756	90,756
Total revenue, gains, & support	1,791,312	1,773,631	1,904,228	1,903,502	1,977,492	2,015,227	2,053,716	2,092,976
Expenses:								
Salaries, wages, & benefits	881,530	865,989	925,061	936,615	943,313	946,284	933,869	944,905
Medical supplies & drugs	325,559	330,375	344,718	324,637	337,871	340,077	341,319	344,036
Purchased services	183,607	189,280	196,037	196,267	201,785	205,843	209,137	213,911
Interest & taxes	63,495	62,742	61,453	60,964	59,338	57,756	56,216	54,717
Depreciation & amortization	130,666	121,237	127,336	126,507	130,650	142,843	157,111	165,204
Maintenance & utilities	53,687	54,030	56,561	57,256	58,898	60,211	61,277	62,824
Lease & rental	17,892	15,506	15,435	15,821	16,216	16,551	16,795	17,200
Other	107,995	122,584	143,924	136,822	141,334	143,709	146,050	148,728
Total expenses & losses	1,764,431	1,761,743	1,870,524	1,854,888	1,889,406	1,913,272	1,921,774	1,951,524
Income from operations	26,881	11,888	33,704	48,614	88,086	101,955	131,943	141,451
Non-operating gains:								
Investment income	60,296	65,452	4,883	23,099	23,561	24,032	24,512	25,003
Derivative valuation adjustments	9,474	4,526	19,093	-	-	-	-	-
Loss on refinancing	-	(5,755)	(1,389)	-	-	-	-	-
Gain on revaluation of equity method investment	-	14,744	-	-	-	-	-	-
Non-operating gains, net	69,770	78,967	22,587	23,099	23,561	24,032	24,512	25,003
Revenues & gains in excess of expenses & losses	96,651	90,855	56,291	71,713	111,647	125,986	156,455	166,454
Other non-operating items:								
Discontinued operations	(4,484)	(26,639)	(2,720)	-	-	-	-	-
Income attributable to non-controlling interest	(7,728)	(9,826)	(15,046)	(14,459)	(14,975)	(15,031)	(15,077)	(15,111)
Total other non-operating operations	(12,212)	(36,465)	(17,765)	(14,459)	(14,975)	(15,031)	(15,077)	(15,111)
Revenues & gains in excess of expenses & losses attributable to NewCo.	\$ 84,439	\$ 54,390	\$ 38,526	\$ 57,254	\$ 96,672	\$ 110,955	\$ 141,378	\$ 151,343
Uses expense related to COPA, excluding D&A expense	-	-	-	-	(10,750)	(27,250)	(43,500)	(49,000)
Net income, including COPA uses attributable to NewCo.	\$ 84,439	\$ 54,390	\$ 38,526	\$ 57,254	\$ 85,922	\$ 83,705	\$ 97,878	\$ 102,343

New Health System "Preliminary Efficiencies" Financial Model Balance Sheet

Balance Sheet - NewCo with Preliminary Efficiency Estimates								
\$'000s	Actuals			Forecasted				
	6/30/13	6/30/14	6/30/15	6/30/16	6/30/17	6/30/18	6/30/19	6/30/20
Current assets:								
Cash & cash equivalents	\$ 130,860	\$ 89,859	\$ 128,580	\$ 128,907	\$ 118,700	\$ 73,698	\$ 60,795	\$ 88,289
Current portion of investments	25,447	28,262	22,904	22,904	22,904	22,904	22,904	22,904
Patient accounts receivable, net	271,216	278,583	274,678	273,154	284,303	289,989	295,789	301,704
Other receivables, net	51,463	60,187	41,588	43,667	45,851	48,143	50,551	53,078
Inventories & prepaid expenses	58,383	59,859	63,930	57,812	60,169	60,562	60,783	61,267
Total current assets	537,370	516,750	531,680	526,444	531,926	495,296	490,821	527,242
Other non-current assets:								
Long-term investments	1,037,563	1,124,957	1,154,927	1,178,026	1,201,586	1,225,618	1,250,131	1,275,133
Property, plant, & equipment, net	1,359,023	1,374,010	1,331,657	1,330,150	1,360,750	1,420,720	1,468,311	1,480,046
Goodwill	169,487	208,262	208,179	208,179	208,179	208,179	208,179	208,179
Net deferred financing, acquisition costs & other charges	33,658	30,067	28,972	27,523	26,147	24,840	23,598	22,418
Other assets	47,091	48,870	53,567	55,174	56,830	58,534	60,290	62,099
Total other non-current assets	2,646,822	2,786,166	2,777,303	2,799,052	2,853,492	2,937,891	3,010,509	3,047,875
Total assets	3,184,192	3,302,916	3,308,983	3,325,497	3,385,418	3,433,187	3,501,330	3,575,117
Current liabilities:								
Current portion of debt & liabilities	75,323	73,791	84,731	84,731	84,731	84,731	84,731	84,731
Accounts payable & accrued expenses	242,267	261,554	270,782	268,682	275,199	280,683	286,301	292,056
Estimated third-party payor settlements	33,932	18,888	18,471	18,841	19,217	19,602	19,994	20,394
Total current liabilities	351,523	354,233	373,985	372,254	379,148	385,017	391,027	397,181
Non-current liabilities:								
Long-term debt & liabilities	1,566,294	1,565,512	1,524,098	1,483,455	1,443,897	1,405,393	1,367,915	1,331,438
Retention bonus liability	-	-	-	-	5,000	-	-	-
Other long-term liabilities	78,447	99,400	81,633	83,265	84,931	86,629	88,362	90,129
Total non-current liabilities	1,644,740	1,664,912	1,605,731	1,566,721	1,533,827	1,492,022	1,456,277	1,421,567
Total liabilities	1,996,263	2,019,145	1,979,715	1,938,975	1,912,975	1,877,038	1,847,304	1,818,748
Net assets:								
Unrestricted	994,348	1,080,586	1,112,232	1,155,028	1,225,975	1,294,648	1,377,450	1,464,681
Temporarily restricted	19,703	20,418	20,508	20,508	20,508	20,508	20,508	20,508
Permanently restricted	1,438	1,446	1,450	1,450	1,450	1,450	1,450	1,450
Noncontrolling interests	172,439	181,321	195,078	209,536	224,511	239,542	254,619	269,730
Total net assets	1,187,929	1,283,771	1,329,268	1,386,522	1,472,443	1,556,148	1,654,027	1,756,369
Total liabilities and net assets	\$ 3,184,192	\$ 3,302,916	\$ 3,308,983	\$ 3,325,497	\$ 3,385,418	\$ 3,433,187	\$ 3,501,330	\$ 3,575,117

New Health System “Preliminary Efficiencies” Financial Model Statement of Cash Flows

Statement of Cash Flows with Preliminary Efficiencies Estimate	Forecasted				
	6/30/16	6/30/17	6/30/18	6/30/19	6/30/20
\$'000s					
Cash flows from operating activities:					
Income from operations	\$ 48,614	\$ 88,086	\$ 101,955	\$ 131,943	\$ 141,451
Uses expense related to COPA, excluding D&A expense	-	(10,750)	(27,250)	(43,500)	(49,000)
	48,614	77,336	74,705	88,443	92,451
Adjustments to reconcile change in net assets to net cash provided by operating activities:					
Depreciation and amortization	126,507	130,650	142,843	157,111	165,204
Loss on extinguishment of debt	-	-	-	-	-
Change in estimated fair value of derivatives	-	-	-	-	-
Equity in net income of JVs, net	-	-	-	-	-
Loss/(Gain) on disposal of assets	-	-	-	-	-
Capital Appreciation Bond accretion and other	-	-	-	-	-
Restricted contributions	-	-	-	-	-
Pension and other defined benefit plan adjustments	-	-	-	-	-
Increase/(Decrease) in cash due to change in:					
Patient accounts receivable, net	1,524	(11,149)	(5,686)	(5,800)	(5,916)
Other receivables, net	(2,079)	(2,183)	(2,293)	(2,407)	(2,528)
Inventories & prepaid expenses	6,118	(2,357)	(393)	(221)	(484)
Net deferred financing, acquisition costs & other charges	1,449	1,376	1,307	1,242	1,180
Other assets	(1,607)	(1,655)	(1,705)	(1,756)	(1,809)
Current portion of debt & liabilities	-	-	-	-	-
Accounts payable & accrued expenses	(2,100)	6,517	5,485	5,618	5,755
Estimated third-party payor settlements	369	377	384	392	400
Retention bonus liability	-	5,000	(5,000)	-	-
Other long-term liabilities	1,633	1,665	1,699	1,733	1,767
Total adjustments	131,814	128,240	136,641	155,911	163,570
Net cash provided by operating activities	180,428	205,577	211,346	244,354	256,022
Cash flows from investing activities:					
Purchases of property, plant, and equipment	(125,000)	(161,250)	(202,813)	(204,703)	(176,938)
Acquisitions, net of cash acquired	-	-	-	-	-
Non-operating gains, net	23,099	23,561	24,032	24,512	25,003
Purchases of held-to-maturity securities	(23,099)	(23,561)	(24,032)	(24,512)	(25,003)
Net distribution from JV's and unconsolidated affiliates	-	-	-	-	-
Proceeds from sale of plant, property, and equipment	-	-	-	-	-
Net cash used in investing activities	(125,000)	(161,250)	(202,813)	(204,703)	(176,938)
Cash flows from financing activities:					
Payments on LT debt and liabilities (net of interest)	(40,643)	(39,559)	(38,504)	(37,477)	(36,478)
Payment of acquisition and financing costs	-	-	-	-	-
Proceeds from issuance of LT debt & other financings	-	-	-	-	-
Income attributable to non-controlling interest	(14,459)	(14,975)	(15,031)	(15,077)	(15,111)
Net amounts received on interest rate swaps	-	-	-	-	-
Restricted contributions received	-	-	-	-	-
Net cash used by financing activities	(55,101)	(54,534)	(53,535)	(52,554)	(51,589)
Net increase/(decrease) in cash and cash equivalents	327	(10,207)	(45,002)	(12,903)	27,494
Cash and cash equivalents at beginning of year	128,580	128,907	118,700	73,698	60,795
Cash and cash equivalents at end of year	\$ 128,907	\$ 118,700	\$ 73,698	\$ 60,795	\$ 88,289

Exhibit 11.9

Insurance Contracts and Payor Agreements in Place at the Time of the Application

Mountain States Health Alliance

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA001	Amendment (to Hospital Services Agreement)	Aetna Health Inc.	Mountain States Health Alliance - KDS & ETASC
MSHA002	2009VAAetnaContract – Physician Group Agreement	Aetna Health Inc.	Mountain States Health Alliance d/b/a Russell County Medical Center; Dickenson Community Hospital; Smyth County Community Hospital ; North Community Physician Services, LLC and Blue Ridge Medical Management Corporation
MSHA003	PHO Participation Agreement	Aetna Health Management, Inc.	NHC
MSHA004	Hospital Services Agreement	Aetna Health, Inc.	Norton Community Hospital
MSHA005	Hospital Services Agreement/Access Agreement	Aetna Health, Inc.	Mountain States Health Alliance
MSHA006	Amendment of Current Agreements	Aetna Health, Inc.	Mountain States Health Alliance
MSHA007	Hospital Services Agreement	Aetna Health, Inc.	Russell County Medical Center
MSHA008	Hospital Services Agreement	Aetna Health, Inc.	Smyth County Community Hospital
MSHA009	Hospital Services Agreement	Aetna Health, Inc.	Unicoi County Memorial Hospital
MSHA0010	Specialist Physician Contract; Access Agreement	Aetna Health, Inc.; Aetna Life Insurance	Individual contracts with each TN physician
MSHA0011	Preferred Provider Agreement	Align Networks, Inc.	Mountain States Health Alliance
MSHA0012	Network-Payor Agreement	Allied National, Inc.	Mountain States Managed Care, Inc.

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0013	Integrated Solutions Health Network, LLC Amerigroup Virginia, Inc. d/b/a AMERIGROUP Community Care Letter of Agreement (Plus Amendments)	Amerigroup Virginia, Inc.	ISHN, LLC
MSHA0014	Medicare Medicaid Dual Integration Participation Attachment to the Provider Agreement	Anthem Health Plans of Virginia, Inc.	Mountain States Health Alliance – Abingdon Physician Partners; Blue Ridge Medical Management; Dickenson Community Hospital Physicians; Johnston Memorial Hospital Physicians; Russell County Medical Center Physicians; Norton Community Physician Services; Smyth County Community Hospital Physicians; Emmaus Community Healthcare, LLC D/B/A Piney Flats Urgent Care; Johnson County Family Medicine
MSHA0015	Anthem Blue Cross and Blue Shield Facility Agreement	Anthem Health Plans of Virginia, Inc.	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
MSHA0016	Amendment to the Anthem Blue Cross and Blue Shield Facility Agreement	Anthem Health Plans of Virginia, Inc.	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

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0017	Medicare Medicaid Dual Integration Participation Attachment to the Provider Agreement	Anthem Health Plans of Virginia, Inc.	Abingdon Physician Partners; Blue Ridge Medical Management; Dickenson Community Hospital Physicians; Johnston Memorial Hospital Physicians; Russell County Medical Center Physicians; Norton Community Physician Services; Smyth County Community Hospital Physicians; Emmaus Community Healthcare, LLC, d/b/a Piney Flats Urgent Care; Jonson County Family Medicine
MSHA0018	Medicare Medicaid Dual Integration Participation Attachment to the Medical Equipment Provider Agreement	Anthem Health Plans of Virginia, Inc.	Mediserve Medical Equipment, Inc. and Community Home Care, Inc.
MSHA0019	Medicare Medicaid Dual Integration Participation Attachment to the Anthem Blue Cross and Blue Shield Medical Equipment Provider Agreement	Anthem Health Plans of Virginia, Inc.	Mediserve Medical Equipment, Inc. and Community Home Care, Inc.
MSHA0020	Anthem Blue Cross and Blue Shield Provider Agreement – Behavioral Health – EC 453B	Anthem Health Plans of Virginia, Inc.	MSMG
MSHA0021	Anthem Blue Cross and Blue Shield Provider Agreement – Primary Care Physician – EC 104A	Anthem Health Plans of Virginia, Inc.	MSMG
MSHA0022	Anthem Blue Cross and Blue Shield Provider Agreement – Specialist EC 303	Anthem Health Plans of Virginia, Inc.	MSMG
MSHA0023	Anthem Blue Cross and Blue Shield Provider Agreement (Reference DME)	Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Just identifies party as Provider, no signature page attached, cannot identify the contracting party

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0024	Anthem Blue Cross and Blue Shield Facility Agreement – Non-Acute	Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
MSHA0025	HMO Medicaid Participation Attachment to the Anthem Blue Cross and Blue Shield Facility Agreement – Non-Acute	Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
MSHA0026	Medicare Advantage Participation Attachment to the Anthem Blue Cross and Blue Shield Facility Agreement – Non-Acute	Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
MSHA0027	Provider Agreement	Appalachian Agency for Senior Citizens	Dickenson Community Hospital
MSHA0028	Provider Agreement	Appalachian Agency for Senior Citizens	Norton Community Hospital
MSHA0029	Provider Agreement	Appalachian Agency for Senior Citizens	Norton Community Physician Services Corporation
MSHA0030	Provider Agreement	Appalachian Agency for Senior Citizens	Mountain States Health Alliance dba Russell County Medical Center
MSHA0031	Provider Agreement	Appalachian Agency for Senior Citizens	Russell County Medical Center dba Riverside Community Medical Clinic
MSHA0032	AllCare for Seniors Provider Agreement	Appalachian Agency for Senior Citizens	Mountain States Health Alliance d/b/a Dickenson Community Hospital
MSHA0033	Provider Agreement and First Amendment to Provider Agreement	Appalachian Agency for Senior Citizens	Southwest Virginia Health Network, Inc.

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0034	AllCare for Seniors Provider Agreement	Appalachian Agency for Senior Citizens	Mountain States Health Alliance d/b/a Russell County Medical Center
MSHA0035	First Amendment to Provider Agreement	Appalachian Agency for Senior Citizens, Inc. (AllCare)	Mountain States Health Alliance d/b/a Russell County Medical Center
MSHA0036	Payor Agreement	Beech Street Corporation	Mountain States Managed Care, Inc.
MSHA0037	Payor Agreement	Beech Street Corporation	Mountain States Managed Care, Inc.
MSHA0038	Physician Hospital Organization Agreement (plus Amendment dated same date)	Beech Street Corporation	Mountain States Managed Care, Inc.
MSHA0039	Addendum to Payor Agreement	Beech Street Corporation	Mountain States Managed Care, Inc.
MSHA0040	Managed Care Administrative Services Agreement	Benefit Plan Administrators, Inc.	Smyth County Community Hospital
MSHA0041	Amendment to Managed Care Administrative Services Agreement	Benefit Plan Administrators, Inc.	Smyth County Community Hospital
MSHA0042	Participating Hospital Agreement	Benefit Resources, Inc.	Russell County Medical Center
MSHA0043	Group Practice Agreement (and Amendment)	Blue Cross Blue Shield of Tennessee, Inc.	Blue Ridge Medical Management Corporation
MSHA0044	Medicare Advantage Provider Agreement	Blue Cross Blue Shield of Tennessee, Inc.	Blue Ridge Medical Management Corporation
MSHA0045	Medicare Advantage Provider Agreement	Blue Cross Blue Shield of Tennessee, Inc.	Mountain States Health Alliance (Johnson City Medical Center; Sycamore Shoals Hospital; Indian Path Medical Center; North Side Hospital; Johnson City Specialty Hospital; Johnson County Health Center; Franklin Transitional Care; Princeton Transitional Care; Indian Path Transitional Care)
MSHA0046	Purchase Order	Blue Ridge Job Corp Center	Smyth County Community Hospital

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0047	Amendment 8 to the Bluepreferred Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee Inc.	Mountain States Health Alliance for Kingsport Ambulatory Surgery Center and East Tennessee Ambulatory Surgery Center
MSHA0048	Amendment 8 to the BlueSelect Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee Inc.	Mountain States Health Alliance for Kingsport Ambulatory Surgery Center and East Tennessee Ambulatory Surgery Center
MSHA0049	Amendment 8 to the Network P Hospice Attachment of the BlueCross BlueShield of Tennessee Medical Services Supplier Agreement	BlueCross BlueShield of Tennessee Inc.	Medical Center Hospice
MSHA0050	Amendment 5 to the Network P Skilled Nursing Facility Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee Inc.	Mountain States Health Alliance for Indian Path Medical Center Transitional Care Center and Princeton Transitional Care Center
MSHA0051	Amendment 5 to the Network S Skilled Nursing Facility Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee Inc.	Mountain States Health Alliance for Indian Path Medical Center Transitional Care Center and Princeton Transitional Care Center
MSHA0052	Dual Eligible Special Needs Plan Amendment to the Bluecare/TennCare Select Attachment	BlueCross BlueShield of Tennessee Inc.	Participating TennCare Provider (BRMMC PCP)
MSHA0053	Dual Eligible Special Needs Plan Amendment to the Bluecare/TennCare Select Attachment	BlueCross BlueShield of Tennessee Inc.	Participating TennCare Provider (BRMMC Specialist)
MSHA0054	Dual Eligible Special Needs Plan Amendment to the Bluecare/TennCare Select Attachment	BlueCross BlueShield of Tennessee Inc.	Participating TennCare Provider (Facilities)

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0055	Blue Advantage Local PPO Medicare Advantage Provider Agreement Ambulatory Surgery Facility Attachment	BlueCross BlueShield of Tennessee Inc.	Kingsport Ambulatory Surgery Center
MSHA0056	Blue Advantage Local PPO Durable Medical Equipment Attachment to the Medicare Advantage Provider Agreement	BlueCross BlueShield of Tennessee Inc.	HealthPlus Pharmacy- DME
MSHA0057	BlueAdvantage Local PPO Medicare Advantage Provider Agreement Skilled Nursing Facility Attachment	BlueCross BlueShield of Tennessee Inc.	Mountain States Health Alliance for Franklin Transitional Care, Princeton Transitional Care and Indian Path Transitional Care
MSHA0058	Amendment 1 to the BlueAdvantage Local PPO Medicare Advantage Provider Agreement Skilled Nursing Facility Attachment	BlueCross BlueShield of Tennessee Inc.	Mountain States Health Alliance for Franklin Transitional Care, Princeton Transitional Care and Indian Path Transitional Care
MSHA0059	BlueCare Network Attachment	BlueCross BlueShield of Tennessee Inc. and Volunteer State Health Plan, Inc. (VSHP)	Mediserve Medical Equipment of Kingsport, Wilson Pharmacy dba Healthplus and Pharmacy
MSHA0060	Amended and Restated BlueCross BlueShield of Tennessee Institution Agreement (plus Amendments effective same day)	BlueCross BlueShield of Tennessee, Inc.	Mountain States Health Alliance (Johnson City, Sycamore Shoals, Indian Path, Johnson County, Franklin Woods, Unicoi County, Kingsport Ambulatory, East Tennessee Ambulatory, Indian Path Med Center, Princeton Transitional)
MSHA0061	Rate Adjustments	BlueCross BlueShield of Tennessee, Inc.	Mountain States Health Alliance (Johnson City, Sycamore Shoals, Indian Path, Johnson County, Franklin Woods, Unicoi County, Kingsport Ambulatory, East Tennessee Ambulatory, Indian Path Med Center, Princeton Transitional)

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0062	Dual Eligible Special Needs Plan Amendment to BlueCare/TennCare Select Attachment	BlueCross BlueShield of Tennessee, Inc.	Not listed
MSHA0063	Medicare Advantage Provider Agreement (plus Amendment)	BlueCross BlueShield of Tennessee, Inc.	Mountain States Health Alliance (Johnson City, Sycamore Shoats, Indian Path, North Side, Johnson City Specialty, Johnson County Health, Franklin Transitional, Princeton Transitional, Indian Path Transitional)
MSHA0064	BCBS of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc.	(Mountain States Health Alliance) Johnston Memorial Hospital
MSHA0065	Behavioral Health Amendment to the BLUECARE Institution Attachment	BlueCross BlueShield of Tennessee, Inc.	Mountain States Health Alliance (unclear which entity – likely Johnston Memorial Hospital)
MSHA0066	BlueCare Institution Agreement	BlueCross BlueShield of Tennessee, Inc.	All MSHA TN Facilities
MSHA0067	Bluegrass Family Health, Inc. Hospital Participation Agreement	Bluegrass Family Health, Inc.	Unicoi County Memorial Hospital
MSHA0068	CareCentrix Provider Agreement	CareCentrix	Mountain States Health Alliance dba MCHC
MSHA0069	Network Participating Facility Agreement	CHA Provider Network, Inc.	Norton Community Hospital
MSHA0070	Amendment to Provider-Contract State Law Coordinating Provisions	ChoiceCare	Smyth County Community Hospital
MSHA0071	Agreement for Medical Services	Christian Care Centers of Johnson City, Inc.	Mountain States Health Alliance
MSHA0072	Participating Provider Agreement – Virginia	CIGNA Behavioral Health, Inc.	Dionis K. Anderson
MSHA0073	Institutional Services Agreement	CIGNA Behavioral Health, Inc.	Mountain States Health Alliance

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0074	CIGNA HealthCare Ambulatory Center, Exhibit A, Fee Schedule and Reimbursement Terms	CIGNA HealthCare of Tennessee, Inc.	Kingsport Ambulatory Surgery Center
MSHA0075	Attachment to Exhibit A (directly above) (regarding max allowable reimbursement)	CIGNA HealthCare of Tennessee, Inc.	Kingsport Ambulatory Surgery Center
MSHA0076	Provider Group Services Agreement	CIGNA HealthCare of Tennessee, Inc.	Blue Ridge Medical Management
MSHA0077	Hospital Services Agreement	Cigna HealthCare of Tennessee, Inc.	Mountain States Health Alliance
MSHA0078	Medical Services/Hospital Participation Contract	Commonwealth of Virginia Department of Health, Office of Family Health Services	Smyth County Community Hospital
MSHA0079	Hospitalization Services Agreement	Commonwealth of Virginia Department of Rehabilitative Services	Smyth County Community Hospital
MSHA0080	Contract Renewal	Commonwealth of Virginia, Department of Mental Health, Mental Retardation and Substance Abuse Services	Smyth County Community Hospital
MSHA0081	Letter Agreement	Commonwealth of Virginia, Virginia Department of Health, Cumberland Plateau Health District	Russell County Medical Center
MSHA0082	Standard Contract	Commonwealth of Virginia, Virginia Department of Health, Cumberland Plateau Health District	Russell County Medical Center

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0083	CMVI Hospital	Comp Management of Virginia, Inc.	Norton Community Hospital
MSHA0084	Facility Participation Agreement (plus Amendment)	Corphealth, Inc. d/b/a LifeSynch	Mountain States Health Alliance (Johnson City Medical; Woodridge Psychiatric; Russell County Medical; Mountain States Health Alliance Outpatient Behavioral Health/Indian Path Medical; Sycamore Shoals)
MSHA0085	Attachment A PHO Reimbursement	Corvel Corporation	Southwest Virginia Healthnet - JMHS
MSHA0086	Hospital Agreement	Corvel Corporation	Russell County Medical Center
MSHA0087	Corvel Preferred Provider Organization Facility Agreement	Corvel Healthcare Corporation	Mountain States Health Alliance
MSHA0088	Corvel Preferred Provider Organization Facility Agreement	Corvel Healthcare Corporation	Kingsport Ambulatory Surgery Center, LLC dba Kingsport Day Surgery
MSHA0089	Physician Agreement	Corvel Healthcare Corporation	Blue Ridge Medical Management Corporation
MSHA0090	Psychiatric Service Agreement for Inpatient Purchase of Service	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	Russell County Medical Center
MSHA0091	Standard Contract	Cumberland Plateau Health District	Russell County Medical Center

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0092	Behavioral Health Services Agreement	Dickenson County Behavioral Health Services	Russell County Medical Center
MSHA0093	Agreement Between Mountain States Health Alliance and The Division of Rehabilitation Services of The Tennessee Department of Human Services	Division of Rehabilitation Services of the Tennessee Department of Human Services	Mountain States Health Alliance
MSHA0094	Memoranda of Understanding and Service Agreement	EvaluMed	Not specified; mentions "Mountain States Health Alliance physical therapist" and "Managed Care"
MSHA0095	Amendment to Hospital Agreement	First Health Group Corp.	Mountain States health Alliance
MSHA0096	The First Health Network Hospital Contract	First Health Group Corp.	Norton Community Hospital
MSHA0097	Participating Hospital Agreement	Fortified Provider Network	Johnston Memorial Hospital
MSHA0098	Psychiatric Bed Day Purchase Agreement	Frontier Health, Inc./PD 1	Russell County Medical Center
MSHA0099	Galaxy Health Network Facility Agreement	Galaxy Health Network	Russell County Medical Center
MSHA0100	Letter of Agreement	Galaxy Health Network	Unicoi County Memorial Hospital
MSHA0101	Galaxy Health Network Facility Agreement	Galaxy Health Network	Russell County Medical Center
MSHA0102	Gateway Health Delegated Credentialing Agreement	Gateway Health	Blue Ridge Medical Management
MSHA0103	Gateway Health Alliance, Inc.	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
MSHA0104	Physician Hospital Organization Participation Agreement	Gateway Health Alliance, Inc.	Southwest Virginia Health Network - JMH PHO(includes rates for both physicians and facility)
MSHA0105	Network Participation Agreement	Gateway Health Alliance, Inc.	Dickenson Community Hospital, Norton Community Hospital, Smyth County

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
			Community Hospital, and Mountain States Health Alliance, d/b/a Russell County Medical Center
MSHA0106	Hospital Participation Agreement	Gateway Health Alliance, Inc.	Russell County Medical Center
MSHA0107	Therapy Management Program Provider Agreement	GENEX Services, dba Network Synergy Group	Mountain States Health Alliance
MSHA0108	Agreement for outpatient services	Grayson Nursing & Rehabilitation Center- Skilled Nursing Facility	Smyth County Community Hospital, Inc.
MSHA0109	Preferred Hospital Agreement	Health Payors Organization, LTD.	Johnson City Medical Center Hospital, Inc.
MSHA0110	Physician Hospital Organization Participation Agreement	Health Value Management dba ChoiceCare Network	Southwest Virginia Health Network
MSHA0111	Hospital Participation Agreement	Health Value Management, Inc. d/b/a ChoiceCare Network	Mountain States Health Alliance
MSHA0112	Amendment One to Hospital Participation Agreement	Health Value Management, Inc. d/b/a ChoiceCare Network	Mountain States Health Alliance
MSHA0113	Physician Hospital Organization Participation Agreement	Health Value Management, Inc. d/b/a ChoiceCare Network	Southwest Virginia Health Network
MSHA0114	Letter of Intent for Participation in HealthKeepers, Inc.'s Network Serving the Virginia Financial Alignment Demonstration for Dual Eligible	Healthkeepers, Inc.	Johnston Memorial Hospital, Dickenson Community Hospital, Norton Community Hospital, Smyth County Community Hospital, Kingsport Day Surgery Center, LLC, Mediserve Medical Equipment of Kingsport-Abingdon, Mountain States Health Alliance, d/b/a, Russell County Medical Center, Mountain States health Alliance d/b/a. Indian Path Medical Center
MSHA0115	Amendment 1 to the Home Health Care Provider Agreement	HealthKeepers, Inc.	Mountain States Health Alliance

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0116	Anthem HealthKeepers Provider Agreement	HealthKeepers, Inc.	Not identified, this packet is not executed
MSHA0117	Medicare Medicaid Dual Integration Participation Attachment to the HealthKeepers, Inc. Skilled Nursing Facility Provider Agreement	HealthKeepers, Inc.	Not identified, this agreement is not executed
MSHA0118	Medical Equipment Supplier	Healthkeepers, Inc., Peninsula Health Care, Inc. and Priority Health Care, Inc.	Community Home Care
MSHA0119	Amendment 1 to the Home Health Care Provider Agreement	Healthkeepers, Inc., Peninsula Health Care, Inc. and Priority Health Care, Inc.	Smyth County Regional Homecare
MSHA0120	Amendment 1 to the Home Health Care Provider Agreement	Healthkeepers, Inc., Peninsula Health Care, Inc. and Priority Health Care, Inc.	Smyth County Regional Homecare
MSHA0121	HMO Home Health Agency Agreement	Healthkeepers, Inc., Peninsula Health Care, Inc. and Priority Health Care, Inc.	Smyth County Community Home Care
MSHA0122	Psychiatric Bed Day Purchase Agreement	Highlands Community Services	Russell County Medical Center
MSHA0123	First Amendment to Agreement - added Unicoi - WC	Holston Distributing Inc.	Mountain States Health Alliance
MSHA0124	Ancillary Agreement - WC	Holston Distributing Inc.	Mountain States Health Alliance
MSHA0125	Horizon Health EAP Services, Inc. Facility Agreement	Horizon Health EAP Services, Inc.	Mountain States Health Alliance dba Sycamore Shoals Hospital
MSHA0126	Horizon Health EAP Services, Inc. Facility Agreement	Horizon Health EAP Services, Inc.	Mountain States Health Alliance dba Johnson City Medical Center (dba Woodridge Psychiatric Hospital)

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0127	Group Provider Agreement	Horizon Health EAP Services, Inc.	Blue Ridge Psychiatry/Woodbridge Hospital Physicians
MSHA0128	Hospice of Southwest Virginia Contract for Hospice Inpatient Acute Care	Hospice of Southwest Virginia	Smyth County Community Hospital
MSHA0129	Hospice of Southwest Virginia Contract for Hospice Inpatient Acute Care	Hospice of Southwest Virginia	Smyth County Community Hospital
MSHA0130	Attachment E-3 Medicare Advantage HMO, POS and PPO Reimbursement	Humana (see Amendment One to Mountain States Health Alliance and Humana Hospital Participation Agreement)	Mountain States Health Alliance
MSHA0131	Amendment to Agreement	Humana Government Business, Inc. d/b/a Humana Military	Mountain States Health Alliance (Unicoi Locations)
MSHA0132	Hospital Participation Agreement	Humana Health Plan, Inc.	Mountain States Health Alliance
MSHA0133	Amendment One to Hospital Participation Agreement	Humana Health Plan, Inc.	Mountain States Health Alliance
MSHA0134	Amendment Two to Hospital Participation Agreement	Humana Health Plan, Inc.	Mountain States Health Alliance
MSHA0135	Physician Participation Agreement	Humana Insurance Company, Humana Health Plan, Inc.	Blue Ridge Medical Management
MSHA0136	HMHS Amendment to Hospital Agreement	Humana Military Health Services, Inc.	Mountain States Health Alliance
MSHA0137	Letter Of Agreement (under USP Lee County)	Integrated Medical Solutions, LLC	Mountain States Health Alliance (IPMC & NCH)
MSHA0138	Eight Amendment to Integrated Solutions Health Network Network Participation Agreement	Integrated Solutions Health Network, LLC, Anew Care Collaborative, LLC, Crestpoint Health Insurance Company	Mountain States Pharmacy at State of Franklin, Mountain States Pharmacy at JCMC, Mountain States Pharmacy at Kingsport, Mountain States Pharmacy at Norton, Mountain States Pharmacy at JMH

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0139	Letter of Agreement (plus Amendment dated July 1, 2014)	INTotal Health, LLC (formerly known as Amerigroup Virginia, Inc.)	ISHN, LLC - Physicians
MSHA0140	6 th Amendment to ISHN Network participation Agreement	ISHN - AnewCare/CrestPoint	Contract between ISHN and its subsidiaries - Professionals
MSHA0141	Sixth Amendment to ISHN Network Participation Agreement (amending March 27, 2012 Agreement)	ISHN Entities (not signed)	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)
MSHA0142	Amendment Seven to ISHN Network Participation Agreement (Amerigroup TennCare Amendment)	ISHN, Anew Care Collaborative, LLC and Crestpoint Health Insurance Company	Blue Ridge Medical Management Incorporated
MSHA0143	Tenth Amendment to Integrated Solutions Health Network Participation Agreement (Amerigroup TennCare Amendment)	ISHN, LLC, Anew Care Collaborative, LLC and Crestpoint Health Insurance Company	Mountain States Health Alliance (Franklin Woods, Indian Path Medical, Johnson City Medical, Woodridge Hospital, Johnson County Community Hospital, Sycamore Shoals, Unicoi County Memorial Hospital, Niswonger Children's Hospital, Kingsport Day Surgery Center, East Tennessee ASC, Johnston Memorial Hospital)

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0144	Network Participation Agreement	ISHN, LLC (and related entities)	Mountain States (all Mountain States Health Alliance locations)
MSHA0145	Amendment to Network Participation Agreement (MA Amendment)	ISHN, LLC (and related entities)	Mountain States (BRMMC, APP, NCPS)
MSHA0146	Seventh Amendment to Network Participation Agreement (MA Amendment)	ISHN, LLC (and related entities)	Mountain States Health Alliance (Johnson City Medical/Woodridge, Quillen Rehab, Johnson County Community Hospital, Johnson County Home Health, Johnson County Family Medicine, Princeton Transitional Care, Franklin Woods, Sycamore Shoals (Hospital and Psych Unit), Medical Center HomeCare Services of Kingsport, Kingsport Day Surgery, Russell County (Medical Center, Psychiatric Unit, Swing Bed, Home Health, Hospice), Mountain States Medical Group Riverside Family Clinic, Smyth County (Community Hospital, Regional Home Care, Frances Marion Manor, Rehab Unit, Glade Springs Family Medicine), Norton Community Hospital, (including Skilled Nursing, Rehab, Home Care, Home Health), Dickenson Community Hospital, Johnston Memorial Hospital, Johnston Memorial Home Care, Mediserve medical Equipment of Kingsport – Greeneville, Morristown, Knoxville, Gray, Abingdon; Wilson Pharmacy, Inc.
MSHA0147	Agreement for Medical Services	Ivy Hall Nursing Home, Inc.	Mountain States Health Alliance
MSHA0148	Preferred Provider Acceptance Agreement	Johnston & Associates, Inc.	Mountain States Health Alliance - WC TN & VA Diagnostic

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0149	Preferred Provider Acceptance Agreement	Johnston & Associates, Inc.	Mountain States Health Alliance - TN WC Rehab
MSHA0150	Preferred Provider Acceptance Agreement	Johnston & Associates, Inc.	Mountain States Health Alliance VA WC Rehab
MSHA0151	Business Associate Addendum	KDM, Inc. dba Durham-Hensley Health and Rehabilitation	Mountain States Health Alliance
MSHA0152	Agreement for Medical Services	KDM, Inc. dba Durham-Hensley Health and Rehabilitation	Mountain States Health Alliance
MSHA0153	Agreement for Medical Services	Lakebridge Medical Investors, LLC dba Lakebridge Health Care Center	Mountain States Health Alliance
MSHA0154	M.D. Individual Practice Association, Inc. Hospital Service Agreement	M.D. Individual Practice Association, Inc.	Russell County Medical Center, Inc.
MSHA0155	Medicaid Addendum to Magellan Behavioral Health, Inc. Provider Agreement	Magellan Behavioral Health, Inc.	Blue Ridge Medical Management Corporation
MSHA0156	Facility and Program Participation Agreement	Magellan Behavioral Health, Inc.	Mountain States Health Alliance
MSHA0157	Amendment(s) to Magellan Behavioral Health, Inc. Provider Agreement.	Magellan Behavioral Health, Inc.	Mountain States Health Alliance
MSHA0158	Facility and Program Participation Agreement	Magellan Behavioral Health, Inc.	Mountain States Health Alliance
MSHA0159	Participating Provider Agreement	Managed Health Network, Inc.	Russell County Medical Center, Inc.
MSHA0160	Amendment to Participating Provider Agreement	Managed Health Network, Inc.	Russell County Medical Center, Inc.
MSHA0161	Medcost Participating Physician Organization Agreement	MedCost, Inc.	Southwest Virginia Healthnet

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0162	MedCost Participating Physician Organization Agreement	MedCost, LLC	Southwest Virginia Healthnet
MSHA0163	Amendment No. 1 Medcost, Inc. Hospital Agreement	Medcost, Inc.	Johnston Memorial Hospital
MSHA0164	Amendment to Hospital Service Agreement	Medical Control Network Solutions, Inc.	Norton Community Hospital
MSHA0165	Facility Service Agreement	Medical Control Network Solutions, Inc.	Norton Community Hospital
MSHA0166	Medical Network Hospital Network Provider Agreement	Medical Network, Inc.	Sycamore Shoals
MSHA0167	Facility Network Participation Agreement	Mental Health Associates, Inc.	ISHN, LLC
MSHA0168	Facility Participation Agreement	Modern Chevrolet	Russell County Medical Center
MSHA0169	Mountain Empire PACE Provider Agreement	Mountain Empire Older Citizens, Inc.	Community Physicians Services Corporation
MSHA0170	Mountain Empire PACE Provider Agreement, as amended	Mountain Empire Older Citizens, Inc.	Norton Community Hospital Home Health
MSHA0171	Mountain Empire PACE Provider Agreement	Mountain Empire Older Citizens, Inc.	Norton Community Physicians Services
MSHA0172	Mountain Empire PACE Provider Agreement	Mountain Empire Older Citizens, Inc.	Norton Community Hospital
MSHA0173	Mountain Empire PACE Provider Agreement	Mountain Empire Older Citizens, Inc.	Community Physicians Services Corporation
MSHA0174	Mountain Empire PACE Provider Agreement	Mountain Empire Older Citizens, Inc.	Community Home Care, Norton Community Hospital
MSHA0175	Multiplan, Inc. Participating Practitioner Agreement	MultiPlan, Inc.	No group contract just individual contracts so multiple contracts with multiple effective dates.

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0176	Letter of Agreement MVP Health Care Services Agreement for Medicare PPO	MVP Health Plan, Inc., MVP Select Care, Inc. and MVP Affiliates	Mountain States Health Alliance and Blue Ridge Medical Management
MSHA0177	Participating Agreement for an Integrated Delivery System or Physician Hospital Organization	National Preferred Provider Network, Inc.	Southwest Virginia Health Network (JM & Physicians)
MSHA0178	Health Care Facility Agreement	Novanet, Inc.	MSHA Hospitals
MSHA0179	HealthCare Professional Agreement (as amended)	Novanet, Inc.	BRMMC
MSHA0180	Health Care Facility Agreement	Novanet, Inc.	KDS
MSHA0181	Health Care Professional Agreement	Novanet, Inc.	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
MSHA0182	Health Care Professional Agreement	Novanet, Inc.	Blue Ridge Medical Management Corporation
MSHA0183	Health Care Facility Agreement Worker's Compensation Benefit Programs	Novanet, Inc.	Kingsport Day Surgery
MSHA0184	Health Care Facility Agreement Worker's Compensation Benefit Programs	Novanet, Inc.	Mountain States Health Alliance
MSHA0185	Optimum Choice, Inc. Hospital Service Agreement	Optimum Choice, Inc.	Russell County Medical Center, Inc.

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0186	Participating Agreement with 4Most Health Network	Physician Services, LC	Southwest Virginia Health Network (Facility & Physician)
MSHA0187	Facility Participation Agreement	Pittston Coal	Russell County Medical Center
MSHA0188	USA Care Plan	Preferred Care	Facility not listed in agreement
MSHA0189	Professional Service Agreement	Premier Comp Solutions, LLC	Mountain States Health Alliance
MSHA0190	Professional Service Agreement	Premier Comp Solutions, LLC	Mountain States Health Alliance
MSHA0191	Letter of Agreement	Prime Health Services, Inc.	Blue Ridge Medical Management Corporation
MSHA0192	PHCS Participating Professional Agreement	Private Healthcare Systems, Inc.	no group contract just multiple individual contracts with multiple effective dates.
MSHA0193	PHCS Participating Facility Agreement	Private Healthcare Systems, Inc.	Mountain States Health Alliance d/b/a Johnson City Medical Center
MSHA0194	Preferred Facility Agreement	Private Healthcare Systems, Inc.	Norton Community Hospital
MSHA0195	Facility Agreement (2 nd , 3 rd , 4 th , 6-8 th Amendments)	Private Healthcare Systems, Inc.	Mountain States Health Alliance
MSHA0196	Letter of Understanding	Public Risk Services, Inc. /The Pool	Mountain States Health Alliance
MSHA0197	TennCare Addendum – Bureau of TennCare required Language – Provider Agreements	River Valley plan	TennCare - Deemed policy for MSHA entities including Physicians
MSHA0198	Agreement for Medical Services	Roan Highlands Medical Investors, LLC dba Roan Highlands Nursing Center	Mountain States Health Alliance
MSHA0199	Hospital Agreement	Russell County Detention Center	Russell County Medical Center
MSHA0200	Network Access Agreement	Sentara Health Plans, Inc.	ISHN, LLC (MSHA & MSMG)

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0201	3 rd Amendment to Network Access Agreement (Cova Commercial)	Sentara Health Plans, Inc.	ISHN, LLC - (MSHA & MMG)
MSHA0202	Letter of intent to participate in the USP LEE provider network	Seven Corners, Inc.	Mountain States Health Alliance
MSHA0203	Medical Equipment Supplier Medicare Advantage Agreement	Southeast Services, Inc.	Community Home Care
MSHA0204	Home Health Care Medicare Advantage Agreement	Southeast Services, Inc.	Smyth County Community Hospital
MSHA0205	Amendment 1 to the Home Health Care Provider Agreement	Southeast Services, Inc.	Smyth County Homecare
MSHA0206	Home Health Care Medicare Advantage Agreement	Southeast Services, Inc.	Norton Community Home Health
MSHA0207	Amendment 1 to the Home Health Care Provider Agreement	Southeast Services, Inc.	Mountain States Health Alliance
MSHA0208	Anthem Blue Cross and Blue Shield's Provider Agreement -SNF	Southeast Services, Inc.	Not identified, this packet is not executed
MSHA0209	Anthem Blue Cross and Blue Shield's Provider Agreement - SNF	Southeast Services, Inc.	Not identified, this packet is not executed
MSHA0210	Southern Health Services, Inc. PHO Agreement / Coventry - VA Medicaid	Southern Health Services, Inc.	ISHN, LLC (MSHA & MSMG)
MSHA0211	Contract	Southwest Virginia Mental Health Institute	Smyth County Community Hospital
MSHA0212	Hospital To Hospital Transfer Agreement	Southwest Virginia Mental Health Institute	Smyth County Community Hospital

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0213	Tennessee Department of Health, Communicable & Environmental Diseases and Emergency Preparedness, HIV/STD Programs , Ryan White Part B Program	State Of Tennessee Department of Health	Unicoi County Memorial Hospital
MSHA0214	Mammography Screening Program	Tennessee Department of Health	Mountain States Health Alliance
MSHA0215	Letter of Agreement	Tennessee Department of Health	Unicoi County Memorial Hospital
MSHA0216	CEDEP Program (Ryan White)	Tennessee Department of Health	Johnson City Medical Center - Facilities to be determined based on vendor forms
MSHA0217	Contract	The Infant Toddler Connection of Mount Rogers	Smyth County Community Hospital
MSHA0218	Amendment No. 1 to The Initial Group Provider Participation Agreement	The Initial Group	Southwest Virginia Health Network - APP
MSHA0219	Managed Care Agreement	The Initial Group, Inc.	ISHN, LLC
MSHA0220	Three Rivers Provider Network Agreement	Three Rivers Provider Network	Southwest Health Network (Hospital Affiliation – Johnston Memorial Hospital)
MSHA0221	Provider Network Agreement	Three Rivers Provider Network, Inc.	Southwest Virginia Health Network - JMH physicians
MSHA0222	Amendment to the Trigon Services, Inc. Home Health Care Agreement	Trigon Services, Inc.	Smyth County Community
MSHA0223	Home Health Care Agreement	Trigon Services, Inc.	Smyth County Community Hospital Home Health
MSHA0224	Amendment to the Trigon Services, Inc. Home Health Care Agreement	Trigon Services, Inc.	Smyth County Community
MSHA0225	Institution Agreement (as amended by VA PCCC Amendment)	TriWest Healthcare Alliance Corp.	Mountain States Health Alliance

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0226	Cooperating Provider Agreement	Trustees of the UMWA 1992 (and 1993) Benefit Plan;	Mountain States Health Alliance d/b/a Russell County Medical Center Home Health
MSHA0227	Cooperating Provider Agreement	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
MSHA0228	Agreement	Trustees of the UMWA 1992 (and 1993) Benefit Plan;	Norton Community Hospital
MSHA0229	Agreement	UMWA Health and Retirement	Mountain States Managed Care, Inc. (TN Facilities)
MSHA0230	Assignment and Assumption Agreement	Unicoi Memorial Hospital	Mountain States Health Alliance
MSHA0231	United Behavioral Health, Inc. Facility Participation Agreement	United Behavioral Health, Inc.	Mountain States Health Alliance d/b/a Indian Path Pavilion
MSHA0232	Fifth Amendment to United Behavioral Health, Inc. Facility Participation Agreement	United Behavioral Health, Inc.	Mountain States Health Alliance d/b/a Indian Path Pavilion
MSHA0233	1 st Amendment to the United Behavioral Health TennCare Program Facility Participation Agreement	United Behavioral Health, Inc.	Mountain States Health Alliance d/b/a Sycamore Shoals Hospital and Woodbridge Psychiatric Hospital
MSHA0234	Ambulatory Surgical Center All Payer Appendix	United Healthcare	East Tennessee Ambulatory Surgery Center

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0235	Ambulatory Surgical Center Compass Payer Appendix - Exchange	United Healthcare	East Tennessee Ambulatory Surgery Center
MSHA0236	Ambulatory Surgical Center All Payer Appendix	United Healthcare	Kingsport Ambulatory Surgery Center
MSHA0237	Ambulatory Surgical Center Compass Payer Appendix - Exchange	United Healthcare	Kingsport Ambulatory Surgery Center
MSHA0238	Durable Medical Equipment Services All Payer Appendix	United Healthcare	Mediserve Medical Equipment of Kingsport, Inc., Mountain States Pharmacy and Community Home Care
MSHA0239	All Payer Appendix	United Healthcare	Mountain States Health Alliance dba MCHC, MCHC of Kingsport, Johnson County Home Health and Norton Home Health, Johnston Memorial Home Health, Unicoi County Home Health , Russell County Home Health and Smyth County Regional Home Care
MSHA0240	All Payer Appendix	United Healthcare	Mountain States Health Alliance dba Medical Center Hospice and Russell County Hospice
MSHA0241	Home Infusion Therapy Services All Payer Appendix	United Healthcare	Mountain States Pharmacy
MSHA0242	Ambulatory Surgical Center Medicare SNP Payer Appendix	United Healthcare	Kingsport Ambulatory Surgery Center

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0243	Medicare SNP Home Health Services Payment Appendix	United Healthcare	Norton Community Home Care, Mediserve Medical Equipment of Kingsport, Mountain States Health Alliance dba Medical Center Home Health, Mountain States Health Alliance dba Johnson County Home Health, Mountain States Health Alliance dba Medical Center HomeCare Services of Kingsport, Smyth County Regional HomeCare, Norton Community Hospital Home Health, Johnston Memorial Home Health, Russell County Home Health
MSHA0244	Ambulatory Surgical Center Medicaid Payer Appendix	United Healthcare	Kingsport Ambulatory Surgery Center
MSHA0245	Home Health Services Medicaid Payer Appendix	United Healthcare	Norton Community Home Care, Mediserve Medical Equipment of Kingsport, Mountain States Health Alliance dba Medical Center Home Health, Mountain States Health Alliance dba Johnson County Home Health, Mountain States Health Alliance dba Medical Center HomeCare Services of Kingsport, Smyth County Regional HomeCare, Norton Community Hospital Home Health, Johnston Memorial Home Health, Russell County Home Health
MSHA0246	Medicaid Hospice Payer Appendix	United Healthcare	Medical Center Hospice, Hospice Johnson City Medical Center, Russell County Hospice
MSHA0247	Amendment to Facility Participation Agreement	United Healthcare of Tennessee, Inc.	East Tennessee Ambulatory Surgery Center
MSHA0248	Amendment to Facility Participation Agreement	United Healthcare of Tennessee, Inc.	Kingsport Ambulatory Surgery Center

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0249	Eleventh Amendment to Facility Participation Agreement	United Healthcare of Tennessee, Inc.	Wilson Pharmacy, Inc.
MSHA0250	Amendment to Facility Participation Agreement	United Healthcare of Tennessee, Inc.	Kingsport Ambulatory Surgery Center
MSHA0251	Network Hospital Provider Agreement (August 22, 2000) -- Amendment to Agreement	United Healthcare Plan of the River Valley, Inc.	Mountain States Health Alliance
MSHA0252	Network Hospital Provider Agreement (November 1, 2004) -- Amendment to Agreement	United Healthcare Plan of the River Valley, Inc.	Dickinson Community Hospital
MSHA0253	Network Hospital Provider Agreement (August 22, 2000) -- Amendment to Agreement	United Healthcare Plan of the River Valley, Inc.	Mountain States Health Alliance
MSHA0254	Network Hospital Provider Agreement (January 1, 2001) -- Amendment to Agreement	United Healthcare Plan of the River Valley, Inc.	Norton Community Hospital
MSHA0255	Agreement	United Mine Workers of American, Combined Benefit Fund, UMWA 1992 Benefit Plan, UMWA 1993 Benefit Plan	Blue Ridge Medical Management Corporation
MSHA0256	Letter of Agreement	United Payors and United Providers, Inc.	Columbia Healthcare Network of Tri-Cities, Inc.
MSHA0257	Medical Group Participation Agreement	UnitedHealthCare Insurance Company	Abingdon Physician Partners
MSHA0258	Medical Group Participation Agreement	UnitedHealthCare Insurance Company	Blue Ridge Medical Management

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0259	Third Amendment to Facility Participation Agreement	UnitedHealthcare Insurance Company	Mountain States Health Alliance – Russell County Medical Center
MSHA0260	Twelfth Amendment to Facility Participation Agreement	UnitedHealthcare Insurance Company	Russell County Medical Center
MSHA0261	Facility Participation Agreement (plus Amendments dated April 1, 2012; August 15, 2013; July 1, 2015)	UnitedHealthcare Insurance Company	Mountain States Health Alliance (Johnson City Medical, Indian Path Medical, Indian Patch Medical Skilled Nursing, Medical Center Home Health, Medical Center Hospice, Quillen Rehab, Johnson City Specialty, Johnson County Community Hospital, Johnson County Home Health, Johnson County Medical Group, Northside, Franklin Woods Community, Princeton Transitional Care, Sycamore Shoals, Medical Center HomeCare Services of Kingsport, Russell County Medical Center (Riverside, Home Care, Hospice), Kingsport Day Surgery, Smyth County Community Hospital (Regional HomeCare, Frances Marion Manor, Glade Springs Clinic), Norton Community Hospital (Skilled Nursing, Rehab, Home Care, Home Health), Dickenson Community Hospital, Johnston Memorial Hospital, Johnston Memorial Home Health, Mediserve Medical Equipment of Kingsport)
MSHA0262	Amendment Number 2 to Medical Group Participation Agreement	UnitedHealthcare Insurance Company	Abingdon Physician Partners
MSHA0263	Second Amendment to Facility Participation Agreement	UnitedHealthcare Insurance Company	Wilson’s Pharmacy

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0264	Amendment Number 2 to Medical Group Participation Agreement	UnitedHealthCare Insurance Company	Abingdon Physician Partners
MSHA0265	Amendment Number 2 to Medical Group Participation Agreement	UnitedHealthCare Insurance Company	Blue Ridge Medical Management
MSHA0266	Amendment Number 12 to Medical Group Participation Agreement	UnitedHealthCare Insurance Company	Blue Ridge Medical Management
MSHA0267	12 th Amendment to Facility Participation Agreement (original Agreement dated December 1, 2007)	UnitedHealthcare Insurance Company, Inc.	Russell County Medical Center
MSHA0268	Amendment to Facility Participation Agreement (original Agreement dated February 1, 2012)	UnitedHealthcare of Tennessee, Inc.	Unicoi County Memorial Hospital
MSHA0269	Amendment to Facility Participation Agreement (original Agreement dated February 1, 2012)	UnitedHealthcare of Tennessee, Inc.	Unicoi Memorial Hospital
MSHA0270	Hospital Provider Agreement - Community Plan	UnitedHealthcare Plan of River Valley, Inc.	Mountain States Health Alliance
MSHA0271	Tennessee Program Network Practitioner Group Provider Agreement - Community Plan	UnitedHealthcare Plan of the River Valley, Inc.	Blue Ridge Medical Management Corporation
MSHA0272	Network Hospital Provider Agreement – Amendment	UnitedHealthcare Plan of the River Valley, Inc.	Dickenson Community Hospital
MSHA0273	Network Hospital Provider Agreement – Amendment	UnitedHealthcare Plan of the River Valley, Inc.	Mountain States Health Alliance (on behalf of: Johnson City Medical; Indian Path Medical; Franklin Woods; Johnson County Community; North Side; Quillen Rehabilitation; Sycamore Shoals; Smyth County; Medical Center Hospice; Kingsport

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
			Ambulatory Surgery; Medical Center Home Care; Hospice Care of Johnson City; Mediserve Medical Equipment of Kingsport; Johnson County Home Health; Johnston Memorial Hospital
MSHA0274	Network Hospital Provider Agreement – Amendment	UnitedHealthcare Plan of the River Valley, Inc.	Mountain States Health Alliance
MSHA0275	Network Hospital Provider Agreement – Amendment	UnitedHealthcare Plan of the River Valley, Inc.	Mountain States Health Alliance
MSHA0276	Network Hospital Provider Agreement – Amendment	UnitedHealthcare Plan of the River Valley, Inc.	Norton Community Hospital
MSHA0277	Home Health Ancillary Provider Services Agreement	Univita Healthcare Solutions LLC	Mountain States Health Alliance
MSHA0278	Health Care Service Provider Agreement	USA Health Network Company, Inc.	Southwest Virginia Healthnet (Base JMH)
MSHA0279	Health Care Service Provider Agreement	USA Health Network Company, Inc.	Southwest Virginia Healthnet (JMH Physicians)
MSHA0280	Health Care Service Facility Agreement	USA Managed Care Organization, Inc.	Norton Community Hospital
MSHA0281	Health Care Service Facility Agreement	USA Managed Care Organization, Inc.	Smyth County Community Hospital
MSHA0282	Health Care Service Facility Agreement (as amended)	USA Managed Care Organization, Inc.	Mountain States Health Alliance
MSHA0283	Facility Agreement (as amended)	Value Options, Inc.	Mountain States Health Alliance dba Indian Path Pavilion, Indian Path Medical Center and Sycamore Shoals Hospital

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0284	Addendum to Provider Agreement	Value Options, Inc.	Mountain States Health Alliance dba Woodbridge Psychiatric Hospital and Sycamore Shoals
MSHA0285	Amendment to Facility Agreement	Value Options, Inc.	Woodbridge Psychiatric Hospital
MSHA0286	Facility Agreement Amendment	Value Options, Inc.	Mountain States Health Alliance
MSHA0287	Facility/Program Agreement	Value Options, Inc.	Mountain States Health Alliance dba Woodridge Psychiatric Hospital
MSHA0288	Addendum to Provider Agreement	Value Options, Inc.	Mountain States Health Alliance dba Woodbridge Psychiatric Hospital
MSHA0289	Standard Contract	Virginia Department of Health	Johnston Memorial Hospital, Inc.
MSHA0290	Standard Contract	Virginia Department of Health	Smyth County Community Hospital
MSHA0291	Virginia Department of Health Office of Purchasing and General Services Standard Contract	Virginia Department of Health, Mount Rogers health district	Johnston Memorial Hospital, Inc.
MSHA0292	Standard Contract	Virginia Department of Health, Mount Rogers Health District	Johnston Memorial Hospital, Inc.
MSHA0293	Virginia Health Network, Inc. Physician – Hospital Organization	Virginia Health Network, Inc.	Southwest Virginia Health Network (JMh & Physicians)
MSHA0294	Hospital Agreement (as amended by those certain Amendments to the June 1, 2001 Agreement Russell County Medical Center and Virginia Health Network, Inc.)	Virginia Health Network, Inc.	Russell County Medical Center
MSHA0295	Physician – Hospital Organization (as amended)	Virginia Health Network, Inc.	Southwest VA. Health Network

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0296	Amendment to the May 1, 1999 Agreement between Mountain States Health Alliance and Virginia Health Network, Inc.	Virginia Health Network, Inc.	Smyth County Community Hospital
MSHA0297	Administrative Contract (plus 1 st Amendment dated 7/1/12)	Virginia Premier Health Plan, Inc.	ISHN, LLC - Base Agreement (Facilities & Physicians)
MSHA0298	1 st Amendment - Group	Virginia Premier Health Plan, Inc.	ISHN, LLC
MSHA0299	Volunteer State Health Plan, Inc. Home and Community Based Services Agreement for Non-Healthcare Providers	Volunteer State Health Plan, Inc.	Home and Community Based Services Non-Healthcare Provider/MSHS dba Mountain States Lifeline
MSHA0300	Amendment to Blue Care/TennCare Select - Primary	Volunteer State Health Plan, Inc.	Blue Ridge Medical Management Corporation
MSHA0301	Attachment BLUECARE Group Practice Specialist/Amendment to TennCare Select	Volunteer State Health Plan, Inc.	Blue Ridge Medical Management
MSHA0302	Amendment to the Bluecare Group Practice Specialist Attachment	Volunteer State Health Plan, Inc.	Blue Ridge Medical Management
MSHA0303	BlueCare Tennessee Professional Agreement	Volunteer State Health Plan, Inc. dba BlueCare Tennessee	Blue Ridge Medical Management Corporation
MSHA0304	Letter of Agreement – Hospital	Windsor Health Plan, Inc.	Unicoi County Memorial Hospital, Inc. & Nursing Home
MSHA0305	Amendment to PHO by and between Beechstreet Corp.	Beech Street Corporation	Southwest Virginia Network (APP)
MSHA0306	Amendment 1	The Initial Group	Southwest Virginia Network (APP)
MSHA0307	Amendment to the Existing Agreement	USA Managed Care Organization, Inc.	Southwest Virginia Network (APP)
MSHA0308	SelectNet Plus, Inc. Hospital Participation Agreement	SelectNet Plus, Inc. (Accorida National)	Russell County Hospital

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0309	National Capital Preferred Provider Organization Participation Agreement	National Preferred Provider Organization (Unicare)	Russell County Medical Center
MSHA0310	Letter of Agreement; Centurion of Tennessee	Centurion	Mountain States Health Alliance
MSHA0311	Contractor for Specimen Collection Agreement	Laboratory Corporation of America Holdings	Johnston Memorial Hospital, Inc.
MSHA0312	Amendment (to Hospital Services Agreement)	Aetna Health Inc.	Mountain States Health Alliance (updating Home Health to reflect inpatient hospice rate).
MSHA0313	Twelfth Amendment to ISHN Network Participation Agreement (amending March 27, 2012 Agreement)	ISHN Entities	Mountain States Health Alliance (adding Inpatient Hospice to Home Health for commercial plan)
MSHA0314	Eighteenth Amendment to ISHN Network Participation Agreement (amending March 27, 2012 Agreement)	ISHN Entities	Mountain States Health Alliance (adding Unicoi Hospital)
MSHA0315	Thirteenth Amendment to ISHN Network Participation Agreement (amending March 27, 2012 Agreement)	ISHN Entities	Mountain States Health Alliance (adding Unicoi Hospital to Optima and annual rate increase)
MSHA0316	MSHA Rate Escalator Effective 1/1/2016 Attachment A	Humana ChoicesCommercial	Kingsport Ambulatory Surgery Center, L.L.C.
MSHA0317	MSHA Rate Escalator Effective 1/1/2016 Attachment A	Humana Choices Commercial	MSHA Hospitals
MSHA0318	MA CAH Rate Structure	Humana Medicare	Dickenson Community Hospital, Inc.
MSHA0319	MSHA Rate Escalator Effective 1/1/2016 Attachment E-1 & E2	Humana Commercial	Kingsport Ambulatory Surgery Center, L.L.C.
MSHA0320	MA Attachment E-3 & E-4	Humana Medicare	Kingsport Ambulatory Surgery Center, L.L.C.
MSHA0321	MSHA Rate Escalator Effective 1/1/2016 Attachment E-1 & E-2	Humana Commercial	MSHA Hospitals

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Mountain States Health Alliance Contracting Party</u>
MSHA0322	MA CAH Rate Structure	Humana Medicare	Johnson County Community Hospital

Exhibit 11.10

Insurance Contracts and Payor Agreements in Place at the Time of the Application

Wellmont Health System

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS001	Physician Hospital Organization Agreement (as amended)	Aetna Health, Inc.	Highlands Wellmont Health Network, Inc.
WHS002	Facility Agreement - Non-Acute (as amended)	Anthem Health Plans of Virginia, Inc.	Holston Valley Ambulatory Surgery Center, Sapling Grove Surgery Center, Bristol Surgery Center
WHS003	Hospice Provider Agreement	Southeast Services, Inc.	Wellmont Hospice
WHS004	Anthem Healthkeepers Skilled Nursing Facility Provider Agreement	Healthkeepers, Inc.	Wellmont Health System d/b/a Mountain View Regional Medical Center
WHS005	Anthem Skilled Nursing Facility Medicare Advantage	Southern Services, Inc. and Anthem Health Plans of Virginia, Inc.	Wellmont Health System d/b/a Mountain View Regional Medical Center
WHS006	Anthem Skilled Nursing Facility Provider Agreement	Southeast Services, Inc.	Wellmont Health System d/b/a Mountain View Regional Medical Center
WHS007	Anthem Blue Cross Blue Shield Provider Agreement, as amended-Laboratory EC624	Anthem Blue Cross Blue Shield and Healthkeepers, Inc.	Mountain View Regional Medical Center
WHS008	Anthem Blue Cross and Blue Shield Facility Agreement	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield	Wellmont Health System
WHS009	Anthem Blue Cross and Blue Shield Provider Agreement and Amendment to Anthem Blue Cross and Blue Shield	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield	Lonesome Pine Hospital

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
	Provider Agreement - Therapy EC 612	(Anthem)	
WHS0010	Amendment to Anthem Blue Cross and Blue Shield Provider Agreement	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield	Wellmont Cardiology Services
WHS0011	Letter of Agreement	Anthem Blue Cross and Blue Shield	Wellmont Cardiology Services
WHS0012	Anthem Blue Cross and Blue Shield Provider Agreement - Specialists - EC308A	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield and Healthkeepers, Inc.	Wellmont Cardiology Services d/b/a Wellmont CVA
WHS0013	Anthem Blue Cross and Blue Shield Provider Agreement - Primary Care Physician - EC104A	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield and Healthkeepers, Inc.	Wellmont Medical Associates
WHS0014	Amendment 4 to the BluePreferred Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee, Inc.	Holston Valley Ambulatory Surgery Center
WHS0015	Amendment 4 to the BlueSelect Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee, Inc.	Holston Valley Ambulatory Surgery Center
WHS0016	Amendment 5 to the BluePreferred Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee, Inc.	Bristol Surgery Center
WHS0017	Amendment 5 to the BlueSelect Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee, Inc.	Bristol Surgery Center

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0018	Amendment 6 to the BluePreferred Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee, Inc.	Sapling Grove Surgery Center
WHS0019	Amendment 6 to the BlueSelect Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee, Inc.	Sapling Grove Surgery Center
WHS0020	Swing Bed Facility Amendments to the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc.	Hancock County Hospital
WHS0021	Medicare Advantage Provider Agreement	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates	Wellmont Health System
WHS0022	Medicare Advantage Provider Agreement	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates	Highlands Wellmont Health Network
WHS0023	CoverKids Amendment to the BlueCare Attachment	BlueCross BlueShield of Tennessee, Inc., participating TennCare provider, BCBST's wholly owned HMO subsidiary, Volunteer State Health Plan, Inc.	Wellmont Health System
WHS0024	Rate Variation Amendment to the BlueCare Network Institution Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc., Volunteer State Health Plan, Inc.	Takoma Regional Hospital

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0025	Swing Bed Facility Amendment to the BlueCare Institution Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates; Volunteer State Health Plan, Inc.	Hawkins County Memorial Hospital SNF
WHS0026	Rate Variation Amendment to the BlueCare Network Institution Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc., Volunteer State Health Plan, Inc.	Hawkins County Memorial Hospital
WHS0027	Amendments to the BlueCare Institution Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc., Volunteer State Health Plan, Inc.	Wellmont Health System
WHS0028	Dual Eligible Special Needs Plan Amendment to the BlueCare/TennCareSelect Attachment	BlueCross BlueShield of Tennessee, Inc., Volunteer State Health Plan, Inc.	Wellmont Health System
WHS0029	Swing Bed Facility Amendment to the BlueCare Institution Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates; Volunteer State Health Plan, Inc.	Wellmont Hancock Hospital-Swingbed
WHS0030	BlueCross BlueShield Of Tennessee Institution Agreement, as amended	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates;	Wellmont Health System Facilities: Hawkins County Memorial Hospital Bristol Regional Medical Center Hancock County Hospital Holston Valley Medical Center

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0031	Medicare Advantage Provider Agreement	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates;	Holston Valley Imaging Center
WHS0032	BlueCross BlueShield of Tennessee Group Practice Agreement, as amended	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates;	Cardiovascular Associates, P.C.
WHS0033	Specialist Consulting Amendment to the various Network Group Practice Attachments	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates;	Cardiovascular Associates, P.C.
WHS0034	Attachment BlueCare Group Practice Specialist to BlueCross BlueShield of Tennessee Group Practice Agreement	Volunteer State Health Plan, Inc.	Wellmont Medical Associates
WHS0035	Attachment BlueCare Group Practice Primary Care to BlueCross BlueShield of Tennessee Group Practice Agreement	Volunteer State Health Plan, Inc.	Wellmont Medical Associates
WHS0036	BlueCross BlueShield of Tennessee Group Practice Agreement (as amended)	BlueCross BlueShield Of Tennessee, Inc. for itself and on behalf of its Affiliates	Wellmont Medical Associates
WHS0037	BluePreferred SM Network Group Practice Attachment to BlueCross BlueShield of Tennessee Group Practice Agreement (as amended)	BlueCross BlueShield Of Tennessee, Inc. for itself and on behalf of its licensed Affiliates	Wellmont Medical Associates, Inc.
WHS0038	BlueSelect SM Network Group Practice Attachment to BlueCross BlueShield of Tennessee Group Practice Agreement	BlueCross BlueShield Of Tennessee, Inc. for itself and on behalf of its licensed Affiliates	Wellmont Medical Associates

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0039	Provider Group Services Agreement (with Addendum)	Cigna HealthCare of Tennessee, Inc.	Wellmont Cardiology Services
WHS0040	Provider Group Services Agreement (with Addendum)	Cigna HealthCare of Tennessee, Inc.	Wellmont Medical Associates
WHS0041	Hospital Services Agreement	Cigna HealthCare of Tennessee, Inc.	Wellmont Health System
WHS0042	Hospital Participation Agreement (as amended)	Health Value management, Inc. d/b/a ChoiceCare Network	Wellmont Health System
WHS0043	Hospital Participation Agreement (as amended)	Humana Health Plan, Inc. and Humana Insurance Company and their affiliates that underwrite or administer health plans	Wellmont Health System
WHS0044	Group Participation Agreement (as amended)	Humana Insurance Company, Humana Health Plan, Inc., and their affiliates that underwrite or administer health plans	Wellmont Medical Associates
WHS0045	Model Practice Amendment to Humana Agreement with Wellmont Medical Associates	Humana Health Plan, Inc. and Humana Insurance Company and their affiliates that underwrite and/or administer health plans	Wellmont Medical Associates and Affiliates
WHS0046	Delegation of Credentialing Services Attachment	Humana Insurance Company, Humana Health Plan, Inc.	Highlands Wellmont Network
WHS0047	Letter of Agreement	Humana Insurance Company, Humana Health Plan, Inc. and their affiliates that underwrite or administer health plans	Wellmont Medical Associates

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0048	Delegation of Credentialing Services Attachment	Humana Insurance Company, Humana Health Plan, Inc. and Health Value Management Inc. d/b/a ChoiceCare Network	Wellmont Medical Associates
WHS0049	Amendment One to the Agreement	Humana, Inc.	Wellmont Medical Associates
WHS0050	Delegation Services Addendum to Participation Agreement	Humana Insurance Company, Humana Health Plan, Inc. and Health Value Management Inc. d/b/a ChoiceCare Network	Highlands Wellmont Health Network
WHS0051	Network Access Agreement (as amended)	Bristol Tennessee Essential Services (BTES)	Highlands Wellmont Health Network
WHS0052	Network Access Agreement (as amended)	Carolina Steel/Hirschfeld Steel Companies	Highlands-Wellmont Health Network
WHS0053	Network Access Agreement (as amended)	Electro-Mechanical Corporation	Highlands-Wellmont Health Network, Inc.
WHS0054	Physician Hospital Organization Agreement	Managed Care of America	Highlands Wellmont Health Network
WHS0055	Network Access Agreement (as amended)	Pittston Coal Management Company	Highlands Wellmont Health Network, Inc.
WHS0056	Amendment to Contract Network Access Agreement; also includes executed Business Associate Agreement	Russell County Board of Education	Highlands Wellmont Health Network
WHS0057	Network Access Agreement (as amended)	Scott County School Board	Highlands Wellmont Health Network, Inc.
WHS0058	Network Access Agreement (as amended); also includes executed Business Associate Agreement	Adventist Health System/Sunbelt, Inc. d/b/a Takoma Adventist (Later	Highlands Wellmont Health Network, Inc.

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
		Takoma Regional)	
WHS0059	Network Access Agreement (as amended); also includes executed Business Associate Agreement	United Coal Company and later The United Company	Highlands-Wellmont Health Network, Inc.
WHS0060	Network Access Agreement (as amended)	Prisma Fibers, Inc.	Highlands-Wellmont Health Network, Inc.
WHS0061	Network Access Agreement (as amended)	Wellmont Health System	Highlands-Wellmont Health Network, Inc.
WHS0062	Amendment to the Medical Group Participation Agreement	UnitedHealthcare Insurance Company on behalf of itself, UnitedHealthcare of Tennessee, Inc., and United's Affiliates	Cardiovascular Associates, PC
WHS0063	Amendment to Medical Group Participation Agreement	UnitedHealthcare Insurance Company on behalf of itself, UnitedHealthcare of the River Valley, and United's Affiliates	Wellmont Medical Associates and Wellmont Cardiology Services
WHS0064	Practitioner Group Provider Agreement	UnitedHealthcare Plan of the River Valley, Inc.	Wellmont Cardiology Services
WHS0065	Amendment to Medical Group Participation Agreement	UnitedHealthcare Insurance Company on behalf of itself, UnitedHealthcare of the River Valley, Inc., and United's Affiliates	Wellmont Medical Associates
WHS0066	Tennessee Program Network Practitioner Group Provider Agreement	UnitedHealthcare Plan of the River Valley, Inc. (f/k/a John Deere Health Plan, Inc.)	Wellmont Medical Associates

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0067	Credentialing Delegation Agreement	UnitedHealthcare Insurance Company, on behalf of itself and UnitedHealthcare of the River Valley, Inc. and United Affiliates	Wellmont Medical Associates
WHS0068	Amendment to the Medical group Participation Agreement	UnitedHealthcare Insurance Company on behalf of itself, UnitedHealthcare of Tennessee, Inc., and United's Affiliates	Cardiovascular Associates, PC
WHS0069	Medical Group Participation Agreement	UnitedHealthcare Insurance Company contracting on behalf of itself, UnitedHealthcare of the River Valley, Inc., and the other entities that are United's Affiliates	Wellmont Medical Associates
WHS0070	Amendment to Agreement of Tennessee Program Network Group Practitioner Provider Agreement	UnitedHealthcare Plan of the River Valley, Inc.	Wellmont Medical Associates
WHS0071	Amendment to the Agreement of Tennessee Program Network Hospital Provider Agreement	UnitedHealthcare Plan of the River Valley, Inc.	Wellmont Health System on behalf of Bristol Regional Medical Center, Holston Valley Medical Center, Lonesome Pine Hospital, Hancock County Hospital, Hawkins County Medical Center, Mountain View Regional Medical Center, Takoma Regional Hospital, Wellmont Hospice, Holston Valley Imaging Center, Bristol Surgery Center, Holston Valley Surgery Center and Sapling Grove Surgery Center

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0072	Facility Participation Agreement	UnitedHealthcare Insurance Company, contracting on behalf of itself, UnitedHealthcare Plan of the River Valley, Inc. and the other entities that are United's Affiliates	Wellmont Health System
WHS0073	Amendment to the Agreement of Tennessee Program Network Hospital Provider Agreement	UnitedHealthcare Plan of the River Valley, Inc.	Wellmont Health System on behalf of Bristol Regional Medical Center, Holston Valley Medical Center, Lonesome Pine Hospital, Hancock County Hospital, Hawkins County Medical Center, Mountain View Regional Medical Center, Takoma Regional Hospital, Wellmont Hospice, Holston Valley Imaging Center, Bristol Surgery Center, Holston Valley, Surgery Center and Sapling Grove Surgery Center
WHS0074	Tennessee Program Network Hospital Provider Agreement (as amended)	UnitedHealthcare Plan of the River Valley, Inc.	Wellmont Health System on behalf of Bristol Regional Medical Center, Holston Valley Medical Center, Lonesome Pine Hospital, Hancock County Hospital, Hawkins County Medical Center, Mountain View Regional Medical Center, Takoma Regional Hospital, Wellmont Hospice, Holston Valley Imaging Center, Bristol Surgery Center, Holston Valley, Surgery Center and Sapling Grove Surgery Center
WHS0075	FOLDER: Wexford House Agreements		
WHS0076	Outsourcing Therapy Services	Rehab Solutions, Inc.	RHA Sullivan, Inc. d/b/a The Wexford House

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
	Agreement		
WHS0077	Anthem Folder		
WHS0078	Amendment to the Skilled Nursing Facility Provider Agreement	Southeast Services, Inc. and Anthem Blue Cross Blue Shield	Generic notice to all participating providers
WHS0079	Amendment to Skilled Nursing Facility Provider Agreement	Southeast Services, Inc. and Anthem Blue Cross Blue Shield	Generic notice to all participating providers
WHS0080	Skilled Nursing Facility Agreement	Trigon Services, Inc.	The Wexford House
WHS0081	HWHN		
WHS0082	Business Associate Agreement	Wellmont Wexford House	Highlands Wellmont Health Network
WHS0083	Preferred Provider Agreement	Wellmont Wexford House	Highlands Wellmont Health Network, Inc.
WHS0084	BCBST		
WHS0085	Network P Skilled Nursing Facility Attachment of the Blue Cross Blue Shield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc. for itself and on behalf of other Payors, including its Affiliates	The Wexford House
WHS0086	2009 BlueCare Compliance Amendment	BlueCross BlueShield of Tennessee, Inc. and Volunteer State Health Plan, Inc.	Generic regulatory amendment to all participating providers
WHS0087	Long Term Care Services Nursing Facility Agreement (as amended)	Volunteer State Health Plan, Inc. for itself and on the behalf of its Affiliates	The Wexford House
WHS0088	Medicare Advantage Provider Agreement	BlueCross BlueShield of Tennessee, Inc.	The Wexford House
WHS0089	BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee on behalf of its licensed Affiliates	The Wexford House

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0090	Network S Skilled Nursing Facility Attachment of the Blue Cross Blue Shield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc. for itself and on behalf of other Payors, including its Affiliates	The Wexford House
WHS0091	BlueAdvantage Local PPO Medicare Advantage Provider Agreement Skilled Nursing Facility Attachment (as amended)	BlueCross BlueShield of Tennessee, Inc., for itself and on behalf of its licensed Affiliates	The Wexford House
WHS0092	Skilled Nursing Facility Network Attachment	BlueCross BlueShield of Tennessee on behalf of itself and its Affiliates	The Wexford House
WHS0093	Humana		
WHS0094	Ancillary Provider Participation Agreement	Health Value Management, Inc. d/b/a ChoiceCare Network	RHA Sullivan, Inc.
WHS0095	UHC		
WHS0096	Amendment to Tennessee Program Network Ancillary Provider Agreement	UnitedHealthCare Plan of the River Valley, Inc.	RHA Sullivan, Inc. d/b/a The Wexford House
WHS0097	Tennessee Program Network Ancillary Provider Agreement	UnitedHealthcare Plan of the River Valley, Inc.	RHA Sullivan d/b/a The Wexford House
WHS0098	Ancillary Provider Participation Agreement	United Healthcare Insurance Company, on behalf of itself, UnitedHealthcare of Tennessee, Inc., and United's Affiliates	The Wexford House
WHS0099	Free Standing Skilled Nursing Facility Medicare Payer Appendix AND Amendment to Ancillary Provider Participation Agreement	United HealthCare Insurance Company, on behalf of itself and United's Affiliates	The Wexford House

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0100	Memorandum of Agreement	The Center for Healthcare Quality	The Wexford House
WHS0101	First Amendment to the Ancillary Service Provider Agreement	HealthSpring of Tennessee, Inc. and HealthSpring Life and Health Insurance Company, Inc.	RHA Sullivan, Inc. d/b/a The Wexford House
WHS0102	Ancillary Service Provider Agreement	HealthSpring of Tennessee, Inc. and HealthSpring Life and Health Insurance Company, Inc.	RHA Sullivan, Inc. d/b/a The Wexford House
WHS0103	Medical Assistance Participation Agreement (Medicaid/TennCare Title XIX Program)	The State of Tennessee Department of Finance and Administration Bureau of TennCare	RHA Sullivan, Inc. d/b/a The Wexford House
WHS0104	Skilled Nursing Facility Participation Agreement	Tricare	RHA Sullivan, Inc. d/b/a The Wexford House
WHS0105	Network Access Agreement (as amended)	ACS Consulting	Highlands Wellmont Health Network, Inc.
WHS0106	Physician Hospital Organization Agreement	A & G Healthcare Services d/b/a Amera-Net	Highlands Wellmont Health Network
WHS0107	Physician-Hospital Organization Agreement	American PPO, Inc.	Highlands Wellmont Health Network
WHS0108	Physician-Hospital Organization Agreement (as amended)	Beech Street Corporation	Highlands Wellmont Health Network
WHS0109	Institutional Services Agreement (as amended)	CIGNA Behavioral Health, Inc.	Wellmont Health System, Inc.
WHS0110	Physician Hospital Organization Agreement	CorVel Corporation	Highlands Wellmont Health Network

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
	(as amended)		
WHS0111	Facility Agreement	Employer's Choice Network, LLC	Highlands Wellmont Health Network on behalf of Lonesome Pine Hospital, Lee Regional Medical Center and Mountain View Regional Medical Center
WHS0112	PHO Agreement	Evolutions Healthcare Systems, Inc.	Highlands Wellmont Health Network
WHS0113	The First Health Network Hospital Contract (as amended)	The First Health Network	Wellmont Health System d/b/a Wellmont Bristol Regional Medical Center, Wellmont Holston Valley Medical Center, Wellmont Ridgeview Pavilion
WHS0114	Health Care Services Agreement	Galaxy Health Network	Highlands Wellmont Health Network
WHS0115	Provider Participation Agreement (as amended)	Health Net Federal Services, LLC on behalf of itself and the subsidiaries and Affiliates of Health Net, Inc.	Wellmont Health System d/b/a Lonesome Pine Hospital & Mountain View Regional Medical Center
WHS0116	Facility Provider Agreement (as amended)	Health Net Federal Services, LLC	Highlands Wellmont Health Network d/b/a Lonesome Pine Hospital, Lee Regional Medical Center and Mountain View Regional Medical Center
WHS0117	HMHS South Hospital Service Agreement (as amended)	Humana Military Healthcare Services, Inc.	Wellmont Bristol Regional Medical Center Wellmont Bristol Regional Medical Center-SNF Wellmont Home Care Wellmont Home Medical Equipment and Respiratory Services Wellmont Infusion Network Wellmont Hospice Wellmont Holston Valley Medical Center Wellmont Holston Valley Medical Center-SNF

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
			Wellmont Hawkins County Memorial Hospital
WHS0118	Physician Hospital Organization Participation Agreement (as amended)	The Initial Group, Inc.	Highlands-Wellmont Health Network
WHS0119	Network Services Agreement (as amended)	Integrated Medical Solutions, LLC	Highlands Wellmont Health Network
WHS0120	Participating Provider Agreement (as amended)	AMERIGROUP Virginia, Inc. d/b/a AMERIGROUP Community Care	Highlands Wellmont Health Network, Inc.
WHS0121	Facility and Program Participation Agreement (as amended)	Magellan Behavioral Health, Inc.	Wellmont Health System, Inc.
WHS0122	Facility Network Participation Agreement (as amended)	Mental Health Associates, Inc.	Bristol Regional Medical Center, Takoma Regional Hospital and Ridgeview Pavilion
WHS0123	Mountain Empire PACE Provider Agreement (as amended)	Mountain Empire Older Citizens, Inc.	Wellmont Health System, Inc. (d/b/a Lonesome Pine Hospital, Lee Regional Medical Center, Mountain View Regional Medical Center, Holston Valley Medical Center, and Bristol Regional Medical Center)
WHS0124	Health Care Provider Network Agreement Physician-Hospital Organization (as amended)	BCE Emergis Corporation	Highlands Wellmont Health Network
WHS0125	Physician Hospital Organization Agreement (as amended)	NovaNet, Inc.	Highlands Wellmont Health Network
WHS0126	Physician Hospital Organization Agreement (as amended)	Prime Health Services, Inc.	Highlands Wellmont Health Network
WHS0127	Physician Hospital Organization Agreement (as amended)	Provider Strategies, Inc. (n/k/a Provider Select, Inc.)	Highlands Wellmont Health Network

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0128	Network Access Agreement (as Amended)	Acordia National, Inc.	Highlands Wellmont Health Network, Inc.
WHS0129	Physician Hospital Organization Agreement (as amended)	Southern Health Services, Inc.	Highlands Wellmont Health Network
WHS0130	United Behavioral Health Provider Agreement (as amended)	United Behavioral Health, Inc.	Wellmont Health System d/b/a Bristol Regional medical Center-Ridgeview Pavilion added 10/1/2004
WHS0131	United Behavioral Health TennCare Program Facility Participation Agreement	United Behavioral Health on behalf of itself and UnitedHealthcare Plan of the River Valley	Wellmont Health System d/b/a Bristol Regional Medical Center, Ridgeview Pavilion and Takoma Regional Hospital
WHS0132	Agreement and Addendum to the Funds Cooperating Provider Agreement	The Trustees of the United Mine Workers of America Combined Benefit Fund, the Trustees of the UMWA 1992 Benefit Plan and the Trustees of the UMWA 1993 Benefit Plan	Wellmont Health System
WHS0133	Physician Hospital Organization Agreement (as amended)	USA Managed Care Organization, Inc.	Highlands Wellmont Health Network
WHS0134	Hospitalization Services Agreement (Fee-For-Services)	Commonwealth of Virginia Department of Rehabilitation Services	Wellmont-Bristol Regional Medical Center, Holston Valley Medical Center and Lonesome Pine Hospital
WHS0135	Administrative Contract (as amended)	Virginia Premier Health Plan, Inc.	Highlands Wellmont Health Network
WHS0136	Facility Amendment Schedule (as amended)	ValueOptions, Inc.	Wellmont Bristol Regional Medical Center
WHS0137	Diagnostic Service Agreement	Veterans Evaluation Services	Wellmont Health System

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0138	Physician Hospital Organization Provider Participation Agreement	Windsor Health Plan, Inc.	Highlands Wellmont Health Network
WHS0139	Rates Only Amendment to Hospital Service Agreement (06/07/2014)	Cigna HealthCare of Tennessee, Inc.	Wellmont Health System
WHS0140	Amendment 4 to the BluePreferred Network Institution Attachment	Blue Cross Blue Shield of Tennessee, Inc. on behalf of itself and its licensed Affiliates	Takoma Regional Hospital Hawkins County Memorial Hospital Bristol Regional Medical Center Hancock County Hospital Holston Valley Medical Center
WHS0141	Amendment 4 to the BlueSelect Network Institution Attachment	Blue Cross Blue Shield of Tennessee, Inc. on behalf of itself and its licensed Affiliates	Takoma Regional Hospital Hawkins County Memorial Hospital Bristol Regional Medical Center Hancock County Hospital Holston Valley Medical Center
WHS0142	Medicare Advantage Provider Agreement (as amended)	BlueCross BlueShield of Tennessee, Inc. for itself and on behalf of its licensed Affiliates	Wellmont Cardiology Services
WHS0143	Medicaid Specialist Center Agreement	HealthKeepers, Inc.	Wellmont Medical Associates, Inc.
WHS0144	Medicaid Primary Care Physician Center Agreement	HealthKeepers, Inc.	Wellmont Medical Associates, Inc.
WHS0145	Amendment to Anthem Blue Cross and Blue Shield Provider Agreement Signature Page	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield and Healthkeepers, Inc.	Wellmont Medical Associates
WHS0146	Signature Page	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield and Healthkeepers, Inc.	Wellmont Medical Associates

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0147	Anthem Blue Cross Blue Shield Provider Agreement-Laboratory	Southeast Services, Inc.	Mountain View Regional Medical Center
WHS0148	Amendment to Anthem Blue Cross and Blue Shield Provider Agreement	Anthem health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield	Wellmont Medical Associates
WHS0149	2015 Rate Variation Amendment to the BlueCare/TennCareSelect Network Attachment	BlueCross BlueShield of Tennessee, Inc.	Hawkins County Memorial Hospital
WHS0150	2015 Rate Variation Amendment to the BlueCare/TennCareSelect Network Attachment	BlueCross BlueShield of Tennessee, Inc.	Hawkins County Memorial Hospital
WHS0151	2015 Rate Variation Amendment to the BlueCare/TennCareSelect Network Attachment	BlueCross BlueShield of Tennessee, Inc.	Holston Valley Medical Center
WHS0152	P4 Pathways Amendment to the BlueCare Network Group Practice attachment	BlueCross BlueShield of Tennessee, Inc. and Volunteer State Health Plan, Inc.	Wellmont Medical Associates
WHS0153	P4 Pathways Amendment to the BluePreferred Network Group Practice Attachment	BlueCross BlueShield of Tennessee, Inc.	Wellmont Medical Associates
WHS0154	P4 Pathways Amendment to the BlueSelect Network Group Practice Attachment	BlueCross BlueShield of Tennessee Inc.	Wellmont Medical Associates
WHS0155	P4 Pathways Amendment to the BlueCoverTN Amendment to the BluePreferred Network Group Practice Attachment	BlueCross BlueShield of Tennessee Inc.	Wellmont Medical Associates

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0156	P4 Pathways Amendment to the TennCare Select Network Group Practice Attachment	BlueCross BlueShield of Tennessee, Inc. and Volunteer State Health Plan, Inc.	Wellmont Medical Associates
WHS0157	Anthem Blue Cross and Blue Shield Provider Agreement (Specialists-EC308A)	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield and Healthkeepers, Inc.	Wellmont Medical Associates
WHS0158	BlueCross BlueShield of Tennessee Hospital Pay-for-Performance Program Guide	BlueCross BlueShield of Tennessee Inc.	THIS IS NOT A CONTRACT
WHS0159	BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc., for itself and on behalf of its wholly-owned subsidiaries	Wellmont Health Systems
WHS0160	BlueCross BlueShield of TN Schedule 1-A	BlueCross BlueShield of Tennessee Inc.	Wellmont Health Systems
WHS0161	BlueCross BlueShield of Tennessee Outpatient Surgery Groupers Attachment 2-A, Schedule	BlueCross BlueShield of Tennessee Inc.	Wellmont Health Systems
WHS0162	BlueCross BlueShield of Tennessee Laboratory Schedule 2-B	BlueCross BlueShield of Tennessee Inc.	Wellmont Health Systems

<u>Reference No.</u>	<u>Agreement Title</u>	<u>Payor</u>	<u>Wellmont Health System Contracting Party</u>
WHS0163	Amendment to the Institution Agreement	BlueCross BlueShield of Tennessee, for itself and on behalf of its licensed Affiliates	Wellmont Health System and following facilities: Bristol Regional Medical Center; Hawkins County Memorial Hospital; Holston Valley Medical Center; Hancock County Hospital; Bristol Surgery Center; Holston Valley Ambulatory Surgery Center; Sapling Grove Surgery Center

Exhibit 11.11

Information regarding existing and future business plans of Mountain States is considered competitively sensitive information under federal antitrust laws and will be subsequently filed.

Exhibit 11.12

Information regarding existing and future business plans of Wellmont is considered competitively sensitive information under federal antitrust laws and will be subsequently filed.

EXHIBIT 11.13

NEW HEALTH SYSTEM ALIGNMENT POLICY

Alignment of Clinical Facilities and Clinical Services by health systems, where appropriate, are a standard and widely accepted mechanism for reducing unnecessary cost in health care, improving quality, and ensuring the services and programs offered are continuously evaluated objectively to ensure efficiency and the best outcome for patients. Among the many benefits of proper alignment are:

1. Assembling a “critical mass” of technology, clinical expertise and financial resources required to develop true centers of excellence.
2. Freeing up resources needed to provide highly technical and resource intensive services that, at a given time, may only be accessed outside the region.
3. Providing financial resources to clinical services that operate at a loss, or are currently not adequately provided, but are vitally important to the health of the region.
4. Improving the financial and clinical performance of services or facilities that currently operate in close proximity of each other.
5. Ensuring overall system financial viability, with an understanding that low overall operating margins inhibit the ability of the system to capitalize and invest in other services important to the region.
6. Realignment of care will improve access and care delivery, and provide effective care at the right locations.

Policy: Alignment of clinical facilities and/or services, where appropriate, may occur after an evaluation of the potential merits and adverse effects related to access, quality and service for patients. The objective of any alignment should include, but may not be limited to: enhanced service to the region, improved quality or scope of care, or enhanced financial performance material to the success of the overall system. Prior to implementing an alignment, it must be determined the benefits of the alignment outweigh the adverse effects.

Application: This policy applies to alignment of clinical facilities and clinical services in those cases where the alignment results in a discontinuation of a major service line or facility such that any such discontinuation would render the service unavailable in that community. This policy is not applicable to alignment of administrative or non-clinical services or programs.

Definitions:

Clinical Facility or Facilities - Any location where inpatient care is provided.

Clinical Service –A scope of patient care generally recognized to be associated with a specific medical or surgical specialty.

Community – The primary service area of a clinical service or facility, generally defined as the area from which 75% of patient volume originates.

Region – the geographic area served by the New Health System

Board Integration Committee – A committee of the Board which shall meet as needed upon a proposal by management to align a facility or service applicable under this policy. The purpose of the committee shall be to evaluate management’s recommendation, and make a recommendation to the Board of Directors prior to the Board’s final approval or rejection of a proposed alignment.

Procedure:

1. Management identifies an opportunity (or opportunities) for alignment which meets the requirement for review as outlined herein.
2. Management will evaluate the opportunity based upon (a) the use of clinical and financial data, and (b) input from physicians and other clinicians relevant to the service or facility which is subject of the alignment. Management will identify the benefits and adverse effects of the proposed alignment, including any cultural impacts. Management may utilize consulting and other independent resources to assist in the evaluation.
3. Upon reaching a conclusion to move forward with alignment, management will notify the Board of its intent, and will request a meeting of the Board Integration Committee. Management will present the proposal for the alignment to the Board Integration Committee.
4. The Board Integration Committee will evaluate the proposal, including the data and input relied upon by management in making its proposal. The Board Integration Committee will formulate a recommendation to the Board of Directors.
5. In considering the recommendation of the Board Integration Committee, the Board shall evaluate the data and input relied upon by the Board Integration Committee, including any data or input which does not support the recommendation.
6. Management shall provide administrative and analytical support to the Board Integration Committee as it contemplates any proposed action.
7. Upon approval by the Board of any alignment, management shall report periodically to the Board Integration Committee on the status of the alignment effort for each project approved, until such project has been completed.

8. One year after the completion of an alignment, management will provide a report to the Board on the results of the alignment, including any lessons learned, physician feedback, community effects and financial impact.

Charter of the Board Integration Committee

Membership. The Board Integration Committee will consist of 10 members (the "Members"), composed of the following:

- A. Six (6) Members shall be non-management Directors, two (2) of whom shall be physicians.
- B. Four (4) Members shall be at-large members who are not Directors and who are not otherwise serving on any committees of the Board of Directors. At least two (2) at-large Members shall be independently practicing physicians.

The Members will be nominated by the Board Governance/Nominating committee, except that the two (2) at-large physician Members will be nominated by the Clinical Council. The initial membership of the Board Integration Committee shall be composed of equal representation from legacy Wellmont Health System and Mountain States Health Alliance until after the second anniversary of the closing of the merger transaction.

1. The Board Integration Committee shall endeavor to ensure management, in making a recommendation to align a service or facility, has deployed a planning process which includes objective financial and clinical data and research, as well as input from affected physicians, clinicians, and other affected stakeholders. The committee will insure a clear vision is articulated by management, including the goals and objectives of the alignment. The committee will evaluate potential community impact of proposed alignment in terms of health status, access, employment and other community considerations.
2. The Board Integration Committee may request that management establish an inventory of current facilities and services and request recommendations for where potential overlap exists and/or synergies could be realized.
3. The Board Integration Committee will ensure management has developed a communication plan and strategy for implementation that considers the various stakeholders affected by any such decision to align a facility or service.

Exhibit 11.14

Overview of IOM Core Metrics: The Institute of Medicine (IOM) recently released a set of core metrics for guidance in population health for use by governments, health systems, insurers, businesses and health departments. (Institute of Medicine, 2015, *Vital signs: Core metrics for health and health care progress*, Washington, D.C.: The National Academies Press) There are 15 core measures grouped into four domains: Healthy People, Care Quality, Care Cost, and Engaged People. Measures within each domain include: *Healthy people:* Life expectancy, well-being, overweight and obesity, addictive behavior, unintended pregnancy, healthy communities; *Care quality:* Preventive services, care access, patient safety, evidence-based care, care match with patient goals; *Care cost:* Personal spending burden, sustainability; *Engaged people:* Individual engagement, community engagement. The IOM report also identified best available measures for each core metric and reported the current national values.

IOM Core Measures

<p>LIFE EXPECTANCY</p> <p>WELL-BEING</p> <p>OVERWEIGHT AND OBESITY</p> <p>ADDICTIVE BEHAVIOR</p> <p>UNINTENDED PREGNANCY</p> <p>HEALTHY COMMUNITIES</p>	<p>1. Life expectancy Infant mortality Maternal mortality Violence and injury mortality</p> <p>2. Well-being Multiple chronic conditions Depression</p> <p>3. Overweight and obesity Activity levels Healthy eating patterns</p> <p>4. Addictive behavior Tobacco use Drug dependence/illicit use Alcohol dependence/misuse</p> <p>5. Unintended pregnancy Contraceptive use</p> <p>6. Healthy communities Childhood poverty rate Childhood asthma Air quality index Drinking water quality index</p>	<p>PREVENTIVE SERVICES</p> <p>CARE ACCESS</p> <p>PATIENT SAFETY</p> <p>EVIDENCE-BASED CARE</p>	<p>7. Preventive services Influenza immunization Colorectal cancer screening Breast cancer screening</p> <p>8. Care access Usual source of care Delay of needed care</p> <p>9. Patient safety Wrong-site surgery Pressure ulcers Medication reconciliation</p> <p>10. Evidence-based care Cardiovascular risk reduction Hypertension control Diabetes control composite Heart attack therapy protocol Stroke therapy protocol Unnecessary care composite</p>	<p>CARE MATCH WITH PATIENT GOALS</p> <p>PERSONAL SPENDING BURDEN</p> <p>POPULATION SPENDING BURDEN</p> <p>INDIVIDUAL ENGAGEMENT</p> <p>COMMUNITY ENGAGEMENT</p>	<p>11. Care match with patient goals Patient experience Shared decision making End-of-life/advanced care planning</p> <p>12. Personal spending burden Health care-related bankruptcies</p> <p>13. Population spending burden Total cost of care Health care spending growth</p> <p>14. Individual engagement Involvement in health initiatives</p> <p>15. Community engagement Availability of healthy food Walkability Community health benefit agenda</p>
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Source: Adapted from the Institute of Medicine (IOM), 2015, *Vital Signs: Core metrics for health and health care progress*. Washington, D.C.: The National Academies Press.

IOM Core Measure Set

Domain	Key Element	Core Measure Focus	Best Current Measure	Current National Performance
Healthy People	Length of Life	Life Expectancy	Life expectancy at birth	79 year life expectancy at birth
	Quality of Life	Wellbeing	Self-reported health	66% report being healthy
	Healthy Behaviors	Overweight and Obesity	Body mass index	69% of adults with BMI >25
		Addictive Behavior	Addiction death rate	200 addiction deaths per 100,000, age 15+
	Unintended Pregnancy	Teen pregnancy rate	27 births per 1,000 females aged 15 to 19	
Healthy Social Circumstances	Healthy Communities	High school graduation rate	80% graduate in 4 years	
Care Quality	Prevention	Preventive Services	Childhood immunization rate	68% of children vaccinated by age 3
	Access to Care	Care Access	Unmet care need	5% report unmet medical needs
	Safe Care	Patient Safety	Hospital acquired infection rate	1,700 HAIs per 100,000 admissions
	Appropriate Treatment	Evidence-Based Care	Preventable hospitalization rate	10,000 avoidable per 100,000 admissions
Person-Centered Care	Care Match with Patient Goals	Patient-clinician communication satisfaction	92% satisfied with provider communication	
Care Cost	Affordability	Personal Spending Burden	High spending relative to income	46% spent >10% income on care, or uninsured in 2012
	Sustainability	Population Spending Burden	Per capita expenditures on health care	\$9,000 health care expenditure per capita
Engaged People	Individual Engagement	Individual Engagement	Health literacy rate	12% proficient health literate
	Community Engagement	Community Engagement	Social support	21% inadequate social support

Source: Adapted from the Institute of Medicine's *Vital Signs: Core Metrics for Health and Health Care Progress*, Table S1: Core Measure Set. Available online at: <http://www.iom.edu/Reports/2015/Vital-Signs-Core-Metrics.aspx>

Exhibit 15.1

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

Pursuant to Grant of Certificate of Public Advantage
By the Tennessee Commissioner of Health

This Plan of Separation (“the Plan”) is prepared as part of the application for Certificate of Public Advantage (“COPA”) submitted jointly by Wellmont Health System and Mountain States Health Alliance (collectively “the Parties”) to the Honorable Dr. John J. Dreyzehner, Commissioner, Tennessee Department of Health (“the Commissioner”). The Plan is intended to set out the process by which the Parties would effect an orderly separation of the new, integrated health system to be created under the COPA (the “New Health System”) in the event that the Commissioner determines that it is necessary to terminate the COPA previously granted to the Parties, as set forth in T.C.A. section 68-11-1303(g).

Upon written notice of a determination by the Commissioner to terminate the COPA pursuant to T.C.A. section 68-11-1303(g), and upon expiration of any period to appeal, or a final ruling adverse to the Parties on appeal, the Parties shall, within thirty (30) days, retain a consultant with expertise in provider operations and competition in the health care industry (“the Consultant”). The Consultant shall assist the Parties in complying with the termination order by analyzing competitive conditions in the markets subject to the Commissioner’s termination order and identifying the specific steps necessary to return the markets to their pre-consolidation competitive state. In undertaking this analysis, the Parties and Consultant shall take into account data submitted in the COPA Application showing the structure of the geographic service area at the time of consolidation, including the number, locations and relative shares of the parties and all other participants. The Parties and Consultant will cooperate with the Commissioner in these efforts. This cooperation shall include, upon the Commissioner’s request, sharing any non-privileged documents, data or other information that the Parties or Consultant may receive, generate or evaluate in the course of this process.

By agreeing that the Consultant will cooperate and share information with the Commissioner, the Parties hereby neither expressly nor implicitly waive any rights they may have with regard to maintaining protections for the privileged, confidential or proprietary content within said information. It is the Parties’ intent to properly manage competitively sensitive information, and thus, to maintain the privileged, confidential and/or proprietary nature of those items and not subject them to public disclosure.

With the assistance from the Consultant, within one hundred (100) days of the Consultant's retention date, the Parties will submit a plan to the Commissioner for divestiture of assets and operations and any other actions that would be appropriate under then-current market circumstances designed to restore, to the extent reasonably practicable, competitive conditions to their pre-consolidation competitive state or otherwise remedy the competitive concerns identified by the Commissioner ("Proposed Plan"). The Proposed Plan will be accompanied by a written report from the Consultant concerning the suitability of the proposed disposition of assets and operations in addressing the competitive deficiencies that resulted in the termination order. The Parties and Consultant will cooperate with the Commissioner in his or her examination and evaluation of the Proposed Plan.

Immediately upon the Commissioner's approval of the Proposed Plan (or of any plan that contains revisions thereto) ("Final Plan"), the Parties shall undertake to execute the Final Plan. Unless the Parties and the Commissioner agree it is not feasible to do so, the Parties will finalize execution of the Plan within two hundred forty (240) days from the date of receipt of written approval by the Commissioner of the Final Plan.

The Proposed Plan may include the following components, absent any then-existing circumstances that would likely negate the effectiveness of said components in restoring competition to its pre-consolidation state:

- Divestiture, into a separate and independent enterprise, of those facilities and other assets of the New Health System that are necessary to establish competition with said enterprise and restore, to the extent reasonably practicable, competitive conditions as they existed immediately prior to the merger in the markets subject to the termination order, along with all rights, title and interest in said assets, as well as applicable associated items including underlying real property, inventories, third-party contracts, names and trademarks, governmental consents, books and records and technologies that are essential to the operation of said assets as a going concern;
- Enablement of physician and non-physician employees of the Parties to be recruited to and employed by the owner of the divested assets, without regard to then-existing contractual restrictions on such recruitment or employment;
- Enablement of any physician to be recruited to, under contract with, and/or extended medical staff privileges by the owner of the divested assets, without regard to then-existing contractual restrictions on such recruitment, contractual relationships, or staff privileges;
- Assignment of any third-party contracts necessary to maintain ongoing, uninterrupted operation of the divested assets, along with cooperation and assistance in obtaining any third-party approvals that are required for such assignments;

- Provision, as needed, of transitional services for up to six months to the owner of the divested assets in the areas of administration, operations, information technology and clinical care, to ensure that the new competitive entity provides health care services with substantially the same level of quality and efficiency as the Parties;
- Maintenance of the same level of administrative, operational and clinical quality of all assets and operations that existed on the day before receipt of the Commissioner’s termination order through the period until obligations under the Plan of Separation expire; and
- Establishment of firewalls and other protective procedures to the extent necessary to enable a separate and independent apparatus for payer contracting by the new competitive entity.

Should the Commissioner believe that it would be beneficial, the Parties will provide for the Commissioner’s benefit an independent third-party health care expert to serve as a monitor (“the Monitor”) for the Plan of Separation. The New Health System would provide the funding for the Monitor.

Through the Monitor, the Commissioner could engage with the Consultant and the Parties to ensure the State’s interests are served. The Monitor would be responsible for ensuring the orderly implementation of the Plan and for providing regular input to the Parties and feedback to the Commissioner.

Should the Parties not fully execute the Plan within the above stated two hundred forty (240) day period, then the Commissioner may require that a Trustee be installed to take over the process of implementing and finalizing the Plan. The Monitor could serve in this role, or another party experienced in the health care industry could be engaged to serve in the role. In either event, the New Health System will be responsible for the costs associated with engaging the Trustee, and the fees and expenses associated with the Trustee’s work.

Exhibit 15.2

Opinion on the Plan of Separation



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February 10, 2016

Dr. John J. Dreyzehner
Commissioner, Tennessee Department of Health
710 James Robertson Parkway
Nashville, Tennessee 37243

RE: Review of the Plan of Separation filed under the Application for Certificate of Public Advantage (“COPA”) by Mountain States Health Alliance and Wellmont Health System

Dear Dr. Dreyzehner:

FTI Consulting (“FTI”) has completed an independent review of the above referenced Plan of Separation between Wellmont Health System and Mountain States Health Alliance (collectively “The Parties”) filed under the COPA Application. The remainder of this letter details the objectives of our review, the findings from our review, and the limitations of this letter.

Objective of the Analysis

The objective of our independent review of the Plan of Separation (the “Plan”) was to assess if the Plan could be operationally implemented without undue disruption to essential health services provided by the Parties. To perform our work, FTI reviewed the following documents/materials:

- Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report, January 7, 2016.
- New Health System Alignment Policy.
- Certificate of Public Advantage, State of Tennessee, Application.
- Exhibit 15.1, Plan of Separation, COPA, State of Tennessee, Application.

Background on FTI Consulting

Founded in 1982, FTI Consulting has over 4,400 professionals in 80 cities around the globe. We are a publicly company traded on the NYSE (FCN), and we have an enterprise value in excess of \$1.7 B. FTI has experts in 16 industry specialties who provide advisory services to all 10 of the world’s top bank holding companies, 94 of the world’s top 100 law firms, and 47 of the Fortune 100 corporations. FTI has been built to address the full range of interrelated issues that can affect enterprise value.

FTI’s Health Solutions practice consists of over 300 professionals including clinicians, healthcare executives, strategists, and functional specialists located in 27 offices across the United States. Most of



our Health Solutions executives have more than 25 years of experience leading health systems, hospitals, and physician organizations; designing and implementing enhanced performance programs; and performing complex healthcare operational and financial analyses.

We advise clients on all aspects of provider performance improvement and planning, and tailor our recommendations to focus on solutions that we believe are most appropriate for each specific client situation. We have also worked with clients as they look to combine services, as well as divest them. In the past three years, we have worked with over 180 healthcare industry clients (Health Systems, Medical Groups, Academic Medical Centers) on a variety of projects.

Findings from the Analysis

In reviewing the Pre-Submission Report and the COPA Application, FTI noted that the inpatient hospitals, other patient care facilities, and ancillary entities specifically included in the proposed combination by the Parties can be clearly delineated as to which Party “contributed” the facility to the new combined entity. This delineation can be used as part of a common basis for developing plans for returning contributed assets and services to their pre-consolidation competitive state should the Plan of Separation be triggered.

FTI reviewed the New Health System Alignment Policy, and noted the following:

- The New Health System will evaluate opportunities for alignment of clinical facilities and clinical services provided by the parties based upon use of clinical and financial data, and inputs from physicians and other clinicians relevant to the service or facility which is the subject of the alignment.
- New Health System Management will identify the benefits and adverse effects of the proposed alignment.
- A New Health System Board Integration Committee will evaluate the proposals for alignment, including the data and inputs relied upon by Management, in formulating their recommendations for alignment.
- The New Health System Board Integration Committee will monitor the status of approved alignment efforts through periodic Management reporting. Furthermore, one year after the completion of the alignment, management will provide a report to the New Health System Board identifying lessons learned, physician feedback, community benefits and financial impact.
- The alignment process and all related analyses, studies, inputs, reporting, and other monitoring activities can also be used in developing plans for returning contributed assets and services to their pre-consolidation competitive state should the Plan of Separation be triggered.

Finally, FTI reviewed the Plan of Separation filed in the COPA Application itself, and noted the following:

- The specified intention of the Plan is to set out the process by which the Parties would effect an orderly separation of the New Health System created under the COPA, in the event that the

Commissioner determines it is necessary to terminate the COPA previously granted to the Parties, as set forth in T.C.A. section 68-11-1303(g).

- The Plan of Separation calls for the retention of a consultant with expertise in provider operations and competition in the healthcare industry to assist in complying with any termination order issued by the Commissioner of the Tennessee Department of Health.
 - The Consultant will be asked to analyze the competitive conditions in the market(s) subject to the Commissioner's termination order, and to identify the specific steps necessary to return the market(s) to their pre-consolidation competitive state. The Consultant will also be asked to take into account the data submitted in the COPA Application showing the structure of the geographic service area at the time of the consolidation.
 - The Consultant will assist the Parties in developing a plan to be submitted to the Commissioner for divestiture of assets and operations and any other actions that would be appropriate under then-current market circumstances designed to restore, to the extent reasonably practicable, competitive conditions to their pre-consolidation competitive state or otherwise remedy the competitive concerns identified by the Commissioner.
 - The final plan for divestiture and other actions must be approved by the Commissioner. FTI notes that the final plan will include a number of reasonable and prudent components outlined below in this letter, but not limited to:
 - Divestiture, into a separate and independent enterprise, of those facilities and other assets of the New Health System that are necessary to establish competition with said enterprise and restore, to the extent reasonably practicable, competitive conditions as they existed immediately prior to the merger in the markets subject to the termination order.
 - Enablement of physician and non-physician employees of the Parties to be recruited to and employed by the owner of the divested assets, without regard to then-existing contractual restrictions on such recruitment or employment.
 - Enablement of any physician to be recruited to, under contract with, and/or extended medical staff privileges by the owner of the divested assets, without regard to then-existing contractual restriction on such recruitment, contractual relationships, or staff privileges.
 - Assignment of any third-party contracts necessary to maintain ongoing, uninterrupted operation of the divested assets, along with cooperation and assistance in obtaining any third-party approvals that are required for such assignments.
 - Provision, as needed, of transitional services for up to six months to the owner of the divested assets in the areas of administration, operations, information technology and clinical care, to ensure that the new competitive entity provides health care services with substantially the same level of quality and efficiency as the Parties.

- Maintenance of the same level of administrative, operational and clinical quality of all assets and operations that existed on the day before receipt of the Commissioner's termination order through the period until obligations under the Plan of Separation expire.
- FTI noted that, under the Plan of Separation, the Commissioner has the ability to trigger the use of an independent third-party monitor, funded by the Parties, should the Commissioner determine that the use of such would be beneficial.
- A Trustee can also be named by the Commissioner under the Plan of Separation to take over the process of implementing the divestiture plan should the plan not be executed within 240 days after the termination order is issued.
- FTI further noted that the Plan of Separation must be updated on an annual basis, and that an evaluation and/or analysis of the Plan of Separation must also be conducted by an independent third party, knowledgeable in the healthcare industry and provider operations, on an annual basis.

Based on our experience as healthcare industry consultants, the above observations, and the findings derived from our review of the relevant documents, we believe that the Pre-Submission Report, The New Health System Alignment Policy, the COPA Application, and The Plan of Separation can serve as the basis for an effective process to restore competition to the pre-consolidation competitive state through an orderly transition that can be operationally implemented without undue disruption to the essential health services provided by the Parties so long as all appropriate clinical, operational, legal and other applicable guidelines and statutes are also followed.

Limitations of This Letter

This letter is only intended for the use by the Parties and the Commissioner of the Tennessee Department of Health in preparing, filing and evaluating a COPA application and should not be used for any other purpose. This letter is based on the performance of the procedures described herein, and is limited to assessing whether the Plan of Separation (and other related documents as noted) can be operationally implemented without undue disruption to essential health services provided by the Parties.

Consistent with the current Tennessee COPA Application guidelines, this letter is based on a one-year time horizon. Our understanding is that one year following the combination, the Plan of Separation and this letter would need to be updated.

FTI does not give, and this letter does not constitute, legal advice. This letter is current as of its date, and FTI has no duty to update it. Among other matters, later changes in market conditions may affect the views expressed in this letter.

Sincerely,

FTI CONSULTING

FTI Consulting, Inc.