

**SECOND AMENDED AND RESTATED
TERMS OF CERTIFICATION
GOVERNING THE CERTIFICATE OF PUBLIC ADVANTAGE
ISSUED TO BALLAD HEALTH
PURSUANT TO THE
MASTER AFFILIATION AGREEMENT AND PLAN OF INTEGRATION
BY AND BETWEEN
WELLMONT HEALTH SYSTEM
AND
MOUNTAIN STATES HEALTH ALLIANCE**

APPROVAL DATE: SEPTEMBER 19, 2017

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- C Access Sub-Index
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- E Essential Services
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- G Forms of Annual Report and Quarterly Report
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- J Scoring; Final Score
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- 1 COPA Managed Care Contract Pricing Limitations and Excess Payment Testing

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These Second Amended and Restated Terms of Certification (as may be amended from time to time, these “Terms of Certification”) dated as of the 27th day of April, 2021 (the “Second Restatement Date”) govern the Certificate of Public Advantage issued on the 31st day of January, 2018, by the **Tennessee Department of Health** (the “Department”) to **Ballad Health**, a Tennessee nonprofit public benefit corporation (the “New Health System”) and the common parent entity of Applicants **Mountain States Health Alliance**, a Tennessee nonprofit public benefit corporation (“Mountain States”), and **Wellmont Health System**, a Tennessee nonprofit public benefit corporation (“Wellmont”).

INTRODUCTION

On February 16, 2016, Mountain States and Wellmont submitted the initial Application with respect to their Cooperative Agreement. Since that time, they provided to the Department supplemental information. On May 22, 2017, the Department deemed the Application to be complete pursuant to Tenn. Code Ann. § 68-11-1303. Public hearings were held pursuant to the COPA Act and the Department received considerable input from the public and from consultants retained by various parties.

For the reasons set forth in its September 19, 2017 Approval Letter (the “Approval Letter”), the Department determined that the Application, in conjunction with the active supervisory regulatory structure set forth in these Terms of Certification, demonstrated by clear and convincing evidence that the likely benefits of a COPA would outweigh any disadvantages attributable to a reduction in competition and approved the Application pursuant to Tenn. Code Ann. § 68-11-1303(d). Pursuant to and contemporaneous with the Closing, on January 31, 2018 (the “Issue Date”), the COPA Parties executed the initial Terms of Certification (the “Initial Terms”), and the Department issued the COPA to the New Health System. On July 31, 2019, the Department and the COPA Parties executed the Amended and Restated Terms of Certification (the “First Restatement of the Terms of Certification”).

The Department and the COPA Parties have agreed to amend and restate the First Restatement of the Terms of Certification by entering into these Second Amended and Restated Terms of Certification, the effectiveness of which on the Second Restatement Date is expressly conditioned upon the COPA Parties’ execution of these Terms of Certification evidencing their joint and several agreement and commitment to abide by, and to be subject to, all of the Terms of Certification.

ARTICLE I DEFINITIONS

The following terms shall have the following meanings for the purposes of these Terms of Certification:

“Access Sub-Index” shall have the meaning set forth in Section 7.01(a).

“Accountable Care Community” means an organization established by a coalition of public and private participants in the health, social science and other sectors for the purpose of strengthening the existing clinical-community linkages within the Geographic Service Area and improving the overall health of the Population.

“Active Supervision” means the ongoing process (as described herein and in the COPA Act) of the Department, the Attorney General, and their respective appointed agents and independent contractors, after the Issue Date and throughout the COPA Term, of (a) evaluating and determining whether the New Health System’s operations continue to result in Public Advantage, and (b) enforcing the COPA, these Terms of Certification and all other Terms and Conditions.

“Advisory Group” shall have the meaning set forth in the COPA Rules.

“Affiliation” means the adoption by the Applicants of the New Health System as their common sole member to oversee all of their and their affiliates’ assets and operations, pursuant to the Cooperative Agreement.

“AGB” shall have the meaning set forth in Section 4.03(d).

“Ancillary Services” means diagnostic or therapeutic services provided by health care providers for patients on an outpatient basis as an adjunct to medical or surgical services.

“Annual Reports” means the Periodic Reports from and after the Issue Date covering each Fiscal Year of the New Health System.

“Annual Review” shall have the meaning set forth in Section 7.02.

“Applicants” means, collectively, Mountain States and Wellmont, and “Applicant” means either Mountain States or Wellmont, as the context requires.

“Application” means the collective written materials submitted by the Applicants to the Department to request the issuance of a COPA in accordance with COPA Rule 1200-38-01-02.

“Approval Date” shall mean September 19, 2017.

“Approval Letter” shall have the meaning set forth in the Introduction.

“Attorney General” means the Attorney General and Reporter for the State of Tennessee.

“Base Charity Care” shall have the meaning set forth in Section 4.03(f)(ii).

“Baseline Spending” shall have the meaning set forth in Section 3.01(b).

“Behavioral Health Plan” shall have the meaning set forth in Section 3.02(a).

“Board” means the board of directors of the indicated COPA Party in office from time to time pursuant to the Cooperation Agreement and the Tennessee Nonprofit Corporation Act.

“Capital Plan” shall have the meaning set forth in Section 3.07(b)(i).

“Capital Projects” shall have the meaning set forth in Section 3.07(b)(i).

“Certificate of Public Advantage” or “COPA” means the Certificate of Public Advantage issued by the Department to the COPA Parties on the Issue Date, including, as the context requires, these Terms of Certification, and as such COPA may be amended from time to time.

“Change of Control” shall have the meaning set forth in Section 9.02(b).

“Children’s Health Plan” shall have the meaning set forth in Section 3.02(b).

“Clinical Council” shall have the meaning set forth in Section 4.02(b)(i).

“Closing” means the consummation of the Affiliation and the other associated transactions contemplated under the Cooperative Agreement.

“CMS” or “Medicare”, as the context requires, means the Centers for Medicare and Medicaid Services.

“Commissioner” means the Commissioner of the Department.

“Cooperative Agreement” means the Master Affiliation Agreement and Plan of Integration by and between Wellmont Health System and Mountain States Health Alliance, dated as of February 15, 2016, and any amendments thereto.

“COPA Act” means the Hospital Cooperation Act of 1993, as amended, Tenn. Code Ann. §§ 68-11-1302 *et seq.*, and, except when clearly inapplicable, the COPA Rules.

“COPA Compliance Office” and “COPA Compliance Officer” shall have the meanings set forth in Exhibit F.

“COPA Hospitals” means the Mountain States Hospitals and the Wellmont Hospitals.

“COPA Modification” or terms of similar import means any addition, modification or other amendment to the existing terms of, as applicable, the COPA, these Terms of Certification, and/or the Cooperative Agreement, effected in accordance with the terms hereof and the COPA Act.

“COPA Monitor” shall have the meaning set forth in Exhibit F.

“COPA Parties” means, collectively, the New Health System, Mountain States and Wellmont.

“COPA Rules” means the Tennessee Rules and Regulations promulgated from time to time in order to implement the COPA Act, presently set forth in Tenn. Comp. R. & Regs. Chapter 1200-38-01.

“COPA Term” means the period beginning on the Issue Date and ending on the effective date of termination when the COPA is terminated, pursuant to its terms or the terms hereof or as permitted by Law, by the Department, the New Health System or a final, non-appealable order of a court of competent jurisdiction.

“Corrective Actions” means the remedial actions invoked by the Department from time to time as a result of a Noncompliance, as described in Article VI hereof.

“Cure” shall have the meaning set forth in Section 6.05(c).

“Department” shall have the meaning set forth in the preamble.

“Economic Sub-Index” shall have the meaning set forth in Section 7.01(a).

“Emergency Services” shall have the meaning of “Emergency Medical Conditions” in Section 1867 of the Social Security Act, 42 U.S.C. § 1395dd.

“Employed Physicians” means physicians employed or controlled by an NHS Entity, including physicians employed by entities directly managed by an NHS Entity, and physicians engaged as an independent contractor by any NHS Entity under agreements which give the NHS Entity control of the physicians’ operations, including control over the contracting of any entity owned or controlled by such physicians.

“Equalization Plan” shall have the meaning set forth in Section 3.08(b).

“Essential Services” shall mean the services set forth on Exhibit E.

“Facilities Assessment” shall have the meaning set forth in Section 3.07(b)(iii).

“Facilities Consultant” shall have the meaning set forth in Section 3.07(b)(iii).

“Final Score” shall have the meaning set forth in Section 7.01(a).

“First Restatement of the Terms of Certification” shall have the meaning set forth in the Introduction.

“Fiscal Year” means a fiscal year of the New Health System following the Issue Date, including, as the context requires, any partial fiscal year.

“Force Majeure Event” means any failure or delay by a COPA Party to fulfill or perform any of the Terms and Conditions when and to the extent such failure or delay is caused by or results from an act beyond such COPA Party’s reasonable control, including, without limitation, (a) acts of God; (b) flood, fire, earthquake, or explosion; (c) war, invasion, hostilities (whether war is declared or not), terrorist threats or acts, riot, or other civil unrest; (d) change in applicable Law

(other than the COPA Act or governmental order pursuant to the COPA Act); (e) actions, embargoes, or blockades in effect after the Issue Date; (f) action by any governmental authority, other than the Department or any other Tennessee entity (with legal standing) acting to enforce the COPA; and (g) any national or regional emergency. The foregoing notwithstanding, any Law or action by any governmental authority shall not be considered a Force Majeure Event if it applies to health systems and hospitals generally, for example a Law affecting health care reform generally, and not the New Health System specifically. If any COPA Party suffers or believes it is reasonably likely to suffer a Force Majeure Event, such COPA Party shall (y) give notice to the Department within ten (10) days after Knowledge of the existence or reasonable likelihood thereof by the New Health System, stating the period of time the failure or delay is expected to continue, and (z) use diligent efforts to end the failure or delay and minimize the effects of such Force Majeure Event.

“GAAP” means generally accepted accounting principles in effect from time to time in the United States.

“Geographic Service Area” or “GSA” means the area covered by the Cooperative Agreement that includes Carter, Cocke, Green, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington Counties in Tennessee; Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise and Wythe Counties in Virginia; and the independent cities of Bristol City and Norton City in Virginia; as well as any additional counties or municipalities in any state in which the New Health System provides services or operates a facility.

“Greene County” shall have the meaning set forth in Section 4.03(b)(iii).

“Healthcare Access Report” shall have the meaning set forth in Section 3.02(d).

“HIE” shall have the meaning set forth in Section 3.05(a).

“HIE Plan” shall have the meaning set forth in Section 3.05(c).

“Hospital” shall have the meaning ascribed to it in the COPA Act.

“HR/GME” shall have the meaning set forth in Section 3.03.

“HR/GME Plan” shall have the meaning set forth in Section 3.03(b).

“Independent Physicians” means physicians who perform clinical services within the Geographic Service Area but are not Employed Physicians.

“Index” means the collective Sub-Indices, each of which consists of Measures and other components used by the Department to objectively track the progress of the Affiliation over time to evaluate Public Advantage.

“Initial Terms” shall have the meaning set forth in the introduction.

“Issue Date” shall have the meaning set forth in the introduction.

“Joint Commission” means the Joint Commission or other national accrediting organization that has been approved by CMS as having standards and a survey process that meets or exceeds Medicare’s requirements for accrediting healthcare organizations and related programs in the United States.

“Jointly-Developed Capital Plan” shall have the meaning set forth in Section 3.07(b)(iii).

“Knowledge of the New Health System” or similar phrase means the actual knowledge of any of the Executive Chair/President, Chief Executive Officer, Chief Financial Officer, Chief Operating Officer or Chief Medical Officer of each COPA Party, after due inquiry by such persons in performing the duties associated with their respective offices with each COPA Party.

“Law” means any law, statute, regulation, ordinance, rule, order, governmental requirement or rule of law (including common law) enacted, promulgated, entered into or imposed by any governmental authority.

“Local Advisory Council” means that certain council defined and described in Exhibit F.

“Managed Care Contracts” or “Payor Contracts” means each contract from time to time entered into between one or more NHS Entities and a Payor, which contract frames, defines and governs their business relationship, including the payments to be made to one or more NHS Entities.

“Material Adverse Event” means any fact, event, change, development or occurrence that, individually or together with any other event, change, development or occurrence, is or is reasonably likely to be, materially adverse to the business, condition (financial or otherwise), assets, operations or results of operations of the New Health System, taken as a whole, or on the ongoing ability of the New Health System to comply in all material respects with the Terms and Conditions. The following are non-exhaustive examples of a Material Adverse Event: (a) any COPA Party (i) becomes insolvent, (ii) is generally unable to pay, or fails to pay, its debts as they become due, (iii) files, or has filed against it, a petition for bankruptcy or pursuant to any other insolvency Law, (iv) makes or seeks to make a general assignment for the benefit of its creditors, or (v) applies for, or consents to, the appointment of a trustee, receiver or custodian for all or a substantial part of its property or business; (b) any COPA Party fails to comply in any material respect with any applicable Laws; (c) any NHS Entity is in material breach and/or default under (i) any of the agreements documenting issues of taxable or tax-exempt bonds issued for the benefit of any COPA Party or its affiliates, including any master indenture to which any COPA Party or affiliate thereof is a party, (ii) any other instrument or agreement evidencing indebtedness of any COPA Party or affiliate thereof, in each case representing indebtedness in excess of \$7,500,000; or (iii) the Letter Authorizing Cooperative Agreement issued by the Commonwealth of Virginia; or (d) any of the Executive Chair/President, Chief Executive Officer, Chief Financial Officer, Chief Operating Officer or Chief Medical Officer of any COPA Party engages in illegal conduct or misconduct materially injurious to the New Health System, such as embezzlement, misappropriation or fraud (whether or not related to such person’s employment), or is convicted of or pleads guilty or nolo contendere to a crime that constitutes a felony (or state Law equivalent) or a crime that constitutes a misdemeanor involving moral turpitude.

“Measure” means a factor or benchmark pertaining to the Index.

“Medically Necessary Services” means the meaning as defined by CMS as services of items reasonable and necessary for the diagnosis or treatment of illness or injury and are Services not included in the list of “particular services excluded from coverage” in 42 CFR § 411.15.

“Monetary Obligation” means an amount of U.S. dollars required to be spent and paid by, or otherwise owed by, the COPA Parties from time to time hereunder.

“Mountain States” shall have the meaning set forth in the preamble.

“Mountain States Hospital” means any Hospital that, directly or indirectly, is majority-owned or controlled by Mountain States.

“New Health System” shall have the meaning set forth in the preamble and, as the context requires, one or more applicable NHS Entities.

“NHS Entities” means, collectively, or otherwise as the context requires, the COPA Parties, all COPA Hospitals and any other entity that is majority-owned or controlled by a COPA Party.

“Noncompliance” means (i) a failure by the New Health System to achieve a Satisfactory Score with respect to the Index, or (ii) a failure by the New Health System to fulfill or perform any Non-Monetary Obligation, Monetary Obligation or any other Term and Condition.

“Non-Monetary Obligation” means any commitment or obligation of the New Health System pursuant to the Terms and Conditions that is, standing alone, not a Monetary Obligation.

“Other Sub-Index” shall have the meaning set forth in Section 7.01(a).

“Pass/Fail Grade” shall have the meaning set forth in Section 7.01(a).

“Payor” means any person, corporation, or entity that pays, or arranges for payment, for all or any part of any COPA Hospital or other medical providers’ medical services or supplies and items for itself or for any other person, corporation or entity, and which negotiates the payment or rate of payment for such Hospital or medical services, supplies and/or items. This includes Payors which are third party administrators, health insurers, self-insured health plans, employer health plans, managed care organizations, health maintenance organizations, administrative service organizations and other similar Payors and health plans which negotiate the payment or rate of payment for Hospital or medical services, supplies and/or items. Payor includes any person, corporation, or entity that develops, leases, or sells access to networks of hospitals. The term does not include Medicare or other governmental healthcare Payors or programs which do not negotiate contracts or payment rates with the New Health System, nor does it include Medicare Advantage Plans that pay based on a predetermined percentage of Medicare rates, for example, 105% of Medicare, so long as the percentage does not change during the COPA Term.

“Periodic Reports” means the Quarterly Reports and Annual Reports to be filed by the New Health System with the Department in accordance with the COPA, these Terms of Certification and the COPA Act.

“Plan of Separation” shall have the meaning set forth in Section 1200-38-01.01 of the COPA Rules.

“Population” means the people residing or domiciled in the Geographic Service Area, and other people utilizing any NHS Entity, as of the indicated time.

“Population Health Initiatives Fund” means the account or accounts, for which the Department shall be the custodian, into which fines, certain past-due Monetary Obligations and other amounts are to be paid by the COPA Parties, pursuant to the Terms and Conditions.

“Population Health Plan” shall have the meaning set forth in Section 3.04(b).

“Population Health Report” shall have the meaning set forth in Section 3.04(e).

“Population Health Sub-Index” shall have the meaning set forth in Section 7.01(a).

“Post-Acute Services” means healthcare services provided following discharge from a COPA Hospital, including but not limited to healthcare services provided at SNFs, rehabilitation hospitals, long-term care hospitals or psychiatric hospitals, and home health, hospice, palliative care and outpatient therapy services.

“Public Advantage” means the likely benefits accruing from the Cooperative Agreement outweigh, by clear and convincing evidence, any disadvantages attributable to a reduction in competition that may result from the Cooperative Agreement, as determined by the Department from time to time in accordance with the COPA, these Terms of Certification and the COPA Act.

“Quarterly Reports” means the Periodic Reports covering each fiscal quarter of the New Health System’s then-current Fiscal Year.

“Required Reports” means all Periodic Reports and all other reports required to be submitted by the New Health System in accordance with the COPA, these Terms of Certification and the COPA Act.

“Restatement Date” shall have the meaning set forth in the preamble.

“Rural Health Plan” shall have the meaning set forth in Section 3.02(c).

“Rural Hospital” means any COPA Hospital not located in Sullivan County, Tennessee, Washington County, Tennessee, Washington County, Virginia or the independent Virginia city of Bristol. The Rural Hospitals as of the Second Restatement Date are Greeneville Community, Hawkins County, Lonesome Pine, Mountain View Regional, Hancock County, Sycamore Shoals, Norton Community, Russell County, Smyth County, Unicoi County, Dickenson Community, and Johnson County.

“Satisfactory Score” means achieving both a score of “Pass” on the Economic Sub-Index and a score of “85” or higher on the Final Score.

“Second Restatement Date” shall have the meaning set forth in the Introduction.

“Service Line” means the following service lines at a COPA Hospital: Orthopedics, Pediatrics, Surgery, Obstetrics/Gynecology, Cardiovascular/Heart, Cancer, Emergency Medicine, Neurology/Neurosurgical, Psychiatric/Behavioral Health, Neonatal, and Trauma.

“Severance Policy” shall have the meaning set forth in Section 3.08(d)(ii).

“SNF” means skilled nursing facility.

“States” means the State of Tennessee and the Commonwealth of Virginia.

“Sub-Index” or “Sub-Indices” shall have the meaning set forth in Section 7.01(a).

“Tennessee Board for Licensing Health Care Facilities” shall have the meaning set forth in Section 4.02(a)(ii)(A).

“Tennessee GSA” means the portion of the Geographic Service Area located within the State of Tennessee.

“Ten-Year Period” shall have the meaning set forth in Section 3.01(a).

“Terms and Conditions” means the collective Terms of Certification, conditions, commitments, obligations, restrictions and other provisions applicable to and binding upon the COPA Parties as set forth herein, in the COPA and in the COPA Act, as each may be amended from time to time.

“Terms of Certification” shall have the meaning set forth in the Introduction.

“Total Charity Care” shall have the meaning set forth in Section 4.03(f)(i).

“Underinsured” means any health plan that does not meet the “Minimum Essential Coverage” standard as defined under the Affordable Care Act in existence as of July 1, 2017.

“Virginia GSA” means the portion of the Geographic Service Area located within the Commonwealth of Virginia.

“Wellmont” shall have the meaning set forth in the Introduction.

“Wellmont Hospital” means any Hospital that, directly or indirectly, is majority-owned or controlled by Wellmont.

“Wise/Norton” shall have the meaning set forth in Section 4.03(b)(ii).

Additional defined terms (i) pertaining to Managed Care Contract pricing limitations are set forth in Addendum 1, and (ii) pertaining to Active Supervision are set forth in Exhibit F. As described in Section 9.04, all exhibits and addenda attached hereto are hereby incorporated herein by reference.

ARTICLE II STATUTORY REQUIREMENTS AND FACTUAL FINDINGS

2.01. General. Tenn. Code Ann. § 68-11-1303(e) lists the potential benefits and disadvantages which the Department shall consider in reviewing the Application. In evaluating this criteria, its determination of Public Advantage, and in developing the content of these Terms of Certification, the Department consulted with the Attorney General, the U.S. Federal Trade Commission, and the Advisory Group, and considered the Application and the oral and written comments, analyses and materials provided to the Department by third parties and the public relating to the Application.

2.02. Background. The region currently served by the Applicants is part of the Appalachian Region and includes ten counties in Northeast Tennessee and eleven counties and two independent cities in Southwest Virginia (the GSA). This region has a number of health, economic and other factors, which when combined, present a unique and challenging environment for the improvement of the quality and access of health care and health outcomes in the region. These unique challenges were reaffirmed in a recent report issued by the Appalachian Regional Commission, Robert Wood Johnson Foundation and the Foundation for a Healthy Kentucky (*Health Disparities in Appalachia*), which found that the performance in the Appalachian Region is worse than the performance in the United States as a whole in seven (7) of the ten (10) leading causes of death: heart disease, cancer, chronic obstructive pulmonary disease (COPD), injury, stroke, diabetes, and suicide. Additionally, the study found the “years of potential life lost” (YPLL), a measure of premature mortality, is 25% higher in the Appalachian Region than in the nation as a whole.

(a) **Health Factors**: The Tennessee State Health Plan outlines four priority factors (smoking, obesity, physical inactivity, and substance abuse) that directly influence six of the top ten leading causes of death in Tennessee including heart disease, cancer and diabetes:

(i) **Smoking**: Approximately 443,000 premature deaths in the United States annually can be attributed to smoking. Studies have also demonstrated that smoking is the cause of various cancers, cardiovascular disease and respiratory conditions, as well as low birthweight and other adverse health outcomes. The percentage of adults who are current smokers is higher in all twenty-one counties in the GSA than in the United States as a whole. Smoking is more common in fifty percent of the Tennessee GSA counties than in Tennessee and more common in fifty percent of the Virginia GSA counties than in Virginia.

(ii) **Obesity**: Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, and osteoarthritis. Two-thirds of the counties in the GSA have a higher percentage of adults who are obese compared with the nation. Moreover, compared to their respective states, 80% of the counties in Tennessee and 100% of the counties in Virginia have a higher percentage of adults who are obese.

(iii) **Physical Inactivity**: Evidence indicates physical activity, independent of its effect on weight, has substantial benefits for health. Decreased physical activity has been associated with an increased risk for several disease conditions such as type 2 diabetes,

cancer, stroke, hypertension, cardiovascular disease and premature mortality. Physical inactivity at the county level is directly related to health care expenditures for circulatory system diseases. Compared with the nation, fewer adults report any physical activity in each of the counties in the GSA; compared with their respective states, fewer adults report any physical activity in 90% of the counties in Tennessee and 100% of the counties in Virginia.

(iv) **Substance Abuse:** Drug overdose deaths are a leading contributor to premature death and are largely preventable. Since 2000, the rate of drug overdose deaths has increased by 137 percent nationwide, and there has been a 200 percent increase in deaths involving opioids (opioid pain relievers and heroin). The State of Tennessee, overall, has seen a statistically significant increase in the drug overdose death rate, with a 13.8% increase from 2014 to 2015. Additionally, Tennessee has one of the highest opioid prescription rates with 96-143 prescriptions per 100 people; Virginia is not far behind with a rate of 72-82.1 per 100 people. Tennessee has seen a 43.5% increase in heroin usage from 2014 to 2015 and Virginia has seen a 38.7% increase for the same period. Additionally, Tennessee has seen a 90.5% increase in synthetic opioid encounters from 2014-2015 and Virginia has seen a 57.1% increase during that same period. The substance abuse statistics for the 21 counties in the GSA are particularly compelling. Over 50% of the counties in Tennessee exceed the state average, with Hancock County having the highest rate in the state. Additionally, Sullivan County has one of the highest rates of Neonatal Abstinence Syndrome (NAS) births in the state. Moreover, the rate of NAS births in the Tennessee GSA is almost four times the rate of the rest of Tennessee. One hundred percent of the counties in Virginia exceed the state rate, with two counties having rates more than three times the state rate, and four counties with rates more than two times the state rate.

(b) **Other Factors Affecting Health Outcomes:** A number of other factors contribute to a unique and challenging environment in which to improve the quality and access of health care and health outcomes in a region, including: (1) the percentage of adults reporting fair or poor health, (2) the number of preventable hospital stays, (3) the ratio of population to primary care providers, and (4) the ratio of population to mental health providers.¹

(i) **Preventable Hospital Stays:** Preventable hospital stays is the hospital discharge rate for ambulatory care-sensitive conditions per 1,000 fee-for-service Medicare enrollees. Hospitalization for diagnoses treatable in outpatient services suggests that the quality of care provided in the outpatient setting was less than ideal and may also represent a tendency to overuse hospitals as a main source of care. The rate of preventable hospital stays is often used to assess the effectiveness and accessibility of primary health care. The rate of preventable hospital stays for all of the counties in the GSA exceeds the state rates for Tennessee and Virginia. The rate in one Tennessee county more than doubles the state rate. That is, preventable hospital stays occur twice as often in this county than in all of Tennessee. Similarly, two Virginia counties have rates that are three times the state rate, and another three counties with rates that double the state rate.

(ii) **Primary Care Physicians:** Access to care requires not only financial coverage, but also access to providers. Studies have demonstrated that sufficient

¹ Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, *County Health Rankings 2017: Tennessee; County Health Rankings 2017: Virginia*.

availability of primary care physicians is essential for preventive and primary care, and when needed, referrals to appropriate specialty care. The statistics for the counties in the GSA reflect a compelling need for greater recruitment and retention of primary care providers. Only two counties in Tennessee have a ratio of population to primary care physicians that is better than the state. At least two counties have ratios double the statewide ratio, and one county, has a ratio that is four times the statewide ratio. In Virginia, all eleven counties have ratios substantially greater than the statewide ratio, with one county having a ratio three times greater and another five counties with ratios of at least two times greater than the statewide ratio.

(iii) **Mental Health Providers:** Approximately thirty percent of the population in the United States lives in a county designated as a mental health professional shortage area. The lack of adequate access to mental health providers in the GSA is overwhelming. For example, the ratio of population to mental health providers in Tennessee is 780:1. Only two counties have ratios less than this amount. Several counties have ratios four to five times greater, and one county has a ratio that is ten times greater than the statewide average. The ratio of county population to mental health providers in the eleven Virginia counties is similarly troubling. Several counties have ratios four to five times greater than the statewide ratio, with one county having a ratio that is 22 times greater.

(c) **Economic Factors and Demographics:** A number of economic factors and the demographics of a particular region also contribute to the unique and challenging environment in which to improve the access and quality of health care and the health outcomes of that region. These factors include: (1) education, (2) percentage of children living in poverty, (3) the average annual income, (4) unemployment rates, (5) population growth, (6) percentage of population over age 65, and (7) percentage of population considered to be rural.²

(i) **Education:** Studies show that individuals with higher educational attainment are more likely to have better health. Specifically, higher educational attainment is linked to lower rates of premature death, smoking, obesity and inactivity. The relationship between higher education and improved health outcomes is well established, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress and healthier lifestyles. Furthermore, education can have multigenerational implications that also make it an important measure for the health of future generations. While the counties in the GSA have been somewhat more successful in achieving high school graduation rates, with only eight counties having graduation rates at or lower than the statewide average, the counties are substantially less successful in attaining any post-secondary education. Only two Tennessee counties have percentages at or higher than the statewide average and the rest of the counties have percentages that are substantially lower. All of the Virginia counties have percentages that are substantially lower than the statewide average, and in several counties by as much as twenty percent.

(ii) **Kids in Poverty:** Poverty can result in an increased risk of mortality, morbidity, depression, and poor health behaviors. Children's risk of poor health and premature mortality may also be increased due to the poor educational achievement associated with poverty. The children in poverty measure is highly correlated with overall poverty rates.

² *Id.*

Only one Tennessee county has a rate of children in poverty that is less than the statewide average, while at least two counties have a poverty rate fifteen to twenty percentage points greater. The children's poverty rate in the Virginia counties is even more dire with seven of the counties having poverty rates almost fifteen percentage points greater than the state. Furthermore, the infant mortality rate is 16% higher in the Appalachian Region than in the nation as a whole.

(iii) **Per Capita Personal Income:** The per capita personal income in Tennessee is \$42,069. The per capita personal income for the ten Tennessee counties ranges from a low of \$23,104 to a high of \$36,918, with most of the counties having an annual income \$12,000 to \$15,000 less than the statewide average. The per capita annual income in Virginia is \$56,732. The per capita personal income for the eleven Virginia counties ranges from a low of \$27,137 to a high of \$37,388, with most of the counties having an average annual income \$12,000 to \$25,000 less than the statewide average.

(iv) **Median Household Income:** The median household income in Tennessee is \$47,200. The median household income for the ten Tennessee counties ranges from a low of \$27,987 to a high of \$45,261, with most of the counties having a median household income \$10,000 to \$20,000 less than the statewide average. The median household income in Virginia is \$66,300. The median household income for the eleven Virginia counties ranges from a low of \$32,135 to a high of \$45,864, with most of the counties having a median household income \$20,000 to \$35,000 less than the statewide average.

(v) **Population Growth and Age of Population Over 65:** The 21 counties in the GSA have seen little population growth, with only three counties experiencing positive growth during the past decade. The remaining counties suffered population losses ranging from 1% to as much as 10%. Additionally, the percentage of the population aged 65 and older in the GSA is substantially greater than the statewide percentages in Tennessee and Virginia, with older adults comprising an additional five percentage points of the population in two-thirds of the counties.

(vi) **Percentage of Rural Population:** The vast majority of the population in the GSA is considered to be rural, with 100% of the population in six counties classified as rural and over fifty percent of the population in eleven counties classified as rural. This factor is a significant contributing factor in influencing health outcomes in a population.³ A number of studies have demonstrated that rural residents experience many difficulties in accessing health care services, which result in higher morbidity and mortality rates compared to those of their urban counterparts. For example, in addition to the lack of health care professionals in rural areas, as discussed above, many rural residents must travel greater distances to access different points of the health care delivery system; however, due to geographic distance, extreme weather conditions, environmental and climatic barriers, lack of public transportation and challenging roads, rural residents may be limited, and in some instances, even prohibited from accessing health care services. The difficulties of access to health care facilities may impair outcomes by increasing patients' physical and emotional stress, reducing the likelihood of seeking

³ According to a recent study done by iVantage Health Analytics, over 670 rural hospitals are in danger of closing. The National Rural Health Association reports that this number represents 1/3 of the rural hospitals in the United States. Since 2014, seven rural hospitals in Tennessee have either closed completely or have closed inpatient services. Thirteen of the New Health System's twenty-one hospitals in the GSA are considered hereunder as rural hospitals.

follow-up care, and limiting proximate family support. More than 50% of vehicle crash-related fatalities occur in rural areas, even though less than one-third of miles traveled in a vehicle occur there and there is an additional 22% risk of injury-related death. Residents of rural counties are 21% more likely to commit suicide than those living in the larger metro counties, and the poisoning mortality rate is 40% higher in the rural counties. Additionally, the infant mortality rate in the rural counties is 19% higher than the rate in the larger metro counties and the teen birth rate is 72% higher in the rural counties.

2.03. Findings. The Department’s evaluation of the potential benefits and disadvantages identified in Tenn. Code Ann. § 68-11-1303(e) and determination of public advantage is set forth in the Approval Letter which is attached as Exhibit A.

ARTICLE III MONETARY OBLIGATIONS AND COMMITMENTS

3.01. General.

(a) Aggregate Spending Commitment. During the COPA Term, the COPA Parties shall fulfill the obligations, commitments and covenants set forth in this Article III. By its countersignature hereto, each COPA Party hereby acknowledges such obligations, commitments and covenants and agrees to fully comply with them. As set forth in Sections 3.02 through 3.05, the New Health System shall spend a minimum of \$308,000,000 over the ten (10) Fiscal Years beginning July 1, 2018 (the “Ten-Year Period”) on initiatives for expanded access to healthcare services, health research and graduate medical education, population health improvement, and a region-wide health information exchange. A corresponding table summarizing the categories of spending and annual spending commitments for the Ten-Year Period is attached hereto as Exhibit B, the timing of which expenditures may be modified pursuant to the plans submitted to, and approved by, the Department pursuant to Section 3.06. Only new and incremental capital expenditures and operating expenses paid by the New Health System pursuant to the approved plans shall count towards satisfaction of the spending commitments. For purposes of determining whether the New Health System is in compliance with the annual spending commitments in any category or subcategory in Exhibit B (as may be modified pursuant to Section 3.06), if the New Health System spends more than the annual spending commitment for such category or subcategory in any Fiscal Year, the excess shall be credited against the annual spending commitment for such category or subcategory for the next Fiscal Year. Further, if the New Health System spends less than the annual spending commitment for an applicable category or subcategory in any Fiscal Year by no more than fifteen percent (15%), such shortfall shall not constitute a Noncompliance if the New Health System’s spending on such category or subcategory, on an aggregate basis for the three Fiscal Years of the applicable three-year plan, equals or exceeds the amount required to be spent during such three Fiscal Years according to such plan.

(b) Incremental Commitments. The amount of each Monetary Obligation set forth in Sections 3.02 through 3.05 shall be incremental, i.e., the monetary obligations constitute additions to the Applicants’ annual baseline spending levels as of the Issue Date (the “Baseline Spending”) in the applicable categories. The Baseline Spending, by category, is set forth in Exhibit B. By way of example, if the Baseline Spending for children’s health services is \$4,000,000, then in the first Fiscal Year of the New Health System the spending commitment for that category is

\$5,000,000 {\$4,000,000 + \$1,000,000}, and over the Ten-Year Period the total spending commitment in that category is \$67,000,000 { {\$4,000,000 x 10} + \$27,000,000}.

(c) Absolute Commitments. The Monetary Obligations set forth in these Terms of Certification are absolute and unconditional commitments. They shall not (i) be conditioned on, and shall be fulfilled regardless of, the amount of any profits or other savings of the New Health System following the Closing, or (ii) be reduced, offset or defrayed by (A) any charitable gift or contribution received by the New Health System or any COPA Party, or (B) any public or quasi-public spending by any federal, state or local government, in each case which is directed at the same or similar initiatives to which such Monetary Obligations relate. If material unforeseen circumstances occur that, to the Knowledge of the New Health System, imperils the financial stability of the New Health System and thereby will prevent it from being able to keep these absolute and unconditional commitments, the New Health System may request a modification to these Terms of Certification in accordance with Section 8.02.

3.02. Expanded Access to Healthcare Services – Total Incremental Spending Commitment \$140,000,000.

(a) Behavioral Health Services – The New Health System shall spend a minimum of \$85,000,000, at the annual incremental spending amounts described in Exhibit B, over the Ten-Year Period on behavioral health services benefitting the communities in the Geographic Service Area. In connection therewith, within six (6) months after the Issue Date, the New Health System shall develop and submit to the Department for its approval a behavioral health services plan for the first three (3) full Fiscal Years (the “Behavioral Health Plan”), which plan shall, among other things, require the New Health System to develop new and/or improved 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. If the Behavioral Health Plan approved by the Department includes the construction of a residential addiction recovery center, the New Health System may count the cost thereof against all of its annual spending commitments for behavioral health services for the Fiscal Years before and after such construction.

(b) Children’s Services – The New Health System shall spend a minimum of \$27,000,000, at the annual incremental spending amounts described in Exhibit B, over the Ten-Year Period on children’s health services benefitting the communities in the Geographic Service Area. In connection therewith, within six (6) months after the Issue Date, the New Health System shall develop and submit to the Department for its approval a children’s health services plan for the first three (3) full Fiscal Years (the “Children’s Health Plan”), which plan shall, among other things, require the New Health System to: (i) facilitate the recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children’s Hospital physician needs assessment; (ii) develop and sustain surgical specialties necessary to sustain trauma services for children including the development of new emergency rooms (with pediatric capabilities) in Kingsport, Tennessee and Bristol, Tennessee; and (iii) deploy pediatric telemedicine and/or rotating pediatric specialty clinics in the Rural Hospitals, to achieve quick diagnosis and treatment of children in the Geographic Service Area in the right setting in close proximity to patients’ homes.

(c) Rural Health Services – The New Health System shall spend a minimum of \$28,000,000, at the annual incremental spending amounts described in Exhibit B, over the Ten-Year Period on rural health services benefitting the communities in the Geographic Service Area. In connection therewith, within six (6) months after the Issue Date, the New Health System shall develop and submit to the Department for its approval an initial comprehensive physician/physician extender needs assessment and recruitment plan for the first three (3) full Fiscal Years (collectively, the “Rural Health Plan”), covering each rural community in the Geographic Service Area. A critical goal of this plan shall be employing physicians primarily in underserved areas and other locations where quantity and/or specialty needs are not being met, and where Independent Physician groups are not interested in, or capable of, adding such specialties or expanding. The New Health System shall consult with the Department on an ongoing basis on the continued development of the Rural Health Plan, although implementation of the initial plan shall commence promptly upon its approval by the Department.

(d) Healthcare Access Report and Access Sub-Index. The Department shall annually produce and provide to the New Health System an Access to Health Services Report (the “Healthcare Access Report”) measuring outcomes of various factors on access to healthcare in the Geographic Service Area, which report will be used to assess the performance of the New Health System against the Access Sub-Index. The Healthcare Access Report shall initially be substantially in the form attached hereto as Exhibit C and may be revised by the Department from time to time in its discretion. Each of the Behavioral Health Plan, Children’s Health Plan and Rural Health Plan shall take into account the Measures set forth in the Healthcare Access Report and Access Sub-Index, as appropriate. The New Health System’s ongoing compliance with the commitments in this Section 3.02 shall constitute one or more Measures within the Access Sub-Index, along with other Measures therein.

3.03. Health Research and Graduate Medical Education (“HR/GME”) – Total Incremental Spending Commitment \$85,000,000.

(a) General. The New Health System shall spend a minimum of \$85,000,000, at the annual incremental spending amounts described in Exhibit B, over the Ten-Year Period on HR/GME benefitting the communities in the Geographic Service Area.

(b) HR/GME Plan. So that the training of both physicians and allied health professionals meets the goals and objectives of the New Health System and the Department, the New Health System shall, within twelve (12) months after the Issue Date, develop (in partnership with East Tennessee State University and other academic institutions) and submit to the Department a plan for the post-graduate training of physicians, nurse practitioners, and physician assistants and other allied healthcare professionals within the NHS Entities for Fiscal Years 2020 and 2021 (the “HR/GME Plan”). The HR/GME Plan shall focus on developing the academic infrastructure of the New Health System to provide effective training for the next generation of healthcare professionals that are needed to address the healthcare needs of the Geographic Service Area. Such focus shall require a program gap analysis and the formation of program development plans based on assessed needs, clinical capacity and availability of programs. In addition, the New Health System may identify fellowship training opportunities to support the regional base of sub-specialty physicians along with collaboration opportunities when professors and research leaders can work together to close gaps in regional specialty services or provide clinical oversight. If

included in an approved HR/GME Plan, contributions or funding to (i) support educational programs aimed at engaging students in secondary education (i.e., middle school and high school) to pursue a variety of licensed and unlicensed careers in healthcare, and (ii) support training programs for more innovative jobs in healthcare (such as navigators, community health workers, peer counselors, etc.) may be counted towards the HR/GME spending commitment.

(c) Health Research. The HR/GME Plan shall include spending investments in research and growth in the health research enterprise in the Geographic Service Area to attract additional research funding from national sources, including in the area of translational research. The initial HR/GME Plan shall indicate budgeted research expenditures for Fiscal Years 2020 and 2021. Thereafter, the New Health System shall update the research expenditures portion of the HR/GME Plan to address subsequent Fiscal Years no later than ninety (90) days prior to the end of the Fiscal Year for which the then-existing HR/GME Plan ends. The New Health System shall allocate spending to priority research projects identified by the New Health System and academic partners in pursuit of this goal.

(d) Graduate Medical Education. The HR/GME Plan shall set forth the targeted number of persons to be trained by physician specialty or healthcare professional category, the location(s) of such training, the schedule for starting such training, and the expected gross annual expenditure related to such training. The HR/GME Plan shall not, and the New Health System and other COPA Parties shall not, reduce or eliminate any medical residency programs or available resident positions presently operated as of the Approval Date by the Applicants at any applicable NHS Entity, except for reductions or eliminations resulting from reductions in state or federal funding to the COPA Hospitals for graduate medical education (which reductions or eliminations shall be disclosed to the COPA Monitor and result in a corresponding reduction of the HR/GME Baseline Spending levels set forth on Exhibit B); provided, however, that such programs may be moved among the NHS Entities, or substituted for residency training in other specialties, if in the best interests of the Population in the applicable community within the Geographic Service Area. Notwithstanding the foregoing, the Department acknowledges that minor and temporary decreases in the number of full-time equivalent residents working at hospitals may reflect year-to-year variations in residents applying for such training, dropping out of such training, electing to rotate to other hospitals, or transferring to another residency program, and shall not be deemed, standing alone, to cause the New Health System to violate this condition, commitment and covenant. Furthermore, if state or federal support for residency positions to the COPA Hospitals is decreased, the New Health System may allocate funding to offset such reductions in order to sustain current or planned residency slots, and in such event such allocated funding shall count toward the required spending on HR/GME.

3.04. Population Health Improvement – Total Incremental Spending Commitment \$75,000,000.

(a) General. In order to enhance the overall population health status consistent with the regional health goals established by the Department, the New Health System shall spend a minimum of \$75,000,000, at the annual incremental spending amounts described in Exhibit B, over the Ten-Year Period on population health improvement for the Geographic Service Area.

(b) Population Health Plan. The New Health System shall develop, perform and execute a plan, for the first three (3) full Fiscal Years, to make investments in new population health improvement initiatives and in existing population health initiatives for which resources are already being expended but which warrant additional resources (the “Population Health Plan”). The initial Population Health Plan shall be developed and submitted to the Department for its approval no later than six (6) months after the Issue Date, and shall take into account, among other things, the Measures set forth in the Population Health Report and in the Population Health Sub-Index.

(c) Department of Population Health Improvement. No later than six (6) months after the Issue Date, the New Health System shall establish a Department of Population Health Improvement to lead the New Health System’s efforts in implementing the Population Health Plan and improving the overall health of the Population. This department shall be staffed with leaders charged with financial compliance, physician relations and community relations and led by a senior executive that reports directly to the Executive Chair/President or the Chief Executive Officer of the New Health System and serves as the administration liaison to the Population Health and Social Responsibility Committee of the Board of Directors.

(d) Accountable Care Communities. In connection with the Population Health Plan and related required expenditures, the New Health System shall pursue opportunities to establish one or more Accountable Care Communities in the Geographic Service Area in partnership with various local, state and federal agencies, Payors, service providers and community groups willing to partner in such efforts. The Department of Population Health Improvement, with oversight from the Population Health and Social Responsibility Committee of the Board of Directors, shall be responsible for developing the mission and vision of each Accountable Care Community by soliciting input from potential partners on the specific initiatives in the Population Health Plan to target specific health needs of the Population. Consistent with the Population Health Plan, the New Health System may provide necessary funding to sustain the infrastructure of each Accountable Care Community, which may include providing financial investments to accountable partners with clear, contractual expectations for such funding.

(e) Population Health Report and Population Health Sub-Index. The Department shall annually produce and provide to the New Health System a Population Health Report (the “Population Health Report”) measuring outcomes of various factors on population health in the Tennessee GSA, which report shall be used to assess performance of the New Health System against the Population Health Sub-Index. The Population Health Report shall initially be substantially in the form attached hereto as Exhibit D and may be revised by the Department from time to time in its discretion after consultation with the New Health System. The New Health System’s ongoing compliance with the commitments in this Section 3.04 shall constitute Measures within the Population Health Sub-Index, along with other Measures therein.

3.05. Region-Wide HIE – Total Incremental Spending Commitment \$8,000,000.

(a) General. In order to prevent Independent Physicians and other healthcare providers in the Geographic Service Area from being disadvantaged by a lack of access to patient electronic health information necessary for the management of their patients, and to further facilitate better patient care and coordination of care for the Population, the New Health System

shall spend a minimum of \$8,000,000 over the Ten-Year Period in developing and providing readily and easily accessible access to patient electronic health information (“HIE”). Any imposition of fees or costs for such access by Independent Physicians or other healthcare providers shall comply with federal anti-kickback statutes and rules, and shall be a minimal amount that shall not exceed what is reasonable based on comparisons with other communities offering such services.

(b) Policy. The policy behind this Section 3.05, and a policy that the HIE Plan shall reflect, is that patient health information should be readily available to healthcare providers in the Geographic Service Area; that cost should not be a barrier to providers obtaining such information; and that any transfer of such information should be for the benefit of the patients in the Geographic Service Area, and not be utilized as a source of commercial or financial gain for the New Health System or other parties. Nothing in this section shall prohibit the New Health System from pursuing funding for research initiatives, so long as those research initiatives are conducted in compliance with applicable privacy laws. Furthermore, any transfer of patient health information should comply with the Health Insurance Portability and Accountability Act and associated regulations on the use of patient information.

(c) HIE Plan. In connection therewith, within twelve (12) months after the Issue Date, the New Health System shall develop and submit to the Department for its approval a plan for Fiscal Years 2020 and 2021 (the “HIE Plan”), which plan shall, among other things, require the New Health System to (i) coordinate with the Independent Physicians and other health care providers in the Geographic Service Area and other relevant third parties to determine the optimal technology solution for expanding the scope and effectiveness of providing access to patient electronic health information to the Independent Physicians and other health care providers, and (ii) take all actions within its control to prohibit the resale or other commercial use of HIE data.

3.06. Plan Acceptance and Modification.

(a) Acceptance. With respect to each plan to be submitted to the Department for its approval described in Sections 3.02 through 3.05, the Department shall approve or propose modification to the plan within thirty (30) days of such submission. If the Department proposes a modification to any such plan, the New Health System shall have thirty (30) days following notice thereof to respond. Failure to timely respond shall constitute acceptance. If the New Health System objects to the modifications proposed by the Department, the COPA Monitor may meet with the New Health System and the Department in an attempt to resolve all issues related to such plan.

(b) Replacement Plans. With respect to each three-year plan described in this Article III, no later than ninety (90) days prior to the expiration of such plan, the New Health System shall develop and submit to the Department for its approval in accordance with Section 3.06(a) a new plan for the next three (3) full Fiscal Years to replace such expiring plan.

(c) Modification. Following the approval, as applicable, and adoption of each plan described in this Article III, the New Health System may, from time to time, request a meeting with the COPA Monitor to discuss possible modifications to any such plan. Such discussions may

include, among other things, proposals to revise the timing (but not the 10-year aggregate amount) of the spending commitments set forth in Exhibit B. In its discretion, the COPA Monitor shall determine whether any plan modifications proposed by the New Health System are material. The COPA Monitor shall accept any plan modifications it determines are not material, but shall notify the Department of any such nonmaterial modification. The COPA Monitor shall refer all proposed plan modifications it determines are material to the Department for its consideration. The Department may accept, decline or revise any proposed modification to any plan referred to it by the COPA Monitor. To the extent any adopted plan is modified pursuant to this Section 3.06(c), the New Health System shall accordingly amend and restate the plan to be effective on a prospective basis.

3.07. Facility Maintenance and Capital Expenditures.

(a) General. During the COPA Term, the New Health System and the other NHS Entities shall maintain and repair, and as needed upgrade or replace, their medical equipment and related software support, physical plant equipment, building systems (HVAC, elevators, parking, etc.), and other machinery, facilities and non-medical equipment at a quality and technological level consistent with industry norms for similarly-sized healthcare systems, in each case promptly when needed. In connection with this commitment, the New Health System shall incur annual capital expenditures for each Fiscal Year, consistent with the plans required by Section 3.07(b), which plans shall exclude any capital expenditures related to the branding or rebranding of the Applicants to the New Health System, other one-time capital expenditures related to the consummation of the Affiliation, capital expenditures related to the other Monetary Commitments set forth in this Article III, and any ordinary course expenses of maintenance or repair that are not capitalized in accordance with GAAP. For the avoidance of doubt, the New Health System shall timely maintain and repair all of its systems, equipment and facilities referenced above, consistent with industry norms for similarly-sized healthcare systems, regardless of whether any maintenance and repair expense is capitalized or not capitalized pursuant to GAAP or other applicable guidance.

(b) Compliance.

(i) Capital Plan. No later than six (6) months after the Issue Date, the New Health System shall develop and submit to the COPA Monitor and the Department a capital expenditures plan for the first three (3) full Fiscal Years (the “Capital Plan”), which plan shall include a list of capital projects the New Health System commits to complete during the three Fiscal Years (the “Capital Projects”), along with the estimated timing of items initially planned for funding and the estimated amount of the capital to be spent. The New Health System may substitute these items in its reasonable discretion based on priorities which emerge from time to time and which may alter the items chosen for funding. Any such substitution of items material in amount and function shall be promptly disclosed to the COPA Monitor together with the reasons for the substitution and the planned treatment of the item(s) being deleted. The Capital Plan shall define what is material in amount and function.

(ii) Replacement Capital Plans. With respect to each Capital Plan, no later than ninety (90) days prior to the expiration of an existing plan, the New Health System shall develop and submit to the COPA Monitor and the Department a new Capital Plan every three (3)

Fiscal Years during the COPA Term to replace the expiring plan. Each Capital Plan shall not require the approval of the Department, but is subject to the provisions of Sections 3.07(b)(iii) and (iv) below. As part of each Annual Report, the New Health System shall include a report on the status of implementation of the then-current Capital Plan, including a summary of all capital expenditures made or not made as scheduled under the Capital Plan and any unplanned, additional capital expenditures made during the year. Each Capital Plan shall not be modified except in accordance with this Section 3.07.

(iii) Facilities Assessment. If, at the end of the third Fiscal Year under each Capital Plan, the New Health System has spent less than ninety percent (90%) of the aggregate required spending for the three (3) year period, the New Health System shall engage a facility consultant experienced with healthcare systems (the “Facilities Consultant”) selected by the COPA Monitor to conduct a review of each COPA Hospital where a scheduled Capital Project was not completed in accordance with the Capital Plan (the “Facilities Assessment”). The Facilities Assessment at each relevant COPA Hospital will include a review of all building structures, building systems (HVAC, elevators, parking, etc.), medical equipment and related software support, physical plant equipment, and other machinery, facilities and non-medical equipment. The Facilities Assessment shall examine the need for replacement, repair and/or renovation of such items based on applicable code requirements, physical deterioration, functional obsolescence and technological obsolescence, and shall further categorize each identified need for maintenance, repair, and/or upgrade or replacement as an immediate, short-term, intermediate or long-term need. The Facilities Consultant shall complete and submit the Facilities Assessment to the New Health System, the COPA Monitor and the Department. Within three (3) months after completion of the Facilities Assessment, the New Health System and the COPA Monitor shall jointly develop and submit to the Department for its approval a new Capital Plan incorporating the findings from the Facilities Assessment (such new Capital Plan may also be referred to as a “Jointly-Developed Capital Plan”). Within thirty (30) days of receipt of any such plan, the Department shall approve or deny the plan in its discretion, to be exercised in accordance with Section 9.03.

(iv) Proposed Modification by the New Health System. In response to material unforeseen circumstances, and so long as the New Health System is not presently under a Jointly-Developed Capital Plan, the New Health System may at any time notify the COPA Monitor and request a modification of the existing Capital Plan. If the COPA Monitor determines the modification is a material change that necessitates obtaining additional information from an objective third party, the New Health System shall then engage a Facilities Consultant selected by the COPA Monitor to conduct a Facilities Assessment of the COPA Hospitals affected by the proposed modification in the same manner as set forth in Section 3.07(b)(iii). Promptly following the completion of the Facilities Assessment, the New Health System and the COPA Monitor shall jointly develop and submit to the Department for its approval a Jointly-Developed Capital Plan. The Department shall approve or deny any such plan within thirty (30) days of receipt of the plan.

(v) Noncompliance under a Jointly-Developed Capital Plan. If at any time during the COPA Term the New Health System does not complete any Capital Project identified in a Jointly-Developed Capital Plan, the New Health System shall deposit in a separate account restricted for such purpose the amount of any shortfall necessary to cover the cost of such capital expenditure until such item is completed. If the New Health System continues in a state

of Noncompliance with respect to performance of any Capital Project identified in such Jointly-Developed Capital Plan for an unacceptable period of time (as will be determined by the Department based on the timeline proposed in such Jointly-Developed Capital Plan, but no longer than 180 days), the New Health System shall forfeit the lesser of \$2,000,000 or an amount equal to twenty percent (20%) of the amount of the required capital expenditure. The Department may assess additional forfeitures annually if the New Health System continues in Noncompliance with respect to any Capital Project. Each such forfeiture payment shall be paid within ten (10) days of the Department's request to the Population Health Initiatives Fund by transfer from the separate account referenced above.

3.08. Employee Benefits and Protections.

(a) General. Upon the Closing, the New Health System shall (i) continue the employment at-will of all then-active employees of any NHS Entity upon similar or improved terms and conditions, (ii) honor prior service credit for purposes of eligibility and vesting under each NHS Entity's employee benefit plans, (iii) honor full credit for vacation and sick leave under each NHS Entity's employee benefit plans and policies accrued as of the Issue Date, and (iv) as described in Section 3.08(b), work as quickly as practicable to address differences in salary/pay rates and employee benefit structures.

(b) Employee Pay/Benefits Equalization. In order to achieve a uniform system of compensation, and competitiveness of pay for attracting and retaining employees, the New Health System shall, by no later than the beginning of the first full Fiscal Year after the Issue Date, create and begin the implementation of a plan (the "Equalization Plan") to spend a minimum of \$70,000,000 over the Ten-Year Period to eliminate differences in salary/pay rates and employee benefit structures among the employees of the New Health System. Such spending commitment shall be incremental, i.e., shall constitute an addition to the Applicants' aggregate spending levels as of the Approval Date on employee pay and benefits. The Equalization Plan shall account for differences in salary/pay rates and employee benefit structures applicable to all levels of employees such that the New Health System offers competitive compensation and benefits for all the NHS Entities' employees. Such plan shall begin to eliminate such differences as soon as practicable after the Issue Date.

(c) Career Development. In order to assist employees in achieving growth in their careers, the New Health System shall, within six (6) months of the Issue Date, combine the career development programs of each Applicant into one (1) system-wide career development program so that employees of the New Health System have the maximum opportunity for career development, enhancement and training. Upon completion, the New Health System shall provide a copy of the system-wide program to the Department, and thereafter explain the implementation and results of such program in each Annual Report.

(d) Employee Retention/Termination/Severance.

(i) Between the Approval Date and the Issue Date, the New Health System shall not have terminated, and during the twenty-four (24) month period commencing with the Issue Date, the New Health System shall not terminate, any employee of any Rural Hospital, whether or not such employee is classified as clinical personnel, nor require any such

employee to enter into an early retirement package or otherwise resign in lieu of termination, except in either case for cause. Thereafter, (A) if the New Health System terminates any employee of a Rural Hospital without cause it shall provide notice to the Department including the basis for the termination within forty-eight (48) hours of such termination and (B) if the New Health System desires to commence a reduction of fifty (50) or more Rural Hospital employees, whether in a single act or a series of related acts, in any ninety (90) day period, the New Health System shall be required to follow the procedures outlined in Section 3.08(d)(ii) below prior to commencing with such planned workforce reduction. In addition, during the same twenty-four (24) month period, the New Health System shall not require any such employee of a Rural Hospital to transfer his or her principal place of employment to a location more than thirty (30) miles from the location of such employee's principal place of employment as a condition to his or her continued employment. Any employee's refusal to accept a transfer to a location more than thirty (30) miles from his or her principal place of employment shall not constitute cause for termination.

(ii) If the New Health System desires to commence with a facility closure, the deletion or material repurposing of any Service Line, and/or any material reduction in workforce during the COPA Term, and such action is permitted under these Terms of Certification, the New Health System shall notify the Department (to the extent it has not already notified the Department) at least sixty (60) days in advance of such action. The notice shall include a severance policy (the "Severance Policy") addressing how employees will be compensated if they are not retained in connection with such action. The Severance Policy shall consider several factors, including but not limited to, each employee's position within his or her current organization and years of service. The policy shall also address outplacement support to be provided to any such employee. Payments made to employees in connection with the Severance Policy shall not offset or limit payments to be made to employees in connection with the spending commitment described in Section 3.08(a) above.

(e) Clarifications. Nothing in this Section 3.08 shall (i) be construed to create any right of action for any individual employee or group of employees of any NHS Entity; (ii) limit any of the restrictions on terminating, repurposing or otherwise materially changing Service Lines or components thereof as set forth in Section 4.03; or (iii) limit the ability of any NHS Entity to terminate any employee for cause.

ARTICLE IV NON-MONETARY OBLIGATIONS AND COMMITMENTS

4.01. General. During the COPA Term, the COPA Parties shall fulfill the obligations, commitments and covenants set forth in this Article IV and thereafter. By its countersignature hereto, each COPA Party hereby agrees to and acknowledges such obligations, terms and conditions, commitments and covenants. Unless the context expressly indicates otherwise, all Non-Monetary Obligations, Monetary Obligations and other commitments and covenants of the New Health System under the Terms and Conditions shall be the joint and several obligations of each of the COPA Parties.

4.02. Quality of Care.

(a) Accreditation, Licensure and Certification.

(i) Joint Commission Accreditation and Medicare Participation.

(A) Each COPA Hospital that is subject to Joint Commission accreditation shall at all times be fully accredited by the Joint Commission, and each COPA Hospital shall at all times maintain compliance with conditions of participation with Medicare.

(B) Each COPA Hospital shall promptly notify the Department and the COPA Monitor of any deficiencies or other noncompliance cited by the Joint Commission or Medicare.

(C) Each COPA Hospital shall submit a plan of correction correcting any such deficiencies or noncompliance within the time provided by a CMS-approved Medicare accreditation program, including the Joint Commission or other federally authorized inspection entity, as set out in any CMS Statement of Deficiencies and Plans of Correction or any document or form that replaces the CMS Statement of Deficiencies and Plans of Correction, and shall notify the Department and the COPA Monitor upon completion.

(ii) State Licensure and Federal Certification Requirements.

(A) Each COPA Hospital (and any healthcare facility within a COPA Hospital such as a laboratory) located in Tennessee shall comply at all times with all requirements, standards, and regulations of the Tennessee Board for Licensing Health Care Facilities (the “TBLHCF”), including without limitation, patient care standards, compliance standards and regulations, reporting standards and regulations, specifications for construction plans, and fire and life safety code regulations.

(B) Each COPA Hospital shall correct any deficiency citations and pay any state and/or federal civil monetary penalties arising from state licensure surveys, compliance inspections, and/or federal certification surveys within the time period provided by the TBLHCF or applicable federal authority, and at all times during the COPA Term shall provide to the Department an explanation of any such deficiencies/penalties, along with an action plan to correct such noncompliance within such time period.

(C) Each COPA Hospital shall at all times comply with the TBLHCF’s reporting requirements and shall promptly report any events or practices detrimental to patient health, safety, or welfare (including without limitation, patient abuse or neglect) and/or any material violations of federal or state Laws. Upon inquiry, the New Health System shall disclose to the COPA Monitor all information related to the events, practices and violations referred to in this Section 4.02(a)(ii)(C).

(D) Each COPA Hospital shall maintain state licensure and federal certification for participation in the Medicare and Medicaid programs.

(b) Clinical Council.

(i) The New Health System shall establish a system-wide, physician-led clinical council (the "Clinical Council").

(ii) The Clinical Council shall be composed of (A) Independent Physicians, (B) Employed Physicians, (C) the Chief Medical Officer of the New Health System and (D) a Chief Nursing Officer of one of the COPA Parties. The Clinical Council shall include representatives of the New Health System's management but the majority will be composed of physicians.

(iii) The Clinical Council may be supported by other clinicians, subject matter experts, and senior management.

(iv) The Chair of the Clinical Council shall be a physician member of the active medical staff(s) of one or more NHS Entities chosen by members of the Clinical Council. The Chair shall serve on the Quality, Service and Safety Committee of the Board of the New Health System and shall provide ongoing reports on the activities of the Clinical Council through the Quality, Service and Safety Committee of the Board.

(v) The Clinical Council shall be responsible for establishing a common standard of care, credentialing standards, consistent multidisciplinary peer review when appropriate, and quality performance standards and best practices requirements for the New Health System, all of which shall be documented as applicable and reported to the Department in each Annual Report.

(vi) The Clinical Council shall also provide input to the New Health System on issues related to clinical integration, and shall support the goals established by the Board of Directors of the New Health System consistent with these Terms of Certification.

(vii) The Clinical Council may also request that the Board of Directors of the New Health System petition the Department to change or update the Target Quality Measures in Exhibit K based on quality improvement priorities of the New Health System.

(c) Data Collection; Reports to the Department.

(i) The New Health System shall report to the Department in the Annual Report on a common and comprehensive set of measures and protocols that will be part of the integrated delivery of healthcare across the entire New Health System in accordance with a schedule determined by the Department from time to time in consultation with the New Health System, as well as track and monitor opportunities to improve healthcare and access to care at the right place and right time for consumers within the Geographic Service Area.

(ii) The New Health System shall collect data for all quality indicators required by the Department and include a summary of all results in the Annual Report. Such summary must include a comparison of publicly available data with publicly available quartile medians.

(iii) The New Health System shall conduct patient satisfaction surveys which conform to federal Medicare HCAHPS requirements and which include questions regarding patient satisfaction with access to care services, the form and frequency of which shall be approved by the Department and the results of which shall be included in the Annual Report.

(iv) The New Health System shall collect and provide in the Annual Report staffing ratios, including the average number of hours of patient care delivered per patient and ratio of RN to LPN and other caregivers such as nurse's aides.

(v) At least every three (3) Fiscal Years, the New Health System shall conduct physician and employee satisfaction surveys comparing results to previous results. The COPA Monitor shall validate that these surveys are conducted. A summary of each survey shall be included in the applicable Annual Report.

(vi) The New Health System shall collect other data as required by the Department or as necessary for reporting on the Index and Measures as identified in Exhibits C, D and K.

(d) Quality Reporting to the Public.

(i) Just as the New Health System shall report to the Department on a common and comprehensive set of measures and protocols that will be part of the integrated delivery of healthcare across the entire New Health System, as well as track and monitor opportunities to improve healthcare and access to care at the right place and right time for consumers, the New Health System shall make available to the public timely information to affect consumer choice and further incentivize the provision of high quality care. Such increased transparency is designed to provide the Population with information for their use to make better healthcare decisions.

(ii) The New Health System shall post on its website the New Health System's CMS Hospital Compare measures for each applicable NHS Entity within thirty (30) days of reporting the data to CMS. The New Health System shall also provide in such public report benchmarking data against the most recently available CMS data, so the public can evaluate and monitor how the applicable NHS Entities compare against hospitals and other healthcare facilities across the States and United States. Given that CMS periodically changes the Hospital Compare measures it requires hospitals to report, and to provide patients with information on the latest CMS Hospital Compare measures, the New Health System shall include all current CMS Hospital Compare measures in its post on its website, rather than any predefined subset of measures.

(iii) The New Health System shall post on its website measures of patient satisfaction for each applicable NHS Entity within thirty (30) days of reporting the data to CMS via the Hospital Consumer Assessment of Healthcare Providers and Systems reporting. The New Health System shall also provide in such public report benchmarking data against the most recently available CMS patient satisfaction scores, so the public has access to how the applicable NHS Entities compare against hospitals and other healthcare facilities across the States and the United States.

(iv) The New Health System shall annually post on its website the specific facility high priority measures set by CMS and the Joint Commission for each applicable NHS Entity. Some examples of the high priority measures previously set by CMS and the Joint Commission include central line-associated bloodstream infections, catheter associated urinary tract infections, and ventilator associated pneumonia infection rates.

(v) The New Health System shall annually post on its website surgical site infection rates for each applicable NHS Entity annually.

(vi) The New Health System shall annually post on its website the ten (10) most frequent surgical procedures performed (by number of cases) at each ambulatory surgery center majority-owned or controlled by the New Health System.

(vii) The New Health System shall improve transparency and reporting on high priority measures for quality and cost improvement by reporting annually on its website the following information for each applicable NHS Entity, aggregated for the facilities across the DRGs that comprise 80% of the discharges from the all NHS Entities: (1) severity adjusted cost/case; (2) length of stay; (3) mortality rate; and (4) thirty (30) day readmission rate. The New Health System shall also report annually these quality measures on its website for the top ten (10) DRGs aggregated across the system annually.

(viii) All references in this Section 4.02(d) to posts on any website shall mean posts that are freely and easily accessible by the public.

4.03. Access to Healthcare Services.

(a) Maintenance as Hospitals.

(i) During the COPA Term, the New Health System shall maintain in operation as full-service tertiary referral hospitals Johnson City Medical Center, Holston Valley Medical Center and Bristol Regional Medical Center.

(ii) It is the intent of the Department to ensure that access to needed services is maintained or improved in the Geographic Service Area. The Department also recognizes that improvements in technology and the increased movement of services toward the outpatient setting are changing the dynamics of how services are provided in rural communities. The commitments contained herein which require, among other things, an objective assessment of physician needs in rural communities, recruitment or employment of needed physicians in the communities, expansion of telemedicine capability, connectivity to pediatric emergency services and tertiary services, and connectivity to addiction treatment and mental health services are expected to improve access to needed services. Subject to Sections 4.03(b) and (c) below, for the first five (5) full Fiscal Years, the New Health System shall maintain in operation as Hospitals all COPA Hospitals in operation at the Approval Date, each of which shall maintain the services existing at such COPA Hospital as of the Approval Date.

(b) Repurposing to a Non-Hospital Facility.

(i) Upon petition to and approval of the Department, in the Department's discretion, the New Health System may repurpose any COPA Hospital to a non-Hospital facility, provided that: (A) such repurposing is consistent with the applicable plans set forth in Article III and with the goal of providing access to affordable healthcare services in the Geographic Service Area, including Hospital services and other healthcare and preventive services based on the demonstrated need of the applicable Population; (B) if such petition is made during the first five (5) full Fiscal Years, such repurposing only alters the physical plant of the COPA Hospital to the degree required to provide the repurposed services; and (C) the New Health System maintains the Essential Services set forth in Exhibit E within the county in which such facility is located, to the extent such COPA Hospital was providing such services as of the date of repurposing. In petitioning the Department with respect to repurposing a COPA Hospital pursuant to this Section 4.03(b)(i), the New Health System shall provide the Department with a copy of any alignment policy and any other reports and/or information from the New Health System explaining the need for such action.

(ii) Notwithstanding the foregoing, the Department acknowledges that significant duplication of services exists in Wise County, Virginia and the independent city of Norton, Virginia (collectively, "Wise/Norton") as a result of the three Rural Hospitals located therein. The Department agrees that the New Health System may repurpose one or more of the Rural Hospitals located in Wise/Norton without prior approval from the Department, provided that (A) the New Health System maintains at least one Rural Hospital in Wise/Norton; (B) such repurposing is consistent with the applicable plans set forth in Article III and with the goal of providing access to affordable healthcare services in the Geographic Service Area, including Hospital services and other healthcare and preventive services based on the demonstrated need of the applicable Population; (C) the New Health System thereafter maintains and/or provides the Essential Services set forth in Exhibit E in Wise/Norton; and (D) no employee classified as clinical personnel may be terminated thereby, except for cause. In addition, the New Health System shall not require any such employee described in (D) above to transfer his or her principal place of employment to a location more than thirty (30) miles from the location of such employee's principal place of employment as a condition to his or her continued employment. Any employee's refusal to accept a transfer to a location more than thirty (30) miles from his or her principal place of employment shall not constitute cause for termination.

(iii) Notwithstanding the foregoing, the Department acknowledges that significant duplication of services exists in Greene County, Tennessee ("Greene County") as a result of the two Rural Hospitals located therein. The Department agrees that the New Health System may consolidate services into one of such Rural Hospitals and repurpose the other Rural Hospital located in Greene County without prior approval from the Department, provided that (A) the New Health System maintains at least one Rural Hospital in Greene County; (B) such repurposing is consistent with the applicable plans set forth in Article III and with the goal of providing access to affordable healthcare services in the Geographic Service Area, including Hospital services and other healthcare and preventive services based on the demonstrated need of the applicable Population; (C) the New Health System thereafter maintains and/or provides the Essential Services set forth in Exhibit E in Greene County; and (D) no employee classified as clinical personnel may be terminated thereby, except for cause. In addition, the New Health System shall not require any such employee described in (D) above to transfer his or her principal place of employment to a location more than thirty (30) miles from the location of such

employee's principal place of employment as a condition to his or her continued employment. Any employee's refusal to accept a transfer to a location more than thirty (30) miles from his or her principal place of employment shall not constitute cause for termination.

(iv) With respect to Sections 4.03(b)(ii) and (iii), Section 3.08 shall not apply, except for Section 3.08(c) and Section 3.08(d)(ii). In addition, the New Health System (I) shall exercise reasonable, good faith efforts to relocate any employees adversely affected by actions taken in accordance with Sections 4.03(b)(ii) and (iii), and (II) shall provide placement services and training to the adversely affected employees that are accepted practices by comparable health care companies in similar circumstances.

(c) Deletion or Repurposing of Other Service Lines or Non-Hospital Facilities.

(i) With respect to any existing or future Service Line, including any material component or procedure of a Service Line, or any existing or future facility of the New Health System that is not a COPA Hospital, the New Health System shall provide the Department with ninety (90) days prior notice of any proposed deletion or repurposing of the entirety of any such Service Line, any key component or procedure thereof or any such facility, including by means of divesting an interest in, or terminating, materially modifying or creating a joint venture with respect to such Service Line, key component or procedure thereof or any such facility, which action the New Health System shall not take if the Department withholds its consent, which the Department shall not unreasonably withhold or delay. In determining its approval or disapproval, the Department may consider any negative impact of any such proposed action on Public Advantage, including, among other factors, any negative impact on (i) access to healthcare services, (ii) quality of care or (iii) the employees of the New Health System. For example, if the New Health System proposes to eliminate a Service Line demonstrated to be redundant, or otherwise duplicative of other Service Lines, and would repurpose employees associated with that Service Line, then such factors may weigh in favor of the Department's approval of such action. Nothing in this Section 4.03 shall limit any of the restrictions on terminating employees set forth in Section 3.08(d).

(ii) Notwithstanding Section 4.03(c)(i), any deletion or repurposing of a non-material portion of a Service Line or facility or non-material component or procedure thereof shall not require notice to and approval of the Department. Following are examples of material deletions or repurposings that would require notice to and approval of the Department: termination of a Cancer Service Line at any COPA Hospital, termination of the Cardiovascular Service Line at any COPA Hospital, or any other change to the nature of a Service Line or facility that would be of a type that the resulting Service Line or facility would, in the ordinary course, require a certificate of need or other regulatory approval before providing services. Further, the following anticipated deletions and repurposings shall be considered pre-approved by the Department as of the Closing: (1) consolidation of Level I Trauma Centers; (2) consolidation of duplicative urgent care centers; (3) consolidation of surgery services at Indian Path and Holston Valley Medical Center; and (4) consolidation of non-medical support services.

(d) Uninsured Discount. The New Health System shall provide uninsured or Underinsured patients a discount off hospital charges. Uninsured or Underinsured patients of the New Health System shall not be charged more than amounts generally billed ("AGB") to

individuals who have insurance covering such care in case of Emergency Services or other Medically Necessary Services.

(e) Charity Care Policy. In order to prevent low income patients who are uninsured from being adversely impacted due to the issuance of the COPA, the New Health System shall adopt a charity care policy for COPA Hospitals that is identical to or more charitable (but in no event less charitable) than, the existing policies of both Applicants and consistent with the Internal Revenue Service's final 501(r) rule. The New Health System shall furnish a copy of its policies relating to charity care to the Department no later than the end of the third (3rd) month following the Closing Date. Thereafter, the New Health System shall furnish to the Department a copy of any revisions to such policies within thirty (30) days of any such revisions. In all cases, the New Health System shall seek to connect individuals/families to healthcare coverage when possible. The New Health System shall inform the public of its charity care and discounting policies in accordance with all applicable Laws and shall post such policies on its website and on the separate websites for all provider components that are part of the New Health System.

(f) Total Charity Care.

(i) In each Annual Report, the New Health System shall report Total Charity Care (defined below) for the 12-month period ending on June 30 each year for the Applicants and for all COPA Hospitals filing a Form 990 for the year ended on or before December 31, 2016, including any hospitals acquired after that date. For the 12-month period ending on June 30 of each year, "Total Charity Care" shall be the sum of Part I, line 7a, column (e) and Part I, line 7(b), column (e) of Schedule H, or the equivalent calculation if Form 990 is not available at the filing of the Annual Report. Total Charity Care for any applicable 12-month period, as described in the following sections and subject to the language below, shall be calculated in a manner consistent from year to year.

(ii) "Base Charity Care" shall be the sum of Part I, line 7a, column (e) and Part I, line 7(b), column (e) of Schedule H for the respective 2017 fiscal years ending on or before December 31, 2017.

(iii) In each period beginning with the 12-month period ended June 30, 2019 and thereafter, the New Health System shall provide Total Charity Care greater than Base Charity Care, as adjusted annually by the Hospital Inflation Adjustment (as defined in Addendum 1 attached).

(iv) Until such time as the New Health System migrates to a synchronized unit-level cost system, Total Charity Care shall be calculated by using the legacy methodologies that Wellmont and Mountain States used to calculate charity care for each organization's Form 990. The legacy Wellmont methodology will be used to calculate the Base Charity Care for the Wellmont Hospitals and the legacy Mountain States methodology will be used to calculate the Base Charity Care for the Mountain States Hospitals. For each year that Total Charity Care is calculated using the legacy methodologies, the methodology shall be provided to the Department. The calculations shall be made on a consistent basis each year and any modification to the methodologies of the calculations will be subject to approval by the Department.

(v) At such time as the New Health System migrates to a synchronized unit-level cost system, Base Charity Care will be adjusted at that time, and Total Charity Care will be adjusted going forward, to reflect one consistent calculation across all reporting COPA Hospitals. The analysis of the changes in amounts resulting from this calculation shall be provided to the Department. The calculation shall be made on a consistent basis each year and any modification to the methodology of the calculation will be subject to approval by the Department.

(vi) If Total Charity Care does not exceed Base Charity Care (as adjusted) for any year, the New Health System may include in the Annual Report an explanation of why Total Charity Care decreased during such year. The COPA Monitor in its discretion may consider such explanation and any relevant market conditions and economic conditions (e.g. Medicaid Expansion) in making its determination about whether to waive any Noncompliance with this Section 4.03(f). The COPA Monitor shall provide its decision with respect to any such waiver to the Department and the New Health System within thirty (30) days after receiving the Annual Report from the New Health System.

(g) Access to Competing Licensed Facilities. The New Health System shall provide access to competing licensed facilities which request access to any NHS Entity for services not offered in the Geographic Service Area by such competing licensed facilities, upon non-discriminatory terms and conditions. The NHS Entity shall charge such competing licensed facility no more than AGB for the applicable services. The New Health System shall continue such access for which it is the sole provider until such time as the competing licensed facility offers the service.

4.04. Board Governance of the New Health System.

(a) Duty of Care. Each member of the Board of the New Health System shall exercise the duties of care, loyalty and obedience to the New Health System required by Law. The New Health System shall establish strict fiduciary policies reflecting such duties, and all Board members shall adhere to such policies.

(b) Number. The Board shall be composed of eleven (11) voting members, including two (2) ex-officio voting members. The two (2) ex-officio voting members shall be the New Health System Executive Chairman, President and Chief Executive Officer and the President of East Tennessee State University.

(c) Composition. The Board, consistent with best practices in health care governance, shall be competency-based. However, it is also recognized that governance of the New Health System should reflect the Geographic Service Area, including both Virginia and Tennessee. As such, the New Health System shall cause, upon the Closing, the following actions to be implemented:

(i) No later than one (1) month after the Closing Date, at least two (2) of the voting members of the Board shall be residents of Virginia, and thereafter such composition shall be sustained through the COPA Term; all such persons shall be appointed through the governance selection process outlined in the bylaws of the New Health System;

(ii) The following Board committees, as they exist from time to time, shall include voting members who reside in Virginia: Finance; Audit and Compliance; Quality, Safety and Service; Population Health and Social Responsibility; and Workforce. Also, at least 30% of the voting members of the Population Health and Social Responsibility Committee shall reside in Virginia; and

(iii) Article III, Section 1 of the New Health System's bylaws in effect as of the Issue Date shall be amended in accordance with this Section 4.04(c).

(d) Ongoing Training. No less than annually, and more frequently as needed due to changes in Laws or otherwise, the Board shall participate in training and education sessions designed to keep the members current on significant developments pertaining to their ongoing management of the New Health System.

(e) Population Health and Social Responsibility Committee. The Population Health and Social Responsibility Committee shall be responsible, as delegated by the Board, for oversight and compliance with the commitments and reporting requirements in the COPA and these Terms of Certification concerning the health of the Population. The members of this committee shall include the Chief Executive Officer and Chief Operating Officer of the New Health System; and their attendance at, and their presence for the duration of, meetings of this committee shall be reported quarterly to the Board and set forth in each Quarterly Report. This committee shall also be responsible for overseeing the efforts of the New Health System's Department of Population Health Improvement in developing the infrastructure and mission of each Accountable Care Community established in the Geographic Service Area. The leadership of each Accountable Care Community shall include members of the Population Health and Social Responsibility Committee.

4.05. Bond Issuances and Indebtedness.

(a) Bonds. In order to demonstrate that the New Health System maintains the financial viability to fulfill its commitments, covenants and obligations hereunder, the Applicants hereby represent and warrant to the Department by their countersignature hereto that (i) the Closing, and the COPA Parties entering into and assuming the obligations under these Terms of Certification, shall not constitute a default, technical or otherwise, under, and (ii) the COPA Parties have obtained all necessary approvals and given all necessary notices with respect to the Closing and these Terms of Certification under, any agreements documenting issues of taxable or tax-exempt bonds issued for the benefit of any Applicant or its affiliates as of the date of Closing, including any master indenture to which any Applicant or its affiliates are a party as of the date of Closing, and under any other instrument or agreement evidencing indebtedness of any Applicant or affiliates as of the date of Closing. During the COPA Term, no COPA Party shall consolidate, modify, redeem or prepay, in whole or in part, any taxable or tax-exempt bond issues to which any COPA Party or any of its affiliates is a party, or seek the issuance of new taxable or tax-exempt bonds, without prior written notice to the Department or as otherwise required pursuant to the Terms and Conditions. If, at any time during the first twelve (12) months after the Issue Date, the New Health System refinances, refunds or otherwise restructures the taxable or tax-exempt bonds to which any COPA Party or any of its affiliates is a party, and the terms of the new bonds do not require a debt service reserve fund, then any cash and investments in debt service reserve funds of

the refunded, called or otherwise defeased bonds shall be used to reduce the total amount of debt issued by the New Health System as part of any such restructuring. If any COPA Party is required, under any agreements documenting issues of taxable or tax-exempt bonds, to provide any notice to any trustee, bank or financial institution, holder of bonds or other person or entity, then the COPA Party shall promptly provide a copy of any such notice to the Department and to the COPA Monitor for their review.

(b) Other Indebtedness. The New Health System shall during the COPA Term provide written notice to the Department before securing any borrowings for indebtedness greater than \$7,500,000, including any senior credit facilities, asset based lines of credit or other loan facilities, with liens or other encumbrances on the assets of the New Health System or other NHS Entities; provided, however, that purchase money indebtedness secured only by liens on equipment purchased, and capital leases for equipment, entered into in the ordinary course of business shall not require prior notice to the Department.

4.06. Domicile; Plan of Separation; Fiscal Year Change. Following the Issue Date, the COPA Parties (a) shall not change their state of incorporation from Tennessee, and (b) shall fully comply with the Plan of Separation terms, including without limitation the commitment of the Applicants not to transfer any Material Operating Assets to each other or to the New Health System during the Short-Term Period (as such terms are defined in the Plan of Separation). The COPA Parties shall not modify the Plan of Separation except with the prior written approval of the Department in accordance with the COPA Act. Furthermore, if the New Health System intends to change its Fiscal Year from a June 30 year-end, the New Health System shall provide the Department with at least ninety (90) days prior written notice and shall specify what COPA Modifications, if any, will be necessitated by such Fiscal Year change. The New Health System shall, with approval of the Department, implement any approved COPA Modifications, including any update of the plans described in Article III, in each case so that such Fiscal Year change does not reduce the obligations of the New Health System hereunder or thereunder.

ARTICLE V MANAGED CARE CONTRACTS AND PRICING LIMITATIONS

5.01. General. During the COPA Term, the New Health System shall fulfill the obligations, commitments and covenants set forth in this Article V, which are intended generally to minimize any adverse impact caused by the Affiliation, on the ability of Payors to negotiate appropriate payment and service arrangements with the New Health System, and to ensure that post-Closing pricing is fair to both consumers and Payors.

5.02. Health Plan Negotiations and Restrictions.

(a) For Payor Contracts which are repriced, renegotiated or executed post-Closing, the terms of Addendum 1 attached to these Terms of Certification, entitled “COPA Managed Care Contract Pricing Limitations,” shall govern all pricing during the COPA Term. The Chief Financial Officer of the New Health System shall certify the New Health System’s compliance with the terms of Addendum 1 in each Annual Report.

(b) The New Health System shall negotiate in good faith with all Payors to include the New Health System in health plans offered in the Geographic Service Area, and the New Health System shall comply with the provisions of Addendum 1 when negotiating and executing contracts with Payors. The New Health System shall agree to resolve, through mediation, any disputes in health plan contracting with Payors. The New Health System shall promptly notify the Department of any mediation occurring pursuant to this commitment and shall update the Department on the progress of such mediation. If mediation is not successful, then the New Health System shall proceed to arbitration with the Payor as set forth in Section 5.08.

(c) The New Health System shall not unreasonably refuse to negotiate with potential new Payor entrants to the market or Payors that have small market shares.

(d) The New Health System shall not make it a condition of contracting or otherwise request that it be the exclusive network provider to any Payor.

(e) The New Health System shall not bargain for or insist upon anti-tiering or anti-steering clauses in any Payor Contracts. Notwithstanding the foregoing, to the extent the New Health System is engaged in risk-based, value-based or shared savings arrangements with Payors, the New Health System may coordinate care within its network of services to ensure continuity of care and lower cost.

(f) The New Health System shall attempt to include in Payor Contracts provisions for improved quality and other value-based incentives based upon priorities agreed upon with each Payor, and such provisions shall be commercially reasonable.

(g) The New Health System shall not include as a condition in any Payor Contract a requirement that a Payor shall (i) not contract with other providers or hospitals in the Geographic Service Area, or in any county contiguous thereto, or (ii) exclusively contract with any or all affiliates of the New Health System.

(h) The New Health System shall also be prohibited from entering into an exclusive arrangement with a sole healthcare provider of any service in the Geographic Service Area without prior approval from the Department. Hospital-based physicians including anesthesiologists, radiologists, pathologists, emergency department physicians, radiation oncologists, pediatric specialties (including neonatology and intensivists), behavioral health physicians and extenders, hospitalists, and critical care specialists are excepted from this requirement.

(i) The New Health System shall not restrict the ability of physicians to see their patients admitted to a COPA Hospital.

(j) Except for Integrated Solutions Health Network, LLC, the New Health System shall not contract with Payors on behalf of any Independent Physicians. Notwithstanding the foregoing, nothing herein shall prohibit any NHS Entity from contracting on behalf of Independent Physicians in a clinically integrated network agreement in compliance with federal antitrust laws.

(k) The New Health System shall not bargain or insist on “most favored nations” or similar clauses in Payor Contracts.

(l) The New Health System shall be prohibited from owning, operating, controlling, or licensing any health plan.

5.03. Managed Care Contract Terms.

(a) The New Health System shall honor all Payor Contract terms and not unilaterally terminate without cause any such contract prior to its stated expiration date.

(b) If either the New Health System or any Payor terminates a Payor Contract, the New Health System shall be subject to Section 11.5 of Addendum 1 for payment terms and compliance.

(c) The New Health System shall negotiate with Payors in good faith and shall attempt in good faith to contract with all Payors that offer terms on a capitated basis, percentage of premium revenue basis or on other terms that require the New Health System to assume risk.

5.04. Competing Services.

(a) The New Health System shall compile with respect to each COPA Hospital a list of Ancillary Services and Post-Acute Services offered at the applicable time by providers competitive with the New Health System, including at least three (3) competitors for each category of service, if, to the Knowledge of the New Health System, such competitors exist in the county in which such COPA Hospital is located or in any contiguous county thereto. The New Health System shall send all such lists to the Department and the COPA Monitor within thirty (30) days of the Issue Date, and thereafter shall provide the COPA Monitor an updated version of such lists on an annual basis.

(b) If a discharged patient, whether an inpatient or outpatient, needs Ancillary Services, Post-Acute Services or other follow-up medical services or supplies at the time of discharge, then the applicable COPA Hospital (via its employees, contractors, and medical staff) shall comply with federal laws governing patient choice. Such COPA Hospital shall not engage in the regular practice of guiding or directing patients to providers (not covered by federal laws governing patient choice) in which any NHS Entity has a material financial or governance interest without first providing to such patients the current list of Ancillary Services and Post-Acute Services referred to in Section 5.04(a). Notwithstanding the foregoing, to the extent the New Health System is engaged in risk-based, value-based or shared savings arrangements with Payors, the New Health System may coordinate care within its network of services to ensure continuity of care and lower cost.

(c) The New Health System shall not oppose the award of a certificate of need in the Geographic Service Area of any healthcare provider seeking to provide inpatient or outpatient or any other services similar to or which compete with the services provided by the New Health System, unless such applicant for the certificate of need does not consistently accept inpatient Medicaid patients or uninsured patients. In the event the New Health System desires to oppose an application for a certificate of need in the Geographic Service Area, the New Health

System shall prepare the relevant materials opposing such application and deliver such materials to the COPA Monitor. The COPA Monitor shall deliver the relevant materials to the Department for its consideration, and such materials shall be included within any administrative record.

5.05. Physician Services.

(a) The New Health System shall not contractually or otherwise restrict physicians or other healthcare providers from performing services outside the New Health System, except as set forth in this Section 5.05(a). Except for Employed Physicians and mid-level physician extenders employed or controlled by an NHS Entity, the New Health System shall release, upon Closing, any physician, non-physician employee, mid-level extender, or other affiliated healthcare provider from any covenant not to compete or similar restriction in favor of any NHS Entity. The New Health System shall not thereafter seek to obtain or enforce (as the case may be) any covenant not to compete from any such person or entity, except any Employed Physician or mid-level physician extender employed or controlled by the New Health System, and then only during the term of his or her employment. Nothing in this Section shall require the New Health System to release any such person or entity from a covenant (i) not to solicit the New Health System's employees, or (ii) not to misappropriate trade secrets or confidential information. Further, the New Health System may reasonably require (A) Employed Physicians and (B) physicians under contract for medical directorships or co-management agreements to keep strictly confidential any competitively-sensitive information about the New Health System.

(b) The New Health System shall not prohibit any Independent Physicians with staff privileges at the New Health System from participating in any networks, health plans, or Payor Contracts.

(c) The New Health System shall not require any physician, or group of physicians, or other healthcare providers other than Employed Physicians and mid-level physician extenders employed or controlled by an NHS Entity, to render services only at the New Health System, except as provided in Section 5.02(h). The New Health System may petition the Department for approval to enter into exclusive contracts with any other physicians and specialists, but if approved, no specialty contract shall have a term exceeding three (3) years.

(d) The New Health System shall provide an open medical staff offering equal access to all qualified physicians according to the criteria of the Joint Commission and the medical staff bylaws.

(e) No more than thirty-five percent (35%) of the physicians practicing in any specialty at the COPA Hospitals located in Washington County, Tennessee at any time may be Employed Physicians. Similarly, no more than thirty-five percent (35%) of the physicians practicing in any specialty at the COPA Hospitals located in Sullivan County, Tennessee at any time may be Employed Physicians. This thirty-five percent (35%) limit shall not apply to the hospital-based physicians listed in Section 5.02(h) and to the following physician specialties: Cardiothoracic Surgeons, Neurosurgeons, Pulmonologists, Hematology and Oncology. In the interest of continued access to services, the Department agrees to waive this requirement for specific specialties upon issuance of the COPA provided that (i) the New Health System provides to the Department a list of each specialty in which the New Health System exceeded this

percentage limitation as of the Approval Date, and (ii) there have been no additional hires in any such specialty since the Approval Date. Thereafter, the New Health System may apply to the Department for any exceptions to this requirement. In no event should the number of Employed Physicians in any specialty reach a level that would materially and adversely affect existing competition.

(f) The New Health System shall provide an open medical staff at each NHS Entity, ensuring equal access to all qualified physicians in the Geographic Service Area according to the criteria of the Joint Commission and the medical staff bylaws of each such entity.

(g) Independent Physicians with privileges at any NHS Entity may obtain privileges at other hospitals or providers and join competing networks or health systems, or health insurance networks, and not jeopardize their privileges at any NHS Entity. Any action with respect to their privileges taken by an NHS Entity shall be based upon the provisions of its medical staff bylaws which govern quality of care and appropriate peer governance.

5.06. Vendor Contracts.

(a) The purchase of equipment and supplies used at the New Health System shall be made with the goal of effectuating the lowest cost consistent with required quality, compatibility and efficiency.

(b) The New Health System shall not bargain for or insist upon restrictions upon its suppliers, vendors or group purchasing organizations preventing or impairing such persons from doing business with entities that compete with the New Health System.

(c) The New Health System shall not require that any vendor include a “most favored nations” or similar clause in contracts. Nothing herein, however, is intended to prohibit the New Health System from entering into group purchasing organization contracts and other joint purchasing agreements that include “most favored nations” clauses as standard provisions thereof.

5.07. Communication with Payors.

(a) Prior to initiating negotiations, the New Health System shall provide, in either electronic or hard copy form, a complete copy of these Terms of Certification to all Payors negotiating Managed Care Contracts with the New Health System.

(b) The Department, as part of its Active Supervision, will investigate complaints from Payors regarding the Managed Care Contracting process and resulting prices, and the Department may take appropriate Corrective Action as a result of any anti-competitive, unreasonable, or bad faith actions on the part of the New Health System.

5.08. Arbitration. Notwithstanding Section 9.11(c), if a Payor and the New Health System cannot agree on rates or any other contract terms, and mediation fails to resolve the dispute, the Department reserves the right to require the New Health System to participate in “Final Offer Arbitration” with the Payor unless the Department agrees to an alternative manner of arbitration. Costs and reasonable attorneys’ fees of the arbitration would be awarded to the prevailing party of the arbitration if “Final Offer Arbitration” or other types of arbitration are utilized.

5.09. Economic Sub-Index. The New Health System’s ongoing compliance with the provisions of this Article V and Addendum 1 shall constitute Measures within the Economic Sub-Index.

ARTICLE VI
ACTIVE SUPERVISION: STRUCTURE, MONITORING, REPORTING AND
NONCOMPLIANCE

6.01. General. The Department’s Active Supervision is a fundamental requirement of the COPA Act in order to assure continuing Public Advantage of the operation of the Affiliation through the New Health System, as governed by the Cooperative Agreement, the COPA and these Terms of Certification, and includes without limitation the Department’s enforcement of all Terms and Conditions during the COPA Term, through Corrective Actions, COPA Modifications, or otherwise. The New Health System shall be subject to, and fully cooperate with, the Department’s Active Supervision, in accordance with the provisions in these Terms of Certification.

6.02. Active Supervision Structure. Promptly following the Issue Date, the Department will complete the organization of the Active Supervision structure and appoint the necessary individuals for positions, substantially as set forth in Exhibit F attached hereto. Initially, such structure will include the following newly created bodies/functions specific to the COPA and these Terms of Certification: the COPA Compliance Office, the Local Advisory Council and the COPA Monitor. Such bodies/functions will have the duties, and will report to and receive reports from the Commissioner and the Department’s Division of Health Planning, in the manner described in Exhibit F. The Department may modify such Active Supervision structure at any time in its discretion upon consultation with the New Health System.

6.03. Monitoring – Access and Meetings; Audits.

(a) Access. Any of the Commissioner, the Attorney General and the COPA Monitor shall have:

(i) upon reasonable notice, access during normal business hours of the New Health System to all non-privileged documents relating to any matters contained in these Terms of Certification, provided that such access shall not unreasonably interfere with the operations of the New Health System;

(ii) upon reasonable notice, access during normal business hours of the New Health System to interview directors, officers, managers or employees of the COPA Parties in relation to any matters contained in these Terms of Certification, provided that such access shall not unreasonably interfere with the operations of the New Health System; and

(iii) rights to call, at any time, with thirty (30) days’ advance notice to the New Health System, a special meeting of the Board of the New Health System, its Executive Committee or its Audit Committee. The failure of a quorum of the Board, the Executive Committee or the Audit Committee, as the case may be, to attend any such special meeting shall constitute an event of Noncompliance and entitle the Department to take any Corrective Action it deems appropriate or necessary.

(b) Audits.

(i) Within two (2) months after the Issue Date, the New Health System and the Department shall together develop a process for reviewing the data and materials to be provided or referenced in the Periodic Reports as described below.

(ii) In addition, the New Health System shall authorize any other audits that are deemed reasonably necessary by the Commissioner, the Attorney General, or the COPA Monitor.

(c) Charges. Pursuant to Tenn. Code Ann. § 68-11-1307(a)(1), the New Health System shall pay all charges incurred by or on behalf of the Department for Active Supervision (including these Terms of Certification), including without limitation the ongoing expenses of the COPA Compliance Office, COPA Monitor, the Local Advisory Council, the Commissioner and the Department's Division of Health Planning, the Attorney General, and any other experts, examiners, assistants, or representatives of the Department. The Department shall work with the New Health System to develop a forecast for the Active Supervision undertaken each year and regularly submit invoices for the charges incurred.

6.04. Monitoring – Reporting Requirements.

(a) General. Pursuant to COPA Rule 1200-38-01-.06 and these Terms of Certification, the New Health System shall timely submit all Required Reports to the Department. Such reports shall be in a format determined by the Department from time to time. The initial formats for each Periodic Report shall be substantially in the forms attached hereto as collective Exhibit G. In each Required Report, the COPA Parties shall provide any information requested by the Department pertaining to compliance with the COPA and the Terms and Conditions and the Department's determination of continuing Public Advantage. The Department shall utilize all such reports as well as other information available to it, or provided by third parties, in performing the Active Supervision. For the avoidance of doubt, each Periodic Report shall address, among other things, the New Health System's explanation (including, when applicable, supporting documentation) of its current compliance (or not) with each of the Terms and Conditions and shall be certified by the Chief Executive Officer and Chief Financial Officer of the New Health System as true and correct to the best knowledge of such persons, after due inquiry. The reports and information called for in this Section 6.04 are in addition to any other reports or information required in other Articles hereof and in the COPA Act.

(b) Annual Reports. The New Health System shall provide to the Department an Annual Report as of the end of each Fiscal Year during the COPA Term, no later than one hundred twenty (120) days after the end of each Fiscal Year. The Annual Report shall include the following items related to compliance (or not) with each of the Terms and Conditions:

(i) A summary comparison by category of patient-related prices charged during the year in review and the preceding year (in such categories as are specified by the Department);

(ii) A summary of steps taken to reduce costs and improve efficiency;

(iii) An update on the status of the Equalization Plan and any implementation achieved, along with any summary of changes in full-time equivalent personnel that occurred during the year in review with analysis of resulting cost savings;

(iv) Updates to the Population Health Plan and the HR/GME Plan, and any implementation achieved;

(v) Any services or functions that were consolidated during the year in review and the resulting cost savings in excess of Two Million Dollars (\$2,000,000);

(vi) Any material changes in volume or availability of any inpatient or outpatient services offered during the year in review;

(vii) A summary containing the number of accredited resident positions for each residency program operated in the Geographic Service Area and the number of such positions that are filled, along with copies of the relevant pages of the Medicare cost reports, as available, showing the number of full time equivalent residents;

(viii) A description of any affiliation agreements moving resident “slots” from one COPA Hospital to another pursuant to Medicare rules, resident programs moved from one COPA Hospital to another, and new programs started;

(ix) A summary of all active academic partnerships of the New Health System for such year in review and dollars spent thereon, along with a description of research topics, the entities engaged in the research, the principal researcher(s) who is/are responsible for each project, any grant money applied for or expected, and the anticipated expenditures;

(x) A report on the outcome of previously reported research projects including references to any published results;

(xi) A summary of the New Health System’s performance in meeting the quality performance standards and best practices requirements established by the Clinical Council pursuant to Section 4.02(b);

(xii) An updated Plan of Separation pursuant to COPA Rule 1200-38-01-.02(2)(a)(17), if amended or as required by subsequent developments;

(xiii) A summary comparison of the New Health System with similar health systems, along with a comparison to one or more rating agency indices for ratio of salaries and benefits to net patient revenue, ratio of operating EBITDA to net revenue, ratio of operating income to net revenue, ratio of capital expenditures to depreciation, ratio of net income to net revenue (excess margin), days of cash on hand, days of net patient revenue outstanding, ratio of long term debt to capitalization, ratio of unrestricted reserves to long term debt and debt service coverage ratio, along with a schedule of values for each component required to make the various ratio calculations;

(xiv) The Total Charity Care information described in Section 4.03(f);

(xv) An updated organizational chart of the New Health System, including an updated listing of the corporate officers and members of the Board;

(xvi) The most recent verifiable values available for the Measures included in the Index per COPA Rule 1200-38-01-.06(6);

(xvii) An explanation of implementation and results of the career development program described in Section 3.08(c); and

(xviii) Any other information expressly required for the Annual Report pursuant to the form of Annual Report, any other Section of these Terms of Certification, or the COPA Act.

The Annual Report for Fiscal Year 2018 shall be a report on the five (5) month period between the Issue Date and June 30, 2018, and accordingly shall not include a full year's worth of data on the items set forth in this Section 6.04(b).

(c) Quarterly Reports. The New Health System shall provide to the Department a Quarterly Report, no later than forty-five (45) days after the end of each fiscal quarter of the New Health System during the COPA Term. Such report shall include information on the key financial metrics, a balance sheet, and the statements of income and cash flows of the New Health System, in each case comparing performance against the same quarter in the prior year and the quarter prior to the quarter in question. This financial information will be provided to the Department on the same timetable as what is publicly reported through EMMA (Electronic Municipal Market Access), meaning that if publicly reported earlier the Quarterly Report would be due prior to the expiration of such forty-five (45) day period. The New Health System shall also provide in each Quarterly Report any other quarterly information required by these Terms of Certification and pursuant to the form of Quarterly Report.

(d) Ongoing Reporting.

(i) In order to demonstrate that the New Health System maintains the financial and operational viability to fulfill the Terms and Conditions, and to provide for proper Active Supervision, the New Health System shall notify the Department, within fifteen (15) days thereof, if it records a liability for or otherwise experiences a Material Adverse Event, or, to the Knowledge of the New Health System, is reasonably likely to experience a Material Adverse Event. Such notification shall include an explanation and supporting documentation. Each such report and all attachments thereto shall be certified by the Chief Executive Officer and Chief Financial Officer of the New Health System as being true and correct in all material respects to their best knowledge, after due inquiry.

(ii) In addition, if at any time the New Health System determines that a Noncompliance has occurred, or, to the Knowledge of the New Health System, is reasonably likely to occur, the New Health System shall notify the Department within fifteen (15) days thereof. Such notification shall include an explanation and supporting documentation, and any actions proposed to Cure (as defined in Section 6.05(c)) such Noncompliance. Each such report and all attachments shall be certified by the Chief Executive Officer and Chief Financial Officer

of the New Health System as being true and correct in all material respects to their best knowledge, after due inquiry.

6.05. Noncompliance.

(a) Department Notice of Noncompliance. When from time to time the Department determines that a Noncompliance has occurred, or is reasonably likely to occur, it may promptly notify the New Health System of the same and provide an explanation and supporting documentation, as available, and any actions proposed in order to Cure such Noncompliance. The New Health System shall notify the Department within fifteen (15) days of its receipt of such notice the extent to which it agrees to comply with any actions proposed by the Department.

(b) Cure. In connection with any Noncompliance reported by the New Health System pursuant to Section 6.04 or notified by the Department pursuant to this Section 6.05, the New Health System shall have sixty (60) days from the date of notice to Cure, or, if not curable within sixty (60) days, to demonstrate substantial progress toward a complete Cure of, the Noncompliance, unless (i) the Noncompliance is not Curable, or (ii) the Noncompliance is due to a Force Majeure Event, in which case the New Health System shall have sixty (60) days from the end of the Force Majeure Event to cure the Noncompliance. The Department (and its designees/agents) shall be provided full access, at reasonable times and upon reasonable notice, to all non-privileged documents and information of the New Health System and its personnel necessary to make a determination concerning the Noncompliance, any Cure thereof, and, if applicable, any Force Majeure Event.

(c) Cure Definition. As used herein, “Cure” means (1) if the Noncompliance arose due to failure to spend and pay, in full, the amount specified by a Monetary Obligation, to pay the amount that remains to be spent and paid, in immediately available funds, either toward the initiative or plan that was the subject of the Monetary Obligation or into the Population Health Initiatives Fund (or as otherwise directed in writing by the Department) and/or, as applicable and as agreed by the Department, to enter into a COPA Modification as proposed by the Department, and (2) if the Noncompliance arose due to a nonfulfillment of a Non-Monetary Obligation, to fully perform such Non-Monetary Obligation and/or, as applicable and as agreed by the Department, to enter into a COPA Modification as proposed by the Department.

(d) Corrective Actions. With respect to any Noncompliance that is not Cured or is not Curable, the Department shall have the right to invoke one or more Corrective Actions, which may include, without limitation, the following: (1) prohibiting payment of bonuses or other incentive compensation above base salary to any executive officer (i.e., any Vice President or above) of any COPA Party with respect to the Fiscal Year in which the Noncompliance occurred (or, as applicable, requiring repayment of such compensation if already received with respect to such Fiscal Year); (2) requiring the COPA Parties to make a remedial contribution in the amount determined by the Department to the Population Health Initiatives Fund, or as otherwise directed in writing by the Department; (3) a COPA Modification; (4) any remedy described in Section 9.08; and (5) if Public Advantage is not evident, termination of the COPA. By their execution and acceptance of these Terms of Certification, the COPA Parties acknowledge that the remedial contributions in the ranges set forth on Exhibit H attached hereto, expressed as fines, are

appropriate and reasonable in amount with respect to the applicable Noncompliance indicated therein.

(e) Remedies. Anything to the contrary herein notwithstanding, if the New Health System does not fully Cure any Noncompliance or if any Noncompliance is not Curable, the Department shall have all rights under the Terms and Conditions and as a matter of Law and equity, including without limitation the institution of legal action, without the requirement of posting any bond or other security, for specific performance and/or damages, a COPA Modification, or termination of the COPA. In all such events, the New Health System shall promptly reimburse the Department for all attorneys' fees and other costs reasonably incurred by or on behalf of the Department in order to enforce its rights hereunder. The COPA Parties shall pay the same within five (5) days of the assessment thereof by the Department.

6.06. Population Health Initiatives Fund. If the Department issues a directive requiring the New Health System to deposit a remedial contribution into the Population Health Initiatives Fund pursuant to Section 6.05(d), after the deposit of such remedial contribution, the Commissioner shall convene the Local Advisory Council, who shall, recommend to the Department how such funds should be spent within the Geographic Service Area or otherwise for the direct benefit of the Population. The Department shall review and, if it deems advisable, revise such recommendations and submit them to the Commissioner, who shall veto, approve or modify such recommendations, whereupon the Department shall direct and effect the expenditures and notify the New Health System. If funds are paid to the Population Health Initiatives Fund due to Noncompliance of a Monetary Obligation, such funds shall be applied consistently with such Monetary Obligation to the extent possible, absent extenuating circumstances.

ARTICLE VII

ACTIVE SUPERVISION; INDEX; ANNUAL REVIEW; FINAL SCORE

7.01. Index and Sub-Indices.

(a) General. Pursuant to COPA Rule 1200-38-01-.03, as part of its exercise of Active Supervision, the Department shall annually use an Index to track demonstration of ongoing Public Advantage. The Index shall consist of the following four (4) sub-Indices, corresponding to the potential benefits and potential disadvantages of the Affiliation for which the COPA has been issued (each a "Sub-Index" and collectively the "Sub-Indices"): (i) improvements in population health (the "Population Health Sub-Index"), (ii) increased access to healthcare and prevention services (the "Access Sub-Index"), (iii) minimization of economic disadvantages resulting from a reduction in competition (the "Economic Sub-Index"), and (iv) other benefits, including without limitation enhancement of quality of care, patient satisfaction, medical research and education (the "Other Sub-Index"). The Index and each Sub-Index, as of the Issue Date, are set forth on Exhibit I attached hereto. Such Index reflects, among other things, the recommendations of the Advisory Group and the Applicants with respect to the Measures included therein. Within six (6) months of the Department's approval of the Plans submitted by the New Health System pursuant to Article III, the Department and the New Health System shall together revisit the measures set forth in the Index and the weights of each measure to ensure that the measures and weights are consistent with those Plans. The application of the Population Health Sub-Index, the Access Sub-Index and the Other Sub-Index shall result in a numerical score ranging from 0-100, and the numerical scores

for these three sub-Indices shall be averaged together (but may have different weights from year to year as determined by the Department) to arrive at an aggregate numerical score for the applicable Fiscal Year (the “Final Score”). The Economic Sub-Index shall be scored on a pass/fail basis (the “Pass/Fail Grade”). The Final Score and the Pass/Fail Grade will be evidence demonstrating, or not, continuing Public Advantage, for purposes of the Annual Review as described in more detail in Section 7.02; provided that a failing grade for the Economic Sub-Index shall demonstrate the lack of continuing Public Advantage.

(b) Measures. Non-Monetary Obligations, Monetary Obligations, outcomes in the Tennessee GSA in population health improvement, access to healthcare services, medical research and education, health information exchange, quality of care and patient satisfaction, and other factors or benchmarks relevant to Public Advantage may all be components or Measures of, or otherwise reflected in, the Index. Those Non-Monetary Obligations and Monetary Obligations that are Measures or components of or reflected in the Index as of the Issue Date are set forth in the Sub-Indices. **Whether or not any Non-Monetary Obligation or Monetary Obligation is included in the Index shall have no bearing on the nature of its obligation as a commitment that shall be reviewed for Noncompliance.**

(c) Modification. The components of each Sub-Index (including any Measure) may be assigned differential weightings, and may be modified from time to time, as determined by the Department. Pursuant to COPA Rule 1200-38-01-.03(4), the Department may, from time to time as it deems necessary, reconvene the Advisory Group to assist in the modification of existing Measures or determination of new Measures.

(d) Data. The data sources that the New Health System and the Department may use for purposes of determining performance or outcomes of the New Health System, or results within the Tennessee GSA against any Measure of the Index, shall be those data sources approved for such use by the Department, and may vary from Measure to Measure and over time. The Department shall approve all adjustments to data sets received from such sources prior to any adjustments being made. In some cases, the Index may include Measures that require data that is not yet available either generally or to the Department and/or the COPA Parties, and the Department and the COPA Parties shall cooperate to adjust the Measures or determine alternative sources if the data required is not available at the time or at the level of detail needed.

7.02. Annual Review Process; Final Score. Pursuant to Tenn. Code Ann. §68-11-1303(g), the Department shall review, on at least an annual basis, the COPA to determine Public Advantage (the “Annual Review”). The Department shall review whether Public Advantage is demonstrated or not for each Fiscal Year during the COPA Term, in accordance with the procedures and requirements of the COPA Act and these Terms of Certification. This Annual Review shall include, without limitation, the following: (i) the determination of the Final Score and Pass/Fail Grade, as described herein and on Exhibit J attached hereto, (ii) the COPA Parties’ degree of compliance with the Terms and Conditions, which will take into account the relative weighting of each pursuant to Section 7.01, and any and all COPA Modifications and Corrective Actions occurring prior to such review, and (iii) trends of the New Health System’s performance hereunder since the Issue Date and other factors (which may or may be reflected in the Index) relevant to the Department’s determination of the likely benefits and disadvantages of the

Affiliation which, as of the time of such determination, can reasonably be expected if the Affiliation is continued.

ARTICLE VIII ACTIVE SUPERVISION: COPA MODIFICATIONS

8.01. Proposed COPA Modification by Department. In addition to any COPA Modifications described in Section 6.05, the Department may at any time notify the New Health System of one or more proposed COPA Modifications and provide a written explanation and any supporting documentation. The Department's proposed COPA Modifications may include, but not be limited to, changes to one or more of these Terms of Certification which are not being satisfied or to address circumstances which demonstrate that the Affiliation is not meeting objectives of lower healthcare costs and improved quality of, or access to, healthcare services. Within sixty (60) days of its receipt of such notice, the New Health System shall notify the Department of its acceptance of such proposal, or, if applicable, any counterproposal, along with its written explanation and any supporting documentation. Within thirty (30) days of the Department's receipt of such notice, the Department and the COPA Parties shall meet and confer in an attempt to resolve any differences. The Department shall agree to any counterproposal only to the extent the Department determines, in its discretion, that the proposed COPA Modifications are necessary to retain, or otherwise will not impair, Public Advantage. If the parties reach agreement on all points, such COPA Modifications shall be effected. To the extent the parties do not agree on all points, the Department shall have all rights conferred upon it pursuant to the COPA Act, including the right to terminate the COPA and enforce the Plan of Separation, and the New Health System shall have all appeal and other rights conferred upon it pursuant to the COPA Act.

8.02. Proposed COPA Modification by New Health System. In response to material unforeseen circumstances, the New Health System may at any time notify the Department and request one or more proposed COPA Modifications and provide a written explanation and any supporting documentation. Within sixty (60) days of its receipt of such notice, the Department shall notify the New Health System of its acceptance of such proposal or, if applicable, any counterproposal, along with its written explanation and any supporting documentation. Within thirty (30) days of the New Health System's receipt of such notice, the Department and the COPA Parties shall meet and confer in an attempt to resolve any differences. The Department shall agree to such proposal(s) only to the extent the Department determines, in its discretion, that the proposed COPA Modifications are necessary to retain, or otherwise will not impair, Public Advantage. To the extent the parties reach agreement, such COPA Modifications shall be effected.

ARTICLE IX MISCELLANEOUS PROVISIONS

9.01. Notices. All notices, requests, consents, claims, demands, waivers, and other communications hereunder (each, a "Notice") shall be in writing and shall be deemed to have been given (a) when delivered by hand (with written confirmation of receipt); (b) when received by the addressee if sent by a nationally recognized overnight courier (receipt requested); or (c) on the third day after the date mailed, by certified or registered mail (in each case, return receipt requested, postage pre-paid). Notices must be sent to the respective parties at the following

addresses (or at such other address for a party as shall be specified in a Notice given in accordance with this Section 9.01):

If to the Department:

Tennessee Department of Health
710 James Robertson Parkway
Nashville, Tennessee 37243
Attention: Commissioner of Health

with a copy to:

Attorney General and Reporter
State of Tennessee
P.O. Box 20207
Nashville, Tennessee 37272
Attention: Attorney General

and a copy to the COPA Monitor, addressed as follows:

Larry L. Fitzgerald
6689 Hastings Lane
Franklin, Tennessee 37069

If to a COPA Party, addressed as follows:

Ballad Health
303 Med Tech Parkway
Suite 300
Johnson City, TN 37604
Attention: Executive Chairman, President and Chief Executive Officer

with a copy to:

Ballad Health
303 Med Tech Parkway
Suite 300
Johnson City, TN 37604
Attention: General Counsel

9.02. Successors and Assigns; Specific Performance.

(a) The COPA Parties may not assign or otherwise transfer any of their rights or obligations under the COPA Act or hereunder, in whole or in part, without the prior written consent of the Department, which may be denied or delayed in the Department's discretion.

(b) Any direct or indirect sale, lease or transfer of control of all or substantially all of a COPA Party's operating assets (collectively, a "Change of Control"), is expressly subject to the prior written approval of the Department and the review and approval of the Attorney General under the Tennessee Nonprofit Hospital Act, Tenn. Code Ann. §§48-58-101, *et. seq.*, and/or the Public Benefit Hospital Sales and Conveyance Act of 2006, as amended, Tenn. Code Ann. §§48-68-201, *et. seq.* As used herein, "Change of Control" includes any merger, consolidation, change of controlling interest by purchase, lease, assignment, transfer of sole membership interest, management contract, or comparable arrangement, or a transfer of all or substantially all operating assets, of any COPA Party.

(c) The COPA and these Terms of Certification are binding on each of the COPA Parties, and their approved successors and assigns. The Department and the Attorney General shall have the right to obtain specific performance of the obligations, commitments and covenants set forth in these Terms of Certification against each of the COPA Parties, and any approved successor or assign, without any requirement to (i) post a bond or other security, or (ii) prove actual damages or that monetary damages will not afford an adequate remedy. The COPA Parties shall pay the costs and reasonable attorneys' fees of the Department and the Attorney General in connection with their enforcement of this Section 9.02(c).

9.03. Interpretation. For purposes of these Terms of Certification, (a) the words "include," "includes," and "including" are deemed to be followed by the words "without limitation"; (b) the word "or" is not exclusive; and (c) the words "herein," "hereof," "hereby," "hereto," and "hereunder" refer to these Terms of Certification as a whole. Unless the context otherwise requires, references herein: (x) to sections, schedules, addenda and exhibits mean the sections of, and schedules, addenda and exhibits attached to, these Terms of Certification; (y) to an agreement, instrument, or other document means such agreement, instrument, or other document as amended, supplemented, and modified from time to time to the extent permitted by the provisions thereof; and (z) to a statute means such statute as amended from time to time and includes any successor legislation thereto and any regulations promulgated thereunder. All references herein to an approval of the Department or the COPA Monitor in its "discretion" shall mean the approval of the Department and/or the COPA Monitor in its reasonable, and not arbitrary or capricious, discretion. The interpretation of these Terms of Certification, as well as any dispute concerning its meaning or terms, is governed by normal principles of Tennessee contract Law, except that these Terms of Certification shall be construed without regard to any presumption or rule requiring construction or interpretation against the party drafting an instrument or causing any instrument to be drafted. To the extent any term hereof conflicts with a term of the Cooperative Agreement, the terms hereof shall govern.

9.04. Addenda and Exhibits. The addenda and exhibits attached and/or referred to herein shall be construed with, and as an integral part of, these Terms of Certification to the same extent as if they were set forth verbatim herein.

9.05. Severability. If any term or provision of these Terms of Certification is invalid, illegal, or unenforceable in any jurisdiction, such invalidity, illegality, or unenforceability shall not affect any other term or provision of these Terms of Certification or invalidate or render unenforceable such term or provision in any other jurisdiction.

9.06. Waiver. No waiver by the Department of any of the provisions hereof shall be effective unless explicitly set forth in writing and signed by an authorized representative of the Department. No waiver by the Department shall operate or be construed as a waiver in respect of any failure, breach, or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power, or privilege arising from the COPA, these Terms of Certification, the COPA Act or the COPA Rule shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power, or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power, or privilege.

9.07. Cumulative Remedies. The rights and remedies under the COPA and these Terms of Certification are cumulative and are in addition to and not in substitution for any other rights and remedies available at Law or in equity or otherwise.

9.08. Equitable Remedies. The COPA Parties each acknowledge and agree that (a) a breach or threatened breach by the COPA Parties of any of the Terms and Conditions would give rise to irreparable harm to the Department and the Population for which monetary damages would not be an adequate remedy, and (b) if such breach or threatened breach occurs, the Department will, in addition to any and all other rights and remedies that may be available to the Department at Law, at equity or otherwise in respect of such breach, be entitled to equitable relief, including a temporary restraining order, an injunction, specific performance and any other relief that may be available from a court of competent jurisdiction, without any requirement to (i) post a bond or other security, or (ii) prove actual damages or that monetary damages will not afford an adequate remedy. Each COPA Party agrees that such party shall not oppose or otherwise challenge the appropriateness of equitable relief or the entry by a court of competent jurisdiction of an order granting equitable relief, in either case, consistent with the terms of this Section 9.08.

9.09. Counterparts; Integration; Effectiveness. These Terms of Certification shall be incorporated by reference into and form a part of the COPA. These Terms of Certification, and any amendments, waivers, consents or supplements hereto (a) may be executed in counterparts (and by different parties hereto in different counterparts), each of which shall constitute an original, but all taken together shall constitute a single contract, and (b) shall constitute the entire agreement governing the relationships among the parties with respect to the subject matter hereof, and supersede all previous agreements and understandings, oral or written, with respect thereto, including without limitation the Initial Terms. These Terms of Certification shall become effective only when (y) the COPA is issued and effective pursuant to the terms hereof and the COPA Act, and (z) they shall have been executed by the Department and when the Department shall have received counterparts hereof that together bear the authorized signatures of each of the other parties hereto.

9.10. Expenses. Each Applicant and the New Health System shall bear its own fees and expenses for legal, accounting, experts, and other professional services retained by such party

pertaining to the Application and the preparation and issuance of the COPA and these Terms of Certification, and their ongoing compliance therewith. As provided in the COPA Act, the COPA Parties, jointly and severally, shall pay all of such costs of the Department and the Attorney General, in connection with the Department's and Attorney General's (a) review and examination of the Application and the preparation and issuance of the COPA and these Terms of Certification, and (b) ongoing Active Supervision of the Affiliation and review, modification, performance and enforcement of the COPA and these Terms of Certification, including without limitation the fees and expenses of the COPA Compliance Office, the Local Advisory Council and the COPA Monitor; provided, however, that the fees and expenses of assistants, experts, and examiners retained by the Department shall not exceed an amount commensurate with usual compensation for like services. Within ten (10) days of the Issue Date, the Department shall provide the COPA Parties with a statement (payable 30 days from receipt) of the Department's and Attorney General's costs for all legal, expert and other professional services incurred through the Issue Date pursuant to clause (a) above.

9.11. Governing Law; Jurisdiction; Venue.

(a) The COPA and these Terms of Certification shall be governed by and construed in accordance with the Laws of the State of Tennessee, without regard to the conflicts of Laws provisions thereof.

(b) The completion of any Plan of Separation, if instituted, shall result in the New Health System being released from all obligations under these Terms of Certification except those obligations set forth in Section 9.12(a).

(c) The repeal of the COPA Act, at any time prior to the twenty-fifth (25th) anniversary of the Issue Date, shall not cause a termination or withdrawal of the COPA or these Terms of Certification, or otherwise in any way impair the continued enforceability of the Terms and Conditions against the COPA Parties or their approved successors or assigns.

(d) Except as otherwise expressly set forth herein, the parties shall submit all disputes arising out of or in connection with the COPA to the exclusive jurisdiction of the Chancery Court of Davidson County, Tennessee, in accordance with the COPA Act.

9.12. Survival.

(a) All obligations of the COPA Parties herein (a) to pay amounts to the Population Health Initiatives Fund, (b) to reimburse the Department for costs and expenses of the Department and the Attorney General, and (c) if applicable, to implement and perform their obligations under the Plan of Separation, shall survive any termination of the COPA.

(b) The provisions of Addendum 1 setting forth pricing limitations and requiring refunds for Excess Payments (i) shall survive termination of the COPA, termination of these Terms of Certification, repeal of the COPA statute, termination or dissolution of the New Health System, or the New Health System or any part of it being placed in bankruptcy, receivership, or otherwise being transferred in whole or in part to any other person or entity; and (ii) shall last until the Department determines that they are no longer necessary to prevent anti-competitive conduct, to protect Payor contracts which were negotiated prior to the termination of

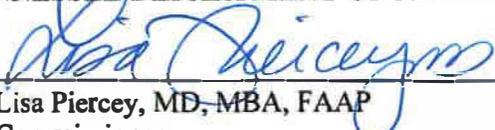
the COPA, and to identify and address any Excess Payments which existed prior to termination of the COPA.

[Signature Page Follows]

IN WITNESS WHEREOF, these Terms of Certification have been executed as of the Second Restatement Date.

DEPARTMENT:

TENNESSEE DEPARTMENT OF HEALTH

By: 
Lisa Piercey, MD, MBA, FAAP
Commissioner

COPA PARTIES:

BALLAD HEALTH

By: 
Alan Levine
Executive Chairman, President and Chief Executive Officer

WELLMONT HEALTH SYSTEM

By: Ballad Health, its Sole Member

By: 
Alan Levine
Executive Chairman, President and Chief Executive Officer

MOUNTAIN STATES HEALTH ALLIANCE

By: Ballad Health, its Sole Member

By: 
Alan Levine
Executive Chairman, President and Chief Executive Officer

APPROVED BY:

TENNESSEE ATTORNEY GENERAL AND REPORTER

By: 
Herbert H. Slatery III
Tennessee Attorney General

**AMENDED AND RESTATED
ADDENDUM 1
COPA MANAGED CARE CONTRACT PRICING LIMITATIONS
AND EXCESS PAYMENT TESTING**

PART I

DEFINITIONS AND GENERAL

This Amended and Restated Addendum 1 is effective as of April 27, 2021 and supersedes the original Addendum 1 which was effective January 31, 2018. All references to “Addendum 1” herein and in the Second Amended and Restated Terms of Certification dated April 27, 2021 (the “Terms of Certification”) are to this Amended and Restated Addendum 1.

1.1 Definitions.

In addition to the terms defined in Article I of the Terms of Certification to which this is attached, and terms defined elsewhere in this Addendum 1, the following definitions shall apply to this Addendum 1:

“Actual Billed Charges” – The amount the New Health System actually bills the responsible party or parties for a Covered Medical Service, supply or item before adjustment for any contractual allowance or discounts with a healthcare provider.

“Actual Outpatient Ratio for Contract Year” – The ratio calculated as set forth in Appendix 2.

“Aggregate Inpatient Payment Deviation” – The deviation calculated as set forth in Appendix 1.

“Aggregate Outpatient Payment Deviation” – The deviation calculated as set forth in Appendix 2.

“Aggregate Payment Deviation” – The deviation calculated as set forth in Section 3.2(a).

“Allowed Amount” – The amount a Payor will pay for a Covered Medical Service, supply or item, including outliers, after adjustment for any contractual allowance or discounts with a healthcare provider. The Allowed Amount includes the amount due from both the Payor as well as the patient via the cost-sharing provisions of a patient’s health plan.

“Anniversary Date” – The date falling on the same day of the month as the effective date of the applicable agreement at intervals of twelve (12) months.

“Annual Testing” – The testing process set forth in Section 3.2.

“Attestation Payor” – A Payor that meets the definition set forth in Section 2.3.

“Base Contract Year” – The Contract Year prior to the first Contract Year to be tested.

“Base Contract Year Inpatient Allowed Amount” – The Allowed Amount for inpatient services for the Base Contract Year.

“Base Contract Year Outpatient Allowed Amount” – The Allowed Amount for outpatient services for the Base Contract Year.

“Base Contract Year Actual Billed Charges” – The Actual Billed Charges for the Base Contract Year.

“Base Contract Year Allowed DRG Weights” – The DRG weights in effect for the Base Contract Year, or a specific commercial Payor’s DRG Weights for the Base Contract Year if those DRG Weights were agreed upon in advance.

“Charge-Based Payor” – A Payor whose fee schedule rates are based upon percentages of charges.

“Contract Year” – The one year period beginning on the effective date of the applicable Payor’s Managed Care Contract with the New Health System, or on the effective date of any renewal year thereafter.

“Cost-Based Items” – Those items described in Section 5.1.

“Covered Medical Service” – A service covered by any Payor.

“Cumulative Inpatient Inflation Adjustment” – The compounded effect of the Hospital Inflation Adjustment beginning with the first Contract Year of the new Payor Contract through the end of the Contract Year for which Allowed Amounts are to be compared to the applicable Payment Indices.

“Cumulative Outpatient Inflation Adjustment” – The compounded effect of the Hospital Inflation Adjustment beginning with the first Contract Year of the new Payor Contract through the end of the Contract Year for which Allowed Amounts are to be compared to the applicable Payment Indices.

“Cumulative Physician Inflation Adjustment” – The compounded effect of the Physician Inflation Adjustment beginning with the first Contract Year of the new Payor Contract through the end of the Contract Year for which Allowed Amounts are to be compared to the applicable Payment Indices.

“Discretionary Testing” – The testing process set forth in Section 3.1(b)(ii).

“DRG Methodology” – Payment methodology which classifies inpatient hospital discharges into Diagnosis Related Groups (“DRGs”) based upon diagnoses, procedures, complications, comorbidities, age and other factors.

“DRG Weights” – The value or weighting factor assigned to various DRGs by Medicare or a Payor.

“Excess Payment” – The payment calculated using the methodology set forth in Section 3.3.

“Excess Payment Testing” – The testing process set forth in Section 3.3.

“Exempt Payor” – A Payor that meets the definition set forth in Section 2.1(a).

“Fiscal Year” - The New Health System fiscal year which begins on July 1 and ends on June 30 of each year.

“Hospital Inflation Adjustment” or (“HIA”) – For the year being tested, the most recently available annual inpatient percentage of increase by Medicare, commonly referred to as the Market Basket and reported by CMS in the Federal Register as part of the Final Rules of the Inpatient Prospective Payment System, plus 0.25 percent. The HIA will not include the multifactor productivity adjustment, statutory adjustment, adjustments for failure to be a meaningful electronic health record user or failure to submit quality data, or any other positive or negative adjustments required by law or regulation. Effective October 1, 2017, the Market Basket is 2.70 percent.

HIA will also include for Payors, who do not offer a quality component in their fee schedules or payment structures at least equal to the adjustment in the schedule below, an additional payment (“Quality Adjustment Factor”). If a Payor does not offer as part of its fee schedules or rate structures a payment for quality or pay-for-performance incentives, the HIA will be increased based upon the difference between the schedule below and the quality component offered by the Payor.

	Adjustment for Absence of Quality
Each Contract Year	1.25%

The HIA shall be applied to hospital inpatient and outpatient services and ambulatory surgery center services rendered by the New Health System.

“Inpatient Baseline Amount” – The baseline amount calculated as set forth in Appendix 1.

“Inpatient Collections Amount” – The amount described in Section 6.1.

“Inpatient Payment Deviation” – The deviation calculated as set forth in Appendix 1.

“Inpatient Payment Indices” – The indices calculated as set forth in Appendix 1.

“Large Network Payor” – A Measured Payor which has a network, with a fee schedule specific to that network, which comprises 2% or more of the total charges (“Gross Revenue”) for the New Health System for the prior Fiscal Year. The same Measured Payor may have several networks, each of which utilize different fee schedules, and each of which could constitute 2% or more of the Gross Revenue; each network attaining the 2% threshold would constitute a separate Large Network Payor. Conversely, several Measured Payors may only constitute one network, because they use a common fee schedule. An example would be PHCS Multiplan.

“Managed Care Contract” – as defined in the Terms of Certification.

“Managed Medicaid Plan” – A contract between a state Medicaid agency and a Payor whereby the state pays the Payor to provide medical services to the state’s Medicaid beneficiaries through the Payor’s network.

“Measured Payor” – A Payor that meets the definition set forth in Section 3.1(a).

“Measured Payor Contract” a contract as defined in Section 3.1(b).

“Medicare Advantage Plan” – A contract between the federal government and a Payor whereby the federal government pays the Payor to provide medical services to Medicare beneficiaries through the Payor’s network.

“National Insurance Network” shall mean a multi-state network that provides coverage to a payor's members outside the payor's service area, but which does not pay claims directly to the New Health System.

“Never In-Network Discount” – The discount described in Section 6.3.

“Never In-Network Payor” – A Payor that has never had a Managed Care Contract with any COPA Party and was therefore never in-network.

“Non-Hospital Outpatient Payment Deviation” - The deviation calculated as set forth in Appendix 3.

“Outpatient Baseline Amount” – The baseline amount calculated as set forth in Appendix 2.

“Outpatient Collections Amount” – The amount described in Section 6.2.

“Outpatient Payment Deviation” – The deviation calculated as set forth in Appendix 2.

“Outpatient Payment Indices” – The indices calculated as set forth in Appendix 2.

“Payment Deviations” – The deviations, whether greater or lesser, of the post-Closing adjusted pricing from the Payment Indices as increased by applicable inflation adjustments.

“Payment Indices” – The indices calculated as set forth in Appendices 1 through 4.

“Physician Inflation Adjustment” – The Hospital Inflation Adjustment without the Quality Adjustment Factor.

Medicare’s annual physician market basket update factor is currently limited by law to 0.50. When and if Medicare begins using an inflation-based update to the physician fee schedule, the Physician Inflation Adjustment used herein will be the Medicare physician market basket rate of increase plus 0.25 percent.

“Physician Services” – Those services described in Appendix 4.

“Physician Services Payment Deviation” - The deviation calculated as set forth in Appendix 4.

“Physician Services Payment Indices” – The indices calculated as set forth in Appendix 4.

“RVUs” (Relative Value Units) –Weighting factors which are used to establish a relative value scale in which the value of physician work for a particular service is rated relative to the value of work for other physician services.

“Small Commercial Payor” – A commercial Measured Payor that does not meet the definition of a Large Network Payor.

“Small Medicare Advantage Payor” – A Measured Medicare Advantage Payor that does not meet the definition of a Large Network Payor.

“Small Payor” – A Measured Payor that meets the definition of a Small Commercial Payor, a Small Medicare Advantage Payor, a Small TennCare Payor, or a Small Virginia Medicaid Payor.

“Small Payor Aggregate Payment Deviation” – The deviation calculated as set forth in Section 3.2(b).

“Small Payor Weighted Inpatient Payment Deviation” - The deviation calculated as set forth in Section 3.2(b).

“Small Payor Weighted Non-Hospital Outpatient Payment Deviation” - The deviation calculated as set forth in Section 3.2(b).

“Small Payor Weighted Outpatient Payment Deviation” - The deviation calculated as set forth in Section 3.2(b).

“Small Payor Weighted Physician Services Payment Deviation” - The deviation calculated as set forth in Section 3.2(b).

“Small TennCare Payor” – A Measured TennCare Payor that does not meet the definition of a Large Network Payor.

“Small Virginia Medicaid Payor” – A Measured Payor for Virginia Medicaid that does not meet the definition of a Large Network Payor.

“Value-Based Payor” – A Payor that meets the definition set forth in Section 2.2(a).

“Weighted Inpatient Payment Deviation” - The deviation calculated as set forth in Section 3.2(a).

“Weighted Non-Hospital Outpatient Payment Deviation” - The deviation calculated as set forth in Section 3.2(a).

“Weighted Outpatient Payment Deviation” - The deviation calculated as set forth in Section 3.2(a).

“Weighted Physician Services Payment Deviation” - The deviation calculated as set forth in Section 3.2(a).

1.2 Compliance with Managed Care Pricing Limitations.

(a) In order to protect patients, employers, Payors and others who utilize the services of or contract with the New Health System, this Addendum 1 shall provide for limits upon, measurement, and reporting of price increases for specific services, including hospital inpatient and outpatient, non-hospital outpatient, physician and physician extender, charge-based and cost-based services. See Tenn. Code Ann. § 68-11-1303(e)(3)(A)-(C). The pricing limitations set forth herein shall apply to both existing Managed Care Contracts which are renegotiated, repriced or executed post-Closing, as well as any future Managed Care Contracts created and executed post-Closing with new Payors. The pricing limitations set forth herein are in addition to the COPA Parties' other commitments set forth in Article V of the Terms of Certification.

(b) The type of contracting relationship that exists between the New Health System and each Payor will determine the method required to demonstrate compliance with Addendum 1. The methods for demonstrating compliance with Addendum 1 for Exempt Payors, Value-Based Payors, and Attestation Payors are described in Part II. The method for demonstrating compliance for Measured Payors is described in Part III. Charge-Based Payors are addressed in Part IV. Cost-Based Items are addressed in Part V, and Never In-Network Payors are addressed in Part VI.

(c) The COPA Parties acknowledge that over time Ballad intends to enter into contracts with Payors that cover all of the New Health System's entities and services. Certain adjustments to Addendum 1 and the testing process set forth herein may need to occur to accomplish this objective. The COPA Monitor will work with the New Health System to address these issues as they arise on a case-by-case basis.

PART II

COMPLIANCE FOR EXEMPT PAYORS, VALUE-BASED PAYORS, AND ATTESTATION PAYORS

The methods for demonstrating compliance with Addendum 1 for Exempt Payors, Value-Based Payors, and Attestation Payors are set forth below.

2.1 Exempt Payors.

(a) Description. "Exempt Payors" are those Payors (i) that do not negotiate any part of their managed care agreements or payment rates with the New Health System; (ii) that are Medicare Advantage Plans that pay the New Health System based on a predetermined percentage of Medicare rates (e.g. 105% of Medicare) so long as the percentage of the Medicare rates does not increase during the COPA Term; (iii) that are Managed Medicaid Plans that pay the New Health System based on a predetermined percentage of a state's Medicaid rates (e.g. 105% of DMAS rates) so long as the percentage of the Medicaid rates does not increase during the COPA Term; or (iv) that are Managed Medicaid Plans that pay the New Health System within a predetermined band of allowable rates set by the State. The New Health System shall demonstrate compliance with Addendum 1 for Exempt Payors as set forth in Section 2.1(b).

(b) Compliance with Addendum 1. On the Anniversary Date of each Managed Care Contract that the New Health System holds with an Exempt Payor, the New Health System shall certify that the Payor continues to meet the definition of an Exempt Payor. If the Payor does not satisfy the definition of an Exempt Payor on the Anniversary Date, that Payor will be considered a Measured Payor subject to the testing set forth in Part III unless it meets the definition of a Value-Based Payor or an Attestation Payor as set forth below. The New Health System shall maintain a current list of Exempt Payors and make this list available for review by the COPA Monitor and the Department upon request.

2.2 Value-Based Payors.

(a) Description. The Department seeks to encourage the New Health System to pursue value-based contracts that align incentives to improve clinical outcomes, patient experience, and cost-efficiency. Value-based contracts will position the New Health System to take on more financial risk as it transitions to a population health improvement organization. “Value-Based Payors” are those Payors whose Managed Care Contracts with the New Health System have no fixed inflator and the inflators are one hundred percent (100%) value-based. The New Health System shall demonstrate compliance with Addendum 1 for Value-Based Payors as set forth in Section 2.2(b).

(b) Compliance with Addendum 1. On the Anniversary Date of each Managed Care Contract that the New Health System holds with a Value-Based Payor, the New Health System shall certify that the Payor continues to meet the definition of a Value-Based Payor. If the Payor does not satisfy the definition of a Value-Based Payor on the Anniversary Date, that Payor will be considered a Measured Payor subject to the testing set forth in Part III unless it meets the definition of an Exempt Payor or an Attestation Payor. The New Health System shall maintain a current list of Value-Based Payors and make this list available for review by the COPA Monitor and the Department upon request.

2.3 Attestation Payors.

(a) Description. “Attestation Payors” are those Payors that do not meet the definition of an Exempt Payor, or a Value-Based Payor, but do execute an attestation form within ninety (90) days of the Anniversary Date of that Payor’s managed care contract with the New Health System stating that the New Health System has not violated the pricing limitations set forth in the Terms of Certification and Addendum 1 for the previous Contract Year. The New Health System shall demonstrate compliance with Addendum 1 for Attestation Payors as set forth below in Section 2.3(b).

(b) Compliance with Addendum 1. On the Anniversary Date of each Managed Care Contract that the New Health System holds with an Attestation Payor, the New Health System shall secure an attestation from that Payor attesting that (a) the Payor was provided a copy of the Terms of Certification and Addendum 1 and (b) the New Health System has not violated the pricing limitations of Addendum 1 in its negotiations or dealings with that Payor for the previous Contract Year. If the Payor does not satisfy the definition of an Attestation Payor within ninety (90) days of the Anniversary Date of that contract, that Payor will be considered a Measured Payor subject to the testing set forth in Part III unless it meets the definition of an Exempt Payor or a

Value-Based Payor. The New Health System shall maintain a current list of Attestation Payors and make this list available for review by the COPA Monitor and the Department upon request.

PART III

COMPLIANCE FOR MEASURED PAYORS

3.1 Compliance for Measured Payors.

(a) Description. “Measured Payors” are Payors that do not meet the definition of Exempt Payor, Value-Based Payor, Attestation Payor, Charged-Based Payor, or Never In-Network Payor for a particular Contract Year.

(b) Compliance with Addendum 1. For each Measured Payor, compliance with Addendum 1 will be evaluated by the COPA Monitor (i) before the New Health System executes, renegotiates or reprices a Managed Care Contract with a Measured Payor after the Closing (each, a “Measured Payor Contract”); (ii) on intervals determined by the COPA Monitor to confirm that the Measured Payor Contract is in compliance with Addendum 1; and (iii) through Annual Testing to ensure that the New Health System’s pricing has not impermissibly increased. The process for evaluation is set forth below:

(i) Process for Evaluating whether proposed Measured Payor Contracts negotiated after the Closing Comply with Addendum 1:

Step 1. The New Health System shall negotiate all of the substantive terms of a new Measured Payor Contract.

Step 2. Before executing the new Measured Payor Contract, the New Health System shall submit a draft of such contract to the COPA Monitor for review.

Step 3. Within fifteen (15) business days of receiving a draft of the new contract and any relevant clarifying materials that may be reasonably requested, the COPA Monitor shall inform the Department and the New Health System of the COPA Monitor’s findings as to whether the substantive terms of the new contract comply with Addendum 1 and the provisions of Article V of the Amended and Restated Terms of Certification.

Step 4. If the COPA Monitor finds that the substantive terms of the new Measured Payor Contract comply with Addendum 1 and the provisions of Article V, the New Health System may move forward with execution of the new Managed Care Contract with the Measured Payor. If the COPA Monitor finds that the substantive terms of the new Measured Payor Contract do not comply with Addendum 1 and the provisions of Article V, the New Health System may not move forward with execution of the new Managed

Care Contract with the Measured Payor until such time as it resolves the noncompliant terms with the COPA Monitor.

Step 5. The New Health System will provide a copy of the relevant pricing sections for each fully executed Measured Payor Contract to the COPA Monitor following execution with the full contract available upon request.

- (ii) Process for Evaluating Whether Measured Payor Contracts Approved by the COPA Monitor and Executed After the Closing Comply with Addendum 1 through Discretionary Testing. In addition to the other compliance measures set forth herein, the COPA Monitor may, at his or her discretion, review a sample of Actual Billed Charges and Allowed Amounts for Measured Payor Contracts currently in effect to confirm that the Measured Payor Contract is in compliance with Addendum 1 (the “Discretionary Testing”).
- (iii) Process for Evaluating Whether Measured Payor Contracts Approved by the COPA Monitor and Executed After the Closing Comply with Addendum 1 through Annual Testing. For each Measured Payor, the COPA Monitor will review on an annual basis whether the New Health System’s pricing has impermissibly increased (the “Annual Testing”), unless the COPA Monitor determines that the facts and circumstances do not warrant Annual Testing. The methodology for conducting the Annual Testing is detailed in Section 3.2. If the COPA Monitor finds that the New Health System's pricing has impermissibly increased, Section 3.3 shall apply.

(c) Consistent Basis. The calculations required by this Part III shall be made on a consistent basis each year and any modification to the methodologies for these calculations shall be subject to approval by the Department.

(d) Review of Methodologies. The Department will evaluate the methodologies set forth in this Part III on the third anniversary of the Closing to ensure that the evaluations are achieving the intended goals.

3.2 Annual Testing for Measured Payors.

(a) For each Large Network Payor, compliance with Addendum 1 will be evaluated on an annual basis by determining whether the Payment Deviation for that Large Network Payor has impermissibly increased. The process for determining if the Payment Deviation has impermissibly increased shall be conducted as set forth below:

Step 1. Calculate the Payment Indices and the Payment Deviations for Inpatient, Outpatient, Non-Hospital Outpatient, and Physician Services. The New Health System will calculate the Payment Indices and Payment Deviations for Inpatient Services,

Outpatient Services, Non-Hospital Outpatient Services, and Physician Services of a Large Network Payor separately as set forth below.

For Inpatient Services: The New Health System shall establish and report to the COPA Monitor and the Department the Inpatient Payment Indices as set forth in Appendix 1(A). Within one hundred twenty (120) days of the end of the Contract Year being tested, the New Health System shall calculate the Inpatient Payment Deviations as set forth in Appendix 1(A). The Inpatient Payment Deviation shall then be multiplied by the percentage of the Allowed Amounts from that Measured Payor that were derived from Inpatient Services for the Contract Year being tested (the "Weighted Inpatient Payment Deviation").

For Outpatient Services: The New Health System shall establish and report to the COPA Monitor and the Department the Outpatient Payment Indices as set forth in Appendix 2(A). Within one hundred twenty (120) days of the end of the Contract Year being tested, the New Health System shall calculate the Outpatient Payment Deviation as set forth in Appendix 2(A). The Outpatient Payment Deviation shall then be multiplied by the percentage of the Allowed Amounts from that Measured Payor that were derived from Outpatient Services for the Contract Year being tested (the "Weighted Outpatient Payment Deviation").

For Non-Hospital Outpatient Services: The New Health System shall establish and report to the COPA Monitor and the Department the Non-Hospital Outpatient Payment Indices as set forth in Appendix 3. Within one hundred twenty (120) days of the end of the Contract Year being tested, the New Health System shall calculate the Non-Hospital Outpatient Payment Deviation as set forth in Appendix 3. The Non-Hospital Outpatient Payment Deviation shall then be multiplied by the percentage of the Allowed Amounts from that Measured Payor that were derived from Non-Hospital Outpatient Services for the Contract Year being tested (the "Weighted Non-Hospital Outpatient Payment Deviation").

For Physician Services: The New Health System shall establish and report to the COPA Monitor and the Department the Physician Services Payment Indices as set forth in Appendix 4. Within one hundred twenty (120) days of the end of the Contract Year being tested, the New Health System shall calculate the Physician Services Payment Deviation as set forth in Appendix 4. The Physician Services Payment Deviation shall then be multiplied by the percentage of the Allowed Amounts from that Measured Payor that were derived from Physician Services for the Contract Year being tested (the "Weighted Physician Services Payment Deviation").

Step 2. Calculate the Aggregate Payment Deviation. The New Health System will add the Weighted Inpatient Payment Deviation, the Weighted Outpatient Payment Deviation, the Weighted Non-Hospital Outpatient Payment Deviation, and the Weighted Physician Services Payment Deviation together to calculate the "Aggregate Payment Deviation" for each Large Network Payor.

Step 3. Test for Compliance. If the Aggregate Payment Deviation for a Large Network Payor is a negative amount, the New Health System has demonstrated compliance with Addendum 1 with respect to that Large Network Payor for the year tested. If the Aggregate Payment Deviation is a positive amount, the New Health System's pricing for that Large Network Payor has impermissibly increased and the provisions of Section 3.3 shall apply.

(b) For the Small Payors, compliance with Addendum 1 will be evaluated on an annual basis by determining whether the Payment Deviation for each category of Small Payors has impermissibly increased. The process for determining if the Payment Deviation for each Small Payor category has impermissibly increased shall be conducted as set forth below:

Step 1. Calculate the Payment Indices and the Payment Deviations for Inpatient, Outpatient, Non-Hospital Outpatient, and Physician Services for each category of Small Payors. The New Health System will calculate the Payment Indices and Payment Deviations for Inpatient Services, Outpatient Services, Non-Hospital Outpatient Services, and Physician Services for each category of Small Payors as set forth below.

For Inpatient Services: The New Health System shall establish and report to the COPA Monitor and the Department the Inpatient Payment Indices as set forth in Appendix 1(B). Within one hundred twenty (120) days of the end of the Fiscal Year being tested, the New Health System shall calculate the Aggregate Inpatient Payment Deviation for each category of Small Payors as set forth in Appendix 1(B). The Aggregate Inpatient Payment Deviation for that category of Small Payors shall then be multiplied by the percentage of the Allowed Amounts from that category of Small Payors that were derived from Inpatient Services for the year being tested (the "Small Payor Weighted Inpatient Payment Deviation").

For Outpatient Services: The New Health System shall establish and report to the COPA Monitor and the Department the Outpatient Payment Indices as set forth in Appendix 2(B). Within one hundred twenty (120) days of the end of the Fiscal Year being tested, the New Health System shall calculate the Outpatient Payment Deviation as set forth in Appendix 2(B). The Outpatient Payment Deviation for that category of Small Payors shall then be multiplied by the percentage of the Allowed Amounts from that category of Small Payors that were derived from Outpatient Services for the year being tested (the "Small Payor Weighted Outpatient Payment Deviation").

For Non-Hospital Outpatient Services: The New Health System shall establish and report to the COPA Monitor and the Department the Non-Hospital Outpatient Payment Indices as set forth in Appendix 3. Within one hundred twenty (120) days of the end of the Fiscal Year being tested, the New Health System shall calculate the Non-Hospital Outpatient Payment Deviation as set forth in Appendix 3. The Non-Hospital Outpatient Payment Deviation for that category of Small Payors shall then be multiplied by the percentage of the Allowed Amounts from that category of Small Payors that were derived from Non-Hospital Outpatient Services for the year being tested (the "Small Payor Weighted Non-Hospital Outpatient Payment Deviation").

For Physician Services: The New Health System shall establish and report to the COPA Monitor and the Department the Physician Services Payment Indices as set forth in Appendix 4. Within one hundred twenty (120) days of the end of the Fiscal Year being tested, the New Health System shall calculate the Physician Services Payment Deviation as set forth in Appendix 4. The Physician Services Payment Deviation for that category of Small Payors shall then be multiplied by the Allowed Amounts from that category of Small Payors that were derived from Physician Services for the year being tested (the "Small Payor Weighted Physician Services Payment Deviation").

Step 2. Calculate the Aggregate Payment Deviation. The New Health System will add the Small Payor Weighted Inpatient Payment Deviation, the Small Payor Weighted Outpatient Payment Deviation, the Small Payor Weighted Non-Hospital Outpatient Payment Deviation, and the Small Payor Weighted Physician Services Payment Deviation for each category of Small Payors together to calculate the "Small Payor Aggregate Payment Deviation."

Step 3. Test for Compliance. If the Small Payor Aggregate Payment Deviation for a category of Small Payors is a negative amount, the New Health System has demonstrated compliance with Addendum 1 with respect to that category of Small Payors for the year tested. If the Aggregate Payment Deviation is a positive amount, the New Health System's pricing for that category of Small Payors has impermissibly increased and the provisions of Section 3.3 shall apply.

(c) Notwithstanding the foregoing, if the New Health System negotiates a fixed inflator in a multi-year Payor Contract that is at or below the HIA in effect at the time the proposed contract is approved by the COPA Monitor and executed, and the HIA subsequently drops below the negotiated fixed inflator after year one of the Payor Contract, the New Health System shall use the negotiated fixed inflator for purposes of Annual Testing for Measured Payors in Section 3.2.

3.3 Excess Payment and Refunding Payors and Patients.

If an Aggregate Payment Deviation calculated in Section 3.2(a) or 3.2(b) is a positive amount, the New Health System's pricing has impermissibly increased with respect to that Payor or category of Payors and an excess payment exists (the "Excess Payment"). Upon the identification of an Excess Payment through the process set forth above (the "Excess Payment Testing"), the New Health System shall work with the COPA Monitor to determine the best way to address the Excess Payment and related refund. To prevent the Excess Payment from recurring, the future Allowed Amounts shall be reduced by the Excess Payment divided by the Allowed Amounts, after the future Allowed Amounts are adjusted for inflation using the applicable Cumulative Inflation Adjustment.

3.4 Refunds of Excess Payments.

If the New Health System's post-Closing pricing increases to the point of becoming an Excess Payment, the New Health System shall develop a plan for paying refunds due to a Large Network Payor, a category of Small Payors, and/or patients as a result of Excess Payment Testing,

including a reasonable process for addressing small payment amounts, and shall provide such plan to the COPA Monitor within sixty (60) days of identification. The New Health System shall follow applicable federal and state laws in refunding those amounts due and owing to Measured Payors and/or patients.

The COPA Monitor can determine that a refund of an excess payment is not required after considering the following:

- (i) The materiality of the refund to the payor and to Ballad
- (ii) Management's explanation of why an excess payment occurred
- (iii) Comments from the payor that paid an excess payment to Ballad

3.5 Timing of Fee Schedule Adjustments and Additional Refunds.

Any fee schedule adjustments which are necessary in order to prevent any Excess Payments from recurring in the balance of a Contract Year or Fiscal Year, as applicable, shall be shared with the Measured Payor within forty-five (45) days after identification. The New Health System will work with the Measured Payor and make best efforts to have such adjustments become effective within ninety (90) days after identification. Such fee schedule adjustments shall include any Excess Payment received by the New Health System during the first seven (7) months of the Contract Year or Fiscal Year following the applicable year being tested, if during this time, contract prices were not adjusted by the New Health System to account for and prevent Excess Payments. Alternatively, the New Health System may make an additional refund to Measured Payors and patients to account for any Excess Payment received during the first seven (7) months of such following Contract Year or Fiscal Year. If the New Health System elects to make an additional Excess Payment refund rather than a fee schedule adjustment, to account for the first seven (7) months of such following Contract Year or Fiscal Year, it shall make such additional refunds to Payors and patients within sixty (60) days.

PART IV

COMPLIANCE FOR CHARGE-BASED ITEMS OR SERVICES

4.1 Certain hospital, physician, ancillary and other healthcare services may be reimbursed on a percentage of a health care provider's charge for such services. Common examples in hospital Managed Care Contracts include, but are not limited to, services not otherwise covered by a Payor's fee schedule and items where the charge may vary based upon the underlying cost such as high cost drugs and implants in the hospital. In addition, some Managed Care Contracts pay for all hospital services based upon a hospital's charges for services. Such contracts often provide for a discount (for example 50%) from a hospital's chargemaster rates for the item or service at issue. This Addendum 1 is intended to place limits upon increases in the New Health System's charges and/or the impact of those increases, upon individuals and entities who utilize the New Health System's services. For hospital inpatient and outpatient, non-hospital outpatient, and Physician Services and any other services billed to Payors based upon charges, the

New Health System shall limit the impact of charge increases as set forth below. This provision does apply to outliers for the purpose of adjusting the outlier threshold and any percentage of charge payment. Outlier payments are further tested as part of the Allowed Amounts for the Payment Indices and Payment Deviation calculations set forth above.

4.2 Charges established in a COPA Hospital chargemaster may be adjusted at the discretion of the New Health System. The New Health System acknowledges, however, that increases in excess of the Hospital Inflation Adjustment will impact Payor Contracts which base reimbursement on a percentage of charges and certain Cost-Based Items, as discussed below. Accordingly, the New Health System agrees to have its charge increases reviewed each year by the COPA Monitor. The review of the annual charge increase will consider whether or not the increase applied across all of the applicable COPA Hospital or varied by department, service or line item. If the charge increase is not applied uniformly across the entire chargemaster, other than Cost-Based Items (addressed below), the New Health System will calculate and implement in its chargemaster a weighted average charge increase by considering the volume of the various departments, service lines or line items and the respective increase in charges. For example, if \$10 million of charges is increased 10%, another \$10 million is increased 5%, and a third group of \$10 million was increased 0%, the weighted average would be 5%. The weighted average charge increase is then compared to the Hospital Inflation Adjustment.

4.3 To the extent that, at any time, the aggregate charge increase after the Closing exceeds the Cumulative Hospital Inflation Adjustment, the New Health System will be required immediately to report any excess increase to all Payors whose payments are impacted by charges and to reduce the payment to charge ratio so that it does not exceed the Hospital Inflation Adjustment. An exemplar calculation is set forth in Appendix 5. In addition, any payments received which were based upon charges which exceed the Hospital Inflation Adjustment in any year being tested or measured must be refunded on a claim by claim basis, to the respective Payors and patients. See Appendix 5.

4.4 This Part IV shall not apply to Cost-Based Items which are addressed in Part V below.

PART V

COMPLIANCE FOR COST-BASED ITEMS

5.1 Some items are reimbursed based upon the cost of the item to the hospital or medical provider (“Cost-Based Items”). Hospitals and other health care providers maintain “mark-up” policies which typically set the charge to Payors as the cost of the item plus some specified mark-up or percentage over and above the cost of the item.

5.2 The New Health System agrees to maintain the mark-up policies in effect for the COPA Parties as of January 1, 2017 as the baseline for measuring its post-Closing mark-ups on Cost-Based Items covered by such mark-up policies.

5.3 The New Health System agrees not to adjust the mark-up policy without the approval of the COPA Monitor, including adjustments to the mark-up policy which are required

to migrate the systems of the COPA Parties to a single system. The New Health System may, however, increase or decrease its charges for items covered by its mark-up policy in effect on January 1, 2017, based upon changes in the underlying cost of a given supply or item (e.g., a drug). Items that have a mark-up based upon a fixed dollar amount (e.g., cost plus \$1.00) may change in cost anytime and the fixed price mark-up may also change once per year by an amount not to exceed the Hospital Inflation Adjustment.

5.4 The mark-up for cost for Cost-Based Items must remain constant, however, during the COPA Term. If the item's charge is based on a cost plus a fixed increase, the fixed increase can be adjusted by the Hospital Inflation Adjustment. If the item's charge is based on a cost plus a percentage mark-up, the mark-up percentage must similarly remain constant during the COPA Term. If the increase in the COPA Hospital mark-up exceeds the Hospital Inflation Adjustment in any given year, a refund is due impacted Payors and patients consistent with Section 3.3 above for Charge-Based Items or services refunds. Charge master mark-up items including supplies and pharmaceuticals use mark-up tables to set charge master pricing.

5.5 Items which are medical devices or supplies which were not covered by a particular COPA Hospital's mark-up policy (by way of example only, new items which did not exist under such policy but are required to be tested for pricing compliance), shall be reported to the COPA Monitor within 90 days of the New Health System furnishing the item.

PART VI

COMPLIANCE FOR NEVER IN-NETWORK PAYORS

6.1 Inpatient Charges. The New Health System shall apply the Never In-Network Discount (as defined in Section 6.3(a)) to each individual bill for inpatient services before that bill is sent to the patient covered by a Never In-Network Payor. Within one-hundred twenty (120) days of the end of each Fiscal Year, the New Health System shall calculate the total amount collected from the Never In-Network Payors and their patients for inpatient charges for that Fiscal Year (the "Inpatient Collections Amount"). If the Inpatient Collections Amount exceeds the total amount of inpatient charges attributed to Never In-Network Payors and their patients adjusted for the Never In-Network Discount, the New Health System shall refund the difference to the Never In-Network Payors or the patients as applicable in equal amounts. The COPA Monitor may, at his or her discretion, audit individual inpatient claims for Never In-Network Payors and their patients to ensure compliance with this section. An exemplar calculation is set forth in Appendix 6.

6.2 Outpatient Charges. Within one-hundred twenty (120) days of the end of each Fiscal Year, the New Health System shall calculate the total amount collected from the Never In-Network Payors and their patients for outpatient charges for that Fiscal Year (the "Outpatient Collections Amount"). If the Outpatient Collections Amount exceeds the total amount of outpatient charges attributed to Never In-Network Payors and their patients adjusted for the Never In-Network Discount, the New Health System shall refund the difference to the Never In-Network Payor or the patient as applicable in equal amounts. An exemplar calculation is set forth in Appendix 6.

6.3 Never In-Network Discount.

(a) The "Never In-Network Discount" shall apply to hospital inpatient services and hospital outpatient services and be the lower of the following:

- (i) the payment rates of the lowest discounted contracted commercial Payor for the FY17 claims data but adjusted for the rate that was in place on January 31, 2018, as agreed to by the New Health System and the COPA Monitor, plus ten percent (10%); or
- (ii) the payment rates of the lowest discounted contracted National Insurance Network for the FY17 claims data but adjusted for the rate that was in place on January 31, 2018, which National Insurance Network shall be agreed to between The New Health System and the COPA Monitor.

(b) The payment rates initially determined in Sections 6.3(a)(i) and 6.3(a)(ii) will be adjusted from time to time for changes in billed charges in a manner consistent with Section 4.3, or whenever approved by the COPA Monitor.

(c) The Never In-Network payment rate will be stated as a percentage of charges for each legacy system, recognizing the difference in Actual Billed Charges, until such time as the chargemasters are unified. At such time, a new payment rate will be calculated and approved by the COPA Monitor.

(d) The New Health System may initially establish a single Never In-Network rate for each legacy system or separate rates within each system, including separate rates for inpatient, outpatient, and other services.

(e) The New Health System shall follow the organization's standard collection practices when dealing with Never In-Network Payors and their patients.

PART VII

APPLICATION TO POST-CLOSING MANAGED CARE CONTRACTS

Managed Care Contracts which the New Health System executes with Payors post-Closing are governed by the terms of this Addendum 1 and the Terms of Certification. Since Measured Payors who execute post-Closing contracts with the New Health System will necessarily not have pre-Closing, payment data available for use as Payment Indices, an alternative methodology must be employed to serve as a substitute for pre-Closing payment data. For contracts executed post-Closing, post-Closing Allowed Amounts shall be compared to pre-Closing Allowed Amounts for peer Measured Payors. The New Health System shall propose peer Measured Payors to the COPA Monitor based on factors including contract terms, quality components offered to the New Health System by such Measured Payor, the number of covered lives, the experience of such Measured Payor in other markets, information related to the performance of such Measured Payor, and the financial stability of such Measured Payor. The peer Measured Payors utilized for comparison

purposes shall be selected by the COPA Monitor. The first year for which post-Closing Managed Care Contracts shall be measured for compliance with this Addendum 1 is one complete Contract Year after the respective COPA Hospitals have operated under such contracts.

PART VIII

TIMING FOR REPORTING

8.1 Timing for Reporting.

(a) Reporting Contracts and Financial Information to the Department. All contracts subject to Excess Payment Testing shall be made available to the COPA Monitor and the Department upon request. In addition, the New Health System shall timely provide all information needed by the COPA Monitor and/or the Department to verify the New Health System's calculations including but not limited to: Allowed Amounts from claims data; case mix; admissions and discharge data; DRG Relative Weights; Actual Billed Charges; Allowed Amounts as a Percentage of Actual Billed Charges; RVUs; Payor mix; utilization; gross and net revenues by Measured Payor; and any other information requested by the COPA Monitor or the Department which, in the COPA Monitor or Department's discretion, would be beneficial in measuring the New Health System's compliance with this Addendum 1.

(b) Reporting of Excess Payment Testing. For Large Network Payors, compliance with this Addendum 1 shall be measured by the New Health System for the Contract Year and reported to the COPA Monitor within 120 days after the conclusion of each full Contract Year after the Closing. For Small Payors, compliance with this Addendum 1 shall be measured by the New Health System and reported to the COPA Monitor within 120 days after the conclusion of each full Fiscal Year after the Closing.

(c) Annual Report to the Department. By November 30, 2019, and by each November 30 thereafter during the COPA Term, the New Health System shall provide a report to the COPA Monitor and the Department to include the following information with respect to the Fiscal Year ended in that calendar year, provided however, that no annual report shall be required if no new contract has been executed during that Fiscal Year.

- (i) A list of any new Payors which executed Managed Care Contracts for the first time during each fiscal year and a verified certification from the New Health System's Chief Financial Officer that the pricing for such contracts complies with this Addendum 1; and
- (ii) A summary of all value-based and risk-based payments at the health system level, including a comparison of such payments to the prior Contract Year's value-based payments.

(d) Electronic Format. The New Health System shall provide the foregoing information in electronic format acceptable to the Department including the header level data, revenue level data and required data fields requested by the Department.

8.2 Recurring Annual Deadlines.

The deadlines set forth in Addendum 1 shall be annual deadlines based upon the Contract Year or Fiscal Year, as applicable, unless otherwise specified.

8.3 Additional Time.

If the New Health System needs additional time to perform any of the obligations in this Addendum 1, it may request, in writing, additional time from the COPA Monitor. A request will be considered timely if received by the COPA Monitor within one (1) week of a deadline.

PART IX

EXCEPTIONS TO PRICE LIMITATION RULES

9.1 The Annual Testing for Measured Payors set forth above does not apply to the following:

(a) That portion of Managed Care Contract payments received for attaining quality targets or goals, so long as quality or value-based contracts are reported to the COPA Monitor and the COPA Monitor has not objected.

(b) Pass-through items in Payor Contracts governed by a COPA Hospital mark-up policy or other method, so long as they are priced consistently with Part IV.

(c) Post-acute care providers such as SNFs, home health agencies, hospices and durable medical equipment providers owned by the New Health System. Because these providers' Payor mixes are primarily governmental, and not negotiated with the New Health System, these providers have been excepted from the terms of this Addendum 1.

(d) Bundled payment items and services in which a COPA Hospital and/or the New Health System as applicable assumes risks for care provided by other providers (such as post-acute care providers like a SNF or home health agency), involving a value-based payment on an episodic basis. Excepting Allowed Amounts and/or payments for this type of risk-based contracting is intended to encourage such contracting. The Parties shall submit the description of bundled payment items and services to the COPA Monitor for review, along with a copy of all related contractual agreements, including the New Health System's base pricing of its services included in the bundle. If such contracting is abused or results in anti-competitive conduct, the Department may take enforcement action.

(e) Items for which the COPA Hospital and/or the New Health System as applicable have accepted risk in the form of a capitated payment or percentage of premiums.

(f) Pharmacies owned or controlled by a COPA Hospital or the New Health System unless the hospital or the New Health System no longer contracts with pharmacy benefit managers, or competition is otherwise reduced in the area of pharmaceuticals or pharmacy services. These services have been excepted, because it is believed that competition exists for these services notwithstanding the Affiliation.

(g) Contract pricing terms which were negotiated pre-Closing. Allowed Amounts which were negotiated with Payors prior to the Closing need not be tested.

PART X

PERIODIC REVIEW

No later than six (6) months before the fourth Anniversary Date of the Issue Date, the New Health System and the COPA Monitor shall meet to review the application and operation of this Addendum 1 in the maintenance of ongoing Public Advantage. If it appears the New Health System (a) has generated operating margin, as defined by Moody's Investors Service, during one or more of the preceding three (3) years that is above the 75th percentile of health systems rated A+ by Moody's Investors Service, or (b) has generated an average operating margin during one or more of the preceding three (3) years that is below the 50th percentile of health systems rated BBB+ by Moody's Investors Service, then modification of this Addendum 1 may be appropriate. If the New Health System proposes an Addendum 1 modification pursuant to this Part IX, the COPA Monitor shall review and make a recommendation to the Department with respect to the proposed modification. In addition, the COPA Monitor may independently propose an Addendum 1 modification to the Department. The Department may accept, decline or revise any proposed Addendum 1 modification referred to it by the COPA Monitor. The Department, however, shall accept a proposed modification only to the extent the Department determines, in its discretion, that it is necessary to retain, or otherwise not impair, Public Advantage. If any such modification is not agreed upon prior to the fifth Anniversary Date of the Issue Date, the Department may consider it a material factor in its Annual Review pursuant to Section 7.02 of the Terms of Certification. Such review of this Addendum 1 shall be repeated every three (3) years thereafter during the COPA Term.

PART XI

GENERAL TERMS

11.1 All Payor claims, billing, and other rules will be followed. It is not the intent of this Addendum 1 to supplant contract terms in any COPA Hospital's or the New Health System's Managed Care Contracts other than specifically addressed herein.

11.2 Should the New Health System have an Excess Payment for any Payor for two consecutive years, the New Health System agrees to perform a root cause analysis audit and provide a report to the COPA Monitor setting forth its plan to address and prevent future Excess Payments from such Payor.

11.3 With respect to any year in which an Excess Payment occurs, the Department may assess a remedial payment against the New Health System in an amount in the Department's discretion but not to exceed five hundred thousand dollars (\$500,000). Any such remedial payment will be paid as directed by the Department.

11.4 Neither this Addendum 1 nor any other provision of the COPA or the Terms of Certification creates a private right of action.

11.5 If a Payor, which has a managed care contract with any COPA Party, subsequently goes out of network the Payor's out of network provisions will dictate payment and no Excess Payments Testing would be required.

PART XII

RESERVATION OF RIGHTS

12.1 In lieu of the provisions of Part IX, the Department reserves the right to change the price limits included herein from time to time if a Payor does not offer quality-based incentives, or for any other reasonable, and not arbitrary and capricious reason.

12.2 In lieu of the provisions of Part IX, the Department reserves the right, from time to time, in its reasonable, and not arbitrary and capricious, discretion, to change the definitions herein, to add or subtract Payors from Excess Payment Testing, to add or subtract service lines of the New Health System, including but not limited to SNFs or pharmacies, and to otherwise change the measurement indices utilized to compare pre-Closing and post-Closing prices. The Department reserves such right depending upon changes in the utilization, Payor mix, method of reimbursement such as value-based contracts, or for any other reasons which cause the Excess Payment Testing herein ineffective in retaining Public Advantage.

APPENDIX 1

INPATIENT PRICING FOR MEASURED PAYORS

The deviation of post-Closing average adjusted inpatient pricing per unit of DRG Weight⁴ from the Inpatient Baseline Amount as increased by the Cumulative Inpatient Inflation Adjustment, whether greater or lesser, constitutes the “Inpatient Payment Deviation.” In addition, Allowed Amounts tested against the Payment Indices shall not include payments to the COPA Hospitals for achieving quality metrics, so long as quality payments are reported to the COPA Monitor and the Department.

A. Inpatient Payment Indices and Inpatient Payment Deviations for Large Network Payors

(i) The Inpatient Baseline Amount shall be calculated for individual Large Network Payors by dividing the New Health System’s Base Contract Year Inpatient Allowed Amounts for each Large Network Payor, by the sum of all DRG Relative Weights associated with Allowed Amounts. The calculation is as follows:

$$\frac{\text{Each Large Network Payor's Base Contract Year Inpatient Allowed Amounts}}{\text{Sum of each Large Network Payor's Base Contract Year Allowed DRG Weights}} = \text{Base Contract Year price per unit of DRG Weight (the "Inpatient Baseline Amount")}$$

For any existing contract that is renegotiated, repriced, or executed after the Closing, the Inpatient Baseline Amount will be increased by the Cumulative Inpatient Inflation Adjustment effective on such renewal date.

(ii) The Inpatient Payment Deviation for each Large Network Payor shall be calculated in three steps as follows:

Step 1.

$$\frac{\text{Each Large Network Payor's [year being tested] inpatient Allowed Amounts}}{\text{sum of each Large Network Payor's [year being tested] Allowed DRG Weights}} = \text{[year being tested] price per unit of DRG Weight}$$

⁴ Which unit has a value of 1.0.

Step 2.

$$\begin{array}{r} \text{[year being tested]} \\ \text{price per unit of} \\ \text{DRG Weight} \end{array} - \left(\begin{array}{r} \text{Base Contract} \\ \text{Year price per} \\ \text{unit of DRG} \\ \text{Weight} \end{array} \times \begin{array}{r} 1 + \\ \text{Cumulative} \\ \text{Inpatient} \\ \text{Inflation} \\ \text{Adjustment} \end{array} \right) = \begin{array}{r} \text{Inpatient} \\ \text{Payment} \\ \text{Deviation} \\ \text{per unit of} \\ \text{DRG} \\ \text{Weight} \end{array}$$

Step 3.

$$\begin{array}{r} \text{[year being tested]} \\ \text{Total DRG} \\ \text{Weights} \end{array} \times \begin{array}{r} \text{Inpatient} \\ \text{Payment} \\ \text{Deviation per} \\ \text{unit of DRG} \\ \text{Weight} \end{array} = \begin{array}{r} \text{Inpatient} \\ \text{Payment} \\ \text{Deviation} \end{array}$$

B. Inpatient Payment Indices and Inpatient Payment Deviation For Small Commercial Payors, Small Medicare Advantage Payors, Small TennCare Payors, and Small Virginia Medicaid Payors

At the end of each Fiscal Year, the Inpatient Payment Indices and Inpatient Payment Deviations for Small Payors shall be calculated using the same methodology used for Large Network Payors as set forth in Section A. The Inpatient Payment Indices and the Inpatient Payment Deviations for Small Payors will be calculated based on the Contract Year ending in the Fiscal Year being tested. Once the Inpatient Payment Deviation for each Small Payor has been calculated, these Inpatient Payment Deviations shall be aggregated within the applicable Small Payor categories (Small Commercial Payors, Small Medicare Advantage Payors, Small TennCare Payors, and Small Virginia Medicaid Payors) (the “Aggregate Inpatient Payment Deviation”) to prevent the small market share of these payors from skewing the post-Closing comparisons. The Aggregate Inpatient Payment Deviation for each category of Small Payors shall then be reviewed for purposes of measuring post-Closing pricing and determining whether a refund is required.

Should any Small Commercial Payor, Small Medicare Advantage Payor, Small TennCare Payor, or Small Virginia Medicaid Payor obtain enough market share to become a Large Network Payor, such Payor will be individually tested along with other Large Network Payors beginning with the first Contract Year with at least six months of experience after being deemed a Large Network Payor. If a Large Network Payor is determined to no longer be a Large Network Payor during a Fiscal Year, such Payor shall be included in the applicable Small Payor group for the first full Contract Year after such Payor is no longer a Large Network Payor.

C. Changes to DRG Weights

The New Health System shall not negotiate changes to DRG Weights with Payors without first notifying the COPA Monitor. The New Health System shall also provide to the COPA Monitor for review and approval an analysis of the impact on revenue resulting from the new DRG Weights and any proposed adjustments to the Payment Indices. The purpose of restricting changes to DRG Weights is to retain the integrity of the calculation above since changes or modifications

in DRG Weights could mask increases in pricing. Notification need not be made to the COPA Monitor or Department for recalibration to DRG Weights implemented by Payors across their entire network of contracted providers in the normal course of business. When DRG Weight changes are made by Payors, such changes will be utilized in the calculations above.

D. Calculation of Inpatient Payment Indices and Inpatient Payment Deviations For Measured Payors Which Do Not Utilize a DRG Methodology

For any and all Measured Payors which do not reimburse on a DRG Methodology, the New Health System will nevertheless assign a DRG to such Payor(s)' discharges (if not already assigned) and will utilize Medicare's DRG Weights, or a specific commercial Payor's DRG Weights agreed upon in advance, for each Contract Year so that Inpatient Payment Indices can be calculated for such Payors. When calculating the Inpatient Payment Deviation, the annual Medicare DRG Weights or agreed upon commercial DRG Weights for the year being tested shall be used.

APPENDIX 2

OUTPATIENT PRICING FOR MEASURED PAYORS

The deviation of post-Closing average adjusted outpatient pricing from the Outpatient Baseline Amount as increased by the Cumulative Outpatient Inflation Adjustment, whether greater or lesser, constitutes the “Outpatient Payment Deviation.” In addition, Allowed Amounts tested against the Payment Indices shall not include payments to the COPA Hospitals for achieving quality metrics, so long as quality payments are reported to the COPA Monitor and the Department.

A. Outpatient Payment Indices and Outpatient Payment Deviations for Large Network Payors

(i) The Outpatient Baseline Amount shall be calculated individually for each Large Network Payor by dividing the New Health System’s Base Contract Year Outpatient Allowed Amounts by the sum of Actual Billed Charges associated with such Allowed Amounts. The calculation is as follows:

$$\frac{\text{each Large Network Payors Base Contract Year Outpatient Allowed Amounts}}{\text{sum of each Large Network Payors' Base Contract Year Actual Billed Charges Associated with such Allowed Amounts}} = \text{Base Contract Year price of Allowed Amounts as a Percentage of Actual Billed Charges Associated with such Allowed Amounts (the “Outpatient Baseline Amount”)}.$$

For any existing contract that is renegotiated, repriced, or executed after the Closing, the Outpatient Baseline Amount will be increased by the Cumulative Outpatient Inflation Adjustment effective on such renewal date.

The Outpatient Payment Deviation for each of the Large Network Payors shall be calculated in three steps as follows:

Step 1.

$$\frac{\text{each Large Network Payors' [year being tested] Outpatient Allowed Amounts}}{\text{sum of each Large Network Payors' [year being tested] Actual Billed Charges Associated with such Allowed Amounts}} = \frac{\text{[year being tested] price of Allowed Amounts as a Percentage of Actual Billed Charges Associated with such Allowed Amounts ("Actual Outpatient Ratio for Contract Year")}}{\text{Actual Billed Charges Associated with such Allowed Amounts ("Actual Outpatient Ratio for Contract Year")}}$$

Step 2.

$$\frac{\text{BASE YEAR ALLOWED AMOUNTS as a Percentage of Actual Billed Charges Associated with Such Allowed Amounts}}{\text{Base Contract Year Charge Amount}} \times \frac{1 + \text{Cumulative Outpatient Inflation Adjustment}}{1 + \text{cumulative charge increase*}} = \text{Adjusted Outpatient Ratio}$$

*Charge master increase as provided to Payors in annual notification

Step 3.

$$\left(\frac{\text{Actual Outpatient Ratio for Contract Year}}{\text{Adjusted Outpatient Ratio}} - 1 \right) \times \text{Actual Billed Charges Associated with such Allowed Amounts for the year being tested} = \text{Outpatient Payment Deviation}$$

B. Outpatient Payment Indices and Outpatient Payment Deviations For Small Commercial Payors, Small Medicare Advantage Payors, Small TennCare Payors, and Small Virginia Medicaid Payors

At the end of each Fiscal Year, the Outpatient Payment Indices and Outpatient Payment Deviations for Small Payors shall be calculated using the same methodology used for Large Network Payors as set forth in Section A. The Outpatient Payment Indices and the Outpatient Payment Deviations for Small Payors will be calculated based on the Contract Year ending in the Fiscal Year being tested. Once the Outpatient Payment Deviation for each Small Payor has been

calculated, these Outpatient Payment Deviations shall be aggregated within the applicable Small Payor categories (Small Commercial Payors, Small Medicare Advantage Payors, Small TennCare Payors, and Small Virginia Medicaid Payors) (the “Aggregate Outpatient Payment Deviation”) to prevent the small market share of these payors from skewing the post-Closing comparisons. The Aggregate Outpatient Payment Deviation for each category of Small Payors shall then be reviewed for purposes of measuring post-Closing pricing and determining whether a refund is required.

Should any Small Commercial Payor, Small Medicare Advantage Payor, Small TennCare Payor, or Small Virginia Medicaid Payor obtain enough market share to become a Large Network Payor, such Payor will be individually tested along with other Large Network Payors beginning with the first Contract Year with at least six months of experience after being deemed a Large Network Payor. If a Large Network Payor is determined to no longer be a Large Network Payor during a Fiscal Year, such Payor shall be included in the applicable Small Payor group for the first full Contract Year after such Payor is no longer a Large Network Payor.

APPENDIX 3

NON-HOSPITAL OUTPATIENT PRICING FOR MEASURED PAYORS

It is the intent of this Addendum 1 to govern, for Measured Payors, all non-hospital outpatient services provided by outpatient diagnostic centers, ambulatory surgery centers, or any other non-hospital outpatient settings for COPA Hospitals and other providers for which the New Health System exercises control or influence over managed care contracting, excluding providers described in Section 9.1(c). The New Health System will provide a list of entities with respect to which the New Health System either has an equity ownership or a management agreement, but for which it does not exercise control or influence over managed care contracting. The COPA Monitor will be immediately notified of any change in the list. Non-Hospital Outpatient Payment Indices and Non-Hospital Outpatient Payment Deviation in these settings shall be subject to the same calculations set forth in Appendix 2 and Section 3.3. The New Health System shall not move or convert or shift non-hospital services to hospital services where such service is not hospital based for Medicare without first notifying the COPA Monitor so that indices can be established for such services.

APPENDIX 4

PHYSICIAN PRICING FOR MEASURED PAYORS

The terms of this Addendum 1 shall apply to services rendered by Employed Physicians, as well as mid-levels, physician extenders and allied health professionals whose practices are owned, controlled, or managed, in whole or in part, by the New Health System and whose rates are negotiated by the New Health System (collectively, "Physician Services"). Physician Services Payment Indices and the Physician Services Payment Deviation in these settings shall be subject to the same calculations set forth in Appendix 1(A) and 1(B) for hospital inpatient services, except that Physician Services pricing shall be measured in terms of RVUs. In addition, the indices shall be updated every year using the Cumulative Physician Inflation Adjustment. If individual Measured Payors have their own RVUs, then such Payor specific RVUs shall be utilized in lieu of Medicare RVUs.

APPENDIX 5

SAMPLE CALCULATIONS – CHARGE-BASED ITEMS OR SERVICES

To adjust the payment to charge ratio, the New Health System will adjust the percentage of charge amounts contained in Payor Contracts following the example below:

Multiply 100 by the increase in the Hospital Inflation Adjustment (assume 2.5%) –	\$102.50
Multiply 100 by the actual increase in charges (assume 10%)	\$110.00
Divide the product of the inflation adjustment by the product of the actual adjustment (Excess Percentage)	93.18%
Multiply the contracted percentage of charge by the Excess Percentage (assume 50%)	46.59%
Payment under Hospital Inflation Adjustment (102.50 *.5)	\$51.25
Payment under the adjustment for the Excess Percentage (110.00*.4659)	\$51.25

APPENDIX 6

EXEMPLAR CALCULATION FOR NEVER IN-NETWORK PAYORS

Below is an example using 30% as the Never In-Network Discount.

FOR INPATIENT CHARGES

Ballad will discount the inpatient bill of \$16,869 by the Never In-Network Discount (30% in this example) making the new balance due from the Never In-Network Payor and/or the patient \$1,808. As it does now, Ballad will try to collect as much as possible of that \$1,808 from the Never In-Network Payor before it bills the patient for the remainder.

<u>Acct #</u>	<u>Type of Account</u>	<u>Total Charges</u>	<u>Insurance Payments</u>	<u>Patient Payments</u>	<u>Current Bal Due</u>	<u>30% Disc Applied</u>	<u>New Balance Due from Never In-Network Payor and/or Patient</u>
65249431	IP	\$ 16,869	\$ 10,000	\$ -	\$ 6,869	\$ 5,061	\$ 1,808

At the end of the FY:

- The total charges attributed to Never In-Network payors and their patients for inpatient services is \$1,000,000 and that amount is adjusted by the Never In-Network Discount (30% in this example). The most Ballad is permitted to collect and keep is \$700,000.
 - If the total amount collected from the Never In-Network Payors and their patients for inpatient charges in the aggregate equals \$600,000, no refund is required.
 - If the total amount collected from the Never In-Network Payors and their patients for inpatient charges in the aggregate equals \$800,000, Ballad would refund \$100,000 to the Never In-Network payor and its patients.

FOR OUTPATIENT CHARGES

Same as Inpatient. As it does now, Ballad will try to collect as much as possible from the Never In-Network Payor before it bills the patient for the balance.

At the end of the FY:

- The total charges attributed to Never In-Network payors and their patients for outpatient services is \$500,000 and that amount is adjusted by the Never In-Network Discount (30% in this example). The most Ballad is permitted to collect and keep is \$350,000.
 - If the amount collected from the Never In-Network Payors and their patients for outpatient charges in the aggregate equals \$300,000, no refund is required.
 - If the amount collected from the Never In-Network Payors and their patients for outpatient charges in the aggregate equals \$400,000, Ballad would refund \$50,000 to the Never In-Network payor and its patients.

EXHIBIT A

September 19, 2017 Approval Letter

(See attached)

EXHIBIT B

Monetary Commitments and Annual Baseline Spending Levels

MONETARY COMMITMENTS⁵

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Expanded Access to HealthCare Services	Behavioral Health Services	\$1,000,000	\$4,000,000	\$10,000,000	\$10,000,000	\$10,000,000	\$10,000,000	\$10,000,000	\$10,000,000	\$10,000,000	\$10,000,000	\$85,000,000
	Children’s Services	1,000,000	2,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	27,000,000
	Rural Health Services	1,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	28,000,000
Health Research & Graduate Medical Education	0	6,000,000	9,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	85,000,000
Population Health Improvement	1,000,000	2,000,000	5,000,000	7,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	75,000,000
Region-wide Health Information Exchange	0	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	750,000	750,000	750,000	750,000	8,000,000
Totals		\$4,000,000	\$18,000,000	\$31,000,000	\$34,000,000	\$37,000,000	\$37,000,000	\$36,750,000	\$36,750,000	\$36,750,000	\$36,750,000	\$308,000,000

⁵ Per Section 3.01 of the attached Terms of Certification, these annual amounts are incremental to the applicable Annual Baseline Spending Level set forth below.

[NOTE: TO BE UPDATED BASED ON FINAL DATA SUBMITTED BY BALLAD]

ANNUAL BASELINE SPENDING LEVELS⁶

Expanded Access to Healthcare Services:	\$ 73,552,804
Behavioral Health Services	\$ 6,631,379
Children’s Health Services	\$ 4,139,890
Rural Health Services	\$ 62,781,535
Health Research & Graduate Medical Education	\$ 8,757,818
Population Health Improvement	\$ 3,058,977
Region-wide Health Information Exchange	\$ 452,359

Notes on the annual Baseline Spending amounts identified above:

- The Baseline Spending amounts represent the best estimates of the Applicants as of the Issue Date.
- With the written approval of the Department, each annual Baseline Spending amount may be adjusted for:
 - Amounts identified as pending or incomplete as of the Issue Date;
 - Errors, including omitted amounts;
 - Identification of additional components that should have been included in Baseline Spending; or
 - Changes arising out of the New Health System’s merger of each Applicant’s financial records following the Issue Date.
- Once each commitment plan required under Article III is finalized, the New Health System and the State will recalculate the Baseline Spending amount related to such plan to reconcile the expenses and offsetting direct patient service revenue, if any, including the current Baseline Spending amounts with those expenses and offsetting direct patient service revenues, if any, associated with the approved plan. This process will be repeated with each new plan or plan modification.

⁶ For purposes of determining the Baseline Spending Levels, the actual aggregate spending levels for each category were averaged over the three full fiscal years of the Applicants preceding the Issue Date. The period may be shorter for some of the categories.

EXHIBIT C

Access Sub-Index

The Department Access to Health Services Report will include the latest data available to the Department on the measures identified below. The Department and the New Health System, as appropriate, will provide data for the Tennessee Geographic Service Area, as data is available and needed. The Department Access to Health Services Report will be used by the New Health System to report most recent verifiable values available for Measures in the Index, as specified in Section 6.04(b)(xvi). Data reported in the Department Access to Health Services Report and the New Health System Annual Report and other sources as deemed appropriate by the Department will be used to calculate the Sub-Index Score outlined in Exhibit J and trends that will be reported in the Department Annual Report.

Target Access to Health Services Measures will be evaluated for the population specified for each measure. If a population is not specified for a Health Services Measure, the population for that Health Services Measure is the population in the Geographic Service Area. For the first year of the Ten-Year Period, the New Health System will be required to maintain baseline performance on the Target Quality Measures. For Measures where the target is to improve, the New Health System will provide baseline data in the first Population Health Plan. The expectation is for improvement over baseline to be achieved and maintained.

The Target Access to Health Services Measures are identified in Table 1. The Targets and Weights for each measure are specified in Table 2.

Table 1: Measures, Descriptions, and Sources

	Measure	Description	Source
1	Population within 10 miles of an urgent care center (%)	Population within 10 miles of any urgent care center; urgent care centers may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	Tennessee U.S. Census Population Data 2010; Facility Addresses

	Measure	Description	Source
2	Population within 10 miles of an urgent care center open nights and weekends (%)	Population within ten (10) miles of any urgent care center open at least three (3) hours after 5pm Monday to Friday and open at least five (5) hours on Saturday and Sunday; urgent care center may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	Tennessee U.S. Census Population Data 2010; Facility Addresses
3	Population within 10 miles of an urgent care facility or emergency department (%)	Population within 10 miles of any urgent care center or emergency room; urgent care centers and emergency rooms may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	Tennessee U.S. Census Population Data 2010; Facility Addresses
4	Population within 15 miles of an emergency department (%)	Population within 15 miles of any emergency room; emergency rooms may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	Tennessee U.S. Census Population Data 2010; Facility Addresses
5	Population within 15 miles of an acute care hospital (%)	Population within 15 miles of any acute care hospital; acute care hospital may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	Tennessee U.S. Census Population Data 2010; Facility Addresses
6	Pediatric Readiness of Emergency Department	Average score of New Health System Emergency Departments on the National Pediatric Readiness Project Survey from the National EMSC Data Analysis Resource Center	Self-assessment performed by New Health System
7	Excessive Emergency Department Wait Times	Percentage of all hospital emergency department visits in which the wait time to see an emergency department clinician exceeds the recommended timeframe.	New Health System Records; CDC National Center for Health Statistics National Hospital Ambulatory Care Survey
8	Specialist Recruitment and Retention	Percentage of recruitment and retention targets set in the Physician Needs Assessment for specialists and subspecialists to address identified regional shortages	New Health System Records

	Measure	Description	Source
9	Personal Care Provider	Percentage of adults who reported having one person they think of as a personal doctor or health care provider	Behavioral Risk Factor Surveillance System
10	Preventable Hospitalizations – Medicare	Number of discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees	Hospital Discharge Data System, Tennessee Department of Health, Division of Policy, Planning, and Assessment
11	Preventable Hospitalizations – Adults	Number of discharges for ambulatory care-sensitive conditions per 1,000 adults aged 18 years and older	Hospital Discharge Data System, Tennessee Department of Health, Division of Policy, Planning, and Assessment
12	Screening – Breast Cancer	Percentage of women aged 50-74 who reported having a mammogram within the past two years	Behavioral Risk Factor Surveillance System
13	Screening – Cervical Cancer	Percentage of women aged 21-65 who reported having had a pap test in the past three years	Behavioral Risk Factor Surveillance System
14	Screening - Colorectal Cancer	Percentage of adults who meet U.S. Preventive Services Task Force recommendations for colorectal cancer screening	Behavioral Risk Factor Surveillance System
15	Screening – Diabetes	Percentage of diabetes screenings performed by the New Health System for residents aged 40 to 70 who are overweight or obese; Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	New Health System Records
16	Screening – Hypertension	Percentage of hypertension screenings performed by the New Health System for residents aged 18 or older	New Health System Records
17	Asthma ED Visits – Age 0-4	Asthma Emergency Department Visits Per 10,000 (Age 0-4)	Hospital Discharge Data System, Tennessee Department of Health, Division of Policy, Planning, and Assessment

	Measure	Description	Source
18	Asthma ED Visits – Age 5-14	Asthma Emergency Department Visits Per 10,000 (Age 5-14)	Hospital Discharge Data System, Tennessee Department of Health, Division of Policy, Planning, and Assessment
19	Prenatal care in the first trimester	Percentage of live births in which the mother received prenatal care in the first trimester	Birth Statistics, Tennessee Department of Health, Division of Policy, Planning, and Assessment
20	Follow-Up After Hospitalization for Mental Illness	Percentage of adults and children aged 6 years and older who are hospitalized for treatment of selected mental health disorders and had an outpatient visit, and intensive outpatient encounter or a partial hospitalization with a mental health practitioner within seven (7) days post-discharge	New Health System Records; NCQA <i>The State of Health Care Quality Report</i>
21	Follow-Up After Hospitalization for Mental Illness	Percentage of adults and children aged 6 years and older who are hospitalized for treatment of selected mental health disorders and had an outpatient visit, and intensive outpatient encounter or a partial hospitalization with a mental health practitioner within thirty (30) days post-discharge	New Health System Records; NCQA <i>The State of Health Care Quality Report</i>
22	Antidepressant Medication Management – Effective Acute Phase Treatment	Percentage of adults aged 18 years and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on an antidepressant medication for at least 84 days (12 weeks)	New Health System Records; NCQA <i>The State of Health Care Quality Report</i>
23	Antidepressant Medication Management – Effective Continuation Phase Treatment	Percentage of adults aged 18 years and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on an antidepressant medication for at least 180 days (6 months)	New Health System Records; NCQA <i>The State of Health Care Quality Report</i>
24	Engagement of Alcohol or Drug Treatment	Adolescents and adults who initiated treatment and who had two or more additional services with a diagnosis of alcohol or other drug dependence within 30 days of the initiation visit.	New Health System Records; NCQA <i>The State of Health Care Quality Report</i>

	Measure	Description	Source
25	SBIRT administration - hospital admissions	Percentage of patients admitted to a New Health System hospital who are screened for alcohol and substance abuse, provided a brief intervention, and referred to treatment (SBIRT)	New Health System Records
26	Rate of SBIRT administration - ED visits	Percentage of patients admitted to a New Health System emergency department who are screened for alcohol and substance abuse, provided a brief intervention, and referred to treatment (SBIRT)	New Health System Records
27	Patient Satisfaction and Access Surveys	Successful completion of patient satisfaction and access surveys, according to Section 4.02(c)(iii)	New Health System Records
28	Patient Satisfaction and Access Survey – Response Report	Report documents a satisfactory plan for the New Health System to address deficiencies and opportunities for improvement related to perceived access to care services and documents satisfactory progress towards the plan.	New Health System Records

Table 2: Targets and Weights for Access Measures

	Measure	Target*	Weight
1	Population within 10 miles of an urgent care center (%)	Maintain or improve	4.0%
2	Population within 10 miles of an urgent care center open nights and weekends (%)	Maintain or improve	4.0%
3	Population within 10 miles of an urgent care facility or emergency department (%)	Maintain or improve	4.0%
4	Population within 15 miles of an emergency department (%)	Maintain or improve	4.0%
5	Population within 15 miles of an acute care hospital (%)	Maintain or improve	4.0%
6	Pediatric Readiness of Emergency Department	Improve	4.0%
7	Excessive Emergency Department Wait Times	Maintain or improve	3.0%

	Measure	Target*	Weight
8	Specialist Recruitment and Retention	Improve	3.0%
9	Personal Care Provider	Maintain or improve	3.5%
10	Preventable Hospitalizations – Medicare	Improve	2.5%
11	Preventable Hospitalizations – Adults	Improve	3.5%
12	Screening – Breast Cancer	Improve	2.0%
13	Screening – Cervical Cancer	Improve	2.0%
14	Screening - Colorectal Cancer	Improve	2.0%
15	Screening – Diabetes	Improve	3.0%
16	Screening – Hypertension	Improve	4.0%
17	Asthma ED Visits – Age 0-4	Improve	2.5%
18	Asthma ED Visits – Age 5-14	Improve	2.5%
19	Prenatal care in the first trimester	Improve	2.0%
20	Follow-Up After Hospitalization for Mental Illness	Improve	3.5%
21	Follow-Up After Hospitalization for Mental Illness	Improve	3.5%
22	Antidepressant Medication Management – Effective Acute Phase Treatment	Improve	1.5%
23	Antidepressant Medication Management – Effective Continuation Phase Treatment	Improve	1.5%
24	Engagement of Alcohol or Drug Treatment	Improve	3.5%
25	Rate of SBIRT administration - hospital admissions	Improve	3.5%
26	Rate of SBIRT administration - ED visits	Improve	3.5%

	Measure	Target*	Weight
27	Patient Satisfaction and Access Surveys	Successful completion of patient satisfaction and access surveys, according to Section 4.02(c)(iii)	10%
28	Patient Satisfaction and Access Survey – Response Report	Report documents a satisfactory plan for the New Health System to address deficiencies and opportunities for improvement related to perceived access to care services and documents satisfactory progress towards the plan.	<u>10%</u>
		TOTAL	100%

* For measures where the target is to improve, the New Health System will provide baseline data and recommended targets in the first Population Health Plan.

EXHIBIT D

Population Sub-Index

The Department Population Health Report will include the latest data available to the Department on the measures identified below. The Department and the New Health System, as appropriate, will provide data for the Tennessee Geographic Service Area, Tennessee Peer Counties, Tennessee, and United States, as data is available at each level. This Department Population Health Report will be used by the New Health System to report most recent verifiable values available for Measures in the Index, as specified in Section 6.04(b)(xvi). Data reported in the Department Population Health Report and the New Health System Annual Report and other sources as deemed appropriate by the Department will be used to calculate the Sub-Index Score outlined in Exhibit J and trends that will be reported in the Department Annual Report.

The Measures, data sources, and methods may be changed at the Department's discretion. The Department may consult on any proposed changes with the New Health System.

Definitions

In addition to the terms defined in Article I of the Terms of Certification to which this Exhibit is attached, and terms defined elsewhere in this Exhibit, the following definitions shall apply to this Exhibit:

“Baseline” means the value of each individual measure available as of the year of the Issue Date.

“Comparison Geographies” means Tennessee Peer Counties, Tennessee, and the United States.

“Priority Population Health Measures” or “Priority Measures”, as the context requires, means the list of 25 measures set forth in Table 1 below.

“Population Health Monitoring Measures” means the remaining measures listed in Table 2 below that are not Priority Population Health Measures and that will be monitored by the Department and the New Health System.

“Tennessee Peer Counties” means the counties selected by the Department for use as a comparison group for measuring outcomes in the COPA Index; these counties include the following Tennessee Counties: Anderson, Cannon, Claiborne, Cumberland, Jefferson, McMinn, Marion, Monroe, Putnam, Roane, Sevier, and White.

“Year 1” means the period that begins with the Issue Date and concludes on June 30, 2019.

Table 1: Department 25 Priority Population Health Measures

The following Priority Population Health Measures have been identified by the Department as being closely related to the Department’s health planning goals set out in the State Health Plan. The New Health System will be evaluated on improvement in these measures. If a population is not specified for a Priority Population Health Measure, the population for that Priority Population Health Measure is the population in the Geographic Service Area.

- 1 Smoking
- 2 Mothers who Smoke During Pregnancy
- 3 Youth Tobacco Use
- 4 Physically Active Adults
- 5 Physically Active Students
- 6 Obesity – Counseling & Education
- 7 Overweight and Obesity Prevalence among TN Public School Students
- 8 Average mPINC Score
- 9 Breastfeeding Initiation
- 10 Infants Breastfed at Six (6) Months
- 11 NAS Births
- 12 Drug Deaths
- 13 Adults – Prescription Drugs
- 14 Children - On-time vaccinations
- 15 Vaccinations - HPV Females
- 16 Vaccinations - HPV Males
- 17 Vaccinations - Flu Vaccine, Older Adults
- 18 Teen Pregnancy Rate
- 19 Third Grade Reading Level
- 20 Dental Sealants

- 21 Frequent Mental Distress
- 22 Infant Mortality
- 23 Low Birthweight
- 24 Increase the number of People with Pre-Diabetes who are Identified and Referred to a Prevention Program.
- 25 Ratio of Premature Deaths (Higher Density / Lower Density Counties)

Beginning in Year 3, the following weights will be applied to the Priority Health Population Measures:

	Priority Measure	Weight
1	Smoking	4.0%
2	Mothers who Smoke During Pregnancy	4.0%
3	Youth Tobacco Use	6.0%
4	Physically Active Adults	2.0%
5	Physically Active Students	6.0%
6	Obesity – Counseling & Education	4.0%
7	Overweight and Obesity Prevalence among TN Public School Students	6.0%
8	Average mPINC Score	4.0%
9	Breastfeeding Initiation	4.0%
10	Infants Breastfed at Six (6) Months	4.0%
11	NAS Births	6.0%
12	Drug Deaths	4.0%
13	Adults - Prescription Drugs	4.0%
14	Children - On-time vaccinations	4.0%
15	Vaccinations - HPV Females	2.0%
16	Vaccinations - HPV Males	4.0%

	Priority Measure	Weight
17	Vaccinations - Flu Vaccine, Older Adults	2.0%
18	Teen Pregnancy Rate	4.0%
19	Third Grade Reading Level	6.0%
20	Dental Sealants	4.0%
21	Frequent Mental Distress	2.0%
22	Infant Mortality	4.0%
23	Low Birthweight	4.0%
24	Increase the proportion of adults with pre-diabetes who are identified and referred to a prevention program.	2.0%
25	Ratio of Premature Deaths (Higher Density / Lower Density Counties)	4.0%
	TOTAL	100%

Scores for the Priority Population Health Measures and related investment and planning processes will be calculated by the Department annually according to the following schedule:

Year 1

For Year 1, the Population Health Sub-Index will be calculated as follows:

<u>Sec.</u>	<u>Commitment/Outcome</u>	<u>Year 1 Percentage Weight</u>
3.04(a)	Investment – Population Health	25
3.04(b)	Implementation of the Population Health Plan	35
	Achievement of Process Measures Identified in Population Health Plan	<u>40</u>
	Total	<u>100</u>

Process / Investment Phase – Year 2

For year 2 in the Process / Investment Phase, the Population Health Sub-Index will be calculated as follows:

<u>Sec.</u>	<u>Commitment/Outcome</u>	<u>Year 2 Percentage Weight</u>
3.04(a)	Investment – Population Health	25
	Achievement of Process Measures identified in the Population Health Plan and augmentation of the Population Health Plan	<u>75</u>
	Total	<u>100</u>

Process / Investment Phase – Year 3

For year 3 in the Process / Investment Phase, the Population Health Sub-Index will be calculated as follows:

<u>Sec.</u>	<u>Commitment/Outcome</u>	<u>Year 3 Percentage Weight</u>
3.04(a)	Investment – Population Health	25
	Achievement of Process Measures identified in the Population Health Plan and augmentation of the Population Health Plan	65 to 75
	Improvement in Priority Measures as compared to Tennessee Geographic Service Area Baseline	<u>0 to10</u>
	Total	<u>100</u>

Progress / Improvement Phase – Years 4, 5, 6, and 7

For each year in the Progress / Improvement Phase, the Population Health Sub-Index will be calculated as follows:

<u>Commitment/Outcome</u>	<u>Years 4, 5, 6, and 7 Percentage Weight</u>
Achievement of Process Measures identified in the Population Health Plan for new initiatives, if any	0 to 25%, <i>as appropriate</i>
Improvement in Priority Measures as compared to Tennessee Geographic Service Area Baseline	<u>75 to 100%</u>
Total	<u>100</u>

- Improvement for a given measure will be determined by comparing the Rate of Change in the Tennessee Geographic Service Area prior to the Issue Date to the Rate of Change in the Tennessee Geographic Service Area between Baseline and the respective year, as determined by the Department.
- Extra Credit: Geographic Service Area measures that are better than existing Tennessee and/or US numbers at Baseline do not qualify for extra credit consideration. A credit of between 0-1% may be given per measure, at the discretion of the Department, for up to 10 measures that improve over the Baseline Tennessee and/or US measures, for a maximum of 5% total available extra credit.

Outcome Phase – Years 8, 9, and 10

For each year in the Outcome Phase, the Population Health Sub-Index will be calculated using the following two sets of measures:

<u>Commitment/Outcome</u>	<u>Years 8, 9, and 10 Percentage Weight</u>
Achievement of Process Measures identified in the Population Health Plan for new initiatives, if any	Up to 25%, <i>as appropriate</i>
Improvement in Priority Measures as compared to Tennessee Geographic Service Area Baseline	37.5 to 50%
Improvement in Priority Measures as compared to Tennessee Peer Counties	<u>37.5 to 50%</u>
Total	<u>100</u>

- Improvement for a given measure will be determined by comparing the Rate of Change in the Tennessee Geographic Service Area prior to the Issue Date to the Rate of Change in the Tennessee Geographic Service Area between Baseline and the respective year, as determined by the Department.
- Extra Credit: Geographic Service Area measures that are better than existing Tennessee and/or US numbers at Baseline do not qualify for extra credit consideration. A credit of between 0-1% may be given per measure, at the discretion of the Department, for up to 10 measures that improve over the Baseline Tennessee and/or US measures, for a maximum of 5% total available extra credit.

Table 2: Measures, Descriptions, and Sources

The following Population Health Measures includes the 25 Priority Population Health Measures listed in Table 1 as well as the 31 additional Population Health Monitoring Measures that will be tracked by the Department for monitoring purposes only.

	Measure	Description	Source
1	Smoking	Percentage of adults who are self-reported smokers (smoked at least 100 cigarettes in their lifetime and currently smoke).	Behavioral Risk Factor Surveillance System
2	Smoking in higher density counties	<u>TN COPA Value</u> : Percentage of adults in Hamblen, Sullivan, and Washington counties who are self-reported smokers (smoked at least 100 cigarettes in their lifetime and currently smoke); <u>TN & U.S. Values</u> : Not stratified by population density.	Behavioral Risk Factor Surveillance System
3	Smoking in lower density counties	<u>TN COPA Value</u> : Percentage of adults in Carter, Cocke, Greene, Hancock, Hawkins, Johnson, and Unicoi counties who are self-reported smokers (smoked at least 100 cigarettes in their lifetime and currently smoke); <u>TN & U.S. Values</u> : Not stratified by population density.	Behavioral Risk Factor Surveillance System
4	Smoking among those with less than a high school education	Percentage of adults with less than a high school education who are self-reported smokers (smoked at least 100 cigarettes in their lifetime and currently smoke).	Behavioral Risk Factor Surveillance System
5	Smoking among those with a high school education or more	Percentage of adults with high school education or more who are self-reported smokers (smoked at least 100 cigarettes in their lifetime and currently smoke).	Behavioral Risk Factor Surveillance System

	Measure	Description	Source
6	Mothers who smoke during pregnancy	Percentage of mothers who report smoking during pregnancy (%).	Birth Statistics, Tennessee Department of Health, Division of Policy, Planning, and Assessment
7	Youth Tobacco Use	Percentage of High School Students who self-reported currently using tobacco (used cigarettes, cigars, chewing tobacco, snuff, or pipe tobacco within the 30 days before the survey).	National Survey on Drug Use and Health
8	Youth - Ever Tried Cigarette Smoking	Percentage of High School Students who self-reported ever trying cigarette smoking, even one or two puffs.	Tennessee Youth Risk Behavior Survey
9	Smoker in the household	Percent of children who live in a household in which someone uses cigarettes, cigars, or pipe tobacco.	Behavioral Risk Factor Surveillance System
10	Physically Active Adults	Adults who reported participating in physical activity such as running, calisthenics, golf, gardening, or walking for exercise over the past month.	Behavioral Risk Factor Surveillance System
11	Physically Active Students	Percentage of High School Students who were not physically active 60+ minutes per day for 5 or more days in last 7 days.	Tennessee Youth Risk Behavior Survey
12	Adult Obesity	Percentage of adults with a body mass index of 30.0 or higher based on reported height and weight.	Behavioral Risk Factor Surveillance System
13	Obesity in higher density counties	<u>TN COPA Value</u> : Percentage of adults in Hamblen, Sullivan, and Washington counties with a body mass index of 30.0 or higher based on reported height and weight; <u>TN & U.S. Values</u> : Not stratified by population density.	Behavioral Risk Factor Surveillance System
14	Obesity in lower density counties	<u>TN COPA Value</u> : Percentage of adults in Carter, Cocke, Greene, Hancock, Hawkins, Johnson, and Unicoi counties with a body mass index of 30.0 or higher based on reported height and weight; <u>TN & U.S. Values</u> : Not stratified by population density.	Behavioral Risk Factor Surveillance System
15	Obesity among those with less than a high school education	Percentage of adults with less than a high school education with a body mass index of 30.0 or higher based on reported height and weight.	Behavioral Risk Factor Surveillance System

	Measure	Description	Source
16	Obesity among those with a high school education or more	Percentage of adults with a high school education or more with a body mass index of 30.0 or higher based on reported height and weight.	Behavioral Risk Factor Surveillance System
17	Obesity Subpopulation Measure	Increase the proportion of physician office visits that include counseling or education related to weight and physical activity.	Data Collection to be led by the New Health System
18	Overweight and obesity prevalence among TN public school students	Proportion of public school students in grades kindergarten, 2, 4, 6, 8, and one year of high school found to be overweight or obese during the school year.	Coordinated School Health Annual Report
19	Average mPINC Score	Maternity Practices in Infant and Nutrition Care survey score based on seven birth facility policies and practices with higher scores denoting better maternity care practices and policies.	CDC Survey of Maternity Practices in Infant Nutrition and Care (mPINC)
20	Breastfeeding Initiation	<u>TN COPA, Peer, and TN Values:</u> Percent of live births whose birth certificates report that baby is breastfed. <u>US Value:</u> Proportion of infants who are ever breastfed.	Birth Statistics, Tennessee Department of Health, Division of Policy, Planning, and Assessment CDC National Immunization Survey
21	Infants breastfed at six (6) months	Percent of infants aged six (6) months whose guardians report at well-child visits they continue to be breastfed.	Data Collection to be led by the New Health System
22	High School Students - Fruit	Percent of high school students who reported not eating fruit or drinking 100% fruit juice during the past 7 days.	Tennessee Youth Risk Behavior Survey
23	High School Students – Vegetables	Percent of high school students who reported not eating vegetables during the past 7 days.	Tennessee Youth Risk Behavior Survey
24	High School Students – Soda	Percent of high school students who report drinking one or more sodas per day for the past 7 days.	Tennessee Youth Risk Behavior Survey
25	NAS (Neonatal Abstinence Syndrome) Births	Number of reported cases with clinical signs of withdrawal per 1,000 TN resident live births.	Tennessee Neonatal Abstinence Syndrome Surveillance System

	Measure	Description	Source
26	Drug Deaths	All drug overdose deaths of Tennessee residents caused by acute poisonings, regardless of intent.	Death Statistics, Tennessee Department of Health, Division of Policy, Planning, and Assessment
27	Drug Overdoses	Non-fatal overdoses of Tennessee residents caused by acute poisonings, regardless of intent.	Hospital Discharge Database System, Tennessee Department of Health, Division of Policy, Planning, and Assessment
28	Painkiller Prescriptions	Opioid prescriptions for pain to patients in Tennessee.	Controlled Substance Monitoring Database
29	High School Students – Prescription Drugs	Percent of high school students who report ever taking prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life).	National Survey on Drug Use and Health
30	Adults – Prescription Drugs	Adults who report using prescription drugs not prescribed by the doctor during the past 30 days.	National Survey on Drug Use and Health
31	Children - On-time Vaccinations	Children receiving on-time vaccinations (% of children aged 24 months receiving 4:3:1:FS:3:1:4 series).	Tennessee Immunization Status Survey
32	Facility OR Population participation in TennIIS	By the end of the first year, link 90% of New Health System facilities in Tennessee to TennIIS.	New Health System and Department Records
33	Vaccinations - HPV Females	Percentage of females aged 13 to 17 years who received ≥ 3 doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent.	Data Collection to be led by the New Health System
34	Vaccinations - HPV Males	Percentage of males aged 13 to 17 years who received ≥ 3 doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent.	Data Collection to be led by the New Health System

	Measure	Description	Source
35	Vaccinations - Meningococcal	Percentage of adolescents aged 13 to 17 years who received ≥ 1 dose of meningococcal conjugate vaccine (MenACWY).	Data Collection to be led by the New Health System
36	Vaccinations - Tdap	Percentage of adolescents aged 13 to 17 years who received ≥ 1 dose of tetanus-diphtheria-acellular pertussis (Tdap) vaccine since age 10 years.	Data Collection to be led by the New Health System
37	Vaccinations - Flu Vaccine, Older Adults	Percent of adults aged 65 and over who self-reported receiving a flu shot or flu vaccine sprayed in nose in the past 12 months.	Behavioral Risk Factor Surveillance System
38	Vaccinations – Flu Vaccine, Adults	Percent of adults aged 18 and over who self-reported receiving a flu shot or flu vaccine sprayed in nose in the past 12 months.	Behavioral Risk Factor Surveillance System
39	Teen Pregnancy Rate	Rate of pregnancies per 1,000 females aged 15-19 years.	Birth Statistics, Tennessee Department of Health, Division of Policy, Planning, and Assessment
40	Third Grade Reading Level	3rd graders scoring “proficient” or “advanced” on TCAP reading assessment (%).	Tennessee Department of Education Base Accountability Files
41	Third Grade Reading Level – Higher Density Counties	<u>TN COPA Value</u> : 3rd graders in Hamblen, Sullivan, and Washington counties who score “proficient” or “advanced” on TCAP reading assessment (%); <u>TN & U.S. Values</u> : Not stratified by population density	Tennessee Department of Education Base Accountability Files
42	Third Grade Reading Level – Lower Density Counties	<u>TN COPA Value</u> : 3rd graders in Carter, Cocke, Greene, Hancock, Hawkins, Johnson, and Unicoi counties who score “proficient” or “advanced” on TCAP reading assessment (%); <u>TN & U.S. Values</u> : Not stratified by population density.	Tennessee Department of Education Base Accountability Files
43	Fluoridated Water	Percent of population on community water systems (CWS) receiving fluoridated water.	CDC, My Water’s Fluoride
44	Children receiving dental sealants	Children receiving dental sealants on permanent first molar teeth (% , 6–9 years).	Data Collection to be led by the New Health System

	Measure	Description	Source
45	Adolescents receiving dental sealants	Adolescents receiving dental sealants on their first and second permanent molars (% , 13–15 years).	Data Collection to be led by the New Health System
46	Frequent Mental Distress	Percentage of adults who reported their mental health was not good 14 or more days in the past 30 days.	Behavioral Risk Factor Surveillance System
47	Frequent Physical Distress	Percentage of adults who reported their physical health was not good 14 or more days in the past 30 days.	Behavioral Risk Factor Surveillance System
48	Infant Mortality	Number of infant deaths (before age 1) per 1,000 live births.	Birth Statistics, Tennessee Department of Health, Division of Policy, Planning, and Assessment
49	Low Birthweight	Percentage of infants weighing less than 2,500 grams (5 pounds, 8 ounces) at birth.	Birth Statistics, Tennessee Department of Health, Division of Policy, Planning, and Assessment
50	Child Mortality	Number of deaths per 100,000 children aged 1 to 18 years.	Death Statistics, Tennessee Department of Health, Division of Policy, Planning, and Assessment
51	Deaths from Diseases of the Heart	Number of deaths due to diseases of the heart per 100,000 population.	Death Statistics, Tennessee Department of Health, Division of Policy, Planning, and Assessment
52	Cancer Deaths	Number of deaths due to all causes of cancer per 100,000 population.	Death Statistics, Tennessee Department of Health, Division of Policy, Planning, and Assessment

	Measure	Description	Source
53	Diabetes Deaths	Number of deaths due to diabetes per 100,000 population.	Death Statistics, Tennessee Department of Health, Division of Policy, Planning, and Assessment
54	Diabetes Adverse Events	Increase the number of people with pre-diabetes who are identified and referred to a prevention program.	Data Collection to be led by the New Health System
55	Suicide Deaths	Number of deaths due to intentional self-harm per 100,000 population.	Death Statistics, Tennessee Department of Health, Division of Policy, Planning, and Assessment
56	Premature Death Ratio	Ratio of years lost before age 75 per 100,000 population for higher density counties to lower density counties.	Death Statistics, Tennessee Department of Health, Division of Policy, Planning, and Assessment

EXHIBIT E

Essential Services For Repurposed COPA Hospitals

- Emergency room stabilization for patients;
- Emergent obstetrical care;
- Outpatient diagnostics needed to support emergency stabilization of patients;
- Rotating clinic or telemedicine access to specialty care consultants as needed in the community;
- Helicopter or high acuity transport to tertiary care centers;
- Mobile health services for preventive screenings, such as mammography, cardiovascular and other screenings;
- Primary care services, including lab services;
- Physical therapy rehabilitation services;
- Care coordination service;
- Access to a behavioral health network of services through a coordinated system of care; and
- Community-based education, prevention and disease management services for prioritized programs of emphasis based on goals established in collaboration with the Department.

EXHIBIT F

ACTIVE SUPERVISION STRUCTURE

The Active Supervision structure required by the COPA Act shall include a COPA Compliance Office, a Local Advisory Council, and a COPA Monitor, in addition to the Commissioner of the Department of Health (“Commissioner”) and the Department of Health’s Division of Health Planning (“Department”). A general description of the duties and responsibilities of these individuals and entities is set out in this Exhibit F.

1. Definitions

In addition to the terms defined in Article I of the Terms of Certification to which this Exhibit is attached, and terms defined elsewhere in this Exhibit, the following definitions shall apply to this Exhibit:

“Enforcement Mechanisms” means any Corrective Action taken by the Department or required of the New Health System to enforce the COPA, including the Terms of Certification.

“COPA Monitor Annual Report” means the report prepared by the COPA Monitor for the Department and the Commissioner, as more particularly described in Section 4 herein.

“COPA Compliance Officer” means the person appointed by the New Health System and approved by the Commissioner to lead the COPA Compliance Office described in Section 2 herein.

“COPA Compliance Office Annual Report” means the report prepared by the COPA Compliance Office for the Department, as more particularly described in Section 2 herein.

“Department Annual Report” means the report published by the Department to fulfill the requirements of Tenn. Comp. R. & Regs. Ch. 1200-38-01-.06, which will include determinations of compliance, the Index scores, the Final Score, the Pass/Fail Grade, and trends relevant to the Active Supervision of the COPA and continued Public Advantage, as more particularly described in Section 6 herein.

2. COPA Compliance Office

The COPA Compliance Officer and his/her representatives (collectively, the “COPA Compliance Office”) will provide an initial step for resolution of complaints that are believed to relate to the requirements of the COPA and the Terms of Certification. The COPA Compliance Office will establish a compliance plan annually, which shall be presented to, and approved by, the Audit and Compliance Committee of the Board, and will seek to resolve any compliance issue based on the facts of any investigation or review. The COPA Compliance Officer shall, at all times, be an individual with proper training in compliance, be qualified to perform investigatory functions, and be knowledgeable generally about hospital and health system operations. The COPA Compliance Officer will be employed by the New Health System but his/her employment

can only be terminated with the written approval of the Commissioner. The COPA Compliance Officer will report directly to the Audit and Compliance Committee of the Board.

The New Health System shall establish a process for receipt of all compliance complaints, and for all COPA-related complaints to be referred promptly to the COPA Compliance Officer.

The duties and responsibilities of the COPA Compliance Office include, but are not limited to, the following:

- Review any complaint, and, when appropriate, investigate and ascertain the facts. Recommend corrective action if a violation of the COPA has occurred.
- If a violation of the COPA is asserted by a Payor, gather the facts. If there is Noncompliance, make a recommendation to management for corrective action, including, if feasible, any recommendations for a cure, and report such Noncompliance and recommendations to the Audit and Compliance Committee of the Board.
- Provide employees of the New Health System the ability to register complaints related to the COPA and the Terms of Certification. Employees shall have the ability to make complaints in an anonymous manner, and the COPA Compliance Office will protect the identity of any such employee.
- Complaints related to the COPA or the Terms of Certification that the COPA Compliance Officer cannot resolve shall be referred to the Audit and Compliance Committee of the Board for direction as to resolution.
- Prepare a log documenting all complaints (and the resolution, if any, of such complaints) related to the COPA and the Terms of Certification. No less than semi-annually, the COPA Compliance Office shall prepare a report containing all complaints, findings, resolutions and open items. Each report shall be simultaneously delivered to the Audit and Compliance Committee of the Board and the COPA Monitor.
- Identify potential systemic problems, particularly those related to compliance with the COPA and the Terms of Certification.
- Prepare and submit the COPA Compliance Office Annual Report, which shall include an account of the activities of the Office, including the number and nature of complaints, identification of any potential violations of the COPA and the Terms of Certification, and other items as identified by the Department. The COPA Compliance Office Annual Report shall be submitted, if not sooner, according to the same time frame applicable to the submission of the Annual Report of the New Health System. See Section 6.04(b) of the Terms of Certification.
- Provide for access to services of the COPA Compliance Office across the Geographic Service Area.
- Prepare a forecast of expenses on an annual basis which supports the functions of the program.

3. Local Advisory Council

Based on a recommendation from the Advisory Group in May 2016, promptly following the Issue Date the Commissioner will appoint a Local Advisory Council (the “Local Advisory Council”) to facilitate input from residents of the Geographic Service Area. This council will be

comprised of 8-10 community leaders from a range of organizations and backgrounds. Members of the Local Advisory Council shall reside in the Geographic Service Area.

The duties and responsibilities of the Local Advisory Council are limited to recommending to the Department how funds in the Population Health Initiatives Fund should be spent.

4. COPA Monitor

The State of Tennessee will retain a COPA Monitor (the “COPA Monitor”) that will be responsible for evaluating the continued Public Advantage of the COPA by monitoring the New Health System’s compliance with the COPA and the Terms of Certification, and by collaborating with the Department to evaluate performance against the Index. The COPA Monitor will be an independent firm with sufficient expertise (or the ability to contract for such expertise) in hospital finance and accounting, auditing, population health management, community health improvement, and data/statistics. The New Health System will be responsible for the expenses related to the COPA Monitor pursuant to Tenn. Code Ann. § 68-11-1307 and COPA Rule 1200-38-01-.03(1).

The duties and responsibilities of the COPA Monitor include, but are not limited to, the following:

- Review the Required Reports from the New Health System for completeness and compliance with the COPA and the Terms of Certification.
- Review the semi-annual reports of the COPA Compliance Officer concerning complaints related to the COPA or the Terms of Certification.
- Conduct audits on a regular basis as needed to verify information provided in the Required Reports and/or to determine compliance with the COPA and the Terms of Certification.
- Review and make recommendations to the Commissioner concerning any requests for modification of any provision of the COPA and the Terms of Certification submitted by the New Health System.
- Based on review of the Required Reports and audits, report on a regular basis as needed to the Commissioner and the Department any findings of Noncompliance or any areas where the New Health System did not achieve target outcomes and/or failed to meet the Index scores needed to demonstrate continued Public Advantage, along with any recommendations of Enforcement Mechanisms.
- No later than the end of February, provide the COPA Monitor Annual Report to the Commissioner and the Department, which shall include without limitation the following: the Index scores, updates on compliance with the COPA and the Terms of Certification, the status of existing Corrective Actions, any recommended Enforcement Mechanisms, if necessary, any additional findings of the COPA Monitor, and any other information requested by the Department.

5. The Commissioner

Pursuant to Tennessee law, the Department is tasked with reviewing, seeking modification of, or terminating a COPA. (Tenn. Code Ann. § 68-11-1303(g)).

The duties and responsibilities of the Commissioner, include, but are not limited to, the following:

- Review findings and recommendations from the COPA Monitor.
- The determination or finding of the continued existence of Public Advantage (or lack thereof).
- In coordination and consultation with the Attorney General, determine necessary Enforcement Mechanisms based on findings identified by the COPA Monitor.

6. Division of Health Planning

The Department's Division of Health Planning will coordinate ongoing monitoring of the New Health System through the COPA Monitor, and provide advice to the Commissioner.

The duties and responsibilities of the Division of Health Planning include, but are not limited to, the following:

- Contract Management.
 - In coordination with the Attorney General and the Department's Procurement Office, coordinate engagement of the COPA Monitor.
 - Oversee the work product of the COPA Monitor and confirm such work product fulfills required obligations.
- Coordinate with the COPA Monitor.
 - Assist the COPA Monitor in obtaining relevant data from the Department and other sources.
- Staff Support to the Local Advisory Council.
 - Assist the Commissioner in identifying and appointing members to the Local Advisory Council.
- Department Annual Report.
 - Draft the Department Annual Report that incorporates findings from (i) the New Health System Periodic Reports, (ii) the COPA Compliance Office Annual Report, (iii) the COPA Monitor Annual Report, (iv) the Healthcare Access Sub-Index, and (v) the Population Health Sub-Index.
 - The Department Annual Report shall be published no later than thirty (30) days after the publication of the COPA Monitor Annual Report

[TO BE PROVIDED]

EXHIBIT G

Forms of Annual Report and Quarterly Report

ANNUAL REPORT CONTENTS:

- Facility Maintenance and Capital Expenditures. Schedule of all maintenance and repair expenses and capital expenditures during the year; Section 3.07(b). Beginning with the NHS Annual Report for third Fiscal Year, NHS shall report whether it has met or exceeded aggregate capital expenditure spending commitments for prior three years per Capital Plan; Section 3.07(b).
- Career Development Plan. Explain implementation and results; Section 3.08(c).
- Clinical Counsel. Common standard of care, credentialing standards, consistent multidisciplinary peer review, and best practices; Section 4.02(b)(v).
- Integrated Delivery System Measures. Common and comprehensive set of measures and protocols that will be part of the IDS; track and monitor opportunities to improve health care and access; Section 4.02(c)(i).
- Quality Indicators. Summary of all results of quality indicators; include comparisons to similarly sized systems in the United States; Section 4.02(c)(ii).
- Patient Satisfaction Survey. Results of the patient satisfaction surveys* required of the NHS; Section 4.02(c)(iii).
- Staffing Ratios. Including hours of patient care delivered per patient and ratio of RN to LPN and other caregivers** ; Section 4.02(c)(iv).
- Staff Survey. Results of the 3-year survey of physician and employee satisfaction***; Section 4.02(c)(v).
- Monitoring Reports
 - o Patient-related prices charged; Section 6.04(b)(i).
 - o Cost-efficiency steps taken; Section 6.04(b)(ii).
 - o Equalization Plan status; Section 6.04(b)(iii).
 - o Updates and implementation of the Population Health Plan and the HR/GME Plan; Section 6.04(b)(iv).
 - o Services or Functions Consolidated; Section 6.04(b)(v).
 - o Changes in volume or availability of inpatient or outpatient services; Section 6.04(b)(vi).
 - o Summary of residency program; Section 6.04(b)(vii).
 - o Movement of any residency “slots”; Section 6.04(b)(viii).
 - o Academic partnerships – money spent, summary of research, status of grant(s); Section 6.04(b)(ix).
 - o Outcomes of previously reported research projects; Section 6.04(b)(x).

- Summary of quality performance standards and best practices established by the Clinical Counsel in Section 4.02(b); Section 6.04(b)(xi).
- Updated Plan of Separation; Section 6.04(b)(xii).
- Comparison of NHS financial ratios with similar health systems; Section 6.04(b)(xiii).
- Total Charity Care information described in Section 4.03(f); Section 6.04(b)(xiv).
- Updated NHS organizational chart including listing of corporate officers and members of the Board; Section 6.04(b)(xv).
- Most recent verifiable values available for Measures in Index; Section 6.04(b)(xvi).
- Information expressly required for the Annual Report pursuant to any other Section of this COPA or the COPA Act; Section 6.04(b)(xviii).
- Summary comparison by COPA Hospital or other applicable healthcare provider affiliated with the NHS of price increase for the NHS to Measured Payors; Addendum 1, Section 9.1(d)(i).
- Summary comparison by COPA Hospital or other applicable healthcare provider affiliated with the NHS of price decreases for the NHS to Measured Payors; Addendum 1, Section 9.1(d)(ii).
- A summary comparison and by the applicable NHS provider, showing gross revenue and net revenue by Measured Payors; Addendum 1, Section 9.1(d)(iii).
- A list of any new Payors which executed Managed Care Contracts during the preceding calendar year and a verified certification from the New Health System Chief Financial Officer that the pricing for such contracts complies with Addendum 1; Addendum 1, Section 9.1(d)(iv).
- All charges and charge increases for non-hospital outpatient services, Physician Services, Charge-Based Items and Cost-Based Items for Measured Payors; Addendum 1, Section 9.1(d)(v).
- A report of chargemaster increases, by year and by provider, showing the impact on Measured Payors of such increases to the extent the increase required an adjustment described in Part VI or Part VII of Addendum 1; Addendum 1, Section 9.1(d)(vi).
- A summary of all value-based payments, broken out by COPA Hospital and by Measured Payor, including a comparison of such payments to the prior year's value-based payments from such Measured Payor; Addendum 1, Section 9.1(d)(vii).

*Form and frequency of survey shall be approved by the Department.

**The manner of calculating the exact ratios shall be approved by the Department.

***The Summary Form shall be approved by the Department.

QUARTERLY REPORT CONTENTS

The Department reserves the right to change these quarterly reporting requirements upon adequate notice.

- Any revisions to Charity Care Policy; Section 4.03(e).
- Report of Population Health and Social Responsibility Committee meetings and member attendance at meeting; Section 4.04(e).
- Key Financial Metrics (comparing each to same quarter in prior year and the quarter prior to the quarter in question); Section 6.04(c).
 - o Balance sheet
 - o Statements of income and cash flow
- YTD Community Benefit Spending per Form 990 reporting guidelines for each reporting entity.
 - o By Category, compared to commitment spending
 - Progress towards distributing grants
 - Internal spending
- Quality Metrics reported to CMS
- Once, within thirty (30) days of the Issue Date: a List of Ancillary and Post-Acute Services offered by competitors (with respect to each COPA Hospital); Section 5.04(a).
 - o Includes but is not limited to: SNF; home health providers; diagnostic service providers; imaging centers; ambulatory surgery centers; etc.
 - o Include at least three competitors for each category of service.
- Status of any outstanding Cures, Corrective Actions, or other remedial actions.
- Any requirements or commitments outlined in the Terms of Certification or in the Index which the New Health System is not meeting or anticipates it will not meet
- Closures / Openings
 - o Plans. Update on plans to close or open any Service Lines or facilities.
 - o Progress. Update on the status of any closures or openings of facilities or Service Lines.
- The COPA Compliance Office Quarterly Reports:
 - o Complaints by type
 - o Resolution of complaints
 - o Status update of any unresolved complaints from previous COPA Compliance Office Quarterly Reports.

EXHIBIT H

REMEDIAL CONTRIBUTIONS

Pursuant to Section 6.05(d) of the Terms of Certification, the Department may assess remedial contribution payments (referred to herein as “fines”) for Noncompliance. The following tables provide the specific sections subject to fines for Noncompliance, and the range thereof within which the Department shall designate a specific amount for each Noncompliance.

I. FINE RANGE \$10,000 - \$100,000

For any Noncompliance that is not Cured relating to any Term or Condition in any of the following sections, the Department may assess a fine in the range of \$10,000 - \$100,000 as follows:

<u>Sec.</u>	<u>Commitment</u>
4.02(b)	Clinical Council
4.02(c)	Data Collection; Reports to the Department
4.02(d)	Quality Reporting to the Public
6.04	Monitoring – Reporting Requirements (each fine in the range noted above would apply per each day late)

II. FINE RANGE \$101,000 - \$250,000

For any Noncompliance that is not Cured relating to any Term or Condition in any of the following sections, the Department may assess a fine in the range of \$101,000 - \$250,000 as follows:

<u>Sec.</u>	<u>Commitment</u>
4.03(g)	Access to Competing Licensed Facilities
4.05(a)	Bonds
4.05(b)	Other Indebtedness
4.06	Domicile; Plan of Separation; Fiscal Year Change
All of Article V and Addendum 1	Managed Care Contracts and Pricing Limitations

III. FINE RANGE \$251,000 - \$1,000,000

For any Noncompliance that is not Cured relating to any Term or Condition in any of the following Sections, the Department may assess a fine in the range of \$251,000 - \$1,000,000 as follows:

<u>Sec.</u>	<u>Commitment</u>
3.02-3.05	Incremental Spending Commitments
3.08	Employee Benefits and Protections
4.02(a)	Accreditation, Licensure and Certification
4.03(a)	Maintenance as Hospitals
4.03(b)	Repurposing to a Non-Hospital Facility
4.03(c)	Deletion or Repurposing of Other Service Lines and Facilities
4.03(d)	Uninsured Discount
4.03(e) & (f)	Charity Care
4.04	Board Governance of the New Health System
6.03	Monitoring – Access & Meetings; Audits

EXHIBIT I

Sub-Indices for Population Health, Access to Care, Economic and Other

POPULATION HEALTH SUB-INDEX

<u>Sec.</u>	<u>Commitment/Outcome</u>	<u>Percentage Weight</u>
Exhibit D	Priority Population Health Measures Achieved	[See Exhibit D]
	Total	<u>100</u>

ACCESS TO CARE SUB-INDEX

<u>Sec.</u>	<u>Commitment/Outcome</u>	<u>Percentage Weight</u>
Exhibit C	Priority Access to Health Services Measures Achieved	[See Exhibit C]
	Total	<u>100</u>

ECONOMIC SUB-INDEX [PASS/FAIL]

<u>Sec.</u>	<u>Commitment/Outcome</u>	<u>Percentage Weight</u>
Article V and Addendum 1	Managed Care Contracts	100
	Total	<u>100</u>

OTHER SUB-INDEX

<u>Sec.</u>	<u>Commitment/Outcome</u>	<u>Percentage Weight</u>
<u>Exhibit K</u>	Target Quality Measures Achieved	25
<u>Exhibit K</u>	Quality Monitoring Measures Achieved	75
	Total	<u>100</u>

EXHIBIT J

SCORING; FINAL SCORE

1. Determine score (Pass or Fail) for Economic Sub-Index.
2. If applicable, determine impact of a failing score on the Economic Sub-Index on continuing Public Advantage.
3. If the result of Item 2 indicates a possible continuing Public Advantage, then determine from the results of the Annual Review the numerical score ranging from 0 to 100 for each Sub-Index (excluding the Economic Sub-Index).
4. Multiply the applicable score for each Sub-Index by its assigned weighting:

Year 1	
<u>Sub-Index</u>	<u>Percentage Weight</u>
Population Health	50%
Access to Care	30%
Other	<u>20%</u>
Total	<u>100%</u>

5. Add results of Item 4 for Final Score.
6. Application of Final Score to Public Advantage:

<u>Final Score</u>	<u>Public Advantage Clear and Convincing?</u>
(≥ 85)	Yes
(60-<85)	Unclear. All facts and circumstances to be considered in determination of continuing Public Advantage. May constitute Noncompliance and/or result in proposal by the Department of a COPA Modification.
(< 60)	No. COPA revoked absent compelling circumstances, including without limitation additional COPA Modifications proposed by the Department.

EXHIBIT K

Other Sub-Index

The Department Other Report will update the Target Quality Measures and Quality Monitoring Measures, if necessary. This Department Other Report will be used by the New Health System to report most recent verifiable values available for Measures in the Index, as specified in Section 6.04(b)(xvi). Data reported in the Department Other Report and the New Health System Annual Report and other sources as deemed appropriate by the Department will be used to calculate the Other Sub-Index Score outlined in Exhibit I and trends that will be reported in the Department Annual Report.

Definitions

In addition to the terms defined in Article I of the Terms of Certification to which this Exhibit K is attached, and terms defined elsewhere in this Exhibit, the following definitions shall apply to this Exhibit:

“Quality Monitoring Measures” means the measures listed on Table 2 below that are not Target Quality Measures that will be monitored by the Department and the New Health System.

“Target Quality Measures” means the list of 16 measures set forth on Table 1 below.

“Year 1” means the period that begins on the Issue Date and concludes on June 30, 2019.

“Year 2” and so on means each succeeding 12-month period during the COPA Term beginning on July 1, 2019.

Target Quality Measures for New Health System

The Target Quality Measures identify areas in which the New Health System should show improvement in quality outcomes. The Clinical Council may request revisions to this list based on quality improvement priorities of the New Health System. The Department may request revisions to this list of Target Quality Measures depending on baseline data, annual performance improvements, and other factors.

Target Quality Measures will be evaluated for the entire patient population and will not be restricted based on the patient’s payor status. Specifically, these Measures will not be limited to the Medicare population. The New Health System shall submit data for the Target Quality Measures at each of the following levels: (1) individual data for each applicable NHS Entity located in Tennessee; (2) aggregate data for the applicable NHS Entities located in Tennessee; and (3) aggregate data for the entire New Health System.

For the first year of the Affiliation, the New Health System will be required to maintain performance on the Target Quality Measures. For each subsequent year, the New Health System will be required to improve performance on the Target Quality Measures, or otherwise maintain performance on the Target Quality Measures such that the New Health System’s performance remains above either (i) the performance of the New Health System during the baseline year or (ii)

the then-current national and/or state estimates of Target Quality Measures, whichever is associated with better quality outcomes.

Table 1: Target Quality Measures

- 1 Pressure Ulcer Rate
- 2 Iatrogenic Pneumothorax Rate
- 3 Central Venous Catheter-Related Blood Stream Infection Rate
- 4 Postoperative Hip Fracture Rate
- 5 PSI 09 Perioperative Hemorrhage or Hematoma Rate
- 6 PSI 10 Postoperative Physiologic and Metabolic Derangement Rate
- 7 PSI 11 Postoperative Respiratory Failure Rate
- 8 PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
- 9 PSI 13 Postoperative Sepsis Rate
- 10 PSI 14 Postoperative Wound Dehiscence Rate
- 11 PSI 15 Accidental Puncture or Laceration Rate
- 12 Central Line-Associated Bloodstream Infection (CLABSI) Rate
- 13 Catheter-Associated Urinary Tract Infection (CAUTI) Rate
- 14 Surgical Site Infection (SSI) Rate
- 15 Methicillin-Resistant Staphylococcus Aureus (MRSA) Rate
- 16 Clostridium Difficile Infection (CDI) Rate

Quality Monitoring Measures for New Health System

The Quality Monitoring Measures provide a broad overview of system quality. The goal of these measures is to continually monitor performance of the New Health System with regard to quality. In connection with the Department’s monitoring of the Quality Monitoring Measures, any underperforming Quality Monitoring Measure for more than one (1) year may be reclassified to a Target Quality Measure, as determined by the Department in its discretion.

For hospital quality performance, Quality Monitoring Measures will include CMS Hospital Compare measures. Hospital Compare measures that are identified as Target Quality Measures

and measures of payment and value of care will be excluded from Quality Monitoring Measures. Quality Monitoring Measures will be evaluated for the entire patient population and will not be restricted based on the patient’s payor status. Specifically, these measures will not be limited to the Medicare population. The New Health System shall submit data for the Quality Monitoring Measures at each of the following levels: (1) individual data for each applicable NHS Entity located in Tennessee; (2) aggregate data for the applicable NHS Entities located in Tennessee; and (3) aggregate data for the entire New Health System.

The New Health System will be evaluated on Quality Monitoring Measures for each applicable NHS Entity.

Quality Monitoring Measures for Year 1 are identified in Table 2.

Table 2: Quality Monitoring Measures

	Measure identifier	Technical measure title	Measure as posted on Hospital Compare
	<i>General information- Structural measures</i>		
1	SM-PART-NURSE	Participation in a systematic database for nursing sensitive care	Nursing Care Registry
2	ACS-REGISTRY	Participation in a multispecialty surgical registry	Multispecialty Surgical Registry
3	SM-PART-GEN-SURG	Participation in general surgery registry	General Surgery Registry
4	OP-12	The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data	Able to receive lab results electronically
5	OP-17	Tracking Clinical Results between Visits	Able to track patients’ lab results, tests, and referrals electronically between visits
6	OP-25	Safe surgery checklist use (outpatient)	Uses outpatient safe surgery checklist
7	SM-SS-CHECK	Safe surgery checklist use (inpatient)	Uses inpatient safe surgery checklist
	<i>Survey of patient’s experiences- Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)</i>		
8	H-COMP-1-A-P	Communication with nurses (composite measure)	Patients who reported that their nurses “Always” communicated well
9	H-COMP-1-U-P	Communication with nurses (composite measure)	Patients who reported that their nurses “Usually” communicated well
10	H-COMP-1-SN-P	Communication with nurses (composite measure)	Patients who reported that their nurses “Sometimes” or “Never” communicated well
11	H-COMP-2-A-P	Communication with doctors (composite measure)	Patients who reported that their doctors “Always” communicated well
12	H-COMP-2-U-P	Communication with doctors (composite measure)	Patients who reported that their doctors “Usually” communicated well

	Measure identifier	Technical measure title	Measure as posted on Hospital Compare
13	H-COMP-2-SN-P	Communication with doctors (composite measure)	Patients who reported that their doctors “Sometimes” or “Never” communicated well
14	H-COMP-3-A-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they “Always” received help as soon as they wanted
15	H-COMP-3-U-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they “Usually” received help as soon as they wanted
16	H-COMP-3-SN-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they “Sometimes” or “Never” received help as soon as they wanted
17	H-COMP-4-A-P	Pain management (composite measure)	Patients who reported that their pain was “Always” well controlled
18	H-COMP-4-U-P	Pain management (composite measure)	Patients who reported that their pain was “Usually” well controlled
19	H-COMP-4-SN-P	Pain management (composite measure)	Patients who reported that their pain was “Sometimes” or “Never” well controlled
20	H-COMP-5-A-P	Communication about medicines (composite measure)	Patients who reported that staff “Always” explained about medicines before giving it to them
21	H-COMP-5-U-P	Communication about medicines (composite measure)	Patients who reported that staff “Usually” explained about medicines before giving it to them
22	H-COMP-5-SN-P	Communication about medicines (composite measure)	Patients who reported that staff “Sometimes” or “Never” explained about medicines before giving it to them
23	H-CLEAN-HSP-A-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were “Always” clean
24	H-CLEAN-HSP-U-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were “Usually” clean
25	H-CLEAN-HSP-SN-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were “Sometimes” or “Never” clean
26	H-QUIET-HSP-A-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their room was “Always” quiet at night
27	H-QUIET-HSP-U-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their room was “Usually” quiet at night
28	H-QUIET-HSP-SN-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their room was “Sometimes” or “Never” quiet at night

	Measure identifier	Technical measure title	Measure as posted on Hospital Compare
29	H-COMP-6-Y-P	Discharge information (composite measure)	Patients who reported that YES, they were given information about what to do during their recovery at home
30	H-COMP-6-N-P	Discharge information (composite measure)	Patients who reported that NO, they were not given information about what to do during their recovery at home
31	H-COMP-7-SA	Care Transition (composite measure)	Patients who “Strongly Agree” they understood their care when they left the hospital
32	H-COMP-7-A	Care Transition (composite measure)	Patients who “Agree” they understood their care when they left the hospital
33	H-COMP-7-D-SD	Care Transition (composite measure)	Patients who “Disagree” or “Strongly Disagree” they understood their care when they left the hospital
34	H-HSP-RATING-9-10	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)
35	H-HSP-RATING-7-8	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)
36	H-HSP-RATING-0-6	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)
37	H-RECMND-DY	Willingness to recommend the hospital (global measure)	Patients who reported YES, they would definitely recommend the hospital
38	H-RECMND-PY	Willingness to recommend the hospital (global measure)	Patients who reported YES, they would probably recommend the hospital
39	H-RECMND-DN	Willingness to recommend the hospital (global measure)	Patients who reported NO, they would probably not or definitely not recommend the hospital
<i>Timely & effective care- Cataract surgery outcome</i>			
40	OP-31	Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery	Percentage of patients who had cataract surgery and had improvement in visual function within 90 days following the surgery
<i>Timely & effective care- Colonoscopy follow-up</i>			
41	OP-29	Endoscopy/polyp surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients	Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy
42	OP-30	Endoscopy/polyp surveillance: colonoscopy interval for patients with a history of adenomatous polyps - avoidance of inappropriate use	Percentage of patients with history of polyps receiving follow-up colonoscopy in the appropriate timeframe
<i>Timely & effective care- Heart attack</i>			

	Measure identifier	Technical measure title	Measure as posted on Hospital Compare
43	OP-3b	Median time to transfer to another facility for acute coronary intervention	Average (median) number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital
44	OP-5	Median time to ECG	Average (median) number of minutes before outpatients with chest pain or possible heart attack got an ECG
45	OP-2	Fibrinolytic therapy received within 30 minutes of emergency department arrival	Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival
46	OP-4	Aspirin at arrival	Outpatients with chest pain or possible heart attack who received aspirin within 24 hours of arrival or before transferring from the emergency department
<i>Timely & effective care- Emergency department (ED) throughput</i>			
47	EDV	Emergency department volume	Emergency department volume
48	ED-1b	Median time from emergency department arrival to emergency department departure for admitted emergency department patients	Average (median) time patients spent in the emergency department, before they were admitted to the hospital as an inpatient
49	ED-2b	Admit decision time to emergency department departure time for admitted patient	Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room
50	OP-18b	Median time from emergency department arrival to emergency department departure for discharged emergency department patients	Average (median) time patients spent in the emergency department before leaving from the visit
51	OP-20	Door to diagnostic evaluation by a qualified medical professional	Average (median) time patients spent in the emergency department before they were seen by a healthcare professional
52	OP-21	Median time to pain medication for long bone fractures	Average (median) time patients who came to the emergency department with broken bones had to wait before getting pain medication
53	OP-22	Patient left without being seen	Percentage of patients who left the emergency department before being seen
54	OP-23	Head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival	Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival
<i>Timely & effective care- Preventive care</i>			

	Measure identifier	Technical measure title	Measure as posted on Hospital Compare
55	IMM-2	Immunization for influenza	Patients assessed and given influenza vaccination
56	IMM-3-OP-27-FAC-ADHPCT	Influenza Vaccination Coverage among Healthcare Personnel	Healthcare workers given influenza vaccination
<i>Timely & effective care- Stroke care</i>			
57	STK-4	Thrombolytic Therapy	Ischemic stroke patients who got medicine to break up a blood clot within 3 hours after symptoms started
<i>Timely & effective care- Blood clot prevention & treatment</i>			
58	VTE-6	Hospital acquired potentially preventable venous thromboembolism	Patients who developed a blood clot while in the hospital who <i>did not</i> get treatment that could have prevented it
59	VTE-5	Warfarin therapy discharge instructions	Patients with blood clots who were discharged on a blood thinner medicine and received written instructions about that medicine
<i>Timely & effective care- Pregnancy & delivery care</i>			
60	PC-01	Elective delivery	Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery was not medically necessary
<i>Complications- Surgical complications</i>			
61	COMP-HIP-KNEE	Hospital level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)	Rate of complications for hip/knee replacement patients
62	PSI-90-SAFETY	Complication/patient safety for selected indicators (composite)	Serious complications
63	PSI-4-SURG-COMP	Death rate among surgical inpatients with serious treatable complications	Deaths among patients with serious treatable complications after surgery
<i>Complications- Healthcare-associated infections (HAI)</i>			
<i>Readmissions & deaths- 30 day rates of readmission</i>			
64	READM-30-COPD	Chronic obstructive pulmonary disease (COPD) 30-day readmission rate	Rate of readmission for chronic obstructive pulmonary disease (COPD) patients
65	READM-30-AMI	Acute myocardial infarction (AMI) 30-day readmission rate	Rate of readmission for heart attack patients
66	READM-30-HF	Heart failure (HF) 30-day readmission rate	Rate of readmission for heart failure patients
67	READM-30-PN	Pneumonia (PN) 30-day readmission rate	Rate of readmission for pneumonia patients
68	READM-30-STK	Stroke 30-day readmission rate	Rate of readmission for stroke patients
69	READM-30-CABG	Coronary artery bypass graft (CABG) surgery 30-day readmission rate	Rate of readmission for coronary artery bypass graft (CABG) surgery patients

	Measure identifier	Technical measure title	Measure as posted on Hospital Compare
70	READM-30-HIP-KNEE	30-day readmission rate following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	Rate of readmission after hip/knee replacement
71	READM-30-HOSP-WIDE	30-day hospital-wide all- cause unplanned readmission (HWR)	Rate of readmission after discharge from hospital (hospital-wide)
<i>Readmissions & deaths- 30-day death (mortality) rates</i>			
72	MORT-30-COPD	COPD 30-day mortality rate	Death rate for COPD patients
73	MORT-30-AMI	Acute myocardial infarction (AMI) 30-day mortality rate	Death rate for heart attack patients
74	MORT-30-HF	Heart failure (HF) 30-day mortality rate	Death rate for heart failure patients
75	MORT-30-PN	Pneumonia (PN) 30-day mortality rate	Death rate for pneumonia patients
76	MORT-30-STK	Stroke 30-day mortality rate	Death rate for stroke patients
77	MORT-30-CABG	Coronary artery bypass graft (CABG) surgery 30-day mortality rate	Death rate for CABG surgery patients
<i>Use of medical imaging- Outpatient imaging efficiency</i>			
78	OP-8	MRI Lumbar Spine for Low Back Pain	Outpatients with low-back pain who had an MRI without trying recommended treatments (such as physical therapy) first. If a number is high, it may mean the facility is doing too many unnecessary MRIs for low-back pain.
79	OP-9	Mammography Follow-Up Rates	Outpatients who had a follow-up mammogram, ultrasound, or MRI within the 45 days after a screening mammogram
80	OP-10	Abdomen CT - Use of Contrast Material	Outpatient CT scans of the abdomen that were “combination” (double) scans (if a number is high, it may mean that too many patients have a double scan when a single scan is all they need).
81	OP-11	Thorax CT - Use of Contrast Material	Outpatient CT scans of the chest that were “combination” (double) scans (if a number is high, it may mean that too many patients have a double scan when a single scan is all they need).

	Measure identifier	Technical measure title	Measure as posted on Hospital Compare
82	OP-13	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery (if a number is high, it may mean that too many cardiac scans were done prior to low-risk surgeries).
83	OP-14	Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT	Outpatients with brain CT scans who got a sinus CT scan at the same time (if a number is high, it may mean that too many patients have both a brain and sinus scan, when a single scan is all they need).