SIXTH 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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SIXTH RESTATEMENT DATE: JULY 1, 2025

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SIXTH 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

These Sixth Amended and Restated Terms of Certification (as may be amended from time to time, these "Terms of Certification") dated as of the 1st day of July, 2025 (the "Sixth 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"). On April 27, 2021, the Department and the COPA Parties executed the Second Amended and Restated Terms of Certification (the "Second Restatement of the Terms of Certification"). On July 1, 2022, the Department and the COPA Parties executed the Third Amended and Restated Terms of Certification (the "Third Restatement of the Terms of Certification"). On July 1, 2023, the Department and the COPA Parties executed the Fourth Amended and Restated Terms of Certification (the "Fourth Restatement of the Terms of Certification"). On January 1, 2025, the Department and the COPA Parties executed the Fifth Amended and Restated Terms of Certification (the "Fifth Restatement of the Terms of Certification")

The Department and the COPA Parties have agreed to amend and restate the Fifth Restatement of the Terms of Certification by entering into these Sixth Amended and Restated Terms of Certification (the "Sixth Restatement of the Terms of Certification"), the effectiveness of which on the Sixth 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.

"Appalachian Highlands Care Network" means the coordinated care program established by the New Health System to connect uninsured patients and their families with free or low-cost clinics, dental services, financial counseling, and preventative care services.

"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).

"Capital Spending Points" shall have the meaning set forth in Exhibit 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.

"Closing Date" means January 31, 2018.

"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 Part I" shall have the meaning set forth in Section 7.01(a).

"Economic Sub-Index Part II" shall have the meaning set forth in Section 7.01(a).

"Electronic Health Record" or "EHR" means an electronic version of a patient's medical history, maintained by the New Health System over time.

"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).

"Fifth Restatement Date" shall have the meaning set forth in the Introduction.

"Fifth Restatement of the Terms of Certification" shall have the meaning set forth in the Introduction.

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

"Financial Assistance Policy" shall mean the official financial assistance policy maintained by the New Health System and which must meet the requirements of Section 4.03(e).

"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.

"Fourth Restatement Date" shall have the meaning set forth in the Introduction.

"Fourth Restatement of the Terms of Certification" shall have the meaning set forth in the Introduction.

"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).

"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).

"Immediate Jeopardy" shall have the meaning ascribed to such term in 42 CFR § 489.3.

"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.

"Medicaid Hospital Investment Program" means the hospital investment program the State of Tennessee's Medicaid program (TennCare) submitted to CMS for approval in May of 2024.

"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.

"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 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.

"Preliminary Score" has the meaning set forth in Section 7.01(a).

"Project Access" means the Project Access Specialty Incentive Pilot Program established by the Department to incentivize additional high-need specialty providers to deliver in-person services for rural communities.

"Provider Needs Assessment" means a detailed analysis of the current and projected supply and demand of physician and physician extender services in the Geographic Service Area.

"PSA" shall have the meaning set forth in Section 5.05(e).

"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.

"Quality/Other Sub-Index" shall have the meaning set forth in Section 7.01(a).

"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 Fifth Restatement Date are Greeneville Community, Hawkins County, Lonesome Pine, Mountain View Regional, Hancock County, Sycamore Shoals, Norton Community, Russell County, Smyth County, Unicoi County[1], Dickenson Community, Johnson County, and Lee County.

[1] Unicoi County Hospital was severely damaged by Hurricane Helene in September of 2024 and, as of the Fifth Restatement Date, Unicoi County Hospital is not currently in operation as a Hospital. Efforts are underway to rebuild Unicoi County Hospital and the New Health System intends to return inpatient acute care services to the community. All other Rural Hospitals are in operation as Hospitals as of the Fifth Restatement Date.

"Satisfactory Score" means achieving both a score of "Pass" on the Economic Sub-Index Part I and a score of "60" 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).

"Sixth Restatement Date" shall have the meaning set forth in the Introduction.

"Sixth Restatement of the Terms of Certification" shall have the meaning set forth in the Introduction.

"SNF" means skilled nursing facility.

"Spending Guidelines" shall have the meaning set forth in Section 3.01(a).

"States" means the State of Tennessee and the Commonwealth of Virginia.

"STRONG LINK" shall have the meaning set forth in Section 3.04(f).

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

"TBLHCF" or "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.

"Third Restatement Date" shall have the meaning set forth in the Introduction.

"Third Restatement of the 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.[2]

(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 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 time 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.[3]

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[2] Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, *County Health Rankings 2017: Tennessee; County Health Rankings 2017: Virginia.*
[3] *Id.*

(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. 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.[4] 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 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-1, the timing of which expenditures may be modified pursuant to the plans submitted to, and

[4] 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.

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. The guidelines to be used for calculation of Baseline Spending and Incremental Spending (the "Spending Guidelines") are set forth in Exhibit B-2. 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-1 (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-1. 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-1, 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-1, 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-1, 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. Additionally, to support access to high-need specialty providers in rural communities, the New Health System shall continue to provide financial operational support for Project Access through the end of the Ten-Year Period. The New Health System will include in the Annual Report: (1) the dollar amount of financial support provided to Project Access each year and (2) the number of encounters for Project Access enrollees.

(d) Access Sub-Index. The Department shall annually produce an Access Sub-Index to measure access to healthcare and prevention services within the Geographic Service Area. The Access Sub-Index shall be substantially in the form attached hereto as Exhibit C and may be revised by the Department from time to time in its discretion after consultation with the New Health System. Each of the Behavioral Health Plan, Children's Health Plan and Rural Health Plan shall take into account the Access Measures set forth in the Access Sub-Index or the Population

Health Measures set forth in the Population Health Sub-Index. 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-1, 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-1); 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-1, 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 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 Sub-Index. The Department shall annually produce a Population Health Sub-Index to measure short-term, mid-term, and long-term outcomes of various factors on population health within the Geographic Service Area. The Population Health Sub-Index shall 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 Population Health Plan shall take into account the Population Health Measures set forth in the Population Health Sub-Index. 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.

(f) STRONG LINK Research Study. The New Health System has established the Striving Toward Resilience and Opportunity for the Next Generation Longitudinal Initiative for Newborns and Kids (the "STRONG LINK") research study in partnership with East Tennessee State University. The purpose of the STRONG LINK research study is to conduct a multi-year longitudinal study of mothers and their children in the Geographic Service Area, by collecting data to better understand their health and well-being. The New Health System shall continue the STRONG LINK study and will report on the STRONG LINK study each year in the New Health System Annual Report.

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 statues 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, or utilizing its own data for commercial purposes, so long as 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. The Department may waive the requirement for a replacement plan to be submitted if the Department determines that the policy goals associated with a particular spending commitment plan have been satisfied. In the event the policy goals associated with a spending commitment plan are satisfied by the New Health System spending less than the Total Incremental Spending Obligation for that category, the New Health System shall propose reallocation of the remaining spending obligation to another spending category. For example, if the Department determines that the policy goals for the Region-wide HIE are satisfied in Fiscal Year 2023 and the New Health System has only spent $3,000,000 of the $8,000,000 spending obligation, the New Health System shall propose reallocation of the remaining $5,000,000 to another spending category (e.g., Rural Health) and the Department may waive the requirement that the New Health System submit a replacement plan for future years.

(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-1. 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. If a nonmaterial modification is approved by the COPA Monitor, the effective date of the proposed modification shall be the date designated by the COPA Monitor.

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, except that the replacement Capital Plan covering fiscal years 2027-2028 shall be a two-year 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.[5]

(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

[5] The Department deemed the Equalization Plan complete on November 29, 2023. No further work or reporting on the Equalization Plan is required by the New Health System after this date.

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 and notice according to Tennessee statute 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. To the extent the New Health System is obligated to notify the Tennessee Health Facilities Commission of a deficiency or other noncompliance cited by the Joint Commission or Medicare under state licensing requirements, notice provided to the Tennessee Health Facilities Commission shall be sufficient notice for purposes of this requirement except for Immediate Jeopardy events. If the New Health System receives an Immediate Jeopardy citation, the New Health System shall notify the Department and the COPA Monitor immediately but no later than two (2) business days following the issuance of the citation in addition to any reporting obligations the New Health System may have under the state licensing requirements.

(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 Quality Improvement 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 levels of LPNs and RNs.

(v) At least every three (3) Fiscal Years, the New Health System shall conduct a full physician engagement survey and a full employee engagement survey and compare the results to previous results. These engagement surveys will include physician and employee satisfaction. In the years between each full survey, the New Health System shall conduct shortened (pulse) physician and employee engagement surveys and compare results to previous results. The COPA Monitor shall validate that these surveys have been 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.

(vii) At least every three (3) Fiscal Years, the New Health System shall conduct a Provider Needs Assessment, which will be provided to the Department for its review. As part of each Provider Needs Assessment, the New Health System will report on the net change of providers by specialty.

(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 the applicable patient population as referenced in Exhibit K to the Terms of Certification 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. The New Health System agrees to maintain in operation as Hospitals all COPA Hospitals in operation as of the Fifth Restatement Date through the end of the Ten-Year Period,[6] each of which shall maintain the services existing at such COPA Hospital as of the Approval Date.[7]

(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

[6] The Department agrees that if the Medicaid Hospital Investment Program is not approved by CMS on or before December 31, 2025, the phrase "through the end of the Ten-Year Period" in this sentence shall be replaced with "through the eighth anniversary of the Issue Date."

[7] Unicoi County Hospital was severely damaged by Hurricane Helene in September of 2024 and, as of the Fifth Restatement Date, Unicoi County Hospital is not currently in operation as a Hospital. Efforts are underway to rebuild Unicoi County Hospital and the New Health System intends to return inpatient acute care services to the community. All other COPA Hospitals are in operation as Hospitals as of the Fifth Restatement Date.

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 4.03(b)(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 Service Lines, Non-Hospital Facilities and Other Services.

(i) Service Lines. With respect to any existing or future Service Line, including any material component of a Service Line, 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, or any material component thereof, including by means of divesting an interest in, or terminating, materially modifying or creating a joint venture with respect to such Service Line or material component thereof, 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. The 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 that would be of a type that the resulting Service Line would, in the ordinary course, require a certificate of need or other regulatory approval before providing services. Nothing in this Section 4.03 shall limit any of the restrictions on terminating employees set forth in Section 3.08(d).

(ii) Non-Hospital Facilities and Other Services. Notwithstanding Section 4.03(c)(i), any deletion or repurposing of a non-material portion of a Service Line, a non-hospital facility, or a service that is not a "Service Line" shall not require notice to and approval of the Department so long as the deletion or repurposing does not materially impact access by eliminating the availability of the service in the community. If the service will continue to be offered by either the New Health System or a third-party, no notice or approval shall be required for the deletion or repurposing. Additionally, if the change to the non-hospital facility or service will enhance competition, no notice or approval shall be required. If the deletion or repurposing will eliminate the availability of the service in the community, the New Health System shall follow the process for notice and approval set forth in Section 4.03(c)(i). The following are examples of deletions or repurposings that would not require notice to and approval of the Department: outsourcing of reference laboratory services where the reference laboratory services will continue to be offered in the region, discontinuance of outpatient rehabilitation services where outpatient rehabilitation services are offered in the community by another provider, the closure of a sleep lab where a sleep lab is offered in the community by another provider, sale of a long-term care facility when the long-term care facility will continue to be operated by the purchaser, sale of the New Health System's minority interest in an ambulatory surgery center joint venture where the ambulatory surgery center will continue to be operated by the purchaser of the minority interest, repurposing of a medical office building, and closure of an urgent care center where another urgent care center is operated by a third-party in the community. 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. For purposes of the following subsections only, capitalized terms not otherwise defined herein shall have the meanings ascribed to such terms in the New Health System's Financial Assistance Policy:

(i) The New Health System will commit to provide FAP-Eligible Individuals with an annual Household Income below 225% of the Federal Poverty Guidelines with 100% financial assistance, unless their Asset Value exceeds $25,000. This commitment shall be memorialized in the Financial Assistance Policy. For the remainder of the Ten-Year Term, the New Health System shall not reduce the Asset Value used for 100% financial assistance as set forth in the Financial Assistance Policy without the prior written approval of the Department, which approval shall not be unreasonably withheld.

(ii) The New Health System will commit to provide FAP-Eligible Individuals having annual Household Income between 225% and 450% of the Federal Poverty Guidelines (taking into account family size according to the US Census Bureau and the number of dependents per IRS rules) with a partial discount, based on a sliding scale of income, on "Amounts Generally Billed" charges. This commitment shall be memorialized in the Financial Assistance Policy.

(iii) The New Health System will commit to maintain its practice of "presumptive eligibility" for patients who could be eligible for free care or discounts under the New Health System's charity policy. This will reduce barriers to receiving charity care (such as producing hard-to-find paperwork) and reduce the number of patient bills labeled as bad debt or referred for collections. This commitment shall be memorialized in the Financial Assistance Policy.

(iv) The COPA Monitor may audit the New Health System's compliance with its Financial Assistance Policy at any time to ensure that the New Health System is honoring these commitments or may direct the New Health System's external auditors to confirm the New Health System's adherence to the Financial Assistance Policy.

(v) The New Health System will commit to maintain the Appalachian Highlands Care Network through the end of the Ten-Year Period. The New Health System will include in the Annual Report: (1) the number of individuals enrolled in the Appalachian Highlands Care Network each year and (2) the number of encounters for Appalachian Highlands Care Network enrollees.

(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 Part I, line 7a, column (e) of Schedule H, or the equivalent calculation if Form 990 is not available at the filing of the Annual Report. If Form 990 is not available at the time the Annual Report is filed, the New Health System shall provide the COPA Monitor with the finalized Form 990 once it is available along with an explanation for any difference between the numbers reported in the Annual Report and the finalized Form 990. 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 Part I, line 7a, column (e) of Schedule H for the respective 2017 fiscal years ending on or before December 31, 2017.

(iii) 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.

(iv) 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.

(v) 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.

(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 (which are excepted from this requirement) include, but are not limited to, anesthesiologists, radiologists, pathologists, emergency department physicians, radiation oncologists, pediatric specialties (including neonatology and intensivists), behavioral health physicians and extenders, hospitalists, and critical care specialists.

(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 10.5 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) Certificates of Need.

(i) Prior to the end of the fourth full Fiscal Year following the Closing Date, 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.

(ii) As set forth in the Tennessee Health Services and Planning Act of 2021, which became effective October 1, 2021, it is the public policy of the State of Tennessee that the establishment and modification of healthcare institutions, facilities, and services must be accomplished in a manner that promotes access to necessary, high quality, and cost-effective services for the health care of the people of this state. In furtherance of this articulated public policy, the Department and the New Health System seek to ensure that the Health Facilities Commission, the state agency charged with considering applications for certificates of need, has access to information relevant to its decision-making process. Therefore, beginning with the fifth full Fiscal Year following the Closing Date, the New Health System may support or oppose an application for 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. The New Health System may appeal a decision of the Health Facilities Commission to an administrative law judge but may not appeal the decision of the administrative law judge. In the event the New Health System appeals a decision to an administrative law judge and the administrative law judge rules in favor of the New Health System, the New Health System agrees to be responsible for its own costs associated with the appeal and will not seek reimbursement of the costs of the appeal to the administrative law judge from the losing party.

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 or obtain (as the case may be) any covenant not to compete from any such person or entity in excess of the term of the contract or employment agreement plus one (1) year following termination of the contract or 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, including Gynecological Oncologists and Surgical Oncologists. 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. The Department shall provide a response to the New Health System within thirty

(30) days of receiving all of the information reasonably necessary to evaluate the waiver request (which information shall be agreed upon by the New Health System and the COPA Monitor in advance). The Department agrees to promptly notify the New Health System as soon as a decision on the waiver request has been made. In no event should the number of Employed Physicians in any specialty reach a level that would materially and adversely affect existing competition. Physicians engaged by a NHS Entity under a Professional Services Agreement ("PSA") will not be considered "Employed Physicians" for purposes of this Section unless the PSA grants the NHS Entity control of the physicians' operations *and* responsibility for negotiating managed care rates for the entity owned or controlled by such physicians. By way of example, if a NHS Entity enters into a PSA with an independent physician group and the PSA allows the NHS Entity to manage the individual physicians performing services under the PSA and bill for the professional services of those physicians under the NHS Entity's managed care contracts but the PSA does not grant the NHS Entity the ability to negotiate managed care rates for the independent physician group entity, those physicians performing services under the PSA shall not be considered "Employed Physicians" for purposes of this Section.

(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.

(h) In order to support the development of the next generation of healthcare professionals in the region and enhance the academic infrastructure of the New Health System, the Department encourages the New Health System to seek out ways to align resources and clinical programs with its academic healthcare partners, including its primary academic partner, East Tennessee State University.

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. The Department, after discussion with the parties to Final Offer Arbitration, shall establish the scope of the dispute or question(s) to be arbitrated through Final Offer Arbitration if it orders the New Health System to participate in Final Offer Arbitration. The Department shall provide any guidance or interpretation of the Terms of Certification, as necessary. Additionally, the 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-Indices. 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 Part I. The New Health System's ongoing compliance with the capital spending levels set forth in Exhibit I shall constitute the Measures within the Economic Sub-Index Part II.

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 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 be substantially in the form attached hereto as Exhibit G and include the following items related to compliance (or not) with each of the Terms and Conditions

1) A schedule of all maintenance and repair expenses and capital expenditures during the year along with a report on whether the New Health System met or exceeded aggregate capital expenditure spending commitments (board approved capital budget) for three years per Capital Plan;

2) A report on any updates to the implementation and results of the Career Development Plan;

3) A roster of the members of the Clinical Council and an update on sub-committee work and initiatives along with a narrative or documentation to address changes to the common standard of care, credentialing standards, consistent multidisciplinary review, and best practices;

4) Information on the New Health System's performance in meeting the quality measures under the Quality/Other Sub-Index;

5) Results of the patient satisfaction surveys for three years and a copy of the plan to address deficiencies and opportunities for improvement related to perceived access to care services;

6) Information on the number of LPNs and RNs employed by the New Health System at the beginning of the Fiscal Year, the number hired during the Fiscal Year, the number who left during the Fiscal Year, and the number who are employed by the New Health System at the end of the Fiscal Year;

7) Results of the employee engagement surveys conducted by the New Health System as set out in Section 4.02(c)(v); Results of the physician engagement surveys conducted by the New Health System as set out in Section 4.02(c)(v);

8) 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);

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

10) An update on the status of the Equalization Plan and a summary of salary and benefit equalization steps taken in the last Fiscal Year;

11) 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);

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

13) A summary of the New Health System's residency and fellowship programs, the New Health System's goals related to each program, a summary of activities and progress towards those goals, and data on the residency program;

14) Data on the "slots" for the residency programs sponsored by the New Health System, 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;

15) Certain information on the New Health System's academic and non-academic partnerships around research activities, research goals, and progress towards those goals;

16) Copies or links to any published reports from research projects conducted by the New Health System and its academic partners pursuant to an approved HR/GME Plan;

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

18) 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;

19) Information on the New Health System's compliance with Section 4.03(e), and the Total Charity Care information described in Section 4.03(f);

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

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

22) 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;

23) Updates to the Population Health Plan, the HR/GME Plan, the HIE Plan, the Behavioral Health Plan, the Children's Health Plan, and the Rural Health Plan and any implementation achieved;

24) Information on the New Health System's recruitment and retention of physicians and advanced practice providers;

25) Information on the New Health System's recruitment and retention of nurses;

26) Information on the New Health System's compliance with Addendum 1.

(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 and maintenance of capital spending (the "Economic Sub-Index"), and (iv) other benefits, including without limitation enhancement of quality of care, patient satisfaction, medical research and education (the "Quality/Other Sub-Index"). The Index and each Sub-Index, as of the Sixth Restatement 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. As described herein and on Exhibit J attached hereto, the application of the Population Health Sub-

Index, the Access Sub-Index and the Quality/Other Sub-Index shall result in a numerical score ranging from 0-100, and the numerical scores for each of these three sub-Indices shall be multiplied by their respective assigned weights (which may change from year to year as determined by the Department), with the resulting numbers added together to arrive at an aggregate numerical score for the applicable Fiscal Year (the "Preliminary Score"), which shall then be reduced by any Capital Spending Points calculated pursuant to the Economic Sub-Index Part II. The resulting number shall be the "Final Score." The Economic Sub-Index Part I 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 Part I 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 not 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:

Joe Landsman
Office of Tennessee Attorney General
P.O. Box 20207, Nashville, TN 37202

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 Sixth Restatement Date.

DEPARTMENT:

TENNESSEE DEPARTMENT OF HEALTH

By:_____
John R. Dunn, DVM, PhD, EMBA-SL
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:_____
Jonathan Skrmetti
Tennessee Attorney General

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

DEPARTMENT:

TENNESSEE DEPARTMENT OF HEALTH

By:_____
John R. Dunn, DVM, PhD, EMBA-SL
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:_____
Jonathan Skrmetti
Tennessee Attorney General

[*Signature Page to the Sixth Amended and Restated Terms of Certification*]

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

DEPARTMENT:

TENNESSEE DEPARTMENT OF HEALTH

By:_____
John R. Dunn, DVM, PhD, EMBA-SL
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:_____
Jonathan Skrmetti
Tennessee Attorney General

[*Signature Page to the Sixth Amended and Restated Terms of Certification*]

ADDENDUM 1
COPA MANAGED CARE CONTRACT PRICING LIMITATIONS AND AUDITING PROCESS

PART I

DEFINITIONS AND GENERAL

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:

"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.

"Audit Process" – The process set forth in Section 3.1(f)(ii).

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

"Compliance Processes" – The applicable processes for determining compliance with the pricing limitations of this Addendum 1 based on the nature of the relationship that exists between the New Health System and the Payor, including, but not limited to, the Audit Process which is applicable to Standard Payors.

"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.

"Cumulative Inflation Adjustments" – The Cumulative Inpatient Inflation Adjustment, Cumulative Outpatient Inflation Adjustment, and/or Cumulative Physician Inflation Adjustment which applies to a particular Standard 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 current Contract Year as set forth on the Standard Payor Annual Report.

"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 current Contract Year as set forth on the Standard Payor Annual Report.

"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 current Contract Year as set forth on the Standard Payor Annual Report.

"Excess Payment" – The payment described 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 evaluated, 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 rate 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.

"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.

"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.

"Memorandum of Approval" – The memorandum described in Section 3.1(f)(i).

"National Insurance Network" – 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 5.2.

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

"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" – The services described in Section 3.1(e).

"Standard Payor" – A Payor that meets the definition set forth in Section 3.1(a).

"Standard Payor Annual Report" – The annual report defined in Section 7.1(c).

"Standard Payor Contract" – A contract as defined in Section 3.1(a).

"Value-Based Payor" – A Payor that meets the definition set forth in Section 2.2(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 and Value-Based Payors are described in Part II. The method for demonstrating compliance for Standard Payors is described in Part III. Charge-Based Payors are addressed in Part IV. Never In-Network Payors are addressed in Part V. Each year, the COPA Monitor shall include in the COPA Monitor Annual Report a summary of the work the COPA Monitor performed to ensure the New Health System has complied with Addendum 1 and that the New Health System's pricing has not impermissibly increased.

(c) The COPA Parties acknowledge that over time the New Health System 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 Compliance Processes 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 AND VALUE-BASED PAYORS

The methods for demonstrating compliance with Addendum 1 for Exempt Payors and Value-Based 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; (iv) that are Managed Medicaid Plans that pay the New Health System within a predetermined band of allowable rates set by the State or (v) that are local or state governments contracting with the New Health System to provide inmate healthcare services. 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. Prior to entering into a Managed Care Contract with an Exempt Payor, the New Health System shall notify the COPA Monitor that the New Health System is entering into a Managed Care Contract with a Payor that the New Health System believes meets the definition of an Exempt Payor. The notice shall include an explanation for why the New Health System believes the Payor meets the definition of an Exempt Payor. Within fifteen (15) days of receiving the notice, the COPA Monitor shall confirm that the Payor meets the definition of an Exempt Payor or provide the New Health System with an explanation for why the COPA Monitor believes the Payor does not meet the definition of an Exempt Payor. Each Annual Report shall include a certification by the New Health System that each Payor previously found to have met the definition of an Exempt Payor continues to meet the definition of an Exempt Payor. If the Payor does not satisfy the definition of an Exempt Payor, that Payor will be considered a Standard Payor subject to Part III unless it meets the definition of a Value-Based 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. Prior to entering into a Managed Care Contract with a Value-Based Payor, the New Health System shall notify the COPA Monitor that the New Health System is entering into a Managed Care Contract with a Payor that the New Health System believes meets the definition of a Value-Based Payor. The notice shall include an explanation for why the New Health System believes the Payor meets the definition of a Value-Based Payor. Within fifteen (15) days of receiving the notice, the COPA Monitor shall confirm that the Payor meets the definition of a Value-Based Payor or provide the New Health System with an explanation for why the COPA Monitor believes the Payor does not meet the definition of a Value-Based Payor. Each Annual Report shall include a certification by the New Health System that each Value-Based Payor previously found to have met the definition of a Value-Based Payor continues to meet the definition of a Value-Based Payor. If the Payor does not satisfy the definition of a Value-Based Payor, that Payor will be considered a Standard Payor subject to Part III unless it meets the definition of an Exempt 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.

PART III

COMPLIANCE FOR STANDARD PAYORS

3.1 Compliance for Standard Payors.

(a) Description. "Standard Payors" are Payors that do not meet the definition of Exempt Payor, Value-Based Payor, Charged-Based Payor, or Never In-Network Payor for a particular Contract Year. "Standard Payor Contracts" are Managed Care Contracts between the New Health System and a Standard Payor which do not fall under Part II, Part IV, or Part V.

(b) Limitations on Contracting with Standard Payors.

(i) For any Standard Payor Contract that is renegotiated, repriced or terminated after the Closing, the New Health System shall not be permitted to increase rates above the Cumulative Inflation Adjustments that have been established for that Standard Payor without a waiver from the Department.

(ii) For purposes of this section, a Standard Payor's contracts which are being negotiated at the same time shall be considered together when determining the Cumulative Inflation Adjustments. By way of example, if a Standard Payor has two commercial contracts, a Medicare Advantage contract, and a TennCare contract with the New Health System (none of which fall under Part II, Part IV, or Part V), and the two commercial contracts and the TennCare contract are being renegotiated at the same time, the contracts may be aggregated if the Standard Payor requests this approach or if the COPA Monitor grants a request from the New Health System. In

this example, the two commercial contracts and the TennCare contract (but not the Medicare Advantage contract) would be aggregated to determine the rate of increase for that Standard Payor.

(iii) If a Managed Care Contract was previously subject to Part II, Part IV, or Part V and no longer satisfies the definitions required for the contract to be covered by that section, then the Managed Care Contract shall be evaluated under this Part III as a Standard Payor Contract.

(c) Hospital Inpatient and Outpatient Pricing for Standard Payors. The terms of this Addendum 1 shall apply to inpatient and outpatient services rendered at acute care facilities whose rates are negotiated by the New Health System.

(d) Non-Hospital Outpatient Pricing for Standard Payors. It is the intent of this Addendum 1 to govern, for Standard 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 8.1(c) of this Addendum 1. 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. 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.

(e) Physician Pricing for Standard 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").

(f) Compliance with Addendum 1. For each Standard Payor, compliance with Addendum 1 will be evaluated by the COPA Monitor (i) before the New Health System executes, renegotiates or reprices a Standard Payor Contract and (ii) at any time at the discretion of the COPA Monitor to confirm 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 Standard 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 Standard Payor Contract with the Standard Payor.

Step 2. Before executing the new Standard Payor Contract, the New Health System shall submit a memorandum for the contract to the

COPA Monitor for review (the "Memorandum of Approval"). The Memorandum of Approval shall include:

- A draft of the new Standard Payor Contract;
- The New Health System's calculation of the percentage change in rates from the prior contract (for existing payors/products only);
- Confirmation that the Payor has agreed to the percentage change in rates as calculated by the New Health System (for existing payors/products only); and
- The Cumulative Inflation Adjustments that may be used in future negotiations with the Standard Payor (for existing payors/products only).

Step 3. Within fifteen (15) business days of receiving the Memorandum of Approval and any relevant clarifying materials that may be reasonably requested, the COPA Monitor shall inform the Department and the New Health System in writing 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 Terms of Certification as amended.

Step 4. If the COPA Monitor finds that the substantive terms of the new Standard 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 Standard Payor.

Step 5. If the COPA Monitor finds that the substantive terms of the new Standard 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 Standard Payor until such time as it resolves the noncompliant terms with the COPA Monitor.

Step 6. Following execution, the New Health System will provide a copy of the fully executed Standard Payor Contract to the COPA Monitor upon request.

(ii) Process for Evaluating Whether Standard Payor Contracts Approved by the COPA Monitor and Executed After the Closing Comply with Addendum 1 through Auditing. In addition to the other compliance measures set forth herein, the COPA Monitor may, at any time, at his or her discretion, audit the New Health System's pricing for the Standard Payor Contracts currently in effect to confirm that the New Health System's pricing has not impermissibly increased (the "Audit Process"). If, through the Audit

Process, the COPA Monitor finds that the New Health System's pricing has impermissibly increased, Section 3.3 shall apply.

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

(h) 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 Standard Payor Policy Changes that Negatively Impact the New Health System's Net Revenue.

If, after a Standard Payor Contract is executed, the Standard Payor makes policy changes that have a material negative impact on the New Health System's net revenue, the New Health System may present the information to the COPA Monitor and request an increase to the Cumulative Inflation Adjustments set forth on the Standard Payor Annual Report that will be used for future contracts with the Standard Payor. The COPA Monitor may consider all relevant factors in determining whether to approve the request, which approval shall not be unreasonably withheld. If approved, the increase to the Cumulative Inflation Adjustments shall be memorialized in an amendment to the Standard Payor Annual Report.

3.3 Excess Payments.

If the COPA Monitor determines that the New Health System's pricing has impermissibly increased with respect to that Payor then an excess payment exists (the "Excess Payment") and the New Health System shall work with the COPA Monitor to determine the best way to address the Excess Payment and any related refund. The COPA Monitor and the New Health System shall agree on what steps, if any, need to be taken to prevent the Excess Payment from recurring.

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.

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. 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 Hospitals or varied by department, service or line item. If the charge increase is not applied uniformly across the entire chargemaster, 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 The New Health System may 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 without the approval of the COPA Monitor. Charge master mark-up items including supplies and pharmaceuticals use mark-up tables to set charge master pricing.

4.4 The New Health System agrees to have any changes to its mark-up formularies reviewed each year by the COPA Monitor. Any changes to the mark-up formularies shall be included when determining whether the New Health System's aggregate charge increase exceeds the Cumulative Inflation Adjustments.

4.5 To the extent that, at any time, the aggregate charge increase after the Closing exceeds the Cumulative Inflation Adjustments, 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 1.

PART V

COMPLIANCE FOR NEVER IN-NETWORK PAYORS

5.1 **Inpatient and Outpatient Charges**. The New Health System shall apply the Never In-Network Discount (as defined in Section 5.2(a)) to each individual bill for inpatient services and outpatient services before that bill is sent to the patient covered by a Never In-Network Payor. 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. If, through this

process, the COPA Monitor finds that the Never In-Network Discount has not been consistently applied, Section 3.3 shall apply.

5.2 Never In-Network Discount.

(a) Each year, the New Health System shall calculate the "Never In-Network Discount" which shall apply to hospital inpatient services and hospital outpatient services and provide it to the COPA Monitor. The Never In-Network Discount shall be the lower of the following:

(i) 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 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.

An exemplar calculation of the Never In-Network Discount is set forth in APPENDIX 2.

(b) The payment rates initially determined in Sections 5.2(a)(i) and 5.2(a)(ii) will be adjusted from time to time for changes in billed charges in a manner consistent with Section 4.5, 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 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 VI

APPLICATION TO MANAGED CARE CONTRACTS

Managed Care Contracts are governed by the terms of this Addendum 1 and the Terms of Certification.

PART VII

TIMING FOR REPORTING

7.1 Timing for Reporting.

(a) Reporting Contracts and Financial Information to the Department. All contracts subject to the Compliance Processes 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 pricing including any information requested by the COPA Monitor or the Department which, in the COPA Monitor or Department's discretion, would be beneficial in evaluating the New Health System's compliance with this Addendum 1.

(b) Annual Listing Provided to the COPA Monitor. In addition to the other requirements set forth in this Addendum 1, the New Health System shall provide to the COPA Monitor by November 30 during the COPA Term a list of all the New Health System's Managed Care Contracts in effect as of the end of the Fiscal Year ended in that calendar year. The list shall include the following information (i) name of the Payor; (ii) the title of the Managed Care Contract; (iii) category the Managed Care Contract falls into (e.g., Exempt Payor, Value-Based Payor, Standard Payor); (iv) the Anniversary Date of the Managed Care Contract; (v) the date the New Health System submitted the information to the COPA Monitor; (vi) the date the COPA Monitor approved the Managed Care Contract category or terms; and (vii) the range of net revenue for the Managed Care Contract. For purposes of this Section, the ranges of net revenue shall be under $5 million, $5 million to $50 million, and above $50 million.

(c) Standard Payor Annual Report Provided to the COPA Monitor. By November 30 of each year during the COPA Term, the New Health System shall provide to the COPA Monitor a report setting forth the agreed upon Cumulative Inflation Adjustments for each Standard Payor Contract for the most-recently ended Fiscal Year beginning with the first Contract Year (the "Standard Payor Annual Report"). The Monitor shall review and verify the calculations provided by the New Health System in its report prior to the Monitor's use of these calculations. The Standard Payor Annual Report will document the Standard Payor Contracts and the existing inflators that have been negotiated each Fiscal Year beginning with the first Contract Year. Each Standard Payor Annual Report shall be in the format attached hereto as APPENDIX 3.

(d) 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.

(e) 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.

7.2 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.

7.3 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 VIII

EXCEPTIONS TO PRICE LIMITATION RULES

8.1 The Pricing Limitations in this Addendum 1 do 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 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.

(h) Lump sum payments the New Health System receives from performance under value-based programs so long as quality or value-based contracts are reported to the COPA Monitor and the COPA Monitor has not objected.

PART IX

PERIODIC REVIEW

No later than six (6) months before the ninth 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 75 percent 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 50 percent 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 ninth 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 X

GENERAL TERMS

10.1 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.

10.2 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.

10.3 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.

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

10.5 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.

10.6 Any disputes arising out of or in relation to this Addendum 1 shall be settled amicably by mutual discussion between the New Health System and the COPA Monitor. If the New Health System and the COPA Monitor are unable to resolve the Addendum 1 dispute through good faith negotiations within thirty (30) days of the disagreement first being identified, the parties agree to engage an independent consultant to review the matter in dispute and mediate the difference in opinion. The decision of the independent consulting firm on the Addendum 1 dispute shall be final and binding on the parties. This dispute resolution process shall only apply to disputes surrounding the terms and conditions of this Addendum 1. To the extent the dispute involves a matter or question related to the broader terms and conditions of the Terms of Certification, the dispute resolution provisions found in the Terms of Certification shall apply.

10.7 Any circumstances or issues arising out of or in relation to this Addendum 1 which are not clearly addressed by the language contained herein shall be resolved through mutual discussion between the New Health System and the COPA Monitor. Once resolved, the New Health System and/or the COPA Monitor may propose clarifications or edits to this Addendum 1 to be considered as part of a future amendment to the Terms of Certification.

PART XI

RESERVATION OF RIGHTS

11.1 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.

11.2 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 the Compliance Processes, 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 Compliance Processes herein to be ineffective in retaining Public Advantage.

APPENDIX 1

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 2

EXEMPLAR CALCULATION FOR NEVER IN-NETWORK PAYORS

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

FOR INPATIENT CHARGES

The New Health System 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, the New Health System 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.

Acct #	Type of Account	Total Charges	Insurance Payments	Patient Payments	Current Bal Due	30% Disc Applied	New Balance Due from Never In-Network Payor and/or Patient
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 the New Health System 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, the New Health System would refund $100,000 to the Never In-Network payor and its patients.

FOR OUTPATIENT CHARGES

Same as Inpatient. As it does now, the New Health System 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 the New Health System 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, the New Health System would refund $50,000 to the Never In-Network payor and its patients.

APPENDIX 3

FORMAT FOR STANDARD PAYOR ANNUAL REPORT

FISCAL YEAR: _____

Payor	**Product Type**	**Term**	**(1) Total HIA Cumulative Carryforward Available from Prior Year** (Column 4 from Previous FY Standard Payor Annual Report)	**(2) HIA Available for Current Year**	**(3) HIA Used in Current Year**	**(4) Total HIA Cumulative Carryforward Available for Next Year (1+2 -3)**
Payor A (example only)	*Commercial*	*1/1/24-12/31/27*	*3.4%*	*3.2%*	*4.0%*	*2.2%*

EXHIBIT A

September 19, 2017 Approval Letter

(See
https://www.tn.gov/content/dam/tn/health/documents/Approval_Letter_granting_COPA.pdf)

EXHIBIT B-1

Monetary Commitments and Annual Baseline Spending Levels

MONETARY COMMITMENTS[8]

		Year 1 (FY2019)	Year 2 (FY2020)	Year 3 (FY2021)	Year 4 (FY2022)	Year 5 (FY2023)	Year 6 (FY2024)	Year 7 (FY2025)	Year 8 (FY2026)	Year 9 (FY2027)	Year 10 (FY2028)	Total
Expanded Access to HealthCare Services	Behavioral Health Services	$1,000,000	$2,667,000	$0	$9,333,000	$12,000,000	$12,000,000	$12,000,000	$12,000,000	$12,000,000	$12,000,000	**$85,000,000**
	Children's Services	1,000,000	1,333,000	0	4,667,000	4,000,000	4,000,000	3,000,000	3,000,000	3,000,000	3,000,000	**27,000,000**
	Rural Health Services	1,000,000	2,000,000	0	5,000,000	4,000,000	4,000,000	3,000,000	3,000,000	3,000,000	3,000,000	**28,000,000**
Health Research & Graduate Medical Education		0	4,000,000	0	11,000,000	11,000,000	11,000,000	12,000,000	12,000,000	12,000,000	12,000,000	**85,000,000**
Population Health Improvement		1,000,000	1,333,000	0	6,667,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	**75,000,000**
Region-wide Health Information Exchange		0	667,000	0	1,333,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	**8,000,000**
Totals		$4,000,000	$12,000,000	$0	$38,000,000	$43,000,000	$43,000,000	$42,000,000	$42,000,000	$42,000,000	$42,000,000	**$308,000,000**

[8] 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.

ANNUAL BASELINE SPENDING LEVELS[9]

Expanded Access to Healthcare Services:	$	89,095,964
Behavioral Health Services	$	6,890,510
Children's Health Services	$	7,831,371
Rural Health Services	$	74,374,082
Health Research & Graduate Medical Education	$	8,757,817
Population Health Improvement	$	2,994,045
Region-wide Health Information Exchange	$	$95,789

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.

[9] 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 B-2

Guidelines For Calculation of Baseline Spending and Incremental Spending

I. Capitalized Terms.

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 B-2, the following definitions shall apply to this Exhibit B-2:

"Baseline Components" means the services, cost centers, and individual expenditures that make up the Baseline Spending in a particular Category.

"Baseline Spending Levels" means the spending levels for the Categories shown on Exhibit B-1 - Page 2, and "Baseline Spending Level" means each of the corresponding Baseline Spending Levels individually.

"Categories" means the categories of Behavioral Health Services, Children's Services, Rural Health Services, Health Research and Graduate Medical Education, Population Health Improvement, and Region-Wide HIE described in Sections 3.02 through 3.05 of the TOC, and "Category" means each of the Categories individually.

"Incremental Components" means the services, cost centers, and individual expenditures for a particular Category in an approved Three-Year Plan which may count towards the Spending Commitment for that Category.

"Incremental Spending" means the actual amount the New Health System spends towards its Spending Commitments for a given Fiscal Year.

"Spending Commitments" means the incremental spending commitments for the Categories described in Sections 3.02 through 3.05, and "Spending Commitment" means each of the Spending Commitments individually.

"Three-Year Plans" means the three-year plans for the Categories described in Sections 3.02 through 3.05, and "Three-Year Plan" means each of the corresponding Three-Year Plans individually.

"Total Practice Cost" means the aggregate costs to the New Health System of the physician or physician extender, including all compensation, professional liability, and continuing education, along with all expenses incurred in the support of the practice including but not limited to nurses, aids, other staff, medical supplies, computers, rent, utilities, insurance, billing, and collection. The Total Practice Costs calculated for Baseline Spending did not include benefits due to the difference that existed between the two legacy health systems' benefit allocations. The Total Practice Costs calculated for Incremental Spending shall include the expenses associated with benefits if the provider is a new provider since the benefit allocations have been reconciled for the New Health System. However, the Total Practice Costs calculated for Incremental Spending shall not include the expenses associated with benefits if the provider is a replacement provider.

II. Baseline Spending Guidelines.

A) Baseline Spending Levels. The Baseline Spending Levels for each Category during the Ten-Year Period are set forth on Exhibit B-1- Page 2.

B) Reporting. In each Annual Report, the New Health System will include the amount of Baseline Spending incurred by the New Health System towards the six Categories for that Fiscal Year when reporting on the Incremental Spending incurred during that Fiscal Year. Once the total Spending Commitment for a particular Category has been satisfied, the New Health System and the Department will agree on what, if any, tracking/reporting on Baseline Spending is required.

C) Consistent Accounting of Baseline Spending. Accounting for Baseline Spending will be performed consistently each year. For purposes of measuring Baseline Spending each year, the New Health System may count any amount reasonably within the Baseline Spending Categories towards satisfaction of the Baseline Spending Level regardless of whether the amount was part of the Baseline Components of the original Baseline Spending calculation for that Category or not. For example:

- The initial level of Baseline Spending for Children's Services included the expenses associated with an employed pediatrician's practice in a rural community. In Year 2, the New Health System could reassign those expenses from Baseline Spending for Children's Services to Baseline Spending for Rural Health Services since these expenses fulfill needs related to both areas. In Year 3, the New Health System may continue to count the expenses towards Baseline Spending for Rural Health Services or reassign those expenses back to Baseline Spending for Children's Services.

- If the initial level of Baseline Spending for Children's Services included the expenses associated with a single employed pediatrician's practice in a rural community, and, in Year 2, the pediatrician's practice added another provider *who was not included in a Three-Year Plan*, the New Health System may count the expenses associated with the new provider towards Baseline Spending for Rural Health Services or Children's Services.

D) Allocation of Baseline Spending among Categories. Spending counted towards the Baseline Spending Levels may not be counted more than once. Baseline Spending may be divided or split fairly among Categories. When a Component is reassigned or reallocated from one Category to another, the Baseline Spending for the applicable Categories will be adjusted to allow for year over year comparisons. Where the expenses fulfill needs related to multiple areas – for example the expense for an adolescent psychologist – the expenses may be allocated between Children's Services and Behavioral Health Services, but the New Health System is not permitted to count the same expense twice. Additionally, no expense may be credited towards Baseline Spending if the amount is counted towards a Three-Year Plan or Capital Plan. For example:

- If the initial Baseline Spending Level for Children's Services included the expenses associated with an employed pediatrician's practice in a rural community, the New Health System could choose to split those Baseline Spending expenses between Children's Services and Rural Health in Year 2 since these expenses fulfill needs related to both areas.

- If the initial Baseline Spending Level for Children's Services included the expenses associated with a single employed pediatrician's practice in a rural community, and, in Year 2, the pediatrician's practice added another provider *who was included in the Children's Health Plan*, the New Health System may count the expenses associated with the new provider towards the Children's Health Spending Commitment but the expenses associated with the new provider could not be counted towards the Children's Services Baseline Spending Level *and* the Children's Health Spending Commitment.

E) Baseline Spending Shortfalls and Excesses. To the extent there is a shortfall in the Baseline Spending Level of a Category for a given year, the Incremental Spending in that same Category shall be applied first to cover the shortfall in Baseline Spending before the Incremental Spending is measured for compliance with the annual Spending Commitments set forth on Exhibit B-1 - Page 1. To the extent the Baseline Spending Level of a Category exceeds the Baseline Spending Level set forth on Exhibit B-1 – Page 2 for a given year, the COPA Monitor may approve the excess Baseline Spending (the amount over the Baseline Spending Level shown on Exhibit B-1 Page 2) being carried forward and applied to the Baseline Spending Level for the same Category for the next Fiscal Year as long as the excess Baseline Spending represents reasonable spending on operations in that Category. For example:

- In Year 5, if the New Health System's Baseline Spending in Behavioral Health Services was $6,000,000 ($890,510 below the Baseline of $6,890,510) and the New Health System's Incremental Spending for Behavioral Health was $13,000,000 ($1,000,000 over the $12,000,000 Spending Commitment for Year 5):

  - The New Health System's Incremental Spending in Behavioral Health would first be applied to the shortfall in Baseline Spending ($13,000,000 - $890,510 = $12,109,490); and

  - The remaining Incremental Spending for Behavioral Health ($12,109,490) would be compared against the Behavioral Health Spending Commitment for Year 5 ($12,000,000) to determine whether the New Health System has satisfied its Monetary Commitment for Behavioral Health for Year 5. Since $12,109,490 is greater than $12,000,000, the New Health System has satisfied its Spending Commitment for Behavioral Health in Year 5. The excess Incremental Spending for Behavioral Health ($109,490) would carryforward to be counted as Incremental Spending for Behavioral

Health Services in Year 6 without the need for an Update to the Spending Plan under Section III(D) since the amount is below the Materiality Threshold for updates to spending plans ($250,000).

- In Year 7, if the New Health System's Baseline Spending in Children's Health Services was $9,000,000 ($1,168,629 above the Baseline Spending Level of $7,831,371) and the New Health System's Incremental Spending for Children's Health Services was $4,000,000 ($1,000,000 over the $3,000,000 Spending Commitment for Year 7):

    - The New Health System has satisfied the Baseline Spending Level for Children's Health Services in Year 7 and the excess Baseline Spending ($1,168,629) would carryforward to be counted as Baseline Spending for Children's Health Services in Year 8 if the COPA Monitor determined that the excess Baseline Spending represents reasonable spending on Children's Health operations and approves the excess Baseline Spending being carried forward and applied to the Baseline Spending Level for Children's Health Services in Year 8.

    - The New Health System has satisfied the Incremental Spending Level for Children's Health Services in Year 7. The COPA Monitor would determine whether the excess Incremental Spending ($1,000,000) requires the submission of an Update to the Spending Plan pursuant to Section III(D) of these guidelines. If no Update to the Spending Plan is required, or if an Update to the Spending Plan is submitted and approved, the excess Incremental Spending ($1,000,000) would carryforward to be counted as Incremental Spending for Children's Health Services in Year 8.

F) Baseline Adjustments. From time to time, there may be circumstances that warrant the recalculation of one or more of the six Baseline Spending Levels. The recalculation of any such amount may be requested by the New Health System or the Department as part of a Three-Year Plan modification pursuant to Section 3.06 of the TOC.

If a change occurs that materially reduces the amount of a Baseline Component and the change is not the result of the New Health System cutting services, the New Health System may present information to the Department and request that the Baseline Component be adjusted to reflect the change or that the Department waive the shortfall based on the facts and circumstances. The Department will determine, in good faith, whether the Baseline Component should be adjusted for the change or waived based on the information provided by the New Health System. For example:

- If the initial Baseline Spending Level for HIE included the expenses associated with providing clinical and patient information to various third

parties and, in Year 3, the implementation of Epic eliminated the need for separate tools to continue to provide clinical and patient information to third parties, the New Health System could request to have the Baseline Spending Level for HIE on Exhibit B-1 – Page 2 adjusted downward to reflect the fact that the New Health System no longer has separate expenses for these tools as a result of the Epic implementation.

III. Incremental Spending Guidelines.

A) Spending Commitments. The Spending Commitments for each Category during the Ten-Year Period are set forth on Exhibit B-1- Page 1.

B) Reporting. In each Annual Report, the New Health System will include the amount of Incremental Spending incurred by the New Health System towards the six Categories for that Fiscal Year, and all direct patient service revenues generated by such spending.

C) Geographic Service Area. Each Incremental Component must be directly related to Public Advantage for the Geographic Service Area. Any expenditure (whether or not included as "Community Benefit" for tax purposes) should be included in a Three-Year Plan only if the expenditure can be linked to a specific Category. For example, student loan forgiveness may not be counted as an Incremental Component unless the physician is rural, or primarily serving children or behavioral health. Contributions to a national organization where the dollars go to national priorities, rather than the local chapter using funds in the Geographic Service Area, should not be counted as an Incremental Component.

D) Consistent Accounting of Incremental Spending. Accounting for Incremental Spending will be performed consistently each year. The New Health System will be required to submit a Three-Year Plan for each Category for approval by the Department pursuant to Section 3.06 of the TOC until the Spending Commitment for that particular Category has been satisfied. Once the Three-Year Plans are approved by the Department, the New Health System will submit an estimate of the amount it expects to spend on each strategy/initiative set forth in the approved Three-Year Plans on an annual basis. The Parties recognize that these are estimates only and the actual amounts the New Health System incurs towards execution of the Three-Year Plans may vary depending on various factors (e.g., construction costs may increase which would require the New Health System to spend more on an initiative than originally budgeted). The New Health System shall provide quarterly updates to the COPA Monitor on Incremental Spending throughout each Fiscal Year. If, during the Fiscal Year, the New Health System determines that the Incremental Spending on an initiative is likely to materially exceed the estimated amount previously budgeted for that year, the New Health System shall promptly submit an update to the spending plan (an "Update to the Spending Plan") for approval by the COPA Monitor in order to receive credit for the excess Incremental Spending above the Materiality Threshold following the process set forth in this Section III(D). An Update to the Spending Plan shall only be required if the excess

amount for the initiative is the greater of (i) $250,000 or (ii) twenty percent (20%) of the budgeted amount for the initiative for that year (the "Materiality Threshold"). Any Incremental Spending on an initiative in excess of the budgeted amount for that year but less than the Materiality Threshold may count towards the Spending Commitment without the need for an Update to the Spending Plan. The COPA Monitor's approval of the Update to the Spending Plan shall not be unreasonably withheld so long as the excess Incremental Spending is reasonably related to the previously approved initiative. If the Update to the Spending Plan for the excess Incremental Spending is approved, the effective date of the Update to the Spending Plan shall be the first day of the applicable Fiscal Year so as to ensure that any excess Incremental Spending which is approved by the COPA Monitor for the Fiscal Year may count towards the Spending Commitment (not just the Incremental Spending which occurred after the COPA Monitor's approval was received). For example:

- The New Health System includes $1,000,000 for Telehealth Expansion as an initiative in the Behavioral Health Plan for FY23-FY25 and the Department approves the Three-Year Behavioral Health Plan. The New Health System budgets to spend $400,000 towards the Telehealth Expansion initiative in FY23. However, the actual costs of the Telehealth Expansion initiative in FY23 are $500,000 due to increased demand for telehealth services. The New Health System may count the full $500,000 towards satisfaction of the Behavioral Health Spending Commitment in FY23 without submitting an Update to the Spending Plan since the excess Incremental Spending amount ($100,000) is below the Materiality Threshold for an Update to the Spending Plan (the greater of $250,000 or 20% of the budgeted amount for the initiative for that year, which in this case was $250,000).

- The New Health System includes $1,000,000 for Telehealth Expansion as an initiative in the Behavioral Health Plan for FY23-FY25 and the Department approves the Three-Year Behavioral Health Plan. The New Health System budgets to spend $400,000 towards the Telehealth Expansion initiative in FY23. However, the actual costs of the Telehealth Expansion initiative in FY23 are $800,000 due to increased demand for telehealth services. If the New Health System seeks to count the full $800,000 towards satisfaction of the Behavioral Health Spending Commitment in FY23, the New Health System would need to submit an Update to the Spending Plan for approval by the COPA Monitor (which approval would not be unreasonably withheld so long as the excess Incremental Spending is reasonably related to the previously approved initiative). If the COPA Monitor approved the Update to the Spending Plan, the New Health System would be permitted to count the full $800,000 it spent in FY23 towards the Behavioral Spending Commitment regardless of whether the excess spending occurred before or after receipt of the COPA Monitor's approval of the Update to the Spending Plan.

- The New Health System includes $12,000,000 for construction of a new facility as an initiative in the Behavioral Health Plan for FY26-28 and the Department approves the Three-Year Behavioral Health Plan. The New Health System budgets to spend $4,000,000 towards the initiative in FY26. However, the actual cost of construction in FY26 are $4,600,000 due to increased labor and supply costs. The New Health System may count the full $4,600,000 towards satisfaction of the Behavioral Health Spending Commitment in FY26 without submitting an Update to the Spending Plan since the excess Incremental Spending amount ($600,000) is below the Materiality Threshold for an Update to the Spending Plan (the greater of $250,000 or 20% of the budgeted amount for the initiative for that year, which in this case was 20% or $800,000).

E) Allocation of Incremental Spending among Categories. Spending counted towards the Spending Commitments may not be counted towards more than one Category. For example:

- If the New Health System includes the expenses associated with recruiting a new pediatrician in the FY23-25 Rural Health Plan, the New Health System may count the expenses associated with recruiting that pediatrician towards the Rural Health Spending Commitment, but the New Health System may not count the expenses towards a different Category's Spending Commitment (e.g., Children's) or count the expenses towards more than one Category (e.g., count the expenses towards Rural and Children's).

F) Net Patient Services Revenues. To the extent direct patient service revenue generated by an Incremental Component is included as an offset to spending, profitable practices or other operations will, after the offset of net revenue, produce a negative spend amount. If a new physician or physician extender shares an office and/or personnel with existing providers, the Total Practice Cost of such new provider will be allocated to the existing provider(s) up to the Baseline Spending Level. However, only the incremental expenses of the Total Practice Cost above the adjusted Baseline Spending Level shall be counted towards the Spending Commitment.

G) Gifts, Contributions, and Governmental Expenditures. Nothing in these guidelines is intended to alter in any way the offset provisions set forth in Section 3.01(c)(ii) of the TOC pertaining to certain gifts, contributions, and governmental expenditures.

H) Overhead. Overhead allocations for providers, including physician organization overhead allocations, may be counted as an Incremental Component towards a Spending Commitment if the overhead allocations represent direct costs incurred in the Incremental Component (e.g., employee benefits and billing costs). General overhead and corporate overhead for the New Health System should not be counted except to the extent it is directly related to supporting the Incremental Component.

Beginning in FY2026, overhead allocations, including physician organization overhead allocations, shall be included to the extent they represent direct costs incurred in the Incremental Component, for example employee benefits and billing costs. However, general system overhead and corporate overhead shall not be counted except to the extent they are directly related to supporting the Incremental Component.

I) Capital Expenditures.

Capital expenditures may not be counted as an Incremental Component if the capital expenditure constitutes a Capital Project pursuant to Section 3.07 of the TOC. For example:

- If the costs to renovate a rural clinic are included in the Capital Plan as a Capital Project, the New Health System may not also include the renovation costs in the Rural Health Plan.

Capital expenditures submitted and approved in a Three-Year Plan may be counted as an Incremental Component when they are placed into service, regardless of whether the funding for a Spending Commitment expenditure is from cash on hand or borrowed funds; provided, however, in the event that a financed expenditure is disposed of prior to the earlier to occur of (i) full repayment of the loan, or (ii) the end of its useful life as determined in accordance with principles applied by the New Health System in its financial records, such previously credited Incremental Component expenditure shall be reduced by the amount of any proceeds received by the New Health System in connection with such disposition. For example:

- The New Health System includes $1,000,000 in the Rural Health Plan for FY23-FY25 to build a new outpatient clinic. The Three-Year Plan is approved. The New Health System borrows $1,000,000 in FY23 to build the new outpatient clinic. The new outpatient clinic opens in FY24. The New Health System may count the $1,000,000 it spent on the new outpatient clinic in the Fiscal Year it opened (FY24) towards the Rural Health Spending Commitment.

- If the New Health System then sells the new outpatient clinic in FY25 to a REIT for $900,000 before the loan is repaid in full, the amount credited towards the Rural Health Spending Commitment for FY24 would be reduced to $100,000 ($1,000,000 minus the $900,000 proceeds of the sale).

J) Category-Specific Guidelines.

Behavioral Health Services.

- Gero-psych is excluded from Behavioral Health Services.

- To the extent the first Behavioral Health Plan includes the addition of a

new physician or physician extender to the Geographic Service Area (a "New Behavioral Health Provider"), the New Health System and the Department agree that the Total Practice Cost of that New Behavioral Health Provider will be offset by the professional services revenue generated by that New Behavioral Health Provider for the three-year period covered by the first Behavioral Health Plan.

- If a physician or physician extender is recruited to replace a provider previously identified in the Baseline Spending for Behavioral Health Services (a "Replacement Behavioral Health Provider"), the New Health System and the Department agree that the Total Practice Cost of that Replacement Behavioral Health Provider will not be offset by professional services revenue generated by that Replacement Behavioral Health Provider for the three year period covered by the first Behavioral Health Plan.

- To the extent the first Behavioral Health Plan includes the addition of facilities, equipment or other non-professional capital or expense, the operating expenses will be offset by the service revenue generated by such items for the three-year period covered by such plan.

Children's Services.

- To the extent the first Children's Health Plan includes the addition of a new physician or physician extender to the Geographic Service Area (a "New Children's Health Provider"), the New Health System and the Department agree that the Total Practice Cost of that New Children's Health Provider will be offset by the professional services revenue generated by that New Children's Health Provider for the three-year period covered by the first Children's Health Plan.

- If a physician or physician extender is recruited to replace a provider previously identified in the Baseline Spending for Children's Health Services (a "Replacement Children's Health Provider"), the New Health System and the Department agree that the Total Practice Cost of that Replacement Children's Health Provider will not be offset by professional services revenue generated by that Replacement Children's Health Provider for the three year period covered by the first Children's Health Plan.

- To the extent the first Children's Health Plan includes the addition of facilities, equipment or other non-professional capital or expense, the operating expenses will be offset by the service revenue generated by such items for the three-year period covered by such plan.

Rural Health Services.

- To the extent the first Rural Health Plan includes the addition of a new physician or physician extender to the Geographic Service Area (a "New Rural Health Provider"), the New Health System and the Department agree that the Total Practice Cost of that New Rural Health Provider will be offset by the professional services revenue generated by that New Rural Health Provider for the three-year period covered by the first Rural Health Plan.

- If a physician or physician extender is recruited to replace a provider previously identified in the Rural Health Baseline (a "Replacement Rural Health Provider"), the New Health System and the Department agree that the expenses associated with that Replacement Rural Health Provider will not be offset by professional services revenue generated by that Replacement Rural Health Provider for the three-year period covered by the first Rural Health Plan.

- To the extent the first Rural Health Plan includes the addition of facilities, equipment or other non-professional capital or expense, the operating expenses will be offset by the service revenue generated by such items for the three-year period covered by such plan.

K) Carryforward Spending. In determining whether the Spending Commitment for a given year has been met for a particular Category, the New Health System may first count any permitted excess Incremental Spending for the same Category from the prior year (the "Carryforward Spending") consistent with the language in Section 3.06(a) of the TOC and these guidelines. For example:

- The New Health System is required to spend $12,000,000 in Year 5 towards Behavioral Health Services and $12,000,000 in Year 6. In Year 5, the New Health System spends $13,000,000 ($1,000,000 over the Year 5 Spending Commitment). If the excess Incremental Spending amount ($1,000,000) is approved under Section III(D), the New Health System may carryforward the excess amount from Year 5 ($1,000,000) to Year 6. If, in Year 6, the New Health System spends $11,200,000, the New Health System may count the $1,000,000 excess from Year 5 together with the $11,200,000 spent in Year 6 to determine whether the Behavioral Health Spending Commitment has been satisfied for Year 6. Since $1,000,000 (Year 5 excess) plus $11,200,000 (Year 6 actual) is $12,200,000 and $12,200,000 is over the $12,000,000 Behavioral Health Spending Commitment for Year 6, the Behavioral Health Spending Commitment for Year 6 has been satisfied.

L) Projected Underspending. The New Health System shall provide quarterly updates to the COPA Monitor on Incremental Spending throughout each Fiscal Year to ensure that the COPA Monitor has visibility on Incremental Spending progress. If, at the

beginning of the fourth quarter of a Fiscal Year, it appears that the New Health System's Incremental Spending in any Category may fall below the Monetary Commitment for that Category set forth on Exhibit B-1 - Page 1 after accounting for any Carryforward Spending in that Category, the New Health System shall formally notify the Department pursuant to Section 6.04(d)(ii) that a shortfall in Incremental Spending for that Category is reasonably likely to occur.

EXHIBIT C

Access Sub-Index

The Department shall annually produce an Access Sub-Index Score to measure access to healthcare and prevention services within the Geographic Service Area. The data sources indicated in Table 1 below will be used to calculate the Access Sub-Index Score as outlined in this Exhibit, and the trends that will be reported in the Department Annual Report. Beginning with FY2026, the Access Sub-Index shall consist of the Access Measures described below. The Access Sub-Index Measures will be evaluated for the population specified for each Measure. If a population is not specified for a Measure, then the population for that Measure is the population in the Geographic Service Area.

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 Access Sub-Index Measure available as of the year of the Issue Date or as of the first year the data is available (as noted in Table 1).

"Access Improvement Measures" means the 12 Measures indicated as "Improvement" on Table 1 below. For each Access Improvement Measure, the New Health System will be required to show improvement such that the value reported for the end of the reporting period is better than that Measure's Baseline to earn credit each Fiscal Year.

"Access Maintenance Measures" means the 3 Measures indicated as "Maintenance" on Table 1 below. For each Access Maintenance Measure, the New Health System will be required to maintain performance on a Measure such that the value reported for the end of the reporting period is within 1% of that Measurement's Baseline or better to earn credit each Fiscal Year.

"Access Reporting Measure" means the Measure indicated as "Report" on Table 1 below. For the Access Reporting Measure, the New Health System will be required to report the information to the Department each Fiscal Year in order to earn credit each Fiscal Year.

"Maintenance of Hospitals Measure" means the Measure indicated as "Maintenance of Hospitals" on Table 1 below. For the Maintenance of Hospitals Measure, the New Health System will be required to maintain all COPA Hospitals in operation as of the Fifth Restatement Date licensed as hospitals in Tennessee each Fiscal Year through Fiscal Year 2028 to earn credit. For any Tennessee COPA Hospital that the New Health System closes between the Fifth Restatement Date through the end of Fiscal Year 2028, the New Health System shall lose half (25%) of the 50% credit for this Measure for the term of the COPA unless/until it is reopened. For any instance in which a COPA Hospital is replaced with Essential Services, the New Health System shall lose only a quarter (12.5%) of the 50% credit for this Measure for the COPA Term unless/until such hospital is reopened. The COPA Monitor and Department must agree that the replacement of a closed hospital with Essential Services is adequate to receive partial credit under this metric. The effect

of which is that by closing a single COPA Hospital, the New Health System would lose 25% of the total available score in the Access Sub-Index, and by closing a second COPA Hospital, an additional 25% of the total Access Sub-index score would be lost. However, if Essential Services are provided within the county of the closed COPA Hospital and are approved for partial credit by the COPA Monitor and the Department as described above, 12.5% of those lost points would be restored. This Measure shall only be used for Fiscal Year 2026 through Fiscal Year 2028.

Table 1: Access Sub-Index Measures

	Measure	Data Source	Expected Performance	Weight
1	Virtual Urgent Care Visits	New Health System Records	Maintenance	2%
2	Population within 15 miles of an emergency department (%)	U.S. Census Population Data 2010; Facility Addresses	Maintenance	2%
3	Population within 15 miles of an acute care hospital (%)	U.S. Census Population Data 2010; Facility Addresses	Maintenance	2%
4*	Pediatric Readiness of Emergency Department	Self-assessment performed by New Health System	Improvement	2%
5*	Emergency Department Wait Times	New Health System Records; CDC National Center for Health Statistics National Hospital Ambulatory Care Survey	Improvement	2%
6*	Appalachian Highlands Care Network Enrollment	New Health System Records	Improvement	2%
7*	Care Coordination Enrollment	New Health System Records	Improvement	2%
8	Maintenance of Hospitals[10]	New Health System Records	Maintenance of Hospitals	50%

[10] If the Medicaid Hospital Investment Program is not fully approved and implemented by July 1, 2025, the Parties will mutually agree upon a substitute measure for the "Maintenance of Hospitals" measure to be used for FY2026-FY2028.

	Measure	Data Source	Expected Performance	Weight
9*	Preventable Hospitalization – Older Adults	Ballad Health analysis of Hospital Discharge Data System, Tennessee Hospital Association and Virginia Hospital and Healthcare Association Inpatient Dataset and Medicare Enrollment	Improvement	2%
10*	Preventable Hospitalizations – Adults	Ballad Health analysis of Hospital Discharge Data System, Tennessee Hospital Association and Virginia Hospital and Healthcare Association Inpatient Dataset and US Census Bureau Fact Finder	Improvement	2%
11*	Screening – Breast Cancer	New Health System Records	Improvement	2%
12*	Screening – Cervical Cancer	New Health System Records	Improvement	2%
13*	Screening - Colorectal Cancer	New Health System Records	Improvement	2%
14*	Screening – Diabetes	New Health System Records	Improvement	2%
15*	Screening – Lung Cancer	New Health System Records	Improvement	2%
16*	Screening – Hypertension	New Health System Records	Improvement	2%
17	Patient Satisfaction and Access Survey – Response Report	New Health System Records	Report	20%
			TOTAL	**100%**

Maintenance (for Measures 1-3) = within 1% of Baseline or better.

*Improvement = any number which represents improvement over Baseline.

EXHIBIT D

Population Health Sub-Index

The Department shall annually produce a Population Health Sub-Index Score to measure short-term, mid-term, and long-term outcomes of various factors on population health within the Geographic Service Area. The data sources indicated in Table 1 below will be used to calculate the Population Health Sub-Index Score as outlined in this Exhibit and the trends that will be reported in the Department Annual Report. Beginning with FY2026, the Population Health Sub-Index shall consist of the Population Health Measures described below. The Population Health Sub-Index Measures will be evaluated for the population specified for each Measure. If a population is not specified for a Measure, then the population for that Measure is the population in the Geographic Service Area.

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 Population Health Sub-Index Measure available as of the year of the Issue Date or as of the first year the data is available (as noted in Table 1).

"Population Health Improvement Measures" means the 16 Measures indicated as "Improvement" on Table 1 below. For each Population Health Improvement Measure, the New Health System will be required to show improvement such that the value reported for the end of the reporting period is above that Measure's Baseline to earn credit each Fiscal Year.

"Population Health Monitoring Measures" means the 8 Measures indicated as "Monitor" on Table 1 below. For the Population Health Monitoring Measures, the New Health System will be required to report performance for all of the Population Health Monitoring Measures to the Department in order to earn the Population Health Monitoring Measures credit in any given Fiscal Year.

"Population Health Reporting Measure" means the Measure indicated as "Report" on Table 1 below. For the Population Health Reporting Measure, the New Health System will be required to report the information to the Department in order to earn credit each Fiscal Year.

Table 1: Population Health Measures

	Measure	Description	Data Source	Expected Performance	Weight
1*	Prenatal Care - Strong Pregnancies Enrollment	Number of enrollments in Strong Pregnancies program in fiscal year	New Health System EHR (all patient data)	Improvement	5.0%
2*	Pregnancy Intervention -	Number of enrollments in the Strong Futures program in fiscal year	New Health System EHR (all patient data)	Improvement	5.0%

	Measure	Description	Data Source	Expected Performance	Weight
	Strong Futures Enrollment				
3*	Average mPINC Score	Weighted system (based on number of live births per facility) mPINC survey score	CDC and the New Health System's internal survey	Improvement	5.0%
4*	Early Childhood Intervention - Strong Starts Enrollment	Number of enrollments in the Strong Starts program in fiscal year	New Health System EHR (all patient data)	Improvement	5.0%
5*	Addiction Recovery - Peer Recovery Enrollment	Number of enrollments in peer recovery services in fiscal year	New Health System EHR (all patient data)	Improvement	5.0%
6*	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 EHR (all patient data)	Improvement	5.0%
7*	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 EHR (all patient data)	Improvement	5.0%
8*	Mothers who Smoke During Pregnancy	Percent of births for which mother indicated she smoked during pregnancy out of total number of live births in the system	New Health System EHR (all patient data)	Improvement	5.0%
9*	Caesarean sections	The percentage of nulliparous women with a singleton, vertex fetus at ≥ 37 weeks of gestation who deliver a liveborn infant by c-section. The numerator includes women delivering by planned c-section due to obstetric indications (placenta previa, HIV infection, prolapsed cord) and primary elective c-sections. The denominator is the number of nulliparous women with a singleton, vertex fetus at ≥ 37 weeks of gestation who deliver a liveborn infant	New Health System EHR (all patient data)	Improvement	5.0%
10*	NAS Births	Percent of infants screened for NAS with clinical s/sx out of total number of live births in the system	New Health System EHR (all patient data)	Improvement	5.0%

	Measure	Description	Data Source	Expected Performance	Weight
11*	Kindergarten ready	# of schools who conduct the readiness assessment in the New Health System's TN GSA	New Health System's tracking report from Niswonger Foundation	Improvement	5.0%
12*	Low Birthweight	Percent of low birth weight births out of total of live births in system	New Health System EHR (all patient data)	Improvement	5.0%
13*	Prenatal smoking cessation enrollment	Number of prenatal enrollments into the cessation program in the fiscal year	New Health System EHR (all patient data)	Improvement	5.0%
14*	Follow-Up After Hospitalization for Mental Illness – 7 Days	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	(1) Employee Health Plan (2) Anewcare's ACO Medicare Shared Savings Program	Improvement	5.0%
15*	Antidepressant Medication Mgmt – Effective Acute Phase Treatment 12 wk	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)	(1) Employee Health Plan (2) Anewcare's ACO Medicare Shared Savings Program	Improvement	5.0%
16*	Engagement of Alcohol or Drug Treatment – 30 Days	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	(1) Employee Health Plan (2) Anewcare's ACO Medicare Shared Savings Program	Improvement	5.0%
17	Third Grade Reading Level	% of 3rd grade students in the New Health System's service area of TN schools who are proficient in reading based on the TDOE test score.	Tennessee Department of Education	Monitor	10%
18	Infant Mortality	Number of children who died prior to reaching their first birthday in the New Health System's service area of TN counties. Rate is per 1,000 live births.	(1) CDC Wonder (2) the Department	Monitor	
19	High School Graduation	Percentage of students graduating within four years of entering high school, and graduation in more than four years for students with an Individual Education Plan in the New Health System's service area of TN schools.	Tennessee Department of Education	Monitor	
20	Employment	Number of unemployed people as a percentage of the labor force for the	Department of Labor	Monitor	

	Measure	Description	Data Source	Expected Performance	Weight
		New Health System's service area of TN counties.			
21	Teen Birth Rate	Percent of live births to teen mothers (15-19 years of age) out of total of live births in the system	New Health System EHR (all patient data)	Monitor	
22	Drug Deaths	Number of drug overdose deaths in the New Health System's service area of TN counties. Rate is per 100,000 residents.	(1) CDC Wonder (2) the Department	Monitor	
23	Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted) in the New Health System's service area of TN counties.	Behavioral Risk Factor Surveillance System	Monitor	
24	Suicide Deaths	Number of suicide deaths in the New Health System's service area of TN counties. Rate is per 100,000 residents.	(1) CDC Wonder (2) the Department	Monitor	
25	STRONG Link Study	Submission of Strong LINK Annual Status Report	New Health System	Report	10.0%
					100%

* Improvement = any number which represents improvement over Baseline.

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.
- During the Ten-Year Period, the COPA Monitor may meet with patients, physicians (employed and non-employed) and community/business leaders 1-2 times annually to discuss if there are issues of compliance with the COPA and shall provide a report of any such meetings to the New Health System Board of Directors and management.

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 Access Sub-Index, (v) the Population Health Sub-Index, (vi) the Quality/Other Sub-Index, and (vii) the Economic Sub-Index.
  - The Department Annual Report shall be published no later than thirty (30) days after the publication of the COPA Monitor Annual Report

EXHIBIT G

Forms of Annual Report and Quarterly Report

ANNUAL REPORT CONTENTS:

NOTE: WHERE NUMERICAL DATA ARE REQUESTED, PROVIDE DATA FOR THE YEAR UNDER REVIEW (OR PARTIAL YEAR AS RELEVANT) AND THE 2 PRIOR YEARS (IF PREVIOUSLY REPORTED).

Requirement	Pursuant to
1. Facility Maintenance and Capital Expenditures. - Schedule of all maintenance and repair expenses and capital expenditures during the year; - Report whether met or exceeded aggregate capital expenditure spending commitments (board approved capital budget) for three years per Capital Plan.	Section 3.07(b) Section 6.04(b)(1)
2. Career Development Plan. Report any updates to the implementation and results of the Career Development Plan. Include the following: a. A summary of workforce development program including budget commitment; b. An explanation of how programs meet the strategic needs of the New Health System; c. A list of training programs/career development programs; d. Provide percentages as well as counts on Key Workforce Development Metrics.	Section 3.08(c) Section 6.04(b)(2)
3. Clinical Council. Provide: - Council roster indicating which members are employed versus independent providers. - Updates on sub-committee work and initiatives. - Narrative or documentation, as applicable, on changes to the following: a. common standard of care; b. credentialing standards; c. consistent multidisciplinary peer review; and d. best practices.	Section 4.02(b) Section 6.04(b)(3)
4. Quality Indicators. - Data for Quality/Other Sub-Index and baseline for the New Health System at the following levels: system level, state level, facility level; - Comparisons to similarly sized systems in the United States as well as National Top Decile and National Average;.	Section 4.02(c)(ii) Section 6.04(b)(4)

	Exhibit K
5. Patient Satisfaction Survey.* - Provide results of the patient satisfaction surveys for three years; - Provide a copy of the plan to address deficiencies and opportunities for improvement related to perceived access to care services; and - Document satisfactory progress toward the prior year's plan.	Section 4.02(c)(iii) Section 6.04(b)(5) Exhibit C
6. Staffing Levels. (Marked Confidential) Provide: - number of LPNs and RNs employed by the New Health System at the beginning of the Fiscal Year; - number of LPNs and RNs newly hired by the New Health System during the Fiscal Year; - number of LPNs and RNs previously employed by the New Health System who have left the New Health System since the beginning of the Fiscal Year (does not include contract labor); and - number of LPNs and RNs employed by the New Health System at the end of the Fiscal Year.	Section 4.02(c)(iv) Section 6.04(b)(6)
7. Staff Surveys.** (Marked Confidential) Provide results of the annual Employee Engagement Survey as set out in Section 4.02(c)(v) for the system, as well as for Bristol Regional Medical Center, Holston Valley Medical Center, Johnson City Medical Center, Johnston Memorial Hospital, and Norton Community Hospital consisting of the following: a. average employee engagement score for i. the organization, ii. managers, and iii. employees; b. participation percentage; and c. comparison between recent survey results and previous results. - Physician Engagement Survey as set out in Section 4.02(c)(v), a score for the system, as well as for Bristol Regional Medical Center, Holston Valley Medical Center, Johnson City Medical Center, Indian Path Community Hospital, Johnston Memorial Hospital, and Norton Community Hospital to include the following: a. participation percentage; and b. comparison between recent survey results and previous results.	Section 4.02(c)(v) Section 6.04(b)(7)

8. Patient-related prices charged. - For years in which the COPA Monitor drafts a report on the New Health System's prices charged for the Fiscal Year in review, the New Health System shall reference the COPA Monitor's conclusions and provide either an electronic copy (Excel) of or link to the most currently applicable chargemaster(s) online (as long as such chargemaster is in an Excel file); **OR** - Provide a. a complete explanation of any material pricing changes to the chargemaster(s) during the year in review (in such categories as are specified by the Department); b. an electronic copy of or link to the most currently applicable chargemaster(s); and c. A summary of any changes to commercial insurance or managed care contracts in which rates are negotiated (Marked Confidential)	Section 6.04(b)(8)
9. Cost-efficiency steps taken. Provide, per year, for the three years: - a list of efficiencies achieved, by category, for amounts greater than $200,000; - Cost per adjusted discharge	Section 6.04(b)(9)
10. Equalization Plan status (Marked Confidential). Provide: - Summary of salary and benefit equalization steps taken in the last fiscal year, - Schedule of FTEs (to include contract labor) per adjusted occupied bed for the system, as well as for Bristol Regional Medical Center, Holston Valley Medical Center, Johnson City Medical Center, Indian Path Community Hospital, Johnston Memorial Hospital, and Norton Community Hospital individually for the fiscal year under review and the prior two fiscal years. (Adjustments may be made to the metrics to ensure the metric is comparable for the 3 (three) years.)	Section 6.04(b)(10)
11. Services or Functions Consolidated. List or describe any services or functions that were consolidated during the year in review that resulted in cost savings in excess of Two Million Dollars ($2,000,000).	Section 6.04(b)(11)
12. Changes in volume or availability of inpatient or outpatient services. List or describe any material changes in volume or availability of any inpatient or outpatient services offered during the year in review.	Section 6.04(b)(12)
13. Summary of residency program. Provide: a. summary of the New Health System's residency and fellowship programs and the New Health System's goals related to each (those who train/work predominantly in the New Health System facilities); b. summary of activities and progress toward goals; c. residency program data to include: i. Name of Program;	Section 6.04(b)(13)

ii. Match rates; iii. Program status; iv. Site; v. Positions; vi. Available positions filled; and vii. Board Passage rate. (The New Health System will require the academic institution to provide the requested information on their residency programs. If an institution chooses not to, the New Health System will report that to the State.)	
14. Movement of any residency "slots". Provide: - data on residency "slots" for residency programs sponsored by the New Health System (# of slots on the Closing Date and for the current year) and - a description of any affiliation agreements moving resident "slots" from one COPA Hospital to another pursuant to Medicare rules, - a description of any resident programs moved from one COPA Hospital to another, and - a description of any new programs started.	Section 6.04(b)(14)
15. Partnerships. - Regarding Academic partnerships, provide: a. a table summarizing research activities; b. a summary of (i) the New Health System's research goals, (ii) research activities and progress toward goals, (iii) involvement of academic and community partners, (iv) money spent funding grants (if any), (v) grant money the New Health System brought in or assisted others in bringing into the region (if any); c. A narrative highlighting two to five New Health System research projects. - Regarding non-Academic partnerships, a narrative highlighting two to five federal or state research projects the New Health System is engaged in that are relevant to the New Health System's HIE, population health, rural health, behavioral health, and children's health goals (e.g., AHC, HRSA, etc.).	Section 6.04(b)(15)
16. Published reports from research projects. Provide copies of or links to any published reports from research projects conducted by the New Health System and its academic partners pursuant to an approved HR/GME Plan;	Section 6.04(b)(16)
17. Updated Plan of Separation.	Section 6.04(b)(17)
18. Comparison of New Health System financial ratios. Provide: - A comparison of the New Health System's financial ratios to the median of similarly rated health systems where available from the rating agencies – Fitch, S&P, and Moody's - 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,	Section 6.04(b)(18)

- 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, and - a schedule of values for each component required to make the various ratio calculations for the New Health System; 6.04(b)(xiii); and - audited financials.	
19. Total Charity Care Information. Provide: - A table for the three most recent fiscal years on (i) charity care provided by New Health System, (ii) unreimbursed TennCare and Medicaid. - A narrative on, as applicable, any (i) decreases in charity care over prior years, (ii) adjustments made to calculations, and (iii) changes in state or federal policies impacting charity care. - Report on compliance with Section 4.03(e)	Section 4.03(f) Section 6.04(b)(19)
20. Updated New Health System organizational chart. Provide a chart with listing of corporate officers and members of the Board.	Section 6.04(b)(20).
21. Data. Provide: - Data for Access Sub-Index and Population Health Sub-Index.	Section 6.04(b)(21)
22. Information expressly required for the Annual Report pursuant to any other section of these Terms of Certification, the Tennessee Cooperation Act, or the COPA Rules.	Section 6.04(b)(22) TOC TN Hospital Cooperation Act COPA Rules
23. Updates to and implementation achieved on the following plans: - the Population Health Plan (Including updates to and implementation achieved on the Striving Toward Resilience and Opportunity for the Next Generation (STRONG) Longitudinal Study) - the HR/GME Plan; - the HIE Plan; - the Behavioral Health Plan; - the Children's Health Plan; - the Rural Health Plan. - The New Health System will report: • (1) the dollar amount of financial support provided to Project Access each year and (2) the number of encounters for Project Access enrollees. • (1) the number of individuals enrolled in the Appalachian Highlands Care Network each year and (2) the number of encounters for Appalachian Highlands Care Network enrollees	Section 6.04(b)(23) Section 3.02 Section 3.03 Section 3.04 Section 3.05 Section 4.03(e)(v)

24. Recruitment and retention of physicians and advanced practice providers (Marked Confidential). Provide: - A schedule that includes for the year in review, as well as the two prior years (For FY25 include FY23 and FY24): a. For the New Health System Medical Staff: i. number of physicians and extenders with medical staff privileges at the beginning of the Fiscal Year broken down by (i) total specialists, (ii) total Primary Care Providers; ii. number of new physicians and extenders with medical staff privileges in the GSA broken down by (i) total specialists, (ii) total Primary Care Providers; iii. number of physicians and extenders with medical staff privileges who have stopped practicing in the GSA broken down by (i) total specialists, (ii) total Primary Care Providers; and iv. number of physicians and extenders with medical staff privileges at the end of the Fiscal Year broken down by (i) total specialists, (ii) total Primary Care Providers. b. For the New Health System Employed Providers: i. number of physicians and extenders employed by the New Health System at the beginning of the Fiscal Year broken down by (i) total specialists, (ii) total Primary Care Providers; ii. number of new physicians and extenders employed by the New Health System in the GSA broken down by (i) total specialists, (ii) total Primary Care Providers; iii. number of physicians and extenders previously employed by the New Health System who have stopped practicing or are no longer employed by the New Health System in the GSA broken down by (i) total specialists, (ii) total Primary Care Providers; and iv. number of physicians and extenders employed by the New Health System at the end of the Fiscal Year broken down by (i) total specialists, (ii) total Primary Care Providers. - A narrative describing the actions taken by the New Health System to bring physicians and extenders to the region. - A narrative describing the actions taken by the New Health System to retain physicians and extenders.	Section 4.03(a)(ii) Sections 3.02(b-c) Section 6.04(b)(24) Exhibit C
25. Recruitment and retention of nurses. (Marked Confidential) - A schedule that includes for the year in review, as well as the two prior years (For FY25 include FY23 and FY24): a. number of nurses working in an acute care inpatient facility of the New Health System at the beginning of the fiscal year broken down by (i) licensed and (ii) unlicensed; b. number of nurses newly hired by the New Health System in an acute care inpatient facility broken down by (i) licensed and (ii) unlicensed; c. number of the New Health System acute care inpatient facility nurses who have newly stopped working in the GSA broken down	Section 6.04(b)(25)

by (i) licensed and (ii) unlicensed; d. subtotal for the New Health System's Virginia facilities; e. subtotal for the New Health System's Tennessee facilities; and f. Grand Total for the region. - A narrative describing the actions taken by the New Health System to bring nurses to the region. - A narrative describing the actions taken by the New Health System to retain nurses.	
26. Information related to compliance with Addendum 1 to be submitted in an electronic format annually, by November 30.	Section 5.02(a) Section 6.04(b)(26) Addendum 1
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 Chief Financial Officer that the pricing for such contracts complies with Addendum 1; and	Addendum 1
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.	Addendum 1

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).
    - Balance sheet
    - Statements of income and cash flow
- YTD Community Benefit Spending per Form 990 reporting guidelines for each reporting entity.
    - By Category, compared to commitment spending
        - Progress towards distributing grants
        - Internal spending
- Quality Metrics reported to CMS
- 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
    - Plans. Update on plans to close or open any Service Lines or facilities.

    - Progress. Update on the status of any closures or openings of facilities or Service Lines.
- The COPA Compliance Office Quarterly Reports:
    - Complaints by type
    - Resolution of complaints
    - 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:

Sec.	Commitment
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:

Sec.	Commitment
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:

Sec.	Commitment
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 Service Lines, Non-Hospital Facilities and Other Services
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 Quality/Other

ECONOMIC SUB-INDEX PART I

Sec.	Commitment/Outcome	Metric
Article V and Addendum 1	Managed Care Contracts	Pass/Fail

ECONOMIC SUB-INDEX PART II

Sec.	Commitment/Outcome	Metric
Exhibit I	Capital Spending	Reduction of up to 6 Capital Spending Points as described below

Calculation of Economic Sub-Index Part II

The Department shall annually calculate the amount of Capital Spending Points by measuring the amount of capital spending as a percentage of depreciation of the New Health System during FY2026, FY2027, and FY2028. For purposes of measuring capital spending as a percentage of depreciation, all of the New Health System's capital spending in the given fiscal year, set forth in the New Health System's audited financial statements, shall be counted.

The number of points in which the Department is authorized to deduct from the Final Score (each, a "Capital Spending Point") shall be calculated as follows:

- If capital spending is below 90 percent of depreciation, the Department may deduct up to 6 Capital Spending Points.
- If capital spending is 90 percent to 94 percent of depreciation, the Department may deduct up to 4 Capital Spending Points.
- If capital spending is 95 percent to 99 percent of depreciation, the Department may deduct up to 2 Capital Spending Points.
- If capital spending is 100 percent of depreciation or above, the Department may deduct 0 Capital Spending Points.

Any amount of capital spending in a given fiscal year that exceeds 100 percent of depreciation may be rolled forward to count towards the next fiscal year's capital spending.

This Economic Sub-Index Part II shall only be used for Fiscal Years 2026 through 2028.

If the New Health System's capital spending in a given fiscal year falls below 100 percent of depreciation, the New Health System may include in the Annual Report an explanation of why the capital spending was below 100 percent of depreciation.

The New Health Systems may apply for a waiver of or relief from any deduction of Capital Spending Points that shall result from its capital spending falling below 100 percent in a fiscal year, with such request made in writing as required by Section 9.01. The New Health System shall submit the request as soon as it believes, or should have reason to believe, that its capital spending may fall below 100 percent of depreciation in a fiscal year. However, in no event shall such a request be submitted later than when the New Health System submits its annual report to the Department as required by Section 6.04(b).

The Department, in its discretion, may consider the explanation provided by the New Health System, as well as any relevant market conditions and economic conditions, in making its determination about whether to waive the deduction of Capital Spending Points. The Department shall provide a response to the New Health System within thirty (30) days of receiving all of the information reasonably necessary to evaluate the waiver request (which information shall be agreed upon by the New Health System and the COPA Monitor in advance). The Department agrees to promptly notify the New Health System as soon as a decision on the waiver request has been made. The Department further agrees that no deductions to the Final Score shall be applied until the Department provides a decision in writing on the waiver request.

POPULATION HEALTH SUB-INDEX

Sec.	Measures	Sub-Index Percentage Weight
Exhibit D	Population Health Improvement Measures	80%
Exhibit D	Population Health Monitoring Measures	10%
Exhibit D	Population Health Reporting Measure	10%
	Total	**100%**

ACCESS SUB-INDEX

Sec.	Measures	Sub-Index Percentage Weight
Exhibit C	Access Improvement Measures	24%
Exhibit C	Access Maintenance Measures	6%
Exhibit C	Maintenance of Hospitals Measure	50%
Exhibit C	Access Reporting Measure	20%
	Total	**100%**

QUALITY/OTHER SUB-INDEX

Sec.	Measures	Sub-Index Percentage Weight
Exhibit K	Quality Improvement Measures	80%
Exhibit K	Quality Monitoring Measures	20%
	Total	**100%**

EXHIBIT J

SCORING; FINAL SCORE

1. Determine score (Pass or Fail) for Economic Sub-Index Part I.

2. If applicable, determine impact of a failing score on the Economic Sub-Index Part I 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). Due to the comprehensive revision of the scoring structure, no numerical score will be calculated for FY25. Instead, compliance with the governing COPA statutes and Terms of Certification will be assessed through a report rather than a numerical score.

4. Multiply the applicable score for each Sub-Index by its assigned weighting:

Sub-Index	**Percentage Weight**
Population Health	20%
Access	40%
Quality/Other	40%
Total	**100%**

5. Add results of Item 4 for a Preliminary Score.

6. Subtract from the Preliminary Score the Capital Spending Points, if any, calculated in accordance with the Economic Sub-Index Part II for a Final Score.

7. As part of the Department's annual assessment of continuing public advantage, the Department may consider reputable information related to advantages and disadvantages beyond the specific Measures found in the Index. To accomplish this, the Department may adjust the Final Score upwards or downwards by 0 to 5% to account for advantages and/or disadvantages submitted by the New Health System or identified by the Department for the Fiscal Year being scored.

8. Application of Final Score to Public Advantage:

Final Score	Public Advantage Clear and Convincing?
(≥ 70)	Advantage is clear and convincing; the COPA continues in effect.
(60-<70)	Advantage is not clear and convincing; a modification to the Cooperative Agreement under the terms of certification will be necessary.
(< 60)	Advantage is not evident; COPA is terminated.

EXHIBIT K

Quality/Other Sub-Index

The Department shall annually produce a Quality/Other Sub-Index to measure other benefits of the COPA, including without limitation enhancement of quality of care, patient satisfaction, medical research and education. The data sources indicated in Table 1 below will be used to calculate the Quality/Other Sub-Index Score as outlined in this Exhibit and the 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:

"Baseline" means the value of each individual Quality Measure available as of the year of the end of Calendar Year 2022.

"Quality Improvement Measures" means the list of 24 Measures indicated as "Improvement" on Table 1 below.

"Quality Monitoring Measures" means the 40 Measures indicated as "Monitor" on Table 1 below.

Quality Improvement Measures for New Health System

The Quality Improvement 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 Quality Improvement Measures depending on baseline data, annual performance improvements, and other factors.

Whenever possible, the Quality Improvement Measures will be evaluated for the entire patient population and will not be restricted based on the patient's payor status. Specifically, the Quality Improvement Measures will not be limited to the Medicare population unless the Quality Improvement Measure is only available for the Medicare population. For hospital improvement performance, Quality Improvement Measures will include CMS Hospital Compare measures. The New Health System shall submit data for the Quality Improvement Measures at each of the following levels: (1) individual data for each applicable New Health System Entity located in Tennessee; (2) aggregate data for the applicable New Health System Entities located in Tennessee; and (3) aggregate data for the entire New Health System.

For each Quality Improvement Measure, the New Health System will be required to show improvement such that the value reported for the end of the applicable year's reporting period is above that Measure's Baseline to earn credit each Fiscal Year. For those Quality Improvement Measures which are reported using SIRS data, the New Health System will earn credit if the New Health System performs "at or better than expected."

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, the Department may reclassify a Quality Monitoring Measure where the New Health System performs below Baseline for two (2) consecutive years to an Improvement Quality Measure. The Department agrees that no more than two (2) Quality Monitoring Measures will be reclassified in any given year and the Department will notify the New Health System of the intent to reclassify a Quality Monitoring Measure no later than January 1 before the reclassification goes into effect for the upcoming Fiscal Year. A corresponding number of Quality Improvement Measures will be reclassified to Quality Monitoring Measures to keep the number of Quality Improvement Measures at 24.

For hospital quality performance, Quality Monitoring Measures will include CMS Hospital Compare measures. Whenever possible, the Quality Monitoring Measures will be evaluated for the entire patient population and will not be restricted based on the patient's payor status. Specifically, the Quality Monitoring Measures will not be limited to the Medicare population unless the Quality Improvement Measure is only available for 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 New Health System 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 Quality Monitoring Measures, the New Health System will be required to report performance for all of the Quality Health Monitoring Measures to the Department in order to earn the Quality Health Monitoring Measures credit in any given Fiscal Year.

Retirement of Quality Improvement Measures or Quality Monitoring Measures

The New Health System will keep these 64 Quality/Other Sub-Index Measures unless CMS changes a Measure. If CMS retires one of the 64 Measures, the Measure will be dropped from the Quality/Other Sub-Index.

If the Measure that is being retired is a Quality Monitoring Measure, the New Health System will propose a different CMS Hospital Compare measure to replace it in the Quality/Other Sub-Index (to keep the number of Quality Monitoring Measures at 40), which the Department may approve or replace.

If the Measure that is being retired is a Quality Improvement Measure, the New Health System will propose a current Quality Monitoring Measure to be scored as a Quality Improvement Measure (to keep the number of Quality Improvement Measures at 24) and the New Health System will propose a different CMS Hospital Compare measure to replace that Measure (to keep the number of Quality Monitoring Measures at 40), which the Department may approve or replace.

Replacement of Quality Improvement Measures or Quality Monitoring Measures

If CMS replaces one of the 64 Quality/Other Sub-Index Measures, the Department will replace the Measure in the Quality/Other Sub-Index.

If the Measure that is being replaced is a Quality Monitoring Measure, there will be no change to the value of the Quality Monitoring Measure.

If the Measure that is being replaced is a Quality Improvement Measure, the New Health System and the Department will determine if the replacement Measure is a Quality Improvement Measure or a Quality Monitoring Measure. If the New Health System and the Department agree to treat the replacement Measure as a Quality Monitoring Measure, the New Health System and the Department will select a current Quality Monitoring Measure to be scored as a Quality Improvement Measure (to keep the number of Quality Improvement Measures at 24 and the number of Quality Monitoring Measures at 40).

Table 1: Quality Improvement Measures and Quality Monitoring Measures

	Measure	Description	Data Source[11]	Expected Performance	Weight
1.	HAI - 1	Central Line-Associated Bloodstream Infection (CLABSI) Rate	NHSN (All Payors) ** CMS Star Measure	Improvement	3.33%
2.	HAI - 2	Catheter-Associated Urinary Tract Infection (CAUTI) Rate	NHSN (All Payors) ** CMS Star Measure	Improvement	3.33%
3.	HAI - 3	Surgical site infections from colon surgery (SSI: Colon)	NHSN (All Payors) ** CMS Star Measure	Improvement	3.33%
4.	HAI - 4	Surgical site infections from abdominal hysterectomy (SSI: Hysterectomy)	NHSN (All Payors) ** CMS Star Measure	Improvement	3.33%
5.	HAI - 5	Methicillin-Resistant Staphylococcus Aureus (MRSA) Rate	NHSN (All Payors) ** CMS Star Measure	Improvement	3.33%
6.	HAI - 6	Clostridium Difficile Infection (CDI) Rate	NHSN (All Payors) ** CMS Star Measure	Improvement	3.33%
7.	H-COMP-1-A-P	Communication with nurses (composite measure)	Press Ganey (All Payors) ** CMS Star Measure	Improvement	3.33%
8.	H-CLEAN-HSP-A-P	Cleanliness of hospital environment (individual measure)	Press Ganey (All Payors) ** CMS Star Measure	Improvement	3.33%
9.	H-COMP-6-Y-P	Discharge information (composite measure)	Press Ganey (All Payors) ** CMS Star Measure	Improvement	3.33%
10.	SEP-1	Sepsis Bundle (Early mgmt bundle, severe sepsis/ septic shock)	Premier (All Payors) **CMS Star Measure	Improvement	3.33%
11.	READM-30-HOSP-WIDE	30-day hospital-wide all- cause unplanned readmission (HWR)	Premier (All Payors) **CMS Star Measure	Improvement	3.33%
12.	PSI 3	Pressure Ulcer Rate	Premier (All Payor)	Improvement	3.33%
13.	PSI 6	Iatrogenic Pneumothorax Rate	Premier (All Payor)	Improvement	3.33%

[11] CMS (MDC FFS) is Medicare Fee For Service.

	Measure	Description	Data Source[11]	Expected Performance	Weight
14.	PSI 8	In Hospital Fall with Hip Fracture Rate	Premier (All Payor)	Improvement	3.33%
15.	PSI 9	Postoperative Hemorrhage or Hematoma Rate	Premier (All Payor)	Improvement	3.33%
16.	PSI 10	Postoperative Acute Kidney Injury Requiring Dialysis	Premier (All Payor)	Improvement	3.33%
17.	PSI 11	Postoperative Respiratory Failure Rate	Premier (All Payor)	Improvement	3.33%
18.	PSI 12	Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate	Premier (All Payor)	Improvement	3.33%
19.	PSI 13	Postoperative Sepsis Rate	Premier (All Payor)	Improvement	3.33%
20.	PSI 14	Postoperative Wound Dehiscence Rate	Premier (All Payor)	Improvement	3.33%
21.	PSI 15	Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate	Premier (All Payor)	Improvement	3.33%
22.	ED 1	Median Time from ED arrival to Transport for Admitted Patients	Premier (All Payor)	Improvement	3.33%
23.	Mortality O/E	Mortality O/E	Premier (All Payor)	Improvement	3.33%
24.	All Cause Mortality	All Cause Mortality	Premier (All Payor)	Improvement	3.33%
25.	PSI-90-Safety	Complication/patient safety for selected indicators (composite)	Premier (All Payors) **CMS Star Measure	Monitor	20%
26.	COMP-HIP-KNEE	Hospital level risk-standardized complication rate {RSCR) following elective primary (THA) and (TKA)	Premier (All Payors) **CMS Star Measure	Monitor	
27.	H-COMP-2-A-P	Communication with doctors (composite measure)	Press Ganey (All Payors) ** CMS Star Measure	Monitor	
28.	H-COMP-3-A-P	Responsiveness of hospital staff (composite measure)	Press Ganey (All Payors) ** CMS Star Measure	Monitor	
29.	H-COMP-5-A-P	Communication about medicines (composite measure)	Press Ganey (All Payors) ** CMS Star Measure	Monitor	
30.	H-COMP-7-SA	Care Transition (composite measure)	Press Ganey (All Payors) ** CMS Star Measure	Monitor	
31.	H-HSP-RATING-9-10	Overall rating of hospital (global measure)	Press Ganey (All Payors)	Monitor	

	Measure	Description	Data Source[11]	Expected Performance	Weight
32.	OP-29	Endoscopy/polyp surveillance: appropriate follow-up interval for normal 17 OP-29 colonoscopy in average risk patients	CMS (MDC FFS) ** CMS Star Measure	Monitor	
33.	OP-18b	Average (median) time patients spent in the emergency department before leaving from the visit	Premier (All Payors) ** CMS Star Measure	Monitor	
34.	Sepsis In-House Mortality	Percentage of patients diagnosed with sepsis who die while hospitalized	Premier (All Payors)	Monitor	
35.	OP-22	Patient left without being seen	EPIC (all payors) **CMS Star Measure	Monitor	
36.	OP23	Head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival	Premier (All Payors) ** CMS Star Measure	Monitor	
37.	HCP COVID - 19(New)	COVID vaccination coverage among health care providers	NHSN (All Payors) ** CMS Star Measure	Monitor	
38.	IMM-3	Immunization for influenza	NHSN (All Payors) ** CMS Star Measure	Monitor	
39.	OP-8	MRI Lumbar Spine for Low Back Pain	CMS (MDC FFS) ** CMS Star Measure	Monitor	
40.	OP-10	Abdomen CT - Use of Contrast Material	CMS (MDC FFS) ** CMS Star Measure	Monitor	
41.	OP-13	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	CMS (MDC FFS) ** CMS Star Measure	Monitor	
42.	READM-30-COPD	Chronic obstructive pulmonary disease (COPD) 30-day readmission rate	Premier (All Payors) ** CMS Star Measure	Monitor	
43.	READM-30-AMI	Acute myocardial infarction (AMI) 30-day readmission rate	Premier (All Payors)	Monitor	
44.	READM-30-HF	Heart failure (HF) 30-day readmission rate	Premier (All Payors)	Monitor	
45.	READM-30-PN	Pneumonia (PN) 30-day readmission rate	Premier (All Payors)	Monitor	
46.	READM-30-CABG	Coronary artery bypass graft {CABG) surgery 30-day readmission rate	Premier (All Payors) **CMS Star Measure	Monitor	
47.	READM-30-HIP-KNEE	30-day readmission rate following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty {TKA)	Premier (All Payors) **CMS Star Measure	Monitor	

	Measure	Description	Data Source[11]	Expected Performance	Weight
48.	OP 32 (New)	rate of unplanned hospital visits after an OP colonoscopy	CMS (MDC FFS) ** CMS Star Measure	Monitor	
49.	OP 35ADM (New)	rate of unplanned hospital visits after an OP chemotherapy	CMS (All Payor) ** CMS Star Measure	Monitor	
50.	OP 35 ED (New)	rate of ED visits for patients receiving an OP chemotherapy	CMS (MDC FFS) ** CMS Star Measure	Monitor	
51.	OP 36 (New)	rate of unplanned hospital visits after hospital outpatient surgery	CMS (MDC FFS) ** CMS Star Measure	Monitor	
52.	MORT-30-COPD	COPD 30-day mortality rate	Premier (All Payor) ** CMS Star Measure	Monitor	
53.	MORT-30-AMI	Acute myocardial infarction (AMI) 30-day mortality rate	Premier (All Payor) ** CMS Star Measure	Monitor	
54.	MORT-30-HF	Heart failure {HF) 30-day mortality rate	Premier (All Payor) ** CMS Star Measure	Monitor	
55.	MORT-30-PN	Pneumonia (PN) 30-day mortality rate	Premier (All Payor) ** CMS Star Measure	Monitor	
56.	MORT-30-STK	Stroke 30-day mortality rate	Premier (All Payor) ** CMS Star Measure	Monitor	
57.	MORT-30-CABG	Coronary artery bypass graft {CABG) surgery 30-day mortality rate	Premier (All Payors) **CMS Star Measure	Monitor	
58.	PSI-4-SURG-COMP	Death rate among surgical inpatients with serious treatable complications	Premier (All Payor) ** CMS Star Measure	Monitor	
59.	HQUIETSP-AP	Patients who reported that the area around their room was "Always" quiet at night	Press Ganey (All Payors) ** CMS Star Measure	Monitor	
60.	HRECMND-DY	Patients who reported YES, they would definitely recommend the hospital	Press Ganey (All Payors) ** CMS Star Measure	Monitor	
61.	READM-30-STK	Stroke 30-day readmission rate	Premier (All Payors)	Monitor	
62.	Hospital Harm-01	Severe Hypoglycemia	CMS (All Payor)	Monitor	
63.	Hospital Harm-02	Severe Hyperglycemia	CMS (All Payor)	Monitor	
64.	ED-2	Average (median) time patients spent in the Emergency Department before leaving from the visit	Premier All payors)	Monitor	