APPLICATION FOR CERTIFICATE OF PUBLIC ADVANTAGE

SUBMITTED BY:

Shannon Health System, Inc.

PUBLIC REDACTED VERSION

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

Page

Shannon Health System, Inc. ("Shannon"), a Texas non-profit corporation respectfully submits this application for a Certificate of Public Advantage pursuant to Texas Health and Safety Code, Section 314A.052. The application seeks a certificate governing the transaction contemplated by an Asset Purchase Agreement, under which Shannon will acquire substantially all of the assets used in the operation of San Angelo Community Medical Center ("SACMC"), an acute care hospital in San Angelo, Texas.

Small towns, cities, and rural communities throughout the United States are losing access to high-quality health care as local hospitals struggle to contain costs while providing essential care. The crisis is particularly acute in Texas, which has witnessed more rural hospital closures than any other state. Twenty hospitals in Texas have closed since 2010. The Texas Legislature recently enacted Chapter 314A (the "Law") to address this crisis by facilitating certain rural hospital transactions and imposing ongoing state supervision to ensure that the transactions benefit the local communities. The transaction contemplated here is exactly what the Texas Legislature intended. It would increase services available to rural communities in Texas by combining hospitals with widely different footprints and focuses; creating substantial cost savings and other efficiencies; fostering the creation of jobs in our local communities; and, most importantly, improving health care access and outcomes for populations disproportionately composed of poor and elderly people. On the other side of the balance, there is no appreciable danger of any meaningful competitive harm from the transaction. Therefore, the Commission should grant the application and issue a Certificate of Public Advantage.

I. THE MERGER AGREEMENT

A. The Parties

Shannon owns and operates Shannon Medical Center ("SMC"), the most comprehensive provider of inpatient hospital and outpatient services for the Concho Valley and surrounding West Texas counties. SMC is a 441-bed licensed acute care hospital located in San Angelo, Texas. As Shannon's flagship hospital, SMC provides West Texas with a Level III lead trauma facility, a nationally-recognized intensive care unit, a Level II neonatal intensive care unit, and state-of-the-art radiology and cardiology departments. Shannon also owns and operates the Shannon Clinic, a physician group serving 18 locations around West Texas. Shannon provides CMS 5-Star ranked inpatient and outpatient services to more than 300,000 patients in 25 West Texas counties. With over 2,900 employees, Shannon offers 40 medical specialties spread across 21 locations, including: SMC; Women and Children's Hospital; Shannon St. John's Campus (behavioral health, skilled nursing facility, inpatient rehabilitation, and wound care services); a surgery center; numerous clinics in West Texas (including San Angelo Clinic, Shannon Clinic Brownwood, Family Health Center of Ozona, and Shannon Clinic Big Spring); urgent care centers; an imaging center; and a skilled nursing facility.

Since its founding in 1932, Shannon has focused on providing exceptional health care to the region. Operating on the basis of a "legacy of caring," Shannon has maintained local ownership and leadership, as well as its non-profit status, to ensure that it can meet the health care and social needs of patients in the Concho Valley and surrounding region.

SACMC is a 171-bed, community acute care hospital affiliated with Community Health Systems ("CHS"),[1] a Tennessee for-profit corporation, and also located in San Angelo, Texas. SACMC has several affiliated entities: Community Surgery Center (an ambulatory surgery center); Community Medical Associates (physician clinic); Community Express Care (urgent care center); and others, which together operate SACMC and other health care facilities and businesses identified in Appendix A.

SACMC employs or contracts with more than 170 health care professionals. It sponsors the Laura W. Bush Institute for Women's Health, which is dedicated to scientific advancements in the field of women's health. In addition, SACMC offers a range of services commensurate with a community hospital of like size, including a Level II neonatal intensive care unit, an accredited heart and vascular program, and an Orthopedic and Total Joint Center. SACMC also operates several ambulatory care facilities, outpatient magnetic resonance imaging services, an emergency department, lab, imaging, and physician services, all located in San Angelo, Texas.

B. Description Of The Transaction

On August 21, 2019, the parties signed a letter of intent leading to the definitive agreement under which Shannon would acquire assets used to operate SACMC. (A copy of the definitive agreement is submitted with this application as Appendix D.) Before entering the transaction, Shannon's leadership and community-led Board of Directors carefully evaluated the need for, and direction of, health care services in the community, including whether an acquisition of SACMC would have a positive impact on residents and help maintain local access to the highest quality care. Through this process, Shannon determined that a transaction would advance its mission to preserve and expand access to quality, community-based, not-for-profit health care services in West Texas. The transaction would combine the high quality and expertise of Shannon's hospitals and clinics with those of SACMC, and would lead to substantial cost savings. Because of Shannon's non-profit status, those cost savings would be reinvested in the community, helping to expand access to much needed health care services.

The proposed transaction comes at a time of sweeping changes in health care. Communities in Texas and across the nation are seeing community hospitals close as they struggle to navigate historic financial, regulatory, and operational challenges. This transaction will ensure that current and future generations of West Texans continue to have access to high quality, affordable care, provided and led by community members. The proposed transaction would generate cost savings that would help Shannon develop additional low cost, high quality, and new services, and protect access to a full complement of health care services in the Concho Valley and West Texas community.

C. The Hospitals

Shannon and SACMC offer different but highly complementary facilities, service lines, and specialties. They operate in largely different geographic service areas. And their volumes and operating statistics indicate that combining facilities would yield substantial benefits by allowing use of unused capacity at SACMC to better coordinate care and alleviate capacity constraints at Shannon. This will lead to the treatment of more high acuity patients, enhanced

quality of care, and a reduction of duplicative and unnecessary costs. All of these factors result in the proposed transaction providing significant benefits to the local community.

1. Facilities, Service Lines, And Specialties

As the most comprehensive provider of inpatient hospital and outpatient services for the Concho Valley and surrounding West Texas counties, Shannon offers care at three hospital campuses, an ambulatory surgery center, 16 clinics, and two urgent care centers, all within San Angelo and Tom Green County. Shannon also offers care outside of San Angelo with clinic locations in Howard and Brown Counties as well as a Family Health Center in Crockett County. Moreover, in line with its aim to satisfy otherwise unmet community needs, at least 18 Shannon providers also travel occasionally to other locations in its secondary service area, including Runnels, McCulloch, Mitchell, Sutton, and Val Verde Counties. SACMC provides care at its main hospital campus and its nearby physician clinics, ambulatory surgery center, imaging center, and two urgent cares, all located within Tom Green County.

Shannon also provides extensive, nationally recognized services in more than forty medical specialties, many of which SACMC does not offer. For instance, Shannon offers extensive neurosurgical and neurological services, open-heart surgery services, inpatient rehabilitation services, and inpatient psychiatric services; none of these services are offered by SACMC at any of its locations. Shannon further offers 3D-mammography, an important tool for early detection of breast cancer, at its Shannon Women's Imaging Center. The Center houses state-of-the-art mammography, ultrasound, bone density, stereotactic breast biopsy, and MRI equipment, facilitating the provision of services that are either difficult to obtain or not available at SACMC. Finally, Shannon provides air ambulance services, including fixed rotor aircraft, which covers 13 counties and more than 131,323 square miles of West Texas. Shannon's AirMed 1 has been awarded the Air Medical Service Award by the Texas Department of State Health Services four times.

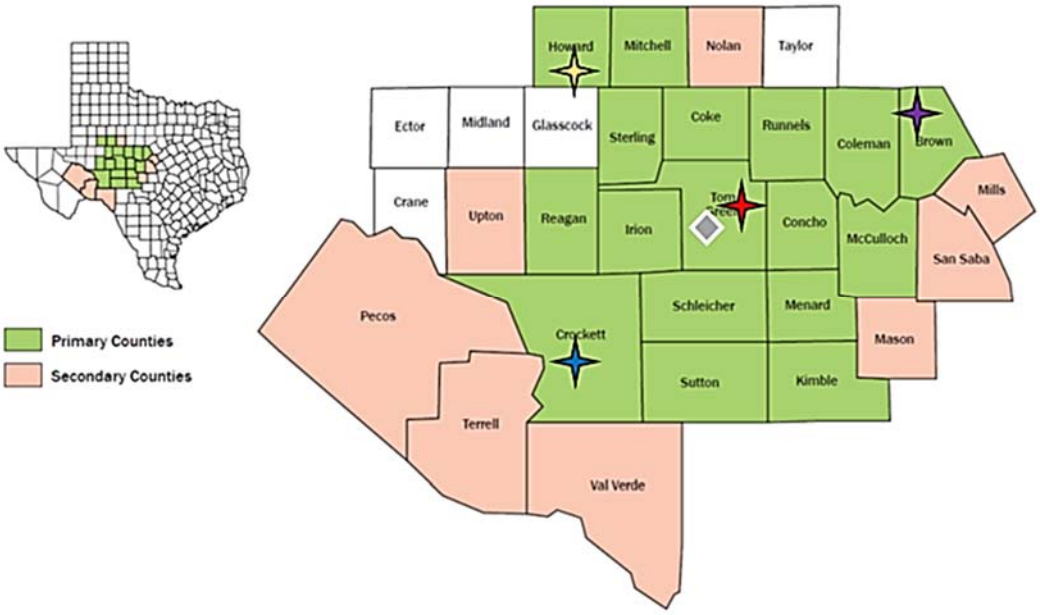
In addition, Shannon has an expansive network of providers and specialists, employing or contracting with more than 275 physicians and advanced practice professionals, including numerous specialists. SACMC generally employs or contracts with primary care or general medicine providers.

2. Geographic Service Areas

Shannon and SACMC serve different geographical areas and care for largely distinct populations. While there is some degree of overlap—both parties serve patients in Tom Green County—Shannon draws patients in and around the Concho Valley. Shannon's primary service area covers 17 counties across West Texas, as demonstrated in green in Figure 1. In its secondary service area, Shannon also draws patients from Val Verde, Terrell, Pecos, Mason, San Saba, Mills, Upton, and Nolan counties (indicated in brown in Figure 1). The 25 counties from which Shannon draws patients have a population of over 300,000 residents. Shannon's locations are identified in the key provided in Appendix A.

SACMC's service area is primarily limited to Tom Green County, as demonstrated in Figure 2. These locations are identified in Appendix B.

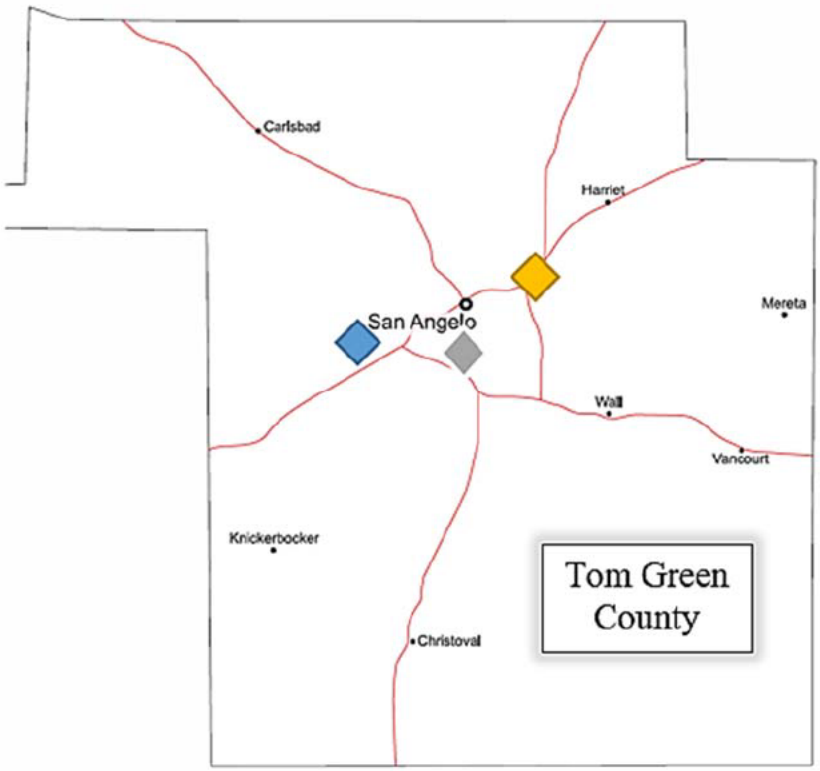
Figure 1: Shannon Primary and Secondary Service Areas*



Legend for Figure 1	
	Shannon's locations in San Angelo (including 3 hospitals, 16 clinics, and 2 urgent care centers)
	Shannon Clinic – Big Spring, Texas
	Shannon Family Health Center – Ozona, Texas
	Shannon Clinic – Brownwood, Texas
	SACMC's locations in San Angelo (including a Family Center, an outpatient therapy location, a sleep center, 2 rehabilitation centers, and an Anticoagulation/Coumadin clinic)

*The primary service area includes counties from which 75% of Shannon's patients are drawn. The secondary service area includes counties from which 90% of Shannon's patients are drawn.

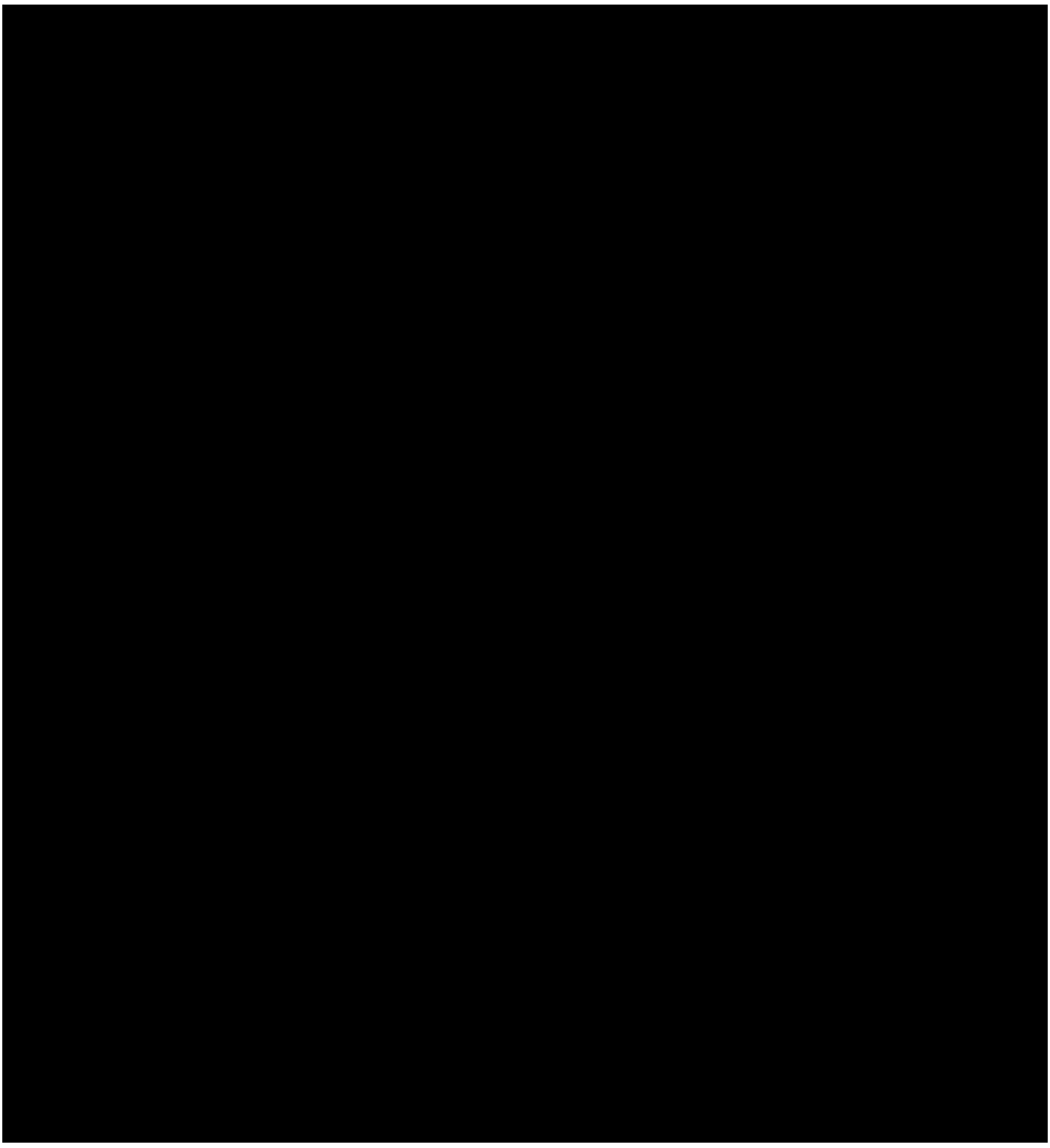
Figure 2: SACMC's Primary Service Area



Legend for Figure 2	
◆	SACMC's locations in San Angelo (including a Family Center, an outpatient therapy location, a sleep center, 2 rehabilitation centers, and an Anticoagulation/Coumadin clinic)
◆	Community ExpressCare – Sherwood Way
◆	Community ExpressCare – Bryant

3. Volumes And Operating Statistics

As demonstrated in Exhibit A, Shannon is the larger hospital, with more than twice as many beds, higher volumes, and greater breadth and depth of service offerings as SACMC. [redacted]



Despite its best efforts to accommodate all patients in need, due to extensive renovations and increasing admissions, Shannon's capacity is currently constrained, and the hospital is forced to transfer hundreds of patients each year. Importantly, even when Shannon's occupancy rate is documented at less than 100%, it may still be at effective capacity because hospital beds are not all "interchangeable"—i.e., certain patients must be placed in specific units or wings. For

example, intensive care unit ("ICU") patients require unique services, equipment, facilities, and staffing not available elsewhere in the hospital. Moreover, Shannon's capacity figures understate its actual constraints, as Shannon does not report capacity utilization for patients who are in observation status or being held in the emergency department waiting for an inpatient bed.

[redacted]

[redacted]

[redacted]. Patients will be better served, and each hospital should realize operating efficiencies. Overall, the transaction will benefit the public by maintaining and improving the quality, efficiency and accessibility of health care in the combined Shannon and SACMC 25-county service area.

II. AUTHORIZATION TO PURSUE APPLICATION

In response to the health care crisis facing Texas communities (discussed below in Section IV), the Texas Legislature explored solutions during its 2019 session to maintain the availability of quality health care in less populated and rural areas. The Legislature concluded that rural hospitals "would benefit from having additional tools to combat challenges and improve health care services."[2] The Legislature and Governor Abbott provided rural hospitals

with those tools by enacting House Bill 3301 (the "Law"), which authorizes certain merging hospitals[3] to apply for Certificates of Public Advantage ("COPAs").

Merging hospitals that wish to obtain a COPA must submit an application to a designated State agency, chosen by the Governor of Texas, after which the agency reviews the application and issues a decision within 120 days of the filing. The Governor selected the Texas Health and Human Services Commission (the "HHSC" or the "Commission") to serve as the designated agency for this application.

If, under the totality of the circumstances, the HHSC finds that the likely benefits of the transaction outweigh any disadvantages associated with a reduction in competition, the Law directs that the COPA shall issue. In making its determination, the Commission must consider the effect of the transaction under certain enumerated factors (the "Criteria for Approval"). The HHSC also may consider whether to include terms or conditions of compliance in connection with the certificate, if necessary.

Further, the Law also provides for the Attorney General of Texas to review the COPA application and advise the HHSC about his or her views on the transaction's effects with regard to quality, efficiency, and accessibility of health care services offered to the public.

To that end, the Law establishes a program whereby after approval, the State will actively supervise the ongoing conduct of the combined entity to ensure that it continues to benefit the public.[4] The Law also states the Legislature's conclusion that the best way to maintain access to quality healthcare in rural Texas is to supplant state and federal antitrust laws with a process for regulatory approval, oversight, and active supervision under the COPA process.

III. CRITERIA FOR APPROVAL

The Law articulates several goals that the transaction should foster, including that the transaction likely benefits the public by maintaining or improving the:

- quality of health care services offered to the public;
- efficiency of health care services offered to the public; and
- accessibility of health care services offered to the public.

While those goals serve as considerations to the parties in entering a covered transaction, the Law provides a simple standard for the Commission in reviewing a COPA application. The HHSC must simply determine under the totality of circumstances whether "the proposed merger would likely benefit the public by maintaining or improving the quality, efficiency, and accessibility of health care services offered to the public," and whether those likely benefits "outweigh any disadvantages attributable to a reduction in competition" that may stem from the transaction. To facilitate this evaluation, the Law provides for COPA applications to provide information about:

- how the proposed merger would likely benefit the public; and

- how the likely benefits resulting from the proposed merger may outweigh any anticompetitive effects of joining together competitors to address unique challenges in providing health care services in rural areas.

The Law calls for the agency to "consider" the effect of the merger on the following factors, but emphasizes that this is a non-exhaustive list:

- quality and price of hospital and health care services provided to Texas citizens;
- preservation of sufficient hospitals within a geographic area to ensure public access to acute care;
- cost efficiency of services, resources, and equipment provided or used by the merging hospitals;
- ability of health care payors to negotiate payment and service arrangements with the merging hospitals; and
- extent of any reduction in competition among physicians, allied health professionals, other health care providers, or other persons providing goods and services to, or in competition with, the merging hospitals.

IV. COMPETITIVE EFFECTS: THE RURAL HEALTH CARE CRISIS IN TEXAS

Rural hospitals in America are facing significant financial challenges—with more than 600 rural health care facilities, including 300 hospitals, currently estimated to be vulnerable to closure.[5] In Texas, this crisis is especially acute, where the State has seen an epidemic of rural hospital closures.[6] Since 2010, 20 rural Texas hospitals have closed—more than in any other state.[7] Moreover, experts believe that rural hospital closures in Texas could nearly double in the immediate future, with 13 additional Texas hospitals at risk of closing.[8] Texas had 300 rural hospitals in the 1960s, when the state population was just over 10 million. That number is down to just 158 rural hospitals in 2019,[9] while the state population has increased to over 28 million.[10] These hospitals, which are often the only health care service providers for many miles, tend to serve older and poorer patients, and accordingly face higher burdens of unpaid or underfunded care, such as Medicare and Medicaid.[11]

The closure of rural hospitals in Texas has affected almost every part of the State. Today, 63 Texas counties—roughly a quarter of the State—have no hospitals.[12] In west central Texas, two hours north of San Angelo, Stamford Memorial Hospital closed its inpatient care units and emergency services in 2018, blaming the "steady decline in hospital inpatients over the past ten years."[13] The remaining 155 rural hospitals in Texas, such as Shannon and SACMC, provide care to more than 3.1 million Texans, serving 12% of the Texas population and covering emergency and local hospital care for 85% of the state's geography.[14] Many rural hospitals face substantial capital needs relating to their physical plant and ongoing operations, unfavorable patient reimbursement trends, and difficulty recruiting health care providers to serve their patients.

West Texas is, if anything, even harder hit than the rest of the State. In West Texas, more than 2.6 million people, or 14% of the state population, live across 131,323 square miles.[15] Of the 108 counties of West Texas, 99 are classified as rural and 54 are sparsely populated, with fewer than seven persons per square mile.[16] Only Alaska has more frontier landmass than Texas, and most of the Texas frontier landmass is in West Texas.[17] Unlike East Texas, which has major urban centers and small towns that dot the highway every 10 to 12 miles, communities in West Texas are much more isolated. In fact, San Angelo is one of only seven health care hubs scattered across the 108 counties of West Texas.

A. Factors Contributing To Rural Hospital Financial Decline

Payor mix. Rural hospitals tend to treat older and less affluent patients, and therefore shoulder a higher burden of unpaid or underfunded care, including Medicare and Medicaid patients, relative to urban hospitals.[18] Medicare and Medicaid reimbursement rates are typically below the actual cost of providing care to program beneficiaries. A recent survey of hospitals conducted by the American Hospital Association calculated that, in 2017, hospitals only received 87 cents for every dollar they spent caring for Medicare and Medicaid beneficiaries.[19] This problem will only get worse as rural communities age and rural hospitals tend to become even more affected by patients shifting from commercial insurance to Medicare.[20]

Hospital reimbursement cuts. Hospitals, which already lose an average of 13 cents on every dollar of government-reimbursed care provided, also have been subject to additional across-the-board federal and state reimbursement cuts, even though the cost of providing services has continued to increase. Cuts include the two percent Medicare payment reduction under Federal Budget Sequestration, a 10% Texas Medicaid outpatient payment reduction in 2011, and a 40% payment reduction for non-urgent use of the emergency room by a Medicaid recipient, among others.[21] The Federal Budget Sequestration was a process introduced by the Budget Control Act to end the 2011 debt-ceiling crisis. It consisted of across-the-board spending cuts that acted as a disincentive to be activated only if Congress did not pass a deficit reduction.[22] Although CMS will implement modest reforms to address the reimbursement gap for rural hospital services, it is too little, too late.[23]

Large disparities remain between urban and rural hospital systems, some of which are likely to worsen, particularly with respect to the population that falls in the coverage gap between Medicaid and the lower limit for Marketplace premium tax credits through the Affordable Care Act ("ACA"). For example, the ACA requires that policymakers reduce Medicaid Disproportionate Share Hospital ("DSH") payments, which are federally mandated payments that state Medicaid programs make to qualifying hospitals that serve a large number of Medicaid and uninsured patients.[24] Congress has delayed the cuts to DSH payments numerous times, and has agreed to keep funding at 2019 levels through May 2020; however, it is expected that the required reductions will be implemented in the near future.[25]

Services shifting from inpatient to outpatient settings. Services increasingly are shifting from an inpatient setting to outpatient settings. For example, outpatient surgeries, laboratory and imaging services were traditionally primarily available in hospitals, but are now offered at stand-alone facilities or by other providers, such as ambulatory surgery centers and Federally Qualified Health Centers. While this has the benefit of providing greater access to health care and more

convenience for patients, ironically, it also reduces the demand for certain reimbursable services traditionally provided by rural hospitals. Consequently, many rural hospitals must still offer these services, and absorb the associated high fixed costs, yet experience much lower volumes of patients across which those fixed costs may be spread.

Higher operating costs for rural hospitals. The operating costs in a rural hospital can be higher on a per-patient basis because of challenging dynamics such as low patient volume, dramatic swings in patient numbers from day to day, recruitment difficulties that drive up payroll costs, and a general lack of scale economies for high volume purchasing and procurement.[26] In contrast, hospitals in urban areas have comparably lower operating costs due to predictable, high-volume patient flows.[27] Rural hospitals are often plagued by inconsistent patient volume from populations facing more acute health problems.[28] This combination reduces the ability of rural hospitals to negotiate lower prices with suppliers while also requiring rural hospitals to provide expensive health care services. Additionally, rural hospitals often experience significant difficulty in recruiting health care providers to their communities.[29] Rural hospitals have a median wage index that is lower than the median urban hospital wage index.[30] Studies have shown that compensation and base salary is a consideration that has significant influence on a physician's decision to accept a position at a rural hospital.[31] Finally, rural hospitals often struggle with capitalization as it relates to large capital expenses to maintain or replace their facilities and expensive medical equipment.[32]

Rural populations suffer from more health problems. The rural hospital crisis is further exacerbated by fundamental health disparities between urban and rural populations. Many studies have shown that rural populations suffer a greater incidence of severe health problems than urban populations.[33] One study notes that the rural health care crisis is exacerbated by the fact that rural populations have a greater rate of diabetes and suffer from a higher exposure to the opioid epidemic.[34]

In Texas, rural populations face numerous health concerns, including adult obesity, lack of health knowledge or education, lack of access to mental health providers, shortage of primary care physicians, and unhealthy behaviors and lifestyles.[35] Moreover, a recent study found that numerous social determinants affect an individual's health status, including: access to insurance, income, employment, and education level achieved.[36] The same study found that:

- 16% of Texas residents do not have health insurance—nearly double the national average of 8.9%;[37]
- rural Texans' per capita income is lower than that of their urban counterparts;
- the unemployment rate in Texas is higher in rural areas than in urban centers; and
- 21.9% of rural Texans do not have a high school diploma, compared with 15.6% of urban populations in Texas.[38]

Additionally, Texas has the largest share of children without health coverage, with more than one in five uninsured children in the United States residing in the state.[39] This highlights the clear need for access to quality health care close to home in rural areas, as well as the fact

that rural hospitals often care for patients with co-morbidities that experience multiple chronic conditions and require regular and expensive care. This care may be reimbursed by Medicaid or Medicare, which often does not cover the cost of the care provided, much less generate a positive margin to allow for reinvestment.

Rural population outmigration. Nearly 35% of rural counties in the United States are experiencing protracted and significant population loss, according to new research.[40] In Texas, the rural population shrunk from 75.9% of the state's population in 1910 to just 15.3% in 2010.[41] Projections based on historic census data predict that 95% of Texas's population growth will occur in metropolitan areas.[42] The decline in rural populations, however, does not obviate the need for health care services in those areas. As rural populations experience a disproportionately higher incidence of many serious health conditions and significant difficulty in accessing quality medical care, it is essential that people that choose to stay or are unable to move continue to have high quality health care available in and around their local communities.

B. The Effect Of Rural Hospital Closures On Local Economies

As a result of the foregoing conditions, rural populations are particularly vulnerable to hospital closures. These serious financial challenges threaten hospital closures and place enormous economic pressure on local economies. Approximately 64 percent of rural hospitals nationwide are considered highly essential to their community's health and economic well-being.[43] One study, which looked at rural counties experiencing a closure between 1990 and 2000, found that the closure of a single hospital in the community reduced per-capita income and increased the unemployment rate by 1.6 percentage points.[44] Furthermore, when local hospitals close, the people in these communities must drive farther to receive health care services and the overall health of local communities deteriorates.[45]

The rural hospital crisis serves as the backdrop for the subject transaction, and demonstrates its vital importance to the community. SACMC faces many of the problems that are endemic to rural health care in Texas. [redacted] As outlined in detail in the subsequent sections, the proposed transaction would strengthen SACMC to remain a vibrant provider in the West Texas community for years to come.

V. BENEFITS OF THE TRANSACTION

As addressed more fully throughout the application, the complementarity of Shannon and SACMC would serve to generate significant benefits to the local community. SACMC patients could access Shannon's broad portfolio of higher-acuity services and specialties currently offered at numerous sites in and around San Angelo. At the same time, the transaction would enable Shannon's patients to receive faster care with shorter wait times by alleviating Shannon's capacity limitations. Further, the transaction would allow Shannon to achieve greater efficiency and scale, so it could invest in new technology that would improve the patient experience and provide greater access to all community residents.

Across the combined facilities, the transaction would permit Shannon to better allocate services and unused capacity at SACMC and outpatient clinics, while ensuring ready access to higher-acuity care through SMC or the Shannon St. John's campus. Health care providers at both merging hospitals would be able to share knowledge and learn from each other to improve quality and the level of services. Physicians, particularly specialists, could render services at any of the three collective campuses, expanding access to a variety of specialties in different locations, leveraging professional expertise to benefit a wider community of patients.

The transaction would coordinate resources and decision making, resulting in improved efficiency, the elimination of waste, and the achievement of cost savings that would be reinvested locally to improve healthcare and maintain jobs in San Angelo. Shannon's commitment to the local community is evident in both its not-for-profit status and its commitment to charity care. The Shannon Trust, established in 1931, is the financial foundation for Shannon, serving Tom Green County residents and beyond. The Trust enables Shannon to grow and develop new ways of providing care, as well as fulfill its non-profit mission. In FY2019, the Shannon Trust contributed $19.5 million to fund capital improvements, purchases, and other community-oriented projects. The transaction would allow SACMC and its providers and patients similarly to benefit from the Trust's legacy and the financial stability it provides.

VI. METHODS FOR ACHIEVING THE STATUTORY OBJECTIVES

The Law calls for a determination of whether likely benefits outweigh competitive harms stemming from the transaction and articulates several criteria for the designated state agency (the HHSC) to consider. As explained below, the contemplated transaction clearly satisfies these criteria. The Commission should therefore approve the application and issue the COPA.

A. Quality Metrics

1. Quality Improvement

Recognition of Shannon's Quality. Shannon has won numerous quality of care accolades. As of 2020, Shannon Medical Center is a CMS 5-Star Rated Hospital. Shannon was one of the nation's Top 50 Cardiovascular Hospitals in 2019, according to IBM Watson Health. In 2019, Shannon also was awarded four Quality Awards from the American Heart Association, including the "Gold Plus" award for Heart Failure and Stroke. In addition, Shannon has received the 2019 Texas Hospital Association Bill Aston Award for Quality; American College of Surgeons Meritorious Hospital Award; 2019 Elite Homecare Award; CMS 5-Star Rating for Skilled Nursing Facility; and the 2019 TMF Physician Practice Quality Improvement Award. Shannon's quality of care has also been recognized through awards given to Shannon by the Immunization Action Coalition, Texas 10 Step Program, National Hospital Organ Donation Campaign; and the National Cardiovascular Data Registry. Shannon's home care, oral health, nursing home, and imaging center services have also received quality of care awards.

In addition, Shannon has achieved numerous accreditations, certifications, and designations, all of which demand a high level of quality to obtain and maintain. These certifications include American College of Surgeons Metabolic and Bariatric Surgery Comprehensive Center Accreditation; The Society of Thoracic Surgeons; Center for

Improvement in Healthcare Quality Acute Care Hospital Program Accreditation; Center for Improvement in Healthcare Quality Disease Specific Certifications for Joint Replacement Surgery and Primary Stroke Center; and Texas Department of State Health Services Trauma Level III Lead Trauma Facility.

Recognition of SACMC's Quality. SACMC has received several accreditations demonstrating quality healthcare: The Joint Commission Accreditation – Hospital and Laboratory; American College of Cardiology Chest Pain Center and Heart Failure Center Accreditations; American Academy of Sleep Medicine Community Sleep Center Accreditation; American College of Radiology Accreditation; and Commission on Cancer: American College of Surgeons Accreditation; and Texas Department of State Health Services Trauma Level III Trauma Facility.

Benefits of the Transaction. The proposed transaction would allow the parties to maintain the high level of quality at Shannon and strengthen quality at SACMC as Shannon and SACMC collaborate to implement the most effective practices, protocols, and programs currently in place at each hospital across the combined system. Specifically, the transaction would allow Shannon to disseminate to SACMC the best practices and protocols that have led to Shannon's CMS 5-star rating, top cardiovascular program and multiple quality awards, ultimately improving quality at SACMC. Further, increased coordination of care—clinical integration—between facilities and providers will likely lead to a reduction of medical errors and cost savings, such as those associated with treatments by different physicians who are not coordinating with each other.[46]

2. Facility Improvement

Shannon has a longstanding history of reinvesting in its operations to improve patient care. For example, Shannon built the Harris Clinic in 2016 at a cost of approximately $26 million and built the Jackson Clinic in 2018 at a cost of approximately $9 million. Shannon also invests $10 million to $15 million annually in routine capital projects. The transaction would allow patients treated at SACMC to benefit from Shannon's resources, and would free up additional capital through cost efficiencies, allowing for greater reinvestment throughout the combined system.

Currently, Shannon is improving the patient experience through a capital improvement project of its bed tower. This project involves a four-floor update that will add over 66,000 square feet of additional space and 43,000 square feet of renovated space. To date, Shannon has completely renovated:

- First floor: Emergency Department Phase "4"
- Second floor: Cafeteria remodel
- Third floor: New post-anesthesia care unit (PACU); renovated ICU patient rooms
- Fourth floor: Cath Lab remodel; Pharmacy remodel

By April 2020, Shannon expects to have completed the following additional renovations or new units:

- First floor: Lab remodel
- Third floor: New GI unit

Shannon also plans to double its rehabilitation room capacity to improve its ability to meet the level of demand for its inpatient rehabilitation services, which notably is a service SACMC does not provide. Shannon will offer comprehensive rehabilitative services to patients overcoming a variety of debilitating illnesses and injuries, such as stroke and other neurological disorders, brain injuries, spinal cord injuries, amputations and complex orthopedic conditions. Patients will receive at least three hours of intensive therapy for five days each week, frequent face-to-face visits with a physician and 24-hour nursing care during their stays.

Although Shannon's investments are helpful to ensuring and expanding access to services, Shannon recognizes that capital projects alone are not the most effective method for meeting its community's needs. Shannon's current construction plan, for example, will not completely fulfill its capacity needs. Rather, the most cost efficient and compelling way of ensuring that quality facilities are available to local patients is through this transaction.

[redacted]

Through the transaction, SACMC's capital needs will be met, benefitting patients, care providers, and employees. Further, Shannon's longstanding ability to provide capital investment as a means of achieving and maintaining high quality services will ensure that future capital needs at SACMC are met as they arise, improving patient experience and outcomes.

3. Integrated Interoperable Medical Records System

The San Angelo community would also benefit from a fully integrated, uniform electronic medical records system deployed across the merged facilities. Currently, Shannon has a fully integrated electronic records system with Epic deployed at all of its sites of care. SACMC uses three electronic records systems depending on the site of care: SACMC's inpatient operations use MedHost, its emergency department uses EDIS, and its outpatient clinics use Athena. [redacted] Having a single system promoting seamless communication among various providers would lead to more accurate, efficient care and ease of use.

Through the transaction, Shannon and SACMC facilities would have a single, fully integrated and interoperable medical records system so that patient histories and treatment records across the various locations would be readily available to physicians at all system locations in real time. The sharing of information between providers across locations would

facilitate better patient care and coordination of treatments, and decrease unnecessary duplication of health care services.[47] Additionally, the broader application of a unified electronic medical record system would foster improved population health initiatives by allowing for more robust data analytics. This benefit cannot be realized without the transaction, as implementation of a common IT platform requires sharing of proprietary information and commitment of significant resources by both systems, which would be infeasible for independent health systems to pursue.

4. Higher Volumes Are Associated With Better Outcomes

Higher patient volumes are associated with better outcomes across a wide range of procedures and conditions. This proposition is supported by numerous articles from members of the academic community and governing specialty organizations.[48] Combining the resources of Shannon and SACMC would allow for the coordination of key service lines that Shannon and SACMC offer separately (such as cardiovascular surgery or dialysis), leading to increased volumes, which would improve quality of those services. Moreover, the transaction likely would allow for the development of new services, which neither entity has the volume to provide separately, such as enhanced post-acute care services, quaternary care, and mental health services. Additionally, the combination would allow for the creation of centers of excellence, which would increase the volumes, and as a result, quality of those services.

The transaction would also allow Shannon and SACMC to treat a larger combined patient base, thereby enhancing population health efforts. Population Health Management ("PHM"), especially at a local level, could help to alleviate access issues in rural communities. By developing rural accountable care and clinically integrated collaborative networks or service delivery platforms, health systems can align rural hospitals and other providers to prepare for and respond to the shift toward value-based health care.[49] PHM can provide a framework for designing, implementing, and measuring the impact of a plan to improve a community's overall health by taking into account a population's varying health needs through engaging with and targeting certain populations.[50] Through PHM initiatives, health systems can gather patient information in an efficient manner to focus on health disparities of smaller sub-populations.[51] In addition, PHM can bolster coordination of care amongst providers and data-driven strategies by collaborating with public health organizations to pool resources and create unified community outreach efforts to enhance proactive health measures.[52]

The population served by Shannon and SACMC has long had significant health challenges compared to the population in the United States generally. The State of Texas, and particularly the area served by Shannon and SACMC, has significantly higher rates of many chronic conditions such as obesity, diabetes, heart disease, and cancer.[53] For comparison purposes, Exhibit B below shows the percentages of physical inactivity, adult obesity, adult smoking, and number of mentally unhealthy days per month in each county in the service area, the overall service area, the state of Texas, and the United States.[54] The service area, which comprises 25 counties, has higher average numbers in all categories than the state of Texas, and higher averages for physical inactivity and adult obesity than the average U.S. percentages. It therefore stands to reason that areas of rural Texas would benefit from increased population health management.

Exhibit B: Geographic Service Area Health Rankings[55]

COUNTY	% Physical Inactive	% Obese (Adult)	Tobacco Abuse (Adult Smoking)	Mentally Unhealthy Days
Brown	29%	32%	18%	3.7
Coke	31%	29%	15%	3.6
Coleman	26%	28%	16%	3.7
Concho	24%	31%	15%	3.1
Crockett	24%	28%	14%	3.4
Howard	24%	37%	16%	3.8
Irion	24%	29%	13%	3.4
Kimble	27%	31%	14%	3.6
Mason	25%	28%	13%	3.5
McCulloch	27%	29%	16%	3.9
Menard	26%	29%	13%	3.5
Mills	26%	28%	14%	3.7
Mitchell	23%	31%	14%	3.2
Nolan	29%	31%	16%	3.7
Pecos	23%	32%	14%	3.2
Reagan	22%	29%	16%	3.5
Runnels	25%	30%	15%	3.6
San Saba	24%	30%	16%	3.8
Schleicher	24%	29%	13%	3.2
Sterling	23%	27%	17%	3.9
Sutton	22%	30%	12%	3.3
Terrell	26%	28%	15%	3.8
Tom Green	23%	29%	15%	3.4
Upton	23%	28%	16%	3.6
Val Verde	24%	27%	16%	3.7
Service Area Average	25%	30%	15%	3.6
Texas Average	23%	29%	14%	3.4
US Average	22%	29%	17%	3.8

Coordination of population health information and enhancement of population health status is consistent with Shannon's health goals. In 2019, Shannon completed a comprehensive Community Health Needs Assessment ("CHNA"). The report involved a year-long study to highlight the more prevalent health needs of residents within Tom Green County. Within Tom Green County, per capita income and educational attainment rates are less than state and national averages. The population is aging: residents who are 65 years and older represent 14.6% of the community, as compared to 11.7% for Texas.[56] And the poverty rate (12.9%) is similar to state and U.S. averages, with the exception of some zip codes, while the uninsured population (16.3%) is higher than the national average (10.5%) but lower than the state average (18.2%).[57]

The CHNA identified the following five predominant health needs in the community: 1) adult obesity; 2) lack of health knowledge/education; 3) lack of mental health providers; 4) shortage of primary care physicians; and 5) healthy behaviors and lifestyles.

While Shannon is working in the community to address and improve these health challenges, the transaction would make it possible to incorporate and utilize SACMC's resources to tackle these challenges. A coordinated and more robust approach will likely have greater reach and overall success across the service area, eliminate unnecessary and duplicative costs, and free up resources of the combined entities to invest in new services and technologies. Separately, as independent systems, the parties are limited from sharing certain information and resources to achieve these initiatives. For example, as discussed above, having an integrated medical records system that can provide comprehensive data analytics on the population served is essential to identifying, addressing, and improving the population health status of the community. The combined entity will attract higher patient volumes across the system that will foster more successful PHM initiatives.

B. Price Metrics

Following Shannon's acquisition of SACMC, the combined system will continue to compete vigorously with hospitals in the region and beyond. In this case, there are separate supervision provisions in place to ensure that consumers will not be harmed by the transaction with respect to prices for health care services.

1. The Parties Must Justify Price Increases And Receive Approval Of The Designated Agency

The Law prevents the parties from increasing inpatient and outpatient prices without justifying such increases to, and receiving approval from, the designated agency. As a preliminary matter, the vast majority of patients at both Shannon and SACMC are insured by government payors which set the reimbursement rates for those patients. [redacted] Nonetheless, there are multiple mechanisms in place restricting Shannon's ability to raise rates post-closing. First, for any change of inpatient and outpatient service rates, the parties must seek approval from the HHSC at least 90 days before the change in rates would take effect. Second, for any change in reimbursement rates under an agreement with a third party payor, the parties must submit a proposal to the HHSC for a change in rates at least 60 days before the execution of a third party payor's reimbursement agreement. The parties must describe the justification for the changed rate if the proposed rates are above a benchmarking amount chosen by the HHSC. Third, for any agreement with insurers that provides for health care services under Medicaid or Medicare, the parties must provide similar justification to the HHSC for the proposed rates, and describe whether the proposed rates exceed the previous rates. For any submission related to a change in rates, the parties must also provide information concerning costs, patient volume, payor mix,

acuity, and other information requested by the HHSC. After reviewing the changes, the HHSC can reject or approve the proposed rates.

Given the effect of the relevant legislation and the resulting active supervision by the HHSC, the parties are prevented from lessening the ability of health care payors to negotiate payment and service arrangements with the hospitals proposed to be merged under the agreement.[58]

2. The Transaction May Also Facilitate New Payment Models That Incentivize Better Quality And Lower Cost

The transaction may also facilitate new payment models. As the statute and active supervision by the HHSC restricts the parties from gaining revenue by simply raising prices, it is likely the parties will be forced to move away from fee-for-service models to value-based models. In a fee-for-service model, providers are paid per person per visit—regardless of clinical outcome. Today, reimbursement models are moving towards value-based reimbursement systems, which incorporate clinical outcomes in provider reimbursement and generally provide differential payments based on measures of clinical quality and cost.[59] For example, a valued-based model can reimburse providers based on their ability to deliver timely and appropriate care. By rewarding providers for their ability to deliver timely and appropriate care, value-based models, in turn, reward greater provision of quality care, improved access, and lower costs than traditional payment models. Value-based models support the goals of health reform: improving patient experience, improving population health, and reducing per capita costs of health care.[60]

The statute's restrictions on raising prices and subsequent supervision over pricing incentivizes the combined organization to consider innovative payment models. The combined entity can establish payment models that are increasingly favored by commercial payors, such as shared savings programs, bundled payments and capitation. These programs are all ways of participating in value-based care, and are linked to improvements in health care cost savings, increased quality, and better health care spending.[61] Relatedly, the transaction will allow the combined entity to facilitate these new payment models with payors. Value-based models are all linked to better care coordination, lower administrative costs with savings used for service line expansions, and increased points of access focusing on convenience to patients and accessibility.[62]

C. Preservation and Access to Care

The same headwinds facing rural hospitals generally, discussed above, are present in Tom Green County. The population in Tom Green County is growing at half the rate of the state of Texas as a whole. Further, Tom Green County is less populous (72 people per square mile) than many areas in Texas, and has a greater portion of residents who are age 65 or older (15%) than the state and national average. A high proportion of SACMC's patients are covered by Medicare or Medicaid. While Shannon has responded to the shift from inpatient to outpatient care by building freestanding emergency departments and ambulatory surgery centers, SACMC also has a small number of outpatient sites of care.

Rural hospitals in the U.S. are facing challenging dynamics that lead to higher operating costs: low patient volume, dramatic daily and seasonal swings in patient numbers, and recruitment difficulties which drive up provider costs. Through the transaction, the combined entity could mitigate the severe risks facing rural hospitals that would otherwise threaten access to care generally across Tom Green County.

1. Clinical Optimization Aids Access To Care

[redacted]

It is only through the proposed transaction that the parties have the incentive and ability to coordinate care in a way that improves efficiency and increases the quality of care provided to patients in the West Texas region.

2. Telehealth Broadens Access To Care

Improvements in the area of telehealth would also substantially increase health care access. Telehealth has expanded the availability of access and treatment to patients residing in rural areas.[63] The spread of telemedicine will assist with the treatment of rural patients who do not have immediate or convenient access to health care facilities. While there are significant benefits that can be realized through telehealth, this new form of technology comes with numerous challenges. For example, telehealth requires substantial communications-related infrastructure in place to be effective. Access to reliable, fast, and affordable broadband is required to support telehealth programs, as well as health information technology and health information exchanges.[64] Rural areas are often plagued by inaccessible internet connections or below-average grade internet connection speeds, which hinder this population from experiencing the benefits of telehealth or other technology-based care.[65]

Inadequate government payor reimbursement creates a challenge for telehealth programs in rural areas as well. For example, as of February 2019, Medicare only reimbursed for live-video conferencing telehealth services in a limited number of scenarios, and Medicare Advantage plans have only been able to offer additional telehealth benefits since January 2020.[66] Thus, the population of people who may benefit the most from telehealth-based care may currently experience the most difficulty accessing it.

In Texas, telemedicine is defined broadly as a health care service delivered by a physician or health professional acting under the delegation and supervision of a physician "to a patient at a different physical location than the physician or health professional using telecommunications or information technology."[67] Telemedicine is expressly authorized as a method for establishing a physician-patient relationship. As the availability of health care resources in rural areas diminishes, telemedicine holds the potential to equalize—or at least improve—access to care for patients in rural and other underserved communities. The use of telehealth services in rural areas increased by 1,393% from 2014 to 2018, and today, Texas Medicaid provides reimbursement for remote patient monitoring (i.e., the real-time streaming of patient data).[68]

Shannon recognized early on the benefits of using telehealth to serve patients in rural communities. In 2016, Shannon implemented a new telemedicine program that connected

pediatric physicians and specialists between Shannon and Cook Children's Medical Center, based in Fort Worth, Texas, for face-to-face visits. Although Shannon is home to several pediatricians, there are instances where specialists such as neonatologists or pediatric cardiologists are needed to help make a diagnosis or determine treatment options. This program, funded by Shannon's Children's Miracle Network, enables families to confer with Cook's pediatric physicians and specialists, while physically remaining in San Angelo.

Shannon's commitment to telehealth and ensuring access to care continues to grow. In 2018, Shannon launched an online, urgent care platform, "Shannon On Demand," for digital health. Patients can download the "Shannon on Demand" app to their phone or tablet, or device and connect with board-certified providers—who are available 24/7—to treat common health conditions with virtually no wait.[69] Through the app, providers give video consultations, make diagnoses, and write prescriptions as necessary. Shannon has leveraged this success with its on-demand digital platform to other areas of telehealth, and plans to combine resources with SACMC to continue and maintain this critical access to health:

- **EPIC/MyChart Clinic Visits**. Shannon MyChart Medical Record Access is an online application that enables a patient to have secure web-based access to portions of their Shannon medical record, and allows a secure, convenient communications channel with Shannon for non-urgent messages.

- **School Based Telehealth**. Shannon uses TytoCare's portable, telemedicine solutions for on-demand school-based care in rural school districts. Tyto offers a device and platform for participants to be evaluated remotely by a physician, after an in-person examination.[70] In 2020, Shannon plans to partner with Angelo State University to offer Shannon On Demand to university students.

- **Skilled Nursing Facilities / Long-Term Care**. Shannon is focused on increasing TytoCare equipment availability in long term care facilities and skilled nursing facilities. In 2020, Shannon plans to provide specialty care follow-ups through telemedicine, for endocrinology, pneumonia, orthopedics, and other services.

Further collaboration between Shannon and SACMC with respect to telehealth will allow SACMC to benefit from Shannon's experience and resources in telehealth, thus providing innovation and expanded healthcare access to SACMC patients, ensuring a pathway to high quality care across more rural areas of West Texas.

3. Improved Recruitment Opportunities Will Also Expand Access To Care

Clinical. Based on a study published by the Association of American Medical Colleges, the United States will experience a shortage of nearly 122,000 physicians by 2032.[71] The study notes that one of the major driving forces for the shortage is a growing, aging population—a 48% increase in the population of individuals over 65 is projected by 2032.[72] As previously discussed, West Texas currently faces a shortage of physicians and other skilled caregivers. By acquiring SACMC, Shannon will be better positioned to recruit and retain physicians and other providers.

Shannon has a successful history of retaining medical care providers. Shannon's success has been attributed to outstanding administrative support of physicians, award-winning clinical settings in which to practice, and [redacted] Shannon has one of the lowest unplanned turnover rates (less than 11%) for full and part-time employees, compared to a 17.9% for South Central regions of the United States, and 17.2% for hospitals with 350 to 500 licensed inpatient beds. In addition, while the national average turnover for physicians is 6.8%, Shannon's physician turnover rate is less than 2%.

Many U.S. hospitals the size of SACMC and in smaller, rural communities find it challenging to recruit and retain physicians, particularly in specialized fields, due to call coverage support.

While Tom Green County has a greater rate of primary care physicians per capita than the average in the state, many of the surrounding counties lack sufficient access to primary care.[73] Many of the facilities located in these counties are short-term and critical access hospitals, while some counties do not even have a hospital located within them.[74] Residents in the surrounding counties rely on medical providers located in Tom Green County. For primary care, Shannon plans to recruit and hire more primary care providers, and requires the physicians to be board-certified applicants.

Access to high-quality care in West Texas will be maintained as a result of Shannon's and SACMC's combined ability and commitment to recruit and retain excellent health care providers in the community. Post-transaction, Shannon plans to expand clinical services to meet the needs of its community. Consistent with the goal of improving access to health care, with the addition of SACMC and its resources, the parties' joint operation can better recruit internal medicine, hospitalists, nurses, family practice practitioners, and other skilled clinical caregivers, shoring up gaps in physician coverage as well as leading to lower operating costs at SACMC as the hospital can decreasingly rely on locums and other contract provider support.

Non-clinical. Shannon estimates it will bring jobs to the area by hiring corporate and administrative staff to replace certain functions that are currently supported by CHSPSC in Tennessee. Additionally, Shannon plans to hire additional marketing staff and medical records coders. Currently, SACMC employs two full time employees on its marketing staff, and receives a corporate allocation from CHS for the rest of its marketing. Similarly, the majority of SACMC's medical records coding is done at the corporate level—through CHS—thus providing an opportunity for Shannon to hire additional support staff.

4. Enhanced Access Will Benefit All Patients, Regardless Of Ability To Pay

The transaction will enhance access for all patients, regardless of their ability to pay. When low-income residents are uninsured or underinsured, they sometimes postpone medical treatments due to the inability to afford care when they need it. This leads to aggravated and more costly health problems that put a greater strain on a given community's medical resources,[75] such as reliance upon emergency room services for otherwise routine primary care—a more costly, less efficient care setting. Low-income residents often also are less mobile,

requiring medical services in localized population centers. This places additional pressure on those providers already in high demand.

Shannon and SACMC are committed to providing services for indigent care, and most importantly, providing the appropriate level of care, in the right acuity setting, at the right time. Shannon's charity care policy for financial assistance covers a large number of indigent patients with a policy threshold at or below 200% of the federal poverty level. Under this charity care policy, in 2017, Shannon spent over $14 million on financial assistance.

In addition, Shannon along with its affiliated physician network, Shannon Clinic, has developed numerous initiatives to manage high-risk patients and improve access, such as:

- Establishing four new Urgent Care locations. Urgent care settings provide care closer to patients, typically at a much lower cost to the patient. Every Urgent Care location is staffed with physician providers.

- Increasing physician recruitment to improve access to primary and specialty providers.

- Promoting utilization of the Shannon Access Clinic in San Angelo to provide follow-up appointments post-discharge for patients that do not have a primary care provider. The Shannon Access Clinic provides, among other services, free quality and accessible cancer screening and diagnostic services to certain indigent patients.

- Continued partnership with MHMR Services for the Concho Valley,[76] the Mental Health and Intellectual and Developmental Disability Authority for seven West Texas counties, to provide primary care services in the behavioral health setting.

Shannon plans to expand the availability of the Shannon Access Clinic to SACMC patients—as well as other partnerships—after the transaction.

5. Better Access Leads To Addressing Gaps In Indigent Care

In addition, while both Shannon and SACMC have programs for charity care, Shannon also has a well-endowed and generous philanthropic operation. Shannon funds more than $60 million towards charity care, indigent care, and charitable contributions per year. Among Shannon's grants include significant funding—over $120,000 in 2018—to La Esperanza Clinic, a primary and preventative health and dental care clinic geared to providing services to the medically underserved of San Angelo and the Concho Valley.

Shannon plans to increase its charity expenditures and continue funding SACMC's existing charitable ventures. For example, SACMC is the exclusive sponsor of the Laura W. Bush Institute for Women's Health ("Bush Institute"). Originally initiated by the Texas Tech University Health Sciences Center as a community-wide effort to improve women's health through research and education, the Bush Institute is located in six West Texas cities and brings together the strengths of Texas Tech's schools of medicine, nursing, allied health sciences,

pharmacy and graduate school of biomedical sciences. Its educational health initiatives include a bilingual/multigenerational women's health program; cancer prevention; and community outreach through the West Texas Conference on Women's Health. For the Bush Institute and the community, the potential for excellence in research is much greater with the pooling of resources from Shannon and SACMC.

Shannon also intends to expand its Shannon Care Coordination program. This program manages high-risk patients with multiple disease processes, addresses social and health care issues, and supports patients' goals of independence in their health care management. Post-closing, Shannon can extend the program to SACMC and utilize SACMC's providers, nurses, and other medical staff to strengthen program.

D. Efficiencies

Shannon's efficiencies analysis confirms the transaction will benefit consumers. Here, Shannon has found ways to eliminate significant ongoing duplication of services and costs through consolidation. While Shannon expects to see cost savings and efficiencies across the combined network, the most significant cost savings—and the focus of this analysis—come from the ability to eliminate redundancies, optimize care, and avoid duplicative capital expenditures. Shannon estimates that the combined system will achieve at least [redacted]

[redacted]

[redacted]

1. Clinical Optimization

[redacted]

2. Selling, General, And Administrative (SG&A)

Shannon estimates that savings from the transaction include both labor and non-labor savings. With regard to potential labor savings, Shannon is committed to the existing workforces at Shannon and SACMC, and the combined system intends to offer all current employees of Shannon and SACMC comparable positions. However, with time, including through attrition, the combined entity will reduce duplication, temporary staffing needs, and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise and competencies within the integrated delivery system.

[redacted]

A significant portion of these savings would be reinvested through financial commitments in the development and continuation of programs outlined above, including services for indigent care, behavioral health services, community health improvement initiatives, and academic or educational outreach. Shannon and SACMC believe that the net effect of the merger on the health care workforce in the region will be positive.

3. More Efficient Use Of Capital

The transaction will allow both hospitals to better utilize capital and eliminate redundant and unnecessary spending. For example, the transaction will allow the parties to more efficiently utilize clinical and administrative space across the two organizations and therefore avoid significant planned capital projects. [redacted]

[redacted]

After the transaction, Shannon plans to utilize the available space at SACMC to accommodate these services and hence eliminate the need for the new construction. SACMC's property comprises 226,704 gross square feet, which has unutilized capacity based on current volumes. For example, the available MOB space at SACMC could be utilized in lieu of Shannon constructing a new 44,667 square foot MOB to house an additional 22 health care providers. Similarly, optimizing clinical services across the Shannon and SACMC campuses will decompress the current parking constraints at Shannon and eliminate the need for a new parking structure. Furthermore, Shannon has plans to construct a new business services building and a dialysis center, both of which would not be necessary if Shannon is able to utilize the available space at the SACMC campus.

The renovation costs associated with repurposing the SACMC facilities for the above purposes was estimated at up to [redacted]—significantly less than what Shannon would have had to spend for construction of a new MOB, parking garage structure, business services building, dialysis center, and hospital addition to the main campus. After netting renovation costs from the potential capital avoidance cost savings, Shannon is expected to save at least [redacted] in additional capital expenditures by using SACMC's existing structures.

The efficiencies and cost savings created by this merger will fund population health, access to care, enhanced health services, and other community-oriented commitments. By aligning Shannon and SACMC's efforts in key service lines and other areas, the combined system will drive cost savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services.

4. One-Time Costs

In addition to estimating the potential efficiencies that could result from the transaction, Shannon considered the potential one-time costs that would be required to achieve these efficiencies. [redacted]

[redacted]

The combined entity will adopt a common IT Platform as soon as reasonably practical after the formation of the combined system. For medical records, Shannon currently uses the Epic system, and Kronos for its HR program. Putting all hospitals and clinics on the same system will enhance care coordination, support staffing, and financial efficiency.

Shannon estimates that it will be able to on-board SACMC's system and train its personnel to fit within its current IT infrastructure with some incremental cost. The common IT platform will allow providers in the combined system to quickly obtain full access to patient records at the point of care. For example, imagine a patient with light chest pains reports to SACMC for examination and numerous tests are performed; the patient receives an initial, accurate diagnosis and is sent home. A few nights later, that same patient experiences the increasingly worse chest pains, but seeks care at Shannon on this occasion. The patient cannot remember what tests were performed at SACMC. However, through the combination and integrated IT platform, physicians at Shannon can easily see what tests and other care were provided at SACMC and can continue to provide appropriate care with full knowledge of the patient's record. This avoids the tests being repeated. This saves the patient and Shannon from multiple inefficiencies, including potentially harmful multiple tests, a long wait to obtain the medical records from SACMC, and duplicate costs for the same tests.

The efficiencies and cost savings created by this transaction will fund population health, access to care, enhanced health services, and other commitments. By aligning Shannon and SACMC's efforts in key service lines and other areas, the combined system will drive cost savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services.

5. Shannon Could Use All Of The Foregoing Savings To Benefit The Local Community

The savings that would result from the reduction of duplicative services, clinical optimization, and capital avoidance can be redeployed towards improving patient care coordination. Better coordinated care results in fewer medical complications, which results in lower overall costs of care. Additionally, these savings could be used to expand service offerings and offer greater points of access. All of this would increase the quality and breadth of care beyond what is available in the local market today.

E. Competition Among Providers

The statute provides that the HHSC's evaluation of the proposed transaction shall include consideration of whether the parties will continue their competitive position, and any reduction in competition among physicians, allied health professionals, other health care providers, or other persons providing goods or services to, or in competition with, hospitals.

The transaction will not result in a reduction in competition among physicians, allied health professionals, other health providers, or any other persons providing goods or services in competition with the hospitals. Shannon would have no power to exercise any market power stemming from any reduction in competition, because a condition of the issuance of the COPA would be thorough, ongoing, and sustained supervision by State regulators. Among other stringent controls on the conduct of the hospitals following the transaction, the statute provides that no "change in rates for hospital services operating under a COPA may "take effect without prior approval of the designated [supervisory] agency." Health & Safety Code § 314A.102(a). Thus, the Law prevents any exercise of anticompetitive pricing powers; Shannon would have no ability to raise prices even *within* the competitive range (let alone above it) without obtaining express approval. The Law provides for a variety of other supervisory powers by the state that would ensure that the transaction would entail no competitive harms at all.

Even putting aside this dispositive fact, the transaction would still not create any competitive harms. While the Commission need not reach this question in order to approve the application, it is significant that Shannon and SACMC are not absolute substitutes. As shown above, even though there are similarities between the general inpatient and outpatient services offered by Shannon and SACMC, there are significant differences in the breadth and depth of services that each party provides. Compared to SACMC, Shannon attracts patients from a far broader area, provides more specialized services, and cares for more severely ill patients.

Competition is valued because of the benefits that it can provide consumers. The "principal objective of antitrust policy is to maximize consumer welfare by encouraging firms to behave competitively."[77] If the agreement is consummated, the transaction's net effect will be to promote, not lessen, the traditional benefits of competition in the parties' geographic areas. Indeed, the transaction promotes competition between such persons or entities and the hospitals, as well as creates opportunities for savings. As the parties combine their efforts to recruit physicians, nurses, and other health providers, Shannon and SACMC will increase the providers in the community, which naturally will spur competition among other inpatient and outpatient facilities in the region, while generating substantial efficiencies.

1. Shannon And SACMC Face Competition With Other Inpatient Facilities And Freestanding Emergency Departments

Shannon and SACMC face competition from a number of hospitals and health systems in their primary and secondary service areas. Post-transaction, the parties will continue to compete with large and significant health systems throughout the region. Robust competition for inpatient hospital services will continue from at least twenty-one other hospitals, shown on a map and listed in Appendix B, all located in surrounding counties, following consummation of the transaction.

Likewise, the parties face competition from freestanding emergency departments, which are separately licensed facilities that provide emergency services and often provide related ancillary services such as laboratory and pharmacy services. Notably, Shannon and SACMC both face current competition from a freestanding emergency department in San Angelo, as listed in Appendix C.

In addition, patients from San Angelo travel to non-San Angelo facilities for tertiary services. Shannon considers these facilities to be competitors for higher-end services. In 2018, hospitals such as Methodist Hospital – San Antonio, Cook Children's - Fort Worth, UT Southwestern Medical Center, Parkland Memorial Hospital – Dallas, University Hospital - San Antonio, Baylor Scott & White Medical Center Temple, and others received patients from San Angelo seeking high-acuity care. Through better coordination of care and elimination of unnecessary and wasteful spending, the combined Shannon and SACMC will free up capital to expand high-acuity service offerings, keeping more care local.

2. Texas Does Not Require Hospitals To Apply For Certificates Of Need

Many states limit health care providers' ability to expand services by requiring them to seek government approval for new entry and expansion of health care providers. State certificate-of-need ("CON") laws typically establish requirements for state approval before a new health care provider can enter a market or an existing provider can make certain capital improvements. For example, if a hospital wants to build a wing or add additional beds, it must seek approval from the state. The state will determine whether there is sufficient public "need" for the capital improvement and either grant or deny the provider's application. Studies have shown that CON laws reduce competition and innovation. CON laws are simply output restrictions that displace competition with regulation and prevent new providers from expanding or entering.[78] The weakest providers—the ones that are inefficient and would have drawn entry that may spurred them to improve—are likely to benefit from the shelter of CON laws. By eliminating competition, CON laws drive up cost, lower quality, and limit the availability of needed services.[79]

Texas is not a CON state. Unlike the 36 states and District of Columbia that have CON regulations, providers in Texas are not shielded by CON laws that force health care providers to seek government approval before expanding facilities, offering new services, or purchasing new equipment. Shannon and SACMC will continue to face the threat of significant competition from other potential providers that can challenge the hospitals simply by arriving at their doorstep.

3. The Combined Entity Will Continue To Face Competition With Other Health Systems In The Region And Beyond

Many health systems in Texas are currently undergoing significant facility and service expansions. For example:

- Lubbock University Medical Center, located in Lubbock, Texas is undergoing a 45-bed expansion project, including 15 ICU beds.[80] The facility currently has 476 licensed beds. In December 2019, Lubbock University Medical Center began construction on a new EMS station and communication center that will be completed in December 2020.[81]

- In 2012, Midland Memorial Hospital completed construction on a $177.6 million new patient tower spanning nine floors and expanding the hospital's emergency department. Currently, the hospital has 228 licensed beds.[82]

- With 1,034 licensed beds, the University Health System in San Antonio is the largest hospital in San Antonio and is a nationally recognized teaching hospital and network of outpatient health care centers, providing over 15 specialties and subspecialties. The University Health System is in the planning stages of a $500 million expansion project expected to open in late 2022. The expansion includes a new 12-story, 300-bed hospital for women, babies, and children, a new 900-space parking structure, and additional shell space for future growth.[83]

- Newly opened in 2017, Houston Methodist – The Woodlands has 146 licensed and staffed beds, and provides numerous inpatient services, including cancer care, cardiology, neurology, neurosurgery, orthopedics, sports medicine, surgery and women's health. In July 2019, Houston Methodist – The Woodlands announced a $240 million expansion that includes a new patient tower for an additional 100 beds and 10 new operating rooms as well as expansions of the endoscopy center, heart center, diagnostic imaging department, and emergency center.[84]

- The 878-bed, $1.3 billion Parkland Health & Hospital System opened four years ago in downtown Dallas. Parkland Health & Hospital System offers, among other high-end inpatient services, a Level I Trauma Center, the second largest civilian burn center in the U.S., and a Level III Neonatal Intensive Care Unit. In early 2019, Parkland Health & Hospital System in Dallas began a $154 million expansion project that includes a six-story medical building that will house the hospital's new comprehensive breast care center.[85]

- Texas Health Harris Methodist Hospital Alliance, located in Fort Worth, has 101 licensed beds and provides medical services such as women's health, emergency care, and heart and vascular services. In 2018, the hospital announced plans for a $74.2 million expansion that will consist of a 65,000 square foot addition to the facility that will house units for critical care, medical-surgical, women and infants' services, along with a new surgical suite and support services wing.[86]

- Announced in late 2018, Texas Health Resources in Mansfield, Texas started construction on a new four-story hospital in Mansfield. The $150 million project will add a 192,400 square foot hospital with 95 beds initially and provide a full range of medical services, including intensive care units, general surgery, women's surgery, orthopedics, a pharmacy, interventional cardiology, and an 80,000 square foot medical office building.[87] Due to open in late 2020, the construction plans also include space for the hospital to expand in the future.

4. The Combined Entity Will Continue To Face Competition From Outpatient And Post-Acute Care Facilities

Services can be categorized into inpatient and outpatient depending on where the procedure is performed and the length of stay; outpatient services usually consist of low-acuity procedures that do not require an overnight stay at a hospital. Outpatient care is offered at sites such as ambulatory surgery centers, primary care clinics, retail clinics, community health clinics, urgent care centers, specialized outpatient clinics, imaging service facilities and emergency departments.[88] As patient volumes are increasingly shifting from inpatient to outpatient settings, the availability of these services will only increase.[89] Overall, the shift to outpatient services has been caused by clinical innovation, patient preferences, and financial incentives.[90]

There are a number of competing, independent outpatient facilities, along with independent nursing homes, assisted living facilities, skilled nursing facilities, and hospice care in Tom Green County that compete for certain patients with the parties. Shannon and SACMC together account for approximately 50% of the outpatient and post-acute care facilities available in Tom Green County, including 1 out of 9 or 11.11% of the skilled nursing facilities. For present purposes, we have focused only on competing outpatient and post-acute care facilities in Tom Green County. Studies have shown that residents of small towns in Texas prefer to drive 40 to 50 minutes to receive inpatient services at a hospital in a larger city, where they believe they will receive better care than in their own community.[91] But for outpatient and post-acute services, studies have shown that most parties prefer to remain within their local area to receive health care services for a minor medical condition.[92]

Appendix C provides a listing of other outpatient and post-acute care facilities within Tom Green County.

5. The Combined Entity Will Continue To Face Competition From Independent Physicians

Nationally, the number of independent physicians has steadily decreased – one study revealed that in 2012, 48.5% of physicians identified as independent compared to 31.4% in 2018.[93] Over 63,000 physicians provide services in Texas—307 of whom practice in Tom Green County.[94] Both Shannon and SACMC continue to value a robust and successful independent physician community as reflected in, among other things, their commitment to maintain open medical staffs. A large number of independent physicians in the community—including approximately thirty OB-GYNs, orthopedic surgeons, urologists, and ENTs—will not be a party to the proposed merger, and will continue when appropriate to utilize Shannon and SACMC facilities. The combined entity intends to collaborate where possible with the independent

physician community in procompetitive arrangements to build an array of service offerings that will be accessible throughout the region. Studies have shown that patients usually make a choice concerning specialists based on physician referrals.[95] The independent physicians in the community will maintain the ability to refer patients to any health care facility. As has always been the case, none will be required to refer to Shannon or SACMC.

6. The Transaction Will Enhance Competition

Strategic collaborations—including mergers—are recommended for organizations that "effectively advocate for, naturally represent, and have trusted relationships with rural constituents to maximize opportunities for efficient use of resources towards systemic and sustained improvements."[96] This is because overall, collaboration between providers of essential health services may meet the needs of rural populations better than if they did not work together.[97] Strategic combinations involving rural hospitals can combine resources to improve access to health care services for rural populations, improve health care quality, create cost saving efficiencies, and provide for opportunities to enhance health knowledge programs.[98] Hospital strategic collaborations can be crucial to address the unique set of system-related problems in rural areas.[99] In particular, a health care-related strategic combination can create more specialty positions and increase brand recognition that can improve rural recruiting.

In short, under this statutory framework, the proposed combination will not give rise to market power or otherwise harm competition. The combined entity will be actively supervised by Texas officials. Active supervision includes submission to and review by the HHSC and the Attorney General of an annual report, as well as the rate review process described here. This supervision will ensure that the combined entity acts in furtherance of the public policies that underlie the Texas legislation's statutory provisions. Moreover, the combined entity will continue to face competition from several independent general acute care hospitals, outpatient facilities, post-acute care facilities and physicians in the geographic service area. Further, post-transaction, the combined entity will continue to operate fully and competitively if the application is granted. For example, most outpatient medical services are delivered outside the hospital setting by independent physicians and other independent providers such as home health, lab, imaging, occupational medicine, hospice, and others. Shannon and SACMC are required to ensure patient choice when selecting these services and will continue to adhere to these policies as a merged organization.

VIII. CONCLUSION

In evaluating this transaction, state officials need not be concerned that better quality and access will lead to supracompetitive prices. The parties will operate under a tightly regulated regime that will prohibit them from increasing reimbursement rates above competitive levels. Most importantly, no alternative arrangements would achieve the same level of benefits that this transaction provides. Two local hospital systems will become fully integrated, offering convenient, affordable care to residents of San Angelo and the surrounding communities. The transaction promotes system-wide coordination of community health initiatives. The hospitals can jointly recruit highly-trained providers, while expanding services locally, thereby reducing the need for patient outmigration. The benefits listed above as well as many other benefits from the transaction could be lost to the community if the application is not approved.

Appendix A

Shannon Locations

Tom Green County	• Shannon Medical Center
	  o 120 E. Harris Ave, San Angelo, TX 76903
	• Shannon St. John's Campus
	  o 2018 Pulliam Street, San Angelo, TX 76903
	• Shannon Women's and Children's Hospital
	  o 201 E. Harris Avenue, San Angelo, TX 76903
	• Shannon Access Clinic
	  o 120 E. Beauregard Avenue, San Angelo, TX 76903
	• Shannon Clinic – Beauregard
	  o 120 E. Beauregard Avenue, San Angelo, TX 76903
	• Shannon Clinic – Harris
	  o 220 E. Harris Avenue, San Angelo, TX, 76903
	• Shannon Clinic – Magdalen
	  o 102 N. Magdalen, San Angelo, TX 76903
	• Shannon Clinic – Pediatrics
	  o 225 E. Beauregard Avenue, San Angelo, TX 76903
	• Shannon Clinic – Red Arroyo
	  o 3016 Vista Del Arroyo Drive, San Angelo, TX 76904
	• Shannon Clinic Bluffs
	  o 3150 Appaloosa Circle, San Angelo, TX 76901
	• Shannon Clinic College Hills
	  o 4141 College Hills, San Angelo, TX 76904
	• Shannon Clinic General and Vascular Surgery
	  o 102 N. Magdalen, San Angelo, TX 76903
	• Shannon Clinic Sunset
	  o 4235 Southwest Boulevard, San Angelo, TX, 76904
	• Shannon Clinic – North
	  o 2626 N. Bryant, San Angelo, TX, 76903
	• Shannon Clinic Southwest: Multi-Specialty Physician Group
	  o 4450 Sunset Drive, San Angelo, TX 76901
	• Shannon Clinic – Jackson
	  o 2237 S. Jackson, San Angelo, TX 76904
	• Shannon Clinic Orthotics
	  o 110 E. Twohig, San Angelo, TX, 76903
	• Shannon Clinic Sleep Center
	  o 3308 W. Loop 306, San Angelo, TX 76904
	• Angelo State Student Clinic
	  o ASU Station # 11019, San Angelo, TX 76909
	• Shannon Urgent Care South

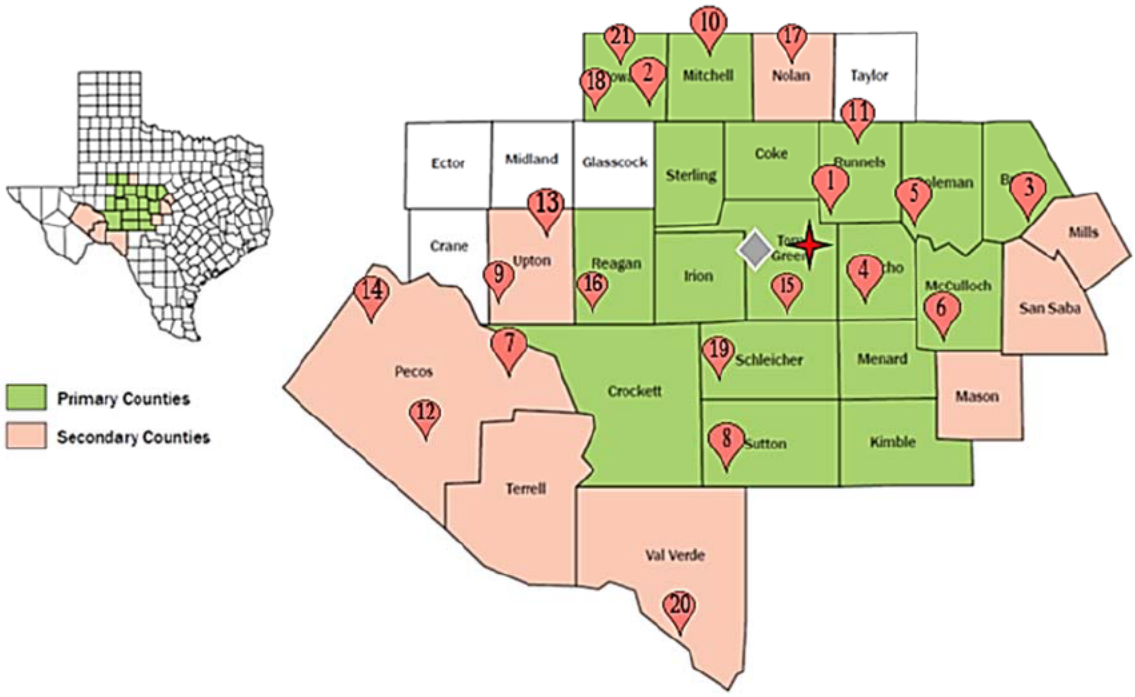
	○ 3502 Knickerbocker Road, San Angelo, TX 76904 • Shannon Urgent Care West ○ 4251 Sunset Drive, San Angelo, TX 76904
Howard County	• Shannon Clinic Big Spring ○ 2503 Gregg Street, Unit C, Big Spring, TX 79720
Crockett County	• Family Health Center ○ 104 N. Avenue H, Ozona, TX
Brown County	• Shannon Clinic – Brownwood ○ 3655 U.S. Hwy 377, Brownwood, TX 76801

SACMC Locations

	• San Angelo Community Medical Center Williams Family Center ○ 3501 Knickerbocker Road, San Angelo, TX 76904 • Community Medical Associates Building One ○ 2142 Sunset Drive, San Angelo, TX 76904 • Community Medical Associates Building Two ○ 2141 Hamilton Way, San Angelo, TX 76904 • Community Medical Associates Building Three ○ 3350 Executive Drive, San Angelo, TX 76904 • Community Health Club ○ 3336 W 306 Loop, San Angelo, TX 76904 • Community Imaging ○ 3605 Executive Drive, San Angelo, TX 76904 • Community Surgery Center ○ 3605 Executive Drive, San Angelo, TX 76904 • Outpatient Therapy (OT/PT/Speech) ○ 3605 Executive Drive, San Angelo, TX 76904
	• Community ExpressCare Sherwood Way ○ 5730 Sherwood Way, San Angelo, TX 76901
	• Community ExpressCare Bryant ○ 402 N. Bryant, San Angelo, TX 76903

Appendix B

Inpatient Facilities within Shannon's Primary and Secondary Service Area



#	Hospital Name	Address	County
1	Ballinger Memorial Hospital District	608 Ave B, Ballinger, TX 76821	Runnels
2	Big Spring State Hospital	1901 North Highway 87, Big Spring, TX 79720	Howard
3	Brownwood Regional Medical Center	1501 Burnett Rd., Brownwood, TX 76801	Brown
4	Concho County Hospital	614 Eaker St., Eden, TX 76837	Concho
5	Coleman County Medical Center	310 South Pecos St., Coleman, TX 76834	Coleman
6	Heart of Texas Healthcare System	P.O. Box 1150, Brady, TX 76825	McCulloch
7	Iraan General Hospital	600 TX-349, Iraan, TX 79744	Pecos
8	Lillian M. Hudspeth Memorial Hospital	308 Hudspeth St., Sonora, TX 76950	Sutton
9	McCamey County Hospital District	2500 S Hwy 305, McCamey, TX 79752	Upton
10	Mitchell County Hospital	997 I-20, Colorado City, TX 79512	Mitchell

#	Hospital Name	Address	County
11	North Runnels Hospital	7821 TX-153, Winters, TX 79567	Runnels
12	Pecos County Memorial Hospital	387 West, I-10, Fort Stockton, TX 79735	Pecos
13	Rankin County Hospital District	1611 TX-Spur, Ranking, TX 79778	Upton
14	Reeves County Hospital District	2323 Texas St., Pecos, TX 79772	Pecos
15	River Crest Hospital	1636 Hunters Glen Rd., San Angelo, TX 76901	Tom Green
16	Reagan Memorial Hospital	1300 N Main Ave., Big Lake, TX 76932	Reagan
17	Rolling Plains Memorial Hospital	200 E Arizona Ave., Sweetwater, TX 7955	Nolan
18	Scenic Mountain Medical Center	1601 W 11th Pl., Big Spring, TX 79720	Howard
19	Schleicher County Medical Center	102 US-277, Eldorado, TX 76936	Schleicher
20	Val Verde Regional Medical Center	801 N. Bedell Ave., Del Rio, TX 78840	Val Verde
21	West Texas VA Health Care System	2400 S. Gregg St., Big Spring, TX 79720	Howard

Appendix C

Other Health Care Facilities (Tom Green County)

	Name	Address	County
Assisted Living Facilities[100]			
	Brookdale South San Angelo	2695 Valleyview Blvd., San Angelo, TX 76904	Tom Green
	Bryant Manor II Assisted Living	521 Spaulding, San Angelo, TX 76903	Tom Green
	Lyndale at San Angelo	6101 Grand Court Rd., San Angelo, TX 76901	Tom Green
	New Haven Assisted Living of San Angelo LLC	2501 Sawgrass Dr., San Angelo, TX 76904	Tom Green
	The Crest – East	430 E 8th St., San Angelo, TX 76903	Tom Green
	The Crest – West	402 E 8th St., San Angelo, TX 76903	Tom Green
	The Springs Memory Care	6102 Grand Court Rd., San Angelo, TX 76901	Tom Green
	The St Angelus	15 N Van Buren, San Angelo, TX 76901	Tom Green
Freestanding Emergency Medical Care Facilities[101]			
	Concho Valley ER	5709 Sherwood Way, San Angelo, TX 79601	Tom Green
Hospice Agencies[102]			
	Hospice of San Angelo Inc	36 E Twohig, Suite 1100, San Angelo, TX 76903	Tom Green
	Interim Hospice of West Texas	3280 Sherwood Way, San Angelo, TX 76901	Tom Green
	Kindred Hospice	112 W Concho Ave., San Angelo, TX 76903	Tom Green
Select Other Health Care Facilities			
	Angelo MRI	4114 South Jackson St., San Angelo, TX 76903	Tom Green
	Baptist Retirement Community	902 N Main St., San Angelo, TX 76903	Tom Green
	Cook Children's Pediatric Specialties	1002 S. Abe St. #B, San Angelo, TX 76903	Tom Green
	Goodfellow AFB Clinic	271 Ft. Richardson Ave., San Angelo, TX 76908	Tom Green
	La Esperanza Clinic	1610 S. Chadbourne St., San Angelo, TX 76903	Tom Green

	La Esperanza Clinic	2033 W. Beauregard Ave., San Angelo, TX 76901	Tom Green
	La Esperanza Health & Dental Clinic	35 E 31st St., San Angelo, TX, 76901	Tom Green
	Trisun Care Center Regency House	3745 Summer Crest Dr., San Angelo, TX 76901	Tom Green
	VA San Angelo Clinic	2018 Pulliam St., San Angelo 76905	Tom Green
	West Texas Ltc Partners Inc.	1915 Greenwood St., San Angelo, TX 76901	Tom Green
	West Texas Medical Associates	3605 Executive Dr., San Angelo, TX 76904	Tom Green
	Women's Imaging & MRI Center	3301 S Bryant Blvd., San Angelo, TX 76903	Tom Green
Skilled Nursing Facilities[103]			
	Arbor Terrace Healthcare Center	609 Rio Concho Dr., San Angelo, TX 76903	Tom Green
	Cedar Manor Nursing and Rehabilitation	1915 Greenwood St., San Angelo, TX 76901	Tom Green
	Elsie Gayer Health Care Center	902 N Main St., San Angelo, TX 76903	Tom Green
	Park Plaza Ltc Partners Inc.	2210 Howard St., San Angelo, TX 76901	Tom Green
	Regency House	3745 Summer Crest Dr., San Angelo, TX 76901	Tom Green
	Sagecrest Alzheimer's Care Center	438 Houston-Harte, San Angelo, TX 76903	Tom Green
	Senior Care of Meadow Creek	4343 Oak Grove Blvd., San Angelo, TX 76904	Tom Green
	Senior Care of San Angelo	5455 Knickerbocker Rd., San Angelo, TX 79604	Tom Green

Appendix D

Copy of the Agreement

WITHHELD FROM PUBLIC RELEASE
NON-PUBLIC & CONFIDENTIAL
FILED UNDER SEAL

[1] CHS is a publicly traded holding company. CHSPSC, LLC, an affiliated entity, provides certain consulting services to SACMC.

[2] H.B. 3301, Bill Analysis, https://capitol.texas.gov/tlodocs/86R/analysis/pdf/HB03301H.pdf#navpanes=0.

[3] "Merger" is defined by the Law as "an agreement among two or more hospitals for the consolidation by merger or other acquisition or transfer of assets by which ownership or control over substantially all of the stock, assets, or activities of one or more previously licensed and operating hospitals is placed under the control of another licensed hospital or hospitals or another entity that controls the hospitals."

[4] The Governor signed the bill in June 2019 and the Law became effective on September 1, 2019. *See* H.B. 3301, 86th Leg. (2019), https://legiscan.com/TX/bill/HB3301/2019.

[5] iVantage Health Analytics, "Rural Relevance – Vulnerability to Value – A Hospital Strength INDEX Study," (Feb. 2016) at 5, https://www.chartis.com/resources/files/INDEX_2016_Rural_Relevance_Study_FINAL_Formatted_02_08_16.pdf.

[6] Determining whether a location is "rural" or "urban" is difficult to delineate; multiple maps published by the U.S. Department of Agriculture show most counties surrounding Tom Green County are "rural," and large swaths of Tom Green County are "rural." Texas Organization of Rural & Community Hospitals (TORCH), "Rural Hospital Impact Study" (Mar. 2017), at 66, https://www.episcopalhealth.org/files/5414/8909/1996/Impact_Study_final_3-7.pdf; *see* U.S. Dep't of Agriculture, "Texas," https://www.ers.usda.gov/webdocs/DataFiles/53180/25598_TX.pdf?v=0.

[7] Ellison, A., "State-by-State Breakdown of 113 Rural Hospital Closures," Becker's Hospital CFO Report (Aug. 26, 2019), https://www.beckershospitalreview.com/finance/state-by-state-breakdown-of-113-rural-hospital-closures-082619.html.

[8] Chang, J., "Losing a Lifeline – What Happened When Milam County's Two Hospitals Closed," GATE HOUSE NEWS (Jul. 26, 2019), https://gatehousenews.com/texas-rural-hospital-closings/.

[9] Texas Organization of Rural & Community Hospitals (TORCH), "Twenty-Five Things to Know About Texas Rural Hospitals," (Revised Sept. 2019), https://files.constantcontact.com/1355b334201/562b2e28-4dfe-41be-9e18-256b232ae044.pdf.

[10] United States and Texas Populations, https://www.tsl.texas.gov/ref/abouttx/census html.

[11] *Id*.

[12] Ramshaw, E., "No Country for Health Care, Part 1: Far From Care," THE TEXAS TRIBUNE (Jan. 4, 2010), https://www.texastribune.org/2010/01/04/health-care-sparse-in-rural-texas/.

[13] Burch, J., "Stamford Healthcare System Closing ER, Discontinuing Inpatient Care," KTXS12 ABC (Jul. 2, 2018), https://ktxs.com/news/big-country/stamford-healthcare-system-closing-er-discontinuing-inpatient-care.

[14] Texas Organization of Rural & Community Hospitals (TORCH), "Twenty-Five Things to Know About Texas Rural Hospitals," (revised Sept. 2019), https://files.constantcontact.com/1355b334201/562b2e28-4dfe-41be-9e18-256b232ae044.pdf.

[15] Shannon AirMed1 Services, https://www.shannonhealth.com/services/airmed1/.

[16] *Id*.

[17] *Id*.

[18] Beutke, K. et al., "A Path Forward for Rural Healthcare," KAUFMANHALL (Apr. 26, 2019), https://www.kaufmanhall.com/sites/default/files/documents/2019-04/a-path-forward-for-rural-healthcare.pdf.

[19] American Hospital Association "Underpayment by Medicare and Medicaid Fact Sheet," (Jan. 2019), https://www.aha.org/system/files/2019-01/underpayment-by-medicare-medicaid-fact-sheet-jan-2019.pdf.

[20] Beutke, K. et al., "A Path Forward for Rural Healthcare," KAUFMANHALL (Apr. 26, 2019), at 1, https://www.kaufmanhall.com/sites/default/files/documents/2019-04/a-path-forward-for-rural-healthcare.pdf.

[21] Texas Organization of Rural & Community Hospitals (TORCH), "Rural Hospital Impact Study," (Mar. 2017), https://www.episcopalhealth.org/files/5414/8909/1996/Impact_Study_final_3-7.pdf.

[22] Pub. L 112-25, S. 365, 125 Stat. 240 (enacted Aug. 2, 2011).

[23] CMS implemented a wage index boost in its final rule on inpatient prospective hospital payments for fiscal year 2020. This rule will benefit rural hospitals by addressing the wide gap in Medicaid payments for hospital services, however this measure may be inadequate to address the significant longstanding and ongoing financial challenges faced by many rural hospitals. Luthi, S., "CMS Finalizes Rural Wage Index Boost," Modern Healthcare (Aug. 2, 2019), https://www.modernhealthcare.com/payment/cms-finalizes-rural-wage-index-boost.

[24] LaPointe, J., "Hospitals Seek Another Delay for $4B Medicaid DSH Payment Cut," Revcycle Intelligence, xtelligent Healthcare Media (Feb. 22, 2019), https://revcycleintelligence.com/news/hospitals-seek-another-delay-for-4b-medicaid-dsh-payment-cut.

[25] La Pointe, J., "Funding Legislation Delays $4B in Medicaid DSH Payment Cuts," Revcycle Intelligence, xtelligent Healthcare Media (Dec. 20, 2020), https://revcycleintelligence.com/news/funding-legislation-delays-4b-in-medicaid-dsh-payment-cuts; *see also* Ollove, M., "Rural and Safety Net Hospitals Prepare for Cut in Federal Support," Stateline, PEW (Oct. 31, 2019), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/10/31/rural-and-safety-net-hospitals-prepare-for-cut-in-federal-support.

[26] *See* Ellison, A., "Rural vs. Urban: A Comparison of Hospitals Costs and Charges," (Feb. 9, 2016), https://www.beckershospitalreview.com/finance/rural-vs-urban-a-comparison-of-hospital-costs-and-charges html; *see also* Williams, D., "Rural Health Care Costs Are They Higher and Why Might They Differ from Urban Health Care Costs?", NORTH CAROLINA MEDICAL JOURNAL (Feb. 2018), http://www ncmedicaljournal.com/content/79/1/51 full#xref-ref-3-1; LaPointe, J. "41% of Rural Hospitals Operating with Negative Margins," Rev Cycle Intelligence (Jul. 6, 2017), https://revcycleintelligence.com/news/41-of-rural-hospitals-operating-with-negative-margins.

[27] Ellison, A., "Rural vs. Urban: A Comparison of Hospitals Costs and Charges," (Feb. 9, 2016), https://www.beckershospitalreview.com/finance/rural-vs-urban-a-comparison-of-hospital-costs-and-charges html.

[28] *Id*., *see also* LaPointe, J. "41% of Rural Hospitals Operating with Negative Margins," Rev Cycle Intelligence (Jul. 6, 2017), https://revcycleintelligence.com/news/41-of-rural-hospitals-operating-with-negative-margins.

[29] Rural Health Information Hub, "Recruitment and Retention for Rural Health Facilities," https://www.ruralhealthinfo.org/topics/rural-health-recruitment-retention; *see also* Rosenberg, J., "Understanding the Health Challenges Facing Rural Communities," AMERICAN JOURNAL OF MANAGED CARE (Feb. 5, 2019), https://www.ajmc.com/conferences/academyhealth-2019/understanding-the-health-challenges-facing-rural-communities.

[30] Thompson, Kristie W., "Rural/Urban and Regional Variation in the 2019 CMS Hospital Wage Index," NC Rural Health Research Program (May 2019), https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2019/04/Wage-Index-Geo-Variation.pdf

[31] Stajduhar, T., "Rural Physician Recruitment – Results from the 2019 Rural Physician and Administration Study," Jackson Physician Search (Jul. 2019), at 3, https://www.jacksonphysiciansearch.com/white-paper-rural-recruitment/.

[32] American Hospital Association, "Rural Report – Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care," (2019), at 7, https://www.aha.org/system/files/2019-02/rural-report-2019.pdf.

[33] *See, e.g.*, Rural and Urban Health, Health Policy Institute, Georgetown University, https://hpi.georgetown.edu/rural/.

[34] Topchik, M., "Rural Relevance 2017: Assessing the State of Rural Healthcare in America," The Chartis Group (2017), https://www.chartis.com/forum/wp-content/uploads/2017/05/The-Rural-Relevance-Study_2017.pdf.

[35] *See e.g*., Shannon, "Community Health Needs Assessment 2019" at 7, https://www.shannonhealth.com/media/2314/final_shannon-chna-2019.pdf.

[36] Rural & Community Health Institute, Texas A&M University, "What's Next? Practical Suggestions for Rural Communities Facing a Hospital Closure," at 6, https://www.episcopalhealth.org/files/2414/9788/5907/Whats_Next_Final_6.12.pdf.

[37] *See id*.; *see also* Fernandez, S., "Texas has the most people without health insurance in the nation – again," THE TEXAS TRIBUNE (Sept. 10, 2019), https://www.texastribune.org/2019/09/10/texas-has-most-people-without-health-insurance-nation-again/.

[38] *Id*.; *see also* Rural & Community Health Institute, Texas A&M University, "What's Next? Practical Suggestions for Rural Communities Facing a Hospital Closure" https://www.episcopalhealth.org/files/2414/9788/5907/Whats_Next_Final_6.12.pdf (citing the rural Health Information Hub, *Texas: State Guide*, https://www ruralhealthinfo.org/states/texas).

[39] Alker, J. & Roygardner, L., "The Number of Uninsured Children is on the Rise," Center for Children and Families, Georgetown University Health Policy Institute (Oct. 2019), at 7, https://ccf.georgetown.edu/wp-content/uploads/2019/10/Uninsured-Kids-Report.pdf.

[40] Johnson, K. & Lichter, D., "Rural Depopulation in a Rapidly Urbanizing America," Carsey School of Public Policy, University of New Hampshire (Feb. 2019), https://carsey.unh.edu/publication/rural-depopulation.

[41] Urban Texas, Texas Demographic Center (Aug. 2017), at 1, https://demographics.texas.gov/Resources/publications/2017/2017_08_21_UrbanTexas.pdf.

[42] *Id*. at 2.

[43] Navigant, "Rural Hospital Sustainability: New Analysis Shows Worsening Situation for Rural Hospitals, Residents," (Feb. 2019), at 2, https://www.navigant.com/-/media/www/site/insights/healthcare/2019/navigant-rural-hospital-analysis-22019.pdf.

[44] Holmes, G., et al., "The Effect of Rural Hospital Closures on Community Economic Health," 41 HEALTH SERV. RES. 2, 467-85 (Apr. 2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702512/pdf/hesr041-0467.pdf.

[45] *Id*. at 481.

[46] Bresnick, J., "Care Coordination Technique Reduces Medical Errors by 30%," Health IT Analytics (Nov. 7, 2014), https://healthitanalytics.com/news/care-coordination-technique-reduces-medical-errors-30 (reporting that better care coordination among residents reduced patient safety issues and medical errors by nearly one-third); Starmer, A., et al., "Integrating Research, Quality Improvement, and Medical Education for Better Handoffs and Safer Care: Disseminating, Adapting, and Implementing the I-PASS Program," Joint Commission Journal on Quality and Patient Safety (2017), https://www.jointcommissionjournal.com/article/S1553-7250(17)30176-9/fulltext (finding that the implementation of a coordinated care program resulted in substantial reductions in medical errors).

[47] *See, e.g.,* O'Brien, J., "Advocate Unifies EHR Platform Ahead of Merger with Aurora," HealthLeaders (Feb. 1, 2018), https://www.healthleadersmedia.com/innovation/advocate-unifies-ehr-platform-ahead-merger-aurora (Advocate Health Care touting its plan to transition to a single EHR by Epic ahead of Advocate's planned merger with Aurora Health Care, which is in line with the health system's efforts to improve consumer experience, improve coordination and operational efficiency, and provide "the highest quality and safest care" for patients).

[48] *See e.g.*, Institute of Medicine, Interpreting the Volume-Outcome Relationship in the Context of Health Care Quality: Workshop Summary (2000), at 4-5, https://www.nap.edu/catalog/10005/interpreting-the-volume-outcome-relationship-in-the-context-of-health-care-quality.

[49] Population Health Management: Texas Organization of Rural & Community Hospitals (TORCH), "Rural Hospital Impact Study" (Mar. 2017), at 52, https://www.episcopalhealth.org/files/5414/8909/1996/Impact_Study_final_3-7.pdf.

[50] Swarthout, M. & Bishop, M., "Population Health Management: Review of Concepts and Definitions," American Society of Health-System Pharmacists, Inc. (Sept. 15, 2017), at 1408 https://academic.oup.com/ajhp/article/74/18/1405/5102626; "Implementing a Successful Population Health Management Program," Philips White Paper, at 5, https://www.usa.philips.com/c-dam/b2bhc/us/Specialties/community-hospitals/Population-Health-White-Paper-Philips-Format.pdf.

[51] *Id*. at 7.

[52] "Population & Public Health" The Office of the National Coordinator for Health Information Technology, Section 10.2 – Use Population Health Management Tools, https://www.healthit.gov/playbook/population-public-health/#section-10-2.

[53] National Center for Health Statistics, "Stats of the State of Texas," Centers for Disease Control and Prevention, https://www.cdc.gov/nchs/pressroom/states/texas/texas htm.

[54] Robert Wood Johnson Foundation & the University of Wisconsin Population Health Institute, "County Health Rankins & Roadmaps," https://www.countyhealthrankings.org/.

[55] Robert Wood Johnson Foundation & the University of Wisconsin Population Health Institute, "County Health Rankins & Roadmaps," https://www.countyhealthrankings.org/.

[56] Shannon Community Health Needs Assessment, at 13.

[57] *Id*., at 14-15.

[58] Research suggests that health insurers already exercise market power. One study assessed whether health insurers charge higher premiums to employers that earn higher profits. Bates, L. et al., "Do Health Insurers Possess Market Power?" American Society of Health Economists (June 1, 2010), at 5, https://ssrn.com/abstract=1879652. The study found evidence of this behavior and concluded that health insurers possess and exercise market power in an increasing number of geographic markets. *Id*. at 21.

[59] National Institute of Diabetes and Digestive and Kidney Diseases, "Changing Landscape: From Fee-for-Service to Value-Based Reimbursement," https://www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/practice-transformation-physicians-health-care-teams/why-transform/changing-landscape-fee-service-value-based-reimbursement.

[60] "The Defining Features of Current Value-Based Care Models," (Sept. 23, 2019), https://healthpayerintelligence.com/news/the-defining-features-of-current-value-based-care-models ("The success of value-based care models depends on care coordination, risk management, quality measurement, and adaptability"); Kent, J., "Value-Based Hospitals More Likely to Adopt Population Health Tools," Health Analytics (Jan. 17, 2019), ("Hospitals participating in value-based care models are investing more than their peers in . . . .solutions to help support population health management, data analytics, and care coordination capabilities"); Deloitte, "Value of patient experience," May 15, 2017, https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-value-patient-experience-050517.pdf ("With the market shift towards value-based and patient-centered models of care, improving patient experience is an increasingly common focus for hospitals").

[61] *See, e.g.,* Beaton, T., "Why Bundled Payments Are a Popular Option for Healthcare Payers," (Dec. 11, 2017), https://healthpayerintelligence.com/news/why-bundled-payments-are-a-popular-option-for-healthcare-payers ("Bundled payments have linked to improvements in healthcare cost savings for both payer and provider organizations").

[62] *See, e.g.,* Beaton, T., "Payers See Cost, Quality Gains with Value-Based Payment Models," Healthpayer Intelligence.com (Aug. 28, 2018), https://healthpayerintelligence.com/news/payers-see-cost-quality-gains-with-value-based-payment-models ("Value-based models are delivering on their promises to reduce costs and improve quality of care").

[63] Arndt, R., "The Growth of Telehealth Improves Continuity of Care in Rural Communities," Modern Healthcare (Jun. 9, 2018), https://www modernhealthcare.com/article/20180609/NEWS/306099954/the-growth-of-telehealth-improves-continuity-of-care-in-rural-communities.

[64] Rural Health Information Hub, "Telehealth Use in Rural Healthcare" https://www.ruralhealthinfo.org/topics/telehealth#challenges.

[65] *Id*.; *see also* Griffis, K., "What Your Practice Needs to Know About Telehealth," (Oct. 9, 2019), https://www.law360.com/health/articles/1207927/what-your-practice-needs-to-know-about-telehealth?nl_pk=65eb8c34-04b1-4a67-b09f-b85ac4c8a68b&utm_source=newsletter&utm_medium=email&utm_campaign=health.

[66] Center for Connected Health Policy "Telehealth Reimbursement" (Feb. 2019), at 1 https://www.telehealthpolicy.us/sites/default/files/2019-

03/TELEHEALTH%20REIMBURSEMENT%202019%20FINAL.pdf. Medicare Advantage plans will be able to offer telehealth services beginning in 2020. *See* https://www.telehealthpolicy.us/telehealth-policy/telehealth-and-medicare.

[67] Tex. Occ. Code § 111.001(4).

[68] Fair Health, "A Multilayered Analysis of Telehealth – How This Emerging Venue of Care is Affecting the Healthcare Landscape" Fair Health White Paper (Jul. 2019), at 2, https://s3.amazonaws.com/media2 fairhealth.org/whitepaper/asset/A%20Multilayered%20Analysis%20of%20Telehealth%20-%20A%20FAIR%20Health%20White%20Paper.pdf; *see also* Telecommunication Services Handbook, Texas Medicaid Provider Procedures Manual, The Texas Medicaid & Healthcare Partnership (TMHP) (Dec. 2019), http://www.tmhp.com/Manuals_PDF/TMPPM/TMPPM_Living_Manual_Current/2_Telecommunication_Srvs.pdf.

[69] Conditions treated include bronchitis, sinus infection, sore throat, urinary tract infection, cough, vomiting, diarrhea, fever, pinkeye, flu, sprains and strains, cold, respiratory infection, and headache.

[70] *See* https://www.tytocare.com/how-tyto-works/ for more information.

[71] *See* Association of American Medical Colleges, "The Complexities of Physician Supply and Demand: Projections from 2017 to 2032," (Apr. 2019), at viii, https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf.

[72] *Id*. at ix.

[73] Shannon Community Health Needs Assessment, at 19.

[74] Strategic Collaborations: Texas Organization of Rural & Community Hospitals (TORCH), "Rural Hospital Impact Study," (March 2017), at 66, https://www.episcopalhealth.org/files/5414/8909/1996/Impact_Study_final_3-7.pdf.

[75] Shannon Community Health Needs Assessment, at 15.

[76] The mission of MHMR is to offer an array of services and supports which respond to the needs of residents with mental illness, intellectual and developmental disabilities, and autism. MHMR operates as a unit of local government, and has a nine-member Board of Trustees who are appointed by Angelo State University, the City of San Angelo, San Angelo ISD, and Tom Green County.

[77] Philip E. Areeda & Herbert Hovenkamp, Antitrust Law: An Analysis of Antitrust Principles and Their Application: Vol. 1, 4 (2nd ed. 2000).

[78] Ohlhausen, M., "Certificate of Need Laws: A Prescription for Higher Costs," 30 Antitrust 1 (Fall 2015), at 51, https://www.ftc.gov/system/files/documents/public_statements/896453/1512fall15-ohlhausenc.pdf.

[79] Fottler, M. & Frimpong, J., "The Effects of Certificate of Need Regulation on Hospital Costs," 36 J. HEALTH CARE FIN. 1, 11 (2010) (finding that CON laws "may actually increase costs"); Stratmann, T. & Wille, D., "Certificate of Need Laws and Hospital Quality," Mercatus Center (Sept. 2016) ("CON regulations lead to lower-quality care for some measures of quality").

[80] "UMC Health Center Expands," https://www.everythinglubbock.com/news/kamc-news/umc-health-center-expands/.

[81] "UMC breaks ground on new EMS station, communications center in Lubbock," https://www.lubbockonline.com/news/20191216/umc-breaks-ground-on-new-ems-station-communications-center-in-lubbock; *see also* "UMC makes $5.1 million investment in East Lubbock EMS headquarters," https://www.kcbd.com/2019/12/16/umc-debuts-new-ems-station-dispatch-center/.

[82] "New tower to bring improvements for patients, employees", https://www kcbd.com/2019/12/16/umc-debuts-new-ems-station-dispatch-center/.

[83] "Growing to Meet the Needs of South Texas," University Health System, https://www.universityhealthsystem.com/about-us/expansion.

[84] "$240 Expansion Planned for Houston Methodist Woodlands," HOUSTON CHRONICLE (Jun. 3, 2019), https://www.houstonchronicle.com/news/health/article/240M-expansion-planned-for-Houston-Methodist-13924999.php.

[85] "Parkland Hospital to Add Six-Story, $154 Million Clinics and Office Building," THE DAILY MORNING NEWS (Jan. 14, 2019), https://www.dallasnews.com/business/real-estate/2019/01/14/parkland-hospital-to-add-six-story-154-million-clinics-and-office-building/.

[86] "74 Million Alliance Forth Worth Hospital Expansion Joins Texas Health's Growth Spurt," DALLAS NEWS (Dec. 21, 2018), https://www.dallasnews.com/business/real-estate/2018/12/21/74-million-alliance-fort-worth-hospital-expansion-joins-texas-health-s-growth-spurt/.

[87] 'This New Mansfield Hospital Will Add 280 Jobs, Offer Unique Approach to Patient Care," FORT WORTH STAR-TELEGRAM (Oct. 10, 2018), https://www.star-telegram.com/news/local/community/mansfield-news-mirror/article219701595.html.

[88] Deloitte Insights "Growth in Outpatient Care – The Role of Quality and Value Incentives," Center for Health Solutions, Deloitte (2018), at 5, https://www modernhealthcare.com/assets/pdf/CH116784829.PDF.

[89] Advisory Board, "The Outpatient Shift Continues: Outpatient Revenue Now 95% of Inpatient Revenue, New Report Reveals," (Jan. 8, 2019), https://www.advisory.com/daily-briefing/2019/01/08/hospital-revenue (reporting hospitals' net outpatient revenue in 2017 was $472 billion, while net inpatient revenue totaled almost $498 billion).

[90] *See id*. at 2.

[91] Chang, J., "Losing a Lifeline – What Happened When Milam County's Two Hospitals Closed," *Gate House News* (Jul. 26, 2019), https://gatehousenews.com/texas-rural-hospital-closings/.

[92] *See, e.g.*, 2011 Survey of Health Care – Consumers in the United States – Key Findings, Strategic Implications, Deloitte Center for Health Solutions, Deloitte (2011), at 17, http://www.statecoverage.org/files/Deloitte_US_CHS_2011ConsumerSurveyinUS_062111.pdf (reporting 54% of individuals would be highly unlikely to go to a hospital that is not the one nearest to their home for necessary care because it offers better care or faster access to services).

[93] 2019 Physician Inpatient/Outpatient Revenue Study, Merritt Hawkins (2019), at 13, https://www merritthawkins.com/uploadedFiles/MerrittHawkins_RevenueSurvey_2019.pdf.

[94] Tameez, H., "Why Does it Take so Long to Get a Doctor's Appointment?" FORT WORTH STAR-TELEGRAM (Mar. 1, 2019), https://www.star-telegram.com/news/local/fort-worth/article225525290.html.

[95] *See e.g.*, Ross, J. & Detsky, A., "Choice? Making Health Care Decisions in the United States and Canada," JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (Oct. 28, 2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835156/.

[96] Strategic Collaborations: Texas Organization of Rural & Community Hospitals (TORCH), "Rural Hospital Impact Study," (March 2017), at 52, https://www.episcopalhealth.org/files/5414/8909/1996/Impact_Study_final_3-7.pdf.

[97] *Id.* at 53.

[98] U.S. Department of Health and Human Services, Health Resources and Services Administration, "A Guide for Rural Health Care Collaboration," (2019), at 2, https://www.hrsa.gov/sites/default/files/hrsa/ruralhealth/resources/hrsa-rural-collaboration-guide.pdf.

[99] *Id*.

[100] Long-term Care Provider Search, Texas Health and Human Services, https://apps.hhs.texas.gov/LTCSearch/.

[101] Freestanding Emergency Medical Care Facilities, Profession Roster Report, Texas Department of State Health Services, https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/facilities-regulation/freestanding-emergency/femc-directory.pdf.

[102] Long-term Care Provider Search, Texas Health and Human Services, https://apps.hhs.texas.gov/LTCSearch/.

[103] Long-term Care Provider Search, Texas Health and Human Services, https://apps.hhs.texas.gov/LTCSearch/.