PUBLIC VERSION

TERMS AND CONDITIONS

GOVERNING THE CERTIFICATE OF PUBLIC ADVANTAGE

ISSUED TO UNION HOSPITAL, INC.

IN CONNECTION WITH THE

ASSET PURCHASE AGREEMENT

BY AND AMONG

UNION HOSPITAL, INC.,
TERRE HAUTE REGIONAL HOSPITAL, L.P.,
REGIONAL HOSPITAL HEALTHCARE PARTNERS, LLC, AND
HTI HOSPITAL HOLDINGS, INC.

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The Indiana General Assembly enacted Indiana Code Section 16-21-15 et seq. (the "**COPA Statute**") in 2021 and subsequently amended the COPA Statute in 2022 and 2025. The General Assembly found that mergers between two hospitals located in a predominantly rural county meeting specific population requirements may benefit the public by maintaining or improving the quality, efficiency, and accessibility of health care services and that the benefits resulting from such a merger, including addressing the unique challenges of providing healthcare services in rural communities, may outweigh the anticompetitive effects of such merger. Further, the General Assembly determined that if a merger is approved under the COPA Statute, it is in the State's best interest to replace competition with state regulation and active supervision and that such merger and the merged entity's subsequent activities should be immune from all state and federal antitrust laws.

The COPA Statute provides a framework by which qualifying hospitals seeking to merge may apply for and, if approved, be granted a certificate of public advantage by the Indiana State Department of Health (the "**Department**"). If issued, the certificate of public advantage replaces competition between the applicants with state regulation by the Department through terms and conditions, annual reviews of whether the certificate of public advantage recipient continues to meet the standards for issuance of a certificate of public advantage, active supervision and monitoring of the certificate of public advantage recipient's conduct to ensure furtherance of the COPA Statute's purposes, limitations on the certificate of public advantage recipient's charge and price increases, required reinvestment of realized cost savings, other commitments regarding access to healthcare, healthcare outcomes and quality, annual reporting, and enforcement mechanisms.

The COPA Statute authorizes the Department to issue a certificate of public advantage if the Department determines that there is clear evidence that, under the totality of the circumstances, (a) the proposed merger will improve the health outcomes, health care access, and the quality of health care provided to the population served by the merging hospitals, and (b) that the likely benefits arising from the proposed merger agreement outweigh any disadvantage attributable to a potential reduction in competition that may result from the proposed merger.

On September 14, 2023, Union Hospital, Inc., an Indiana non-profit corporation, and Terre Haute Regional Hospital, L.P., a Delaware limited partnership (collectively, the "**Applicants**"), submitted an application for a certificate of public advantage (the "**Original Application**") to the Department, the Indiana Office of the Secretary of Family and Social Services ("**FSSA**") and the Office of the Indiana Attorney General (the "**Attorney General**").

After an initial review of the Original Application, the Department issued a written request for additional information ("**RFI 1**") on October 27, 2023. The Applicants responded to RFI 1 on January 9, 2024, and submitted additional information requested by the Department on February 6, 2024.

The Department issued a second written request for additional information ("**RFI 2**") on February 13, 2024, and requested transaction-level data pursuant to a third written request for additional information on April 2, 2023 ("**RFI 3**"). The Applicants provided the requested transaction-level data on June 1, 2024, and completed their response to RFI 2 on July 29, 2024. On August 6, 2024, the Department notified the Applicants that the Original Application as amended by the subsequent submissions was complete. This notice commenced the Department's 120-day review period.

After receiving the Original Application, the Department opened a portal for thirty days, allowing interested members of the public to submit comments. The comment period concluded on September 6, 2024. The Department received 395 public comments. In addition, the Department received a submission from staff of the Federal Trade Commission ("**FTC**") on September 5, 2024, and comments from the Attorney General on September 27, 2024.

Subsequent to the Original Application being deemed complete, the Applicants submitted additional information regarding benefits that may arise as a result of the Merger and responded to the FTC's and Attorney General's comments. On November 22, 2024, the Applicants withdrew the Original Application.

On February 5, 2025, the Applicants submitted a new application to the Department, FSSA, and the Attorney General (the "**2025 Application**"). The Department deemed the 2025 Application complete on February 21, 2025. This commenced the Department's 120-day review period.

After receiving the 2025 Application, the Department opened a portal for thirty days, again allowing interested members of the public to submit comments. This second comment period concluded on March 23, 2025. The Department received 393 public comments. In addition, the Department received a supplemental submission from staff of the FTC on March 17, 2025, and comments from the Attorney General on April 17, 2025. On May 1, 2025, the Department conducted a public town hall at Ivy Tech Community College in Terre Haute. At the town hall, forty-four comments were made by local officials, current and retired employees of both Applicants, and community members.

Subsequent to the 2025 Application being deemed complete, the Applicants submitted additional information regarding benefits that may arise as a result of the Merger and responded to the FTC's and Attorney General's comments.

For the reasons set forth in its Report and Determination attached hereto as **Exhibit A,** the Department determines that the merger described in the 2025 Application (the "**Merger**") satisfies the requirement of I.C. § 16-21-15-4 and that the Applicants have demonstrated that there is clear evidence that, under the totality of the circumstances, (a) the Merger will improve the health outcomes, health care access, and the quality of health care provided to the population served by the Applicants' hospitals, and (b) that the likely benefits arising from the Merger outweigh any disadvantage attributable to a potential reduction in competition that may result from the Merger (the "**Public Advantage**"). Therefore, the Department issues the COPA to Union Hospital, Inc. subject to these Terms and Conditions.

PART I.
DEFINITIONS

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

"**2025 Application**" is defined in the introductory section of these Terms and Conditions.

"**Active Supervision**" means the process required by the COPA Statute of the Department, the Attorney General, and their respective designees, after the Issue Date and continuing throughout the COPA Term, of evaluating, monitoring and determining whether Combined Enterprise's operations continue to result in Public Advantage and enforcing the COPA, these Terms and Conditions, and the COPA Statute.

"**Affiliate**" means any entity controlling, controlled by or under common control with UHI, including any entity in which Union Health System, directly or indirectly, owns more than a ten percent (10%) ownership interest, provided however that "Affiliate" shall not include any critical access hospital.

"**Annual Report**" means the report UHI will prepare and deliver to the Department pursuant to Section 2.12.

"**Annual Review**" means the review performed by the Department pursuant to Section 5.1.

"**Applicants**" is defined in the introductory section of these Terms and Conditions.

"**Approved Implementation Plan**" means the implementation plan approved pursuant to Section 2.11 and any amendments thereto approved by the Department.

"**Asset Purchase Agreement**" means the Asset Purchase Agreement, effective as of September 12, 2023, as amended on October 23, 2023, entered into between: (i) UHI, as the

buyer; and (ii) THRH and RHP, as sellers, and HTI Hospital Holdings, Inc., a Delaware corporation, as seller guarantor.

"**Attorney General**" is defined in the introductory section of these Terms and Conditions.

"**Combined Enterprise**" means the post-Merger enterprise consisting of Regional Hospital and Regional Healthcare Partners (including their respective administrative and clinical operations) and the Union Healthcare Providers (including their respective administrative and clinical operations).

"**Commitments**" means, collectively, the Quality Commitments, Pricing Commitments, Population Health Commitments, Preservation of Access Commitments, Enhancement Commitments, Employment and Economic Commitments, and Other Commitments.

"**COPA**" means the Certificate of Public Advantage granted by the Department on the Issue Date by the Department to UHI with respect to the Merger.

"**COPA Board Amendments**" is defined in Section 2.10.

"**COPA Hospitals**" means Union Hospital and Regional Hospital.

"**COPA Pricing Term**" means the period from the Issue Date until the fifth (5^{th}) anniversary of the expiration of the COPA Term plus any Extension Time in connection with Significant Violations that exist prior to the expiration of the Pricing Commitments, including the Commitments attached as Exhibit B – Addendum 3.

"**COPA Statute**" is defined in the introductory section of these Terms and Conditions.

"**COPA Term**" means the period from the Issue Date until termination or revocation of the COPA.

"**Deficiency Notice**" means a written notice delivered by the Department pursuant to Section 6.4(i).

"**Department**" is defined in the introductory section of these Terms and Conditions and includes any successor agency thereto.

"**Department Action**" is defined in Section 6.4(i).

"**Determination Date**" means November 9, 2025.

"**Employment and Economic Commitments**" means those commitments described in Section 2.6.

"**Enhancement Commitments**" means those commitments described in Section 2.5.

"**Executive Leadership**" means the president and chief executive officer (who may be separate individuals) of an entity and their direct reports.

"**Extension Time**" means (i) if the Significant Violation can be cured, the amount of time during which one or more Significant Violations existed after UHI became or should have become aware of the existence of the Significant Violation before it was cured or (ii) if the Significant Violation cannot be cured, a reasonable amount of time, as determined by the Department, reflective of the harm caused to the public by the Significant Violation.

"**Fiscal Year**" means the UHI fiscal year, which begins on January 1 and ends on December 31 of each year.

"**FSSA**" is defined in the introductory section of these Terms and Conditions.

"**FTC**" is defined in the introductory section of these Terms and Conditions.

"**Initial Implementation Plan**" is defined in Section 2.11.

"**Issue Date**" means the date of consummation of the Merger, which consummation shall occur within ninety days of the Determination Date.

"**Material Adverse Event**" means any fact, event, change, development or occurrence that, individually or together, with any other fact, 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 Combined Enterprise, taken as a whole.

"**Merger**" is defined in the introductory section of these Terms and Conditions.

"**Noncompliance**" means a failure by UHI or any other member of the Combined Enterprise to comply with the COPA Statute or one (1) or more of these Terms and Conditions.

"**Noncompliance Notice**" means a written notice delivered by UHI pursuant to Section 6.1.

"**Original Application**" is defined in the introductory section of these Terms and Conditions.

"**Other Commitments**" means those commitments described in Section 2.8.

"**Payor**" means an individual, organization or entity, including governmental entities like Medicare and Medicaid, that pays for health care services rendered by any member of the Combined Enterprise.

"**Plan of Correction**" means UHI's response to a Deficiency Notice outlining UHI's plan to correct the Noncompliance.

"**Population Health Commitments**" means those commitments described in Section 2.7.

"**Preservation of Access Commitments**" means those commitments described in Section 2.4.

"**Pricing Commitments**" means those commitments described in Section 2.3.

"**Public Advantage**" is defined in the introductory section of these Terms and Conditions.

"**Quality Commitments**" means those commitments described in Section 2.2.

"**Quarterly Meetings**" is defined in Section 2.13.

"**Quarterly Reports**" is defined in Section 2.13.

"**Regional Healthcare Partners**" means all Purchased Assets (as defined in the Asset Purchase Agreement) of RHP that: (i) were acquired by UHI or an Affiliate of UHI, pursuant to the Asset Purchase Agreement; and (ii) are incorporated into the administrative and clinical operations of the Combined Enterprise. The term includes any Facility Employees of RHP employed by the Combined Enterprise.

"**Regional Hospital**" means all Purchased Assets (as defined in the Asset Purchase Agreement) of THRH that: (i) were acquired by UHI pursuant to the Asset Purchase Agreement; and (ii) are incorporated into the administrative and clinical operations of the Combined Enterprise.

"**RFI 1**," "**RFI 2**," and "**RFI 3**" are defined in the introductory section of these Terms and Conditions.

"**RHP"** means Regional Hospital Healthcare Partners, LLC, an Indiana limited liability company, which employs the physicians and advanced professional providers and operates physician practices in Terre Haute, Indiana.

"**Rural Health Clinics**" means the rural health clinic in Brazil, Indiana, and the rural health clinic in Clay City, Indiana, both of which are owned and operated by UHI.

"**Secretary**" means the secretary for health and family services appointed by the Governor of the State of Indiana or any successor role thereto as determined by the Governor of the State of Indiana; provided that if no such role exists, "Secretary" shall mean such person as is designated by the Governor of the State of Indiana from time to time.

"**Service Area**" means, collectively, the Indiana counties of Clay, Greene, Parke, Sullivan, Vermillion, and Vigo.

"**Significant Reimbursement Change**" means any change that, individually or cumulatively, materially adversely changes the manner or amount of reimbursement paid to UHI

or Union Health System through the Medicare or Medicaid programs in such a way that, based on reasonable projections prepared by UHI would, once fully implemented, result in a material financial loss for UHI or Union Health System and that disproportionately affects UHI or Union Health System compared to similarly situated Indiana hospital systems.

"**Significant Violation**" means:

(a) Any of the following not cured within thirty (30) days: (i) any violation of Sections 2.10 (Appointments to Boards of Directors), (ii) any failure to submit a plan or report under Sections 2.11 (Implementation Plan) or 2.13 (Quarterly Reporting), (iii) any failure to pay expenses under 2.16 (Department Expenses), (iv) any failure to comply with Section 4.3 (Access), or (v) any failure to cooperate with audits and investigations under Section 4.4 (Audits and Investigations), or

(b) Any of the following not cured within forty-five (45) days: (i) any failure to submit an Annual Report under Section 2.12 (Annual Reporting), (ii) any material violation of the Pricing Commitments, (iii) any material repeated violation of a Commitment that is not a Pricing Commitment, (iv) any material violation of or failure to complete a Plan of Correction, (v) any violation of the COPA Statute, or (vi) any other material violation of these Terms and Conditions, which alone or when aggregated with other violations of these Terms and Conditions, materially reduces the Public Advantage.

The period available to cure each Significant Violation shall start the day on which UHI becomes aware of the existence of the Significant Violation.

"**Terms and Conditions**" means these Terms and Conditions governing the COPA granted to UHI in connection with the Asset Purchase Agreement, including any exhibits, attachments, and appendices, as may be amended from time to time in accordance with the terms and conditions hereof.

"**THRH**" means Terre Haute Regional Hospital, L.P., a Delaware limited partnership, which owns and operates Regional Hospital, a licensed acute care hospital located in Terre Haute, Indiana.

"**UHI**" means Union Hospital, Inc., an Indiana non-profit corporation.

"**Union Health System**" means Union Health System, Inc., an Indiana non-profit corporation, which is the sole member of UHI.

"**Union Healthcare Providers**" means UHI (including Union Hospital and the Rural Health Clinics), Union Medical Group, Center for Occupational Health, Inc., Union Hospital Therapy, LLC, and any other Affiliate of UHI that provides health care services.

"**Union Hospital**" means the licensed acute care hospital located in Terre Haute, Indiana that is owned and operated by UHI.

"**Union Medical Group**" means Union Associated Physicians Clinic, LLC, an Affiliate of UHI, which operates a multi-specialty physician clinic employing, as of the Determination Date, approximately 215 physicians and allied health care providers.

PART II.
OBLIGATIONS AND COMMITMENTS

2.1. **General Compliance**. During the COPA Term, UHI and the other members of the Combined Enterprise shall comply with the COPA Statute and these Terms and Conditions. During the COPA Pricing Term, UHI and the other members of the Combined Enterprise shall comply with the Pricing Commitments and these Terms and Conditions.

2.2. **Quality Commitments**. To allow the Department to monitor the Merger's impact on quality performance, and to allow the Department and the public to hold UHI accountable for continuing to provide high-quality services post-Merger and to ensure that the quality of health care services provided by the Combined Enterprise does not decline after the Merger, UHI made certain commitments related to quality that are set forth in **Exhibit B – Section A** (the "**Quality Commitments**"). In order to mitigate the risk that the Merger would have a negative impact on quality of health care services and ensure that UHI implements these commitments, which the Department relied upon in its assessment of the 2025 Application, UHI shall fulfill the Quality Commitments and comply with the accountability mechanisms described in **Exhibit B – Section A**.

2.3. **Pricing Commitments**. UHI made certain commitments related to pricing and payor contract negotiations as set forth in **Exhibit B – Section B** (the "**Pricing Commitments**"). In order to monitor the Merger's impact on pricing, to limit the Combined Enterprise's ability to increase the cost to payors of health care services provided by the Combined Enterprise as a result of the Merger and ensure that UHI implements these commitments, which the Department relied upon in its assessment of the 2025 Application, UHI shall fulfill the Pricing Commitments and comply with the accountability mechanisms set forth in **Exhibit B – Section B** during the COPA Pricing Term.

2.4. **Preservation of Access Commitments**. UHI made certain commitments related to preserving access to health care services as set forth in **Exhibit B – Section C** (the "**Preservation of Access Commitments**"). In order to mitigate the risk that the Merger would have a negative impact on access to health care services and ensure that UHI implements these commitments, which the Department relied upon in its assessment of the 2025 Application, UHI shall fulfill the Preservation of Access Commitments and comply with the accountability mechanisms set forth in **Exhibit B – Section C**.

2.5. **Enhancement Commitments**. UHI made certain commitments related to enhancement of facilities and services as set forth in **Exhibit B – Section D** (the "**Enhancement Commitments**"). In order to ensure that UHI implements these commitments, which the Department relied upon in its assessment of the 2025 Application, UHI shall fulfill the

Enhancement Commitments and comply with the accountability mechanisms set forth in **Exhibit B – Section D**.

2.6. Employment and Economic Commitments. UHI made certain commitments related to the affected workforce and economic impact as set forth in **Exhibit B – Section E** (the "**Employment and Economic Commitments**"). In order to ensure the affected workforce is protected, mitigate the impact of the Merger on the economy long-term and ensure that UHI implements these commitments, which the Department relied upon in its assessment of the 2025 Application, UHI shall fulfill the Employment and Economic Commitments and comply with the accountability mechanisms set forth in **Exhibit B – Section E**.

2.7. Population Health Commitments. UHI made certain commitments related to population health improvement as set forth in **Exhibit B – Section F** (the "**Population Health Commitments**"). In order to monitor progress around the population health improvement initiatives and ensure UHI implements the commitments, which the Department relied upon in its assessment of the 2025 Application, UHI shall fulfill the Population Health Commitments and comply with the accountability mechanisms set forth in **Exhibit B – Section F**.

2.8. Other Commitments. UHI made certain other commitments as set forth in **Exhibit B – Section G** (the "**Other Commitments**"). In order to ensure that UHI implements the commitments, which the Department relied upon in its assessment of the 2025 Application, UHI shall fulfill the Other Commitments and comply with the accountability mechanisms set forth in **Exhibit B – Section G**.

2.9. UHI Notice of Consummation of the Merger. On the date of the consummation of the Merger, UHI shall submit to the Department a written notice executed by UHI's chief executive officer and chief financial officer certifying to the occurrence of the consummation of the Merger and acknowledging and agreeing to these Term and Conditions and the Exhibits attached hereto.

2.10. Appointments to Boards of Directors. Within sixty (60) days after the Issue Date, UHI and Union Health System shall amend their governing documents, which amendments (the "**COPA Board Amendments**") shall be acceptable to the Department in its sole discretion:

(i) to allow the Governor of the State of Indiana to appoint two (2) of the voting members of the board of directors of UHI and Union Health System during the COPA Term;

(ii) Until expiration of the COPA Term, UHI and Union Health System shall not amend, modify, restate or supplement the COPA Board Amendments without the consent of the Department.

(iii) Effective as of the date of the COPA Board Amendments, the Governor of the State of Indiana shall have the right to appoint directors identified in Section 2.10(i) and at least one such director shall be a member of the audit, governance and executive

committees, and if there is a committee specifically formed to address compliance with the COPA, such committee, of the board of directors of UHI and Union Health System.

(iv) The directors that are appointed pursuant to Section 2.10(i) shall be residents of the Service Area and shall have the same fiduciary duties to UHI and Union Health System as all other directors. UHI and Union Health System may propose names for consideration, but the appointments shall be made at the sole discretion of the Governor of the State of Indiana. The out of pocket expenses incurred by directors appointed by the Governor of the State of Indiana shall be reimbursed pursuant to Section 2.16.

2.11. Implementation Plan. Within ninety (90) days after the Issue Date, UHI shall submit to the Department for its review, in writing, its initial plan for implementation of the Commitments (the "**Initial Implementation Plan**"), which, among other things, shall include, unless the Department otherwise reasonably approves, in reasonable detail, the plans, tasks, resource requirements, deadlines, risks and mitigation mechanisms for the implementation and execution of the Commitments, UHI's methodologies and procedures for measuring, tracking, reporting and reinvesting in the Service Area realized cost savings, and the Combined Enterprise's plans to maintain and improve quality as measured by the quality metrics during the COPA Term. The Department may provide, in its discretion, UHI with comments and feedback concerning the Initial Implementation Plan, which UHI will incorporate into an updated Initial Implementation Plan so long as the comments and feedback are consistent with these Terms and Conditions. Within thirty days (30) days after receiving the Department's comments and feedback, UHI shall submit for the Department's approval, an updated Initial Implementation Plan, which shall incorporate feedback and comments regarding the Initial Implementation Plan provided by the Department in its discretion and additional details developed since submission of the Initial Implementation Plan, and shall demonstrate to the Department, in its discretion, that the Commitments are reasonably likely to be completed and achieve the Public Advantage. Within thirty (30) days after UHI submits the updated Initial Implementation Plan (or such longer period as the Department may require), the Department will either approve the updated Initial Implementation Plan or provide UHI with additional feedback, which UHI shall incorporate into the Initial Implementation Plan and re-submit to the Department within ten (10) days or such longer time as the Department may allow. Once approved, the Initial Implementation Plan shall be the Approved Implementation Plan.

2.12. Annual Reporting.

(i) Reporting Requirement. No later than April 30th of each year, UHI shall submit an Annual Report to the Department covering the prior Fiscal Year. The first Annual Report, covering the portion of the 2025 Fiscal Year after the Issue Date shall be submitted no later than April 30, 2026. Given the short time period that is covered by the first Annual Report, the contents of the first Annual Report (but only the first Annual Report) will consist of a narrative summary of the steps UHI has taken to integrate hospital operations, develop the Implementation Plan, and begin pursuing the

Commitments and reasonably available and/or obtainable baseline data requested by the Department. All other Annual Reports shall follow the format for the Annual Reports established under subsection (ii) below. UHI shall timely submit all required reports; provided that upon request, the Department may, in its sole discretion, approve an extension of the Annual Report due date, upon a showing of good cause. IDOH may request the data and documentation reasonably necessary to verify statements made in the Annual Report UHI shall identify for the Department the employee(s) most knowledgeable about each section or category of information in the Annual Report and provide contact information for these individuals. Each Annual Report shall be certified by the Chief Executive Officer and Chief Financial Officer of UHI as true and correct in all material respects to the best of the individual's knowledge after due inquiry. UHI shall timely submit all required reports. Such reports shall be in a format specified by the Department after consultation with UHI. A copy of the Annual Report shall also be submitted to the Office of the Attorney General and the General Assembly in an electronic format under I.C. § 5-14-6 and will be posted on the Department's website.

(ii) Annual Report Contents. Within sixty (60) days of the Issue Date, UHI shall submit in writing to the Department its proposed format of the Annual Report. The Annual Report shall be in such format and contain such information and documentation as the Department shall reasonably require, but at a minimum, the Annual Report shall address UHI's compliance (or non-compliance) with, and steps taken to achieve, each Commitment set forth on **Exhibit B**, the Approved Implementation Plan, and each of the Terms and Conditions pursuant to the COPA Statute, a summary of steps taken to reduce costs (including the cost of care provided), to reduce amounts paid by Payors and to improve efficiency, a description of any services or functions consolidated during the year, a description of any material changes in volume or availability of services offered, and a list of all Noncompliance Notices, Department Actions and Plans of Correction, in each case, initiated during the relevant year or that have not been fully resolved prior to the beginning of the relevant year with a summary of their current status. Within thirty (30) days or such longer period as the Department may require, the Department will either approve the proposed form of the Annual Report or provide, in its discretion, UHI with comments and revisions, which UHI shall incorporate the proposed form of the Annual Report within ten (10) days or such longer time as the Department may allow.

2.13. Quarterly Reports and Meetings with the Department.

(i) Reporting Requirement. In addition to the Annual Reporting requirements set forth in Section 2.12, the Department and UHI shall meet on a quarterly basis within thirty (30) days of the end of each calendar quarter to review the topics identified in Section 2.13(ii) (the "**Quarterly Meetings**"). No later than fifteen (15) days prior to each Quarterly Meeting, UHI shall prepare a report for the most recently ended Fiscal Year quarter (the "**Quarterly Report**"). Within sixty (60) days of the Issue Date, UHI and the Department shall discuss and agree upon the schedule for the Quarterly Meetings.

(ii) Quarterly Report Contents. Within sixty (60) days of the Issue Date, UHI shall submit in writing to the Department its proposed format of the Quarterly Report. The Quarterly Report shall be in such format and contain such information and documentation as the Department shall reasonably require, but at a minimum, the Quarterly Report shall address the actions taken during the relevant quarter in connection with each Commitment set forth on **Exhibit B** and the Approved Implementation Plan, the information required to be reported pursuant to any Commitment, and a list of all Noncompliance Notices, Department Actions and Plans of Correction, in each case, initiated during the relevant quarter or that have not been fully resolved prior to the beginning of the relevant quarter with a summary of their current status. Within thirty (30) days or such longer period as the Department may require, the Department will either approve the proposed form of the Quarterly Report or provide, in its discretion, UHI with comments and revisions, which UHI shall incorporate the proposed form of the Quarterly Report within ten (10) days or such longer time as the Department may allow.

2.14. Annual Public Listening Sessions. In the first quarter of each Fiscal Year during the COPA Term (and in the case of the Fiscal Year in which the COPA is granted, during the first full calendar quarter after the Issue Date), UHI shall host at least one public listening session during which the residents of the Service Area can provide oral and/or written feedback regarding the Merger, the Combined Enterprise's service quality, efficiency and accessibility of care, and effects of the COPA. UHI shall publicly advertise the date, time, and location for each listening session on each hospital's website and social media account at least thirty (30) days before the event, which shall be scheduled during times and at locations convenient to the general public. The public listening sessions shall be open to the public, will be live streamed on a public accessible website (or other means approved by the Department that provides for the real time remote viewing of the listening sessions) and shall be recorded and made publicly available by UHI. UHI shall also publicly advertise to residents of the Service Area that oral and/or written feedback regarding the Merger may be provided at each listening session and shall not require registration or collection of personal identifying information, other than the person's county of residence from any person submitting or making comments. The date and time of each listening session shall be subject to the Department's approval. UHI shall provide written notice to the Department and the Attorney General of the schedule for listening sessions, and the Department's and Attorney General's representatives may attend. UHI shall include a summary of the listening sessions in its Annual Report, including number of attendees, any materials presented by UHI at the listening session, copies of any written feedback received from the public and a summary of any oral public comments received.

2.15. "Healthier Together" Transparency Website.

(i) "Healthier Together" Transparency Website Requirement. Throughout the COPA Term and thereafter, solely with respect to the Pricing Commitments through the COPA Pricing Term, UHI shall establish and maintain a publicly available website containing information relating to the COPA, the quality of services, access to care, and the affordability of health care in the Service Area in light of the Merger. Within thirty (30)

days of the Issue Date, UHI shall publish a transparency webpage branded "Healthier Together" to provide the public understandable and accessible updates regarding the COPA and ongoing community health improvements as well as make publicly available updates and reporting measures required by the Commitments.

(ii) "Healthier Together" Transparency Website Contents. At a minimum, the "Healthier Together" website shall include quality and patient satisfaction measures designated for quarterly reporting, employee and physician satisfaction survey results, the results of research studies, a summary of how cost savings realized as a result of the COPA are being reinvested, price transparency information by Payor in a format approved by the Department and a section that allows for individuals to submit complaints and/or comments related to the COPA. The Department may direct UHI to include other non-confidential information that is reasonably related to the COPA on the "Healthier Together" website if the Department determines such information may be beneficial to the public.

2.16. Department Expenses. Pursuant to the COPA Statute, UHI shall be responsible for the reasonable costs incurred by the Department to cover the costs of the ongoing monitoring and Active Supervision associated with the COPA, including any fees for consultants and experts, which shall be selected by the Department in its sole discretion. The Department will invoice UHI for these costs, which shall be paid by UHI within thirty (30) days of receipt. Such costs and fees must be commensurate with the usual compensation for like services. On an annual basis, the Department will work with UHI to develop a forecast for the Department's costs associated with the COPA; provided that such forecast shall not limit UHI's responsibility for the costs the Department actually incurs in connection with the ongoing monitoring and Active Supervision. If the Department intends to engage an expert to serve as a monitor under Section 6.3(ii)(B), then the Department will engage a monitor that has no conflict of interests and to make a good faith effort to engage a monitor that is mutually agreeable to the Department and UHI. However, if UHI and the Department are unable to reach an agreement on the monitor, then the Department may engage the monitor without UHI's agreement. UHI shall be responsible for the costs of the monitor under Section 6.3(ii)(B), which shall not exceed $500,000 per year.

PART III.
NOTIFICATIONS AND APPROVALS

3.1. Organizational Changes during the COPA Term. UHI shall notify the Department at least thirty (30) days prior to any significant change in UHI's organizational structure or any change in Union Health System's or UHI's Executive Leadership during the COPA Term (provided, however, that UHI becomes aware of a change in Union Health System's or UHI's Executive Leadership less than thirty (30) days prior to the date of such change due to an individual's resignation or termination for cause, UHI shall notify the Department promptly upon it becoming aware of such pending change).

3.2. Material Adverse Event during the COPA Term. In order to demonstrate that UHI maintains the financial and operational viability to fulfill the Terms and Conditions, and for the

Department to provide for proper Active Supervision, UHI shall notify the Department within fifteen (15) days if it experiences a Material Adverse Event during the COPA Term, or, to the knowledge of UHI, is reasonably likely to experience a Material Adverse Event during the COPA Term. 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 UHI as being true and correct in all material respects to their best knowledge, after due inquiry. A notice of a Material Adverse Event shall be resolved in the same manner as a Noncompliance Notice in Section 6.1.

PART IV.
ACTIVE SUPERVISION: STRUCTURE, MONITORING, AND NONCOMPLIANCE

4.1. **General**. The Department's Active Supervision is a fundamental requirement of the COPA Statute. UHI and the other members of the Combined Enterprise shall be subject to, and fully cooperate with, the Department's and the Attorney General's Active Supervision, in accordance with the COPA Statute and these Terms and Conditions.

4.2. **Structure**. The Department is required by I.C. § 16-21-15-7 to actively supervise and monitor the Combined Enterprise throughout the COPA Term to ensure that the Combined Enterprise's conduct furthers the purpose of the COPA and the Public Advantage. The Department may contract with consultants and experts as necessary to carry out this supervision and monitoring. The Department, among other things, will conduct this supervision and monitoring through review of reports, complaints from the public, and notification of deficiencies from UHI. The Department will have a complaint section on its website for the public to bring concerns about the COPA to the Department. The Department will review complaints and determine appropriate action based on the complaint. Appropriate action may include an investigation of the complaint based upon the authority granted under I.C. § 16-21-15-9 and these Terms and Conditions.

4.3. **Access**. UHI shall grant the Department, the Department's contracted designee(s) and the Attorney General:

(i) upon reasonable advance written notice, access during normal business hours to all non-privileged documents relating to compliance with I.C. § 16-21-15, the 2025 Application, or these Terms and Conditions, provided that such access shall not unreasonably interfere with the operations of the Combined Enterprise;

(ii) upon reasonable advance written notice, access during normal business hours of UHI to interview directors, officers, managers, or employees of the Combined Enterprise in relation to any matters contained in the I.C. § 16-21-15, the 2025 Application, or these Terms and Conditions, provided that such access shall not unreasonably interfere with the operations of the Combined Enterprise; and

(iii) the right to call, at any time, upon thirty (30) days' advance written notice to UHI, a meeting with UHI's or Union Health System's Executive Leadership team and/or the UHI or Union Health System governing board.

4.4. **Audits and Investigations**. UHI and the other members of the Combined Enterprise shall cooperate with audits and investigations that are deemed reasonably necessary by the Department or the Attorney General to ensure compliance with I.C. § 16-21-15 and these Terms and Conditions, including without limitation, providing such documents and information as the Department or the Attorney General may request from time to time.

PART V.
ACTIVE SUPERVISION: DEPARTMENT ANNUAL REVIEW

5.1. **Annual Review**. The Department is required by I.C. § 16-21-15-6 to perform an annual review of the COPA during the COPA Term to determine whether the Combined Enterprise is continuing to meet the standards required for issuance of the COPA, including compliance with the statutory requirements and these Terms and Conditions (the "**Annual Review**"). The Annual Review shall occur within ninety (90) days of UHI's submission of the Annual Report to the Department.

5.2. **Evaluation Process**. During the Annual Review, the Department will determine whether, under the totality of the circumstances, the likely benefits resulting from the Merger continue to outweigh any disadvantages attributable to a potential reduction in competition that may result from the Merger. Any determination of failure will be addressed through the corrective action process set forth in Section 6.3 or, if appropriate, through a modification of these Terms and Conditions in accordance with Part VII. As part of the Annual Review, the Department will use a pass/fail evaluation of each Commitment and assess overall compliance with these Terms and Conditions. Any determination of failure will be addressed through the corrective action process set forth in Part VI or if appropriate in the discretion of the Department, modification of these Terms and Conditions. The Department's assessment of each Commitment will be included in an annual written report prepared by the Department.

PART VI.
ACTIVE SUPERVISION: EVENTS OF NONCOMPLIANCE

6.1. **UHI Notice of Noncompliance**. If at any time during the COPA Term, UHI determines or becomes aware that a Noncompliance has occurred or is reasonably likely to occur (whether through the passage of time or otherwise), UHI shall promptly notify the Department by delivery of a "**Noncompliance Notice**" to the Department. Such Noncompliance Notice shall include an explanation in reasonable detail and supporting documentation regarding the Noncompliance and related circumstances or events, and any actions proposed by UHI to make reasonable efforts to cure the Noncompliance along with the proposed timeline for curing the Noncompliance.

6.2. Department Notice of Noncompliance. The Department shall review and investigate to the extent necessary each of the following:

(i) any Noncompliance Notice received from UHI;

(ii) any Noncompliance discovered during the Department's Annual Review, regular monitoring or otherwise; and

(iii) any Noncompliance discovered as a result of a complaint or investigation relating to the COPA.

6.3. Department Authority with Respect to Noncompliance and Significant Violations.

(i) In connection with compliance with these Terms and Conditions, the Department shall acknowledge and document receipt of a Noncompliance Notice and take no action provided, however, that if the Noncompliance Notice reports a Noncompliance that is the same or substantially similar to a prior Noncompliance, the Department may take one or more of the following actions:

(A) Investigate the Combined Enterprise's activities.

(B) Require a Plan of Correction pursuant to Section 6.4.

(C) Issue a reasonable fine based on the impact of the Noncompliance on the Public Advantage. The fine shall be payable to the Healthy Hoosier's Foundation, Inc. (or any successor thereto) and the funds invested into the Service Area in a manner designed to address the areas of need affected by the Noncompliance.

(ii) If Union has committed a Significant Violation, the Department may take any of the actions listed above as well as one or more of the following actions:

(A) Require Union and/or Union Health System to limit the total compensation of its most senior executive officer to a maximum amount that is consistent with executive compensation in health systems of similar size (if the senior executive's compensation is above market).

(B) Appoint an independent third-party monitor to oversee and evaluate UHI's and Union Health System's adherence to rectifying the Noncompliance and preventing future violations. UHI and Union Health System shall cooperate with any independent third-party monitor appointed by the Department in the performance of this activity as outlined in Part IV.

(C) Revoke the COPA in accordance with Section 8.2.

6.4. Process for Handling a Noncompliance.

(i) If the Department issues a finding of Noncompliance, then the results of the Department's review will be provided to UHI as a Deficiency Notice, which shall describe the Noncompliance with reasonable specificity and the Department's proposed action in connection with such finding of Noncompliance, including without limitation, any proposed action or actions by the Department in connection with a continuation or repetition of such Noncompliance or similar Noncompliance or the failure to comply with an associated Plan of Correction (a "**Department Action**").

(ii) UHI shall respond to the Deficiency Notice within thirty (30) days including, if requested by the Department, a written proposed Plan of Correction to address each Noncompliance. The proposed Plan of Correction shall include actions to be taken by UHI and/or other members of the Combined Enterprise, the time period to eliminate the Noncompliance, a progress report schedule, and the anticipated result of the action.

(iii) Upon receipt and review of UHI's response to the Deficiency Notice, Department may (A) finalize its finding of Noncompliance and the related Department Action as originally issued; or (B) finalize its finding of Noncompliance and the related Department Action with modifications; and in each case, if it requested a proposed Plan of Correction from UHI, the Department may (x) accept the Plan of Correction as written; (y) accept the Plan of Correction with modification; or (z) reject the Plan of Correction and request re-submission within ten (10) business days. If the resubmitted Plan of Correction is not acceptable to the Department in its sole discretion, the Department may determine the contents of the Plan of Correction in its discretion. The Department's unilateral determination of the contents of the Plan of Correction shall constitute an "agency action" under the Indiana Orders and Procedures Act.

(iv) Once finalized by the Department, the Department Action, and once accepted by the Department, a Plan of Correction, shall be considered part of these Terms and Conditions, and UHI shall comply with the Department Action and any related Plan of Correction, including notifying the Department when such Plan of Correction is complete. Any failure to comply with a Department Action or a Plan of Correction shall constitute a Noncompliance. If UHI is unable to comply with the requirements of a Plan of Correction, then UHI shall be required to show good cause for such failure to comply with such Plan of Correction, which circumstances the Department will consider when evaluating such Noncompliance.

(v) A Plan of Correction may be amended in accordance with Section 7.2 or Section 7.3; provided however, that if the Department determined the contents of a Plan of Correction pursuant to the last sentence of Section 6.4(iii), the Department may amend such Plan of Correction in its discretion. The Department's unilateral amendment shall constitute an "agency action" under the Indiana Orders and Procedures Act.

PART VII.
ACTIVE SUPERVISION: MODIFICATIONS TO THE TERMS AND CONDITIONS

7.1. **Annual Review of the Terms and Conditions**. The Terms and Conditions will be evaluated annually during the COPA Term (and to the extent applicable, the COPA Pricing Term) to determine if additional requirements or modifications are necessary for UHI to continue to meet the requirements for the issuance of the COPA.

7.2. **Proposed COPA Modification by Department**. In addition to other actions that are permitted by the COPA Statute, the Department, with the consent of the Secretary, may notify UHI of one or more proposed modifications of these Terms and Conditions. For each proposed modification, the Department shall provide a written explanation. The Department's proposed modifications may include, but are not limited to, changes to one or more Terms and Conditions that are not being satisfied, to address any change in circumstances that affect the feasibility or meaningfulness of these Terms and Conditions or to ensure that the Merger improves the health outcomes, health care access, and the quality of health care provided to the population served by the COPA Hospitals, and that the likely benefits arising from the Merger outweigh any disadvantage attributable to a potential reduction in competition that may result from the Merger. Within thirty (30) days of its receipt of such notice, UHI 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 (or such longer period as the Department deems necessary) of the Department's receipt of such notice, the Department and UHI shall meet and confer in an attempt to resolve any differences. The Department shall adopt a counterproposal if the Department, with the consent of the Secretary, determines that a counterproposal to the proposed modification is necessary to achieve the Public Advantage. If the Department and UHI agree on a modification to the Terms and Conditions, then such modification shall become an amendment to these Terms and Conditions and UHI shall thereafter be obligated to comply with such modification. If the Department and UHI do not agree on a modification, then the Department, with the consent of the Secretary, may adopt a modification that it determines is necessary to ensure that the Merger achieves the Public Advantage after taking into consideration UHI's ability to perform or achieve the modification and/or take such other action as are permitted by the COPA Statute. The Department's unilateral adoption of a modification shall constitute an "agency action" under the Indiana Orders and Procedures Act. When considering modifications, the Secretary's consent shall not be unreasonably withheld or delayed.

7.3. **Proposed COPA Modification by UHI**. UHI may at any time notify the Department and request one or more modifications to the Terms and Conditions due to changes in circumstances that have materially affected its ability to comply with one or more of the Terms and Conditions that did not arise from a management or execution failure or to further ensure that the Merger improves the health outcomes, health care access, and the quality of health care provided to the population served by the Combined Enterprise, and that the likely benefits arising from the Merger outweigh any disadvantage attributable to a potential reduction in competition that may result from the Merger. For each proposed modification, UHI will provide a written

explanation, including an explanation of the effect of the modification on the Public Advantage, and any supporting documentation. Within thirty (30) days of its receipt of such notice (or such longer period as the Department deems necessary), the Department, with the consent of the Secretary, shall notify UHI of its acceptance of such proposal or, if applicable, any counterproposal, along with its written explanation. The Department will consider the effect of the modification on the overall Public Advantage when determining whether to approve a requested modification. Within thirty (30) days of UHI's receipt of such notice, the Department and UHI shall meet and confer in an attempt to resolve any differences. If the Department, with the consent of the Secretary, and UHI agree on a modification, then such modification shall become an amendment to the Terms and Conditions and UHI shall thereafter be obligated to comply with such modification. If the Department and UHI do not agree on such modification, then the Department may adopt a modification that it determines is necessary to ensure that the Merger achieves the Public Advantage after taking into consideration UHI's ability to perform or achieve the modification and/or take such other action as are permitted by the COPA Statute. When considering modifications, the Secretary's consent shall not be unreasonably withheld or delayed. Additionally, if Union experiences a Significant Reimbursement Change or a Material Adverse Event, Union may petition the Department for a reduction in its financial commitments under the COPA proportionately to the negative financial impact and the Department's approval shall not be unreasonably withheld.

PART VIII.
TERMINATION AND REVOCATION OF THE COPA

8.1. **Termination**. UHI may file a notice pursuant to I.C. § 16-21-15-5 to terminate the COPA no earlier than the fifth anniversary of the Issue Date if at the time of such filing, no Significant Violation then exists or is the subject of an unresolved Noncompliance Notice, which notice of termination shall be filed at least thirty (30) days prior to the requested date of termination. The Department shall grant a properly filed notice to terminate as required by I.C. § 16-21-15-5(b).

8.2. **Revocation**. The Department may revoke the COPA if the Department determines any of the following has occurred:

(i) UHI or any other member of the Combined Enterprise has materially failed to comply with these Terms and Conditions or I.C. § 16-21-15 and has failed without good cause to correct a Noncompliance.

(ii) The issuance of the COPA was based on a material misrepresentation in the 2025 Application.

(iii) After providing UHI with a Noncompliance Notice, UHI has failed to pay a fee that is authorized by I.C. § 16-21-15.

(iv) The Department determines as part of its Annual Review process that the benefits determined in the issuance of the COPA no longer outweigh the disadvantages attributable to the reduction in competition resulting from the Merger.

8.3. Effect of Termination or Revocation. The COPA Term shall end on the date the termination or revocation of the COPA becomes effective; provided however, that:

(i) any Plans of Correction that as of the date the termination or revocation of the COPA becomes effective have not been completed shall remain in effect in accordance with their terms, UHI shall remain obligated to complete all such Plans of Correction, and in connection with the monitoring and supervision of such Plans of Correction, Part I, Section 2.16, Part IV, Part VI, Section 8.3, Part IX, and UHI's reporting obligations with respect thereto shall survive the termination or revocation of the COPA until completion of all such Plans of Correction;

(ii) the Pricing Commitments, including the Commitments attached as Exhibit B – Addendum 3, and in connection with the monitoring and supervision of such Pricing Commitments, Part I, Sections 2.3, 2.12, 2.13, 2.15, and 2.16, Part IV, Part V, Part VI, Part VII, Section 8.3, Part IX, and UHI's reporting obligations with respect thereto shall survive the termination or revocation of the COPA until the expiration of the COPA Pricing Term**;**

(iii) any Plans of Correction relating to the Pricing Commitment, including the Commitments attached as Exhibit B – Addendum 3, that as of the date of expiration of the COPA Pricing Term have not been completed shall remain in effect in accordance with their terms, UHI shall remain obligated to complete all such Plans of Correction, and in connection with the monitoring and supervision of such Plans of Correction, Part I, Section 2.16, Part IV, Part VI, Section 8.3, Part IX, and UHI's reporting obligations with respect thereto shall survive the termination or revocation of the COPA until completion of all such Plans of Correction;

(iv) Section 2.16 and the obligation to make any refunds required pursuant to Exhibit B – Addendum 3 shall survive termination or revocation of the COPA and expiration of the COPA Pricing Term.

PART IX.
MISCELLANEOUS PROVISIONS

9.1. Notices. All notices (including for Noncompliance Notices, Deficiency Notices and proposed modifications), requests, consents, claims, demands, waivers, and other communications hereunder 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 9.1):

If to the Department:

Attn: Commissioner
Indiana Department of Health
2 N. Meridian Street
Indianapolis, Indiana 46204
LWeaver@health.in.gov

with a copy to:

Attn: Chief Legal Officer
Indiana Department of Health
2 N. Meridian Street
Indianapolis, Indiana 46204
KMacKinnon@health.in.gov

If to the Attorney General:

Indiana Attorney General
Government Center South
IGCS 5th Floor
302 West Washington Street
Indianapolis, Indiana 46204
scott.barnhart@atg.in.gov

If to UHI, addressed as follows:
Steven M. Holman
Chief Executive Officer
Union Health
1606 North Seventh St.
Terre Haute, Indiana 47804
sholman@union.health

with a copy to:

Amy T. Hock
Chief Legal Officer
Union Health 1606 North Seventh St.
Terre Haute, Indiana 47804
ahock@union.health

with a copy to:

Steven H. Pratt
Hall, Render, Killian, Heath & Lyman
500 N. Meridian Street, Suite 400
Indianapolis, IN 46204-1293
spratt@hallrender.com

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

9.3. Waiver. Except when a response time is required by these Terms and Conditions, the failure to exercise, or delay in exercising, any right, remedy, power, or privilege arising from the COPA or these Terms and Conditions, shall not 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.

9.4. Cumulative Remedies. The rights and remedies under the COPA and these Terms and Conditions 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. Acceptance of these Terms and Conditions shall not limit a party's right to challenge a particular term if inconsistent with or non-compliant with the law.

9.5. Effectiveness. These Terms and Conditions shall become effective on the Issue Date.

9.6. Conflict. If there is any conflict between these Terms and Conditions and the 2025 Application, then the terms set forth in these Terms and Conditions shall govern.

9.7. Governing Law; Jurisdiction.

(i) The COPA and these Terms and Conditions shall be governed by and construed in accordance with the laws of the State of Indiana, without regard to the conflicts of laws provisions thereof.

(ii) Any action arising out of or in connection with the COPA and/or these Terms and Conditions to the exclusive jurisdiction of the district court having jurisdiction over Marion County, Indiana; provided however, that prior to UHI filing any action, it is required to exhaust all administrative remedies.

(iii) These Terms and Conditions do not create a private right of action.

9.8. Discretion. All references herein to the Department's or Secretary's "discretion" shall mean the approval of the Department or the Secretary in its reasonable, and not arbitrary

or capricious, discretion. These Terms and Conditions shall not be amended or replaced except pursuant to Section 7.2 or 7.3.

EXHIBIT A
REPORT AND DETERMINATION

(attached)

INDIANA STATE DEPARTMENT OF HEALTH

UNION HOSPITAL, INC. AND TERRE HAUTE REGIONAL HOSPITAL, L.P.

APPLICATION FOR CERTIFICATE OF PUBLIC ADVANTAGE

Report and Determination

December 11, 2025

The Indiana General Assembly enacted Indiana Code Section 16-21-15 *et seq* (the "COPA Statute") in 2021 and subsequently amended the COPA Statute in 2022 and 2025. The General Assembly found that mergers[1] between two hospitals located in a predominantly rural county meeting specific population requirements may benefit the public by maintaining or improving the quality, efficiency, and accessibility of health care services and that the benefits resulting from such a merger, including addressing the unique challenges of providing healthcare services in rural communities, may outweigh the anticompetitive effects of such merger.[2] Further, the General Assembly determined that if a merger is approved under the COPA Statute, it is in the State's best interest to replace competition with state regulation and active supervision and that such merger and the merged entity's post-merger activities supervised pursuant to the COPA Statute should be immune from all state and federal antitrust laws.[3]

The COPA Statute provides a framework by which qualifying hospitals seeking to merge may apply for and, if approved, be granted a certificate of public advantage (a "COPA") by the Indiana State Department of Health (the "Department"). If issued, the COPA replaces competition between the applicants with state regulation by the Department through terms and conditions,[4] annual reviews of whether COPA recipient continues to meet the standards for issuance of a COPA,[5] active supervision and monitoring of the COPA recipient's conduct to ensure furtherance of the COPA Statute's purposes,[6] limitations on the COPA recipient's charge increases of individual services,[7] required reinvestment of realized cost savings,[8] annual reporting,[9] and enforcement mechanisms.[10] While a COPA is not issued for a definite term and could remain in

[1] While the COPA Statute use the term "merger," the term refers generally to any change of ownership, including asset acquisitions and mergers. Ind. Code § 16-21-15-1.5 (2025).
[2] Ind. Code § 16-21-15-0.5 (2025).
[3] *Id*.
[4] Ind. Code § 16-21-15-4(e) (2025).
[5] Ind. Code § 16-21-15-6 (2025).
[6] Ind. Code § 16-21-15-7 (2025).
[7] *Id*.
[8] *Id*.
[9] Ind. Code § 16-21-15-8 (2025).
[10] Ind. Code § 16-21-15-9 (2025).

place indefinitely as long as the recipient remained in compliance with the terms and conditions, a COPA recipient may terminate a COPA upon thirty days' notice after five years.[11]

This Report and Determination has been prepared in connection with the Department's review of an application for a COPA (the "Application") filed on February 5, 2025, by Union Hospital, Inc. ("Union") and Terre Haute Regional Hospital, L.P. ("THRH") regarding Union's proposed acquisition by Union of substantially all of the assets of THRH and Regional Healthcare Partners, LLC ("RH Partners").

THE COPA STATUTE

The COPA Statute applies to a predominantly rural county that has a population less than 140,000 people, is not contiguous to a county with a population of more than 250,000 people, and has only two hospitals located in the county, both of which participate in the statewide trauma system and one of which is a teaching hospital with a medical residency program.[12] If the two hospitals enter into a "merger agreement," either hospital (an "applicant") may, prior to May 13, 2025, submit to the Department an application for a COPA in the manner prescribed by the Department and provide copies of the application to the Office of the Secretary of Family and Social Services ("FSSA") and the Office of the Attorney General ("OAG").[13] At a minimum, the application must include a copy of the merger agreement and describe the proposed merger.[14] In addition to filing the application, the applicant must also pay a filing fee and the reasonable charges incurred by the Department.[15]

The Department is charged with reviewing applications. In its review, the Department is required to consider a myriad of factors, including economic and financial considerations and qualitative and quantitative public and population health benefits. Indiana Code Section 16-21-15-4 ("Section 4") sets forth the Department's standard for review of COPA applications and its decision.

Section 4 contains two subsections that describe the Department's standards for review and approval of an application. Section 4(a) requires the Department to determine whether there is "clear evidence" that the proposed transaction "would benefit the population's health outcomes, health care access, and quality of healthcare; and meet the standards described in this section."[16] Section 4(c) separately requires that the Department grant the application if it determines, under the totality of the circumstances, "there is clear evidence that the proposed merger would benefit the population's health outcomes, health care access, and quality of care in the county; and the

[11] Ind. Code § 16-21-15-5 (2025).
[12] Ind. Code § 16-21-15-1 (2025).
[13] Ind. Code § 16-21-15-3 (2025).
[14] *Id.*
[15] *Id.*
[16] Ind. Code § 16-21-15-4(a) (2025).

likely benefits resulting from the proposed merger outweigh any disadvantages attributable to a potential reduction in competition that may result from the proposed merger."[17]

Section 4 further requires the Department to consider during its review of an application the transaction's effect on the following "Named Factors":

1. The quality and price of hospital and health care services provided to Indiana residents, including the demonstration of population health improvement of the region serviced and the extent to which medically underserved populations have access to and are projected to use the proposed services;

2. The preservation of sufficient health care services within the geographic area to ensure public access to acute care;

3. The cost efficiency of services, resources, and equipment provided or used by the hospitals that are a party to the merger agreement, including avoidance of duplication of services to better meet the needs of the community;

4. The ability of health care payors to negotiate payments and service agreements with the hospitals proposed to be combined;

5. Employment; and

6. Economic impact.[18]

Harmonizing the three subsections, the standard for the Department's review is the applicants must provide specific and credible evidence that after considering all relevant factors:

- the benefits arising from the proposed merger that are likely to be implemented and achieved would improve the health outcomes, health care access, and quality of care of the population served by the applicants, including the population of the county in which the applicants are located; and

- the aggregate benefits arising from the proposed merger, whether affecting health outcomes, health care access, and quality of care or otherwise, that are likely to be implemented and achieved outweigh any disadvantages attributable to a potential reduction in competition that may result from the proposed merger.

This standard reflects the General Assembly's determination that a merger may benefit the public by maintaining or improving the quality, efficiency, and accessibility of health care services

[17] Ind. Code § 16-21-15-4(c) (2025).
[18] Ind. Code § 16-21-15-4(c) (2025).

offered to the public, while also requiring that the benefits resulting from the merger outweigh any anticompetitive effects of the proposed merger. The standard established by the General Assembly differs from the standard for mergers under federal antitrust law, which prohibit mergers and acquisitions that may substantially lessen competition or tend to create a monopoly.[19]

When analyzing mergers, the Federal Trade Commission ("FTC") and Department of Justice use the analytical framework set forth in their jointly-issued *Merger Guidelines*[20] to "evaluate the competitive impacted of a proposed merger."[21] Similarly, the OAG applies the federal antitrust laws and *Merger Guidelines* when analyzing proposed mergers.[22] Indiana's antitrust laws have been interpreted to be consistent with the federal antitrust laws. [23]

The General Assembly could have required the Department to review a COPA application using the standards employed by state and federal antitrust agencies but using the same standard would render the COPA Statute a nullity and/or duplicative of existing state and federal antitrust laws. Instead, the General Assembly directed the Department to replace competition with regulation if the benefits to population health outweighed the anticompetitive effects of the proposed merger and to separately consider whether the proposed merger would improve the health outcomes, health care access, and quality of care of the population served by the applicants.

The General Assembly's 2024 enactment of Indiana Code 25-1-8.5 (the "Notice Statute") distinguishes the COPA Statute's analytical framework from the framework used by the FTC. The Notice Statute requires advance notice of certain healthcare transactions to be provided to the OAG, the State's antitrust enforcement agency,[24] to allow it time to review the transactions. Some public commenters previously asserted that the Notice Statute's enactment evidences the General

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[19] 15 U.S.C. § 18 (2025).

[20] U.S. Department of Justice and the Federal Trade Commission, *Merger Guidelines* (December 18, 2023) (hereinafter "*Merger Guidelines*").

[21] Federal Trade Commission, Federal Trade Commission Staff Submission to Indiana Health Department Regarding the Certificate of Public Advantage Application of Union Health and Terre Haute Regional Hospital 8 (September 5, 2024) (hereinafter "*FTC First Application Comment*").

[22] Office of the Indiana Attorney General, The Office of Attorney General Todd Rokita's Comments on the Application for Certificate of Public Advantage Submitted by Union Hospital, Inc. and Terre Haute Regional Hospital, L.P. 3 (Sept. 27, 2024) (hereinafter "*OAG First Application Comment*").

[23] *Brownsburg Community School Corp. v. Natare Corp.*, 824 N.E.2d 336, 348 (Ind. 2005). *See Rumple v. Bloomington Hospital*, 422 N.E.2d 1309, 1315 (Ind. Ct. App. 1981) ("This section has been held to be modeled after section 1 of the Sherman Antitrust Act,15 U.S.C. 1 (1976), and has been interpreted consistent with federal law interpreting 15 U.S.C 1.") (Internal citations omitted); *Berghausen v. Microsoft Corp.*, 795 N.E.2d 592, 594 (Ind. Ct. App. 2002) ("The Indiana Act was modeled after section two of the Sherman Antitrust Act, 15 U.S.C. 2 … and has been interpreted consistent with the federal law interpreting the Federal Act.") (Internal citations omitted); *Thompson v. Vigo County Bd. Of County Com'rs*, 876 N.E.2d 1150, 1155 (Ind. Ct. App. 2007)) ("Due to the dearth of decisions under the Indiana statute, our courts use decisional law under the similar federal antitrust law, section 4 of the Clayton Anti-Trust Act, 15 U.S.C. Section 15.") (Internal citations omitted); *and City of Auburn Through Bd. Of Public Works and Safety v. Mavis*, 468 N.E.2d 584, 585 (Ind. Ct. of App. 1984) ("Due to the dearth of decisions under IC 24-1-2-3 & -7, Indiana courts use decisional law under the similar federal antitrust law, Section 4 of the Clayton Anti-Trust Act, 15 U.S.C. Section 15") (Internal citations omitted).

[24] Ind. Code § 24-1-1-5.1 and 24-1-1-5.2 (2025); Ind. Code § 24-1-2-5 and 24-1-2-5.1 (2025); Ind. Code § 24-1-3-3.1 (2025); Ind. Code § 24-1-4-2 and 24-1-4-5 (2025).

Assembly's concerns about lack of competition in healthcare and/or intent to promote competition in healthcare.[25] Those comments imply that the Notice Statute's enactment after adoption of the COPA Statute should change the Department's standard for review of a COPA application. However, the General Assembly neither amended nor repealed the COPA Statute when it enacted the Notice Statute. Moreover, in the 2025 legislative session, the General Assembly amended the COPA Statute after extensive debate will full knowledge that Union and THRH had filed a COPA application.[26] While the amendment prohibits submission of applications after May 13, 2025, it did not change the standards for issuance of a COPA.

Therefore, the Department finds that with respect to mergers covered by the COPA Statute, the General Assembly has not changed its determination that replacing competition with regulation will benefit the public if the standards for COPA approval are satisfied. At the same time, while incorporating the analytical framework used by the FTC, the Department's analysis necessarily is broader and may consider factors and benefits that would not be considered by state and federal antitrust authorities.[27]

If the Department grants a COPA, the COPA recipient must comply with the COPA's terms and conditions and submit an annual report to the Department, the OAG and the General Assembly.[28] The COPA Statute specifies certain information that must be included in the annual report. In addition, the COPA Statute requires the Department to actively monitor and supervise the COPA recipient throughout the COPA's term to ensure the recipient's conduct furthers the purposes of the COPA Statute,[29] and until July 1, 2026, the Department must further determine that the COPA recipient continues to meet the standards for COPA issuance.[30]

Throughout the COPA's term, the recipient may not increase its charge for any individual service by more than the increase in the prior year's Consumer Price Index for Medical Care.[31] In

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[25] FTC First Application Comment at 2 ("In its final report, the task force recommended that the state require merging healthcare entities to provide at least six months' notice of mergers and acquisitions to the state so that they can be reviewed appropriately. The Indiana state legislature recently adopted this recommendation by passing legislation broadening the Indiana Attorney General's authority to monitor the consolidation of healthcare providers, which became effective in July 2024."); OAG First Application Comment at 2 ("Indeed, the General Assembly has consistently and frequently expressed concerns with health care pricing and competition in Indiana markets, both before and after passage of the COPA law, and has pursued measures intended to promote competition, e.g., the Reporting of Health Care Entity Mergers and Acquisitions law passed in the 2024 Session.").

[26] Senate Enrolled Act No. 119 (2025) (signed by the Indiana Governor on Apr. 22, 2025); Feb. 12, 2025 Senate Health and Provider Services Committee Hearing on SB 119 https://iga.in.gov/session/2025/video/committee_health_and_provider_services_3900/ (visited May 21, 2025).

[27] In its April 17, 2025 comments, the OAG recognized that "the Department of Health must use traditional antitrust analysis in combination with COPA statute guidelines." Office of the Indiana Attorney General, The Office of Attorney General Todd Rokita's Comments on the Resubmission of the Application for Certificate of Public Advantage Submitted by Union Hospital, Inc. and Terre Haute Regional Hospital, L.P. 3 (Apr. 17, 2025) (hereinafter "*OAG Second Application Comment*").

[28] Ind. Code § 16-21-15-8 (2025).

[29] Ind. Code § 16-21-15-7(a) (2025).

[30] Ind. Code § 16-21-15-6 (2025).

[31] Ind. Code § 16-21-15-7 (2025).

addition, for the first five years, the recipient must invest the realized cost savings from the efficiencies and improvements identified in its COPA application for the benefit of the community it serves.[32]

In addition to its active supervision and monitoring role, the Department can investigate a COPA recipient, require the recipient to take action or refrain from action and revoke the COPA, if it determines the recipient is not complying the COPA Statute or its COPA terms and conditions, the COPA was obtained on the basis of material misrepresentation, the recipient failed to pay a fee or the COPA's benefits no longer outweigh the anticompetitive effects of the merger.[33]

Finally, the COPA Statute allows a COPA recipient to request termination of its COPA five years after its date of issuance.[34] Upon termination, the COPA recipient ceases to be subject to the provisions of the statute (including the limitation on charge increases) and any terms and conditions of the COPA, and the merger ceases to be immune from state and federal antitrust laws. However, the Department recognizes that five years after the COPA's issuance, there will be few, if any, effective means for assuring that the population served by the COPA recipient will not suffer the anticompetitive effects arising from the merger that were mitigated by the COPA.

APPLICANTS

Union Hospital, Inc.

Union is an Indiana non-profit corporation that owns and operates, and holds the Indiana hospital license for, Union Hospital located north of I-70 at 1606 North Seventh St., Terre Haute, Indiana. Union's sole member is Union Health System, Inc., an Indiana non-profit corporation ("Union Health System"). Union Hospital provides comprehensive health care services to residents of Vigo County, Indiana, and several surrounding counties, including Clay, Parke and Vermillion counties in Indiana. It is a full-service acute care hospital licensed for 341 beds (and currently staffs and operates 257 acute care beds). In 2022 and 2023, Union Hospital's average inpatient census was 197 and 210, respectively, and Union Hospital's average outpatient census was 28 and 16, respectively.[35] It provides in-patient and out-patient services, including medical, surgical, obstetric, pediatric, coronary care, post-coronary care, emergency, and intensive care services. Union Hospital is a Level III trauma center[36] and the only certified trauma center located

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[32] *Id.*

[33] Ind. Code § 16-21-15-9 (2025).

[34] Ind. Code § 16-21-15-5 (2025).

[35] 2025 Application for Certificate of Public Advantage (submitted by Union and THRH) 26 (February 5, 2025) (hereinafter "*2025 App.*"). *See also* 2025 App. at 27 (Outpatient census is calculated as total patient hours in observation status divided by 24 hours divided by 365 days).

[36] A Level III trauma center has demonstrated an ability to provide prompt assessment, resuscitation, surgery, intensive care and stabilization of injured patients and emergency operations, has twenty-four hour immediate coverage by emergency medicine physicians and the prompt availability of general surgeons and anesthesiologists, has transfer agreements for patients requiring more comprehensive care at a Level I or Level III trauma center and provides back-up care for rural and community hospitals. American Trauma Society, *Trauma Center Levels Explained* https://www.amtrauma.org/page/traumalevels (visited May 21, 2025).

in Vigo County, Indiana or any of the surrounding counties.[37] Union Hospital is a referral center for services such as neonatal intensive care, open heart surgery, cardiac rehabilitation, radiology, cardiopulmonary services, and radiation therapy. Union Hospital also educates and trains physicians through its family medicine residency program, which has an emphasis on primary care. The residency program has graduated 238 family medicine physicians with individual cohorts of six to seven residents per year.[38]

Union employs approximately 889 nurses, five advanced practice providers, and thirty-seven physicians.[39] In total, Union employs over three thousand associates and over 2,480 full time equivalents ("FTEs"), making it one of the largest employers in the Wabash Valley Community.[40]

Union Hospital offers a number of major healthcare services as shown in Table 1 below. Union's "popular" types of care and services include primary care, heart health, orthopedics, cancer care, surgery, neurology, and women's health.[41]

Table 1: Healthcare Services offered at Union Hospital.[42]

Location	*General Services*	*Inpatient/Outpatient Basis*
Union Hospital	• ***Academic Health Centers***	• ***Yes (3 locations)***
	• After Hours Access Nurse	• Yes
	• ***Accountable Care Organization***	• ***Yes***
	• Behavioral Health	• Emergency Room/IP consults only
	• Cardiology	
	o Cardiac Cath Lab	• Inpatient and Outpatient
	o Cardiac Rehab	• Outpatient
	o Cardiac Testing	• Inpatient and Outpatient
	o Cardiovascular Surgery	• Inpatient
	o Electrophysiology	• Outpatient
	o ***TAVR***	• ***Outpatient***
	• ***Convenient/Urgent Care***	• ***Yes (two locations)***
	• ***Diabetes Education***	• ***Inpatient and Outpatient***
	• Dialysis	• Inpatient
	• Emergency Department	• Yes
	o ***Accredited Chest Pain Center***	• ***Inpatient***
	o Accredited Stroke Center	• Inpatient
	o Trauma Services	• Inpatient
	• ***ENT***	• ***Outpatient***
	• Family Medicine	• Inpatient and Outpatient
	• ***Family Medicine Residency***	• ***Yes***
	• General Surgery	• Inpatient and Outpatient
	• Hospitalists	• Inpatient

[37] Indiana Hospital Association, *Trauma Hospitals in Indiana* https://archive.ihaconnect.org/member/resources/Pages/Trauma-Hospitals-in-Indiana.aspx (visited May 21, 2025).
[38] 2025 App. at 10; Union Health, Inc., *Union Hospital Family Medicine Residency Current Residents* https://uhfmr.org/index.php/about-us/current-residents (visited May 14, 2025).
[39] 2025 App. at 21-22 (Union reported that eight physicians are employed via a professional services agreement.).
[40] 2025 App. at 94.
[41] Union Health, Inc., *Find Medical Services* https://www.myunionhealth.org/services/ (visited May 14, 2025).
[42] 2025 App. at 14-16.

Location	General Services	Inpatient/Outpatient Basis
	• Infusion Center	• Outpatient
	• ***At-Home Monitoring***	• ***Outpatient***
	• Medical Rehab	• Inpatient
	• Hospice	• Inpatient
	• Intensive Care	• Inpatient
	• Internal Medicine	• Inpatient and Outpatient
	• Laboratory	• Inpatient and Outpatient
	• Maternal Health	• Yes
	• Labor & Delivery	• Inpatient
	• ***Level III NICU***	• ***Inpatient***
	• Nurse Navigators	• Outpatient
	• OB Hospitalists	• Inpatient
	• Neurology	• Inpatient and Outpatient
	• ***Neurosurgery***	• ***Inpatient and Outpatient***
	• OB/GYN	• Inpatient and Outpatient
	• ***Occupational Medicine***	• ***Outpatient***
	• Oncology	
	o Medical	• Inpatient and Outpatient
	o Radiation	• Outpatient
	• ***Ophthalmology***	• ***Outpatient***
	• Orthopedic Surgery	• Inpatient and Outpatient
	• ***Outpatient Pharmacy***	• ***Yes***
	• ***Pain Management***	• ***Outpatient***
	• ***Palliative Care Program***	• ***Inpatient***
	• Pediatrics	• Inpatient and Outpatient
	• ***Pediatric Therapy***	• ***Outpatient***
	• Physical Therapy	• Inpatient and Outpatient
	• ***Podiatry***	• ***Inpatient and Outpatient***
	• ***Population Health Program***	• ***Yes***
	• Pulmonary Rehab	• Outpatient
	• Pulmonology	• Inpatient and Outpatient
	• Radiology	• Yes
	o CT	• Inpatient and Outpatient
	o ***Dexascan***	• ***Outpatient***
	o Mammography	• Outpatient
	o MRI	• Inpatient and Outpatient
	o PET CT	• Outpatient
	o US	• Inpatient and Outpatient
	o Interventional	• Inpatient and Outpatient
	• ***Retinal Surgery***	• ***Outpatient***
	• ***Rheumatology***	• ***Outpatient***
	• Respiratory Therapy	• Inpatient and Outpatient
	• ***Sleep Lab***	• ***Outpatient***
	• ***Specialty Pharmacy***	• ***Outpatient***
	• Speech Therapy	• Inpatient and Outpatient
	• Surgery	• Yes
	• Surgery	• Inpatient
	o ***Ambulatory Surgery***	• ***Outpatient***
	o Endoscopy	• Inpatient and Outpatient
	o Robotics	• Inpatient and Outpatient
	• Urology	• Inpatient and Outpatient
	• Wound Care (Hyperbaric Medicine)	• Outpatient

Note: ***Bold/italicized services are not offered by THRH or RH Partners.***

Union Hospital's Behavioral Health program provides inpatient consultations or consultations in the emergency room and does not provide services are in a primary care setting or have a dedicated in-patient capability.[43] As a result, Union Hospital patients suffering from mental health conditions such as depression, anxiety, and substance use disorders receive specialized behavioral healthcare only if they are hospitalized for another medical concern or being seen in the emergency room.

Union also owns and operates Union Hospital – Clinton ("Union Hospital Clinton") located at 801 S. Main St., Clinton, Indiana. Union Hospital Clinton is licensed separately from Union Hospital, has Medicare and Medicaid provider numbers separate from Union Hospital, and is designated by CMS as a "critical access hospital."[44] Union Hospital Clinton primarily serves residents of Parke and Vermillion counties in Indiana.[45] Union Hospital Clinton has twenty-five licensed beds[46] and provides, among other services, cardiology services, imaging services, surgery services and an emergency department.[47] Union Hospital Clinton is Chest Paint Accredited and designated as a Stroke Ready Center.[48]

Union Health [redacted] owns Union Associated Physicians Clinic, LLC, an Indiana limited liability company ("Union Physicians"), which operates a multi-specialty physician clinic with approximately 180 physicians and allied health providers.[49] These providers provide services, including cardiology, ENT, family medicine, obstetrics/gynecology, oncology and urology, at approximately 20 locations in Clay, Parke and Vigo counties in Indiana and Clark County in Illinois.[50] Union Physicians' locations are predominantly north of I-70, other than three family medicine locations and one surgery center/rehabilitation location.[51] Union and Union Physicians employ or contract with 94 primary care physicians (physicians who are board certified in family medicine, internal medicine, pediatrics, or obstetrics-gynecology).[52]

In addition, providers employed by Union and/or Union Physician Services provide healthcare services at several other locations in Clay, Putnam, Sullivan and Vigo Counties, Indiana and in east central Illinois, including smaller hospitals, healthcare centers and nursing homes.[53]

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[43] Union Health, Inc., *Behavioral Health* https://www.myunionhealth.org/services/behavioral-health/conditions-we-treat (visited May 14, 2025); 2025 App. at 14.
[44] 2025 App. at 14 fn. 12.
[45] 2025 App. at 17.
[46] Ind. Dept. of Health, *Hospital Directory* https://www.in.gov/health/reports/QAMIS/hosdir/wdirhos.htm (visited May 20, 2025).
[47] Union Health, Inc., *Union Hospital Clinton* https://www.union.health/about-us/union-hospital-clinton/ (visited May 14, 2025).
[48] Union Health, Inc., *Union Hospital Clinton* https://www.union.health/about-us/union-hospital-clinton/ (visited May 14, 2025).
[49] 2025 App. at 5 and 19.
[50] Att. II.c.1 to 2025 App.
[51] Union Health, Inc., *Find a Location* https://www.union.health/locations/ (visited May 14, 2025).
[52] 2025 App. at 41.
[53] 2025 App. at 23.

Union is a member of the Stratum Med Accountable Care Organization ("ACO"), which is a group of doctors, hospitals and other healthcare providers who come together voluntarily to provide coordinated high-quality care to Medicare patients.[54] Union Hospital's ACO covers 9,679 patients.[55] The population health team at Union Hospital consists of fifty-two full-time employees including ambulatory pharmacists, palliative care providers, nurse navigators, and dieticians.[56]

Union Hospital holds the following accreditations[57]:

- Magnet Recognition Program (from American Nurses Credentialing Center)
- Level III OB and NICU (from the Indiana Department of Health)
- Blue Distinct for Cardiac Care (from Anthem Blue Cross Blue Shield)
- Cardiovascular & Pulmonary Rehabilitation Certification (from American Association of Cardiovascular and Pulmonary Rehabilitation)
- Chest Pain ACHE Accreditation (from the American College of Health Care Executives)
- ACHC Primary Stroke Center (from the Accreditation Commission for Health Care)
- Total Joint ACHE Accreditation (from the American College of Health Care Executives)
- ACS Commission on Cancer (from the American Cancer Society)
- Stroke Gold Plus/ Target: Stroke Honor Roll Elite (from American Heart Association/American Stroke Association)
- American Society Gastrointestinal Endoscopy Recognition Program (from American Society Gastrointestinal Endoscopy)
- Blue Distinct for Maternity Care (from Anthem Blue Cross Blue Shield)
- Gold Safe Sleep Champion (from Cribs for Kids)

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[54] Centers for Medicare and Medicaid Services, *Accountable Care Organizations (ACOs): General Information* https://www.cms.gov/priorities/innovation/innovation-models/ACO#:~:text=Accountable%20Care%20Organizations%20(ACOs)%20are,the%20Medicare%20patients%20they%20serve (visited May 16, 2025).
[55] 2025 App. at 39.
[56] 2025 App. at 39.
[57] 2025 App. at 43-44.

- Alliance for Innovation on Maternal Health (from the Alliance for Innovation on Maternal Health)

Terre Haute Regional Hospital, L.P.

THRH owns and operates, and holds the Indiana hospital license for, Regional Hospital located south of I-70 at 3901 South 7th St., Terre Haute, Indiana. Regional Hospital is licensed for 278 beds (and staffs and operates significantly fewer acute care beds)[58] and operates a full-service acute care hospital. In 2022 and 2023, Regional Hospital's average daily inpatient census was sixty-four (64) and its average outpatient census was 2.1 and 2.0, respectively.[59] THRH is ultimately owned by HCA Healthcare, Inc. ("HCA"), a for-profit healthcare company that "owns and operates 186 hospitals and approximately 2,400 ambulatory sites of care, including surgery centers, free standing emergency rooms, urgent care centers and physician clinics in 20 states and the United Kingdom."[60] Regional Hospital provides healthcare services to residents of Vigo County, Indiana, and several surrounding counties, including Clay, Greene and Sullivan counties in Indiana.[61] Regional Hospital provides many of the same in-patient and out-patient clinical services provided by Union Hospital, including cardiovascular services (including open-heart surgery and cardiac catheterization), oncology services (including radiation therapy and outpatient infusion), and labor and delivery (including neonatal intensive care). Until August 2024, Regional Hospital maintained a Level III trauma center but closed it "because of continuing financial losses and staffing challenges"[62] due to the loss of multiple surgeons, failure to recruit replacement surgeons and resulting revenue losses.[63] Regional Hospital continues to participate in Indiana's statewide trauma system. Regional Hospital also provides inpatient behavioral health services and specialized inpatient services, including intensive care and inpatient rehabilitation care.[64]

Table 2 below highlights the healthcare services offered by THRH and RH Partners.

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[58] 2025 App. at 10; Terre Haute Regional Hospital, *Indiana Market 2023-2025 Strategic Plan* 5 (Oct. 4, 2022) (Attachment P to Request for Information 1 submitted in connection with the 2023 Application for Certificate of Public Advantage submitted by Union and THRH (September 14, 2023) (hereinafter "*2023 App.*") (as of 2022, Regional Hospital staffed [redacted] acute care beds) (withheld from public release).

[59] 2025 App. at 26-27. THRH does not track outpatient census in the ordinary course of business. Outpatient census was calculated using the same methodology as used by Union: Outpatient census is calculated as total patient hours in observation status divided by 24 hours divided by 365 days.

[60] HCA Management Services, L.P., *Corporate Profile* https://investor.hcahealthcare.com/corporate-profile/default.aspx (visited May 19, 2025).

[61] 2025 App. at 17.

[62] Letter from Monica Cintado, Sr. Vice Pres., HCA Healthcare, to Dr. Lindsay Weaver, State Health Commr, Ind. Dept. of Health (May 7, 2025) (hereinafter "*Cintado Letter*"). [redacted]

[63] 2025 App. at 56.

[64] 2025 App. at 10.

Table 2: Healthcare Services offered by THRH and RH Partners[65]

Location	*General Services*	*Inpatient/Outpatient Basis*
	• After Hours Access Nurse	• Yes
	• Behavioral Health	• ***Inpatient***
	• Cardiology	• Inpatient and Outpatient
	o Cardiac Cath Lab	• Inpatient and Outpatient
	o Cardiac Rehab	• Outpatient
	o Cardiac Testing	• Inpatient and Outpatient
	o Cardiovascular Surgery	• Inpatient and ***Outpatient***
	o Electrophysiology	• Outpatient
	• Dialysis	• Inpatient
	• Emergency Department	• Yes
	o Accredited Stroke Center	• Inpatient
	o Trauma Services	• Inpatient
	• Family Medicine	• Inpatient and Outpatient
	• General Surgery	• Inpatient and Outpatient
	• Hospitalists	• Inpatient and ***Outpatient***
	• Infusion Center	• Outpatient
	• Medical Rehab	• Inpatient
	• Hospice	• Inpatient
	• Intensive Care	• Inpatient
	• Internal Medicine	• Inpatient and Outpatient
	• Laboratory	• Inpatient and Outpatient
	• Maternal Health	• Yes
	• Labor & Delivery	• Inpatient
	• Level III NICU	• No (but THRH licensed as a Level II Special Care Nursery)
	• Nurse Navigators	• Outpatient
	• Neurology	• Inpatient and Outpatient
	• OB/GYN	• Inpatient and Outpatient
	• Oncology	• Inpatient and Outpatient
	o Medical	• Inpatient and Outpatient
	o Radiation	• Outpatient
	• Orthopedic Surgery	• Inpatient and Outpatient
	• Pediatrics	• Inpatient and Outpatient
	• Pediatric Therapy	• N
	• Physical Therapy	• Inpatient and Outpatient
	• Pulmonary Rehab	• Outpatient
	• Pulmonology	• Inpatient and Outpatient
	• Radiology	• Inpatient and Outpatient
	o CT	• Inpatient and Outpatient
	o Mammography	• Inpatient and Outpatient
	o MRI	• Inpatient and Outpatient
	o PET CT	• Outpatient
	o US	• Inpatient and Outpatient
	o Interventional	• Inpatient and Outpatient
	• Respiratory Therapy	• Inpatient and Outpatient
	• Speech Therapy	• Inpatient and Outpatient
	• Surgery	• Inpatient and Outpatient
	o Surgery	• Inpatient and Outpatient
	o Endoscopy	• Inpatient and Outpatient
	o Robotics	• Inpatient and Outpatient
	• Urology	• Inpatient and Outpatient
	• Wound Care (Hyperbaric Medicine)	• Outpatient

Note: ***Bold/italicized services are not offered by Union Hospital.***

[65] 2025 App. at 16-17.

THRH does not participate in any ACOs and does not have a family medicine residency training program. THRH employs approximately two hundred and fourteen (214) nurses and two (2) advanced practice nurses.[66] THRH does not employ any physicians, but contracts with three primary care physicians.[67] THRH employs approximately seven hundred (700) individuals, which represent around five hundred (500) FTEs.[68] Regional Hospital is the only hospital in the area that is accredited by The Joint Commission.[69] Regional Hospital also holds an advanced certification as a Primary Stroke Center from The Joint Commission.[70]

Regional Hospital has historically relied on single practice physicians from RH Partners or independent practitioners.[71] As of the Application date, RH Partners employed [redacted].[72] RH Partners' employed physicians and nurse practitioners are specialists in surgery [redacted], cardiovascular surgery [redacted], cardiology [redacted], hematology/oncology [redacted], urology [redacted], obstetrics/gynecology [redacted] and behavioral health [redacted].[73] Since the Application date, RH Partner has experience a number of physician departures [redacted].[74] RH Partners employs no primary care physicians. RH Partners' office locations are all south of I-70 in Terre Haute, Linton, Shelburn and Sullivan, Indiana.[75]

Overlapping and Non-Overlapping Healthcare Services offered by Union Hospital and Regional Hospital

Union Hospital and Region Hospital offer several overlapping and non-overlapping healthcare services as described in Table 3.[76]

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[66] 2025 App. at 22.
[67] 2025 App. at 41.
[68] 2025 App. at 95.
[69] Terre Haute Regional Hospital, *About Terre Haute Regional Hospital* https://regionalhospital.com/about/index.dot (visited May 20, 2025); The Joint Commission, Quality Report, https://www.qualitycheck.org/quality-report/?keyword=terre%20haute%20regional%20hospital%20&bsnid=7224 (visited May 20, 2025) (THRH Accreditation decision was effective on Dec. 13, 2023).
[70] The Joint Commission, *Quality Report* https://www.qualitycheck.org/quality-report/?keyword=terre%20haute%20regional%20hospital%20&bsnid=7224 (visited May 20, 2025) (THRH Accreditation decision was effective on July 23, 2024).
[71] 2025 App. at 56.
[72] 2025 App. at 20-21.
[73] 2025 App. at 20-21, 49.
[74] Union Health, Inc., *Response to IDOH 7/17/2025 Questions* (July 25, 2025) (on file with Department and withheld from public disclosure).
[75] 2025 App. at 20-21.
[76] 2025 App. at 16-17. *See also* Blue & Company, *Blue and Company Financial Projections for HUD,* [redacted] (submitted as Attachment III.a.1.3 to 2025 App.) (withheld from public disclosure).

Table 3: Overlapping and Non-Overlapping Healthcare Services offered at Union Hospital and Regional Hospital.

Overlapping Services	• **Behavioral Health*** • **Cardiology** • **Dialysis** • **Emergency Care** • **Family Medicine** • **General Surgery** • **Infusion Center** • **Intensive Care** • **Internal Medicine** • **Labor & Delivery** • **Maternity** • **Medical Rehab** • **Neurology** • **OBGYN** • **Oncology** • **Orthopedic Surgery** • **Pediatrics** • **Pulmonary** • **Radiology** • **Speech Therapy** • **Surgery** • **Urology** • **Wound Care**
Services only at Union Hospital	• At-home Monitoring • Convenient Care • Ear, Nose, and Throat • Family Medicine Residency • Joint Replacement • Level III NICU • Level III Trauma Center • Occupational Medicine • Ophthalmology • Pain Management • Palliative Care • Population Health • Rheumatology • Sleep medicine • Dexascan • Ambulatory Surgery
Services only at RegionaL Hospital	• Behavioral Health Inpatient Unit

*Service only offered as inpatient or ER consult by Union Hospital

PROPOSED TRANSACTION

On September 12, 2023, Union, THRH, RH Partners and HTI Hospital Holdings, Inc. ("HTI") entered in an asset purchase agreement (the "Purchase Agreement"), which was subsequently amended on October 23, 2023. Pursuant to the Purchase Agreement, Union or an affiliate of Union would acquire substantially all of the assets of THRH and RH Partners (the "Proposed Merger") for a purchase price of [redacted], subject to adjustment for working capital.[77] In addition to acquiring the operating assets of THRH and RH Partners, subject to pre-

[77] 2025 App. at 12-13; Attachment I.e to the 2025 App. (withheld from public disclosure).

employment screening and verification, Union will offer employment to all THRH and RH Partners' employees (other than certain senior level executives) at wage and salary levels consistent with such employees' wages or salaries immediately prior to the closing of the Proposed Merger and other benefits comparable to the benefits provided to similarly situated Union employees.[78]

APPLICATION

On September 14, 2023, Union and THRH (together, the "Applicants") submitted an application to the Department, FSSA and OAG (the "2023 Application"). After an initial review of the Application, the Department issued a written request for additional information ("RFI 1") on October 27, 2023. The Applicants responded to RFI 1 on January 9, 2024, and submitted additional information requested by the Department on February 6, 2024.

The Department issued a second written request for additional information ("RFI2") on February 13, 2024, and requested transaction-level data pursuant to a third written request for additional information on April 2, 2023 ("RFI3"). The Applicants provided the requested transaction-level data on June 1, 2024, and completed their response to RFI 2 on July 29, 2024. On August 6, 2024, the Department notified the Applicants that the 2023 Application was complete. This notice commenced the Department's 120-day review period.

The Department opened a portal for interested members of the public to submit comments. The comment period concluded thirty days after the Department's review period commenced on September 6, 2024. The Department received 392 public comments. Approximately 14% of the comments were in favor of the Proposed Merger and approximately 86% of the comments were against the Proposed Merger. In addition, the Department received comments from staff of the FTC on September 5, 2024,[79] and comments from the OAG on September 27, 2024.[80] Both the FTC staff and the OAG advised the Department that they opposed the Proposed Merger because the Proposed Merger would result in a substantial reduction in competition in violation of state and federal antitrust laws.

Subsequent to the Application being deemed complete, the Applicants submitted additional information regarding benefits that may arise as a result of the Proposed Merger and responded to the FTC and OAG comments. The Applicants withdrew the 2023 Application on November 22, 2024.

On February 5, 2025, the Applicants submitted the Application to the Department, the OAG and FSSA. The Department deemed the Application complete on February 21, 2025.

The Department opened a second portal for thirty days for interested members of the public to submit comments. The comment period concluded on March 23, 2025. During the comment

[78] 2025 App. at 12-13, 31; Purchase Agreement Section 7.1 (withheld from public disclosure).
[79] FTC First Application Comment.
[80] OAG First Application Comment.

period, the Department received 393 public comments. Approximately 32% of the comments were in favor of the Proposed Merger and approximately 65% were against the Proposed Merger. In addition, the Department received supplemental comments from the FTC staff on March 17, 2025,[81] and supplemental comments from the OAG on April 17, 2025.[82] Both the FTC staff and the OAG advised the Department that they continued to oppose the Proposed Merger.

On May 2, 2025, the Department conducted a public meeting in a town hall format at Ivy Tech Community College in Terre Haute, Indiana. Approximately 245 people attended the meeting, and 44 local officials, current and retired employees of the Applicants and community members made public comments. Approximately 63% of the speakers indicated that they were in favor of the Proposed Merger and 25% of the speakers indicated that they were against the Proposed Merger. The Department also received forty additional written comments at the public meeting. Approximately 65% of the additional commenters opposed the Proposed Merger and approximately 18% of the additional commenters supported the Proposed Merger.

Subsequent to the Application being deemed complete, the Applicants submitted additional information regarding the benefits that may arise as a result of the Proposed Merger, the potential anticompetitive effects of the Proposed Merger and the future viability of Regional Hospital.

APPLICANTS' ELIGIBILITY TO SUBMIT A COPA APPLICATION

The Applicants were eligible to submit the Application because they and Vigo County satisfy the requirements of Section 1 of the COPA Statute. According to the United States Census Bureau, Vigo County has a population less than of 140,000 and is not contiguous to a county with a population greater than 250,000.[83] In addition, Vigo County is predominantly rural with 88.4% of its land area classified as rural by the Census Bureau.[84] Finally, there are only two hospitals located in Vigo County (the Applicants), both are enrolled in Indiana's statewide trauma system and Union maintains a medical residency program.[85]

Some public commenters asserted that the Applicants were not eligible to seek a COPA after THRH closed its Level III trauma center in August 2024.[86] The Department finds that the plain language of the COPA Statute refers to a "trauma care system," not "trauma centers," and

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[81] Federal Trade Commission, *Federal Trade Commission Staff Submission to Indiana Health Department Regarding 2025 Certificate of Public Advantage Application of Union Health and Terre Haute Regional Hospital* (March 17, 2025) (hereinafter "*FTC Second Application Comment*").
[82] OAG Second Application Comment.
[83] U.S. Census Bur., County-level 2020 Census Urban and Rural Information for the U.S., Puerto Rico, and Island Areas sorted by state and county FIPS codes (updated September 2023); https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html (visited May 20, 2025) (hereinafter "*County-level Census Information*"). As of the 2020 Census, Vigo County had a population of 106,153.
[84] *Id*.
[85] 2025 App. at 10.
[86] *See* OAG Second Application Comment at 3; Anonymous Public Comment ("Does this acquisition even [qualify] since the following criteria no longer applies? Has only two (2) hospitals that are both in the statewide comprehensive trauma care system under IC 16-19-3-28 and one (1) of the hospitals is a teaching hospital with a medical residency program. Terre Haute Regional Hospital no longer participates as a trauma facility.").

that the Applicants' hospitals participate in the State's trauma system because in addition to Union Hospital's Level III trauma center, THRH participates in the statewide trauma registry.[87]

On the basis of the foregoing, the Department finds that the Applicants are eligible to submit an application seeking a COPA.

THE GEOGRAPHIC AREA SERVED BY THE APPLICANTS

In the 2025 Application, the Applicants describe the counties they primarily serve (Vigo, Clay, Greene, Parke, Sullivan and Vermillion counties in Indiana) as their "Service Area."[88] These same counties were described as the "Wabash Valley Community" in the 2023 Application.[89] Because the terms "Service Area" and "Wabash Valley Community" are used as a shorthand description of the community in which the Applicants provide healthcare services but are not intended to describe the geographic market in which the Applicants compete, this Report refers to these counties as the "Wabash Valley Community."

The Applicants included portions of these counties within their "primary service areas"[90] for in-patient services using Indiana Hospital Association discharge data for 2019 through the first quarter of 2023:[91] Table 4 identifies the ZIP codes and counties comprising each Applicant's primary service area.

[87] It should also be noted that in its consideration of the 2025 amendment to the COPA Statute, the members of the General Assembly were aware of the Application and that THRH had closed its trauma center but indicated that the intention of the COPA Statute was to allow the Applicants to file a COPA application.
[88] 2025 App. at 4. *See* "*Geographic Markets in which Applicants Compete*" below.
[89] 2023 App. at 3.
[90] "Primary service area" as defined for purposes of the Application is the smallest number of ZIP codes from which an Applicant obtains eighty percent of its discharges.
[91] 2025 App. at 17. It is noted that the Applicants did not include any of their discharges of patients located in the State of Illinois; however, in light of the COPA Statute's focus on Indiana residents, the Department has determined that the lack of information regarding Illinois patients does not significantly hinder the Departments' analysis.

Table 4: Primary Service Areas

ZIP Code (County)	THRH	UNION
[redacted]		

Union's primary service area includes almost all of Vigo County, along with portions of the counties of Clay, Greene, Parke, Sullivan and Vermillion. THRH's primary service area is entirely contained within Union's primary service area, including almost all of Vigo County.[92]

The Wabash Valley Community is located in western Indiana and its most significant urban area is Terre Haute. Other significant Wabash Valley Community urban areas are Clinton (Vermillion County), Rockville (Park County), Brazil (Clay County), Sullivan (Sullivan County), Bloomfield (Greene County) and Linton (Greene County). I-70 and US 40 are major East-West highways that roughly bifurcate the northern and southern portions of the Wabash Valley

[92] For a discussion concerning the FTC's comments regarding the appropriateness of this definition of primary service area, *see* FTC First Application Comment at 18-19.

Community. US 41, IN 63 and IN 54 are major north-south highways that connect the larger cities and towns within the Wabash Valley Community.

Demographics

According to the U.S. Census Bureau, approximately 216,000 residents live in the Wabash Valley Community. The Wabash Valley Community as a whole is characterized as being older, poorer and more rural than Indiana as a whole. Vigo County is included within the Terre Haute Metropolitan Statistical Area,[93] but nearly one quarter of Vigo County residents live in a rural area and over 88% of its land area is rural.[94] The population in the other five counties ranges from approximately 15,000 to 31,000 residents, with more than half living in rural areas.[95] The majority of residents in the Wabash Valley Community identify as White, and except for residents of Clay County, each counties' residents earn an average median household income that is less than the state median household income. The Wabash Valley Community has a greater percentage of its residents over the age of 65 than Indiana as a whole, and consistent with general demographic trends, this group is expected to grow.[96] Approximately 17% of the residents of the Wabash Valley Community live in poverty[97] and approximately 7% are uninsured.[98] Table 5 below contains specific demographic information for each county as compared to Indiana as a whole.[99]

Table 5: Select Demographic Information (2021)
(highlighted cells identify characteristics that are worse than Indiana as a whole)

	Total Population	% White	%Female	% 65+ years old	% High School Graduates	% in Poverty	% Uninsured	Median Household Income
Indiana	6,805,985	78.00%	50.40%	16.40%	33.00%	12.1%	6.9%	$62,723
Wabash Valley Community	215,834	89.32%	49.73$	18.10%	37.19%	17.1%	7.7%	$52,203 (weighted average of county medians)
Clay	26,466	94.60%	50.20%	18.80%	41.60%	11.1%	6.8%	$64,245
Greene	30,803	94.90%	50.10%	20.00%	39.30%	14.3%	7.1%	$55,504
Parke	16,156	95.40%	52.40%	20.00%	38.80%	16.0%	8.5%	$55,683
Sullivan	20,817	91.10%	45.10%	18.40%	42.50%	16.2%	5.9%	$47,606

[93] 2025 App. at 5.
[94] County-level Census Information.
[95] County-level Census Information.
[96] 2025 App. at 51-52.
[97] Union Hospital, Inc., *Community Health Needs Assessment & Implementation Framework 2021* (submitted as Att. V.b to 2023 App.) 6-22 (hereinafter "*CNA*").
[98] 2025 App. at 52.
[99] App. at 51-52; U.S. Census Bur., *Income and Poverty Interactive Data Tool* https://www.census.gov/programs-surveys/saipe/data/tools.html (visited May 22, 2025).

	Total Population	% White	%Female	% 65+ years old	% High School Graduates	% in Poverty	% Uninsured	Median Household Income
Vermillion	15,439	95.60%	50.50%	20.30%	41.20%	12.4%	6.7%	$53,540
Vigo	106,153	84.20%	49.90%	16.70%	33.60%	20.4%	7.3%	$48,421

A shrinking labor force characterizes the Vigo County employment landscape. As Figure 1 below illustrates, while the U.S. and Indiana experienced employment growth, the Terre Haute MSA[100] experienced a net loss of employed residents since 2010.[101]

Figure 1. U.S., Indiana, and Terre Haute Employment

Vigo County's largest employers are Vigo County School Corporation employing 2,217 individuals, followed by Union Health System (2,099), and Indiana State University (1,536). The manufacturing industry as a whole is a significant employer in Vigo County, employing approximately 5,598 individuals, and there are nearly 470 working farms export soybeans, corn, forestry, wheat, and hay. It is home to large plastics manufacturing, chemical manufacturing, food manufacturing, and food processing companies. By industry, the top employer sectors in Vigo County include the healthcare and social assistance employing 9,048 individuals, followed by government (8,582), retail (7,287), and manufacturing (5,598).

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[100] The Terra Haute Metropolitan Statistical Area is comprised of the counties of Clay, Sullivan, Vermillion and Vigo as of July 2023. Previously, it also included Parke County. U.S. Census Bur., *Delineation Files* https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html (visited May 22, 2025.

[101] Indiana Business Review, *Terre Haute Forecast 2022* https://www.ibrc.indiana.edu/ibr/2021/outlook/terrehaute.html (visited May 22, 2025).

For the other five counties, the top four largest employer sectors are listed in descending order[102]:

- Sullivan County: government (1,979), retail (804), manufacturing (745), and farming (424).
- Vermillion County: construction (943), retail (789), government (745), and manufacturing (710).
- Parke County: government (1,023), retail (693), manufacturing (543), and farming (546).
- Greene County: government (1,972), retail (1,423), construction (799), and farming (838).
- Clay County: manufacturing (2,896), government (1,230), retail (1,257), and food service (672).

Health Status of the Wabash Valley Community

The Wabash Valley Community faces significant health needs. In 2021, Union completed a Community Needs Assessment (the "CNA") to identify the health needs within the Wabash Valley Community. The CNA evaluated primary and secondary data sources and identified the following as significant, often inter-related, health needs:[103]

- Access to Health Care / Primary Care
- Drug and Alcohol Dependency
- Cancer
- Diabetes
- Economy
- Food Insecurity
- Heart Disease
- Birth Outcomes / Infant Mortality
- Behavioral Health
- Obesity
- Lack of Exercise
- STIs
- Breast Cancer
- Tobacco / Vaping
- Lack of Transportation
- Women's Health

[102] Stats Indiana and Ind. Dept. of Workforce Dev., *Hoosiers by the Numbers In-Depth Regional Profiles* https://www.hoosierdata.in.gov/profiles.asp?scope_choice=a&county_changer=18153&id=2&page_path=Area+Profiles&path_id=11&menu_level=smenu1&panel_number=1 (visited May 22, 2025).
[103] CNA at 4.

The CNA further identified heart disease, diabetes, cancer, stroke, and women's health-related issues as the greatest health risks in the Wabash Valley Community. Leading risk factors for developing heart disease and stroke include high blood pressure, high cholesterol, smoking and secondhand smoke exposure, obesity, unhealthy diet, and physical inactivity. These risk factors are prevalent in the Wabash Valley Community and contribute to residents' poor health outcomes. Table 6 below summarizes some of the Wabash Valley Community's key leading health risk factors.[104] The CNA compares the Wabash Valley Community to Indiana as a whole, and every risk factor is worse in the Wabash Valley Community as compared to the rest of the state, except for STIs. Additionally, the CNA identified substance use dependency as a top health-related concern.

Table 6: Health Risk Factors in the Wabash Valley Community (2023)
(highlighted cells identify characteristics that are worse than Indiana as a whole)

	Clay	Green	Parke	Sullivan	Vermillion	Vigo	Wabash Valley Community	Indiana
Adult Smoking	22%	23%	25%	25%	24%	24%	24%	20%
Adult Obesity	39%	38%	41%	42%	42%	37%	39%	37%
Physical Inactivity	27%	27%	29%	29%	27%	27%	27%	26%
STIs (newly diagnosed chlamydia per 100,000)	381.3	291.3	330.6	222.6	354.9	593.2	451.7	495.7
Mammography Screening	33%	35%	35%	31%	32%	33%	33%	39%

Healthcare Service Gaps in the Wabash Valley Community

The Applicants identified several healthcare service gaps within the Wabash Valley Community in the Application.

Behavioral Health. The Wabash Valley Community lacks access to mental healthcare providers compared to the rest of the state. In 2022, the Wabash Valley Community had 1,583 psychiatric in-patient records of which 580 patients (36.64%) received care at Regional Hospital. The remaining 1,003 patients received care in forty other Indiana hospitals as far away as Fort Wayne and South Bend.[105] Across Indiana, there is one mental healthcare provider for every 530 residents. None of the Wabash Valley Community counties' ratios is less than the statewide average. In 2023, Vigo County had the best ratio with one mental healthcare provider for every

[104] Compare Counties, *County Health Rankings and Road Maps* https://www.countyhealthrankings.org/health-data (visited May 22, 2025) (hereinafter "*Compare Counties*").
[105] Indiana Hospital Association, *Inpatient Outmigration* (submitted as Att. IV.d.1.(i) to 2025 App.).

570 residents, while Sullivan County had the worst ratio with one mental healthcare provider for every 2,310 residents.[106]

Physician Shortages. The Applicants describe in the Application that a physician shortage exists in the Wabash Valley Community for the following specialties: cardiology, urology, gastroenterology, neurology, neurosurgery, and oncology. The physician shortages are attributable to aging physicians, challenges in recruiting for a rural location, lack of depth in some specialties and the resulting increased call coverage requirements.[107]

Other Healthcare Service Providers in the Wabash Valley Community

The Wabash Valley Community contains a variety of healthcare facilities that provide an array of services ranging from general acute care to addiction rehabilitation. In addition to the Applicants, who are primarily located in Vigo County, and Union Hospital Clinton located in Vermillion County, there are three other hospitals: Ascension St. Vincent Clay in Clay County ("Ascension Clay Hospital"), Greene County General Hospital in Greene County ("Greene County Hospital"), and Sullivan County Community Hospital in Sullivan County ("Sullivan County Hospital").[108] Like Union Hospital Clinton, these three hospitals are critical access hospitals,[109] and none have a verified trauma center.[110] Residents of the Wabash Valley Community also seek hospital care from hospitals physically located outside of the Wabash Valley Community.[111]

In addition to these six hospitals and their related locations, there are fifty-one other providers of inpatient and outpatient service providers in the Wabash Valley Community.[112] Twenty-two of these providers provide homecare, hospice, and inpatient senior living

[106] Compare Counties.
[107] 2025 App. at 55-56.
[108] 2025 App. at 59-60.
[109] Indiana Department of Health, Indiana *Critical Access Hospitals by Public Health Preparedness Districts (2023)* (available at https://www.in.gov/health/trauma-system/files/CAH-by-PHPD-2023-no-dunn.pdf) (visited May 22, 2025).
[110] Indiana Department of Health, *Trauma Centers* https://www.in.gov/health/trauma-system/indianas-trauma-system/trauma-centers/ (visited Nov. 3, 2024).
[111] *See* "*Geographic Markets in which the Applicants Compete*" below.
[112] 2025 App. at 62-64. These facilities may largely be disregarded for purposes of this analysis as they do not provide comparable services to those offered by the Applicants. Of the 51 providers: 22 provide homecare, hospice, and inpatient senior living arrangements.

arrangements,[113] eight are Federally Qualified Health Centers,[114] six provide specialized care,[115] six provide physical therapy,[116] six are primary or general care clinics,[117] and one is an addiction treatment facility.[118] While many of these locations provide services also provided by the Applicants, most do not provide the types of healthcare services provided by hospitals or only provide outpatient services.

THE APPLICANTS' PROPOSED PLANS

To ensure the Proposed Merger will benefit the population's health outcomes, health care access, and quality of care, the Applicants have agreed to 62 Commitments across seven categories: Quality, Pricing, Preservation of Access, Enhancement, Employment and Economic Impact, Population Health, and Other.[119]

Table 7: Commitments of the Applicants

Quality Commitments	
1	UHI will implement a common clinical IT platform across the Combined Enterprise[120] within 24 months of the Merger to support quality improvement, care management, and population health improvement efforts.
2	UHI will report on specific quality measures of the Combined Enterprise quarterly and annually against pre-Merger baselines to ensure the Department and the community have the ability to monitor quality performance post-Merger. The reporting shall include all patients served post-Merger.

[113] 2025 App. at 62-64 (Amedisys Home Health, Bethesda Gardens Assisted Living, Cobblestone Crossing Assisted Living, Heart-to-Heart Hospice, Intrepid USA Healthcare & Hospice-at-Home Services, Southern Care Hospice, VNA Hospice, Glenburn Home & Health, Signature Healthcare, Springhill Village Senior & Assisted Living, Sycamore Manner Assisted Living, Terre Haute Nursing Home & Rehab, Westridge Healthcare, Heritage House of Clinton, Vermillion Convalescent Center, Indiana Home Care Plus, Clay City Senior Citizens Housing, Exceptional Living Center, Town Park Assisted Living, Autumn Trace Assisted Living, Envive Healthcare of Sullivan, and Millers Merry Manor).

[114] 2025 App. at 62-64 (Valley Professionals FQHC North, Valley Professionals FQHC South, Valley Professionals FQHC West, Wabash Valley Health Center FQHC, Valley Professionals FQHC Cayuga, Valley Professionals FQHC Clinton, Valley Professionals FQHC Bloomfield, and Valley Professionals FQHC Rockville). A Federally Qualified Health Center is a nonprofit health center or clinic that serve medically underserved areas and populations by providing primary care services regardless of ability to pay.

[115] 2025 App. at 62-64 (Eye Specialists of Indiana Cataract Center, Horizon Health Specialty Clinic, Horizon Health Sycamore Pain & Wellness Center, Rayus Imaging Center, Terre Haute Surgical Center, and Sullivan Surgicenter).

[116] 2025 App. at 62-64 (Athletico Physical Therapy Downtown, Athletic Physical Therapy East, ATI Physical Therapy, Independence Rehab & Physical Therapy, Terre Haute Physical Therapy, and Valley Rehab Physical Therapy).

[117] 2025 App. at 62-64 (Horizon Health Primary Care Clinic, VA Outpatient Clinic, Clay County Health Center, Greene County Health Lonetree, Greene County Health Shakamak, and Greene County Health Worthington).

[118] 2025 App. at 62-64 (Anabranch Recovery Center).

[119] COPA Terms and Conditions – Exhibit B "Commitments."

[120] Certain terms used to describe the Commitments are defined in the Terms and Conditions.

3	The Combined Enterprise will be required to make good faith efforts to ensure a material reduction, in quality does not occur compared to pre-Merger baselines.
4	UHI will report on specific patient satisfaction measures of the Combined Enterprise against pre-Merger baselines to ensure the Department and the community may monitor the effect of the Merger on patient satisfaction.
5	The Combined Enterprise will establish a Quality Committee responsible for overseeing the integration of THRH and RHP-affiliated providers into the Combined Enterprise, ensuring quality and safety best practices for the Combined Enterprise, and reviewing quality and credentialing across the Combined Enterprise.
Pricing Commitments	
1	UHI Charges established in the UHI Chargemaster and Professional Charges established in the Professional Chargemaster that were in effect as of the Determination Date, may be adjusted at the discretion of UHI, provided that the percentage increase to the UHI Chargemaster and the Professional Chargemaster in any Fiscal Year shall not exceed the Annual Increase in CPI Medical for such Fiscal Year.
2	The Combined Enterprise will limit price increases in compliance with the "Pricing Limitations" attached [to the Commitments] as Addendum 3.
3	UHI will implement the UHI Chargemaster and Professional Chargemaster for all services provided across the Combined Enterprise immediately upon the Issue Date.
4	The Combined Enterprise shall negotiate in good faith with all Payors to include the Combined Enterprise in the health plans offered in the Service Area and comply with the competitive contracting provisions set forth in Ind. Code § 27-1-37-8 (as in effect on July 1, 2025).
5	The Combined Enterprise shall negotiate in good faith with all potential new Payor entrants to the market and Payors that have small market shares. Union Hospital will not unreasonably refuse to negotiate and accept reasonable terms and rates offered by potential new Payor entrants to the market or Payors that have small market shares.
6	The Combined Enterprise shall work in good faith to include in Payor Contracts reasonable provisions for improved quality and other value-based incentives based upon priorities as mutually agreed upon with each Payor.
7	The Combined Enterprise shall honor all Payor Contract terms and not unilaterally terminate without cause any such contract prior to its stated expiration date.
8	The Combined Enterprise 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, or other terms that require the Combined Enterprise to assume risk.
9	The Combined Enterprise shall not bargain or insist on "most favored nations" or similar clauses in Payor Contracts.
10	The Combined Enterprise shall provide all Payors with a written notice of all Pricing Commitments and Addendum 3 in its entirety and shall negotiate with Payors in good faith.

Preservation of Access Commitments	
1	The Combined Enterprise will maintain inpatient acute care facilities at both Union Hospital and Regional Hospital and maintain inpatient acute care facility access to at least pre-Merger levels in totality during the COPA Term.
2	The Combined Enterprise will maintain Emergency Rooms at both Union Hospital and Regional Hospital and maintain emergency care access to at least pre-Merger levels during the COPA Term.
3	The Combined Enterprise will maintain at least a Level III trauma program at Union Hospital and maintain Level III trauma care access to at least pre-Merger levels during the COPA Term.
4	The Combined Enterprise will maintain an Intensive Care Unit (ICU) at Union Hospital during the COPA Term and will expand the availability of ICU services by increasing the number of ICU beds from twenty-four to thirty-six within the first three years.
5	Within one month of the Merger, the Combined Enterprise will convert the Regional Hospital ICU into an Acuity Adaptable Unit (AAU). Once converted, the Combined Enterprise will maintain the AAU at Regional Hospital for the COPA Term.
6	The Combined Enterprise will continue to offer cardiac catheterization services at Union Hospital and Regional Hospital during the COPA Term. If it is determined that the catheterization services currently offered at Regional Hospital should be consolidated to a single location, Union Hospital shall expand access to cardiac catheterization services at Union Hospital as part of the consolidation plan.
7	The Combined Enterprise shall obtain the approval of the Department at least sixty (60) days in advance of making any material change to a Service Line if the change would adversely impact the health outcomes, health care access, or quality of health care of the Service Area.
8	Within six months of the Merger, the Combined Enterprise will consolidate Wound Care Services at Union Hospital by adding two additional Wound Care treatment rooms. Once consolidated, the Combined Enterprise will continue to offer Wound Care Services within the Combined Enterprise and maintain Wound Care access to at least pre-Merger levels for the COPA Term.
9	The Combined Enterprise will maintain chemotherapy infusion services at Union Hospital and maintain chemotherapy infusion access to at least pre-Merger levels during the COPA Term. If it is determined that the chemotherapy infusion services currently offered at Regional Hospital should be consolidated to a single location, Union Hospital shall expand access to chemotherapy services at Union Hospital as part of the consolidation plan in order to maintain chemotherapy infusion access to at least pre-Merger levels during the COPA Term.
10	Within six months of the Merger, the Mother-Baby/NICU/Pediatric Units at Union Hospital and Regional Hospital will be consolidated at Union Hospital so that all expectant mothers seeking care at Union Hospital will have access to Level III maternal and neonatal care. Once consolidated, UHI will continue to offer Level III maternal and neonatal care within the Combined Enterprise and maintain Level III maternal and neonatal care and pediatric service access to at least pre-Merger levels for the COPA Term.
11	UHI will report emergency and service line diversion data on a quarterly basis to ensure emergency care access is maintained to at least pre-Merger levels of the Combined Enterprise for the COPA Term.

Enhancement Commitments	
1	The Combined Enterprise will invest at least $30,000,000 in the facilities at Regional Hospital over five years. At least $15,000,000 of this investment will be obligated in the first three years of the COPA Term.
2	The Combined Enterprise will invest at least $75,000,000 in Union Hospital over five years. At least $37,500,000 of this investment will be obligated in the first three years of the COPA Term.
3	The Combined Enterprise will invest at least $5,000,000 to add oncology treatment-related technology for the residents of the Service Area over five years.
4	The Combined Enterprise will recruit additional Primary Care Physicians and Advance Practice Providers (APPs) during the COPA Term to the Service Area and work in good faith to add at least fifteen new primary care providers in the first five years.
5	The Combined Enterprise will recruit additional Specialty Physicians to improve the availability of specialty care in the Service Area and work in good faith to add at least twenty-one new Specialty Physicians in the first five years.
6	The Combined Enterprise will recruit additional pharmacists during the COPA Term and work in good faith to add at least three new pharmacists in the first five years.
7	The Combined Enterprise will increase the number of behavioral health inpatient beds during the COPA Term with at least 20 beds added to the Service Area in the first five years.
8	Within the first 60 days of the Merger, the Combined Enterprise will expand UHI's after-hours nurse access program to make it available to all patients seeking care within the Combined Enterprise.
9	The Combined Enterprise will increase the number of Well Child Checks provided for patients 0-17 years of age across the Combined Enterprise during the COPA Term.
10	The Combined Enterprise will increase the number of Preventive Well Patient Visits provided for patients 18-39 years of age across the Combined Enterprise during the COPA Term.
11	The Combined Enterprise will increase the number of Preventive Well Patient Visits provided for patients 40-64 years of age across the Combined Enterprise during the COPA Term.
12	The Combined Enterprise will increase the number of Medicare Annual Wellness Visits during the COPA Term with a goal of having seventy percent (70%) or more of attributed patients of the Combined Enterprise receiving a Medicare Annual Wellness Visit each year by the end of the COPA Term.
13	The Combined Enterprise will increase the Transitional Care Management services offered during the COPA Term with a goal of having ninety percent (90%) or more of eligible attributed patients of the Combined Enterprise offered Transitional Care Management services each year by the end of the COPA Term.
Employment and Economic Impact Commitments	
1	The Combined Enterprise will offer employment to all employees who are employed by THRH and RHP at the time of the Merger.

2	The Combined Enterprise will offer employment to THRH and RHP employees at salary and hourly wage levels that are the same as, or better than, THRH and RHP levels.
3	The Combined Enterprise will honor full credit for paid time off balances accrued as of the Issue Date of THRH and RHP employees who transition to employment by UHI or an Affiliate.
4	The Combined Enterprise will conduct annual employee and physician satisfaction surveys to help reduce turnover and improve retention of employees of the Combined Enterprise and will report the results in each Annual Report and on its "Healthier Together" transparency website.
5	UHI shall cooperate and work with the Department and a nonprofit organization or a postsecondary educational institution that is jointly selected by the Department and UHI to conduct an independent research study of the economic impact of the COPA. UHI and the nonprofit organization or postsecondary educational institution will identify the funding sources for the study.
6	UHI shall create and implement a plan to annually redress any economic concerns or negative impacts identified in the research study conducted under Employment and Economic Impact Commitment #5.
7	The Combined Enterprise shall notify the Department at least sixty (60) days in advance of making a material reduction in employment or staffing.
Population Health Commitments	
1	Within the first twelve months, the Combined Enterprise will expand UHI's Health Equity Plan to cover all patients receiving care from the Combined Enterprise.
2	Within the first twelve months, the Combined Enterprise will expand UHI's Population Health Improvement Plan to cover all patients receiving care from the Combined Enterprise.
3	The Combined Enterprise will provide at least twelve "pop-up clinics" each year to provide health care services to the homeless community in the Service Area.
4	Within the first twelve months of the Merger, the Combined Enterprise will establish a new food access point of the Combined Enterprise to help address food insecurity.
5	UHI shall cooperate and work with the Department and a nonprofit organization or a postsecondary educational institution which is jointly selected by the Department and UHI to provide information and data required by the organization or institution to conduct an independent research study of the impacts of the COPA on the community's health metrics and outcomes as described in Ind. Code § 16-21-15-4.5. UHI and the nonprofit organization or postsecondary educational institution will identify the funding sources for the study.
6	UHI shall create and implement a plan to redress any community health concerns or negative impacts identified in the research study conducted under Population Health Commitment #5.
7	UHI will establish an Accountable Health Community to bring multiple stakeholders together to improve the health and well-being of the Wabash Valley by addressing social determinants of health.
8	UHI will work with its community partners in the Accountable Health Community to reduce the high rates of tobacco and vaping use during pregnancy in the Service Area.

9	UHI will work with its community partners in the Accountable Health Community to reduce the high rates of infant mortality in the Service Area.
10	UHI will work with its community partners in the Accountable Health Community to promote breastfeeding in the Service Area.
Other Commitments	
1	**Charity Care / Financial Assistance**: The Combined Enterprise will immediately expand the Union Hospital Financial Assistance Policy to apply to all patients seeking care. Once expanded, the Combined Enterprise shall maintain a Financial Assistance Policy during the COPA Term that is at least as generous as the Union Hospital Financial Assistance Policy implemented at the time of the Merger.
2	**Reinvestment of Cost Savings**: UHI will reinvest into the Service Area the cost savings realized in the first five years of the Merger to help improve the health status of the community.
3	**Graduate Medical Education**: UHI will invest at least an additional $6,900,000 in Graduate Medical Education each year during the first five years of the Merger.
4	**General Psychiatry Residency Training Program**: The Combined Enterprise will pursue a new General Psychiatry Residency Training Program to help address the critical need for psychiatrists in the region and use good faith efforts to add at least two (2) new residents each year of the four-year program.
5	**Health Plan Ownership Prohibitions**: Except for its existing participation in Southeastern Indiana Health Organization Inc., which shall be grandfathered, the Combined Enterprise shall be prohibited from owning, operating, controlling, or licensing any health plan or insurance product.
6	**Regional Hospital Representation on UHI Board of Directors**: Union Hospital will add a representative from Regional Hospital to the UHI Board of Directors within three (3) months of the Issue Date.

EFFECT OF THE PROPOSED TRANSACTION AND PLANS ON THE NAMED FACTORS

In its review of the proposed transaction and Union's associated plans for the Service Area, the Department conducted a comprehensive evaluation of the anticipated impacts on health care access, quality, and outcomes for the Service Area. Union's plans articulated through the 62 Commitments above are structured to align with and address the statutory Named Factors, which directly informed the Department review.

Recognizing the potential risks associated with reduced competition, including concerns about declining quality, the Department placed particular emphasis on Commitments that introduce new levels of transparency and implement safeguards against quality decreases. These protections are especially critical to ensure consolidation does not compromise patient outcomes or clinical standards and accountability.

The Department further sought assurances that existing service levels and access to health care delivery would be preserved, if not expanded, as a result of the Proposed Merger. The Commitments to maintain current service lines and to require Department approval prior to any significant changes provide a safeguard against service disruption are responsive to these concerns. Additionally, the planned increase in psychiatric and intensive care unit (ICU) bed capacity in the Service Area addresses a growing demand for higher-acuity services in the region amidst rising behavioral health needs and an aging population.

The Commitments also include targeted initiatives aimed at improving population health outcomes, with a focus on vulnerable populations such as individuals experiencing housing instability or food insecurity. The requirement to convene stakeholders to address poor health metrics demonstrates a strategic approach to addressing public health challenges. Because poor population health is directly tied to rising health costs and economic impacts such as workforce, these approaches to addressing health disparities and improving outcomes have broad effects.

The Pricing Commitments, particularly those outlined in Addendum 3, are central to reducing the impact of the Proposed Merger on payor negotiations and patient affordability and guarding against price increases holistically. In addition to the COPA Statute's limitation on chargemaster increases, these provisions establish an absolute limitation of 265% of Full Medicare for commercial payor aggregate rates for inpatient and outpatient services. The pricing limitations further prohibit Union from converting service delivery locations from non-hospital-based billing to hospital-based billing without Department approval. This billing location provision rooted in the principles of site neutrality helps protect employers and consumers from unwarranted increases in the cost of care. Furthermore, Union is required to offer all Indiana employers a direct-to-employer arrangement at or below the 265% of Full Medicare benchmark. These pricing limitations extend beyond the COPA Term and remain in effect for five years after termination of the COPA (a minimum of ten years), providing long-term protection against excessive pricing.

Employment protections and workforce development initiatives, including guaranteed offers of employment at the same or better wages and salaries, investments in graduate medical education, and the creation of new training programs, are expected to positively influence both the economic stability of the Service Area and the availability of qualified health care professionals.

Taken together, the Commitments, if fully implemented and effectively overseen, are likely to result in meaningful improvements in health care access, quality, and outcomes for the community served. The weighting of the relative benefit of each of the 62 Commitments is analyzed at the conclusion of this report.

CONSIDERATION OF WHETHER THE PLANS THAT ARE LIKELY TO BE IMPLEMENTED AND ACHIEVED WOULD IMPROVE HEALTH OUTCOMES, HEALTHCARE ACCESS AND HEALTHCARE QUALITY OF THE POPULATION SERVED BY THE APPLICANTS AND OF VIGO COUNTY

Improvement in health outcomes, access, and quality for the population of the Service Area is dependent on Union's achievement of the proposed plans and implementation of the Commitments following consummation of the Proposed Merger.

The potential risk that Union's plans, particularly the Commitments, will not be implemented is mitigated by the Terms and Conditions. The Terms and Conditions establish requirements for Union to create and seek Department approval of detailed Implementation Plans, provide ongoing reporting to the Department, make publicly available information concerning the Merger and the Commitments, and provide opportunities for public input on the impact of the Merger. Finally, the robust enforcement options for instances of noncompliance will increase the likelihood Union will execute the plans for the benefit of the population served.

Implementation Plans

The COPA Terms and Conditions require Union to seek Department approval of a detailed Implementation Plans. Within ninety (90) days of consummation of the Proposed Merger, a written Initial Implementation Plan must be submitted. This Initial Implementation Plan must include the tasks, resource requirements, deadlines, risks and mitigation mechanisms for implementation and execution of the Commitments as well as Union's methodologies and procedures for measuring, tracking, reporting and reinvesting in the Service Area the realized cost savings. The Department may provide Union with comments and feedback consistent with the Terms and Conditions, which must be incorporated into an updated plan. Union is required to demonstrate to the Department through the Implementation Plan that the Commitments are reasonably likely to be completed and achieve the Public Advantage.[121]

The exercise of creating and submitting for Department review and approval the Implementation Plan compels Union to undertake a thorough assessment of the resources and tasks required for execution. This process necessitates the identification of personnel, resources, and timelines, thereby facilitating the development of detailed project plans. In addition to enhancing internal planning and accountability, this structured approach provides the Department with greater transparency into Union's operational activities. As a result, it enables more robust oversight and fosters an environment in which expectations and progress can be clearly monitored and evaluated.

Annual Reporting

Union must submit an Annual Report to the Department each year by April 30th comprehensively addressing all activities related to the COPA for the prior Fiscal Year. Each

[121] COPA Terms and Conditions Section 2.11.

Annual Report must be certified by Union's Chief Executive Officer and Chief Financial Officer and be in a format specified by the Department. A copy of the Annual Report must also be submitted to the Office of the Attorney General and the General Assembly and will be posted on the Department's website.[122]

The Annual Report must address Union's compliance (or non-compliance) with, and steps taken to achieve, each Commitment, the Approved Implementation Plan, and each of the Terms and Conditions pursuant to the COPA Statute. Given the importance of guarding against price increases caused by the Proposed Merger, the Annual Report must also include a summary of steps taken to reduce the costs of care delivered, reduce amounts paid by Payors and to improve efficiency. In order to ensure access to health care services is maintained within the Service Area, Union must also provide a description of any services or functions consolidated during the year and a description of any material changes in volume or availability of services offered. Finally, the Annual Report must include a list of all Noncompliance Notices, Department Actions and Plans of Correction initiated during the relevant year or in prior years that have not been fully resolved.[123]

Each Commitment requires, at a minimum, an attestation of compliance in the Annual Report. Many of the Commitments also require specific data and reporting beyond attestation. The Department retains the authority to require additional information as necessary to assess Union's compliance and/or progress toward fulfilling each Commitment.

For example, for each of the Enhancement Commitments related to provider recruitment and workforce expansion, Union must include in the Annual Report a description of its progress towards meeting this Commitment. The information must include specific data points, including the number of providers recruited and their practice areas, the sources and methods of recruitment, the number of offers extended, the number of new providers retained and their practice areas, the employment location of each retained provider, the funding spent on recruitment efforts, a description of any challenges or unique circumstances in recruitment in the prior year and plans to address.[124]

Similarly, the Commitment to conduct at least 12 Pop-Up Clinics per year to provide healthcare services to the homeless community in the Service Area requires detailed reporting in the Annual Report. Union must include a detailed listing of each Pop-Up clinic conducted, including the date, location, duration, number of patients served, a summary of services provided, the number of employees and non-employees that provided services at the clinic, the resources used to conduct the clinic and any other information that would enable the Department to determine compliance.[125]

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[122] COPA Terms and Conditions Section 2.12(i).
[123] COPA Terms and Conditions Section 2.12(ii).
[124] COPA Terms and Conditions – Exhibit B "Commitments" Enhancement Commitments #4-6.
[125] COPA Terms and Conditions – Exhibit B "Commitments" Population Health Commitment #3.

Finally, the Commitment for Union to reinvest into the Service Area the cost savings in the first five years of the Merger requires the Annual Report to include detail of the cost savings realized each year and a description of how those savings are being reinvested to help improve the health status of the community.[126]

Quarterly Reporting and Meetings with the Department

In addition to the Annual Reporting requirements, Union is required to meet with the Department on a quarterly basis and submit a Quarterly Report. The Quarterly Report must address the actions taken during the relevant quarter in connection with each Commitment and the Approved Implementation Plan, the information required to be reported pursuant to any Commitment, and a list of all Noncompliance Notices, Department Actions and Plans of Correction initiated during the relevant quarter or that have not been fully resolved from prior quarters.[127] These regular touchpoints will allow the Department to consistently monitor progress toward implementation of the Commitments and take action, if needed.

Transparency Website

Throughout the duration of the COPA Term, Union is required to maintain a publicly accessible transparency website that serves as a centralized and reliable source of information for the public. This website entitled "Healthier Together" must include comprehensive and regularly updated content pertaining to the COPA, including the quality of health care services, access to care, and the affordability of health care within the Service Area, particularly in the context of the Merger.

The website must be designed to ensure that all information is presented in a manner that is both understandable and accessible to a broad audience. It will provide clear, timely updates on the implementation and progress of the COPA, as well as ongoing initiatives aimed at improving community health outcomes. In addition, the website must publish all updates and reporting measures required under the Commitments, thereby reinforcing transparency, accountability, and public engagement.[128]

Furthermore, Union is required to make publicly available the finalized reports of research studies evaluating the impact of the COPA on community health metrics and outcomes and the economic conditions within the Service Area.[129] These reports are essential for assessing the broader implications of the Merger and for informing future policy and planning decisions.

[126] COPA Terms and Conditions – Exhibit B "Commitments" Other Commitment #2.
[127] COPA Terms and Conditions Section 2.13.
[128] COPA Terms and Conditions Section 2.15.
[129] COPA Terms and Conditions – Exhibit B "Commitments" Population Health Commitment #5 and Employment and Economic Impact Commitment #5.

The "Healthier Together" website must also include the results of the annual employee and physician satisfaction surveys.[130] These surveys are intended to support workforce stability, which is a critical component in each of the areas of healthcare access, quality, and outcomes.

Finally, this website must include detail on the reinvestment of cost savings into the Service Area. This section of the website will allow the community to gain insight into the amount of cost savings realized each year and how those cost savings are being reinvested to help improve the health status of the community.[131]

Annual Listening Session

The Terms and Conditions require Union to host at least one public listening session annually during which the residents of the Service Area can provide oral and/or written feedback regarding the Merger, Union's service quality, efficiency and accessibility of care, and effects of the COPA. The date, time, and location for each listening session must be publicly advertised on each hospital's website and social media account at least thirty (30) days before the event and must be live streamed, recorded and made publicly available.

The date and time of each listening session is subject to the Department's approval and Union must notify the Department and the Attorney General of the schedule for listening sessions. A summary of the listening sessions must be included in the Annual Report, including the number of attendees, any materials presented at the listening session, copies of any written feedback received from the public and a summary of any oral public comments received.[132]

Board of Directors Appointment

To ensure the State of Indiana has a meaningful and ongoing opportunity to engage directly with Union leadership regarding the COPA and its implications for the Public Advantage, the Terms and Conditions provide the Governor with the authority to appoint two members to Union's Board of Directors for the duration of the COPA Term. Furthermore, at least one of these gubernatorial appointees must serve on key committees, including the audit, governance, and executive committees, as well as any future committee established to oversee COPA compliance. This structure is designed to guarantee that the Governor's appointees have comprehensive access to relevant information and an active role in critical decision-making processes, thereby reinforcing transparency, accountability, and alignment with the public interest.[133]

Penalties and Noncompliance

The likelihood of Union's implementation of its proposed plans and commitments is further strengthened by the deterrence effect of the established penalties and effects of

[130] COPA Terms and Conditions – Exhibit B "Commitments" Employment and Economic Impact Commitment #4.
[131] COPA Terms and Conditions – Exhibit B "Commitments" Other Commitment #2.
[132] COPA Terms and Conditions Section 2.14.
[133] COPA Terms and Conditions Section 2.10.

noncompliance. The Department is equipped with a wide range of enforcement options if Union fails to comply with the COPA Statute or the Terms and Conditions.

As is typical in regulatory oversight frameworks, the Department has the authority to investigate Union's activities to determine compliance with the Terms and Conditions and require and oversee implementation of a Plan of Correction in the case of noncompliance. The Department may also issue a fine in an amount based on the impact to the Public Advantage. The fine must be paid to the Healthy Hoosiers Foundation, Inc. and the funds invested into the Service Area in a manner designed to address the areas of need affected by the noncompliance.

The Terms and Conditions define specific instances of noncompliance that constitute a Significant Violation. These more material actions include repeated violations of the Commitments, any material violation of the Pricing Commitments, any violation of the COPA Statute, failure to submit the Annual Report, and failure to cooperate with audits and investigations, among other activities.

In the case of a Significant Violation, the Department may appoint an independent third-party monitor to oversee and evaluate Union's adherence to rectifying noncompliance and preventing future violations. Additionally, to ensure appropriate accountability and leadership engagement in executing the plans to improve healthcare access, quality, and outcomes, the Department may also require Union to limit the total compensation of its most senior executive officer to a maximum amount that is consistent with executive compensation in health systems of similar size.[134]

CONSIDERATION OF WHETHER THE AGGREGATE BENEFITS ARISING FROM THE TRANSACTION THAT ARE LIKELY TO BE IMPLEMENTED AND ACHIEVED OUTWEIGH ANY DISADVANTAGES TO A POTENTIAL REDUCTION IN COMPETITION THAT MAY RESULT FROM THE PROPOSED MERGER

The second element of the Department's analysis is whether the Applicants have provided specific and credible evidence that, after considering all relevant factors, the aggregate benefits arising from the Proposed Merger that are likely to be implemented and achieved, whether affecting health outcomes, health care access, and quality of care or otherwise, outweigh any disadvantages due to a potential reduction in competition that may result from the Proposed Merger. This analysis requires the Department to balance:

- the disadvantages arising from any potential reduction in competition that may result from the Proposed Merger (the "Anticompetitive Effects"); and

- the aggregate benefits arising from the Proposed Merger that are likely to be implemented and achieved (the "COPA Benefits").

[134] COPA Terms and Conditions Section 6.3.

The Department finds that the analytical framework described in the Merger Guidelines and case law applying Section 7 of the Clayton Act[135] provides the appropriate framework for the Department's determination of the Anticompetitive Effects. However, as discussed above, the Department finds that its consideration of COPA Benefits must be broader than the "cognizable efficiencies" credited by the FTC, which must be merger-specific, verifiable, prevent a reduction in competition and not anticompetitive.[136] If the Department credited only "cognizable efficiencies," its analytical framework would not meaningfully differ from the FTC's framework. In that case, a COPA would be issued only if a proposed acquisition would "not substantially lessen competition" in a relevant market. The Department's adoption of such framework would be inconsistent with the General Assembly's intent to replace competition with regulation. Therefore, the Department finds that to be credited as a COPA Benefit, a benefit must be merger-specific, verifiable and likely to be implemented and achieved but does not have to prevent a reduction in competition. For example, a benefit that improves health outcomes, healthcare access or quality of care, if merger-specific, verifiable and likely to be implemented would be a potential COPA Benefit.

Competitive effects analysis

In its analysis of the Anticompetitive Effects, the Department must identify the relevant market or markets in which the Applicants compete, assess the potential reduction in competition and consider defenses that may limit the effects of any potential reduction in competition. Merger analysis is a predictive exercise that requires analysis and review of substantial information. The purpose of the analysis, however, is not to predict with certainty the precise effects of a merger, but to assess the totality of risk presented by the merger.[137] To assess the anticompetitive effect, the Department reviewed, with the assistance of special counsel and economists, extensive information submitted by the Applicants, including transaction-level data, statewide discharge data and comments received from the public, the FTC and the OAG.

Competition between hospitals is characterized as "two-stage" competition. First, hospitals compete with each other to be included in health plans because a hospital that is "in network" is much more attractive to patients than one that is "out of network" and therefore, more expensive. Health insurers use the competition between hospitals to reduce the insurers' costs, the benefits of which flow to purchasers of health insurance, such as employers, employees and purchasers of individual plans. These benefits include lower premiums and lower out of pocket costs, even though consumers of healthcare services are somewhat insulated from the costs. Second, hospitals compete with each other to attract patients, including individual health plan members, directly and through physician referrals. At this stage of competition, while the out-of-

[135] Section 7 of the Clayton Act (15 U.S.C. § 18) prohibits acquisitions where "the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly."
[136] Merger Guidelines § 3.3.
[137] Merger Guidelines at § 1.

pocket costs of services are relevant to the consumer, quality and availability of services become particularly important.[138]

Relevant Markets

"A relevant antitrust market is an area of effective competition, comprising both product (or service) and geographic elements."[139] Identifying relevant markets is a two-fold task – identifying the products and services that are reasonable substitutes for each other (the "product market") [140] and identifying the geographic area in which purchasers may rationally look for those good and services (the "geographic market").[141] Relevant markets can be identified, among other things, through direct evidence of substantial competition between the merging parties, industry or public recognition or use of the "hypothetical monopolist test."[142]

Product Markets in which the Applicants Compete

Both Applicants operate general acute care hospitals, providing a range of primary and secondary care services on an inpatient and outpatient basis. Courts and the FTC have repeatedly determined that the product market for analyzing hospital mergers is a cluster of general acute care services sold to commercial payors and their customers/members.[143] Cluster markets are appropriate and provide analytic convenience when "the competitive conditions for multiple [products or services] are reasonably similar."[144] Thus, while abdominal surgery and treatment of severe infection are not substitutes for each other, the competitive conditions (e.g., competition between acute care hospitals for the treatment of those conditions) are substantially the same when the hospitals provide the same services. As noted above in Table 3, the Applicants provide a wide range of overlapping inpatient healthcare services. In addition, commercial insurers must be able to offer their customers/members the entire breadth of hospital services. Therefore, the Department finds that "general acute care services" constitutes a relevant product market.

It should be noted that the general acute care services market does not include "outpatient services, rehabilitation services, psychiatric services or complex tertiary or quaternary services, as

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[138] *Fed. Trade Comm'n. v. Advocate Health Care Network*, 841 F.3d 460, 471 (7th Cir. 2016); *Fed. Trade Comm'n. v. Penn State Hershey Med. Ctr*., 838 F.3d 327, 342 (3d Cir. 2016); Miles, John J., 2 Health Care and Antitrust L. § 15:1 (2023); FTC First Application Comment at 17.
[139] Merger Guidelines at § 4.3.
[140] *Advocate Health Care Network*, 841 F.3d at 471 (citing *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962).
[141] *Penn State Hershey Med. Ctr.*, 838 F.3d at 338 (quoting *Gordon v. Lewistown Hosp.*, 423 F.3d 184, 212 (3d Cir. 2005)).
[142] Merger Guidelines at § 4.3. *See* discussion of "Hypothetical Monopolist Test" below.
[143] Merger Guidelines at § 4.3.D.3; FTC First Application Comment, fn. 90; *Fed. Trade Comm'n v. Hackensack Meridian Health, Inc., 30 F.4th 160, 166 (3d Cir. 2022)*; *Advocate Health Care Network*, 841 F.3d at 468; *Penn State Hershey Med. Ctr.*, 838 F.3d at 338; *ProMedica Health Sys., Inc. v. F.T.C.*, 749 F.3d 559, 568 (6th Cir. 2014).
[144] Merger Guidelines at § 4.3.D.3.

those services are offered by a different set of competitors"[145] and patients are typically willing to travel significantly further for tertiary and quaternary services.[146]

The Applicants offer a wide range of outpatient services, such as cardiac catheterization, cancer care, infusion, and urology.[147] Outpatient services are provided by hospitals and by other types of healthcare providers, such as imaging centers, surgery centers and some specialty clinics. While the providers of outpatient services are broader than just hospitals, the competitive conditions for outpatient services are reasonably similar given the limited number of other providers of outpatient services within the Wabash Valley Community.[148] Therefore, the Department finds that "outpatient services" constitute a relevant product market.

Finally, it should be noted that there are certain product markets in which the Applicants do not compete. For example, Regional Hospital offers in-patient behavioral health services, but Union Hospital offers behavioral health services only in its emergency room and on a consult-basis. Similarly, Union offers a broad range of primary care services through Union Physicians and offers convenient/urgent care services.[149]

Geographic Market in which the Applicants Compete

Generally, consumers prefer to obtain healthcare services close to home.[150] As a result, competition for primary and secondary care services between hospitals tends to be localized, which limits the ability of insurers to create competition between hospitals by replacing local hospitals with more distant hospitals.[151] When determining a geographic market for general acute care services, the question is what hospitals are effective substitutes for the Applicants.[152]

Determining the geographic market is necessarily a fact-intensive exercise.[153] Patient origin information can provide insights into the geographic area from which the Applicants draw their patients; however, reliance solely on patient origin data may result in an overbroad geographic market because it does not mean that a hospital located outside of the area is sufficiently substitutable to prevent the Applicants from raising their prices.[154] Instead, the

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[145] *F.T.C. v. OSF Healthcare System*, 852 F. Supp. 2d 1069, 1076 (N.D. Ill. 2012).
[146] *ProMedica Health Sys., Inc.*, 749 F.3d at 566.
[147] 2025 App. at 14-16.
[148] *See* fn. 112.
[149] 2025 App. at 14, 19.
[150] *Fed. Trade Comm'n v. Advocate. Health Care Network*, 841 F.3d 460, 464 (7th Cir. 2016); *Fed. Trade Comm'n v. Penn State Hershey Med. Ctr*., 838 F.3d 327, 341 (3d Cir. 2016).
[151] *Advocate Health Care Network. Health*, 841 F.3d at 475–76.
[152] *See F.T.C. v. Tenet Health Care Corp*., 186 F.3d 1045, 1052–53 (8th Cir. 1999) ("A properly defined geographic market includes potential suppliers who can readily offer consumers a suitable alternative to the defendant's services." "If patients use hospitals outside the service area, those hospitals can act as a check on the exercise of market power by the hospitals within the service area.").
[153] *See* FTC First Application Comment at 24.
[154] *Penn State Hershey Med. Ctr*., 838 F.3d at 340 (3d Cir. 2016).

question is the likely response of insurers to price increases imposed by Union after consummation of the Proposed Merger.[155]

The "Hypothetical Monopolist Test" is a method used to define relevant antitrust markets. "The generally accepted definition of a 'relevant antitrust market' is a set of substitute products over which a hypothetical monopolist could exercise market power by negotiating a small but significant non-transitory increase in price."[156] Having established that general acute care services and outpatient services are relevant product markets, in establishing the relevant market, the question is over what area could a hypothetical monopolist (e.g., Union after consummation of the Proposed Merger) impose small but significant non-transitory increase in price (a "SSNIP"). The antitrust agencies often use a SSNIP of five percent.[157]

Diversion ratios are one starting point of the Hypothetical Monopolist Test. This analysis calculates the effect of removing one hospital from an insurer's network and determining the hospitals to which the first hospital's patients would divert. The percentage of the first hospital's patients that would divert to a second hospital is the "diversion ratio." A high diversion ratio between two hospitals indicates that the hospitals are closer competitors and closer substitutes for insurers.[158] Calculation of diversion ratios can incorporate multiple factors, including geographic location, healthcare services required by patients and other patient characteristics. By including all Indiana hospitals in the analysis, it incorporates patients' preferences for nearby hospitals but does not require definition of a specific geographic market.

In addition to considering primary service areas and diversion ratios, qualitative information can provide additional evidence concerning the relevant market. This information includes the Applicant's ordinary course business documents, public comments received by the Department and payors' views and reactions to the Proposed Merger.[159]

As part of the Application, the Department requested information concerning the Applicants' 80% Primary Service Areas[160] for inpatient (as a proxy for general acute care services) and outpatient services. Identifying patient origin was a useful screen that did not require the Applicants to engage in extensive data analysis. The 80% Primary Service Areas were the beginning of the Department's analysis.

The Department also reviewed the Applicants' ordinary course of business documents and information, along with public comments received by the Department. The FTC also calculated the Applicant's 75% Primary Service Area for general acute care services, which included an estimate of the Applicant's market share in Illinois. The FTC and Department also estimated

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[155] *See* FTC First Application Comment, fn. 68.
[156] FTC First Application Comment at 24.
[157] Merger Guidelines at § 4.3.B.
[158] Merger Guidelines at § 4.2.B. *See* FTC First Application Comment at 20-21.
[159] Merger Guidelines at § 4.1.
[160] The "80% Primary Service Area" is the smallest set of ZIP Codes from which the Applicants obtain eighty percent of their discharges.

diversion ratios using different methodologies and the Applicants provided their analysis of the 80% Primary Service Area. Each of these analyses is considered below.

Relevant Markets Based on 80% Primary Service Area

Based on Indiana Hospital Association data, the Applicants' combined 80% Primary Service Area is comprised of the following ZIP Codes: [redacted].[161] Because the Indiana Hospital Association data and the Department's do not include Illinois hospitals, no Illinois ZIP Codes were included in the Applicant's 80% Primary Service Area. As discussed below, the FTC incorporated Illinois discharge data in its analysis.[162]

Using the Department's data, the Department calculated the Applicants' market shares within their combined 80% Primary Service Area with respect to inpatient discharges for all payors (commercial payors, Medicare, Medicaid and self-pay patients) and separately for commercial payors:

Table 8: 80% Primary Service Area Inpatient Market Shares (Based on Discharges)

	All Payors			Commercial Payors		
Year	Regional Hospital	Union Hospital	Combined	Regional Hospital	Union Hospital	Combined
2018	[redacted]		75.79%	[redacted]		67.31%
2019			78.19%			70.63%
2020			79.39%			69.07%
2021			78.03%			76.84%
2022			79.45%			
2023			79.27%			
Total			**78.24%**	[redacted]		**71.57%**

From 2018 to 2021, Regional Hospital's share of all payor discharges decreased approximately [redacted], while Union Hospital's share has increased approximately [redacted] and for commercial payors, the changes during the same period are more marked – [redacted] decrease for Regional Hospital and [redacted] increase for Union Hospital. During the same period, however, the Applicants' combined market share in the 80% Primary Service Area increased. In addition, while more than eighteen other hospitals provided services to patients located in the 80% Primary

[161] 2025 App. at 17. For this analysis, the combined 80% Primary Service Area is the combination of the Applicants' 80% Primary Service Areas. It should be noted that Regional Hospital's 80% Primary Service Area is entirely contained within Union Hospital's 80% Primary Service Area. In addition, the market shares in Tables 8 through 12 do not include Union Hospital Clinton's market share and as such, Union Hospital's market share is understated.

[162] However, inclusion of Illinois discharges likely does not significantly affect the Department's analysis because in 2019, Illinois discharges were approximately 2.08% of Union Hospital's and Regional Hospital's combined discharges. FTC First Application Comment at 19.

Service Area, none of the other hospitals, including the hospitals located in the Wabash Valley Community, exceeded 2.7% of the discharges within the 80% Primary Service Area.[163]

The Department's data for 2022 and 2023 does not distinguish between commercial and non-commercial payors; therefore, the Applicants' commercial market shares for those two years could not be determined.[164] Discussions between the Applicants may have started prior to the General Assembly's passage of the COPA Statute in 2021 and certainly moved forward in earnest in 2023. In addition, the COVID-19 pandemic impacted discharges in 2020 and 2021. Therefore, it could be argued that 2019 discharges data are the data most reflective of the ordinary course of business.[165] However, the Department recognizes that while six-year-old data alone may no longer be reflective of the current state of competition, more recent data may reflect changes in the Applicants' competitive behaviors in anticipation of the Proposed Merger.[166] After balancing these considerations, the Department's analysis used 2018 through 2021 discharge data because this information would largely be unimpacted by the anticipatory effects of the Proposed Merger.

The Applicants suggested that the Department should consider 2023 data in light of Regional Hospital's "significant decline" in commercial market share.[167] However, the Applicants did not raise these arguments until significantly late in the Department's review if the Application. The Applicants raised similar arguments during the First Application but failed to account for differences in the Applicants' categorization of Medicare Advantage plan discharges reported to the Indiana Hospital Association as commercial or non-commercial payors, which understated Regional Hospital's market share. While the data discrepancies effect data prior to 2023, the effect is less significant in 2021 and earlier years because Medicare Advantage plans were less common and the Applicants' respective Medicare Advantage plan discharges were relatively stable. The Applicants' economist, Dr. Pflum, submitted an analysis of the Applicants' market share in their

[163] None of the other hospitals located in the Wabash Valley Community provide the same breadth of services as the Applicants. *See* Blue & Company, *Blue and Company Financial Projections for HUD,* [redacted] (submitted as Attachment III.a.1.3 to 2025 App.) (withheld from public disclosure).

[164] While the Applicants provided the Department with data for 2022 and 2023 that distinguished between commercial and non-commercial payors, the Applicants aggregated (or "binned") procedures at a higher level than the Department. The Applicants higher level of aggregation may overstate the diversion of patients to hospitals other than the Applicants, thereby enlarging the set of hospitals that are the Applicants' competitors and reducing the Applicants' market share.

[165] *See* FTC First Application Comments at 19.

[166] For example, as late as 2023 and 2024, THRH had strategic plans for improving its financial condition and expanding services. *See* Terre Haute Regional Hospital, *Indiana Market 2023-2025 Strategic Plan* 5 (Oct. 4, 2022) (submitted as Attachment P to Request for Information 1 submitted in connection with the 2023 App. (withheld from public release) and Terre Haute Regional Hospital, *Terre Haute Regional Hospital 2024 Strategic Plan* 4 (Nov. 6, 2023) (submitted as Attachment Q to Request for Information 1 submitted in connection with the 2023 App.) (withheld from public release). It appears that these plans have been abandoned in light of recent public comments made by THRH.

[167] Pflum, Kevin, *Analysis of the potential competitive impact of the proposed merger between Union Hospital, Inc. and Terre Haute Regional Hospital under Indiana's certificate of public advantage* (May 9, 2025) (hereinafter "*Pflum 2025 Analysis*").

80% Primary Service Area that attempted to account for the data discrepancy at Union but used a broader binning methodology that increased the apparent number of competing hospitals.[168]

Table 9: Dr. Pflum 80% Primary Service Area Inpatient Market Shares (Based on Discharges)[169]

	All Payors			Commercial Payors		
Year	Regional Hospital	Union Hospital	Combined	Regional Hospital	Union Hospital	Combined
2019	[redacted]	[redacted]	75.5%	[redacted]	[redacted]	68.6%
2020	[redacted]	[redacted]	75.6	[redacted]	[redacted]	66.2%
2021	[redacted]	[redacted]	73.4%	[redacted]	[redacted]	61.5%
2022	[redacted]	[redacted]	74.5%	[redacted]	[redacted]	63.1%
2023	[redacted]	[redacted]	75.4%	[redacted]	[redacted]	65.5%

From 2019 to 2023, Regional Hospital's share of all payor discharges decreased approximately [redacted], while Union Hospital's share has increased approximately [redacted] and for commercial payors, the decrease for Regional Hospital is more marked the same period – a [redacted] decrease for Regional Hospital – while Union Hospital's share increased [redacted]. During this time period, however, the Applicants' combined market share stated relatively flat, which suggests that at least some of Regional Hospital's patients were shifting to Union Hospital.

Separately, the FTC calculated the Applicants' combined 75% Primary Service Area for inpatient discharges. In its calculations, the FTC used 2019 discharge data "to avoid aberrations in the normal course of hospital operations caused by the COVID-19 pandemic and to precede the initial merger discussions that occurred in the 2020-2021 timeframe"[170] and incorporated Illinois discharge data that was not available to the Department or considered by the Applicants. While the ZIP codes included within the FTC's 75% Primary Service Area and the 80% Primary Service Area calculated by the Department are different, the Applicants' combined market share of 77.5%[171] is substantially the same.

The Department also calculated the Applicants' market shares within their combined 80% Primary Service Area with respect to outpatient encounters at hospital facilities:

[168] It is not known whether the data discrepancy effected the data of non-Applicant hospitals within the Indiana Hospital Association data set.
[169] Pflum 2025 Analysis at 4.
[170] FTC First Application Comment at 19.
[171] FTC First Application Comment at 19.

Table 10: 80% Primary Service Area Outpatient Market Shares (Based on Discharges)

	All Payors			Commercial Payors		
Year	Regional Hospital	Union Hospital	Combined	Regional Hospital	Union Hospital	Combined
2018			58.42%			51.98%
2019			58.77%			50.38%
2020			57.68%			47.92%
2021			54.65%			57.73%
2022			61.06%			
2023			62.76%			
Total			58.80%			52.56%

Like the inpatient data, the Department's data did not distinguish between commercial and non-commercial payors in 2022 and 2023. While the Applicants' outpatient market shares services are less than their inpatient market shares, they show a similar pattern with Regional Hospital's market share decreasing, Union Hospital's market share increasing and their combined market share increasing.

While more than twenty-three other hospitals provided outpatient services to patients located in the 80% Primary Service Area, no hospital located outside of the 80% Primary Service Area had a market share greater than 1.8%. The Applicants' lower outpatient market share is likely accounted for by the three other hospitals located in the Wabash Valley Community providing a higher proportion of outpatient encounters.

Relevant Market Based on Vigo County Residents

The Department also calculated the Applicant's market shares for discharges from 2018 to 2023 of patients located in Vigo County.[172]

Table 11: Vigo County Inpatient Market Shares (Based on Discharges)

	All Payors			Commercial Payors		
Year	Regional Hospital	Union Hospital	Combined	Regional Hospital	Union Hospital	Combined
2018			90.50%			83.67%
2019			91.34%			87.01%
2020			91.18%			84.45%
2021			91.59%			88.70%
2022			91.83%			
2023			90.94%			
Total			91.25%			86.30%

[172] Vigo County was defined as being comprised of the following ZIP Codes: 47801-47809, 47851, 47858, 47863, 47866, 47869, 47870, 47871, 47876, 47878, 47880 and 47885.

Within Vigo County, the Applicants' market share of all discharges is above 90%, and for commercial payors, it is well above 80%. Similar to the relative market shares within the 80% Primary Service Area, Regional Hospital's share decreased, but Union Hospital's share increased by more than the decrease, particularly for commercial payors. While at least thirteen other hospitals treated patients residing in Vigo County, none of these other hospitals treated more than 1.6% of such patients. In the aggregate, the other three hospitals located in the Wabash Valley Community treated less than 0.4% of Vigo County patients.

For outpatient encounters with Vigo County residents, the results were similar:

Table 12: Vigo County Outpatient Market Shares (Based on Discharges)

	All Payors			Commercial Payors		
Year	Regional Hospital	Union Hospital	Combined	Regional Hospital	Union Hospital	Combined
2018	[redacted]		91.30%	[redacted]		87.59%
2019			91.06%			86.55%
2020			90.62%			85.37%
2021			87.31%			85.79%
2022			89.86%			
2023			90.25%			
Total			89.97%			86.26%

Notably, none of the other hospitals treated more than 1.7% of outpatients residing in Vigo County and the three other hospitals located in the Wabash Valley Community treated less than 2.5% of outpatients residing in Vigo County.

Qualitative Information Corroborates that the Applicants are Each Other's Closest Competitors

While analyses of a primary service area do not necessarily reflect a relevant antitrust market, the foregoing analyses are consistent with an initial conclusion that the Applicants are not only close competitors but are also each other's closest competitors. They are located near each other and offer many overlapping services.[173] This initial conclusion is corroborated by the Applicants' ordinary course of business documents and the other analyses discussed below.

[redacted]

[173] *See* Table 3. *See also* Blue & Company, B*lue and Company Financial Projections for HUD,* [redacted] (submitted as Attachment III.a.1.3 to 2025 App.) (withheld from public disclosure); FTC First Application Comment at 30.

[redacted]

Other information submitted by the Applicants reflect similar market shares.[178] Numerous public comments received by the Department also reflect that residents of the Wabash Valley Community considered the Applicants to be close competitors:[179]

- On the COPA document, Union lists all of the other care facilities that are nearby that patients have access to but in reality, none of those other facilities have the capability to deal with the level of patients that Union [Hospital] and Regional [Hospital] do or they are simply too far away for a large part of the population. This will plain and simply be a monopoly of care. Period. Taking away access to choice is the very definition of a monopoly. You are giving patients no choice but to travel elsewhere or choose a lower level of care if they don't want to come to Union. We can do better for our community but this isn't it.

- [As a resident], I firmly believe it is creating a monopoly in the community and people will have no choice. Alternative care is 60 miles away…. We need competition to keep both hospitals on their toes.

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[174] Terre Haute Regional Hospital, *Terre Haute Regional Hospital 3-Year Strategic Plan* 4 (Oct. 23, 2019) (submitted as Attachment III.i.3 to 2025 App.) (withheld from public release).

[175] Terre Haute Regional Hospital, *Indiana Market 2023-2025 Strategic Plan* 5 (Oct. 4, 2022) (submitted as Attachment P to Request for Information 1 submitted in connection with the 2023 App.) (withheld from public release).

[176] Terre Haute Regional Hospital, *Terre Haute Regional Hospital 2024 Strategic Plan* 4 (Nov. 6, 2023) (submitted as Attachment Q to Request for Information 1 submitted in connection with the 2023 App.) (withheld from public release).

[177] Dunne Consulting Group, *Strategic Market and Clinical Services Growth Projections* at 6 (Oct. 25, 2024) (submitted as Attachment M to Request for Information 1 submitted in connection with the 2023 App.) (withheld from public release).

[178] *See* Union Hospital, Inc., *2020-2022 Combined Volume* (analyzing market shares) (submitted as Attachment R to Request for Information 1 submitted in connection with the 2023 App. (withheld from public release); Terre Haute Regional Hospital, *Competitor Analysis* (analyzing Q3 2020 – Q2 2022 discharges by service line) (submitted as Attachment S to Request for Information 1 submitted in connection with the 2023 App.) (withheld from public release).

[179] *See also* FTC First Application Comment at 20 ("During the FTC investigation, we learned that patients are less likely to travel to Indianapolis for services they can receive locally in Terre Haute and are more willing to travel to Indianapolis for high acuity services, including some that may not be offered by Union [] or THRH.").

- The community wants a choice without having to travel an hour or more away.

Relevant Market Based on Diversion Ratios (Hospitals Located in Vigo County)

The preceding analyses focused on patient origin – the hospitals where patients located in a particular geographic are actually treated. However, they do not address the question of the hospitals would patients go to if their preferred hospital was not available (e.g., if it was no longer in-network). Diversion ratios can be used to address this question. A high diversion ratio between two hospitals indicates they are closer competitors and closer substitutes for insurers.

Today THRH and Union negotiate separately with commercial payors. As such, commercial payors can leverage one hospital against the other. For example, if THRH demands higher reimbursements or other improved contract terms, the payor can threaten to contract exclusively with Union. The opposite is also true – if Union demands higher reimbursements or other improved contract terms, the payor can threaten to contract exclusively with THRH. Consummation of the Proposed Merger eliminates this competitive constraint and prices may rise (or quality decrease) as a result. The higher the diversion ratio, the higher the presumed price increase and the greater the presumed harm.

Using 2018-2021 Indiana Hospital Association discharge data, the Department calculated the commercial inpatient and outpatient diversion ratios for Regional Hospital and Union Hospital taking into account the patient's location, demographics and admission type/services. The discharge data contained data for all hospitals located in Indiana and as discussed above, the 2018-2021 time period was selected because it predates most discussions between the Applicants concerning the Proposed Merger and the Department's 2022 and 2023 data does not distinguish between commercial and non-commercial payor. The diversion ratios are presented in the tables below.

The first column of the following tables identifies the hospitals to which patients seeking inpatient care would be diverted, and the second column identifies the predicted percentage of Union Hospital's patients diverted to each such hospital if a payor removed Union from its network.

Table 13 summarizes the diversion ratio from Union Hospital to other hospitals for inpatient services.

Table 13: Inpatient Diversion Ratios from Union Hospital to Other Hospitals (All Commercial Discharges 2018-2021)

Hospital	Diversion
TERRE HAUTE REGIONAL HOSPITAL	41.44%
INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL	8.28%
ST. VINCENT INDIANAPOLIS	7.51%
UNION HOSPITAL CLINTON	5.85%
INDIANA UNIVERSITY HEALTH UNIVERSITY HOSPITAL	5.17%
HENDRICKS REGIONAL HEALTH	4.96%
SULLIVAN COUNTY COMMUNITY HOSPITAL	3.63%
ST. VINCENT CARMEL	1.91%
INDIANA UNIVERSITY HEALTH BLOOMINGTON	1.84%
ST. VINCENT CLAY	1.70%
ORTHOINDY HOSPITAL	1.65%
FRANCISCAN HEALTH INDIANAPOLIS	1.53%
INDIANA UNIVERSITY HEALTH WEST HOSPITAL	1.44%
INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	1.32%
ST. VINCENT HEART CENTER	1.25%
GREENE COUNTY GENERAL HOSPITAL	1.25%
FRANCISCAN HEALTH MOORESVILLE	1.21%
SIDNEY & LOIS ESKENAZI HOSPITAL	0.95%
COMMUNITY HOSPITAL NORTH	0.74%
PUTNAM COUNTY HOSPITAL	0.74%
INDIANA UNIVERSITY HEALTH ARNETT HOSPITAL	0.64%
FRANCISCAN HEALTH LAFAYETTE EAST	0.51%
Other	4.47%

The above calculation indicates that if Union Hospital was no longer available to patients seeking inpatient care, 41.44% of its current patients would seek inpatient care from Regional Hospital. Only 6.85% of Union Hospital's patients would seek inpatient care from the other hospitals located in the Wabash Valley Community, with the remaining patients seeking inpatient care from more distant hospitals located in or closer to the Indianapolis metropolitan area.

Table 14 summarizes the diversion ratio from Regional Hospital to other hospitals for inpatient services.

Table 14: Inpatient Diversion Ratios from Regional Hospital to Other Hospitals (All Commercial Discharges 2018-2021)

Hospital	Diversion
UNION HOSPITAL	64.31%
SULLIVAN COUNTY COMMUNITY HOSPITAL	5.48%
ST. VINCENT INDIANAPOLIS	4.12%
INDIANA UNIVERSITY HEALTH METHODIST	3.54%
INDIANA UNIVERSITY HEALTH UNIVERSITY	3.06%
INDIANA UNIVERSITY HEALTH BLOOMINGTON	2.43%
GREENE COUNTY GENERAL HOSPITAL	2.12%
HENDRICKS REGIONAL HEALTH	1.96%
ORTHOINDY HOSPITAL	1.12%
ST. VINCENT CARMEL	1.04%
UNION HOSPITAL CLINTON	0.98%
FRANCISCAN HEALTH INDIANAPOLIS	0.92%
GOOD SAMARITAN	0.89%
ST. VINCENT HEART CENTER	0.86%
FRANCISCAN HEALTH MOORESVILLE	0.72%
PUTNAM COUNTY HOSPITAL	0.70%
ST. VINCENT CLAY	0.66%
INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	0.61%
INDIANA UNIVERSITY HEALTH WEST HOSPITAL	0.54%
Other	3.94%

The above calculation indicates that if Regional Hospital was no longer available to patients seeking inpatient care, 64.31% of its current patients would seek inpatient care from Union Hospital. Only 8.26% of Regional Hospital's patients would seek inpatient care from the other hospitals located in the Wabash Valley Community, with the remaining patients seeking inpatient care from more distant hospitals located in or closer to the Indianapolis metropolitan area.

These high diversion ratios between Regional Hospital and Union Hospital further confirm that they are close competitors for inpatients.

Table 15 summarizes the diversion ratio from Union Hospital to other hospitals for outpatient services.

Table 15: Outpatient Diversion Ratios from Union Hospital to Other Hospitals (All Commercial Discharges 2018-2021)

Hospital	Diversion
TERRE HAUTE REGIONAL HOSPITAL	33.14%
UNION HOSPITAL CLINTON	11.39%
SULLIVAN COUNTY COMMUNITY HOSPITAL	9.96%
ST. VINCENT CLAY	8.56%
ST. VINCENT INDIANAPOLIS	5.54%
HENDRICKS REGIONAL HEALTH	3.86%
INDIANA UNIVERSITY HEALTH UNIVERSITY HOSPITAL	3.33%
INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL	2.85%
GREENE COUNTY GENERAL HOSPITAL	2.13%
FRANCISCAN HEALTH MOORESVILLE	2.11%
PUTNAM COUNTY HOSPITAL	1.84%
ST. VINCENT CARMEL	1.38%
ORTHOINDY HOSPITAL	1.23%
FRANCISCAN HEALTH INDIANAPOLIS	1.21%
RILEY HOSPITAL FOR CHILDREN AT INDIANA	1.12%
SIDNEY & LOIS ESKENAZI HOSPITAL	1.08%
INDIANA UNIVERSITY HEALTH BLOOMINGTON	1.05%
INDIANA UNIVERSITY HEALTH WEST HOSPITAL	0.91%
GOOD SAMARITAN	0.78%
INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	0.69%
COMMUNITY HOSPITAL NORTH	0.68%
COMMUNITY HOSPITAL EAST	0.57%
Other	4.58%

The above calculation indicates that if Union Hospital was no longer available to patients seeking outpatient care, 33.14% of its current patients would seek outpatient care from Regional Hospital. 20.66% of Union Hospital's patients would seek outpatient care from the other hospitals located in the Wabash Valley Community, with the remaining patients seeking inpatient care from more distant hospitals located in or closer to the Indianapolis metropolitan area.

Table 16 summarizes the diversion ratio from Regional Hospital to other hospitals for outpatient services.

Table 16: Outpatient Diversion Ratios from Regional Hospital to Other Hospitals (All Commercial Discharges 2018-2021)

Hospital	Diversion
UNION HOSPITAL	43.46%
SULLIVAN COUNTY COMMUNITY HOSPITAL	15.42%
ST. VINCENT CLAY	8.64%
GREENE COUNTY GENERAL HOSPITAL	3.68%
ST. VINCENT INDIANAPOLIS	2.95%
HENDRICKS REGIONAL HEALTH	2.80%
UNION HOSPITAL CLINTON	2.48%
PUTNAM COUNTY HOSPITAL	2.46%
GOOD SAMARITAN	1.51%
INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL	1.34%
INDIANA UNIVERSITY HEALTH BLOOMINGTON	1.04%
INDIANA UNIVERSITY HEALTH UNIVERSITY HOSPITAL	0.97%
SIDNEY & LOIS ESKENAZI HOSPITAL	0.95%
FRANCISCAN HEALTH INDIANAPOLIS	0.88%
FRANCISCAN HEALTH MOORESVILLE	0.86%
ST. VINCENT CARMEL	0.60%
ST VINCENT NEIGHBORHOOD HOSPITALS	0.53%
COMMUNITY HOSPITAL NORTH	0.53%
Other	8.91%

The above calculation indicates that if Regional Hospital was no longer available to patients seeking outpatient care, 43.46% of its current patients would seek outpatient care from Union Hospital. 27.74% of Regional Hospital's patients would seek outpatient care from the other hospitals located in the Wabash Valley Community, with the remaining patients seeking inpatient care from more distant hospitals located in or closer to the Indianapolis metropolitan area.

That the diversion ratios for outpatient care between Regional Hospital and Union Hospital are lower than the inpatient care diversion ratios is not surprising. They are the only two hospitals in the Wabash Valley Community that are not critical access hospitals, but they and the critical access hospitals are able to provide a broad range of outpatient services. Nonetheless, the outpatient diversion ratios between the two hospitals are the highest and, in each case, almost three times the next closest diversion ratio. This indicates that Regional Hospital and Union Hospital are also each other's closest competitors for outpatient services.

During its investigation, the FTC estimated inpatient diversion ratios based on the Department's 2019 discharge data supplemented by Illinois discharge data, taking into account patients' geographic location, health condition and patient characteristics. The FTC estimated that

47.6% of Union Hospital's patients would seek care at Regional Hospital and 77.7% of Regional Hospital's patients would seek care at Union Hospital.[180] The FTC stated that:

> These high diversion ratios are unsurprising, given that Union Health and THRH serve patients from a similar geographic area with similar health conditions, and there are very few nearby third-party hospitals. These diversion ratios indicate that a merger between Union [] and THRH would eliminate direct head-to-head competition and likely lead to significant price increases, as well as reduced business incentives to maintain or improve quality. These diversion ratios far exceed many recent hospital merger cases where courts found the proposed mergers to be anticompetitive.[181]

Furthermore, the diversion ratios can be used to construct a hypothetical monopolist for purposes of the Hypothetical Monopolist Test. Using the Gross Upward Price Pressure Index/2 ("GUPPI/2") formula, the diversion ratio threshold for satisfying the SSNIP test can be determined. The GUPPI/2 formula is:

$$Price\ Increase = Diversion\ Ratio_{12}\ x\ Margin\ x\ \frac{Price_2}{Price_1}\ x\ Passthrough\ Rate$$

Rearranging the equation to solve for the diversion ratio results in the following:

$$Diversion\ Ratio_{12} = Price\ Increase \Big/ (Margin\ x\ \frac{Price_2}{Price_1}\ x\ Passthrough\ Rate)$$

The Department estimated the Applicants' commercial margins, relative prices and passthrough rates and determined that the Hypothetical Monopolist Test would be satisfied for inpatient services if diversion ratios exceeded 18.5% to 20% and for outpatient services if diversion ratios exceeded 16.8% to 20.5%. In each of the above Tables 13 through 16, the diversion ratios from Union Hospital to Regional Hospital and from Regional Hospital to Union Hospital exceed these thresholds. Therefore, for purposes of the Hypothetical Monopolist Test, this implies that a merger of Union Hospital and Regional Hospital would allow the combined enterprise to profitably impose a SSNIP and that a relevant market for inpatient services and outpatient services would be composed solely of Union Hospital and Regional Hospital.

The foregoing analyses considered a number of potential relevant markets, based on various service areas and estimates of diversion ratios. These analyses, including the Applicant's own analysis, confirm that Regional Hospital and Union Hospital compete within a relevant market for inpatient services (i.e., general acute care services) and outpatient services. The conclusion is robust because each analysis leads to the conclusion that Regional Hospital and Union Hospital are each other's closest competitors. This conclusion is also consistent with the

[180] FTC First Application Comment at 20-21.
[181] FTC First Application Comment at 21-22 (internal citations omitted).

hospitals being located 5.5 miles apart in the same city, offering similar services and being the only non-critical access hospitals in the Wabash Valley Community.

Anticompetitive Effects

Having established that Regional Hospital and Union Hospital are competitors within relevant antitrust markets for general acute care services and outpatient services, the Department must assess the anticompetitive effects arising from the Proposed Merger in order to balance them against the aggregate benefits arising from the Proposed Merger. High market concentration coupled with substantial increases in concentration often indicate a proposed merger may result in substantial anticompetitive harm. Reflecting this concern, the United States Supreme Court established a presumption when it held that "a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market[,] is so inherently likely to lessen competition substantially that it must be enjoined in the absence of [rebuttal] evidence."[182] The Merger Guidelines implement this presumption through the use of the Herfindahl-Hirschman Index ("HHI"),[183] which is the sum of the squares of each market participant's market share. For example, if there is one market participant with 100% market share, the HHI is 10,000, and if there are ten market participants each with a 10% market share, the HHI is 1,000. The increase from the pre-merger HHI to the post-merger HHI is a measure of the increase in concentration resulting from the merger. Under the Merger Guidelines, a market is considered highly concentrated if its post-merger HHI is greater than 1,800 and the increase in concentration resulting from the merger is greater than 100 points.[184]

80% Primary Services Area and Vigo County Resident Geographic Markets

The Department reviewed several potential measures of the increase in concentration, including increases in concentration for inpatient and outpatient services in the 80% Primary Service Areas and Vigo County, the FTC's concentration analyses within the 75% Primary Service Area and Vigo County and increases in concentration resulting from a market constructed using the Hypothetical Market Test. Each of these analyses are presented below.

[182] *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 363 (1963).
[183] Merger Guidelines at § 2.1.
[184] Merger Guidelines at § 2.1. Under the prior Merger Guidelines (adopted in 2010), a market was highly concentrated if the post-merger HHI was greater than 2,500 and the presumption arose if the increase was greater than 200 points. Even under the prior Merger Guidelines, the Proposed Merger would be presumptively anticompetitive.

Table 17: 80% Primary Service Area Concentration Analysis for General Acute Care Services (Based on Department Data)[185]

Hospital	Share of all Discharges	Share of Commercially Insured Discharges
UNION HOSPITAL	61.0%	60.4%
TERRE HAUTE REGIONAL HOSPITAL	17.2%	11.2%
UNION HOSPITAL CLINTON	2.6%	1.7%
INDIANA UNIVERSITY HEALTH BLOOMINGTON HOSPITAL	2.6%	3.5%
GREENE COUNTY GENERAL HOSPITAL	2.6%	2.7%
SULLIVAN COUNTY COMMUNITY HOSPITAL	2.1%	2.7%
ST. VINCENT INDIANAPOLIS	1.9%	2.8%
INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL	1.8%	2.7%
INDIANA UNIVERSITY HEALTH UNIVERSITY HOSPITAL	1.5%	2.4%
HENDRICKS REGIONAL HEALTH	0.8%	1.5%
ST. VINCENT HEART CENTER	0.6%	0.7%
ST. VINCENT CLAY	0.6%	0.6%
FRANCISCAN HEALTH MOORESVILLE	0.5%	0.7%
ST. VINCENT CARMEL	0.5%	<0.1%
FRANCISCAN HEALTH INDIANAPOLIS	0.4%	0.6%
ORTHOINDY HOSPITAL	0.4%	<0.1%
MONROE HOSPITAL	0.4%	0.3%
INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	0.3%	0.5%
GOOD SAMARITAN	0.2%	0.3%
INDIANA UNIVERSITY HEALTH WEST HOSPITAL	0.2%	0.4%
SIDNEY & LOIS ESKENAZI HOSPITAL	0.2%	0.2%
COMMUNITY HOSPITAL NORTH	0.2%	0.2%
COMMUNITY HOSPITAL SOUTH	0.1%	0.1%
PUTNAM COUNTY HOSPITAL	0.1%	0.1%
RILEY HOSPITAL FOR CHILDREN AT INDIANA UNIVER	0.1%	0.1%
INDIANA UNIVERSITY HEALTH SAXONY HOSPITAL	<0.1%	0.2%
DAVIESS COMMUNITY HOSPITAL	<0.1%	0.1%
All Others (< 0.1% Share)	0.9%	0.9%
Combined Union-THRH (including Union Hospital Clinton)	80.9%	73.3%
Pre-Merger HHI	4,382	4,042

[185] The concentration analysis for all discharges uses discharge data from 2018 through 2023. The concentration analysis for commercial patients uses discharge data from 2018 through 2021. For purposes of calculating the HHI, Union Hospital and Union Hospital Clinton have been treated as a single entity.

Post-Merger HHI	6,573	5,430
Change in HHI	2,191	1,388

Table 18: 80% Primary Service Area Concentration Analysis for Outpatient Services (Based on Department Data)[186]

Hospital	Share of all Discharges	Share of Commercially Insured Discharges
UNION HOSPITAL	47.6%	42.6%
TERRE HAUTE REGIONAL HOSPITAL	11.2%	10.0%
SULLIVAN COUNTY COMMUNITY HOSPITAL	10.6%	13.2%
GREENE COUNTY GENERAL HOSPITAL	10.2%	10.8%
ST. VINCENT CLAY	5.7%	6.8%
UNION HOSPITAL CLINTON	4.1%	3.8%
INDIANA UNIVERSITY HEALTH BLOOMINGTON HOSPITAL	1.7%	1.6%
HENDRICKS REGIONAL HEALTH	1.3%	1.8%
ST. VINCENT INDIANAPOLIS	0.9%	1.3%
INDIANA UNIVERSITY HEALTH UNIVERSITY HOSPITAL	0.8%	0.7%
RILEY HOSPITAL FOR CHILDREN AT INDIANA UNIVERSITY	0.7%	1.0%
INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL	0.6%	0.6%
GOOD SAMARITAN	0.5%	0.6%
PUTNAM COUNTY HOSPITAL	0.5%	0.8%
FRANCISCAN HEALTH MOORESVILLE	0.4%	0.5%
MONROE HOSPITAL	0.4%	0.4%
FRANCISCAN HEALTH INDIANAPOLIS	0.3%	0.3%
SIDNEY & LOIS ESKENAZI HOSPITAL	0.3%	0.3%
INDIANA UNIVERSITY HEALTH WEST HOSPITAL	0.2%	0.2%
ORTHOINDY HOSPITAL	0.2%	0.3%
ST. VINCENT CARMEL	0.1%	0.3%
INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	0.1%	0.2%
DAVIESS COMMUNITY HOSPITAL	0.1%	0.2%
COMMUNITY HOSPITAL EAST	0.1%	0.1%
FRANCISCAN HEALTH CRAWFORDSVILLE	0.1%	<0.1%
DEACONESS MIDTOWN HOSPITAL	0.1%	0.2%
INDIANA UNIVERSITY HEALTH BEDFORD HOSPITAL	0.1%	<0.1%
COMMUNITY HOSPITAL NORTH	<0.1%	0.1%
ST. VINCENT HEART CENTER	<0.1%	0.1%

[186] The concentration analysis for all discharges uses discharge data from 2018 through 2023. The concentration analysis for commercial patients uses discharge data from 2018 through 2021. For purposes of calculating the HHI, Union Hospital and Union Hospital Clinton have been treated as a single entity.

All Others (< 0.1% Share)	0.9%	1.1%
Combined Union-THRH (including Union Hospital Clinton)	63.0%	56.4%
Pre-Merger HHI	3,061	2,605
Post-Merger HHI	4,219	3,531
Change in HHI	1,158	925

Table 19: Vigo County Concentration Analysis for General Acute Care Services (Based on Department Data)[187]

Hospital	Share of all Discharges	Share of Commercially Insured Discharges
UNION HOSPITAL	71.8%	74.0%
TERRE HAUTE REGIONAL HOSPITAL	19.4%	12.4%
ST. VINCENT INDIANAPOLIS	1.6%	2.3%
INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL	1.6%	2.4%
INDIANA UNIVERSITY HEALTH UNIVERSITY HOSPITAL	1.4%	2.2%
ST. VINCENT CARMEL	0.5%	1.0%
ST. VINCENT HEART CENTER	0.4%	0.55
FRANCISCAN HEALTH MOORESVILLE	0.4%	0.7%
FRANCISCAN HEALTH INDIANAPOLIS	0.4%	0.5%
UNION HOSPITAL CLINTON	0.3%	0.3%
ORTHOINDY HOSPITAL	0.3%	0.8%
INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	0.2%	0.5%
SULLIVAN COUNTY COMMUNITY HOSPITAL	0.2%	0.3%
SIDNEY & LOIS ESKENAZI HOSPITAL	0.2%	0.2%
COMMUNITY HOSPITAL NORTH	0.1%	0.2%
HENDRICKS REGIONAL HEALTH	0.1%	0.3%
INDIANA UNIVERSITY HEALTH WEST HOSPITAL	0.1%	0.3%
INDIANA UNIVERSITY HEALTH SAXONY HOSPITAL	<0.1%	0.2%
COMMUNITY HOSPITAL SOUTH	<0.1%	0.1%
All Others (< 0.1% Share)	0.9%	0.8%
Combined Union-THRH (including Union Hospital Clinton)	91.6%	86.6%

[187] The concentration analysis for all discharges uses discharge data from 2018 through 2023. The concentration analysis for commercial patients uses discharge data from 2018 through 2021. For purposes of calculating the HHI, Union Hospital and Union Hospital Clinton have been treated as a single entity.

Pre-Merger HHI	5,596	5,687
Post-Merger HHI	6.695	7,518
Change in HHI	1,400	1,840

Table 20: Vigo County Concentration Analysis for Outpatient Services (Based on Department Data)[188]

Hospital	Share of all Discharges	Share of Commercially Insured Discharges
UNION HOSPITAL	73.1%	70.5%
TERRE HAUTE REGIONAL HOSPITAL	16.9%	15.8%
SULLIVAN COUNTY COMMUNITY HOSPITAL	1.7%	2.1%
ST. VINCENT INDIANAPOLIS	1.0%	1.7%
INDIANA UNIVERSITY HEALTH UNIVERSITY HOSPITAL	0.9%	0.9%
UNION HOSPITAL CLINTON	0.9%	1.25
RILEY HOSPITAL FOR CHILDREN AT INDIANA UNIVERSITY	0.8%	1.3%
INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL	0.6%	0.8%
ST. VINCENT CLAY	0.6%	0.8%
HENDRICKS REGIONAL HEALTH	0.4%	0.6%
FRANCISCAN HEALTH MOORESVILLE	0.4%	0.6%
SIDNEY & LOIS ESKENAZI HOSPITAL	0.3%	0.3%
FRANCISCAN HEALTH INDIANAPOLIS	0.3%	0.3%
ST. VINCENT CARMEL	0.2%	0.4%
PUTNAM COUNTY HOSPITAL	0.2%	0.3%
ORTHOINDY HOSPITAL	0.2%	0.3%
GREENE COUNTY GENERAL HOSPITAL	0.2%	0.2%
INDIANA UNIVERSITY HEALTH WEST HOSPITAL	0.1%	0.2%
INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	0.1%	0.2%
INDIANA UNIVERSITY HEALTH BLOOMINGTON HOSPITAL	0.1%	0.2%
COMMUNITY HOSPITAL EAST	0.1%	0.2%
COMMUNITY HOSPITAL NORTH	0.1%	0.2%
GOOD SAMARITAN	0.1%	0.1%
All Others (< 0.1% Share)	0.7%	1.0%
Combined Union-THRH (including Union Hospital Clinton)	90.9%	87.5%

[188] The concentration analysis for all discharges uses discharge data from 2018 through 2023. The concentration analysis for commercial patients uses discharge data from 2018 through 2021. For purposes of calculating the HHI, Union Hospital and Union Hospital Clinton have been treated as a single entity.

Pre-Merger HHI	5,766	5,407
Post-Merger HHI	8,266	7,670
Change in HHI	2,500	2,263

For each of the above-described geographic areas, the pre-merger HHI is significantly greater than 1,800 and the change in HHI is significantly greater than 100. Thus, for each geographic area, the market for general acute care services and outpatient services is highly concentrated and the increase in HHI is well above the threshold for establishing that the Proposed Merger is presumptively anticompetitive.

Applicant's 80% Primary Service Area Analysis

In Dr. Plfum's report, the Applicants did not provide sufficient information to calculate the HHI for the Applicant's proposed 80% Primary Service Area for inpatient services; however, considering Union Hospital's and Regional Hospital's 2023 market shares alone, the pre-Proposed Merger HHI would be 3,482 and the increase in the HHI as a result of the Proposed Merger would be 692. The Applicants' proposed 80% Primary Service Area is highly concentrated and the increase in the HHI is well above the threshold for establishing that the Proposed Merger is presumptively anticompetitive.

FTC's Vigo County Resident Analysis and 75% Primary Service Area

The FTC considered the market concentration for general acute care services for residents residing in Vigo County and for its 75% Primary Service Area, which incorporated Illinois discharges.

Table 21: FTC Table 6: Shares and Concentration Analysis
Hospitals Serving Patients Residing Located in Vigo County
(Based on 2019 IN Discharge Data and Adjusted to Reflect Illinois Hospitals)[189]

Hospital	Share of All Discharges	Share of Commercially Insured GAC Discharges
Union Hospital	**55.9**	**58.9**
Union Hospital Clinton	**0.1**	**
Terre Haute Regional Hospital	**23.6**	**14.6**
Indiana University Health Methodist Hospital	2.4	2.9
St. Vincent Indianapolis	1.7	3.4
Indiana University Health University Hospital	1.9	2.8
Riley Hospital for Children at Indiana University Health	1.2	1.9
St. Vincent Carmel		1.1
OrthoIndy Hospital		1.1
All Others, including IL Hospitals (<1.0% of Discharges)	13.2	13.3
Combined Union Health-THRH	**79.6**	**73.5**
Pre-merger HHI	3,757	3,833
Post-merger HHI	6,398	5,558
Change in HHI	2,640	1,724

[189] FTC First Application Comment at 27.

Table 22: FTC Table 7: Shares and Concentration Analysis
Hospitals Serving Patients Residing Located in Vigo County
(Based on 2019 IN Discharge Data and Adjusted to Reflect Illinois Hospitals)[190]

Hospital / System	Share of All Discharges	Share of All GAC Discharges
Union Hospital	**53.8**	**57.2**
Union Hospital Clinton	**2.4**	**2.5**
Terre Haute Regional Hospital	**16.1**	**14.2**
Indiana University Health Methodist Hospital	2.9	3.1
St. Vincent Indianapolis	2.3	2.5
Indiana University Health University Hospital	1.7	1.8
Bloomington Meadows Hospital	1.7	
Riley Hospital for Children at Indiana University Health	1.5	1.6
Sullivan Community Hospital	1.1	1.5
Green County General Hospital	7.9	1.2
All Others, including IL Hospitals (<1.0% of Discharges)	15.1	14.4
Combined Union Health-THRH	**72.2**	**73.9**
Pre-merger HHI	3,507	3,863
Post-merger HHI	5,312	5,558
Change in HHI	1,805	1,694

For both geographic areas, the market for general acute care services was highly concentrated and the increase in HHI significantly exceeded the threshold for establishing that the Proposed Merger is presumptively anticompetitive. The FTC further noted that the Primary Service Areas may be broader than a properly defined geographic market; any such overbreadth only overstates the competitive significance of the other hospitals.

Hospitals Located in Vigo County

As discussed above, "hospitals located in Vigo County" constitute a relevant market when considering diversion ratios. In other words, if one Vigo County hospital were to acquire the other Vigo County hospital (as in the Proposed Merger), the merged entity would find a SSNIP profitable because the profit received from patients who would divert to the other Vigo County hospital would be greater than the losses from patients who diverted to hospitals outside of Vigo County. Moreover, by definition the Proposed Merger would be a merger to monopoly. To illustrate this point:

[190] FTC First Application Comment at 29.

Table 23: Hospitals Located in Vigo County Concentration Analysis for Inpatient Services (All Discharges)[191]

Hospital	All Discharges (2018-2022)	Share of All Discharges (2018-2022)	All Discharges (2023)	Share of All Discharges (2023)
UNION HOSPITAL	79,055	73.6%	18,187	79.0%
TERRE HAUTE REGIONAL HOSPITAL	28,398	26.4%	4,821	21.0%
Combined Union-THRH	107,453	100%	23,008	100%
Pre-Merger HHI		6,111		5,407
Post-Merger HHI		10,000		10,000
Change in HHI		3,889		3,313

Table 24: Hospitals Located in Vigo County Concentration Analysis for Outpatient Services (All Discharges)[192]

Hospital	All Discharges (2018-2022)	Share of All Discharges (2018-2022)	All Discharges (2023)	Share of All Discharges (2023)
UNION HOSPITAL	1,375,930	85.2%	344,370	89.0%
TERRE HAUTE REGIONAL HOSPITAL	238,991	14.8%	42,692	11.0%
Combined Union-THRH	1,614,921	100%	387,062	100%
Pre-Merger HHI		7,478		8,037
Post-Merger HHI		10,000		10,000
Change in HHI		2,522		1,962

The foregoing tables consider all discharges, not just commercial discharges, because the Department did not have the commercial discharge information available, but they illustrate that the Proposed Merger would be a merger to monopoly and that the markets are highly concentrated and the increases in HHI significantly exceeded the threshold for establishing that the Proposed Merger is presumptively anticompetitive. The FTC considered the same market using 2019 discharge data with a similar result:

[191] 2025 App. at 28.
[192] 2025 App. at 28.

Table 25: FTC Table 5: Shares and Concentration Analysis
Hospitals Located in Vigo County
(Based on 2019 IN Discharge Data)[193]

Hospital	Share of All Discharges	Share of Commercially Insured GAC Discharges
Union Hospital	67.9	78.4
Terre Haute Regional Hospital	32.1	21.6
Combined Union Health-THRH	**100**	**100**
Pre-merger HHI	5,644	6,613
Post-merger HHI	10,000	10,000
Change in HHI	4,356	3,387

Proposed Merger is Presumptively Anticompetitive

Based on the high HHIs and the increases in HHI across multiple potential relevant markets being significantly greater than the threshold established by the Merger Guidelines, the Department finds that the Proposed Merger is presumptively anticompetitive.

Potential Reductions in Anticompetitive Harm

The market concentration analysis outlined in the prior sections established a presumption that the Proposed Merger is may substantially lessen competition or tend to create a monopoly in a relevant market, but it is a presumption that is rebuttable. Once the presumption is established, under the traditional antitrust analysis of a merger, the burden shifts to the Applicants to demonstrate that the Proposed Merger does not substantially lessen competition or tend to create a monopoly in a relevant market.[194]

For purposes of the Department's analysis of the Application, the Department is considering this rebuttal evidence as it considers the quantum of the disadvantages attributable to a potential reduction in competition that may result from the Proposed Merger as it balances such disadvantages against the benefits arising from the Proposed Merger that are likely to be implemented and achieved.

[193] FTC First Application Comment at 26.
[194] Merger Guidelines at § 3; OAG First Application Comment at 19.

Entry is unlikely

One argument to rebut the presumption of anticompetitive harm is that the merger would result in another competitor entering a relevant market and that such entry would be sufficient to "prevent[] the merger from substantially lessening competition or tending to create a monopoly in the first place."[195] In order to prevent the anticompetitive effects, the entry must "timely, likely, and sufficient in its magnitude, character, and scope to deter or counteract the competitive effects of concern."[196] To be timely, the entry "must be rapid enough to replace lost competition before any effect from the loss of competition due to the merger may occur" and be durable.[197] To be likely, the entry must be "so likely that no substantial lessening of competition is threatened by the merger" and consideration must be given to why the entry had not been previously planned.[198] To be sufficient, the "[e]ntry must at least replicate the scale, strength, and durability of one of the merging parties."[199]

Despite the Applicants' assertion that Indiana's lack of a certificate of need law means there are no barriers to entry "if another organization decided to open a new hospital in the Service Area,"[200] there are significant barriers to entry for inpatient services. Building a new hospital is a multi-year undertaking. The Applicants put forth no evidence that any third party is considering expansion of inpatient services in the Wabash Valley Community of a size and scale that would be sufficient to prevent the anticompetitive effects of the Proposed Merger. Even if a potential entrant were to initiate preparations for entry shortly after consummation of the Proposed Merger, because of the extended design, construction and regulatory approval timeline, any such entry would not be timely and might not be at a sufficient scale to prevent the anticompetitive effects.[201] As such, with respect to inpatient services, the Department finds that entry will prevent the Proposed Merger's anticompetitive effects with respect to inpatient services.

With respect to outpatient services, while some barriers to entry may be less and there are other providers of specific outpatient services within the various relevant markets, the Applicants have not presented any evidence that such providers would expand their services or other providers would enter such that the harms arising from the Proposed Merger would be prevented. In addition, any such providers would be unlikely to provide the broad scope of outpatient services

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[195] Merger Guidelines at§ 3.2.
[196] Merger Guidelines at 31 (quoting *FTC v. Sanford Health*, 926 F.3d 959, 965 (8th Cir. 2019)); *see also* OAG First Application Comment at 19-20.
[197] Merger Guidelines at § 3.2.
[198] Merger Guidelines at § 3.2.
[199] Merger Guidelines at § 3.2.
[200] 2025 App. at 69.
[201] OAG First Application Comment at 18 (citing *F.T.C. v. ProMedica Health Sys., Inc.*, No. 3:11-cv-47, 2011 WL 1219281 at *31–34 (N.D. Ohio Mar. 29, 2011) (finding sufficient and timely new entry was unlikely for a variety of reasons, including the capital costs and regulatory hurdles inherent in constructing a hospital)). *See also* Community Health Network, *Community Health Network Expands With a New Healthcare Campus in Westfield* https://www.ecommunity.com/news/2024/community-health-network-expands-new-healthcare-campus-westfield (visited June 2, 2025) (stating construction of 100-bed inpatient tower would require at least two years after announcement).

provided by the Applicants. Therefore, with respect to outpatient services, the Department finds that entry is unlikely to prevent the Proposed Merger's anticompetitive effects with respect to outpatient services. Moreover, even if entry by outpatient service provider(s) was timely, likely and sufficient, any such entry would not prevent the Proposed Merger's anticompetitive effects with respect to inpatient services.

The Applicants have not met their Burden of Proving THRH is a Failing Firm

In the 2025 Application, the Applicants asserted that "Regional Hospital has faced significant operational challenges for a number of years which have led to a decrease in patient volumes, a reduction in service lines, and a significant decline in competitive viability."[202] Among the reasons cited for the declining patient volumes and service line reductions are the lack of a primary care referral base and the small number of employed physicians, with many specialties having a single physician specialist. The Applicants further asserted that "[w]ithout the Merger, Regional Hospital expects its operational challenges to lead to further service line reductions.[203]

Subsequently in a May 7, 2025 letter to the Commissioner, HCA senior vice president Monica Cintado stated, "If the COPA application is denied, then market conditions are such that HCA will need to seriously consider ending services or closing [Regional Hospital]."[204] To support this statement, she explained that THRH's EBITDA has been negative since 2022, it has experienced decreased admissions, decreased inpatient surgeries, and decreased outpatient surgeries since 2018 and over the preceding twelve months had been regularly operating at less than thirty percent average occupancy.[205] She further explained that THRH's reliance on solo physicians impacts its financial results because it has to hire locums coverage or temporarily suspend services if a physician requires time off and that THRH has experience significant difficulties in recruiting physicians.[206]

The 2023 Application did not mention that HCA is or could be considering closing Regional Hospital. The Applicants raised the issue for the first time in June 2024 in their response to the Department's RFI2 [redacted][207] Only in May 2025, HCA did state it would "need to seriously consider ending services or closing the hospital." Notably, HCA never stated that it "would close" Regional Hospital; instead, it asserts that Union is the only interested or viable buyer for Regional Hospital and it will need to "consider ending services or closing the hospital."[208]

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[202] 2025 App. at 7.
[203] 2025 App. at 7.
[204] Cintado Letter at 3.
[205] Cintado Letter at 1-2.
[206] Cintado Letter at 2.
[207] Att. P to RFI2 (withheld from public disclosure).
[208] Citado Letter at 3; Att. P to RFI2 (withheld from public disclosure).

Evidence that the assets to be acquired in a merger will "imminently cease playing a competitive role in the market even absent a merger," can rebut the presumption that a merger will substantially reduce competition in a relevant market.[209] Merging parties often assert, like the Applicants, that absent a merger, the seller will close or otherwise exit the market because of the seller's weak or weaking financial position.[210] The Merger Guidelines recognize the "failing firm" defense, which requires:

- THRH faces the grave probability of business failure;
- the prospects of THRH's reorganization are dim or non-existent; and
- Union is the only available purchaser of THRH at a price greater than its liquidation value.[211]

HCA argues that THRH's negative EBITDA since 2022, reliance on solo practitioners and recruiting challenges mean that HCA will need to consider reducing services or closing Regional Hospital because it is unlikely to become profitable. In reviewing both Applications, the FTC reviewed THRH's profitability and concluded that THRH was profitable and stable.[212] [redacted] While the Department acknowledges that THRH's EBITDA has been negative since 2022, which suggests that THRH has not been profitable on an operating basis, and has difficulty recruiting physicians, it is also notable that THRH has been for sale since 2019[213] and appears to have abandoned its strategic plans.[214] Moreover, given that HCA will only state that it "will need to consider" reducing services or closing the hospital, it is difficult for the Department to conclude that THRH faces the grave possibility of business failure or that its prospects of reorganization are dim.

Moreover, HCA has not met its burden of showing Union is the only available purchaser of Regional Hospital at a price greater than its liquidation value. As described in the Cintado letter, HCA conducted a targeted outreach to six hospital systems in 2019 and 2020, none of whom expressed interest in a transaction, and pursued letters of intent with at least two other potential buyers in 2022, who declined to move forward "in light of [Regional Hospital's] declining financials."[215] However, HCA has not presented the Department with any evidence of THRH's liquidation value, which the Department believes is likely less than the purchase prices discussed

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[209] Merger Guidelines at § 3.1.
[210] *See* FTC Second Application Comment at 4-6).
[211] Merger Guidelines at § 3.1 (internal citations omitted).
[212] FTC First Application Comment at 10-14; FTC Second Application Comment at 2-3.
[213] Cintado Letter at 3.
[214] *See* fn. 166.
[215] Cintado Letter at 3.

with potential buyers in 2022, and [redacted]

Therefore, while the Department acknowledges that there is a risk that the breadth of Regional Hospital's services may decline and that HCA may ultimately decide to close Regional Hospital, the Applicants have not met their burden of proof with respect to the "failing firm" defense sufficiently to eliminate the anticompetitive effects of the Proposed Merger. However, as the Department balances the anticompetitive effects and the COPA's benefits, it may consider those risks as part of its balancing test.

Asserted Powerful Buyers will not Reduce Merger Harm

Courts and the federal antitrust agencies have recognized that the presence of powerful "may constrain the ability of the merging parties to raise prices"[216] in certain circumstances. The Applicants assert in the Application that commercial payors in the Service Area (particularly Anthem/Elevance and United Health Group) have "considerable strength to negotiate" and that "[b]y the sheer strength of their respective market shares and size… have, and will continue to have, the power to robustly negotiate provider contracts without any protections."[217] Union further asserts that Anthem/Elevance and United Health Group are "powerful buyers" that will restrict Union's ability to raise price after consummation of the Proposed Merger because Anthem/Elevance has a 69% commercial health market share in the Terre Haute Metropolitan Statistical Area and United Health Group has an 11% commercial health market share in the Terre Haute Metropolitan Statistical Area. [218]

In the healthcare industry, prices for commercially insured patients are determined through bilateral negotiations between hospitals and insurers. This is the first stage of the "two-stages" of competition between hospitals – where hospitals compete to be included in an insurer's network. Health insurers use this competition between hospitals to reduce their costs and their insured premiums. Therefore, it is important to consider, the role of the insurer and the relative bargaining power between hospitals and insurers. In many respects, it is logical that if an insurer has market power, it will have greater bargaining leverage vis a vis hospitals; by the same token a hospital that has market power will have greater bargaining leverage vis a vis insurers.

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[216] U.S. Department of Justice and the Federal Trade Commissionm, *Horizontal Merger Guidelines* § 8 (2010) (hereinafter "*2010 Merger Guidelines*"); *United States v. Archer-Daniels-Midland Co.*, 781 F. Supp. 1400 (S.D. Iowa 1991).

[217] 2025 App. at 67-68; *see also* 2023 App. at 68.

[218] Letter from Michael R. Greer, Hall, Render, Killian, Heath & Lyman, P.C. to Kelly MacKinnon, Chief Legal Officer, Ind. State Dept. of Health 2 (Oct. 4, 2024) (on file with the Department) (hereinafter "*Greer Letter*") (citing Competition in Health Insurance: A comprehensive study of U.S. Markets, Am. Med. Ass'n (2023) https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf) (hereinafter "*2023 AMA Insurance Study*")); Letter from Steven Holman, President & CEO, Union Health, Inc., to Dr. Lindsay Weaver, State Health Commr, Ind. Dept. of Health 11 (May 7, 2025) (on file with the Department) (citing 2023 AMA Insurance Study).

Union suggests the Proposed Merger will not lead to significant impacts on pricing because Anthem is a powerful buyer that will constrain Union's pricing after consummation of the Proposed Merger for the following reasons:

- the Terre Haute MSA commercial insurance market is highly concentrated with an HHI of 4,987; [219]
- Anthem has a 69% market share in the Terre Haute MSA;[220]
- Anthem insures [redacted] of Union's commercially insured patients; [221]
- Anthem already reimburses Union at a lower rate than THRH, which shows it is already dictating terms as a powerful buyer;[222]
- Union will continue to face significant competition from more than 16 hospitals, including large health systems;[223] and
- THRH's diminishing competitive viability, including limited specialty options and service line closures, means that THRH is unlikely to be a meaningful substitute for Union in insurer networks.[224]

Union further argues that economic literature "shows that a large, sophisticated, and powerful buyer who dominates a relevant market is able to constrain any potential anticompetitive harms resulting from a merger of two sellers in that same market."[225] In support of this argument, it cites to a 2023 study that "found that in states where an insurers' [HHI] was greater than 3,500 (indicating a highly concentrated market), hospital mergers did not result in any appreciable price effects when compared to prices in less concentrated insurer markets"[226] and a 2020 study that "demonstrated that an increase in insurer concentration (measured by HHI) predicted a lower impact… on price increases."[227]

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[219] Greer Letter at 3 (citing 2023 AMA Insurance Study).
[220] Greer Letter at 3 (citing 2023 AMA Insurance Study); 2025 App. at 67.
[221] Greer Letter at 3 (citing PYA, Acquisition Benefit Analysis Report prepared for Union Health, Inc. (May 10, 2024)) (withheld from public release).
[222] Greer Letter at 3 (citing Hospital Price Transparency Study, RAND (2024), https://www.rand.org/health-care/projects/hospital-pricing.html).
[223] Greer Letter at 3 (citing 2023 App. at 65).
[224] Greer Letter at 3; 2025 App. at 67.
[225] Greer Letter at 1 (citing E. Barette, G. Gowrisankaran & R. Town, *Countervailing Market Power and Hospital Competition*, NAT'L BUREAU OF ECON. RES. (2020) (hereinafter "*Barrette (2020)*"); K. Brand, C. Garmon & T. Rosenbaum, *In the Shadow of Antitrust Enforcement: Price Effects of Hospital Mergers from 2009 to 2016*, 66 J. OF L. AND ECON., 639, 658 (2023) (hereinafter "*Brand (2023)*"); S. Loertscher and L.M. Marx, *Merger Review for Markets with Buyer Power*, J. OF POL. ECON. (2019)).
[226] Greer Letter at 2 (citing Brand (2023) at 658).
[227] Greer Letter at 2 (Barrette (2020)).

The studies cited by Union do not necessarily support the conclusion that one powerful buyer will constrain the ability of a monopolist to increase prices. The Brand (2023) article considered the price effects of actual mergers and analyzed the price effects of mergers between hospitals with high diversion ratios and mergers between hospitals in concentrated insurance markets. However, the factors were analyzed independently. In other words, one analysis considered mergers between hospitals based on diversion ratios and found that "the price effects of hospital mergers are by far the highest when the diversion ratio from the treated hospital is greater than 15%."[228] A second analysis considered mergers between hospitals based on the level of insurance market concentration and found that "hospitals in states where the insurance HHI is above 3,500 do not show appreciable price effects, with point estimates near zero."[229] However, Brand (2023) did not consider the price effect of merger like the Proposed Merger where the hospitals have high diversion ratios and a concentrated insurance market. Thus, the analysis is insufficient to assess whether an insurer with market power could constrain the pricing of a hospital with market power.

The authors of Barrette (2020) used Health Care Cost Institute claims data to estimate patient preferences and willingness to pay per person to measure hospital bargaining leverage. The measure of hospital bargaining leverage is regressed against measures of insurer concentration to "measure how insurer concentration affects hospital prices on average and also whether insurer concentration counterbalances hospital bargaining leverage in its pricing impact."[230] The authors then use a hypothetical merger that increases willingness to pay per person by 14.4%[231] to assess the expected increase in price based on insurer concentration and "find that this hypothetical merger would increase the mean hospital price" by between .98% (if the insurer HHI is 5,386 (higher than Terre Haute)) and 2.8% (if the insurer HHI is 4,430 (lower than Terre Haute)).[232]

Barrette (2020) did not measure the effects of actual mergers. Instead, the authors identified a relationship between increases in insurer concentration and the impact of hospital concentration on hospital prices and concluded that higher insurer concentration leads to lower hospital prices. However, it does not necessarily follow that a merger resulting in higher hospital concentration will result in lower prices when faced with high insurer concentration. Other economics literature predicts that an insurer's predicted price increase will be higher if it has a higher market share, shows empirically that merger induced price increases are greater for large insurers than for small insurers and reports that "retrospective analysis indicates that the health

[228] Brand (2023) at 656.
[229] Brand (2023) at 658.
[230] Barrette (2020) at 2.
[231] The mean change in willingness to pay per person based on an analysis of 23 mergers. Garmon, C., *The accuracy of hospital merger screening methods*, 48 RAND J. OF ECON. 1068 (2017) (hereinafter "*Garmon (2017)*"). It should be noted that only one of the mergers considered in this article had pair-wise diversion ratios similarly to those of the Applicants.
[232] Barrette (2020) at 19-20.

insurers who believed to be able to counteract post-merger price increases were both not able to do that."[233]

In light of the foregoing, the Department finds that the literature cited by Union does not support the argument that higher insurer concentration will sufficiently limit Union's ability to increase prices post-Proposed Merger because the literature does not consider the situation where the insurers will be forced to negotiate with only one hospital system. In addition, the data analyzed in Barrette (2020) does not include data from Blue Cross Blue Shield systems, including Anthem, even though the largest insurer in a majority of high concentration insurer markets is a Blue Cross Blue Shield system. Thus, for many markets, the Barrette (2020) analysis's "largest insurer" is really the second-largest insurer at best.

Union argues that the fact that Anthem pays it less today is evidence that Anthem is a powerful buyer. While Anthem may have the superior bargaining power prior to consummation of the Proposed Merger, bargaining power is relative and after consummation of the Proposed Merger, Anthem (and the other insurers) will only have one hospital system in Vigo County with which it can negotiate, which necessarily will change the relative bargaining positions. In addition, while Union may be paid less by Anthem on an absolute basis, the Department's analysis showed that in recent years, Union has begun to close the pricing gap. This would be consistent with Union's assertion that Regional Hospital is less of a meaningful substitute due to its recent service line closures but does not mean that the two hospitals do not compete with each other and constrain each other's pricing. As discussed earlier, there are good arguments that Union Hospital and Regional Hospital alone constitute a relevant market, which means the Proposed Merger is a merger to a monopoly.[234] For commercially insured inpatients residing in Vigo County, 86.4% of them went to Union Hospital or Regional Hospital, and eight of the next ten hospitals (by percentage discharges) are located in Marion or Hamilton Counties, more than seventy miles from Terre Haute. Even when considering the 80% Primary Service Area, which is the largest geographic market, 71.6% of inpatients residing in the 80% Primary Service Area went to Union Hospital or Regional Hospital. For insurers who want to include a Terre Haute hospital in their networks or offer their insureds a reasonably proximate hospital after consummation of the Proposed Merger, Union will be the only choice because the Proposed Merger would result in one "powerful buyer" negotiating with a "powerful seller."

While it may be true that in certain circumstances, a powerful buyer or powerful buyers may constrain the merged parties from increasing prices,[235] it should not be "presume[d] that the presence of powerful buyers alone forestalls adverse competitive effects flowing from the merger and [e]ven buyers that can negotiate favorable terms may be harmed by an increase in market

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[233] Roos A-F, Croes RR, Shestalova V, Varkevisser M, Schut FT, *Price effects of a hospital merger: Heterogeneity across health insurers, hospital products, and hospital locations*. 28 HEALTH ECON. 1130–1145 (2019).
[234] *See* Tables 23-25 above.
[235] *See United States v. Archer-Daniels-Midland Co.*, 781 F. Supp. 1400, 1418 (S.D. Iowa 1991) (the merged parties' market share ranged between 30% and 38% and there were multiple sophisticated buyers of high-fructose corn syrup who could switch suppliers to encourage price decreases, encourage new entrants and refuse to negotiate long-term contracts without price concessions); 2010 Merger Guidelines § 8.

power [or] market power can be exercised against others."[236] In light of the foregoing, the Department finds that insurer concentration would not constrain Union's ability to increase prices as a result of the Proposed Merger.

Summary of Anticompetitive Effects

In conclusion, the Department finds that the Proposed Merger is presumptively anticompetitive and that the Applicants have not demonstrated that traditional defenses to a presumptively anticompetitive merger – entry, failing firm and powerful buyers – will overcome the presumption of anticompetitive harm.

Analysis of whether the COPA Benefits outweigh the Anticompetitive Effects

In evaluating whether the COPA Benefits outweigh the potential anticompetitive effects of the Proposed Merger, the Department undertook a comprehensive harm-benefit analysis. This assessment involved a detailed examination of each Commitment, with particular attention to the anticipated advantages and the specific implementation actions required to fulfill those obligations.

Each commitment was evaluated and categorized along a gradient scale that considered multiple factors, including:

- **Magnitude of Impact**: The extent to which the Commitment would positively affect the Service Area and its residents, particularly in terms of health outcomes, access to care, quality improvement, and economic stability.

- **Baseline Likelihood**: The probability that the proposed activity or improvement would have occurred independently of the Proposed Merger, thereby distinguishing merger-specific benefits from general operational enhancements.

- **Enforceability**: The degree to which the Commitment could be monitored, verified, and enforced over time, ensuring accountability and sustained compliance.

This structured approach enabled the Department to weigh the public interest holistically, thereby informing its determination regarding the overall net effect of the Proposed Merger under the COPA framework.

[236] 2010 Merger Guidelines § 8.

Table 26: Quality Commitments

Commitment	Harm	Neutral	Benefit
1: Common clinical IT platform at both hospitals			
2: Quality measure reporting			
3: Prohibition on material reduction in quality			
4: Patient satisfaction measure reporting			
5: Establishment of Quality Committee for integration			

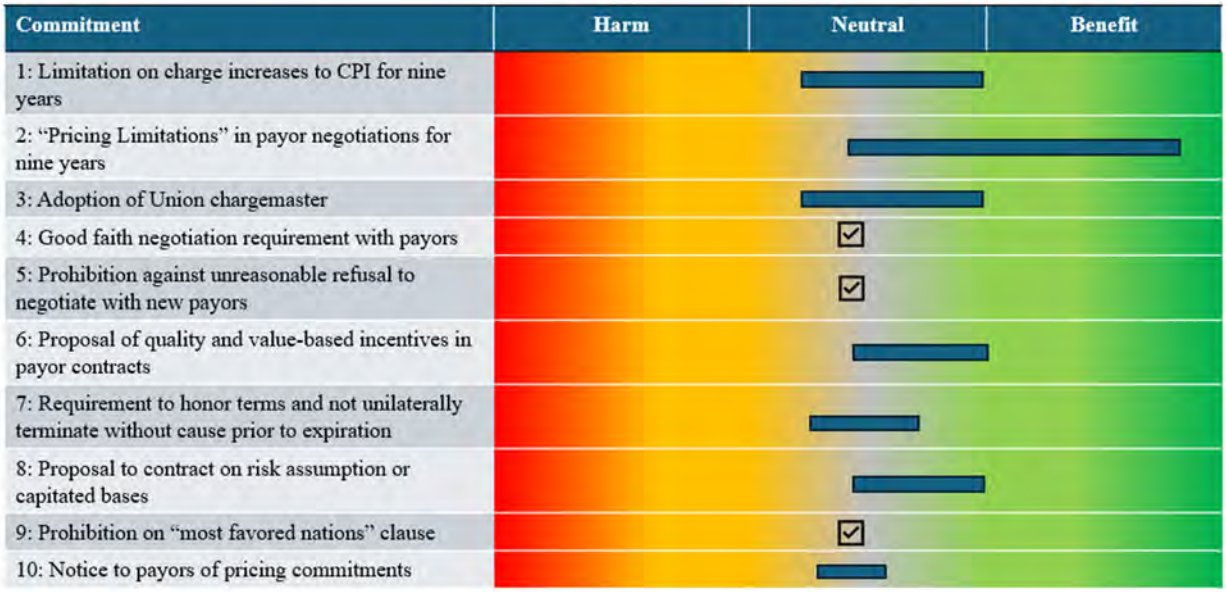
The five Quality Commitments established under the COPA framework are designed to ensure that the quality of health care services does not deteriorate relative to pre-Merger baselines. These Commitments also aim to promote transparency by requiring the implementation of tools and mechanisms that allow for ongoing monitoring of both clinical quality and patient satisfaction.

Among the 59 quality measures proposed for regular reporting by the Parties, many are existing data reporting requirements under quality programs. However, the frequency and accessibility of this reporting represent an enhancement over current practices. Under the Quality Commitments, these measures must be reported more consistently and consolidated into a single, publicly available platform on the "Healthier Together" transparency website. This centralized reporting structure is likely to improve public access to meaningful data and facilitate informed oversight.

While the preservation of existing quality standards is a critical objective, the Commitment to make good faith efforts to prevent any material decline in quality relative to pre-Merger levels is primarily viewed as a protective measure rather than a benefit. It serves as a safeguard against potential adverse outcomes rather than a proactive enhancement of care. In the Department's evaluation of the Commitments, those that function as protective mechanisms are weighted less heavily than those that represent substantive improvements or innovations in health care delivery.

Moreover, certain activities associated with the Proposed Merger may be necessary to ensure a smooth integration. While such activities may offer operational stability, they do not necessarily provide the same value in improving health care access, quality, and outcomes as those initiatives that are uniquely designed to benefit the Service Area. For instance, the implementation of a shared clinical information technology platform across both hospitals and the establishment of a joint Quality Committee are merger-specific actions. These initiatives likely enhance integration, coordination, and consistency in care delivery between the merging entities but do not alone offer meaningful advantages to the population served.

Table 27: Pricing Commitments



The Pricing Commitments are designed to reduce the risk of increased health care costs for residents, employers, and payors within the Service Area following the Proposed Merger and establish both qualitative and quantitative protections.

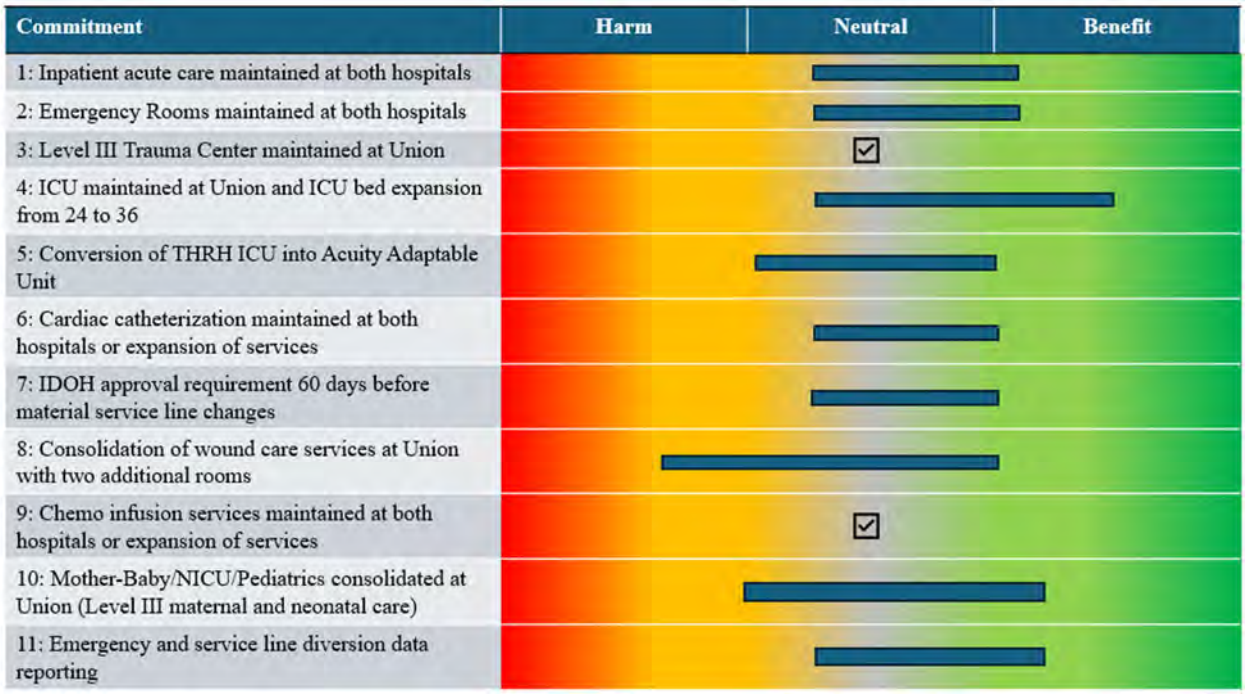
The limitation on charge increases and the adoption of Union Hospital's chargemaster (which generally reflects lower charges than Regional Hospital's for most services and items) serve as direct protections for charge-based payors and health care consumers that do not have separately negotiated contractual rates.

Among these Commitments, the limitations placed on third-party payor pricing deliver the most substantial and measurable benefit. These limitations are expected to have a meaningful impact on controlling costs for commercial insurers and self-funded employers, who represent a substantial portion of the payor mix. The absolute limitation on price to 265% of Medicare will deliver unprecedented levels of cost containment for consumers of health care. By capping negotiated inpatient and outpatient aggregate rate increases, the limitations offer a direct and tangible safeguard against post-Merger price increases. Additionally, the requirement for Union to offer a direct-to-employer arrangement allows the employer community to innovate in health care delivery.

Other Commitments, such as the promotion of value-based care models and risk-based contracting, are conceptually aligned with broader health goals of improving quality and reducing costs. However, these Commitments are somewhat limited in their enforceability. Union is only required to propose such contract terms, and there is no guarantee that payors will accept them. As a result, the actual impact of these initiatives remains uncertain and contingent on future negotiations.

Finally, several of Union's stated Pricing Commitments reflect existing legal obligations or standard industry practices rather than new or merger-specific benefits. For instance, Indiana law already prohibits the use of "most favored nations" clauses in payor contracts, which restrict payors from receiving less favorable terms than other insurers.[237] Similarly, Commitments to negotiate in good faith and to avoid unreasonable refusals to engage with new market entrants are widely recognized as baseline expectations in provider-payor relations. These provisions, while important, do not represent incremental value attributable to the Proposed Merger or the COPA. Still, these protections place controls on negotiating that mitigate the risk of Union exerting increased market power as a result of the Proposed Merger.

Table 28: Access Commitments



Union's Access Commitments are designed to preserve service availability at both Union and Regional Hospitals following the Proposed Merger. These Commitments serve multiple purposes:

- protecting against the risk of service consolidation at a single facility due to the Proposed Merger;
- mitigating the possibility Regional Hospital might otherwise be forced to reduce or eliminate certain services due to workforce or operational challenges; and

[237] Ind. Code § 27-8-11-9.

- expanding access to high quality services.

Key among these Commitments is the pledge to maintain inpatient acute care, emergency department services, and cardiac catheterization capabilities at both hospital campuses, subject to consolidation for efficiencies paired with corresponding expansion of services. Inpatient acute care and emergency department access, in particular, are foundational to community health care access, and their preservation ensures that patients across the Service Area continue to receive timely, geographically distributed care. Without the Proposed Merger, workforce and operational challenges may cause a reduction in these services offerings at Regional Hospital.

Additional Commitments, such as Union Hospital's continued operation of a Level III Trauma Center and the provision of chemotherapy infusion services, are viewed by the Department as a continuation of existing service delivery rather than new or expanded offerings or protection of at-risk services. As such, these measures provide reassurance but do not constitute incremental benefits attributable to the Proposed Merger.

The consolidation of certain services, even if potentially improving operational efficiency, can reduce geographic access for patients. The Preservation of Access Commitments are intended to offset these risks through targeted expansions or care quality enhancements, but to varying degrees of success.

For example, the consolidation of wound care services at Union Hospital introduces an access barrier for patients who previously received this type of care at Regional Hospital. This impact is only partially mitigated by the addition of two new treatment rooms at Union Hospital.

In contrast, the reconfiguration of intensive care services presents a more balanced trade-off. Regional Hospital's existing Intensive Care Unit (ICU) will be converted into an Acuity Adaptable Unit, potentially lowering the acuity of care available at that site. However, the overall ICU bed capacity across both hospitals will increase by 50% from 24 beds to 36 beds. This expansion represents a meaningful increase in system-wide critical care capacity, even if it results in some redistribution of services.

The consolidation of maternal and pediatric services (including the Mother-Baby Unit, Neonatal Intensive Care Unit (NICU), and pediatrics service line) at Union Hospital may reduce access for residents living closer to Regional Hospital. However, all patients will gain access to a higher level of care through Union Hospital's Level III maternal and neonatal facility.

Finally, procedural safeguards such as the requirement to seek Department approval before making additional service line changes, and the obligation to report emergency and service line diversion data, are not direct benefits. However, they serve as protective measures to ensure transparency and accountability, helping to prevent future reductions in access and maintain continuity of care post-Merger.

Table 29: Enhancement Commitments

Commitment	Harm	Neutral	Benefit
1: Investment of $30M at THRH facility			
2: Investment of $75M at Union facility			
3: Investment of $5M in oncology-related treatment technology			
4: Recruitment of 15 Primary Care physicians and APPs			
5: Recruitment of 21 Specialty physicians			
6: Recruitment of three pharmacists			
7: Increase of 20 inpatient behavioral health beds			
8: Expansion of Union's after-hours nurse access program			
9: Increase in the number of well-child checks			
10: Increase in the number of well patient visits for ages 18-39			
11: Increase the number of well patient visits for ages 40-64			
12: Increase in patients receiving a Medical Annual Wellness Visit			
13: Increase in eligible attributed patients offered Transitional Care Management services			

The Enhancement Commitments represent financial investments into facilities and technology, recruitment activity to strengthen the provider workforce, the expansion of behavioral health beds and the existing after-hours nurse access program at Union, and activities to increase preventive services.

A central component of these Commitments is the planned financial investment of $75 million in Union Hospital facilities over the first five years post-Proposed Merger, with at least half of that investment being obligated within the first three years. While this figure appears substantial, the Department determined that it does not represent a meaningful increase over Union Hospital's historical capital investment levels. As such, this Commitment is viewed as a continuation of existing investment patterns rather than a Proposed Merger-specific enhancement. In contrast, the investment of capital expenditures at Regional Hospital in the amount of $30M in the first five years, with at least half of that investment being obligated within the first three years, is less likely to occur without the Proposed Merger.

The recruitment Commitments for primary care providers, specialty physicians, and pharmacists will ensure access remains stable or is improved amidst a challenging health care workforce landscape across the state and nation. These efforts are expected to stabilize and potentially improve access to care across the Service Area, especially in underserved areas or specialties facing high demand.

In increasing preventive care visits across patient populations of all ages, Union can screen for chronic illnesses issues, assess future risk, update vaccinations, and build a relationship with a health care provider. However, this type of preventive care is a standard component of health systems and is likely to be a targeted goal of the Applicants regardless of the Proposed Merger.

The expansion of Union Hospital's after-hours nurse access program further supports patient engagement and care continuity, particularly for individuals managing chronic conditions or seeking guidance outside of regular clinic hours. While not transformative on its own, this enhancement contributes to a more responsive and patient-centered care environment.

Among all Enhancement Commitments, the planned addition of 20 inpatient behavioral health beds in the Service Area stands out as the most significant. Behavioral health services are critically under-resourced in many communities, including in the Wabash Valley, and this expansion addresses a pressing need without reducing access to other services. Unlike other Commitments that maintain or redistribute existing resources, this initiative represents a clear and measurable increase in service capacity and is likely to directly improve healthcare access and outcomes.

Table 30: Employment and Economic Impact Commitments

Commitment	Harm	Neutral	Benefit
1: Employment offer to THRH and Regional Partners employees		☑	
2: Employment offer at same or better salary and wage levels		☑	
3: Full credit for THRH employee Paid Time Off		☑	
4: Annual employee and physician satisfaction surveys			
5: Research study on economic impact of COPA			
6: Plan to remediate any economic concerns identified in research study			
7: IDOH notification requirement 60 days before a material reduction in employment			

The Employment and Economic Impact Commitments are primarily structured to mitigate potential adverse consequences resulting from the Proposed Merger. By guaranteeing continued employment for Regional Hospital and RHP staff at equal or improved salary and wage levels, and by preserving accrued paid time off balances, Union aims to maintain the prevailing employment and economic conditions within the Service Area. These provisions provide stability for local workforce during the transition period but do not result in improvement beyond current state for the community.

A transparency mechanism within these Commitments is the requirement to conduct and publicly disclose the results of an annual employee and physician satisfaction survey. The publication of these findings on the "Healthier Together" website provides the community with insight into workforce sentiment and organizational culture. While the survey is intended to

support employee retention and reduce turnover, the absence of a requirement to address concerns in response to unfavorable survey results limits the potential impact of this initiative.

Additionally, the requirement to conduct a research study assessing the economic impact of the Merger, along with the obligation to implement remediation measures based on its findings, represents a monitoring tool rather than a direct benefit. As this study would not be necessary in the absence of the Proposed Merger, the Department views it as a mechanism to identify and address potential disadvantages rather than a source of affirmative value to the affected population.

To further safeguard against employment disruptions, the Commitments include a provision requiring notification to the Department before any reduction of ten (10) or more employees, or fifty percent (50%) or more of any practice group or department, whether through a single action or a series of related actions within any ninety (90) day period. This measure is intended to reduce the risk of unexpected layoffs or structural changes that could negatively impact service delivery and access to care.

Table 31: Population Health Commitments

Commitment	Harm	Neutral	Benefit
1. Expansion of Union's Health Equity Plan			
2. Expansion of Union's Population Health Improvement Plan			
3. 12+ "pop-up clinics" for homeless community annually			
4. New food access point to address food insecurity			
5. Research study on COPA impacts to community health			
6. Remediate health metric concerns identified in research study			
7. Accountable Health Community (AHC) creation			
8. AHC activity to reduce tobacco and vaping use during pregnancy			
9. AHC activity to address infant mortality rates			
10. AHC activity to promote breastfeeding			

The Population Health Commitments are designed to advance health outcomes across the Service Area by addressing systemic barriers to care and targeting specific public health challenges.

While the expansion of Union's Health Equity Plan and Population Health Improvement Plan under the Proposed Merger may result in broader reach and impact, this type of policy expansion is typical integration activity. For this reason, their associated benefits are not weighted as heavily as other value-added Population Health Commitments.

Among the more impactful Population Health Commitments is the obligation to host a minimum of twelve "pop-up clinics" annually for individuals experiencing homelessness. These

clinics are intended to provide direct access to essential health and social services for one of the most vulnerable populations in the Service Area. Similarly, the establishment of a new food access point to address food insecurity represents a tangible intervention that is expected to improve health outcomes by mitigating a key social determinant of health.

The requirement to conduct a research study on the COPA's impact on community health, along with the obligation to implement remediation measures based on the study's findings, serves as a monitoring mechanism rather than a direct benefit. As with the economic impact study, this initiative would not be necessary absent the Proposed Merger. Therefore, while it provides a valuable tool for identifying and addressing potential adverse effects, it does not constitute a meaningful enhancement to population health in and of itself.

A particularly significant set of Commitments is the creation of an AHC, which will convene stakeholders across the Wabash Valley Community to collaboratively address three pressing public health concerns: tobacco and vaping use during pregnancy, high infant mortality rates, and low rates of breastfeeding initiation. These issues are areas in which the Service Area currently performs below the state average, underscoring the need for targeted intervention. The AHC model is expected to improve care coordination, foster alignment between clinical and community resources, and facilitate data sharing. The reporting requirements associated with the AHC also increase the likelihood of achieving sustainable improvements in health outcomes. These Commitments represents a strategic and community-driven approach to population health and are likely to yield measurable benefits for the population served.

Table 32: Other Commitments

Commitment	Harm	Neutral	Benefit
1. Adoption of Union Financial Assistance Policy			
2. Reinvestment of cost savings to improve health status of the community		☑	
3. Investment of $6.9M in Graduate Medical Education annually			
4. New Psychiatry Residency Training Program			
5. Prohibition on new health plan ownership or control			
6. Required Regional Health representation on UHI Board			

The "Other Commitments" encompass a range of initiatives expected to result in measurable improvements in health care access, quality, and outcomes for the community, with several offering particularly meaningful benefits.

One such initiative is the expansion of Union Hospital's Financial Assistance Policy to apply uniformly to all patients seeking care at any location within the system. Under this Commitment, Union must maintain a Financial Assistance Policy throughout the COPA Term that is at least as generous as the policy previously in place. This provision ensures that access to care

remains attainable for low-income individuals and families and may even broaden eligibility for financial support.

The Commitments also include a substantial investment in workforce development through the allocation of $6.9 million annually to Graduate Medical Education (GME) for the first five years following consummation of the Proposed Merger. This investment is complemented by the creation of a new General Psychiatry Residency Training Program. These initiatives are designed to address provider shortages and enhance access to care by cultivating a pipeline of qualified health care professionals who will serve the Service Area. Importantly, these programs are unlikely to be implemented absent Union's obligations under the COPA, underscoring their value as merger-specific benefits.

While most Other Commitments are expected to yield benefits, it is important to note the requirement to reinvest cost savings resulting from the Proposed Merger into community health improvement is a statutory obligation under the COPA framework.[238] As such, it does not represent a voluntary enhancement and is not weighted as heavily in the Department's benefit analysis.

Similarly, the requirement for Regional Hospital representation on the Union Board of Directors contributes to operational continuity and governance stability, which may support the overall success of the integration. However, its direct impact on improving health care access, quality, or outcomes is limited and therefore considered less significant in the context of evaluating community benefit.

CONCLUSIONS

Through the comprehensive harm-benefit analysis and a detailed evaluation of each of the 62 Commitments of Union, the Department finds that the aggregate benefits of the Proposed Merger are likely to outweigh the potential disadvantages associated with reduced competition. These Commitments represent a robust framework of protections and value-added enhancements that directly address key health policy priorities of the State of Indiana, most notably the imperative to reduce the cost of care and improve health outcomes.

The policies embedded in the Commitments are designed to go beyond simply eliminating potential harm. Objectives such as reducing costs below current levels and improving health outcomes to address substandard public health metrics represent an intention to improve health care for the impacted population. These measures are particularly important in a landscape where affordability remains a barrier to care and the acuity of the population continues to increase due to the aging population and existing service gaps.

These protections are not merely procedural, as demonstrated by the requirements for Union to continually produce substantive information about plans and progress toward full

[238] Ind. Code § 16-21-15-7(d).

implementation of the Commitments and compliance with the Terms and Conditions. These measures are essential in safeguarding the community from the adverse effects that can accompany consolidation. Without these protections, the risk of service degradation, cost escalation, and erosion of public trust would be significantly heightened. The transparency and reporting requirements embedded in the Commitments provide the Department and the public with the tools necessary to monitor performance, enforce compliance, and ensure that promised benefits are realized.

The Department acknowledges that mergers of this scale inherently carry risks, particularly the possibility of diminished quality, increased prices, and reduced accountability due to decreased market competition. In response, the COPA framework replaces traditional market competition with a regulatory structure grounded in enforceable Commitments and Terms and Conditions. Through this mechanism, the Department has instituted enhanced oversight protocols, transparency requirements, and accountability measures to ensure that Union fulfills its obligations and that the public interest is protected.

While the Department finds that the Applicants have not overcome the burden to disprove the presumption of anticompetitive harm, it concludes that the Applicants have provided sufficient evidence that the benefits arising from the Proposed Merger will result in meaningful improvements in health outcomes, access to care, and quality of services for the population served, including residents of the counties in which the Applicants currently operate.

Ultimately, the Department finds that the aggregate benefits arising from the Proposed Merger, as structured through the Commitments and subject to ongoing oversight and regulation by the Department, are sufficient to outweigh the potential disadvantages attributable to a reduction in competition. The Department's comprehensive harm-benefit analysis and the detailed examination of each of the 62 Commitments weight heavily toward net benefits being delivered to the Wabash Valley Community. The Department finds these COPA Benefits sufficient to overcome the presumption of harm that may occur due to the Proposed Merger.

DECISION

The COPA is granted, and the Applicants are directed to take all actions necessary to ensure compliance with the Terms and Conditions and implementation of the Commitments.

EXHIBIT B
COMMITMENTS

(attached)

EXHIBIT B
COMMITMENTS

This **Exhibit B** describes the Combined Enterprise's 62 commitments to ensure there is clear evidence that the Merger will benefit the population's health outcomes, health care access, and quality of care and ensure that the likely benefits resulting from the Merger outweigh any disadvantages attributable to a potential reduction in competition that may result from the Merger.

A. QUALITY COMMITMENTS

In order to monitor quality performance and ensure that the quality of health care services provided in the Service Area does not decline after the Merger, the Combined Enterprise shall fulfill the Quality Commitments set forth below.

Quality Commitment #1

UHI will implement a common clinical IT platform across the Combined Enterprise within 24 months of the Merger to support quality improvement, care management, and population health improvement efforts.

- This commitment will require UHI to implement a common clinical IT platform across the Combined Enterprise to allow for better coordinated care. The common clinical IT platform will support the Combined Enterprise's efforts to improve quality and enhance care management across the region. This implementation is expected to cost approximately $17.5 million.

- Accountability Mechanism: UHI shall include in each Annual Report an update on its progress towards meeting the commitment and the expenses associated with the implementation. Failure to comply with this commitment within 24 months may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Quality Commitment #2

UHI will report on specific quality measures of the Combined Enterprise quarterly and annually against pre-Merger baselines to ensure the Department and the community have the ability to monitor quality performance post-Merger. The reporting shall include all patients served post-Merger.

- This commitment will ensure that the Department and the community receive regular updates on the quality performance of the Combined Enterprise and are able to compare that against pre-Merger quality performance of Union Hospital and Regional Hospital (where possible). This level of quality reporting is not currently required of any hospital in Indiana and this level of quality reporting would not be available to the public absent the Merger. The proposed quality measures that UHI must report on are attached as Addendum 1.

- Accountability Mechanism: UHI shall report its performance on all quality measures for all patients served against pre-Merger baselines and on a year-over-year and trend basis for the duration of the COPA Term in its Annual Report. UHI shall report on those quality measures

designated for quarterly reporting on the "Healthier Together" transparency website that will be available to the public. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Quality Commitment #3

The Combined Enterprise will be required to make good faith efforts to ensure a material reduction in quality does not occur compared to pre-Merger baselines.

- Accountability Mechanism: Upon receiving quality data reported under Quality Commitment #2, the Department will review and notify UHI if there appears to be a Material Reduction in Quality Performance for the Key Quality Measures. The "Key Quality Measures" are: (i) overall mortality (All Cause Mortality), (ii) overall readmissions (READM-30-HOSPWIDE), and (iii) the composite score for patient safety indicators (PSI 90). A "Material Reduction in Quality Performance" shall mean:

    - UHI's performance on any of the Key Quality Measures in a given year has changed (in a negative manner) by twenty percent or more of UHI's baseline performance as shown on Addendum 1.

        - For example, if UHI's PSI 90 mean was 0.94 in the baseline year, UHI's mean performance in 2027 at 1.13 would constitute a Material Reduction in Quality Performance because UHI's performance on this measure in 2027 was more than 20% above UHI's baseline performance.

        - For example, if UHI's mean for READM-30-HOSPWIDE was 1.32 in the baseline year, UHI's mean performance in 2027 at 1.55 would not constitute a Material Reduction in Quality Performance because UHI's performance on this measure in 2027 was less than 20% above UHI's baseline performance.

UHI shall respond to the Department within thirty (30) days of notice from the Department of a potential Material Reduction in Quality Performance for any of the Key Quality Measures together with an explanation for the reduction in quality, including any factors the Department should consider in determining whether the reduction in the Key Quality Measure is material. The Department shall issue a determination within thirty (30) days of UHI's explanation as to whether the reduction in the Key Quality Measure is material. A Material Reduction in Quality Performance in the Key Quality Measures and/or a failure to comply with the process required under this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Quality Commitment #4

UHI will report on specific patient satisfaction measures of the Combined Enterprise against pre-Merger baselines to ensure the Department and the community may monitor the effect of the Merger on patient satisfaction.

- This commitment will ensure that the Department and the community receive regular updates on patient satisfaction associated with the Combined Enterprise to compare that against pre-Merger patient satisfaction at Union Hospital and Regional Hospital (where possible). This level of patient satisfaction reporting is not currently required of any hospital in Indiana and this level of patient satisfaction reporting would not be available to the public absent the Merger. The proposed patient satisfaction measures that UHI must report on are attached as Addendum 2.

- Accountability Mechanism: UHI shall report its performance on patient satisfaction measures of the Combined Enterprise against pre-Merger baselines and on a year-over-year and trend basis for the duration of the COPA Term in its Annual Report. UHI shall report on those patient satisfaction measures designated for quarterly reporting on the "Healthier Together" transparency website that will be available to the public. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Quality Commitment #5

The Combined Enterprise will establish a Quality Committee responsible for overseeing the integration of THRH and RHP-affiliated providers into the Combined Enterprise, ensuring quality and safety best practices for the Combined Enterprise, and reviewing quality and credentialing across the Combined Enterprise.

- This commitment will ensure a committee exists to monitor the Combined Enterprise's performance on the healthcare quality and patient satisfaction measures, including those measures required by the Terms and Conditions, and make recommendations to the Board of Directors to promote ongoing improvement. Through regular meetings, the Committee will identify potential integration issues early and ensure a smooth transition. Once integrated, the Quality Committee will work to establish quality and safety best practices that will be implemented across the Combined Enterprise.

- Accountability Mechanism:

    - The Quality Committee will consist of physicians, executives, and members of the UHI Board of Directors. The Quality Committee shall include the Chief Medical Officer of the Combined Enterprise, additional physician representation from inpatient and outpatient practices of multiple specialties from both Union Hospital and Regional Hospital, and independent and employed physician representatives. At the request of a member of the Board of Directors serving on the Quality Committee, UHI shall make available remote participation options for Quality Committee meetings.

    - UHI shall include in its Annual Report a statement attesting to compliance and providing reasonable detail, including a listing of Quality Committee members with their practice

group and affiliation, the dates on which the Quality Committee convened, a description of the Quality Committee's initiatives, a summary of the Quality Committee's efforts to implement and improve quality and safety best practices across the Combined Enterprise, copies of all reports provided to the UHI Board of Directors and a summary of the steps taken by the Board of Directors or at the Board of Director's direction to implement the Quality Committee's recommendations. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

B. PRICING COMMITMENTS

In order to monitor the Merger's impact on pricing and to limit the Combined Enterprise's ability to increase the price to Payors of health care services provided by the Combined Enterprise, the Combined Enterprise shall fulfill the Pricing Commitments set forth below. Capitalized terms used herein but not otherwise defined shall have the meanings ascribed to such terms in Addendum 3.

Pricing Commitment #1

UHI Charges established in the UHI Chargemaster and Professional Charges established in the Professional Chargemaster that were in effect as of the Determination Date, may be adjusted at the discretion of UHI, provided that the percentage increase to the UHI Chargemaster and the Professional Chargemaster in any Fiscal Year shall not exceed the Annual Increase in CPI Medical for such Fiscal Year.

- This commitment will ensure that UHI complies with the pricing limitations set forth in Ind. Code § 16-21-15-7(c) and further enhance the public benefit by limiting increases in Charges by the other members of the Combined Enterprise. The permitted increase shall be calculated by determining the percentage change (a) in the annual average of the monthly Consumer Price Index for Medical Care as published by the federal Bureau of Labor Statistics ("CPI Medical") for the immediately preceding Fiscal Year (the "Preceding Year") compared to (b) the annual average of the monthly CPI Medical for the year prior to the immediately preceding Fiscal Year ("Baseline Year"). If such percentage change is negative, the Annual Change in CPI Medical shall be deemed to be zero percent (0%), but future Annual Changes in CPI Medical shall be calculated by determining the percentage change (x) in the annual average of the monthly CPI Medical for the Preceding Year compared to (y) the annual average of the monthly CPI Medical for the Baseline Year in which the percentage change was negative, until the Fiscal Year after the calculation results in a percentage increase.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance and the other information required by Addendum 3. The Department may request the information reasonably necessary to verify the attestation. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred. In addition to the actions set forth in the Terms and Conditions, if a Payor complains that any member of the Combined Enterprise has violated this commitment, the Department may investigate the complaint under the Terms and Conditions and require remedial action if appropriate.

Pricing Commitment #2

The Combined Enterprise will limit price increases in compliance with the "Pricing Limitations" attached hereto as Addendum 3.

- This commitment will help mitigate the risk of significant health care cost increases by limiting the rates that the Combined Enterprise may negotiate with Payors post-Merger or that Payors are required to pay any member of the Combined Enterprise.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance and the other information required by Addendum 3. The Department may request the information reasonably necessary to verify the attestation. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred. In addition to the actions set forth in the Terms and Conditions, if a Payor complains that any member of the Combined Enterprise has violated this commitment, the Department may investigate the complaint under the Terms and Conditions and require remedial action if appropriate.

Pricing Commitment #3

UHI will implement the UHI Chargemaster and Professional Chargemaster for all services provided across the Combined Enterprise immediately upon the Issue Date.

- Regional Hospital's charges are higher than Union Hospital's charges. This commitment will result in an immediate reduction in the charges for services provided to the community.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance, including reasonable detail concerning the implementation of the applicable chargemaster. The Department may request the information reasonably necessary to verify the attestation. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred. In addition to the actions set forth in the Terms and Conditions, if a Payor complains that any member of the Combined Enterprise has violated this commitment, the Department may investigate the complaint under the Terms and Conditions and require remedial action if appropriate.

Pricing Commitment #4

The Combined Enterprise shall negotiate in good faith with all Payors to include the Combined Enterprise in the health plans offered in the Service Area and comply with the competitive contracting provisions set forth in Ind. Code § 27-1-37-8 (as in effect on July 1, 2025).

- This commitment will help mitigate the risk that the COPA could have an adverse impact on the ability of Payors to negotiate with the Combined Enterprise post-Merger.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance. The Department may request the information reasonably necessary to verify the

attestation. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred. In addition to the actions set forth in the Terms and Conditions, if a Payor complains that any member of the Combined Enterprise has violated this commitment, the Department may investigate the complaint under the Terms and Conditions and require remedial action if appropriate.

Pricing Commitment #5

The Combined Enterprise shall negotiate in good faith with all potential new Payor entrants to the market and Payors that have small market shares. Union Hospital will not unreasonably refuse to negotiate and accept reasonable terms and rates offered by potential new Payor entrants to the market or Payors that have small market shares.

- This commitment will help mitigate the risk that the Combined Enterprise could discriminate against new Payor entrants or managed care plans with small market shares post-Merger.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance. The Department may request the information reasonably necessary to verify the attestation. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred. In addition to the actions set forth in the Terms and Conditions, if a Payor complains that any member of the Combined Enterprise has violated this commitment, the Department may investigate the complaint under the Terms and Conditions and require remedial action if appropriate.

Pricing Commitment #6

The Combined Enterprise shall work in good faith to include in Payor Contracts reasonable provisions for improved quality and other value-based incentives based upon priorities as mutually agreed upon with each Payor.

- This commitment will help mitigate the risk that prices could increase post-Merger by requiring the Combined Enterprise to pursue value-based payment models for the Combined Enterprise that incentivize higher-quality and lower-cost care.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance. The Department may request the information reasonably necessary to verify the attestation. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred. In addition to the actions set forth in the Terms and Conditions, if a Payor complains that any member of the Combined Enterprise has violated this commitment, the Department may investigate the complaint under the Terms and Conditions and require remedial action if appropriate.

Pricing Commitment #7

The Combined Enterprise shall honor all Payor Contract terms and not unilaterally terminate without cause any such contract prior to its stated expiration date.

- This commitment will help mitigate the risk that prices could increase post-Merger by requiring the Combined Enterprise to honor those contracts for the Combined Enterprise negotiated with Payors pre-Merger and post-Merger.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance. The Department may request the information reasonably necessary to verify the attestation. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred. In addition to the actions set forth in the Terms and Conditions, if a Payor complains that any member of the Combined Enterprise has violated this commitment, the Department may investigate the complaint under the Terms and Conditions and require remedial action if appropriate.

Pricing Commitment #8

The Combined Enterprise 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, or other terms that require the Combined Enterprise to assume risk.

- This commitment will help mitigate the risk that prices could increase post-Merger by requiring the Combined Enterprise to work towards risk-based arrangements for the Combined Enterprise that shift some of the economic risk from Payors to health care providers.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance. The Department may request the information reasonably necessary to verify the attestation. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred. In addition to the actions set forth in the Terms and Conditions, if a Payor complains that any member of the Combined Enterprise has violated this commitment, the Department may investigate the complaint under the Terms and Conditions and require remedial action if appropriate.

Pricing Commitment #9

The Combined Enterprise shall not bargain or insist on "most favored nations" or similar clauses in Payor Contracts.

- This commitment will help mitigate the risk that prices could increase post-Merger by prohibiting the Combined Enterprise from bargaining for or insisting on "most favored nations" or similar clauses in Payor Contracts.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance. The Department may request the information reasonably necessary to verify the

attestation. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred. In addition to the actions set forth in the Terms and Conditions, if a Payor complains that any member of the Combined Enterprise has violated this commitment, the Department may investigate the complaint under the Terms and Conditions and require remedial action if appropriate.

Pricing Commitment #10

The Combined Enterprise shall provide all Payors with a written notice of all Pricing Commitments and Addendum 3 in its entirety and shall negotiate with Payors in good faith.

- This commitment will help mitigate the risk that prices could increase post-Merger by requiring the Combined Enterprise to notify all Payors of the Pricing Commitments and related obligations and negotiate with all Payors in good faith.

- Accountability Mechanism:

    - Upon initiation of negotiations by the Combined Enterprise with a Payor, UHI shall provide the Payor with a notice in a form approved by the Department, which provides background on the COPA and lists the specific commitments that relate to Payor negotiations. The notice will state that if the Payor believes the Combined Enterprise has not met any of the Pricing Commitments, then the Payor should contact the Department. The relevant Department representative's contact information shall be included in the notice.

    - UHI shall include in each Annual Report a statement attesting to compliance. The Department may request the information reasonably necessary to verify the attestation.

    - Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred. In addition to the actions set forth in the Terms and Conditions, if a Payor complains that any member of the Combined Enterprise has violated this commitment, the Department may investigate the complaint under the Terms and Conditions and require remedial action if appropriate.

C. PRESERVATION OF ACCESS COMMITMENTS

In order to ensure the Merger does not have a negative impact on access to health care services, the Combined Enterprise shall fulfill the Preservation of Access Commitments set forth below.

Preservation of Access Commitment #1

The Combined Enterprise will maintain inpatient acute care facilities at both Union Hospital and Regional Hospital and maintain inpatient acute care facility access to at least pre-Merger levels in totality during the COPA Term.

- This commitment will ensure that patients in the Service Area have continued access to inpatient acute care facilities at two convenient locations.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance and providing reasonable detail, including pre-Merger and post-Merger and year-over-year and trend basis inpatient acute care utilization data for the duration of the COPA Term, bed count for the Combined Enterprise and such other information as will enable the Department to determine compliance and whether access has decreased from the pre-Merger baseline. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Preservation of Access Commitment #2

The Combined Enterprise will maintain Emergency Rooms at both Union Hospital and Regional Hospital and maintain emergency care access to at least pre-Merger levels during the COPA Term.

- This commitment will ensure that patients in the Service Area have continued access to dedicated emergency room facilities at two convenient locations.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance and providing reasonable detail, including pre-Merger and post-Merger and year-over-year and trend basis emergency service line utilization data for the Combined Enterprise for the duration of the COPA Term and such other information as will enable the Department to determine compliance and whether access has decreased from the pre-Merger baseline. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Preservation of Access Commitment #3

The Combined Enterprise will maintain at least a Level III trauma program at Union Hospital and maintain Level III trauma care access to at least pre-Merger levels during the COPA Term.

- This commitment will ensure that patients in the Service Area have continued access to a Level III trauma facility (or higher).

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance and providing reasonable detail, including pre-Merger and post-Merger and year-over-year and trend basis trauma utilization data for the duration of the COPA Term for the Combined Enterprise and such other information as will enable the Department to determine compliance and whether access has decreased from the pre-Merger baseline. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Preservation of Access Commitment #4

The Combined Enterprise will maintain an Intensive Care Unit (ICU) at Union Hospital during the COPA Term and will expand the availability of ICU services by increasing the number of ICU beds from twenty-four to thirty-six within the first three years.

- This commitment will ensure that patients in the Service Area have continued access to an ICU at Union Hospital.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance and providing reasonable detail, including pre-Merger and post-Merger and year-over-year and trend basis ICU utilization data and bed count for the duration of the COPA Term for the Combined Enterprise and such other information as will enable the Department to determine compliance. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Preservation of Access Commitment #5

Within one month of the Merger, the Combined Enterprise will convert the Regional Hospital ICU into an Acuity Adaptable Unit (AAU). Once converted, the Combined Enterprise will maintain the AAU at Regional Hospital for the COPA Term.

- This commitment will ensure that patients in the Service Area have continued access to ICU-level services at Regional Hospital.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance and providing reasonable detail, including year-over-year and trend basis AAU utilization data and bed count for the duration of the COPA Term for Regional Hospital and such other information as will enable the Department to determine compliance. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Preservation of Access Commitment #6

The Combined Enterprise will continue to offer cardiac catheterization services at Union Hospital and Regional Hospital during the COPA Term. If it is determined that the catheterization services currently offered at Regional Hospital should be consolidated to a single location, Union Hospital shall expand access to cardiac catheterization services at Union Hospital as part of the consolidation plan.

- This commitment will ensure that patients in the Service Area have continued access to cardiac catheterization labs at two convenient locations.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance and providing reasonable detail, including pre-Merger and post-Merger and year-over-year and trend basis cardiac catheterization utilization data for the duration of the COPA

Term for the Combined Enterprise and such other information as will enable the Department to determine compliance. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Preservation of Access Commitment #7

The Combined Enterprise shall obtain the approval of the Department at least sixty (60) days in advance of making any material change to a Service Line if the change would adversely impact the health outcomes, health care access, and quality of health care of the Service Area.

- This commitment will ensure that there will be no adverse impacts to the key services provided at Union Hospital and Regional Hospital without the Department's approval. "Service Line" means the following service lines offered at Union Hospital or Regional Hospital: Cardiology, Emergency Medicine, General Surgery, Oncology, Orthopedics, Neurology/Neurosurgery, Obstetrics/Gynecology, Pediatrics, Pulmonology, Trauma, and Urology. UHI's notice to the Department at least sixty (60) days in advance of the intended change must include the reason for the change, how access to care will be maintained or improved, and how the change will affect the quality of care provided. The Department shall respond to a request for approval within thirty (30) days and will base its decision on the overall effect of the Service Line change on the Public Advantage, including the cost, and the effect on access to care and the quality of care provided. UHI may not implement the intended change without the approval of the Department. This requirement does not apply to any changes described in the Commitments as those changes are considered pre-approved by the Department as part of the COPA approval process.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Preservation of Access Commitment #8

Within six months of the Merger, the Combined Enterprise will consolidate Wound Care Services at Union Hospital by adding two additional Wound Care treatment rooms. Once consolidated, the Combined Enterprise will continue to offer Wound Care Services within the Combined Enterprise and maintain Wound Care access to at least pre-Merger levels for the COPA Term.

- This commitment will ensure that patients have continued access to a comprehensive Wound Care program. Consolidating the service at a single location will lead to increased volumes and support the long-term stabilization of the program.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance and providing reasonable detail, including pre-Merger and post-Merger and year-over-year and trend basis Wound Care service utilization data for the duration of the COPA Term for the Combined Enterprise and such other information as will enable the Department to determine compliance and whether access has decreased from the pre-Merger baseline. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and

Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Preservation of Access Commitment #9

The Combined Enterprise will maintain chemotherapy infusion services at Union Hospital and maintain chemotherapy infusion access to at least pre-Merger levels during the COPA Term. If it is determined that the chemotherapy infusion services currently offered at Regional Hospital should be consolidated to a single location, Union Hospital shall expand access to chemotherapy services at Union Hospital as part of the consolidation plan in order to maintain chemotherapy infusion access to at least pre-Merger levels during the COPA Term.

- This commitment will ensure that patients in the Service Area have continued access to chemotherapy infusion services in the community.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance and providing reasonable detail, including pre-Merger and post-Merger and year-over-year and trend basis chemotherapy infusion service utilization data for the duration of the COPA Term for the Combined Enterprise and such other information as will enable the Department to determine compliance to determine if and whether access has decreased from the pre-Merger baseline. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Preservation of Access Commitment #10

Within six months of the Merger, the Mother-Baby/NICU/Pediatric Units at Union Hospital and Regional Hospital will be consolidated at Union Hospital so that all expectant mothers seeking care at Union Hospital will have access to Level III maternal and neonatal care. Once consolidated, UHI will continue to offer Level III maternal and neonatal care within the Combined Enterprise and maintain Level III maternal and neonatal care and pediatric service access to at least pre-Merger levels for the COPA Term.

- This commitment will ensure that patients in the Service Area have continued access to Level III maternal and neonatal care.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance and providing reasonable detail, including pre-Merger and post-Merger and year-over-year and trend basis maternity, neonatal care, and pediatric service utilization data for the duration of the COPA Term for the Combined Enterprise and such other information as will enable the Department to determine compliance and whether access has decreased from the pre-Merger baseline. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Preservation of Access Commitment #11

UHI will report emergency and service line diversion data on a quarterly basis to ensure emergency care access is maintained to at least pre-Merger levels of the Combined Enterprise for the COPA Term.

- This commitment will ensure that patients in the Service Area have continued access to emergency care services, particularly Medicaid and self-pay patients at the pre-Merger levels.

- Accountability Mechanism: UHI shall report to the Department emergency department and other service line diversion hours on a quarterly basis in accordance with the quarterly quality measure reporting schedule. If the Department determines diversion practices are resulting in decreased access to emergency care, the Department may require the Combined Enterprise to develop and implement an improvement plan to decrease diversion hours. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

D. ENHANCEMENT COMMITMENTS

In order to ensure that benefits of the Merger outweigh the potential disadvantages, the Combined Enterprise shall fulfill the Enhancement Commitments set forth below. These facility enhancements and service enhancements would not be implemented without the Merger.

Enhancement Commitment #1

The Combined Enterprise will invest at least $30,000,000 in the facilities at Regional Hospital over five years. At least $15,000,000 of this investment will be obligated in the first three years of the COPA Term.

- This commitment will ensure that UHI makes adequate capital investments to maintain the Regional Hospital facilities and equipment.

- Accountability Mechanism:

    - UHI shall include in each Annual Report an update on its progress towards meeting this commitment with a detailed accounting of all investments made in the prior Fiscal Year with a description of each investment, the dollar amount associated with each investment, the necessity and benefit of the investment, the service lines impacted, and an explanation of how the investment will improve the population's health outcomes, health care access, and quality of care.

    - At any time, the Department has the authority to request additional information on investments, past or present. Any request shall be reasonable and in writing. UHI shall provide the requested information to the Department within thirty (30) days. Failure to comply with this commitment by the end of year five may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Enhancement Commitment #2

The Combined Enterprise will invest at least $75,000,000 in Union Hospital over five years. At least $37,500,000 of this investment will be obligated in the first three years of the COPA Term.

- This commitment will ensure that UHI makes adequate capital investments to maintain Union Hospital's facilities and equipment.

- Accountability Mechanism:

    - UHI shall include in each Annual Report an update on its progress towards meeting this commitment, with a detailed accounting of all investments made in the prior year with a description of each investment, the dollar amount associated with each investment, the necessity and benefit of the investment, the service lines impacted, and an explanation of how the investment will improve the population's health outcomes, health care access, and quality of care.

    - At any time, the Department has the authority to request additional information on investments, past or present. Any request shall be reasonable and in writing. UHI shall provide the requested information to the Department within thirty (30) days. Failure to comply with this commitment by the end of year five may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Enhancement Commitment #3

The Combined Enterprise will invest at least $5,000,000 to add oncology treatment-related technology for the residents of the Service Area over five years.

- This commitment will ensure that UHI is investing in new technology to enhance the oncology services offered in the Service Area.

- Accountability Mechanism:

    - UHI shall include in each Annual Report an update on its progress towards meeting this commitment, with a detailed accounting of all investments made in the prior year with a description of each investment, the dollar amount associated with each investment, the necessity and benefit of the investment, the location(s) of the investment, and utilization data including number of patients and services provided using the oncology treatment-related technology.

    - At any time, the Department has the authority to request additional information on investments, past or present. Any request shall be reasonable and in writing. UHI shall provide the requested information to the Department within thirty (30) days. Failure to comply with this commitment by the end of year three may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Enhancement Commitment #4

The Combined Enterprise will recruit additional Primary Care Physicians and Advance Practice Providers (APPs) during the COPA Term to the Service Area and work in good faith to add at least fifteen new primary care providers in the first five years.

- This commitment will ensure that UHI or its Affiliates is expanding access to Primary Care Physicians and APPs to the Service Area, specifically those practicing in Family Medicine, Internal Medicine, Pediatric Medicine, and Obstetrics/Gynecology. This commitment is independent of and in addition to the hiring of THRH and RHP employees and the replacement of retiring, terminated, or exiting employees of the Combined Enterprise.

- Accountability Mechanism: UHI shall include in each Annual Report its progress towards meeting this commitment, including: the number of physicians and APPs recruited and their practice areas, the sources and methods of recruitment, the number of offers extended made, the number of new physicians and APPs retained and their practice areas, the employment location of each retained physician and APP, the funding spent on recruitment efforts, a description of any challenges or unique circumstances in recruitment in the prior Fiscal Year and plans to address. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Enhancement Commitment #5

The Combined Enterprise will recruit additional Specialty Physicians to improve the availability of specialty care in the Service Area and work in good faith to add at least twenty-one new Specialty Physicians in the first five years.

- This commitment will ensure that UHI or its Affiliates is expanding access to Specialty Physicians in the Service Area. UHI expects to recruit physicians in a variety of specialties, including Orthopedics, Oncology, Neuroscience, Urology, Surgery, Pulmonology/Critical Care, and Cardiovascular Care. This commitment is independent of and in addition to the hiring of THRH and RHP employees and the replacement of retiring, terminated, or exiting employees of the Combined Enterprise.

- Accountability Mechanism: UHI shall include in each Annual Report its progress towards meeting this commitment, including: the number of physicians recruited and their practice areas, the sources and methods of recruitment, the number of offers extended made, the number of new physicians retained and their practice areas, the employment location of each retained physician, the funding spent on recruitment efforts, a description of any challenges or unique circumstances in recruitment in the prior Fiscal Year and plans to address. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Enhancement Commitment #6

The Combined Enterprise will recruit additional pharmacists during the COPA Term and work in good faith to add at least three new pharmacists in the first five years.

- This commitment will ensure that Union Hospital is expanding the number of pharmacists available to the Combined Enterprise. This commitment is independent of and in addition to the hiring of Regional Hospital and Regional Healthcare Partners employees and the replacement of retiring, terminated, or exiting employees of the Combined Enterprise.

- Accountability Mechanism: UHI shall include in each Annual Report its progress towards meeting this commitment, including: the number of pharmacists recruited and their practice areas, the sources and methods of recruitment, the number of offers extended made, the number of new pharmacists retained and their practice areas, the employment location of each retained pharmacist, the funding spent on recruitment efforts, a description of any challenges or unique circumstances in recruitment in the prior year and plans to address. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Enhancement Commitment #7

The Combined Enterprise will increase the number of behavioral health inpatient beds during the COPA Term with a total of at least 20 beds added to the Service Area in the first five years.

- This commitment will ensure that UHI is expanding access to inpatient behavioral health services for residents of the Service Area.

- Accountability Mechanism: UHI shall include in each Annual Report an update on its progress towards meeting this commitment, including pre-Merger and post-Merger and year-over-year and trend basis inpatient behavioral health bed count and the number of patients served each year across the Combined Enterprise for the duration of the COPA Term. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Enhancement Commitment #8

Within the first 60 days of the Merger, the Combined Enterprise will expand UHI's after-hours nurse access program to make it available to all patients seeking care within the Combined Enterprise.

- This commitment will ensure that the Combined Enterprise is expanding round-the-clock access to telephone nurse triage services for patients. This service ensures that patients can contact a nurse with medical questions at any time of day and can quickly schedule an appointment with a provider when appropriate.

- Accountability Mechanism: UHI shall include in each Annual Report its progress towards meeting this commitment. Once implemented, UHI shall report on the number of patients who utilize the

after-hours nurse access program each year compared to the pre-Merger (baseline) level and on a year-over-year and trend basis for the duration of the COPA Term. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Enhancement Commitment #9

The Combined Enterprise will increase the number of Well Child Checks provided for patients 0-17 years of age across the Combined Enterprise during the COPA Term.

- This commitment will ensure that the Combined Enterprise is expanding Well Child Checks which assess ongoing growth and development and allow for early identification and intervention of developmental delays. Well Child Checks also provide opportunities for administration of age-appropriate vaccines to reduce preventable disease, thus improving patient outcomes and decreasing health care costs. The goal for the percentage of patients receiving Well Child Checks will be provided after a full year of combined baseline data is available.

- Accountability Mechanism: UHI will report on the number of Well Child Checks across the Combined Enterprise in each Annual Report, along with a comparison to the number of pre-Merger (baseline) visits and on a year-over-year and trend basis for the duration of the COPA Term. UHI will additionally report any other meaningful progress towards the established percentage goal, including a description of steps taken to achieve the increase in visits. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Enhancement Commitment #10

The Combined Enterprise will increase the number of Preventive Well Patient Visits provided for patients 18-39 years of age across the Combined Enterprise during the COPA Term.

- This commitment will ensure that the Combined Enterprise is expanding Preventive Well Patient Visits, which offer several key benefits for seemingly healthy young adults. These visits provide an opportunity to screen for medical issues, assess future risk, encourage a healthy lifestyle, update vaccinations, and build a trusting relationship with a health care provider. Preventive Well Patient Visits can also identify conditions such as high blood pressure, high blood sugar, and high cholesterol, which may not have symptoms in early stages, and help manage existing medical conditions using the latest evidence-based advice.

- Accountability Mechanism: UHI will report on the number of Preventive Well Patient Visits across the Combined Enterprise in each Annual Report, along with a comparison to the number of pre-Merger (baseline) visits and on a year-over-year and trend basis for the duration of the COPA Term. UHI will additionally report any other meaningful progress towards the established percentage goal, including a description of steps taken to achieve the increase in visits. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Enhancement Commitment #11

The Combined Enterprise will increase the number of Preventive Well Patient Visits provided for patients 40-64 years of age across the Combined Enterprise during the COPA Term.

- This commitment will ensure that the Combined Enterprise is expanding Preventive Well Patient Visits, which are designed to screen for medical issues through tools such as mammograms and colonoscopies. These visits help detect malignancies at a younger age and/or earlier stage of disease progression and provide an opportunity to screen for medical issues, assess future risk, encourage a healthy lifestyle, update vaccinations, and build a trusting relationship with a health care provider. Preventive Well Patient Visits can also identify conditions such as high blood pressure, high blood sugar, and high cholesterol, which may not have symptoms in early stages, and help manage existing medical conditions using the latest evidence-based advice.

- Accountability Mechanism: UHI will report on the number of Preventive Well Patient Visits across the Combined Enterprise in each Annual Report, along with a comparison to the number of pre-Merger (baseline) visits and on a year-over-year and trend basis for the duration of the COPA Term. UHI will additionally report any other meaningful progress towards the established percentage goal, including a description of steps taken to achieve the increase in visits. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Enhancement Commitment #12

The Combined Enterprise will increase the number of Medicare Annual Wellness Visits during the COPA Term with a goal of having seventy percent (70%) or more of attributed patients of the Combined Enterprise receiving a Medicare Annual Wellness Visit each year by the end of the COPA Term.

- This commitment will ensure the Combined Enterprise is expanding Medicare Annual Wellness Visits that are designed to help health care providers enhance patient activation and engagement, identify health risks such as depression and falls, and connect beneficiaries to behavioral counseling, such as nutrition counseling and smoking cessation, and preventive care services, including vaccinations and cancer screenings. These visits are intended to prevent disease and disability, improve quality of life and reduce health care expenditures for Medicare and Medicare beneficiaries.

- Accountability Mechanism: UHI will report on the number of Medicare Annual Wellness Visits across the Combined Enterprise in each Annual Report, along with a comparison to the number of pre-Merger (baseline) visits and on a year-over-year and trend basis for the duration of the COPA Term. UHI will additionally report any other meaningful progress towards the established percentage goal, including a description of steps taken to achieve the increase in visits. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Enhancement Commitment #13

The Combined Enterprise will increase the Transitional Care Management services offered during the COPA Term with a goal of having ninety percent (90%) or more of eligible attributed patients of the Combined Enterprise offered Transitional Care Management services each year by the end of the COPA Term.

- This commitment will ensure that the Combined Enterprise is expanding Transitional Care Management services that are designed to help patients transition back to a community setting after a stay at an inpatient facility. These services are intended to improve care coordination and reduce preventable readmissions, medical errors, and mortality during the 30 days following discharge from the acute care setting and intended to reduce health care expenditures for Medicare and Medicare beneficiaries.

- Accountability Mechanism: UHI will report on the number and types of Transitional Care Management services offered and provided across the Combined Enterprise in each Annual Report, along with a comparison to the number of pre-Merger (baseline) visits and on a year-over-year and trend basis for the duration of the COPA Term. UHI will additionally report any other meaningful progress towards the established percentage goal, including a description of steps taken to achieve the increase in visits. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

E. EMPLOYMENT AND ECONOMIC IMPACT COMMITMENTS

In order to mitigate any negative impacts on the affected workforce and to evaluate the impact of the Merger on the economy, the Combined Enterprise shall fulfill the Employment and Economic Impact Commitments set forth below.

Employment and Economic Impact Commitment #1

The Combined Enterprise will offer employment to all employees who are employed by THRH and RHP at the time of the Merger.

- This commitment is designed to protect the THRH and RHP assembled workforces by ensuring they are offered employment by the Combined Enterprise. These offers of employment cannot be revoked for at least sixty (60) days after the Issue Date, and Union must remain available to answer questions or concerns of THRH and RHP employees who receive an offer.

- Accountability Mechanism: UHI shall include a statement in the first Annual Report attesting to compliance, including the number of THRH and RHP employees offered employment at the time of the Merger and the acceptance rate of offers extended and a comparison of the offered terms and conditions related to this Commitment to previous employment terms and conditions of THRH and RHP employees. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Employment and Economic Impact Commitment #2

The Combined Enterprise will offer employment to THRH and RHP employees at salary and hourly wage levels that are the same as, or better than, THRH and RHP levels.

- This commitment is designed to protect the THRH and RHP assembled workforces by ensuring that they are offered compensation at Union Hospital or an Affiliate that is the same as, or better than, the compensation offered at THRH and RHP.

- Accountability Mechanism: UHI shall include a statement in the first Annual Report attesting to compliance and providing reasonable detail, including average salary and wage data pre-Merger and post-Merger by position, a comparison of offered salary and wage levels post-Merger to previous salary and wage levels of THRH and RHP employees pre-Merger. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Employment and Economic Impact Commitment #3

The Combined Enterprise will honor full credit for paid time off balances accrued as of the Issue Date of THRH and RHP employees who transition to employment by UHI or an Affiliate.

- This commitment is designed to protect the THRH and RHP assembled workforces by ensuring that they are given credit for paid time off when they transition employment to UHI or an Affiliate.

- Accountability Mechanism: UHI shall include a statement in the first Annual Report attesting to compliance, produce relevant employee handbooks or policies that demonstrate compliance and a report of paid time off balances of employees pre-Merger evidencing compliance with the commitment. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Employment and Economic Impact Commitment #4

The Combined Enterprise will conduct annual employee and physician satisfaction surveys to help reduce turnover and improve retention of employees of the Combined Enterprise and will report the results in each Annual Report and on its "Healthier Together" transparency website.

- This commitment will ensure that the Combined Enterprise is monitoring employee and physician satisfaction post-Merger and sharing this information with the Department.

- Accountability Mechanism: As part of each Annual Report, UHI will report on the results of the most recently conducted employee and physician satisfaction surveys, data on retention rates for the Combined Enterprise employees in each Annual Report, including a comparison to pre-Merger (baseline) and year-over-year and trend basis retention rates for the duration of the COPA Term and any steps taken that year to address concerns raised in the surveys. UHI will also post the survey results on its "Healthier Together" transparency website. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The

Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Employment and Economic Impact Commitment #5

UHI shall cooperate and work with the Department and a nonprofit organization or a postsecondary educational institution that is jointly selected by the Department and UHI to conduct an independent research study of the economic impact of the COPA. UHI and the nonprofit organization or postsecondary educational institution will identify the funding sources for the study.

- This commitment will allow the Department and the community to better understand the economic impact of the COPA over time.

- Accountability Mechanism: UHI will cooperate with the nonprofit organization or postsecondary educational institution that is conducting the study to provide the data reasonably necessary to facilitate the study. The Department will obtain annual reports from the nonprofit organization or postsecondary educational institution selected to conduct the independent research study and direct UHI to make these annual reports and the finalized report available on the "Healthier Together" transparency website. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Employment and Economic Impact Commitment #6

UHI shall create and implement a plan to annually redress any economic concerns or negative impacts identified in the research study conducted under Employment and Economic Impact Commitment #5.

- Within ninety (90) days of completion of the research study conducted under Employment and Economic Impact Commitment #5, UHI shall provide the Department with a detailed plan to redress any economic concerns or negative impacts identified in the study. The Department shall respond to the submission of the plan within thirty (30) days and may direct additional reasonable steps or remedial measures be included based on concerns identified in the study.

- Accountability Mechanism: Any plan required under this commitment will be made available on the "Healthier Together" transparency website following acceptance by the Department. As part of each Annual Report, UHI will report on the status of and any updates to the plan and such other information as will reasonably enable the Department to determine compliance. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Employment and Economic Impact Commitment #7

The Combined Enterprise shall notify the Department at least sixty (60) days in advance of making a material reduction in employment or staffing.

- If the Combined Enterprise desires to commence a material reduction in employment or staffing, the Combined Enterprise shall be required to notify the Department at least sixty (60) days before taking such action. A material reduction is defined as a reduction of ten (10) or more Combined Enterprise employees, or fifty percent (50%) or more of any practice group or department, whether in a single act or a series of related acts, in any ninety (90) day period during the COPA Term. UHI's notice to the Department shall include the reason for the reduction, how access to care and quality of care will be maintained, the number of employees impacted, each employee's position, years of service, and a description of outplacement support to be provided to the employee.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

F. POPULATION HEALTH COMMITMENTS

In order to monitor progress around the population health improvement initiatives the Combined Enterprise is implementing as a result of the Merger, the Combined Enterprise shall fulfill the Population Health Commitments set forth below.

Population Health Commitment #1

Within the first twelve months, the Combined Enterprise will expand UHI's Health Equity Plan to cover all patients receiving care from the Combined Enterprise.

- UHI's Health Equity Plan is designed to eliminate health disparities and provide equitable care throughout the organization and the Service Area. Without the Merger, the plan would only cover the residents of the Service Area who receive care from Union Hospital. The expansion of the Health Equity Plan is expected to improve the health of the community and reduce the cost of care.

- Accountability Mechanism: UHI shall report in reasonable detail on implementation progress of the Health Equity Plan in each Annual Report and provide such information as will enable the Department to determine compliance. Failure to comply with this commitment within twelve months may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Population Health Commitment #2

Within the first twelve months, the Combined Enterprise will expand UHI's Population Health Improvement Plan to cover all patients receiving care from the Combined Enterprise.

- UHI's Population Health Improvement Plan consists of eight initiatives which are designed to address certain "social determinants of health" including factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care. Without the Merger, the plan would only cover the residents of the Service Area who receive care from Union Hospital. The expansion of the Population Health Improvement Plan is expected to improve the health of the community and reduce the cost of care.

- Accountability Mechanism: UHI shall report in reasonable detail on implementation progress of the Population Health Improvement Plan in each Annual Report and provide such information as will enable the Department to determine compliance. Failure to comply with this commitment within twelve months may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Population Health Commitment #3

The Combined Enterprise will provide at least twelve "pop-up clinics" each year to provide health care services to the homeless community in the Service Area.

- "Pop Up Clinics," which are conducted by a team of physicians, therapists, pharmacists, and other health professionals working together, provide screenings, education, access to free medications and wrap-around support services (e.g., food distribution sites, shelters, and low-income housing) to individuals who are experiencing homelessness. These clinics help promote health care equality by enabling health care to be within everyone's reach.

- Accountability Mechanism: UHI shall include in each Annual Report a detailed listing of each Pop-Up clinic conducted, including the date, location, duration, number of patients served, a summary of services provided, the number of employees and non-employees that provided services at the clinic, and the resources used to conduct the clinic. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Population Health Commitment #4

Within the first twelve months of the Merger, the Combined Enterprise will establish a new food access point of the Combined Enterprise to help address food insecurity.

- Food insecurity is closely associated with higher use of emergency department visits, inpatient admissions, and high health care costs. Helping individuals move out of a food insecurity crisis can have a significant impact on their ability to focus on their overall health.

- Accountability Mechanism: UHI shall include in each Annual Report information on the food access point, including the location, dates and hours of operation, number of individuals and families served, a description of services provided, the number of employees and non-employees that provided services, and the resources used to operate the food access point. Failure to comply with this commitment within twelve months may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Population Health Commitment #5

UHI shall cooperate and work with the Department and a nonprofit organization or a postsecondary educational institution which is jointly selected by the Department and UHI to provide information and data required by the organization or institution to conduct an independent research study of the impacts of the COPA on the community's health metrics and outcomes as described in Ind. Code § 16-21-15-4.5. UHI and the nonprofit organization or postsecondary educational institution will identify the funding sources for the study.

- The commitment will allow the Department and the community to better understand the impact of the population health improvement efforts that are implemented as a result of the Merger.

- Accountability Mechanism: UHI will make relevant data available to the nonprofit organization or postsecondary educational institution that is conducting the study. The Department will obtain annual reports from the nonprofit organization or postsecondary educational institution selected to conduct the independent research study and direct UHI to make these annual reports and the finalized report available on the "Healthier Together" transparency website. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Population Health Commitment #6

UHI shall create and implement a plan to redress any community health concerns or negative impacts identified in the research study conducted under Population Health Commitment #5.

- Within ninety (90) days of completion of the research study conducted under Population Health Commitment #5, UHI shall provide the Department with a detailed plan to redress any community health concerns or negative impacts identified in the study. The Department shall respond to the submission of the plan within thirty (30) days and may direct additional reasonable steps or remedial measures be included based on concerns identified in the study.

- Accountability Mechanism: Any plan required under this commitment will be made available on the "Healthier Together" transparency website following acceptance by the Department. As part of each Annual Report, UHI will report on the status of and any updates to the plan and such other information as will enable the Department to reasonably determine compliance. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Population Health Commitment #7

UHI will establish an Accountable Health Community to bring multiple stakeholders together to improve the health and well-being of the Wabash Valley by addressing social determinants of health.

- The Accountable Health Community members will (1) identify specific areas of need within the Service Area, (2) collaborate to provide seamless and integrated care to individuals and families, (3) encourage alignment between clinical and community services to be more responsive to the needs of the Service Area, (4) share data, as allowable, to identify the greatest areas of need and track progress, and (5) advocate for policy changes at the local and state level to support community health. The mission and vision of the Accountable Health Community will be developed by soliciting input from potential partners on the initiatives in the Population Health Plan to target specific health needs of the Service Area.

  UHI will provide necessary funding to sustain the infrastructure of the Accountable Health Community, which may include providing financial investments to Accountable Health Community partners with clear, contractual expectations for such funding.

- Accountability Mechanism: UHI shall include in each Annual Report an update on its progress towards meeting the commitment and report on progress towards meeting the population health goal. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Population Health Commitment #8

UHI will work with its community partners in the Accountable Health Community to reduce the high rates of tobacco and vaping use during pregnancy in the Service Area.

- This commitment will address the Service Area's high rates of tobacco and vaping use during Pregnancy. Today, five of the six counties Union Hospital and Regional Hospital serve report rates of tobacco and vaping use during pregnancy above the State average.

- The Combined Enterprise shall (1) implement a health-related social needs screening tool to identify patients who are pregnant and using tobacco and/or vaping, (2) develop processes to connect patients to tobacco dependence treatment programs in the community and/or clinical navigators, (3) implement quality improvement processes to enable integration of tobacco dependence treatment best practices into routine prenatal care, and (4) demonstrate meaningful use of the Combined Clinical IT platform to address tobacco dependence in pregnant patients. The Combined Enterprise will collaborate with the Accountable Health Community to accomplish these objectives.

- Accountability Mechanism: Union Hospital shall include in each Annual Report an update on its progress towards meeting the commitment and report on progress towards meeting the population health goal. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Population Health Commitment #9

UHI will work with its community partners in the Accountable Health Community to reduce the high rates of infant mortality in the Service Area.

- This commitment will address the Service Area's high rates of infant mortality. Today, all six counties Union Hospital and Regional Hospital serve report rates of infant mortality above the State average.

- The Combined Enterprise shall (1) expand Union Hospital's "Confirmation of Pregnancy" clinic model throughout the Service Area to help identify women early in their pregnancies and connect them to resources, (2) implement a health-related social needs screening tool to identify pregnant women experiencing homelessness, food insecurity, or other basic social needs that can be addressed by community partners, (3) develop processes to connect those patients identified to resources of community partners, and (4) implement community-wide campaigns across the clinical setting and community setting to encourage safe sleep arrangements. The Combined Enterprise will collaborate with the Accountable Health Community to accomplish these objectives.

- Accountability Mechanism: Union Hospital shall include in each Annual Report an update on its progress towards meeting the commitment and report on progress towards meeting the population health goal. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Population Health Commitment #10

UHI will work with its community partners in the Accountable Health Community to promote breastfeeding in the Service Area.

- This commitment will address the Service Area's low rates of breastfeeding initiation. Today, five of the six counties Union Hospital and Regional Hospital serve report breastfeeding initiation below the State average.

- The Combined Enterprise shall (1) implement clinical best practices in the hospital setting to encourage breastfeeding, (2) establish a breastfeeding education campaign with community partners to target a mother's primary support network and encourage breastfeeding, (3) establish outpatient clinical lactation services through referral from pediatric primary care providers, and (4) demonstrate meaningful use of the Combined Clinical IT platform to promote and track breastfeeding.

- Accountability Mechanism: UHI shall report in reasonable detail on implementation progress of the breastfeeding commitment in each Annual Report, including a description of the clinical best practices used in the hospital setting to encourage breastfeeding and how those best practices are implemented, a description of activities completed under the education campaign, the number of patients referred and receiving outpatient clinical lactation services, a description of how the Combined Clinical IT platform is used to promote and track breastfeeding, a list of the Accountable Health Community partners involved and a summary of their involvement, and pre-Merger and post-Merger and year-over-year and trend basis county breastfeeding data for the

duration of the COPA Term. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

G. OTHER COMMITMENTS

In addition to the commitments set forth above, the Combined Enterprise shall fulfill the Other Commitments set forth below.

Other Commitment #1
Charity Care / Financial Assistance

The Combined Enterprise will immediately expand the Union Hospital Financial Assistance Policy to apply to all patients seeking care. Once expanded, the Combined Enterprise shall maintain a Financial Assistance Policy during the COPA Term that is at least as generous as the Union Hospital Financial Assistance Policy implemented at the time of the Merger.

- This commitment will ensure that low-income patients who are uninsured will not be adversely impacted by the Merger.

- Accountability Mechanism: UHI shall include in its Annual Report a statement attesting to compliance. Union Hospital shall also report on the number of patients who applied for Financial Assistance Policy each year and the number of patients who were approved. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Other Commitment #2
Reinvestment of Cost Savings

UHI will reinvest into the Service Area the cost savings realized in the first five years of the Merger to help improve the health status of the community.

- This commitment will ensure the cost savings realized in the first five (5) years of the Merger are reinvested in initiatives to help improve the health status of the community consistent with Ind. Code § 16-21-15-7(d).

- Accountability Mechanism: UHI shall include in its Annual Report a statement attesting to compliance and including reasonable detail, including the cost savings realized each year, how those cost savings are being reinvested to help improve the health status of the community and such other information as will reasonably enable the Department to determine compliance. A summary of the realized costs savings and reinvestments shall be made available on the "Healthier Together" transparency website. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Other Commitment #3
Graduate Medical Education

The Combined Enterprise will invest at least an additional $6,900,000 in Graduate Medical Education each year during the first five years of the Merger.

- UHI is committed to helping develop the next generation of health care professionals that are needed to address the long-term health care needs of the Service Area. This commitment is to ensure that UHI continues to invest in and expands its investment in the next generation of health care providers for the Combined Enterprise, specifically physicians practicing in the area of Family Medicine.

- Accountability Mechanism: UHI shall include in each Annual Report an update on its progress towards meeting this commitment, including a report of the amount invested to date, specific uses of the funds, and plans for future investments, the number of physicians who are participating in the graduate medical education program each year (by class) and such other information as will enable the Department to determine compliance. Failure to comply with this commitment by the end of year five may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Other Commitment #4
General Psychiatry Residency Training Program

The Combined Enterprise will pursue a new General Psychiatry Residency Training Program to help address the critical need for psychiatrists in the region and use good faith efforts to add at least two (2) new residents each year of the four-year program.

- This commitment will help address the shortage of psychiatrists in the region and support the expansion of inpatient behavioral health services and is in addition to the additional investments in Other Commitment #3.

- Accountability Mechanism: UHI shall include in each Annual Report an update on its progress towards meeting this commitment and such other information as will enable the Department to determine compliance. Once the program is established, UHI shall also report on the number of physicians who are participating in the residency program each year. Failure to comply with this commitment by the end of year five may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Other Commitment #5
Health Plan Ownership Prohibition

Except for its existing participation in Southeastern Indiana Health Organization Inc., which shall be grandfathered, the Combined Enterprise shall be prohibited from owning, operating, controlling, or licensing any health plan or insurance product.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Other Commitment #6
Regional Hospital Representation on the Union Hospital Board of Directors

Union Hospital will add a representative from Regional Hospital to the UHI Board of Directors within three (3) months of the Issue Date.

- Accountability Mechanism: UHI shall include in each Annual Report a statement attesting to compliance and provide the name and title of the member of the UHI Board of Directors representing Regional Hospital. Failure to comply with this commitment may be deemed a "Noncompliance" under the Terms and Conditions. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred.

Addendum 1
Quality Measures

UHI shall report its performance on all 59 of the quality measures listed in each Annual Report. Performance on each quality measure shall be shown against the pre-Merger baselines and on a year-over-year and trend basis for the duration of the COPA Term. In addition, UHI shall report on those quality measures designated for quarterly reporting on the "Healthier Together" transparency website.

	Measure ID	Measure	Baseline	Data Source	Measure Definition
Quality Measures to Monitor			**2024**		
1	HAI -1	CLABSI	4	EMR	# of patients who developed hospital acquired infection
2	HAI -2	CAUTI	1	EMR	# of patients who developed hospital acquired infection
3	HAI - 3	SSI - Colon	1	EMR	# of patients who developed hospital acquired infection
4	HAI - 4	SSI-Hysterectomy	0	EMR	# of patients who developed hospital acquired infection
5	HAI - 5	MRSA	1	EMR	# of patients who developed hospital acquired infection
6	HAI - 6 *	C-Diff infection	28	EMR	# of patients who developed hospital acquired infection
7	SEP-1 *	Sepsis Bundle	58.1%	EMR	Percent of compliance for 6-hour Sepsis Bundle
8	COMP-HIP-KNEE	Complication Rate following Toal Hip/Knee Arthroplasty	2.54	EMR Premier	Rate of patients who experience a complication after elective TKR/THR
NDNQI Measures			**2024**		
9	Patient Falls *	Falls with any type of injury	50	EMR	# of patients who had a fall related injury
10	Pressure Ulcer Prevalence	Pressure Injuries (HAPI) , any level	112	EMR	# of patients who developed pressure ulcer
Emergency Metrics			**2024**		
11	OP-18b*	Median Time ED Arrival to ED Discharge Minutes	183	EMR	Time in ED for discharged patients
12	OP-22	ED Left Without Being Seen	0.77%	EMR	Percent of Registered ED patients
Patient Safety Indicators			**2024**		
13	PSI 03	Pressure Ulcer Stage 3/4	0.35	EMR, Premier	Rate per 1000 using Premier benchmark
14	PSI 06	Iatrogenic Pneumothorax	0.24	EMR, Premier	Rate per 1000 using Premier benchmark

* Designated for quarterly reporting.

	Measure ID	Measure	Baseline	Data Source	Measure Definition
15	PSI 08	In hospital fall with hip fracture- new for	Pending	EMR, Premier	Rate per 1000 using Premier benchmark
16	PSI 09	Perioperative Hemorrhage or Hematoma	1.58	EMR, Premier	Rate per 1000 using Premier benchmark
17	PSI 10	10 Post-Op Acute Kidney Injury requiring Dialysis	7.30	EMR, Premier	Rate per 1000 using Premier benchmark
18	PSI 11	Post-Op Respiratory Failure	14.62	EMR, Premier	Rate per 1000 using Premier benchmark
19	PSI 12	Perioperative PE or DVT	2.86	EMR, Premier	Rate per 1000 using Premier benchmark
20	PSI 13	Post-Op Sepsis	4.71	EMR, Premier	Rate per 1000 using Premier benchmark
21	PSI 14	Post-Op Wound Dehiscence	2.39	EMR, Premier	Rate per 1000 using Premier benchmark
22	PSI 15	Unrecognized Abdominopelvic Accidental Puncture or Laceration	1.04	EMR, Premier	Rate per 1000 using Premier benchmark
23	PSI 90	Complications / patient safety for selected indicators	0.94	EMR, Premier	Rate per 1000 using Premier benchmark
Mortality			**2024**		
24	All Cause Mortality *	Overall Mortality	0.83	EMR, Premier	Rate per 1000 using Premier benchmark
25	MORT-30-AMI	Acute Myocardial Infarction (AMI) Mortality	1.02	EMR, Premier	Rate per 1000 using Premier benchmark
26	MORT-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) Mortality	0.89	EMR, Premier	Rate per 1000 using Premier benchmark
27	MORT-30-CABG	Coronary Artery Bypass Graft (CABG) Mortality	1.40	EMR, Premier	Rate per 1000 using Premier benchmark
28	MORT-30-HF	Heart Failure (HF) Mortality	0.91	EMR, Premier	Rate per 1000 using Premier benchmark
29	MORT-30-PN	Pneumonia (PNA) Mortality	0.72	EMR, Premier	Rate per 1000 using Premier benchmark
30	Sepsis Mortality	Sepsis Mortality	1.02	EMR, Premier	Rate per 1000 using Premier benchmark
31	MORT-30-STK	Stroke Mortality	0.17	EMR, Premier	Rate per 1000 using Premier benchmark

* Designated for quarterly reporting

	Measure ID	Measure	Baseline	Data Source	Measure Definition
32	Hip/Knee Mortality	Total Hip and Total Knee	0.00	EMR, Premier	Rate per 1000 using Premier benchmark
Readmissions			**2024**		
33	READM-30-HOSPWIDE *	Overall Readmission	15.35%	EMR Premier	Percent of all inpatients who readmitted w/in 30 days
34	READM-30-AMI	AMI Readmission Rate	12.64%	EMR, Premier	Percent of all inpatients who readmitted w/in 30 days
35	READM-30-COPD	COPD Readmission Rate	23.03%	EMR, Premier	Percent of all inpatients who readmitted w/in 30 days
36	READM-30-CABG	CABG Readmission Rate	8.05%	EMR, Premier	Percent of all inpatients who readmitted w/in 30 days
37	READM-30-HF	HF Readmission Rate	22.82%	EMR, Premier	Percent of all inpatients who readmitted w/in 30 days
38	READM-30-PN	PNA Readmission Rate	19.74%	EMR, Premier	Percent of all inpatients who readmitted w/in 30 days
39	READM-30-HIP-KNEE	Hip/Knee Readmission Rate	11.11%	EMR, Premier	Percent of all inpatients who readmitted w/in 30 days
Hospital Harm			**2024**		
40	CMS 506	Safe Use of Opioids	Pending	CMS	Rate for safe use of Opioid prescribing
41	ePC-02	NTSV	19.3%	EMR	Rate of cesarean births among nulliparous women with a term, singleton baby in a vertex position
42	PC-05	Exclusive Breast Feeding	62.1%	EMR	Number of newborns who are exclusively fed human milk during their entire hospitalization
43	PC-06	Unanticipated complication of birth (rate)	0.09	EMR	Rate of unexpected complications in healthy full-term newborns
44	STK 02	Discharged on antithrombotic medication	99.7%	EMR	Stroke accreditation scorecard
45	STK 05	Completed therapy by end of day 2	96.6%	EMR	Stroke accreditation scorecard

* Designated for quarterly reporting

	Measure ID	Measure	Baseline	Data Source	Measure Definition
46	STK 06	Discharged on Statin	95.1%	EMR	Stroke accreditation scorecard
47	HH 02	Severe Hyperglycemia (new for 2026) setting baseline		EMR	Number of IP hospital days for patients > 18 with a hyperglycemic event / total qualifying IP hospital days.
48	HH 03	Severe hypoglycemia (new for 2026) setting baseline		EMR	Number of IP hospitalizations for patients > 18 who were administered at least one hypoglycemic medication during the encounter.
HEDIS Measures			**2024**		
49	CBP	Controlling Blood Pressure <140/90	74.54%	EMR	Percent of all patients with meet measure
50	BCS-E	Breast Cancer Screening	57.15%	EMR	Percent of all patients with meet measure
51	COL-E	Colorectal Cancer Screening	55.94%	EMR	Percent of all patients with meet measure
52	HBD	HbA1c Poorly Controlled > 8.0%	20.87%	EMR	Percent of all patients with meet measure lower percent is better
Procedure Specific Outcomes			**2023 (CMS)**		
53	OP - 29	OP-29 - Colonoscopy	79%	EMR, CMS	% of appropriate follow-up interval for normal Colonoscopy in average risk patients
54	OP- 32	OP-32 Hospitalizations post OP Colonoscopy	11.5	EMR, CMS	Rate of hospital visits after an OP Colonoscopy
55	OP - 35 ADM	OP-35 ADM - Admissions for OP Chemotherapy	13.2	EMR, CMS	Rate of admissions for patients receiving OP Chemotherapy
56	OP - 35 ED	OP-35 ED – ED visits for patients receiving OP Chemotherapy	4.3	EMR, CMS	Rate of ED visits for patients receiving OP Chemotherapy
57	OP- 36	OP-36 – Hospitalizations post OP Surgery	0.7	EMR, CMS	Rate of hospital visits after an OP Surgery
Behavioral Health Inpatient			**2023**		
58	FAPH-7	Follow-up After Psychiatric Hospitalization (FAPH) measure	30%	CMS	Percent of patients who follow-up with an OP visit within 7 days.

* Designated for quarterly reporting

	Measure ID	Measure	Baseline	Data Source	Measure Definition
59	MedCont	Medication continuation following inpatient psychiatric discharge (Med Cont) measure	75.50%	CMS	Percent of patients who fill at least 1 prescription between 2 days prior and up to 30 days after discharge.

* Designated for quarterly reporting

Addendum 2
Patient Satisfaction Measures

UHI shall report its performance on all 15 of the patient satisfaction measures listed below in each Annual Report. Performance on each patient satisfaction measure shall be shown against the pre-Merger baselines and on a year-over-year and trend basis for the duration of the COPA Term. In addition, UHI shall report on the patient satisfaction measures designated for quarterly reporting on the "Healthier Together" transparency website.

	CMS ID	Measure	Baseline	Data Source	Measure Definition
HCAHPS			**2024 (Q323-Q224)**		
1	H-COMP-1-A-P	Nurses always communicated well	90%	Qualtrics, CMS	NRC then Qualtrics in July 2024 - CMS Star
2	H-COMP-2-A-P	Doctors always communicated well	89%	Qualtrics, CMS	NRC then Qualtrics in July 2024 - CMS Star
3	H-COMP-3-A-P	Patient received help as soon as they wanted - responsiveness	81%	Qualtrics, CMS	NRC then Qualtrics in July 2024 - CMS Star
4	H-COMP-5-A-P	Staff explained about medicines before giving them	71%	Qualtrics, CMS	NRC then Qualtrics in July 2024 - CMS Star
5	H-CLEAN-HSP-A-P	Room and Bath were always clean	86%	Qualtrics, CMS	NRC then Qualtrics in July 2024 - CMS Star
6	H-QUIET-HSP-A-P	Area around room was always quiet	82%	Qualtrics, CMS	NRC then Qualtrics in July 2024 - CMS Star
7	H-COMP-6-Y-P	Patient reported Yes , they were given discharge information	86%	Qualtrics, CMS	NRC then Qualtrics in July 2024 - CMS Star
8	H-COMP-7-SA	Patient strongly agree they understood their discharge care	80%	Qualtrics, CMS	NRC then Qualtrics in July 2024 - CMS Star
9	H-HSP-RATING-9-10	Patient gave rating of 9 or 10	87%	Qualtrics, CMS	NRC then Qualtrics in July 2024 - CMS Star

* Designated for quarterly reporting

10	H-RECMND-DY	Patient reported Yes, they would definitely recommend.	87%	Qualtrics, CMS	NRC then Qualtrics in July 2024 - CMS Star
Patient Experience Modern Survey			**2024**		
11*		Overall Net Promoter Score*	79	Qualtrics	Qualtrics July - Dec 17, 2024
12		Overall Care Trend	95%	Qualtrics	Qualtrics July - Dec 17, 2024
13		Success in getting Care	91%	Qualtrics	Qualtrics July - Dec 17, 2024
14		Cared about as a Person	91%	Qualtrics	Qualtrics July - Dec 17, 2024
15		Trust to take care of needs	91%	Qualtrics	Qualtrics July - Dec 17, 2024

* Designated for quarterly reporting

Addendum 3
Pricing Limitations

[*see attached*]

ADDENDUM 3
PRICING LIMITATIONS
PART I.
DEFINITIONS AND GENERAL

1.1. Definitions.

In addition to the terms defined elsewhere in the Terms and Conditions to which this Addendum is attached, the following definitions shall apply to this Addendum:

"Absolute Price Limitation." The pricing limitation described in Section 2.1(a).

"Anniversary Date." The date falling on the same day of the month (or the immediately preceding day if no such day exists) as the effective date of the applicable agreement at intervals of twelve (12) months.

"Annual Change in CPI Medical." The percentage change for a Contract Year shall be calculated by determining the percentage change (a) in the annual average of the monthly CPI Medical for the immediately preceding Fiscal Year (the "Preceding Year") compared to (b) the annual average of the monthly CPI Medical for the year prior to the immediately preceding Fiscal Year (the "Baseline Year"). If such percentage change is negative, the Annual Change in CPI Medical shall be deemed to be zero percent (0%), but future Annual Changes in CPI Medical shall be calculated by determining the percentage change (x) in the annual average of the monthly CPI Medical for the Preceding Year compared to (y) the annual average of the monthly CPI Medical for the Baseline Year in which the percentage change was negative, until the Fiscal Year after the calculation results in a percentage increase.

"Annual Pricing Report." The Annual Pricing Report required by Section 7.3.

"Applicable Start Date." With respect to any Payor Contract, the later of the Determination Date, or the effective date of such Payor Contract and with respect to any chargemaster, mark-up policy or mark-up formula, the Determination Date.

"Charge-Based Payor." A Payor whose fee schedule Rates are based upon percentages of charges or is party to a Charge-Based Payor Contract.

"Charge-Based Payor Contract." A Payor Contract that meets the definition set forth in Section 4.1.

"Chargemaster." Each of the Professional Services Chargemaster or the UHI Chargemaster.

"Charges." The amounts set forth on the Professional Services Chargemaster or the UHI Chargemaster.

"Commercial Payor." A private insurance company that provides health insurance plans through employers or directly to consumers. This definition does not include government programs like Medicare or Medicaid, Medicare Advantage plans, TRICARE, or Medicaid managed care plans.

"Contract Year." The one-year period beginning on the effective date of the applicable Payor's Payor Contract with UHI or on the effective date of any renewal year thereafter.

"CPI Medical." The Consumer Price Index for All Urban Consumers: Medical Care in the US City Average published by the United States Bureau of Labor Statistics (Series CUSR0000SAM).

"Department." The Indiana Department of Health.

"Direct-to-Employer Arrangement." A Payor Contract between any member of the Combined Enterprise or a Narrow Network of which the Combined Enterprise is a member and an employer that provides health care benefits for covered services under an employee benefits plan.

"Excess Payment." The payment described in Section 10.2.

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

"Fiscal Year." UHI's fiscal year, which begins on January 1 and ends on December 31 of each year.

"Full Medicare." The amount the Medicare program pays for a covered service, including all hospital-specific Medicare adjustments.

"Inpatient Services." The services described in Section 1.3(a).

"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.

"Narrow Network." An arrangement that limits the hospitals that a covered individual may use to obtain covered services under an employee benefit plan.

"Never In-Network Payor." A Payor that has never had a Payor Contract with any member of the Combined Enterprise and was therefore never in-network.

"Outpatient Services." The services described in Section 1.3(b).

"Payor." An entity, governmental authority, organization, insurance plan or individual that is responsible for paying for health care services provided to patients.

"Payor Contract." A contract entered into between any member of the Combined Enterprise and a Payor that frames, defines, and governs their business relationship, including the payments to be made to any member of the Combined Enterprise.

"Physician Services." The services described in Section 1.3(c).

"Price" or "Prices." The amount(s) actually paid or payable to any member of the Combined Enterprise by any Payor or other person or entity in respect of a service or item.

"Professional Charge" or "Professional Charges." The amount(s) set forth on the Professional Chargemaster (e.g., a list price).

"Professional Chargemaster." The comprehensive listing of all technical billable services and items provided to a patient as part of a professional visit.

"Rate" or "Rates." The amount(s) set forth in any Payor Contract as the amount (net of any contractual adjustments) payable to any member of the Combined Enterprise in respect of any service or item.

"Request Memorandum." The written memorandum submitted to the Department in connection with the approval of a Payor or Payor Contract.

"Standard Payor." A Payor that is party to a Standard Payor Contract.

"Standard Payor Contract." A Payor Contract that meets the definition set forth in Section 5.1(a).

"Value-Based Payor." A Payor that is party to a Value-Based Payor Contract.

"Value-Based Payor Contract." A Payor Contract that meets the definition set forth in Section 3.2(a).

"Value-Based Program Payment." Any payment to a member of the Combined Enterprise as an incentive from a Payor to improve quality, improve coordination of care, or decrease cost of care.

"UHI Charge" or "UHI Charges." The amount(s) set forth on the UHI Chargemaster (e.g., a list price).

"UHI Chargemaster." The Combined Enterprise's comprehensive listing of all facility billable services and items.

1.2. Pricing Limitations.

(a) This Addendum 3 is intended to mitigate the potential for the Combined Enterprise to exercise market power as a result of the Merger and increase prices and out-of-pocket costs paid by patients, employers, Payors, and others who utilize the services of or contract with the Combined Enterprise and to ensure that the Public Advantage is maintained. This Addendum 3 provides 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.

(b) The provisions of this Addendum 3 apply to all Payor Contracts entered into, amended, changed, modified or supplemented after the Determination Date, to which any member of the Combined Enterprise, that are in effect on or after the Determination Date and to the chargemaster, markup policies and markup formulas of any member of the

Combined Enterprise, and are in addition to UHI's other obligations set forth in Part III of the Terms and Conditions.

(c) For each Payor Contract, the nature of the contracting relationship between a member of the Combined Enterprise and the Payor shall determine certain approval and compliance requirements.

(i) Exempt Payors and Value-Based Payor Contracts are described in Part III;

(ii) Standard Payor Contracts are described in Part V;

(iii) Charge-Based Payor Contracts are addressed in Part IV; and

(iv) Out of Network Payors, including Never-in-Network Payors, are addressed in Part VI.

1.3. Applicability.

(a) Hospital Inpatient Pricing. This Addendum 3 applies to inpatient services rendered at all facilities whose Charges, Prices and/or Rates are negotiated, controlled, or influenced by any member of the Combined Enterprise ("Inpatient Services").

(b) Outpatient Pricing. This Addendum 3 applies to outpatient services rendered at all facilities whose Charges, Prices and/or Rates are negotiated, controlled or influenced by any member of the Combined Enterprise and all non-hospital outpatient services provided by outpatient diagnostic centers, ambulatory surgery centers, or any other non-hospital outpatient settings or other non-hospital facilities (excluding physician, mid-level, physician extender and allied health professional services), whether owned or operated by any member of the Combined Enterprise (collectively, "Outpatient Services"), excluding providers described in Section 8.1(c) of this Addendum 3.

(c) Physician Pricing. This Addendum 3 applies to services rendered by physicians, mid-levels, physician extenders and allied health professionals, whether employed or contracted, whose practices are owned, controlled, or managed, in whole or in part, by any member of the Combined Enterprise and whose Charges, Prices and/or Rates are negotiated, controlled or influenced by any member of the Combined Enterprise (collectively, "Physician Services").

PART II.
GENERAL PRICING LIMITATIONS

2.1. Absolute Limitation to 265% of Full Medicare.

(a) Notwithstanding anything to the contrary herein, under no circumstance shall the aggregate of all Rates payable by any Commercial Payor (other than an Exempt

Payor) or Prices paid by any Commercial Payor (other than an Exempt Payor) for Inpatient Services and Outpatient Services, when calculated in the aggregate based on the total of all claims paid, exceed two hundred sixty-five percent (265%) of the aggregate amount that would have been paid under Full Medicare for the same services (the "Absolute Price Limitation"), which percentage is subject to modification as described later in this Section. The aggregate percentage shall be calculated on a rolling four-quarter basis to reduce volatility from payment timing.

(b) To the extent that after the Determination Date the Rates or Prices negotiated with a Commercial Payor for Inpatient Services and Outpatient Services would cause the Combined Enterprise to exceed the Absolute Price Limitation, the Rates or Prices negotiated with such Commercial Payor for Inpatient Services and Outpatient Services shall, in the aggregate, be limited to an amount that will cause the Combined Enterprise to comply with the Absolute Price Limitation. If, as of the Determination Date, the aggregate of all Rates or Prices paid for Inpatient Services and Outpatient Services for all Commercial Payors is less than the Absolute Price Limitation, the rate of increase of the Rates or Prices for each Commercial Payor shall be limited to the increase permitted for that Commercial Payor under the appropriate part of this Addendum 3 based on the Commercial Payor's category, but in no event shall the aggregate of all claims paid for Inpatient and Outpatient Services to Commercial Payors exceed the Absolute Price Limitation described in Section 2.1(a).

(c) UHI will not be singled out for any negative treatment under State Medicaid or other state reimbursement programs due to its COPA status.

2.2. Billing Location.

(a) No member of the Combined Enterprise shall convert services that are billed on the Determination Date as non-hospital-based locations to hospital-based locations without the advanced written approval from the Department. In the event a member of the Combined Enterprise seeks to convert services from non-hospital-based billing to hospital-based billing during the COPA Pricing Term, UHI may request the Department's approval by explaining, in writing, the basis for the change. The Department shall respond to the request within thirty (30) business days after receipt of the request and all reasonable clarifying information requested by the Department, and the Department shall confirm in writing to UHI the starting date for such thirty (30) business day period.

(b) For the avoidance of doubt, this Section shall not apply to the implementation or expansion of the 340B drug program to locations that are billed on the Issue Date as hospital-based locations.

PART III.
EXEMPT PAYORS, VALUE-BASED PAYOR CONTRACTS AND DIRECT TO EMPLOYER ARRANGEMENTS

The approval requirements for Exempt Payors and Value-Based Payor Contracts are set forth below.

3.1. 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 any member of the Combined Enterprise; (ii) that are Medicare Advantage Plans that pay a member of the Combined Enterprise based on a predetermined percentage of Medicare rates (e.g. 105% of Medicare) so long as the percentage of the Medicare rates has not increased at any time after the Determination Date; (iii) that are Managed Medicaid Plans that pay a member of the Combined Enterprise based on a predetermined percentage of a state's Medicaid rates (e.g. 105% of Medicaid rates) so long as the percentage of the Medicaid rates has not increased at any time after the Determination Date; or (iv) that are Managed Medicaid Plans that pay a member of the Combined Enterprise at the Indiana Health Coverage Programs Medicaid fee schedule.

(b) Approval Process. To the extent that any member of the Combined Enterprise is aware of upcoming substantive negotiations with an Exempt Payor after the Issue Date regarding a new Payor Contract with an Exempt Payor or a renewal of an existing Payor Contract with an Exempt Payor, UHI shall notify the Department regarding such negotiations, and if any member of the Combined Enterprise is not aware in advance of such negotiations, UHI shall promptly, and in any event within three (3) business days after the commencement of negotiations with an Exempt Payor for a new Payor Contract or a renewal of an existing Payor Contract, notify the Department of such negotiations. Prior to any member of the Combined Enterprise entering into a Payor Contract with an Exempt Payor or amending or otherwise changing, modifying or supplementing a Payor Contract with an Exempt Payor that changes in any manner the Price for health care services ultimately paid by the Exempt Payor or any other person or entity, UHI shall submit to the Department a Request Memorandum certified by the Chief Financial Officer of UHI as true and correct that summarizes the material terms of the proposed Payor Contract. The Department shall confirm that the Payor meets the definition of an Exempt Payor or provide UHI with an explanation for why the Department reasonably believes the Payor does not meet the definition of an Exempt Payor within thirty (30) days of receiving the notice and all reasonable clarifying materials requested by the Department, and the Department shall confirm in writing to UHI the starting date for such thirty (30) day period. The Department shall be provided access to the information reasonably necessary to make its determination.

(c) If a Payor ceases to qualify as an Exempt Payor, UHI shall immediately notify the Department and comply with the Approval Process applicable to the Payor's new type of Payor.

(d) UHI shall maintain a current list of Exempt Payors and make this list available for review by the Department upon request.

3.2. Value-Based Payor Contracts.

(a) Description. "Value-Based Payor Contracts" are those Payor Contracts with any member of the Combined Enterprise that have no fixed inflators and, to the extent inflators exist, such inflators are one hundred percent (100%) value-based and create financial risk for the member of the Combined Enterprise party thereto based upon changes or improvements in significant and material measures of health care access, quality and outcomes, cost savings or such other measures as the Department may approve. If such contracting is abused, results in anti-competitive conduct or negatively impacts the Public Advantage, the Department may take action pursuant to Part VI or Part VII of the Terms and Conditions or Part X.

(b) Approval Process. To the extent that any member of the Combined Enterprise is aware of upcoming substantive negotiations after the Issue Date with a Value-Based Payor regarding a new Value-Based Payor Contract or a renewal of an existing Value-Based Payor Contract, UHI shall notify the Department regarding such negotiations, and if any member of the Combined Enterprise is not aware in advance of such negotiations, UHI shall promptly, and in any event within three (3) business days after the commencement of negotiations for a new Value-Based Payor Contract or renewal of an existing Value-Based Payor Contract, notify the Department of such negotiations. Prior to any member of the Combined Enterprise entering into a Payor Contract that UHI believes meets the definition of a Value-Based Payor Contract or amending or otherwise changing, modifying or supplementing a Value-Based Payor Contract that changes in any manner the Price for health care services ultimately paid by the Value-Based Payor or any other person or entity, UHI shall submit to the Department a Request Memorandum certified by the Chief Financial Officer of UHI as true and correct that summarizes the material terms of the proposed Payor Contract, attaches a copy of the Value-Based Payor Contract, and explains the basis for the Payor Contract qualifying as a Value-Based Payor Contract. The Department shall confirm that the Payor meets the definition of a Value-Based Payor or provide UHI with an explanation for why the Department reasonably believes the Payor does not meet the definition of a Value-Based Payor within thirty (30) days of receiving the notice and all reasonable clarifying materials requested by the Department, and the Department shall confirm in writing to UHI the starting date for such thirty (30) day period. The Department shall be provided access to the information reasonably necessary to make its determination.

(c) If a Payor Contract ceases to qualify as a Value-Based Payor Contract, UHI shall immediately notify the Department and comply with the approval process applicable to the new type of Payor or Payor Contract.

(d) UHI shall maintain a current list of Value-Based Payor Contracts and make this list available for review by the Department upon request.

3.3. Direct to-Employer Arrangements.

(a) Description. By January 1, 2027, the Combined Enterprise will offer to employers in the State of Indiana a Direct-to-Employer Arrangement that includes Inpatient Services, Outpatient Services and Physician Services with the average of the services offered at or below the Absolute Pricing Limitation.

(b) Approval Process. Prior to any member of the Combined Enterprise entering into a Payor Contract that UHI believes meets the definition of a Direct-to-Employer Arrangement or amending or otherwise changing, modifying or supplementing a Direct-to-Employer Arrangement that changes in any manner the Price for health care services ultimately paid by the employer party thereto or any other person or entity after the Issue Date, UHI shall submit to the Department a Request Memorandum certified by the Chief Financial Officer of UHI as true and correct that summarizes the material terms of the proposed Payor Contract, attaches a copy of the Direct-to-Employer Arrangement, and explains the basis for the Payor Contract qualifying as a Direct-to-Employer Arrangement. The Department shall confirm that the Payor Contract meets the definition of a Direct-to-Employer Arrangement or provide UHI with an explanation for why the Department reasonably believes the Payor Contract does not meet the definition of a Direct-to-Employer Arrangement within thirty (30) days of receiving the notice and all reasonable clarifying materials requested by the Department, and the Department shall confirm in writing to UHI the starting date for such thirty (30) day period. The Department shall be provided access to the information reasonably necessary to make its determination.

(c) If a Payor Contract ceases to qualify as a Direct-to-Employer Arrangement, UHI shall immediately notify the Department and comply with the approval process applicable to the new type of Payor or Payor Contract.

(d) UHI shall maintain a current list of Direct-to-Employer Arrangement and make this list available for review by the Department upon request.

PART IV.
CHARGE-BASED PAYOR CONTRACTS, 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 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 Payor Contracts pay for all hospital services based upon a hospital's charges for services ("Charge Based Payor Contracts"). Such contracts often provide for a discount (for example 50%) from a chargemaster amounts for the item or service at issue. This Part IV places limits upon increases in the Combined Enterprise's Charges and the impact of those increases upon Charge-Based Payors and the individuals and entities who utilize the Combined Enterprise's services. For hospital inpatient and outpatient, non-hospital outpatient, and Physician Services and

any other services or items billed to Payors based upon Charges, the Combined Enterprise shall limit the impact of Charge increases as set forth below.

4.2. Chargemaster Increases.

UHI Charges established in the UHI Chargemaster and Professional Charges established in the Professional Chargemaster that were in effect as of the Determination Date, may be adjusted at the discretion of UHI, provided that the percentage increase to the UHI Chargemaster and the Professional Chargemaster in any Fiscal Year shall not exceed the Annual Increase in CPI Medical for such Fiscal Year.

4.3. Charge-Based Payor Contracts.

(a) Approval Process. In addition to the limitations set forth in Section 4.2, the following process shall be used in connection with the Department's review of the proposed entry by any member of the Combined Enterprise into any Charge-Based Payor Contract or any amendment or other change, modification or supplement to a Charge-Based Payor Contract by any member of the Combined Enterprise that changes in any manner the Price for health care services ultimately paid by the Charge-Based Payor or any other person or entity:

Step 1. To the extent that any member of the Combined Enterprise is aware of upcoming substantive negotiations with a Charge-Based Payor regarding a new Charge-Based Payor Contract or a renewal of an existing Charge-Based Payor Contract after the Issue Date, UHI shall notify the Department regarding such negotiations, and if any member of the Combined Enterprise is not aware in advance of such negotiations, UHI shall promptly, and in any event within three (3) business days after the commencement of negotiations for a new Charge-Based Payor Contract or renewal of an existing Charge-Based Payor Contract, notify the Department of such negotiations.

Step 2. The applicable member of the Combined Enterprise shall negotiate with the Charge-Based Payor all of the substantive terms of the new Charge-Based Payor Contract or any amendment or other change, modification or supplement to an existing Charge-Based Payor Contract that changes in any manner the Price for health care services ultimately paid by the Standard Payor or any other person or entity.

Step 3. Before execution of the proposed Charge-Based Payor Contract, UHI shall submit to the Department a Request Memorandum, certified by the Chief Financial Officer of UHI as true and correct, which shall include the following:

- A final draft of the new Charge-Based Payor Contract;
- A summary of the substantive terms of the proposed Charge-Based Payor Contract; and

- If applicable, UHI's calculation of the percentage change in Prices from the prior contract with the Charge-Based Payor, in reasonable detail.

Step 4. Within thirty (30) business days after receiving the Request Memorandum and any reasonable clarifying materials that may be requested, the Department shall inform UHI in writing whether the Department has determined that the substantive terms of the proposed Charge-Based Payor Contract comply with this Addendum 3. The Department shall confirm in writing to UHI the starting date for such thirty (30) business day period.

Step 5. If the Department determines that the substantive terms of the proposed Charge-Based Payor Contract comply with this Addendum 3 and the provisions of Part II of the Terms and Conditions, the applicable member of the Combined Enterprise may move forward with execution of the new Charge-Based Payor Contract with the Charge-Based Payor on the same terms and conditions as provided to the Department in the applicable Request Memorandum. Examples of compliance and non-compliance with the Absolute Price Limitation are attached hereto as Appendix A.

Step 6. If the Department reasonably determines that the substantive terms of the proposed Charge-Based Payor Contract do not comply with this Addendum 3 (and the examples attached as Appendix A) and the provisions of Part II of the Terms and Conditions, then the applicable member of the Combined Enterprise shall not move forward with execution of the proposed Charge-Based Payor Contract with the Charge-Based Payor until such time as UHI resolves the noncompliant terms with the Department and the Department determines that the substantive terms of the proposed Charge-Based Payor Contract comply with this Addendum 3 and the provisions of Part II of the Terms and Conditions at which time, the applicable member of the Combined Enterprise may move forward with execution of the new Charge-Based Payor Contract with the Charge-Based Payor on the same terms and conditions as provided to the Department in the applicable Request Memorandum.

Step 7. Following execution, UHI will provide a copy of the fully executed Charge-Based Payor Contract to the Department upon the Department's request.

(b) When calculating the percentage change in UHI Charges or Professional Charges, if the increase(s) are not uniform across all services and items, the estimated impact of the increase(s) shall be calculated as a weighted average of the prior year's volume of the various departments, service lines or line items and the respective increase in Prices.

(c) An administrative amendment or coding-only amendment to an existing Charge-Based Payor Contract which does not affect Prices or Rates shall be exempt from the process described in Section 4.3(a) above and instead, UHI shall provide a summary of

the changes to the Charge-Based Payor Contract, certified by the Chief Financial Officer as true and correct, and upon the Department's request, provide a fully-executed copy of such amendment.

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

(e) Review of Methodologies. The Department will meet with UHI to evaluate the methodologies set forth in this Part IV before the third anniversary of the Issue Date as described in Part IX to ensure that the evaluations are achieving the intended goals.

PART V.
STANDARD PAYOR CONTRACTS

5.1. Standard Payor Contracts.

(a) Description. "Standard Payor Contract" is a Payor Contract, including but not limited to, a reference-based Payor Contract, that is neither with an Exempt Payor nor a Value-Based Payor Contract or a Charge-Based Payor Contract.

(b) Limitations on Standard Payor Contracts. No member of the Combined Enterprise shall increase Rates (whether through negotiation, application of external reference benchmarks or otherwise) of any Standard Payor Contract that was or is entered into, amended, changed, modified, supplemented, or terminated and replaced after the Determination Date, that creates a violation of the Absolute Price Limitation.

(c) Approval Process. The following process shall be used in connection with the Department's review of the proposed entry by any member of the Combined Enterprise into any Standard Payor Contract or any amendment or other change, modification or supplement to a Standard Payor Contract by any member of the Combined Enterprise that changes in any manner the Price for health care services ultimately paid by the Standard Payor or any other person or entity:

> Step 1. To the extent that any member of the Combined Enterprise is aware of upcoming substantive negotiations after the Issue Date with a Standard Payor regarding a new Standard Payor Contract or a renewal of an existing Standard Payor Contract, UHI shall notify the Department regarding such negotiations, and if any member of the Combined Enterprise is not aware in advance of such negotiations, UHI shall promptly, and in any event within three (3) business days after the commencement of negotiations for a new Standard Payor Contract or renewal of an existing Standard Payor Contract, notify the Department of such negotiations.
>
> Step 2. The applicable member of the Combined Enterprise shall negotiate with the Standard Payor all of the substantive terms of the new Standard

Payor Contract or any amendment or other change, modification or supplement to an existing Standard Payor Contract that changes in any manner the Price for health care services ultimately paid by the Standard Payor or any other person or entity.

Step 3. Before execution of the proposed Standard Payor Contract, UHI shall submit to the Department a Request Memorandum certified by the Chief Financial Officer of UHI, which shall include:

- A final draft of the new Standard Payor Contract;
- A summary of the substantive terms of the proposed Standard Payor Contract;
- If applicable, UHI's calculation of the percentage change in Rates from the prior contract with the Standard Payor, in reasonable detail; and
- UHI's calculation of its Rates as a percentage of Full Medicare in the aggregate based on claims paid, including the New Standard Payor Contract Rate.

Step 4. Within thirty (30) business days after receiving the Request Memorandum and any reasonable clarifying materials that may be requested, the Department shall inform UHI in writing whether the Department has determined that the substantive terms of the proposed Standard Payor Contract comply with this Addendum 3. The Department shall confirm in writing to UHI the starting date for such thirty (30) business day period.

Step 5. If the Department determines that the substantive terms of the proposed Standard Payor Contract comply with this Addendum 3 and the provisions of Part II of the Terms and Conditions, the applicable member of the Combined Enterprise may move forward with execution of the new Standard Payor Contract with the Standard Payor on the same terms and conditions as provided to the Department in the applicable Request Memorandum. Examples of compliance and non-compliance with the Absolute Price Limitation are attached hereto as Appendix A.

Step 6. If the Department reasonably determines that the substantive terms of the proposed Standard Payor Contract do not comply with this Addendum 3 (and the examples attached as Appendix A) and the provisions of Part II of the Terms and Conditions, then the applicable member of the Combined Enterprise shall not move forward with execution of the proposed Standard Payor Contract with the Standard Payor until such time as UHI resolves the noncompliant terms with the Department and the Department determines that the substantive terms of the proposed Standard Payor Contract comply with this Addendum 3 and the provisions of Part II of the Terms and Conditions at which time, the applicable member of the Combined Enterprise may move forward with execution of the new Standard Payor

Contract with the Standard Payor on the same terms and conditions as provided to the Department in the applicable Request Memorandum.

Step 7. Following execution, UHI will provide a copy of the fully executed Standard Payor Contract to the Department upon the Department's request.

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

(e) Review of Methodologies. The Department will meet with UHI to evaluate the methodologies set forth in this Part V before the third anniversary of the Issue Date as described in Part IX to ensure that the evaluations are achieving the intended goals.

5.2. Standard Payor Policy Changes that Negatively Impact UHI's Net Revenue.

If, after a Standard Payor Contract is executed, the Standard Payor unilaterally makes policy changes that, when considered alone, would cause or actually causes a Material Adverse Event for the Combined Enterprise or results in the Combined Enterprise having an operating margin during one or more of the preceding three (3) years that is below 50 percent of health systems rated BBB+ by Standard & Poor's, then UHI may present the information to the Department and request an increase to the Absolute Price Limitation set forth in Section 2.1(a) that will be used for future Standard Payor Contracts that are affected by such Standard Payor's policy change. The Department may consider all relevant factors in determining whether to approve the request, which approval shall be made in the Department's discretion. Any such approval shall be in writing and memorialized in an amendment to the Annual Pricing Report.

If the requisite benchmark data is not available, the Department reserves the right, in its discretion, to modify the benchmarks set forth in the preceding paragraph.

PART VI.
OUT OF NETWORK PAYORS

6.1. Description. Under the federal No Surprises Act, which went into effect January 1, 2022, the Combined Enterprise is prohibited from billing patients more than the in-network cost sharing amount for services covered by the No Surprises Act. The Combined Enterprise shall comply with the federal No Surprises Act.

6.2. Previously In-Network Payors. If a Payor, which previously had a Payor Contract with a member of the Combined Enterprise goes out of network, then the Payor Contract's out of network provisions will dictate payment.

PART VII.
REPORTING AND COMPLIANCE REVIEWS

7.1. General

UHI shall make copies of all contracts that are subject to the Addendum 3 available to the Department upon request. In addition, UHI shall timely provide all information reasonably requested by the Department that, in the Department's discretion, will assist the Department in evaluating the Combined Enterprise's compliance with this Addendum 3. UHI shall retain all copies of all contracts that are subject to this Addendum 3, Request Memoranda, Annual Pricing Reports and supporting documentation until the second (2nd) anniversary of the expiration of the Pricing Commitments.

7.2. Initial Report. No later than ninety (90) days after the Issue Date, UHI shall deliver to the Department a written report, which shall be certified as true and correct by the Chief Financial Officer of UHI, and shall include the following:

(a) A list of all of the Combined Enterprise's Payor Contracts that were in effect as of after the Determination Date, including the following information: (i) name of the Payor; (ii) the title of the Payor Contract; (iii) the category of the Payor Contract (e.g., Exempt Payor, Value-Based Payor Contract, Standard Payor Contract, or Charge-Based Payor Contract); (iv) the Anniversary Date of the Payor Contract; (v) the last date of amendment or other change, modification or supplement to the Payor Contract; and (vi) the net revenue for the Payor Contract during the prior Fiscal Year.

(b) For each listed Value-Based Payor Contract, a description of all value-based payments by measurement criteria.

(c) For each listed Standard Payor Contract, (i) the percentage increase in Rates and Prices from the Applicable Start Date through the next Anniversary Date after the Determination Date; and (ii) any agreed-upon inflators or increases. When calculating the percentage change in Rates and Prices, if the increase(s) are not uniform across all services and items, the increase shall be calculated as a weighted average of the actual dollar volume of the various departments, service lines or line items and the respective increase in Rates and Prices.

(d) For each listed Charge-Based Payor Contract, (i) the percentage increase in Rates and Prices from the Applicable Start Date through the next Anniversary Date after the Determination Date; (ii) any agreed-upon inflators or increases. When calculating the percentage change in Rates and Prices, if the increase(s) are not uniform across all services and items, the increase shall be calculated as a weighted average of the actual dollar volume of the various departments, service lines or line items and the respective increase in Rates and Prices.

7.3. Annual Pricing Report. No later than April 30 of each year in which the Pricing Commitments are in effect and the April 30 following the Fiscal Year in which the Pricing Commitments terminate, UHI shall deliver to the Department a written report in respect of the Fiscal

Year ending on the prior December 31st, which shall be certified as true and correct by the Chief Financial Officer of UHI, and shall include the following:

(a) a list of all of the Combined Enterprise's Payor Contracts that were in effect during the Fiscal Year, including the following information: (i) name of the Payor; (ii) the title of the Payor Contract; (iii) the category of the Payor Contract (e.g., Exempt Payor, Value-Based Payor Contract, Direct-to-Employer Arrangement, Standard Payor Contract, or Charge-Based Payor Contract) and whether its category changed during the Fiscal Year; (iv) the Anniversary Date of the Payor Contract; (v) the last date of amendment or other change, modification or supplement to the Payor Contract; (vi) the date UHI submitted the applicable Request Memorandum; (vii) a statement in reasonable detail of whether the Payor Contract exceeds the Absolute Price Limitation as of the end of the Fiscal Year and the amount of such excess; and (viii) a list of the services that are currently billed as hospital-based services as of the end of the Fiscal Year.

(b) The Department may request additional information reasonably necessary for the Department to conduct its active supervision, which may include:

(i) A list of Payors that are Exempt Payors as of the end of the Fiscal Year, a certification that each such Payor continues to meet the definition of an Exempt Payor, and a list of all Payors previously listed as Exempt Payors that have ceased to be Exempt Payors.

(ii) For each Value-Based Payor Contract, a summary by measurement criteria of all value-based payments for the Fiscal Year with a comparison to the prior Fiscal Year and a certification that all such Value-Based Payor Contracts continue to meet the definition of Value-Based Payor Contract.

(iii) A list of all Payor Contracts previously listed as Value-Based Payor Contracts that have ceased to be Value-Based Payor Contracts.

(iv) For each listed Direct-to-Employer Arrangement, (i) the amount paid by the Payor or any other person or entity for Inpatient Services, Outpatient Services and Physician Services (separately stated and in total), (ii) the Full Medicare amount payable in respect of Inpatient Services, Outpatient Services and Physician Services (separately stated and in total), and (iii) the percentage of Full Medicare for Inpatient Services, Outpatient Services and Physician Services (separately stated and in total).

(v) A description in reasonable detail of the Combined Enterprise's efforts to offer Direct-to-Employer Arrangements, a list of all employers approached by the Combined Enterprise and/or with whom the Combined Enterprise negotiated such an arrangement (whether or not such negotiation was successful or completed), a list of all such arrangements entered into during the Fiscal Year, a list of all such arrangements not entered into during the Fiscal Year and the reasons

therefor, and a list of all such arrangements terminated during the Fiscal Year and the reasons therefor.

(vi) For each listed Standard Payor Contract, (i) the actual increase in Rates and Prices from the Applicable Start Date through the end of the Fiscal Year; (ii) the actual increase in Rates and Prices for the Fiscal Year; and (iii) any agreed-upon inflators or increases. When calculating the percentage change in Rates and Prices, if the increase(s) are not uniform across all services and items, the increase shall be calculated as a weighted average of the actual dollar volume of the various departments, service lines or line items and the respective increase in Rates or Prices.

(vii) For each listed Charge-Based Payor Contract, (i) the actual increase in Rates and Prices from the Applicable Start Date through the end of the Fiscal Year; (ii) the actual increase in Rates and Prices for the Fiscal Year; and (iii) any agreed-upon inflators or increases. When calculating the percentage change in Rates and Prices, if the increase(s) are not uniform across all services and items, the increase shall be calculated as a weighted average of the actual dollar volume of the various departments, service lines or line items and the respective increase in Rates or Prices.

(viii) A summary in reasonable detail of the increase(s) in the UHI Chargemaster and Professional Chargemaster during the preceding Fiscal Year, including (i) the Annual Change in CPI Medical for each Chargemaster, and (ii) the permitted percentage increase as determined in accordance with Section 4.2. If the increase(s) are not uniform across an entire Chargemaster, the estimated impact of the increase(s) shall be calculated as a weighted average of the actual volume of the various departments, service lines or line items and the respective increase in such Chargemaster.

(ix) A summary in reasonable detail of the increase(s) in the UHI Chargemaster and the Professional Chargemaster (x) from the Determination Date, through the end of the Fiscal Year and (y) for the Fiscal Year, including (i) the Annual Increase in CPI Medical, (ii) the applicable limitation(s) set forth in Section 4.2 and (iii) the percentage increase(s) in the UHI Chargemaster and the Professional Chargemaster. If the increase(s) are not uniform across an entire Chargemaster, the estimated impact of the increase(s) shall be calculated as a weighted average of the actual volume of the various departments, service lines or line items and the respective increase in such Chargemaster.

(x) Confirmation that the Combined Enterprise's mark-up policy that was in effect on the Determination Date, remains in effect.

(xi) Confirmation in reasonable detail that the mark-up for services and items with a fixed dollar amount markup has not exceeded the Absolute Price Limitation during the Fiscal Year.

(xii) A list of all individuals or entities that have any of the following interests in any member of the Combined Enterprise: (i) an ownership interest, whether voting or non-voting, of at least five percent (5%) in the aggregate; (ii) a controlling interest, even if less than a five percent (5%) interest; and (iii) any ownership interest, whether direct or indirect, of (A) a practitioner at any member of the Combined Enterprise or (B) a private equity-backed entity or a private equity fund; provided however, members of the Combined Enterprise that are directly or indirectly wholly owned by Union Health System do not need to be listed;

(xiii) Certification by the Chief Financial Officer that the Combined Enterprise is in compliance with the terms of this Addendum 3.

(xiv) A summary of the work UHI performed to ensure the Combined Enterprise has complied with this Addendum 3 and that the Combined Enterprise's pricing has not impermissibly increased.

(xv) A listing of any complaints, including a reasonable description, filed against UHI under the federal No Surprises Act along with the resolution and status of each complaint.

(xvi) The status of all corrective actions and refunds required by the Department pursuant to Part X.

(c) Electronic Format. UHI shall provide the foregoing information in an electronic format, including the header level data, revenue level data and required data fields, upon notice from the Department of the specific electronic format and data template acceptable to the Department.

7.4. Additional Time.

If UHI needs additional time to perform any of the obligations in this Addendum 3, the Department may grant an extension upon a showing of good cause.

7.5. Compliance Reviews.

The Department may review the Combined Enterprise's compliance with this Addendum 3 as (i) as part of each Annual Pricing Report and (ii) at any time at the sole discretion of the Department. If as part of any such review, the Department reasonably determines that the Combined Enterprise's pricing has impermissibly increased, then Part X shall apply in addition to any other compliance measures set forth herein or in the Terms and Conditions.

PART VIII.
EXCEPTIONS TO PRICE LIMITATION RULES

8.1. The limitations set forth in this Addendum 3 do not apply to the following:

(a) That portion of Payor Contract payments received for attaining quality targets or goals, so long as the Payor Contract has otherwise been approved by the Department in accordance with this Addendum 3.

(b) Post-acute care providers such as skilled nursing facilities, home health agencies, hospices and durable medical equipment providers owned by the Combined Enterprise; provided however, the Department reserves the right to impose limitations or take action pursuant to Part VI or Part VII of the Terms and Conditions or Part X with respect to contracts with non-governmental Payors if such contracting is abused, results in anticompetitive conduct or negatively impacts the Public Advantage.

(c) Bundled payment items and services in which a member of the Combined Enterprise assumes all of the risks for care provided by other providers (such as post- acute care providers like a skilled nursing facility, physicians, 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. In addition to UHI notifying the Department before any substantive negotiations with a Payor occur after the Determination Date regarding such terms if any member of the Combined Enterprise is aware of such negotiations prior to their commencement (and if not, UHI shall notify the Department within three (3) business days after commencement of negotiations), before entering into a bundled payment arrangement, UHI shall submit the description of bundled payment items and services to the Department for review, along with a copy of all related contractual agreements, including UHI's base pricing of its services included in the bundle. If such contracting is abused, results in anti-competitive conduct or negatively impacts the Public Advantage, the Department may take action pursuant to Part VI or Part VII of the Terms and Conditions or Part X.

(d) Items for which UHI has accepted risk in the form of a capitated payment or percentage of premiums; provided that UHI notified the Department before entering into a capitated payment or percentage of premiums arrangement and if any member of the Combined Enterprise is aware of such negotiations prior to their commencement, UHI notified the Department prior to commencement (and if not, UHI shall notify the Department within three (3) business days after commencement of negotiations). If such contracting is abused, results in anti-competitive conduct or negatively impacts the Public Advantage, the Department may take action pursuant to Part VI or Part VII of the Terms and Conditions or Part X.

PART IX.
PERIODIC REVIEW

No later than six (6) months before the third Anniversary Date of the Issue Date, UHI and the Department shall meet to review the application and operation of this Addendum 3 in the maintenance of ongoing Public Advantage. If it appears the Combined Enterprise (a) has generated an operating margin, as defined by Standard & Poor's, during one or more of the preceding three (3) years that is above 50 percent of health systems rated A+ by Standard & Poor's, or (b) has generated an operating margin during one or more of the preceding three (3) years that is below 50 percent of health systems rated BBB+ by Standard & Poor's, then modification of this Addendum 3 may be appropriate, which may be proposed by the Department or UHI. If UHI proposes an Addendum 3 modification pursuant to this Part IX, the Department shall review the proposed modification. The Department, with the consent of the Secretary, may accept, decline, or revise any proposed Addendum 3 modification proposed by UHI, and will use reasonable efforts to do so within thirty (30) days of the request and receipt by the Department of all reasonable clarifying materials requested by the Department. The Department shall confirm in writing to UHI the starting date for such thirty (30) business day period. 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. Such review of this Addendum 3 shall be repeated every three (3) years thereafter during the COPA Pricing Term. If the requisite benchmark data is not available, the Department will determine, in its discretion, the benchmark data to use going forward.

PART X.
GENERAL TERMS AND ENFORCEMENT

10.1. All Payor claims, billing, and other rules will be followed**.** It is not the intent of this Addendum 3 to supplant contract terms in any Payor Contracts other than specifically addressed herein.

10.2. Any violation of this Addendum 3 may be deemed a Noncompliance and the Department may take any action permitted by the Terms and Conditions or the COPA Statute. The Department will consider the facts and circumstances in determining whether a Noncompliance has occurred. In addition and without limiting the foregoing, the Department may do any of the following:

(a) If the Department determines that the pricing of any member of the Combined Enterprise has impermissibly increased with respect to a Payor, an excess payment exists (the "Excess Payment") and (i) such member of the Combined Enterprise shall report the non-compliance to the affected Payor(s), amend the Payor Contract to bring it in to compliance with this Addendum III and, if the refund amount is material, the Department may reasonably order a refund of the Excess Payment to the applicable Payor (who may be an individual in the case of services that were paid by individuals, whether as a co-payment, as an uninsured person, because their deductible was not met or otherwise). In addition, UHI shall work with the Department to determine the steps required to prevent the Excess Payment from reoccurring.

(b) In addition to the foregoing, if the aggregate increase after the Determination Date exceeds the amount permitted by this Addendum III, the applicable member of the

Combined Enterprise will be required immediately to report any excess increase to all Payors whose payments are impacted by the excess increase, to reduce the payment-to-charge-ratio so that it does not exceed the amount permitted by this Addendum III and, if the refund amount is material, the Department may reasonably order a refund of the Excess Payment to the applicable Payor (who may be an individual in the case of services that were paid by individuals, whether as a co-payment, as an uninsured person, because their deductible was not met or otherwise).

(c) If there are more than two (2) material Excess Payments in a Fiscal Year or an Excess Payment for any Payor that is material for two (2) consecutive years, such occurrence may be deemed a Non-Compliance, and in addition to any other Department Action, UHI shall perform a root cause analysis audit and provide a report to the Department setting forth its plan to address and prevent future Excess Payments from such Payor within ninety (90) days.

10.3. This Addendum 3 does not create a private right of action**.**

10.4. Any certifications required under this Addendum 3 shall be certifications to the best of the individual's knowledge after due inquiry.

PART XI.
DEPARTMENTAL MODIFICATIONS AND ACTIONS

11.1. The Department reserves the right to propose changes to this Addendum 3 in accordance with the modification process set forth in Part VII of the Terms and Conditions.

11.2. UHI may propose changes to this Addendum 3 in accordance with the modification process set forth in Part VII of the Terms and Conditions.

11.3. Any action taken by the Department under this Addendum 3 shall constitute an "agency action" under the Indiana Orders and Procedures Act.

Appendix A
Absolute Price Limitation Examples

As set forth in the examples below, the determination of whether Union is above or below 265% of Full Medicare is calculated using the aggregate percentage of Union's rates based on claims paid compared to the current percentage of Full Medicare. For purposes of these calculations, all Inpatient Services and Outpatient Services for a Payor shall be considered together in the aggregate. Physician Services provided outside the hospital-setting shall not be included in these calculations.

I. Example A - In Compliance

Scenario: Union negotiates rates with Standard Payor C that are 300.0% of Full Medicare.

Payer Category	Gross Charges	Payments	% Reimbursed	Current % of Full Medicare
Payor A (All Claims)	$361,647,604	$167,017,491	46.18%	220.6%
Payor B (All Claims)	$95,264,459	$58,165,440	61.06%	300.0%
Payor C (All Claims)	$46,187,834	$27,955,128	60.52%	300.0%
Payor D (All Claims)	$18,605,720	$11,422,657	61.39%	300.0%
Payor E (All Claims)	$11,996,018	$7,282,862	60.71%	300.0%
Payor F (All Claims)	$7,857,879	$4,773,422	60.75%	300.0%
Payor G (All Claims)	$290,706	$185,433	63.79%	300.0%
Total	**$541,850,221**	**$276,802,432**	**51.08%**	**246.9%**

Outcome: The negotiated rate for Payor C's new contract (300.0%) is above 265% of Full Medicare. However, because Union's rates as a percentage of Full Medicare in the aggregate are still below 265% of Full Medicare (246.9%), Union is in compliance with the Absolute Price Limitation and may proceed with finalizing the Standard Payor C contract.

II. Example B - Not In Compliance

Scenario: Union negotiates rates with Standard Payor A that are 280.0% of Full Medicare.

Payer Category	Gross Charges	Payments	% Reimbursed	Current % of Full Medicare
Payor A (All Claims)	$361,647,604	$212,032,413	58.63%	280.0%
Payor B (All Claims)	$95,264,459	$50,127,911	52.62%	258.5%
Payor C (All Claims)	$46,187,834	$26,907,050	58.26%	288.8%
Payor D (All Claims)	$18,605,720	$8,749,286	47.02%	229.8%
Payor E (All Claims)	$11,996,018	$7,626,228	63.57%	314.1%
Payor F (All Claims)	$7,857,879	$4,537,889	57.75%	285.2%
Payor G (All Claims)	$290,706	$44,366	15.26%	71.8%
Total	**$541,850,221**	**$310,025,144**	**57.22%**	**276.6%**

Outcome: The negotiated rate for Payor A's new contract (280.0%) is above 265% of Full Medicare. This alone is not problematic. However, because Union's rates as a percentage of Full Medicare in the aggregate are now above 265% of Full Medicare (276.6%), Union is not in compliance with the Absolute Price Limitation and may not proceed with finalizing the Standard Payor A contract.