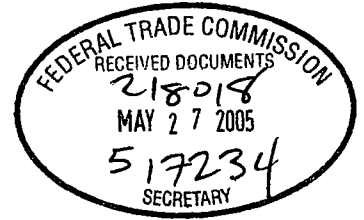


ORIGINAL

**UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES**



In the matter of)
)

Evanston Northwestern Healthcare)
Corporation,)
)
_____)

Docket No. 9315

Public Record

RESPONDENT'S PROPOSED POST-TRIAL FINDINGS OF FACT

VOLUME I of IV

WINSTON & STRAWN LLP

35 West Wacker Dr.
Chicago, IL 60601-9703
(312) 558-5764

1700 K Street, N.W.
Washington, DC 20006
(202) 282-5000

TABLE OF CONTENTS

VOLUME I

| | Page |
|--|-------|
| Abbreviations of Terms | xxxvi |
| | |
| I. THE PARTIES..... | 1 |
| A. Evanston Northwestern Healthcare..... | 1 |
| 1. The Three ENH Hospitals..... | 2 |
| a. Evanston Hospital | 3 |
| b. Glenbrook Hospital..... | 3 |
| c. HPH..... | 4 |
| 2. ENH Faculty Practice Associates | 4 |
| 3. ENH Research Institute..... | 4 |
| 4. ENH Foundation | 5 |
| B. Evanston Hospital And HPH Before The Merger | 5 |
| 1. Pre-Merger Evanston Hospital..... | 5 |
| 2. HPH Pre-Merger | 6 |
| a. HPH Was A Community Hospital With Limited Services Before The Merger..... | 6 |
| b. HPH Had Financial Problems Before The Merger | 7 |
| c. HPH Had Quality Of Care Problems Before The Merger | 7 |
| | |
| II. DYNAMICS OF MANAGED CARE | 9 |
| A. Overview: Interaction Among Relevant Players (Patients, Employers, Private Payors And Providers) | 9 |
| B. Types Of Managed Care Plans | 10 |
| 1. HMO | 10 |
| 2. PPO | 11 |

| | | |
|-------|---|----|
| 3. | POS | 11 |
| 4. | Indemnity | 12 |
| C. | Role Of Outpatient Services | 12 |
| D. | Managed Care Contracting | 12 |
| 1. | Selective Contracting | 12 |
| 2. | Scope Of MCO Contracts | 12 |
| 3. | Reimbursement Methodologies | 13 |
| a. | Discount-Off-Charges Contracts | 13 |
| b. | Per Diem | 14 |
| c. | Case Rates | 15 |
| d. | Capitation | 15 |
| E. | Different Type of Hospitals (Academic And Community) | 15 |
| F. | The Impact Of The Balanced Budget Act Of 1997 On Managed Care | 16 |
| G. | Hospitals Have Felt Substantial Pressure To Reduce Costs | 17 |
| H. | Chicago Healthcare Market | 17 |
| a. | Relevant Hospitals | 17 |
| b. | Relevant MCOs..... | 18 |
| i. | Aetna | 18 |
| ii. | Blue Cross..... | 18 |
| iii. | CCN | 19 |
| iv. | Cigna..... | 19 |
| v. | Great West | 20 |
| vi. | HFN..... | 20 |
| vii. | Humana..... | 21 |
| viii. | PHCS | 22 |
| ix. | Unicare..... | 22 |

| | | |
|------|---|----|
| x. | United..... | 23 |
| I. | MCO Negotiating Trends In The Chicago Area Market | 24 |
| 1. | Hospitals Use Termination Letters To Open Negotiations With MCOs..... | 25 |
| 2. | System-Wide Contracts Are Gaining Popularity..... | 25 |
| 3. | The Contract Negotiation “Pendulum” Is Swinging Back In Favor Of MCOs..... | 25 |
| III. | PRE-MERGER BACKGROUND | 27 |
| A. | Northwestern Healthcare Network | 27 |
| 1. | Purpose Of The Network | 27 |
| 2. | Structure And Powers Of The Network..... | 28 |
| 3. | Managed Care Contracting By The Network | 30 |
| 4. | Failures And Limitations Of The Network..... | 30 |
| B. | NH North | 31 |
| C. | Other Failed Merger Negotiations And Failed Joint Ventures Involving HPH | 32 |
| IV. | THE MERGER..... | 34 |
| A. | Merger Negotiations | 34 |
| 1. | Initial Merger Discussions | 34 |
| 2. | Letter Of Intent | 35 |
| B. | Reasons For The Merger..... | 37 |
| 1. | HPH’s Reasons For The Merger..... | 38 |
| a. | The Merger Would Improve Quality Of Care At HPH And In The Community In General..... | 38 |
| b. | The Merger Would Address HPH’s Deteriorating Financial Condition..... | 39 |
| c. | The Merger Would Provide A Good “Fit” | 39 |
| 2. | Evanston Hospital’s Reasons For The Merger | 40 |

| | | |
|----|--|----|
| a. | The Merger Would Allow Evanston Hospital To Improve Quality Of Care By Expanding The Volume Of Its Services | 40 |
| b. | The Merger Would Allow Evanston Hospital To Improve Quality Of Care By Rationalizing Its Services | 40 |
| c. | The Merger Would Result In Corporate Efficiencies | 41 |
| d. | The Merger Would Provide Evanston Hospital With An Additional Teaching Site | 41 |
| C. | Merger Consummation | 41 |
| D. | Effect Of The Merger On ENH’s Operations | 42 |
| E. | Post-Merger Healthcare Foundation Of Highland Park..... | 43 |
| V. | ANALYTIC FRAMEWORK..... | 44 |
| A. | The Court Should Analyze The Price Increases In The Context Of The Relevant Market..... | 44 |
| 1. | All Experts Agree That Price Increases Alone Are Not Anticompetitive..... | 44 |
| 2. | All Experts Agree That One Must Rule Out Viable Alternative Explanations Before Concluding That A Price Increase Is The Result Of Anticompetitive Market Power | 44 |
| 3. | Market Definition Provides The Necessary Framework In Which To Evaluate These Alternative Explanations..... | 44 |
| B. | The Court Should Evaluate The Competitive Effects Of The Merger | 45 |
| 1. | The Court Should Evaluate Price Effects Of The Merger | 45 |
| 2. | The Court Should Evaluate Quality Effects Of The Merger As A Pro-Competitive Effect | 45 |
| 3. | The Court Should Take Into Account Other Competitive Effects Considerations..... | 46 |
| a. | The Court Should Evaluate Issues Pertaining To Market Entry And Repositioning | 46 |
| b. | The Court Should Evaluate The Financial Condition Of HPH Before The Merger | 47 |
| c. | The Court Should Evaluate ENH’s Not-For-Profit Status | 47 |

| | | |
|-----|---|----|
| C. | ENH’s Economist Experts Analyzed The Facts Of The Case In The Context Of This Analytic Framework | 48 |
| 1. | Dr. Monica Noether | 48 |
| 2. | Professor Jonathan Baker..... | 49 |
| VI. | RELEVANT MARKET..... | 51 |
| A. | The Relevant Product Market Consists Of All Acute Care Hospital-Based Services | 51 |
| 1. | The Product At Issue Being Sold Includes All Acute Care Hospital-Based Services | 51 |
| 2. | The Relevant Customers, <i>i.e.</i> , MCOs, Purchase All Acute Care Hospital-Based Services Together..... | 51 |
| a. | MCOs Purchase Inpatient And Outpatient Services Together | 51 |
| b. | MCOs Purchase Primary, Secondary And Tertiary Services Together | 52 |
| 3. | Dr. Noether Has Correctly Defined The Relevant Product Market..... | 52 |
| 4. | Dr. Haas-Wilson Has Not Correctly Defined The Relevant Product Market | 53 |
| B. | The Relevant Geographic Market Consists Of Multiple Competitor Hospitals In The Chicago Area..... | 53 |
| 1. | The Court Should Consider Patient Preferences And Physician Admitting Patterns When Evaluating The Relevant Geographic Market | 53 |
| a. | Patient Preferences Are Relevant To The Geographic Market Analysis..... | 53 |
| i. | Geographic Proximity Is Relevant To Patient Preferences..... | 54 |
| ii. | Travel Patterns Are Relevant To Patient Preferences..... | 55 |
| b. | Physician Admitting Patterns Are Relevant To The Geographic Market Analysis | 58 |
| 2. | The Court Should Consider The Fact That There Are Multiple Hospitals In The Chicago Area When Evaluating The Relevant Geographic Market | 58 |

| | | |
|----|--|----|
| a. | Advocate Lutheran General | 59 |
| b. | Condell..... | 59 |
| c. | Lake Forest Hospital..... | 60 |
| d. | Loyola | 60 |
| e. | Northwestern Memorial | 60 |
| f. | Rush North Shore And Rush Presbyterian..... | 61 |
| g. | St. Francis | 62 |
| h. | Swedish Covenant..... | 62 |
| i. | University Of Chicago | 62 |
| j. | University Of Illinois At Chicago..... | 62 |
| 3. | The Relevant Geographic Market Broadly Encompasses A Large Number Of Competitor Hospitals In The Chicago Area | 63 |
| a. | MCO Testimony And Documents Confirm A Broad Geographic Market | 63 |
| b. | Third Party Hospital Documents Confirm A Broad Geographic Market | 64 |
| c. | ENH Testimony And Documents Confirm A Broad Geographic Market | 66 |
| d. | Other Third Party Testimony And Documents Confirm A Broad Geographic Market..... | 67 |
| e. | Dr. Noether Defined A Reasonable Relevant Geographic Market..... | 67 |
| f. | Dr. Haas-Wilson Did Not Define A Reasonable Geographic Market | 68 |
| C. | ENH's Market Share Is Less Than That In Other Hospital Merger Cases..... | 69 |
| 1. | ENH's Core Market Consists Of About 20 Zip Codes..... | 69 |
| 2. | ENH's Service Area Consists Of About 51 Zip Codes | 69 |
| 3. | The Concentration Resulting From The Merger Is Acceptable..... | 70 |

VOLUME II

VII. THE MERGER RESULTED IN NO ANTICOMPETITIVE EFFECTS 72

A. The Court Should Consider Various Economic Factors In Its Competitive Effects Analysis 72

1. Dr. Haas-Wilson’s Analysis Is Based On A Bargaining Theory..... 72

2. The Pertinent Pricing Analysis Under Dr. Haas-Wilson’s Bargaining Theory Has Both Theoretical And Empirical Dimensions 72

a. As A Theoretical Matter, Complaint Counsel Must Show More Than That ENH’s Prices Increased After The Merger 72

i. Price Changes Alone Are Not Evidence Of Market Power 72

ii. Complaint Counsel Must Evaluate And Eliminate Viable Alternative Explanations 73

iii. In Particular, Complaint Counsel Must Rule Out “Learning About Demand” To Show That ENH Exercised Market Power As A Result Of The Merger..... 74

iv. The Court Should Consider Both Price Levels And Price Changes When Evaluating Whether Price Increases Were The Result Of Market Power From The Merger. 74

b. As An Empirical Matter, Complaint Counsel Must Show That ENH’s Post-Merger Prices Increases Were The Result Of Market Power..... 74

3. This Court Also Should Take Into Account Other Competitive Effects Considerations 74

B. The Pre-Merger Competitive Landscape Is Inconsistent With Dr. Haas-Wilson’s Bargaining Theory 76

1. This Case Involves A Differentiated Product 76

2. Evanston Hospital And HPH Were Not Close Substitutes..... 76

a. Evanston And HPH Were Not Close Substitutes From A Product Perspective..... 76

| | | |
|------|---|----|
| i. | Evanston Hospital And HPH Offered A Different Breadth of Services | 76 |
| ii. | Evanston Hospital And HPH Were Hospitals Of Very Different Sizes | 77 |
| iii. | Unlike Evanston Hospital, HPH Had No Teaching Component..... | 78 |
| b. | Evanston Hospital And HPH Were Not Close Substitutes From A Geographic Perspective..... | 78 |
| c. | Evanston Hospital And HPH Had Much Closer Substitutes Than Each Other | 78 |
| i. | Evanston Hospital Had Several Closer Substitutes Than HPH | 79 |
| (1) | Evanston Hospital’s Closest Substitutes From A Product Perspective Were Advocate Lutheran General And Northwestern Memorial | 79 |
| (2) | Evanston Hospital’s Closest Substitutes From A Geographic Perspective Were St. Francis And Rush North Shore..... | 80 |
| ii. | HPH’s Closest Substitutes From Both A Product And Geographic Perspective Were Lake Forest Hospital And Condell | 80 |
| C. | Dr. Haas-Wilson’s Bargaining Theory Does Not Take Into Account The Fact That Evanston Hospital And HPH Had Very Different Negotiating Strategies And Contract Rates Before The Merger | 81 |
| 1. | Evanston Hospital And HPH Had Different Pre-Merger Negotiating Strategies..... | 82 |
| a. | HPH Had An Aggressive Pricing Strategy Before The Merger..... | 82 |
| b. | Evanston Hospital, In Contrast, Did Not Focus On MCO Negotiations Before The Merger | 82 |
| i. | Before 1999, Evanston Hospital Did Not Institute An Aggressive MCO Negotiation Policy | 82 |
| ii. | Evanston Hospital’s Pre-Merger MCO Contract Negotiator Used A Passive Negotiation Style | 83 |

| | | | |
|----|------|---|----|
| | (1) | Sirabian Was In Charge Of Evanston Hospital’s Pre-Merger MCO Negotiations | 83 |
| | (2) | Sirabian’s Goal Was To Obtain “Win-Win Contracts” | 84 |
| | (3) | Sirabian Did Not Threaten Termination As A Means To Obtain Aggressive Rates..... | 84 |
| | (4) | Sirabian Let Contracts Lapse And Did Not Intiate Contract Renegotiations..... | 85 |
| | iii. | Many Evanston Hospital Contracts Had Not Been Renegotiated In A Number Of Years..... | 85 |
| c. | | By The Late 1990’s, Changing Financial Conditions Put Pressure On Evanston Hospital To Focus On MCO Contract Rates..... | 86 |
| | i. | Evanston Hospital Realized The Adverse Financial Effect Of The Balanced Budget Act Until In Late 1998 And 1999..... | 86 |
| | ii. | Since The Late 1990s, Evanston Hospital/ENH, Along With Other Hospitals, Have Been Under Pressure To Reduce Costs..... | 87 |
| | iii. | By The Late 1990s, Evanston Hospital No Longer Could Rely As Heavily On Its Investment Income | 88 |
| 2. | | Evanston Hospital And HPH Had Different Negotiated MCO Contract Rates Before The Merger | 89 |
| D. | | Dr. Haas-Wilson’s Bargaining Theory Does Not Eliminate All Viable Alternative Explanations For ENH’s Post-Merger Price Increases, Such As Learning About Demand | 89 |
| | 1. | “Price” Can Be Defined In Several Ways..... | 89 |
| | a. | Charges | 89 |
| | b. | Contract Rates..... | 89 |
| | c. | Reimbursement Rates | 89 |
| 2. | | The Factual Evidence Is Consistent With The Learning About Demand Alternative Explanation For The Price Increases At Issue..... | 90 |

| | | |
|----|---|-----|
| a. | Coincident With The Merger, ENH Learned That It Was “Leaving Money On The Table” Through Proper Due Diligence..... | 90 |
| b. | At The Time Of The Merger, Evanston Hospital Learned About The Demand For Its Services Through Bain’s Consulting Services | 92 |
| | i. Bain Advised ENH That HPH Had More Favorable MCO Contracts | 92 |
| | ii. Bain Advised ENH That It Had Expired Or Outdated MCO Contracts | 95 |
| | iii. Bain Advised ENH That It Was Under-Market As Compared To Its Peer Academic Hospitals | 96 |
| | iv. Bain Advised ENH On MCO Contract Renegotiations..... | 96 |
| | (1) Bain Advised ENH On A Post-Merger 96Negotiation Schedule..... | |
| | (2) Bain Advised ENH On Negotiation Tactics | 97 |
| | v. Bain’s Advice Paid Off – But The Successful Contract Renegotiations Were Not Due To The Merger..... | 99 |
| c. | Individual MCO Negotiations Are Consistent With The Learning About Demand Theory | 100 |
| | i. Aetna..... | 101 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With Aetna Were Outdated And Undermarket | 101 |
| | (2) ENH’s Post-Merger Negotiations With Aetna Were Not Anticompetitive | 102 |
| | ii. Blue Cross..... | 103 |
| | (1) Evanston Hospital Pre-Merger Contract Rates Exceeded HPH’s Pre-Merger Contract Rates..... | 103 |
| | (2) ENH’s Post-Merger Negotiations With Blue Cross Were Not Anticompetitive..... | 104 |

| | | |
|-------|---|-----|
| iii. | Cigna..... | 106 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With Cigna Were Outdated And Undermarket | 106 |
| | (2) ENH’s Post-Merger Negotiations With Cigna Were Not Anticompetitive | 106 |
| iv. | CCN | 106 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With CCN Were Outdated And Undermarket | 106 |
| | (2) ENH’s Post-Merger Negotiations With CCN Were Not Anticompetitive..... | 107 |
| v. | Great West | 107 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With One Health/Great West Were Outdated And Undermarket..... | 107 |
| | (2) ENH’s Post-Merger Negotiations With Great West Were Not Anticompetitive..... | 108 |
| vi. | HFN..... | 109 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With HFN Were Outdated And Undermarket | 109 |
| | (2) ENH’s Post-Merger Negotiations With HFN Were Not Anticompetitive..... | 110 |
| vii. | Humana..... | 110 |
| | (1) Before the Merger, Evanston Hospital Acquired Some Humana Physician Office Sites..... | 110 |
| | (2) ENH’s Post-Merger Negotiations With Humana Were Not Anticompetitive | 111 |
| viii. | PHCS..... | 112 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With PHCS Was Outdated And Undermarket | 112 |

| | | | |
|-----|------|--|-----|
| | (2) | ENH's Post-Merger Negotiations With PHCS Were Not Anticompetitive..... | 113 |
| ix. | | Preferred Plan..... | 115 |
| | (1) | Evanston Hospital's Pre-Merger Contract Rates With Preferred Plan Were Outdated And Undermarket..... | 115 |
| | (2) | ENH's Post-Merger Negotiations With Preferred Plan Were Not Anticompetitive..... | 115 |
| x. | | Unicare..... | 116 |
| | (1) | Evanston Hospital's Pre-Merger Contract Rates With Unicare And Rush Prudential Were Outdated And Undermarket | 116 |
| | (2) | ENH's Post-Merger Negotiations With Unicare Were Not Anticompetitive | 117 |
| xi. | | United..... | 119 |
| | (1) | Evanston Hospital's Pre-Merger Contract Rates With United Were Outdated And Undermarket | 119 |
| | (2) | ENH's Post-Merger Negotiations With United Were Not Anticompetitive..... | 119 |
| | (3) | United And ENH Renegotiated Their 2000 Contract To Accommodate United's Contracting Goals | 121 |
| d. | | By 2002, ENH Learned That, On A Whole, Its Chargemaster Contained Prices That Were Undermarket | 125 |
| | i. | Description Of A Chargemaster..... | 125 |
| | ii. | ENH Consolidated Its Chargemaster After The Merger..... | 125 |
| | iii. | ENH, With The Assistance Of Deloitte Consulting, Brought Its Chargemaster Up To Market In 2002 | 126 |
| e. | | Factual Evidence Is Inconsistent With Dr. Haas-Wilson's Bargaining Theory | 130 |
| | i. | Dr. Haas-Wilson's Bargaining Theory Is Not Grounded In Theory Or Common Sense..... | 130 |

| | | |
|------|--|-----|
| d. | Dr. Haas-Wilson’s Empirical Analysis Fails To Account For Viable Alternative Explanations For The Price Increases At Issue, Such As Learning About Demand..... | 142 |
| 4. | Empirical Analysis of Price <i>Levels</i> Also Supports Learning About Demand..... | 144 |
| a. | Dr. Noether’s Control Groups Are An Appropriate Basis To Compare Price Levels..... | 144 |
| i. | The Criteria Used By Dr. Noether To Select Her Control Group Are Appropriate..... | 144 |
| ii. | Dr. Noether’s Characterization Of ENH As A Major Teaching Hospital Is Consistent With MCO Views..... | 145 |
| iii. | Dr. Haas-Wilson’s Criticisms Of Dr. Noether’s Control Groups Are Unfounded..... | 146 |
| (1) | Dr. Haas-Wilson’s Sum Of Squares Measure Of Breadth Of Service Is Misleading..... | 146 |
| (2) | Dr. Haas-Wilson’s Focus On “Quarternary Services” Is Misguided..... | 147 |
| (3) | Dr. Haas-Wilson’s Criticisms Of Dr. Noether’s Control Group Based On Differences In Public Perception Are Unfounded..... | 147 |
| b. | Dr. Noether Cleaned Pertinent MCO Data More Effectively Than Dr. Haas-Wilson..... | 148 |
| c. | Dr. Noether’s Empirical Analysis Confirms That The Learning About Demand Theory Applies In This Case..... | 150 |
| i. | Aetna..... | 151 |
| ii. | Blue Cross..... | 151 |
| iii. | Humana..... | 152 |
| iv. | United..... | 152 |
| d. | Professor Baker’s Empirical Analysis Confirms That The Learning About Demand Theory Applies In This Case..... | 153 |
| i. | The Results Of Professor Baker’s Analysis Are Consistent With The Learning About Demand Theory..... | 155 |

| | | |
|-----|--|-----|
| ii. | Professor Baker’s Empirical Analysis Overstates ENH’s Post-Merger Price Increase Because That Analysis Does Not Measure Quality-Adjusted Prices..... | 156 |
|-----|--|-----|

VOLUME III

| | | |
|-------|---|-----|
| VIII. | MERGER IMPACT ON QUALITY | 158 |
| A. | Definition And Measurement Of Healthcare Quality..... | 158 |
| 1. | Definition Of Quality In Healthcare | 158 |
| 2. | Measuring Healthcare Quality | 158 |
| a. | Strengths And Weaknesses Of Quality Measures | 159 |
| b. | Quality Measures Must Be Valid..... | 161 |
| B. | Dr. Chassin Employed Accepted Methodology For The Study Of Healthcare Quality | 162 |
| C. | Dr. Chassin Has Extensive Experience Evaluating And Assessing Healthcare Quality | 164 |
| D. | Overview Of Changes In Healthcare Quality At HPH As A Result Of The Merger..... | 166 |
| 1. | ENH Corrected Problems With Clinical Practice At HPH That Existed Before The Merger..... | 167 |
| a. | The Merger Improved Quality Of Care In HPH’s Ob/Gyn | 167 |
| i. | Overview..... | 167 |
| ii. | Evanston Hospital Had A Relationship With HPH Before The Merger Through The Illinois Perinatal Network..... | 168 |
| iii. | HPH Ob/Gyn Department Had Serious Problems Before The Merger..... | 169 |
| (1) | HPH Had Insufficient Obstetrician Coverage Before The Merger..... | 170 |
| (2) | HPH’s Ob/Gyn Department Had Poor Nurse/Physician Teamwork Before The Merger..... | 170 |

| | | | |
|-----|-----|---|-----|
| | (3) | HPH Lacked Effective Obstetrical Leadership Before The Merger..... | 171 |
| | (4) | There Were Inappropriate Procedures In HPH’s Ob/Gyn Department Before The Merger..... | 172 |
| iv. | | ENH Improved Quality Of Care At HPH’s Ob/Gyn Department After The Merger | 173 |
| | (1) | ENH Expanded Obstetrician Coverage At HPH After The Merger | 173 |
| | (2) | ENH Improved HPH’s Nurse/Physician Teamwork After The Merger..... | 175 |
| | (3) | ENH Improved HPH’s Ob/Gyn Leadership And Quality Assurance Program After The Merger..... | 176 |
| | (4) | ENH Addressed The Inappropriate Procedures In Ob/Gyn At HPH After The Merger..... | 177 |
| | (5) | ENH Implemented Obstetric Committee Practice Protocols At HPH After The Merger..... | 177 |
| | (6) | ENH Introduced The Preoperative Gynecologic Surgical Review Program At HPH After The Merger | 178 |
| v. | | Patient Outcomes In ENH’s OB/GYN Services Are Consistent With, Or Better Than, National Benchmarks..... | 180 |
| vi. | | Dr. Romano’s Undue Reliance On Administrative Data To Evaluate HPH’s Obstetrical Service Is Invalid | 182 |
| b. | | The Merger Improved Quality Of Care In HPH’s Nursing Services..... | 183 |
| | i. | Overview..... | 183 |
| | ii. | HPH’s Pre-Merger Nursing Services Needed Improvement..... | 184 |

| | | | |
|------|-----|---|-----|
| | (1) | HPH Had Issues Concerning Nurse Recruiting, Vacancy And Turnover Rates Before The Merger..... | 184 |
| | (2) | HPH Had Issues Concerning Nurse Training Before The Merger..... | 185 |
| | (3) | HPH Had Issues Concerning Nurse/Physician Relationships Before The Merger..... | 186 |
| iii. | | ENH Improved HPH's Nursing Services And Culture After The Merger | 188 |
| | (1) | ENH Improved HPH's Nurse Recruiting, Vacancy And Turnover After The Merger | 189 |
| | (2) | ENH Improved HPH's Nurse Training After The Merger..... | 190 |
| | (3) | ENH Improved HPH's Nurse/Physician Relationships After The Merger | 191 |
| c. | | The Merger Substantially Improved HPH's Quality Assurance Program | 192 |
| | i. | Overview..... | 192 |
| | ii. | HPH's Quality Assurance Was Inadequate Before The Merger..... | 193 |
| | (1) | HPH's Pre-Merger Organizational Structure Hindered Quality Assurance Activities | 194 |
| | (2) | HPH's Pre-Merger Adverse Event Case Reviews Were Suboptimal..... | 195 |
| | (3) | HPH's Ob/Gyn Department Was Particularly Poor At Disciplining Problem Physicians | 196 |
| iii. | | ENH Improved HPH's Quality Assurance Program Soon After The Merger | 196 |
| | (1) | The Merger Improved The Reporting Of Adverse Events At HPH | 197 |

| | | | |
|----|------|--|-----|
| | (2) | ENH’s Addition Of Strong Department Leadership At HPH Helped Correct Problems With Physician Discipline | 197 |
| | (3) | ENH Improved The Process Of Reviewing HPH Physician Credentialing Status | 199 |
| d. | | The Merger Improved HPH’s Quality Improvement Program..... | 199 |
| | i. | HPH’s Pre-Merger QI Program Was Inadequate..... | 200 |
| | ii. | ENH Exported Its Superior Quality Improvement Processes To HPH Soon After The Merger..... | 200 |
| | iii. | Data From HPH’s Pre-Merger Care Maps Cannot Be Used To Assess Quality Improvements At HPH Post-Merger..... | 202 |
| | iv. | Improvements In The Care Of Heart Attack Patients At HPH Demonstrates The Improvement In HPH’s QI Program Post-Merger..... | 202 |
| | (1) | ENH Improved The Provision Of Aspirin To Heart Attack Patients At HPH | 203 |
| | (2) | HPH Improved The Provision Of Beta Blockers To Heart Attack Patients After The Merger..... | 204 |
| | (3) | The Minor Change In Performance On The NRMI Measures Are Based On An Extremely Small Sample..... | 205 |
| | (4) | The Merger Resulted In A Dramatic Improvement In The Care Of Heart Attack Patients At HPH | 206 |
| e. | | ENH Corrected Serious Deficiencies In HPH’s Physical Plant | 206 |
| | i. | Overview..... | 206 |
| | ii. | Before The Merger, HPH Passed The Joint Commission’s Accreditation Inspections, Which Are Not A Comprehensive Assessment Of Hospital Quality, Because It Had Advance Notice Of The Inspections | 207 |

| | | |
|------|---|-----|
| iii. | A 1999 IDPH Survey Uncovered Numerous Physical Plant Deficiencies At HPH That Were Not Identified By The 1999 Joint Commission Accreditation Survey | 208 |
| iv. | Before The Merger, HPH Nearly Lost Its Medicare Accreditation Due To Serious Physical Plant Deficiencies That Threatened Patient Safety | 209 |
| v. | Pre-Merger Due Diligence Performed By ENH Identified Even More Serious Physical Plant Deficiencies | 209 |
| vi. | ENH Remedied The Substantial Deficiencies To HPH's Physical Plant And Made Additional Capital Improvements That Enhanced The Quality Of Care At HPH..... | 211 |
| (1) | ENH Opened A New Open Heart Surgery Suite At HPH | 212 |
| (2) | ENH Opened A New Ambulatory Care Center At HPH..... | 212 |
| (3) | ENH Purchased New Equipment For The Operating Rooms | 212 |
| 2. | ENH Made Additional Improvements To Quality Of Care And Introduced New High Quality Services | 213 |
| a. | ENH Initiated A Cardiac Surgery Program At HPH After The Merger..... | 213 |
| i. | Overview..... | 213 |
| ii. | HPH Was Not Well-Positioned To Begin A Cardiac Surgery Program | 214 |
| iii. | ENH Recruited A Talented Physician Leader For Cardiac Surgery Immediately After The Merger..... | 215 |
| iv. | Evanston Hospital And HPH, Since The Merger, Have An Integrated Cardiac Surgery Program That Shares An Affiliation With Other Hospitals | 216 |
| v. | HPH Had Equal Or Lesser Ability To Accept A New Cardiac Surgery Program Than The ENH-Affiliated Hospitals..... | 218 |

| | | |
|------|--|-----|
| vi. | The Post-Merger, Integrated ENH/HPH Cardiac Surgery Program Provides Excellent Care To Patients | 218 |
| | (1) The Mortality Rate For Cardiac Surgery At HPH Compares Favorably To The Best Surgery Centers In The Country | 218 |
| | (2) HPH Complication Rates For Cardiac Surgery Are Below National Benchmarks..... | 220 |
| vii. | The Merger Was Essential To The Success Of HPH’s Cardiac Surgery Program..... | 221 |
| | (1) As A Result Of The Merger HPH Is An Integrated Part Of The ENH Cardiac Surgery Program | 221 |
| | (2) Due To The Level Of Integration Engendered By The Merger, HPH Performs Higher Quality Cardiac Surgery Than Affiliated Hospitals..... | 222 |
| b. | ENH Successfully Established An Interventional Cardiology Program At HPH..... | 224 |
| | i. Overview..... | 224 |
| | ii. Before The Merger, HPH Could Not Treat Heart Attack Patients With Interventional Cardiology Procedures..... | 224 |
| | iii. After The Merger, ENH Established A Successful Interventional Cardiology Program At HPH | 224 |
| | (1) HPH’s Interventional Cardiology Program Has Obviated The Need To Transfer Acute Heart Attack Patients To Other Hospitals..... | 225 |
| | (2) The Interventional Cardiology Program At HPH Has Achieved High Quality Outcomes..... | 226 |
| | (3) On-Site Cardiac Surgery At HPH Is Needed To Continue The Interventional Cardiology Program..... | 226 |
| c. | The Merger Substantially Improved HPH’s Intensive Care Services | 227 |

| | | |
|------|--|-----|
| i. | Overview..... | 227 |
| ii. | HPH’s ICU Had Gaps In Patient Care Before The Merger..... | 228 |
| iii. | The Addition Of Intensivist Coverage After The Merger Eliminated The Gaps In ICU Patient Care At HPH | 229 |
| (1) | Intensivists Have Broad ICU Responsibilities At HPH | 230 |
| (2) | The Intensivist Program Complemented The Introduction Of Cardiac Surgery At HPH | 231 |
| (3) | The Intensivist Program Improved Nursing Care In The HPH ICU..... | 232 |
| iv. | The Intensivist Program Improved The Overall Quality Of Care For HPH’s Critically Ill Patients..... | 232 |
| v. | HPH Had No Plans To Adopt An Intensivist Program Before The Merger | 233 |
| d. | The Merger Substantially Improved Oncology Services At ENH..... | 233 |
| i. | Overview..... | 233 |
| ii. | Pre-Merger Cancer Services At HPH Were Typical Of A Community Hospital..... | 234 |
| (1) | Pre-Merger Cancer Services At HPH Lacked Full Time Employed Oncologists | 234 |
| (2) | Pre-Merger Cancer Support And Ancillary Services At HPH Were Limited..... | 235 |
| (3) | Pre-Merger Cancer Patients At HPH Lacked Access To Specialists..... | 235 |
| (4) | Pre-Merger Cancer Services At HPH Lacked Academic Research And Clinical Trials | 235 |
| (5) | Pre-Merger Cancer Services At HPH Had Inadequate Facilities And Equipment..... | 236 |
| (6) | Pre-Merger Cancer Services At HPH Lacked Quality Assurance | 237 |

| | | |
|------|---|-----|
| iii. | ENH Made Major Improvements To The HPH Oncology Program That Significantly Expanded HPH's Cancer Services And Improved The Quality Of Cancer Care At HPH | 237 |
| (1) | The Kellogg Cancer Center Brought A Multidisciplinary Approach To HPH..... | 237 |
| (2) | ENH Improved Ancillary And Support Services For Cancer Patients After The Merger..... | 239 |
| (3) | ENH Provided More Qualified Staff And An Academic Affiliation To HPH's Cancer Program After The Merger | 240 |
| (4) | ENH Improved Patient Access To Specialists At HPH After The Merger | 240 |
| (5) | ENH Provided Increased Academic Research And Clinical Trials To HPH's Cancer Program After The Merger | 240 |
| (6) | ENH Provided State-Of-The-Art Equipment And Advanced Services To HPH's Cancer Program After The Merger | 241 |
| e. | The Merger Substantially Expanded And Improved Laboratory Services At HPH | 242 |
| i. | Overview | 242 |
| ii. | ENH Decided To Close CML Because It Was Inefficient..... | 243 |
| iii. | ENH Found Several Quality Issues When It Took Over The HPH Lab On June 1, 2000..... | 243 |
| (1) | ENH Found That The HPH Lab Had Equipment Issues | 243 |
| (2) | ENH Found That The HPH Lab Had Personnel Issues..... | 244 |
| (3) | ENH Found That The HPH Lab Had Environmental Controls Issues | 245 |
| (4) | ENH Found That The HPH Lab Had Water Issues..... | 245 |

| | | | |
|-----|------|--|-----|
| | (5) | ENH Found That The HPH Lab Did Not Have A Histology Laboratory..... | 245 |
| | (6) | ENH Found That The HPH Lab Did Not Have A Cytology Laboratory..... | 245 |
| | (7) | ENH Found That The HPH Lab Did Not Have Adequate Laboratory Manuals | 246 |
| iv. | | ENH Made Numerous Quality Improvements To The HPH Lab | 246 |
| | (1) | ENH Improved The HPH Lab's Equipment..... | 246 |
| | (2) | ENH Improved The HPH Lab's Personnel..... | 247 |
| | (3) | ENH Improved The HPH Lab's Environmental Systems | 247 |
| | (4) | ENH Improved The HPH Lab's Water System..... | 247 |
| | (5) | ENH Constructed A Histology Laboratory At The HPH Lab | 247 |
| | (6) | ENH Constructed A Cytology Laboratory At The HPH Lab | 247 |
| | (7) | ENH Improved The HPH Lab's Laboratory Manuals..... | 247 |
| | (8) | ENH Improved The HPH Lab's Quality Control | 247 |
| | (9) | ENH Improved Microbiology Testing | 248 |
| | (10) | ENH Improved Immunology Testing | 248 |
| | (11) | ENH Improved Molecular Diagnostic Testing..... | 248 |
| | (12) | ENH Improved The HPH Lab's Computer System..... | 249 |
| | (13) | ENH Established Oversight Of The HPH Lab By ENH Specialists | 249 |
| | (14) | ENH Established The Rotation Of Pathologists Among The ENH Hospitals | 249 |

VOLUME IV

- v. ENH’s Improvements To The HPH Lab Have Improved Quality And/Or Resulted In Efficiencies250
 - (1) ENH’s Improvements To The HPH Lab Dramatically Improved The Turnaround Time For Tests Performed In The HPH Lab250
 - (2) ENH Brought Its Academic Focus On Pathology To HPH.....250
 - (3) On-Site Testing Has Substantial Advantages Over Outsourcing.....250
 - (4) ENH Realized Substantial Cost Savings From The Dissolution of CML251
 - (5) HPH Pathologists Now Engage in Teaching Activities.....252

- f. The Merger Resulted In Structured And Service Improvements To The HPH Emergency Department.....251
 - i. Overview.....251
 - ii. HPH’s Pre-Merger ED Needed Improvement252
 - (1) In General, HPH’s ED Facilities Were Inadequate Before The Merger252
 - (2) HPH Had Physician Staffing Problems Before The Merger.....252
 - (3) HPH’s Fast Track Was Inadequate Before The Merger.....253
 - iii. ENH Significantly Improved The HPH ED After The Merger.....254
 - (1) ENH Substantially Expanded And Renovated The HPH ED.....254
 - (a) Phase I Of The HPH ED Renovation.....254
 - (i) Patient Rooms Were Redesigned.....254
 - (ii) Critical Care Rooms Were Updated.....255

| | | | |
|----|-------|--|-----|
| | (iii) | Isolation Rooms Were Added..... | 255 |
| | (b) | Phase II Of The HPH Renovation | |
| | (i) | The HPH ED Registration Area Was Made More Private..... | 255 |
| | (ii) | The HPH ED Triage Area Was Significantly Expanded..... | 256 |
| | (iii) | The HPH ED Waiting Area Was Remodeled | 256 |
| | (2) | ED Physician Coverage Was Expanded Post-Merger..... | 256 |
| | (i) | Double Coverage At HPH's ED Improved Quality Of Care | 256 |
| | (ii) | The Rotation Of ED Physicians At ENH Improved Quality Of Care..... | 257 |
| | (iii) | Other Staffing Changes At HPH's ED Improved Quality Of Care..... | 258 |
| | (3) | ENH Improved HPH's Fast Track Design And Processes | 258 |
| | (4) | ENH Coordinated HPH's ED And Its Cardiac Services..... | 259 |
| | (5) | ENH Increased Nurse Staffing In HPH's ED | 259 |
| | (6) | ENH Improved HPH's ED In Other Ways As Well | 259 |
| g. | | ENH Improved Pharmacy Services At HPH Post-Merger | 261 |
| | i. | Overview | 261 |
| | ii. | ENH Improved Drug Dispensing Services At HPH After The Merger | 261 |
| | (1) | ENH Added A Third-Shift Pharmacist To HPH..... | 261 |
| | (2) | ENH Added An Automated Drug Distribution System (Pyxis) To HPH | 262 |

| | | |
|------|---|-----|
| iii. | ENH Added Clinical Pharmacy Services At HPH After The Merger | 264 |
| iv. | HPH's Institute For Safe Medication Practices Surveys Confirm That ENH's Enhancements To HPH's Pharmacy Services Have Improved Quality Of Care..... | 266 |
| h. | ENH's Deployment Of EPIC At HPH Has Dramatically Improved The Quality Of Care | 267 |
| i. | Overview..... | 267 |
| ii. | Epic Integrates All Patient Information Into A Single Data Repository That Is Accessible By All Caregivers And The Patient..... | 268 |
| iii. | Sources Outside Of ENH, Including The Federal Government, Have Been Calling For The Use Of Electronic Medical Records..... | 268 |
| iv. | The Sharing Of Information Is Important To Patient Care And Patient Safety..... | 269 |
| v. | ENH Made A Patient-Centric Integrated Electronic Health Record Its Top Priority And Chose Epic Because It Was Best Suited To Accomplish This Goal..... | 269 |
| vi. | ENH Planned From The Outset To Deploy Epic At HPH And In Affiliate Outpatient Offices | 270 |
| vii. | ENH Aggressively Deployed Epic Throughout The ENH System..... | 270 |
| (1) | Initial Steps | 270 |
| (a) | Workflow Analysis..... | 270 |
| (b) | Build..... | 271 |
| (c) | Hardware Deployment..... | 271 |
| (d) | Training..... | 271 |
| (e) | Support System | 272 |
| (2) | Deployment..... | 272 |

| | | |
|--------|--|-----|
| | (7) Epic Improves Quality Of Care When There Are Drug Recalls..... | 279 |
| xiv. | ENH's Accomplishment In The Deployment of EPIC Is Unique | 280 |
| xv. | ENH Has Been Recognized By Numerous Outside Sources For Its Successful Deployment Of Epic | 280 |
| xvi. | Other Academic Hospitals In The Chicago Area Are Looking To Learn From ENH's Successful Deployment Of Epic | 281 |
| xvii. | Epic Has Not Been Implemented By Community Hospitals | 281 |
| xviii. | Epic Is Far Superior To Meditech, The System Used At HPH Before The Merger | 281 |
| i. | The Merger Improved The Quality Of Radiology, Radiation Medicine, And Nuclear Medicine At HPH | 282 |
| | i. Overview | 282 |
| | ii. HPH's Pre-Merger Radiology Equipment Was Antiquated And Productivity Was Lower Than It Should Have Been With Respect To Radiology Services | 282 |
| | iii. ENH Made Substantial Post-Merger Improvements To Radiology And Radiation Medicine Services That Improved The Quality Of Care At HPH..... | 283 |
| | (1) ENH Upgraded The Equipment And Systems At HPH And Extended Its Technology To HPH | 283 |
| | (2) ENH Added Additional Radiology Staff And Improved Access To Specialists At HPH | 284 |
| | (3) HPH Would Not Have Been Able To Make The Improvements In Radiology And Radiation Medicine Without The Merger | 284 |
| | iv. ENH Made Significant Post-Merger Improvements To The Nuclear Medicine Department At HPH | 284 |
| j. | The Medical Staff Integration And Academic Involvement Of Physicians Which Resulted From The Merger Improved The Quality Of Care At HPH..... | 284 |

| | | |
|------|---|-----|
| i. | Overview | 284 |
| ii. | HPH Physicians Rotate Through All Three ENH Campuses | 285 |
| iii. | HPH Physicians Take Part In Teaching Activities For Residents And Medical Students At Evanston Hospital | 285 |
| iv. | HPH Physicians Participate In Departmental Conferences That Broaden Their Skills | 286 |
| v. | HPH Physicians Have Obtained Faculty Appointments As A Result Of The Merger | 286 |
| vi. | ENH Provides HPH Physicians With A Continuing Medical Education Stipend | 287 |
| vii. | HPH Has Gained An Academic Affiliation, Which Has Enabled It To Recruit Better Physicians | 287 |
| k. | The Merger Improved The Quality Of Psychiatric Services At HPH | 287 |
| i. | Overview | 287 |
| ii. | Before The Merger, The Adolescent Psychiatry Services Available At Both Highland Park And Evanston Hospitals Were Limited | 288 |
| iii. | HPH's Adolescent Psychiatry Physical Facility Contained Hazards For Adolescent Patients | 288 |
| iv. | Consolidating Adolescent Psychiatric Services At HPH Allowed HPH To Offer New And Expanded Services | 288 |
| v. | ENH Expanded And Remodeled The Adolescent Psychiatry Unit To Make It Safer | 289 |
| vi. | The Improvements Made By ENH In Consolidating And Expanding Psychiatric Services At HPH Improved The Quality Of Care | 289 |
| E. | After The Merger, ENH Continued To Provide High Quality Hospital Services | 290 |
| 1. | ENH Has Been Independently Recognized For Having High Quality Of Care | 290 |

| | | |
|----|---|-----|
| a. | ENH Received Solucient’s 100 Top Hospital Award..... | 290 |
| b. | ENH Received Awards From HealthGrades For Clinical Excellence..... | 290 |
| c. | ENH Received Recognition From The Leapfrog Group | 291 |
| d. | ENH Hospitals Have Received National Recognition For Its Healthcare Quality | 291 |
| e. | US News & World Report Recognized ENH As A Top Hospital..... | 291 |
| f. | ENH Received The KLAS And Davies Award For Epic..... | 291 |
| 2. | There Is No Evidence That Quality Deteriorated At Evanston Hospital After The Merger..... | 291 |
| F. | The Programs Or Services ENH Improved And Added At HPH After The Merger Exceed National And State Quality Benchmarks | 292 |
| 1. | HPH’s Post-Merger Performance In Treating Patients With Acute Myocardial Infarction Exceeds The Average In Illinois Hospitals | 292 |
| 2. | HPH’s Post-Merger Cardiac Surgery Outcomes Exceed National Benchmarks..... | 292 |
| 3. | ENH Is A National Leader In The Implementation Of Electronic Medical Records | 292 |
| 4. | ENH Exceeds National Benchmarks For Its Cesarean Section Rate..... | 293 |
| 5. | ENH Exceeds National Benchmarks For Its Operative Vaginal Delivery Rate | 293 |
| 6. | ENH’s Preoperative Gynecologic Surgical Review Program Is Unique..... | 293 |
| 7. | Post-Merger HPH Is A Leader In Terms Of Its Full-Time Intensivist Program..... | 293 |
| G. | Dr. Romano’s Analysis Did Not Properly Evaluate ENH’s Significant Quality Improvements At HPH | 293 |
| 1. | Dr. Romano Relies Heavily Upon Flawed Administrative Data..... | 294 |
| H. | Dr. Romano Placed Undue Reliance On Patient Satisfaction Surveys..... | 297 |
| a. | Overview..... | 297 |

| | | |
|------|---|-----|
| b. | Dr. Romano Improperly Relied On Unreliable Patient Satisfaction Surveys | 298 |
| i. | Press Ganey Survey Response Rates Are Too Low To Draw Valid Conclusions..... | 298 |
| ii. | Press Ganey’s Rating Scale Has A Ceiling Effect..... | 299 |
| iii. | Press Ganey Uses Mean, Not Percentage, Scores..... | 299 |
| iv. | The Rhea & Kaiser Survey Is Not A Valid Measure Of Patient Satisfaction At HPH | 300 |
| c. | Dr. Romano Improperly Relied On Insufficient Press Ganey Data..... | 300 |
| IX. | OTHER COMPETITIVE EFFECTS CONSIDERATIONS | 302 |
| A. | The Merger Was Not Anticompetitive Because Of Low Barriers To Market Entry And Repositioning By Competitors | 302 |
| 1. | The Illinois CON Law Is Not A Barrier to Entry | 302 |
| a. | Most CON Applications Are Approved | 302 |
| b. | Most CON Applications Are Approved In A Timely Manner | 303 |
| c. | The CON Requirements In Illinois Have Been Revised And, As A Result, Fewer Projects Require CON Approval | 303 |
| d. | ENH’s Competitors Have Been Able To Expand Their Facilities And Services Pursuant To The CON Process | 303 |
| i. | Northwestern Memorial Has Expanded Its Facilities And Services | 303 |
| ii. | Condell Has Expanded Its Facilities And Services..... | 303 |
| iii. | Lake Forest Hospital Has Expanded Its Facilities And Services | 304 |
| B. | The Merger Was Not Anticompetitive Because HPH’s Financial Condition Was Declining Before The Merger..... | 304 |
| 1. | HPH’s Board Of Directors Determined That, Due To The Financial Condition Of HPH, HPH Could No Longer Maintain The Status Quo As An Independent Hospital | 304 |

| | | |
|----|--|-----|
| 2. | The HPH Board Decided That Merging With Evanston Hospital Was The Best Option For The Future Of HPH..... | 306 |
| 3. | HPH’s Financial Condition Was Rapidly Declining | 307 |
| 4. | Evanston Hospital’s Due Diligence Revealed That HPH’s Financials Were On A “Downward Spiral”..... | 309 |
| a. | HPH Was Losing Money And Being Supported With Investment Income..... | 311 |
| b. | HPH’s Debt Capacity Was Severely Constrained | 312 |
| c. | HPH’s Cash And Investments Were Insufficient To Compete In The Marketplace..... | 313 |
| d. | HPH’s Joint Ventures Were Losing Money | 314 |
| e. | HPH Made Insufficient Capital Expenditures | 315 |
| f. | HPH’s Collection Rates/Accounts Receivable Were Declining..... | 316 |
| g. | Due Diligence Revealed That HPH’s Future Financial Projections Were Unrealistic | 317 |
| 5. | Expert Testimony Confirms The Significance Of HPH’s Declining Financial Condition..... | 319 |
| C. | ENH’s Not-For-Profit Status Is Relevant To The Competitive Effects Analysis..... | 320 |
| 1. | Not-For-Profit Status Plays A Role In Hospital Pricing..... | 320 |
| 2. | The Opinions Of Complaint Counsel’s Not-For-Profit Expert Support The Fact That ENH, As A Not-For-Profit Entity, Acts Differently Than A For-Profit Entity..... | 320 |
| 3. | The Pre-Merger HPH Foundation Is Evidence Of How A Not-For-Profit Hospital Benefits The Community | 321 |
| 4. | The Creation Of The Independent Highland Park Healthcare Foundation As A Result Of The Merger Demonstrates How ENH Acts To Benefit The Community As A Not-For-Profit | 322 |
| a. | The Healthcare Foundation of Highland Park is Required to Monitor the Commitments ENH Made to the Community | 323 |
| b. | The Highland Park Healthcare Foundation Contributes Funds to HPH for the Benefit of the Community | 323 |

| | | | |
|----|----|---|--|
| | c. | The Highland Park Healthcare Foundation Provides Grants To Community Organizations..... | 324 |
| X. | | REMEDY..... | 325 |
| | A. | Divestiture Is Not A Proper Remedy Because The Merger Was Necessary To Achieve Quality Improvements At HPH..... | 325 |
| | | 1. | HPH Was Not Capable Of Remediating Its Quality Problems, Implementing New Services, Or Improving Old Ones Without The Merger..... |
| | | | 325 |
| | | a. | HPH Lacked The Financial Capacity To Implement Necessary Quality Improvements..... |
| | | | 325 |
| | | b. | HPH Lacked The Capacity To Effect Organizational Change |
| | | | 326 |
| | | 2. | The Improvements Made By ENH Could Not Have Been Achieved Through Joint Ventures |
| | | | 327 |
| | | 3. | The Geographic Proximity Of Evanston Hospital To HPH Was Essential To Improving The Quality At HPH..... |
| | | | 328 |
| | | 4. | The Merger Enabled HPH To Make Quality Improvements And Offer Services That Are Not Generally Offered By, And/Or Not Feasible For, Community Hospitals |
| | | | 328 |
| | | a. | ENH Upgraded HPH To The Epic System..... |
| | | | 328 |
| | | b. | ENH Vastly Improved HPH’s Oncology Services |
| | | | 329 |
| | | c. | ENH Improved HPH’s ICU Services By Adding The Services Of Intensivists..... |
| | | | 329 |
| | | d. | ENH Provided Much-Needed Improvements To HPH’s Ob/Gyn Services |
| | | | 330 |
| | B. | Divestiture Is Not A Proper Remedy Because It Would Erode Quality Of Care Improvements Resulting From The Merger And Thus Harm Consumers..... | 330 |
| | | 1. | Divestiture Would Have Adverse Quality Of Care Consequences Pertaining To Cardiac Procedures At HPH |
| | | | 331 |
| | | a. | Divestiture Would Result In The Loss Of Cardiac Surgery At HPH..... |
| | | | 331 |
| | | b. | Divestiture Would Result In The Loss Of Interventional Cardiology Program at HPH..... |
| | | | 332 |

| | | |
|------|---|-----|
| c. | Divestiture Would Result In Loss Of Nursing Improvements Resulting From Improved Cardiac Care At HPH After The Merger | 333 |
| d. | Divestiture Would Result In Loss Of ICU Nurse Acuity Gained From The Cardiac Surgery Program | 333 |
| e. | Divestiture Would Result In A Decline In Quality Of Care For Patients With AMI..... | 333 |
| i. | HPH Would Lose Its Capacity To Treat AMI Patients..... | 33 |
| ii. | There Would Be An Increase In Transfers Of Patients With AMI From HPH To Other Hospitals..... | 333 |
| iii. | Delays In Transfer Would Harm Patients..... | 334 |
| 2. | Divestiture Would Result In HPH Returning To A Community Hospital Governance Model | 334 |
| a. | Loss Of Integrated Medical Staffs Would Deprive HPH of Clinical, Academic and Research Activities..... | 335 |
| i. | Divestiture Would Result In HPH’s Loss Of Academic Involvement By HPH Physicians At Evanston Hospital Campus | 335 |
| ii. | Divestiture Would Result In HPH’s Loss Of Research Partnerships With Physicians At Evanston Hospital | 335 |
| iii. | Divestiture Would Result In HPH’s Loss Of Department Conferences And Case Consultation..... | 335 |
| 3. | Divestiture Would Result In HPH’s Loss Of ENH Quality Improvement And Quality Assurance Programs | 335 |
| 4. | Divestiture Would Result In HPH’s Loss Of The Benefits Of Epic..... | 336 |
| 5. | Divestiture Would Result In A Diminished Ability By HPH To Recruit High-Caliber Physicians And Hospital Administrators..... | 337 |
| C. | Divestiture Is Not A Proper Remedy Because ENH Cannot “Unlearn” About Its Demand | 337 |
| D. | Divestiture Is Not A Proper Remedy Because The Merger Was Between Two Members Of An Approved Network | 337 |

E. Divestiture Is Not A Proper Remedy Because It Would Undo Efficiencies
Of The Merger338

Exhibit And Demonstrative ListAttachment A

Witness ListAttachment B

Abbreviations of Terms

1. “AAMC” – Association of American Medical Colleges
2. “ACC” – Ambulatory Care Center
3. “ACOG” – American College of Obstetricians and Gynecologists
4. “Advocate Lutheran General” – Advocate Lutheran General Hospital, which is part of the Advocate system
5. “Advocate North Side” – Advocate North Side Health Network
6. “Aetna” – Aetna Inc., including Aetna Health Management, Aetna Health Plans of Illinois, Aetna Health Plans of the Midwest and Aetna U.S. Healthcare of Illinois
7. “AHA” – American Heart Association
8. “AHRQ” – Agency for Healthcare Research and Quality
9. “AMI” – Acute Myocardial Infarction
10. “ASHP” – American Society of Health System Pharmacists
11. “Bain” – Bain & Company
12. “Balanced Budget Act” – Balanced Budget Act of 1997
13. “Blue Cross” – Blue Cross and Blue Shield of Illinois, including Blue Advantage, Blue Choice, Blue Cross and Blue Shield Association, Health Care Service, HMO Illinois (HMOI), and Managed Care Network Preferred (MCNP).
14. “CABG” – Coronary Artery Bypass Grafting
15. “CCN” – the entity before First Health Group acquired CCN in August 2001, and includes Affordable, CCN and Healthcare Compare
16. “CCOP” – Community Clinical Oncology Program
17. “CDSS” – Clinical Decision Support Systems
18. “CEO” – Chief Executive Officer
19. “Children’s Memorial” – Children’s Memorial Hospital

20. “CHRPP” – Chicago Hospital Risk Pooling Program
21. “Cigna” – Cigna Corporation, including CIGNA HealthCare of Illinois, and CIGNA Healthplan of Illinois
22. “CML” – Consolidated Medical Labs
23. “COO” – Chief Operating Officer
24. “CON” – Certificate of Need
25. “Condell” – Condell Medical Center
26. “COTH” – Council of Teaching Hospitals
27. “CPI” – Consumer Price Index
28. “CPOE” – Computerized Physician Order Entry
29. “CPT Codes” – Current Procedural Terminology
30. “Deloitte” – Deloitte Consulting
31. “DRG” – Diagnosis-Related Groups
32. “ED” – Emergency Department
33. “ENH” – Evanston Northwestern Healthcare Corporation, post-Merger
34. “ENT” – Ear, Nose and Throat
35. “Evanston Hospital” – pre-Merger Evanston and Glenbrook Hospitals when referred to in the past tense, and Evanston Hospital alone when referred to in the present tense
36. “Great West” – Great-West Life & Annuity Insurance Company, including One Health Plan of Illinois, One Health Plan, Great-West Healthcare of Illinois and Great-West Healthcare
37. “HCFA” – Healthcare Finance Administration
38. “Healthcare Foundation” – Healthcare Foundation of Highland Park
39. “HFN” – HFN, Inc.
40. “HHI” – Herfindahl-Hirschman Index

41. "HHS Letter" –Letter from the Department of Health and Human Services, received On July 14, 1999, by Peter Friend, HPH's Chief Operating Officer
42. "HIPPA" – Health Insurance Portability and Accountability Act of 1996
43. "HMO" – Health Maintenance Organizations
44. "HPH" – Highland Park Hospital
45. "HPH Lab" – Immediate Response or "Stat" Laboratory within HPH
46. "Humana" – Humana, Inc., including Employers Health (EHI), Humana Health Plan, Humana HealthChicago, Humana Insurance and Michael Reese Health Plan
47. "ICU" – Intensive Care Unit
48. "IDPH" – Illinois Department of Public Health
49. "IOM" – Institute of Medicine
50. "IRB" – Institutional Review Board
51. "ISMP" – Institute for Safe Medication Practices
52. "IT" – Information Technology
53. "JAMA" – The Journal of the American Medical Association
54. "JCAHO" or "Joint Commission" – Joint Commission for the Accreditation of Healthcare Organizations
55. "Kaufman Hall" – Kaufman Hall & Associates
56. "Lakeland" – Lakeland Health Services
57. "LDRP" – Labor, Delivery, Recovery and Postpartum
58. "Loyola" – Loyola University Medical Center
59. "MCOs" – Managed Care Organizations/Private Payors
60. "MedPAC" – Medicare Payment Advisory Commission
61. "Merger" – Merger of Highland Park Hospital with Evanston and Glenbrook Hospitals on January 1, 2000

62. "Merger Guidelines" – The 1992 Horizontal Merger Guidelines, as amended
63. "NAMM" – North American Medical Management
64. "Network" or "NHN" – Northwestern Healthcare Network
65. "NIH" – National Institutes for Health
66. "NH North" – A failed attempt by Evanston Hospital, HPH and another hospital to form a three-way hospital merger
67. "North Shore" – Northern suburbs of the Chicago, Illinois metropolitan area where ENH is located
68. "Northwestern Memorial" – Northwestern Memorial Hospital
69. "NPDB" – National Practitioner Data Bank
70. "NPIC" – National Perinatal Information Center
71. "Ob/Gyn" – Obstetrics and Gynecology
72. "OR" – Operating Room
73. "PACS" – Pictorial Archiving Communication System
74. "PCI" – Percutaneous Coronary Interventions
75. "PCP" – Primary Care Physicians
76. "PHCS" – Private Healthcare Systems
77. "PHO" – Physician-Hospital Organization
78. "PMSA" – Primary Metropolitan Statistical Area
79. "POS" – Point of Service
80. "PPO" – Preferred Provider Organizations
81. "PPONS" – Pulmonary Physicians of the North Shore
82. "Press Ganey" – Press Ganey, Associates, Inc.
83. "PROMIS" – Patient Reported Outcome Measurement Information System

Pursuant to the Court's Order on Post Trial Briefs on April 6, 2005, and Rule 3.46 of the Federal Trade Commission Rules of Practice ("Rules"), 16 C.F.R. § 3.46, Respondent Evanston Northwestern Healthcare Corporation ("ENH") hereby submits its Proposed Findings of Fact. In addition, pursuant to Rules 3.46(b) and (c), ENH also submits its Post-Trial Exhibit List and Witness List attached hereto as Attachments A and B, respectively.

I. THE PARTIES

A. Evanston Northwestern Healthcare

1. ENH is a not-for-profit, integrated health care delivery system that is affiliated with Northwestern University's Feinberg School of Medicine. (Neaman, Tr. 1281-82; RX 1004 at ENH GW 3501; RX 1425 at ENHE F22 1393). The ENH health care delivery system consists of, among other things, three hospitals, a physician multispecialty faculty group practice, a multimillion dollar research enterprise affiliated with Northwestern University and a charitable foundation. (Neaman, Tr. 1281-83).

2. ENH's mission "is to preserve and improve human life . . . through the provision of superior clinical care, academic excellence, and innovative research." (RX 1004 at ENH GW 3501).

3. Throughout the years, ENH has been nationally recognized as faithfully serving this mission.

(a) Since the mid 1990s, Evanston Hospital/ENH¹ has been named ten times by Solucient both as a Top 15 Teaching Hospital and a Top 100 Hospital in the country. (Neaman, Tr. 1290-91; O'Brien, Tr. 3544-45; RX 1425 at ENHE F22 1393; RX 787 at ENH GW 4194). ENH was named a Top 15 Teaching Hospital and Top 100 Hospital by Solucient in 2004. (O'Brien, Tr. 3544).

(b) ENH has received the National Quality Award, which is given to a provider with a demonstrated outstanding program to improve the quality of healthcare delivery to its community. (Neaman, Tr. 1291).

(c) ENH has also received recognition from US News & World Report as one of "America's Best Hospitals." ENH specifically was recognized for its neurosciences, orthopedics and hormonal disorders programs. (Neaman, Tr. 1291).

¹ Unless otherwise indicated, the term "Evanston Hospital," when used in the past tense, refers to both Evanston Hospital and Glenbrook Hospital before the Merger. The term "Evanston Hospital," when used in the present tense, refers to the current Evanston Hospital alone. The term "ENH" refers to the post-Merger entity (Evanston Hospital, Glenbrook Hospital and Highland Park Hospital).

- (d) In 2004, ENH received the KLAS and Davies Awards, both given to the hospital with the top-ranked medical information system. (Neaman, Tr. 1291).
- (e) In 2005, ENH received the Leapfrog Award for being the top hospital system in Illinois. (Neaman, Tr. 1291). Using the Leapfrog data, Consumers Digest named ENH one of 50 exceptional hospitals in the United States and the only such hospital in Illinois. (O'Brien, Tr. 3549-50).

4. ENH is located in the northern suburbs of the Chicago, Illinois metropolitan area referred to as the "North Shore." (Holt-Darcy, Tr. 1425). The North Shore is a geographic area, primarily affluent, starting in northern Cook County and southern Lake County and extending through the towns of Kenilworth, Wilmette, Winnetka, Highland Park and Lake Forest, among others. (Holt-Darcy, Tr. 1425; Ballengee, Tr. 162-63). The communities within the North Shore that stretch from Evanston up to Highland Park are suburban, bedroom communities with single family homes and sizable plots of land, and a limited retail environment. (Hillebrand, Tr. 2030-31).

5. ENH is a member of numerous hospital teaching organizations – including the Northwestern University Medical Center, the Council on Teaching Hospitals and the Association of American Medical Colleges ("AAMC"). (Neaman, Tr. 1282-83).

6. Mark Neaman, who joined ENH in 1973, has served as its Chief Executive Officer ("CEO") since 1992. (Neaman, Tr. 1278). Jeffrey Hillebrand, who joined ENH in 1974, has served as its Chief Operating Officer ("COO") since 1998. (Hillebrand, Tr. 1827, 2009).

1. The Three ENH Hospitals

7. ENH owns and operates three acute-care hospitals: Evanston Hospital, Glenbrook Hospital and, since the merger at issue on January 1, 2000 (the "Merger"), Highland Park Hospital ("HPH"). (Neaman, Tr. 954). These fully-integrated hospitals provide a broad array of primary, secondary and tertiary acute-care inpatient and outpatient services. (Neaman, Tr. 1291-93).

8. Evanston Hospital/ENH has been affiliated with Northwestern Medical School since at least 1930. (Neaman, Tr. 1282). Evanston Hospital strengthened its academic relationship with Northwestern University Medical School between 1992 and 1996. (RX 584 at ENH JH 2951-52; RX 132 at ENH JH 275). As a result, from the mid-1990's to the present day, the Evanston Hospital/ENH hospitals have been classified as teaching or academic hospitals by the Medicare Payment Advisory Commission ("MedPAC"), a federal government agency. (Neaman, Tr. 1283, 1286-87).

9.

(REDACTED)

(Foucre, Tr. 1114, *in camera*; RX 1208 at UHCENH 3380, *in camera*; Ballengee, Tr. 212; Neaman, Tr. 1379).

10. Having an academic affiliation and being a teaching institution creates an environment which permits the presence of medical residents, and is attractive to young physicians and the very best physicians. (Neaman, Tr. 1289). From a marketing standpoint, consumers believe that academic teaching institutions provide care “a notch above” community hospitals and community-based physicians. (Neaman, Tr. 1289).

11. All three ENH hospitals operate as if they were a single hospital entity. (Hillebrand, Tr. 1839-42). ENH has one Medicare identification number for all three hospitals. (Hillebrand, Tr. 1840-41). And all three hospitals share one professional staff. (Wagner, Tr. 3953).
(REDACTED)

(Hillebrand, Tr. 1839-40; Foucre, Tr. 890; Holt-Darcy, Tr. 1514, *in camera*).

12. A single unified medical staff is in place for the ENH system, meaning physicians can admit patients to any of the three hospitals. (Hillebrand, Tr. 1840-41). Attending physicians are on faculty at Northwestern University’s Feinberg School of Medicine. (Neaman, Tr. 1287).

13. Close to half of ENH’s hospital services are paid by the federal government. (Neaman, Tr. 1312). The rates and schedules at which hospitals are reimbursed by the government for providing goods and services to individuals covered by Medicare and Medicaid are publicly available and non-negotiable. (Neaman, Tr. 1312, 1317-18; Hillebrand, Tr. 1721).

14. Approximately 45% of ENH’s hospital services are paid by non-governmental entities providing medical insurance, including MCOs, based on negotiated rates. (Neaman, Tr. 1312).

15. ENH’s remaining 5% of hospital patients are uninsured and, therefore, pay for services out-of-pocket at prices set by the hospital, or receive free care from the hospital. (Neaman, Tr. 1312).

a. Evanston Hospital

16. Evanston Hospital has more than 400 beds and is located in Evanston, Illinois. (Neaman, Tr. 1291). Evanston Hospital provides an extremely wide array of inpatient and outpatient services, from basic hospital services (such as obstetrics) to more intensive services (such as cardio-angiogenesis; Rosengart, Tr. 4496). (Neaman, Tr. 1291).

(REDACTED) (Mendonsa, Tr. 565-66, *in camera*).

b. Glenbrook Hospital

17. Glenbrook Hospital is a medical-surgical hospital with approximately 125-150 beds that is located in Glenview, Illinois. (Neaman, Tr. 1292). Glenbrook Hospital was built by Evanston Hospital and opened in 1977. (Neaman, Tr. 1292; Hillebrand, Tr. 1827).

18. Glenbrook Hospital provides a broad array of both inpatient and outpatient services, but it does not provide obstetrics services. (Neaman, Tr. 1292).

19. Glenbrook Hospital has a Center of Excellence in orthopedics and does a significant amount of work in neurology, particularly movement disorders. (Neaman, Tr. 1292).

c. HPH

20. HPH has approximately 200 beds and is located in Highland Park, Illinois. (Neaman, Tr. 1292). Since the Merger, HPH provides a significant amount of medical-surgical care. (Neaman, Tr. 1292). HPH's inpatient and outpatient services range from general obstetrics, but not high-risk obstetrics, to cardiac surgery. (Neaman, Tr. 1292-93).

21. As discussed in more depth below in Section VIII, HPH's services have changed dramatically both in breadth and depth since the Merger. (Neaman, Tr. 1293). In particular, ENH has enhanced substantially the quality and complexity of care at HPH as a result of the Merger in the following areas, among others: (1) obstetrical and gynecologic services; (2) nursing services; (3) quality assurance; (4) quality improvement; (5) physical plant renovations; (6) cardiac surgery; (7) interventional cardiology services; (8) intensive care unit services; (9) oncology services; (10) laboratory services; (11) emergency services; (12) pharmacy services; and (13) electronic medical records technology.

2. ENH Faculty Practice Associates

22. ENH Faculty Practice Associates is comprised of about 500 employed primary and specialty care physicians. (Neaman, Tr. 1287-88).

23. The ENH Faculty Practice Associates does not include the approximately 1200 non-employed, private practice physicians who have admitting privileges at the three ENH hospitals. (Neaman, Tr. 1282).

3. ENH Research Institute

24. The ENH Research Institute, founded in 1996, performs translational clinical research, meaning research that is taken from the bench to the bedside. (Neaman, Tr. 1289-90). The ENH Research Institute's translational research directly supports ENH's nucleus of clinical activities, such as oncology, cardiology, imaging, and patient outcomes. (Hillebrand, Tr. 2007).

25. The ENH Research Institute receives funding from the federal government, including the National Institutes for Health ("NIH"), the National Cancer Institute and the Department of Defense. (Hillebrand, Tr. 2007-08; Neaman, Tr. 1290). The Research Institute also receives small sums of money from corporations. (Hillebrand, Tr. 2008). The Research Institute competes for NIH grants with all other major research institutes in the United States. (Neaman, Tr. 1289-90).

26. In 2004, NIH restructured its clinical research initiatives, including the creation of the Patient Reported Outcome Measurement Information System ("PROMIS"), which is a top

NIH priority for measuring the quality of healthcare. (Hillebrand, Tr. 2008). In 2004, and as part of the PROMIS initiative, the ENH Research Institute was named the National Coordinating Center for NIH's patient outcome studies. (Hillebrand, Tr. 2009).

27. ENH has over \$100 million in NIH grants. (Neaman, Tr. 1290). In terms of NIH funding, ENH ranks twelfth nationally and first in Illinois. (Neaman, Tr. 1290).

4. ENH Foundation

28. The ENH Foundation is the fund-raising arm of ENH. (Neaman, Tr. 1290). Ronald Spaeth (President of HPH before the Merger) has been the president of the ENH Foundation since February 2005. (Spaeth, Tr. 2236; Neaman, Tr. 1326).

29. As the head of the ENH Foundation, Spaeth is responsible for growing "friends and funds" from ENH's communities and to ensure that ENH has the support from these communities for the various healthcare programs the hospital provides. (Spaeth, Tr. 2237; Neaman, Tr. 1327). Spaeth and the Foundation seek support from ENH's many grateful patients and others who have a history of supporting the hospital's various research programs and facility extensions. (Spaeth, Tr. 2237).

B. Evanston Hospital And HPH Before The Merger

1. Pre-Merger Evanston Hospital

30. (REDACTED) (Mendonsa, Tr. 529, *in camera*; Holt-Darcy, Tr. 1505-06, *in camera*; RX 107 at GWL 859).

31. (REDACTED) (Holt-Darcy, Tr. 1509, *in camera*). (REDACTED) (Holt-Darcy, Tr. 1509-10, *in camera*). (REDACTED) (Mendonsa, Tr. 529, *in camera*).

32. In comparison with HPH, (REDACTED) (Holt-Darcy, Tr. 1515, *in camera*). Evanston Hospital recruited high-quality physicians and staff with great success before the Merger. (CX 6304 at 11 (Livingston, Dep.)).

33. Evanston Hospital once offered sophisticated services, such as solid organ transplants and specialized care for severe burns. For example, Evanston Hospital had a heart transplant program for 6-10 years, but discontinued it because it did not have sufficient volume to allow its physicians to perform a "first-class" job. (Neaman, Tr. 1295). Evanston Hospital also had a burn unit from 1972 until the late 1980s or early 1990s. (Hillebrand, Tr. 2010). But Evanston Hospital closed its burn unit because demand for such services has dropped

dramatically due to the widespread adoption of smoke detectors in homes. (Hillebrand, Tr. 2010). In February 2003, however, Evanston Hospital had burn treatment services as defined by the Illinois Health Facilities Planning Board. (D. Jones, Tr. at 1678-79). As of February 2005, ENH still treats burn patients, but no longer in a designated burn unit. (Hillebrand, Tr. 2010).

34. In 1997, Evanston Hospital Corporation changed its name to Evanston Northwestern Healthcare because consumer surveys determined that the “Northwestern” and “Evanston” names were associated with high value. (Hillebrand, Tr. 1782). Adding “Northwestern” to Evanston’s brand clarified the hospital’s relationship with Northwestern Medical School and benefited both the hospital and the university. (Spaeth, Tr. 2133).

2. Pre-Merger HPH

35. Pre-Merger HPH was a not-for-profit hospital and a subsidiary of Lakeland Health Services (“Lakeland”). (Newton, Tr. 472; RX 563 at ENH TH 1572). Lakeland contained four operating units: HPH, the HPH Foundation, Lakeland Health Ventures, Inc. and Groveland Health Services, Inc. (RX 563 at ENH TH 1572; RX 218 at ENHL TH 330).

36. The HPH Foundation was HPH’s fundraising arm before the Merger. (Styer, Tr. 4954). The HPH Foundation was tasked with soliciting funds to support HPH from individuals and corporations in the general Highland Park community. (Styer, Tr. 4954-55, 5001). The HPH Foundation was dissolved immediately before, and in anticipation of, the Merger. (Styer, Tr. 4953).

37. Lakeland Health Ventures, Inc. was a for-profit operating unit of Lakeland. (RX 563 at ENH TH 1572). Lakeland Health Ventures, Inc. operated Lakeland Primary Care Associates, physician practice management services, real estate ventures and numerous joint ventures such as a fitness center and a mail order pharmacy. (RX 563 at ENH TH 1572).

38. Groveland Health Services, Inc. provided healthcare services and products in a non-institutional setting. (RX 218 at ENH TH 330).

39. HPH also owned 50% of Highland Park Healthcare, Inc., a physician-hospital organization (“PHO”). (RX 563 at ENH TH 1572).

(REDACTED)

(Chan, Tr. 789, *in camera*).

40. Spaeth was HPH’s president and CEO from 1983 up until the Merger. (Spaeth, Tr. 2235).

a. HPH Was A Community Hospital With Limited Services Before The Merger

41. Before the Merger, HPH offered a “normal set” of general primary and secondary inpatient and outpatient services. (Spaeth, Tr. 2239; Neaman, Tr. 1306). Unlike Evanston Hospital,

(REDACTED)

(Holt-Darcy, Tr. 1506, *in camera*).

42. (REDACTED)
(Spaeth, Tr. 2239; Chan, Tr. 746; Chan, Tr. 838, *in camera*).
(REDACTED)

(Hillebrand, Tr. 1944, *in camera*).

43. Before the Merger, many members of the Highland Park community tended to go to Northwestern Memorial Hospital (“Northwestern Memorial”), the University of Chicago, Loyola University Medical Center, Rush University Medical Center, or the Mayo Clinic because HPH could not fully satisfy their health care needs. (Spaeth, Tr. 2246). Before the Merger, HPH physicians tended to refer their patients away from HPH for a number of different healthcare services. (Spaeth, Tr. 2246). The Highland Park community viewed HPH as a “good community hospital, but if you were really sick, you went somewhere else.” (Spaeth, Tr. 2243-44).

b. HPH Had Financial Problems Before The Merger

44. As discussed in more depth in Section IX.B.4. below, HPH had serious financial problems before the Merger.

45. HPH’s operating income steadily declined as the 1990s progressed. (CX 6305 at 2-3, 5 (Stearns, Dep.)). From 1996 to 1999, HPH was not making money from operations on a year-to-year basis. (Kaufman, Tr. 5811). In 1999, HPH had operating losses of over \$3 million, and its audited financials reported an \$11 million loss. (Spaeth, Tr. 2307; CX 1732 at 4; RX 609 at EY 236).

46. At the time of the Merger in 2000, HPH attempted to offset its operational losses with investment income, it had \$120 million in debt that exceeded its cash and investments by \$3 million, it required millions in “critical” facility improvements due to years of insufficient capital investments, and it lacked sufficient cash reserves to meet the competitive challenges of the Chicago marketplace. (Kaufman, Tr. 5806-07, 5811, 5814-16; H. Jones, Tr. 4097-99, 4119; RX 465 at FTC-KHA 2179; RX 569 at ENH JH 1215, 1225-26).

c. HPH Had Quality Of Care Problems Before The Merger

47. As discussed in more depth in Section VIII below, before the Merger, HPH had quality of care problems that were exacerbated by the hospital’s financial problems.

48. The quality problems that existed at HPH before the Merger included, among others: (1) problems in the Obstetrics and Gynecology Department; (2) ineffective quality assurance programs; (3) a dysfunctional nursing culture; (4) weak quality improvement programs; (5) difficulties in getting private practicing physicians to respond to calls about patients; and (6) a series of deficiencies in the physical plant that affected patient safety. (Chassin, Tr. 5191-92).

49. HPH's pre-Merger physical plant deficiencies so adversely affected the reliable operation of the hospital that they put the hospital's Medicare certification in jeopardy. (Chassin, Tr. 5286-87; RX 525 at ENH JH 11548).

II. DYNAMICS OF MANAGED CARE

A. Overview: Interaction Among Relevant Players (Patients, Employers, Private Payors And Providers)

50. Hospitals, like most health care providers, compete for their ultimate consumers, the patients, on both quality and price dimensions. (Noether, Tr. 6011).

51. Included in “quality” are both service and clinical dimensions. (Noether, Tr. 6016). Patients can assess service dimensions directly (for example, convenience, promptness, courtesy of staff, physical aspects of the facility such as the availability of private rooms). (Noether, Tr. 6018-19). But they generally rely on their physicians for assistance to evaluate clinical dimensions. (Noether, Tr. 6018-19).

52. Direct price competition for patients is often attenuated: patients generally pay only a portion of their bill and thus do not face (or react to) the entire amount of any change in price made by a hospital. (Haas-Wilson, Tr. 2464).

53. Hospitals compete to be on the “preferred panel” of the health plans offered by MCOs. (Haas-Wilson, Tr. 2456-57). MCOs build provider networks to compete effectively with other MCOs for employer health plan contracts. (Haas-Wilson, Tr. 2456-57).

54. Employers generally fall into one of two categories – self-insured and fully-insured. Self-insured employers are those that are responsible for the actual medical expenses of their employees but decide to pay MCOs to access and manage the network as well as to process claims. (Mendonsa, Tr. 480). Fully-insured employers are only liable for premiums, but not the actual healthcare dollars utilized by employees. (RX 1743 at 7).

55. Employers want to limit the amount they spend on employee health benefits, and, as a result, price competition among MCOs is important. (Haas-Wilson, Tr. 2461). Therefore, MCOs are interested in obtaining the lowest rates possible from the providers they include in their networks, and this fosters price competition among hospitals (and other providers). (Haas-Wilson, Tr. 2457-58).

56. Since employers must compete for qualified labor, they attempt to assure that their employees are reasonably satisfied with the health plan(s) that they offer. (Noether, Tr. 5936-37). Consequently, employers demand adequate provider networks that span the range of basic and specialty services that their employees may need, have good quality reputations, and are geographically convenient to employees and their families. (Noether, Tr. 5936-37).

57. All of these dimensions can be grouped into a category of attributes labeled “choice.” (RX 987 at FTC-LFH 229; Hillebrand, Tr. 1834; Mendonsa, Tr. 479). Different networks and plans may provide varying degrees of these dimensions for different prices so that employers make the price-choice tradeoffs that best meet their needs. (RX 1346 at BCBSI-ENH 5536).

58. In recent years, consumers (*i.e.*, patients/employees) have demanded broad provider networks with few restrictions from their managed care plans. (Hillebrand, Tr. 1761-62; RX 1189 at ENHL JL 14126; RX 1346 at BCBSI-ENH 5539). More tightly controlled, traditional Health Maintenance Organizations (“HMOs”) – which offer limited provider networks, have gatekeeper requirements and impose severe financial penalties for use of other providers or services not authorized by a primary care physician – have given way largely to more loosely structured Preferred Provider Organizations (“PPOs”) with large provider networks and few financial incentives. (RX 987 at FTC-LFH 229; Hillebrand, Tr. 1834; Mendonsa, Tr. 479).

59. At the same time, the distinctions between HMOs and PPOs have blurred. (Noether, Tr. 5982). Many HMO plans offer substantial networks, and gatekeeper referrals are no longer always necessary. (Noether, Tr. 5982).

60. Consequently, price competition among hospitals is generally attenuated. (Noether, Tr. 5980-81). For example, HMO networks in the Chicago metropolitan area market are broad. (Noether, Tr. 5982 (*explaining* DX 7045)).

61. **(REDACTED)** (RX 1393 at ENHL BW 3684, *in camera*). As a new effort to address this phenomenon, some MCOs have created “tiered” networks, which are broad networks in the aggregate that provide financial incentives for employees to use a limited subset of the network providers that have relatively lower negotiated rates. (RX 1346 at BCBSI-ENH 5536).

62. Moreover, self-insured employer groups have vehicles available to them to control costs. (Dorsey, Tr. 1471-72). A cafeteria plan, for example, could achieve cost savings. (Dorsey, Tr. 1471-72). In a cafeteria plan, employees pay a higher out-of-pocket fee to access a more expensive provider, and a lower out-of-pocket fee to access a less expensive provider. (Dorsey, Tr. 1471).

B. Types Of Managed Care Plans

63. The purpose of a network is to provide employers and their employees with access to the facilities they want and a discount for using those hospitals. (Mendonsa, Tr. 485). Access means making sure that employees can get to the facilities to which they prefer to be admitted. (Mendonsa, Tr. 485). Such access generally is provided through one of the following managed care products.

1. HMO

64. An HMO product provides prepaid health insurance coverage to members through a network of physicians, hospitals and other health care providers that contract with the HMO to furnish such services. (RX 1743 at 6). An HMO is generally an insured product, meaning that the insurance company takes the risk. (Neary, Tr. 585).

65. Traditionally, an HMO requires that a member's primary physician approve access to hospitals, specialty physicians and other health care providers. As a result, the HMO product is the most restricted form of managed care. (RX 1743 at 6). The primary physician is called a gatekeeper, who manages the relationship with the patient and will refer the patient to a selected panel of specialists. (Hillebrand, Tr. 1834). Pediatricians, family-medicine physicians, internists, and occasionally obstetricians act as the "gatekeeper." (Hillebrand, Dep. 1834).

66. In an HMO network, there are significant economic incentives for the patient to only go to in-network providers. (Hillebrand, Tr. 1759-60). HMO networks work on a fixed reimbursement methodology, and only provide benefits to patients if they go to in-network hospitals. (Hillebrand, Tr. 1759-60). HMO members receive no benefits for out-of-network usage. (Mendonsa, Tr. 477).

67. **(REDACTED)**
(Hillebrand, Tr. 1834; Mendonsa, Tr. 479; Holt-Darcy, Tr. 1543, *in camera*). Consumers have rejected closed-panel HMOs and increasingly have demanded "choice." (RX 987 at FTC-LFH 229; Hillebrand, Tr. 1834; Mendonsa, Tr. 479). At most, Chicago had 25% HMO penetration, as compared to 50-60% in Los Angeles, New York and the District of Columbia. (Mendonsa, Tr. 479).

2. PPO

68. A PPO includes some elements of managed health care, but typically includes more cost-sharing with the member, through co-payments and annual deductibles. (RX 1743 at 6). With a self-insured PPO product, the employer that contract with the insurance company is responsible ultimately for the payment of expenses beyond the co-payment and deductible. (Neary, Tr. 586).

69. PPOs provide members more freedom to choose a hospital or physician. (RX 1743 at 6). In a PPO, the member is encouraged, through financial incentives, to use participating health care providers that have contracted with the PPO to provide services at more favorable rates. (RX 1743 at 6). If a member chooses not to use a participating health care provider, the member may be required to pay a greater portion of the provider's fees. (RX 1743 at 6).

70. A PPO plan offers employers the ability to have different co-pays, deductibles and other means to make employees partially accountable and responsible for paying for their own care. (Hillebrand, Tr. 1833-34).

3. POS

71. A point of service product ("POS") tends to have a different configuration and generally involves a network smaller than a PPO network. (Ballengee, Tr. 142). POS plans are traditionally between HMOs in terms of freedom and price. (Ballengee, Tr. 142-3; Mendonsa, 479). For example, with a POS product, a member accesses a higher benefit level by utilizing a primary care physician. (Mendonsa, Tr. 478-79).

4. Indemnity

72. In the 1980s, the predominant form of managed care insurance in Chicago was indemnity insurance. (Hillebrand, Tr. 1832). However, as of February 2005, indemnity insurance was virtually nonexistent in the Chicago market. (Hillebrand, Tr. 1832).

C. Role Of Outpatient Services

73. Inpatient services are those that require an overnight stay at the hospital. (Ballengee, Tr. 144). Over the last couple of decades, the proportion of hospital services that are delivered on an outpatient basis (*i.e.*, services that do not require an overnight stay) has increased substantially. (CX 6321 at 82; RX 267 at EY97 2050; Neaman, Tr. 1153).

74. The shift toward outpatient care is evident at ENH itself. (Neaman, Tr. 1295-96). In the seven years from 1997-2003, ENH's percentage of gross revenue obtained from its outpatient care has increased. (RX 267 at EY97 2050; Neaman, Tr. 1153). ENH's percentage of outpatient services is approximately 45%. (Neaman, Tr. 1295-96).

D. Managed Care Contracting

1. Selective Contracting

75. Typically, MCOs are able to obtain discounts from providers' list prices if the MCOs can credibly promise to steer patient volume toward the providers. (Dorsey, Tr. 1474-75). Such steerage can only occur if certain providers are "preferred" members of the plan's network. (Hillebrand, Tr. 1760-61). Patients are given financial incentives, through lower out-of-pocket expenditures, to use the preferred providers. (Hillebrand, Tr. 1759-60).

(REDACTED) (RX
1393 at ENHL BW 3691, *in camera*).

76. Such "selective contracting" has been one of the fundamental tools of managed care. (Noether, Tr. 5980-81). Selective contracting, however, has not historically played a major role in managed care in the Chicago area. (Noether, Tr. 5981).

2. Scope Of MCO Contracts

77.

(REDACTED)
(Foucre, Tr. 1123, *in camera*; Ballengee, Tr. 200; Holt-Darcy, Tr. 1585, *in camera*).

(REDACTED)

(Mendonsa, Tr. 557, *in camera*; Ballengee, Tr. 200).

(REDACTED) (Foucre, Tr. 1122, *in camera*;
Mendonsa, Tr. 556, *in camera*; Holt-Darcy, Tr. 1585, *in camera*; Noether, Tr. 5906).

3. Reimbursement Methodologies

78. Hospitals use a variety of MCO contract reimbursement methodologies. (Hillebrand, Tr. 1833). **(REDACTED)**

(RX 387 at H 2637, *in camera*; RX 1503 at 3651, 3656-67, 3684, *in camera*).

79. The rates negotiated by MCOs with hospitals are kept extremely confidential. For example, ENH did (and does) not know the rates a particular MCO has negotiated with ENH's competitor hospitals. (Neaman, Tr. 1344; Ballengee, Tr. 193-94).

a. Discount-Off-Charges Contracts

80. A discount-off-charges rate is a negotiated discount from a hospital's list price or chargemaster. (Chan, Tr. 667).

81. Discount-off-charges rates may be preferred by a hospital because they offer less risk to a hospital. (Chan, Tr. 673). Payments from MCOs are received more timely under this reimbursement method, and fewer resources are spent "chasing underpayments" from MCOs. (RX 1266 at AE 15228).

82. **(REDACTED)**
(Ballengee, Tr. 227, 270-71, *in camera*; RX 1503, *in camera*; Neary, Tr. 772, *in camera*; RX 257 at GWL 3987; RX 1187 at GWL 26, *in camera*; RX 1047 at 9). In fact, hospitals all over the country have requested, and are requesting, discount-off-charges MCO contracts. (RX 1615 at 4).

83. When managed care contracting first began in the Chicago area, the most common payment methodology for inpatient and outpatient services was the discount-off-charges method. (Sirabian, Tr. 5703-04, 5725).

(REDACTED)

(Neary, Tr. 630; Dorsey, Tr. 1474; Mendonsa, Tr. 558, *in camera*; Holt-Darcy, Tr. 1572-73, *in camera*).

84. **(REDACTED)**
(RX 270 at ENH-RNSMC 312, *in camera*; RX 371 at CMC 17637; RX 233 at ALGH 1676, *in camera*; RX 244, *in camera*; RX 407, *in camera*; RX 275, at RHC 7799).

85. **(REDACTED)**

(Chan, Tr. 671; Chan, Tr. 852-853, *in camera*).

(REDACTED)

(RX 663 at ENHL TC 16939; Chan, Tr. 852-53, *in camera*).

86. Since 2000, Chicago area hospitals have negotiated even more aggressively for the discount-off-charges on inpatient services. Even entire healthcare systems, such as Advocate, informed MCOs that it had made great efforts to move additional contracts to the discount-off-charges methodology. (RX 1266 at AE 15228).

87. (REDACTED)

(Dorsey, Tr. 1485; Mendonsa, Tr. 558, 566-67, *in camera*; Holt-Darcy, Tr. 1600, *in camera*).

88. In particular, escalator clauses protect a MCO from a hospital's chargemaster increases. (Newton, Tr. 459).

(REDACTED)

(Mendonsa, Tr. 566-67, 558, *in camera*).

(REDACTED)

(Mendonsa, Tr. 567, *in camera*).

89. (REDACTED) (CX
5072 at 18-19, *in camera*; Ballengee, Tr. 260-61, *in camera*.)
(REDACTED)

(Ballengee, Tr. 260-61, *in camera*).

90.

(REDACTED)

(Mendonsa, Tr. 567, *in camera*).

91. To date, the primary payment methodology for outpatient services is the discount-off-charges method. (Sirabian, Tr. 5704).

b. Per Diem

92. (REDACTED) (Mendonsa, Tr. 524-25, *in camera*).

(REDACTED)

(Ballengee, Tr. 228, *in camera*).

(REDACTED)

(Ballengee, Tr. 228, *in camera*).

93.

(REDACTED)

camera).

(REDACTED)

(Chan, Tr. 785-86, *in camera*).

(Neary, Tr. 766-67, *in*

94.

(REDACTED)

(CX 5068 at 27, *in camera*; Chan, Tr. 785-786, *in camera*; RX 278 at ENH JL 5335, 5338).

95. (REDACTED)

(Chan, Tr. 786, *in camera*).

(REDACTED)

(CX 1099 at 12, *in camera*).

(REDACTED)

(Chan, Tr. 818, *in camera*).

c. Case Rates

96. (REDACTED)

(Ballengee, Tr. 229, *in camera*).

(REDACTED)

(Ballengee, Tr. 229, *in camera*).

d. Capitation

97. (REDACTED)

Tr. 1537-38, *in camera*).

(REDACTED)

(Mendonsa, Tr. 525, *in camera*; Holt-Darcy,

38, *in camera*).

(Mendonsa, Tr. 525, *in camera*; Holt-Darcy, Tr. 1537-

98. Despite the expectation that capitated contracts would become a prevalent payment mechanism in Chicago, this expectation never materialized. (RX 584 at ENH JH 2951).

E. Different Type of Hospitals (Academic And Community)

99. (REDACTED)

(Holt-Darcy, Tr. 1589, *in camera*).

100. A community hospital offers services that are relatively simple, such as medical, surgical and maternity. (Ballengee, Tr. 158).

101. (REDACTED)

(Neary, Tr. 622; Foucre, Tr. 935; Foucre, Tr. 1112, *in camera*; Mendonsa, Tr. 565, *in camera*).

102. (REDACTED)

(Ballengee, Tr. 158; Holt-Darcy, Tr. 1590, *in camera*).

103. (Mendonsa, Tr. 565, *in camera*).
(REDACTED)

(Mendonsa, Tr. 565, *in camera*; Ballengee, Tr. 158-59, 189; Holt-Darcy, Tr. 1590, 1592-93, *in camera*).

104. (REDACTED)
(Holt-Darcy, Tr. 1590, *in camera*; Foucre, Tr. 1121-22, *in camera*).

F. The Impact Of The Balanced Budget Act Of 1997 On Managed Care

105. Congress passed the Balanced Budget Act of 1997 ("Balanced Budget Act") as part of a larger deficit reduction package. Pub. L. 105-33, 1997 H.R. 2015. Overall, the Balanced Budget Act was intended to reduce the annual rate of Medicare spending growth. (Neaman, Tr. 1314). The Balanced Budget Act did, in fact, reduce expenditures in a number of areas, including: general hospital payments, teaching, research, home care and payments to physicians. (Neaman, Tr. 1314).

106. The reduction in general hospital payments placed significant strain on hospitals' abilities to cover many of their high fixed (or shared) costs. (Noether, Tr. 5973). Additionally, these reductions limited hospitals' abilities to care for their uninsured patients. According to federal regulations, hospitals must provide emergency care to all who require it, regardless of their ability to pay. 42 U.S.C. 1395dd; 42 C.F.R. § 489.24.

107. The reduction in Medicare payments for teaching and research also had an adverse impact on hospitals' bottom lines. (RX 528 at ENH RS 005507).

(REDACTED)

(RX 1205 at FTC-RNSM 361, *in camera*). The overall impact was to reduce academic hospitals' Medicare revenues. (Neaman, Tr. 962; Hillebrand, Tr. 1837).

108. Finally, because hospitals provide both physician and home care services to their patients, the reduction in payments due to the Balanced Budget Act for these services further reduced hospital revenues. (Neaman, Tr. 1315).

109. Passage of the Balanced Budget Act coincided with a continuing decline in the growth of payments from MCOs. (RX 1346 at BCBSI-ENH 5540).

(REDACTED)

(RX 1393 at ENHL BW 3681, *in camera*). Meeting costs via cross-subsidization was standard practice among certain hospital administrators. (Haas-Wilson, Tr. 2684-85).

110. Both ENH and HPH realized that the Balanced Budget Act would have a significant effect on their finances. (RX 491; RX 551 at ENH DR 3196). One HPH analysis

projected that the hospital would lose over \$3 million in revenue in 1999. (RX 491). As an academic hospital, ENH was facing a larger effect, projecting a loss of \$80 million in revenue over 5 years, a prediction that came true. (RX 551 at ENH DR 3196; Hillebrand, Tr. 1844).

G. Hospitals Have Felt Substantial Pressure To Reduce Costs

111.

(REDACTED)

(RX 1393 at ENHL BW 3681, *in camera*).

112. In addition, costs have risen due to personnel shortages, Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) compliance, infrastructure changes in anticipation of Y-2K, increased consumer demand for new technologies, homeland security measures, malpractice costs and a rising number of uninsured Americans. (H. Jones, Tr. 4108; Hillebrand, Tr. 1779).

113. These cost constraints, combined with reduced payment rates, adversely impacted the operating margins of hospitals. (Spaeth, Tr. 2260, 2262-63; Neaman, Tr. 963, 1314-15; H. Jones, Tr. 4108).

114. Personnel shortages have been among the cost drivers at hospitals in recent years. (H. Jones, Tr. 4108). Shortages among personnel affect not only the bottom line of hospitals, but also the quality of care they aim to provide. (RX 1109 at FTC-IFHA 598).

115. HIPAA also created standards for electronic health information transactions, such as claims, payment and coordination of benefits. (RX 1109 at FTC-IFHA 598). Such electronic exchanges were intended to protect the privacy of files that were individually identifiable and to set security provisions to maintain medical records privacy. (RX 1109 at FTC-IFHA 598). These requirements imposed additional costs on hospitals. (RX 1109 at FTC-IFHA 598; RX 1189 at ENHL JL 14125).

H. Chicago Healthcare Market

a. Relevant Hospitals

116. There are about 100 hospitals in the Chicago area market. (Noether, Tr. 5982). These hospitals are differentiated along a number of attributes, including geography and complexity of service offerings. (Noether, Tr. 5911).

117. Before 2000, five health care systems in the Chicago area were responsible for over 43% of total inpatient admissions. (RX 531 at 13819).

(REDACTED)

(RX 1053 at AHHC 364, *in camera*; RX 1095 at AHHC 375, *in camera*; RX 1141 at AHHC 386, *in camera*).

118. Local industry observers doubt that the healthcare market in the Chicago area will ever be reduced to a few large integrated delivery systems. (RX 1420 at CIG/ENH 1142).

119. Certain hospitals that compete with ENH are discussed in more depth in Section VI.B. 2.

b. Relevant MCOs

120. A large number of MCOs operate in the Chicago area. The largest of these MCOs are discussed below.

i. Aetna

121. Aetna Inc. ("Aetna") and its wholly owned subsidiaries constitute the nation's largest health benefits company based on membership as of December 31, 2000. (RX 1047 at 5). Aetna offers full-risk, where Aetna assumes the financial risk of health care costs, and employer-funded products, where employers assume the financial risk of health care costs. (RX 1650 at 6). Approximately 60% to two-thirds of Aetna's business in 2000 was self-insured. (Mendonsa, Tr. 480).

122. Aetna's health care benefit products include HMO, POS, PPO, and indemnity plans. (RX 1650 at 6).

123. Aetna reported net income of \$127.1 million in 2000. (RX 1047 at 35). By 2003, Aetna's net income increased seven-fold to \$933.8 million. (RX 1650 at 28). Aetna held \$13.776 billion in total assets in 2000. (RX 1047 at 36). Aetna held \$11.24 billion in total assets in 2003. (RX 1650 at 29).

124. Aetna is large and very successful nationally, but has been relatively unsuccessful in the Chicago area. (Hillebrand, Tr. 1895). For example, Aetna is the fourth or fifth largest insurer in the Chicago area behind Blue Cross and Blue Shield of Illinois ("Blue Cross"), United, Humana, Inc. ("Humana") and Unicare Life and Health Insurance Company ("Unicare"). (Mendonsa, Tr. 481).

125. During the late 1990s, Aetna's business was declining in the Chicago area market. (Hillebrand, Tr. 1725). In 2000, Aetna had approximately 500,000 covered lives in the Chicago area. (Mendonsa, Tr. 480). In 2000, Aetna had a network of 88 out of about 100 hospitals in the Chicago area. (Mendonsa, Tr. 484).

ii. Blue Cross

126. Blue Cross is the largest insurer in Chicago. (Foucre, Tr. 939; Hillebrand, Tr. 1806). Blue Cross Blue Shield has a share of approximately 52-53%, and has about 2 million members in Illinois (Foucre, Tr. 949; Mendonsa, Tr. 481).

127. Patients insured by Blue Cross represent approximately 20% of ENH's business. (Hillebrand, Tr. 1806).

128. In 2000, Blue Cross contracted with hospitals for its HMO product, HMO Illinois; its PPO product, Blue Cross PPO; and its Blue Choice product. (RX 844 at ENH JL 2023).

129. Health Care Service Corporation, the parent of Blue Cross Blue Shield of Illinois ("Blue Cross"), had total assets totaling about \$3.6 billion in 2001 and about \$3.3 billion in 2000. (RX 1198 at 4). Health Care Service Corporation's total assets equaled about \$4.2 billion in 2002, and grew to about \$5 billion in 2003. (RX 1587 at 5). Health Care Service Corporation posted net gains of over \$347 million in 2001 and \$173 million in 2000. (RX 1198 at 7). By 2003, Health Care Service Corporation posted net gains of over \$624 million. (RX 1587 at 7).

130. Health Care Service Corporation is comprised of Blue Cross Blue Shield of Illinois, Blue Cross Blue Shield of Texas and Blue Cross Blue Shield of New Mexico. (RX 1198 at 8).

iii. CCN

131. CCN was a provider of "network services," not a health insurer. (RX 832 at ENHL BW 12757). In 2000, CCN contracted with hospitals for its group health, automobile medical liability, and worker's compensation products. (RX 827 at ENH JL 12622).

132. In 2000, the magazine *Business Insurance* ranked CCN as the largest PPO in the nation. (RX 832 at ENHL BW 12757). In 2000, CCN managed more than \$6 billion nationally in healthcare costs annually for over 9,500 employers, labor unions trust funds, national and self-insured employers and insurance carriers. (RX 801 at ENHL TC 2556). CCN had over 290,000 physicians and 2,700 hospitals in its networks. (RX 832 at ENHL BW 12757).

133. First Health acquired CCN in August 2001 for approximately \$198 million. (RX 1661 at 58; RX 1469 at 8). First Health's net income was \$152,734,000 in 2003, up from \$132,938,000 in 2002, \$102,920,000 in 2001, and \$82,619,000 in 2000. (RX 1661 at 50; RX 1469 at 104).

iv. Cigna

134. Cigna is one of the largest investor-owned employee benefits organizations in the United States. (RX 1743 at 3). Cigna's subsidiaries are major providers of health care employee benefits through the workplace. (RX 1743 at 3).

135. Cigna, itself, is a holding company for several subsidiaries engaged in health care, group life, accident and disability insurance. (RX 1743 at 3).

136. Cigna offers HMO, POS, PPO and traditional indemnity medical insurance products. (RX 1742 at 6-7).

137. Cigna offers two varieties of HMO products. (RX 1742 at 7). In one type, the member selects a primary care physician who is responsible for primary care and preventive care and who must refer the member to a participating specialist for care. (RX 1742 at 7). Cigna's "open access" HMO removes the requirement of a referral from the member's primary care physician for specialist services. (RX 1742 at 7).

138. Cigna's POS product allows members to choose out-of-network providers for a higher cost in the form of a deductible or cost-sharing. (RX 1742 at 8).

139. Under Cigna's PPO product, participants are free to use any health care provider. (RX 1742 at 10).

140. Cigna considered initiating a variable co-pay product that would differentiate hospitals by co-pay amounts based on the rate agreements negotiated. (RX 910).

141. Cigna posted net income of \$668 million in its 2003 financial statements. (RX 1742 at 54). Cigna reported net income of \$515 million for the second quarter of 2004. (RX 1715 at 1). Cigna holds over \$11.6 billion in assets. (RX 1742 at 55).

v. Great West

142. Great West Healthcare ("Great West") was formerly known as One Health. (Neary, Tr. 581).

143. Great West is "the smallest payor at issue" in this case. (Neary, Tr. 614). During the 1997-2004 time period, Great West covered approximately 100,000 lives. (Neary, Tr. 585). Great West sells HMO, PPO and POS insurance products. (Neary, Tr. 585; Dorsey, Tr. 1428).

144. During the 1997-2004 time period, approximately 90% of Great West's business was self-insured. (Neary, Tr. 586). Rate increases on self-insured products are paid for by the client. (Neary, Tr. 586-87).

145. At the end of 1999, Great West had roughly 105 hospitals in its network in Illinois. (Dorsey, Tr. 1430).

vi. HFN

146. HFN, Inc. ("HFN") is a healthcare network that provides services through MCOs, physicians and hospitals. (RX 1710 at 1; Chan, Tr. 727). **(REDACTED)**
(RX 1803, *in camera*). HFN is the largest such network in the six-county Chicago area, contracting with 103 hospitals and 31,405 physicians. (RX 1710 at 1).

147. **(REDACTED)**
(RX 1803, *in camera*).

148.

(REDACTED)

(RX 1803, *in camera*).

149.

(REDACTED)

camera; RX 1830 at HFN 516-18, *in camera*).

(RX 1803, *in*

(REDACTED)

(RX 1803, *in camera*).

150.

(REDACTED)

(RX 1840 at HFN 72, *in camera*).

(REDACTED)

(RX 1803, *in camera*.)

vii. Humana

151. Humana is one of the nation's largest publicly traded health benefits companies, based on 2003 revenues of \$12.2 billion. (RX 1743 at 4, 27).

152. Humana's net income was \$228.9 million in 2003 as compared to \$142.8 million in 2002. (RX 1743 at 38). For the year ending December 31, 2003, commercial and individual PPO premium revenues at Humana totaled approximately \$3.4 billion, or 27.9% of Humana's total revenues and "administrative services only" ("ASO") fees, e.g., fees that a self-insured client would pay to an insurance company for processing claims. (RX 1743 at 6).

153. Nationally and as of 2003, Humana had approximately 6.8 million members in its medical insurance programs, and 463,300 contracts with physicians, hospitals, and other providers of health care. (RX 1743 at 4). Humana had about 3,300 contracts with hospitals. (RX 1743 at 10). About 70% of Humana's premiums and administrative fees were from members located in Illinois, Florida, Texas, Kentucky and Ohio. (RX 1743 at 4).

154. In Chicago, Humana is the third largest MCO in the market. (Foucre, Tr. 939-40). Humana has a share of about 10-11%. (Foucre, Tr. 949).

155. Humana was unique in Chicago among MCOs in that it owned hospitals and physicians. (Hillebrand, Tr. 1863, 1867). Humana operated its hospitals, physicians and insurance products as a completely integrated provider during the 1980s. (Hillebrand, Tr. 1838). In fact, other insurers distinguished themselves from Humana with billboards on the Kennedy Expressway in Chicago that said: "We are your insurance company, not your doctor." (Hillebrand, Tr. 1867).

viii. PHCS

156. PHCS is not an insurance company. (Hillebrand, Tr. 1892; Ballengee, Tr. 204). PHCS is an organization that has come together to collectively negotiate prices with providers on behalf of independently owned businesses. (Hillebrand, Tr. 1892). PHCS is therefore different from Cigna, Aetna, United Healthcare and other MCOs that offer insurance. (Ballengee, Tr. 204).

157. PHCS's customers are insurance companies. (Ballengee, Tr. 143). PHCS also has contracts for federal employee plans, Taft-Hartley union plans, and has some direct employers such as the Salvation Army. (Ballengee, Tr. 143).

158. PHCS's customers pay PHCS for the use of the network on a per member basis. (Ballengee, Tr. 144). PHCS's customers make the payments to hospitals for hospital costs. (Ballengee, Tr. 144). PHCS takes a fee for what it provides to other smaller insurance companies that are part of its group. (Ballengee, Tr. 204). PHCS does not share the financial risk with its customers for healthcare costs. (Ballengee, Tr. 144).

159. PHCS also has third-party administrators ("TPAs") that handle administrative services for employers and other self-insured entities. (Ballengee, Tr. 143).

160. In 2003, PHCS reported that its net revenue climbed to \$153 million, an increase of 6% over 2002. (RX 1615 at 3). PHCS's earnings exploded by "an astounding 50%" in 2003. (RX 1615 at 3).

161. PHCS was ranked as the "Top National PPO in Chicago" by *Crain's Chicago Business* in 2003. (RX 1615 at 6). PHCS is also recognized in other regions as one of the largest networks in the nation. (RX 1615 at 6).

ix. Unicare

162. Unicare is a product marketed by Wellpoint, Inc. ("Wellpoint"), a publicly traded company. (RX 1663 at 7, 11; Holt-Darcy, Tr. 1416). As of November 2004, Wellpoint, Inc., refers to the entity created by the merger of Wellpoint Health Networks and Anthem, Inc. (Holt-Darcy, Tr. 1416).

163. Wellpoint, Unicare's parent company, is a huge and very successful national insurance company. (RX 1663). Unicare is a national brand operating from coast-to-coast. (Holt-Darcy, Tr. 1416).

164. Wellpoint's total assets in 2003 exceeded \$14.788 billion. (RX 1663 at 50). In 2003, Wellpoint's reported net income was \$935,229,000. (RX 1663 at 48). In 2000, by contrast, Wellpoint's reported net income was just \$342,287,000. (RX 1663 at 48).

165. As of December 31, 2003, Wellpoint served approximately 15 million medical members nationwide. (RX 1663 at 6). Wellpoint's merger with Anthem added approximately 11.9 million medical members to its rolls. (RX 1663 at 7).

166. Wellpoint launched the Unicare brand and entered the Illinois marketplace in the late-1990's as a PPO. (Holt-Darcy, Tr. 1417). Unicare has been in the Chicago area since the early-1990's. (Holt-Darcy, Tr. 1417-18).

167. (Holt-Darcy, Tr. 1535, *in camera*). (REDACTED) (REDACTED) (Holt-Darcy, Tr. 1535, *in camera*).

168. (REDACTED) (Holt-Darcy, Tr. 1504-05, *in camera*; RX 1663 at 6). Unicare purchased the Rush Prudential health plan network business and converted it to Unicare. (Holt-Darcy, Tr. 1417).

x. United

169. United is a subsidiary of United Healthcare, Incorporated ("United Healthcare"), which itself is a subsidiary of United Health Group. (Foucre, Tr. 877).

170. By 2003, United Healthcare served approximately 8.3 million members in the country. (RX 1663 at 6). In Chicago, United is the second largest insurer as measured by membership. (Foucre, Tr. 939; Hillebrand, Tr. 1868). The current membership of United's network in Chicago is approximately 875,000. (Foucre, Tr. 880-81).

171. United Health Group is a multi-billion dollar insurance company. (Foucre, Tr. 939). As of February 2005, United Health Group was worth over \$30 billion. (Foucre, Tr. 939). United Health Group's most current 10-K filed with the Securities Exchange Commission reports that United Health Group received \$28.823 billion in revenues in 2003. (RX 1662).

172. United Healthcare's strongest financial year in its history occurred in 2000. (RX 1071 at 7). United Healthcare reported record revenues of \$21.1 billion, a 12% increase over 1999. (RX 1071 at 7). In 2000, United Healthcare's operating earnings increased by 27% over its 1999 operating earnings. (RX 1071 at 7). In 2000, United Healthcare posted net earnings of \$736 million. (RX 1071 at 7).

173. William W. McGuire, Chairman and Chief Executive Officer of United Health Group earned in excess of \$91,953,914 in 2003. (RX 1662 at 225, 227). Dr. McGuire's compensation included a \$5,550,000 bonus on top of his salary of \$1,996,154. (RX 1662 at 225). In 2003, Dr. McGuire also exercised stock options with a realized value of \$84,176,032. (RX 1662 at 227).

174. Robert J. Sheehy, Chief Executive Officer of United Healthcare, was paid a salary of \$485,000 plus a bonus of \$500,000 in 2003. (RX 1662 at 225). In 2003, Mr. Sheehy exercised stock options with a realized value of \$9,283,536. (RX 1662 at 227).

175. United has five primary health insurance products that it sells to employers. (Foucre, Tr. 881). Two products are sold on the HMO license and have no out-of-network benefits. (Foucre, Tr. 881). One of the products on United's HMO license requires a gatekeeper physician while the other product does not. (Foucre, Tr. 881).

176. From 2001 through 2004, approximately 75% of United's business was self-insured. (Foucre, Tr. 881-82).

177. In the late 1990s, United Healthcare acquired numerous other insurance companies, such as Share, Chicago HMO, MetLife, and Travelers, and quickly became one of the larger players in Chicago. (Hillebrand, Tr. 1838-39). At present, United has a share in Chicago of approximately 15%. (Foucre, Tr. 949).

178. By the end of 2002, approximately 98 hospitals were in United's network in the Chicago area. (Foucre, Tr. 881). (REDACTED)
(Foucre, Tr. 1122-23, *in camera*).

I. MCO Negotiating Trends In The Chicago Area Market

179. Relationships between hospitals and MCOs have long been strained. (Spaeth, Tr. 2298). As MCOs have become more aggressive with hospitals and physicians, hospitals and physicians have responded by becoming more aggressive with MCOs. (Neaman, Tr. 1347-48).

180. During the late 1990's and early 2000s, there has been a trend of hospitals getting more aggressive in their negotiation tactics. (Dorsey, Tr. 1475). (REDACTED) (RX 1393 at ENHL BW 3682, *in camera*).

181. (REDACTED) (RX 1393 at ENHL BW 3682, *in camera*).

182. To be sure, however, (REDACTED) (Mendonsa, Tr. 546, *in camera*). (REDACTED) (Mendonsa, Tr. 559, *in camera*; Holt-Darcy, Tr. 1588, *in camera*). (REDACTED) (Holt-Darcy, Tr. 1588, *in camera*). (REDACTED) (Holt-Darcy, Tr. 1586-87, *in camera*).

183. (REDACTED) (Holt-Darcy, Tr. 1587, *in camera*). (REDACTED) (Holt-Darcy, Tr. 1587-89, *in camera*).

1. Hospitals Use Termination Letters To Open Negotiations With MCOs

184.

(REDACTED)

(Dorsey, Tr. 1475, 1487; Ballengee, Tr. 198; Holt-Darcy, Tr. 1534-35, *in camera*; Chan, Tr. 734-35; Mendonsa, Tr. 559, *in camera*; RX 61; RX 172; RX 1372 at BCBSI-ENH 24630, *in camera*; RX 1075 at CIG/IL 200374, *in camera*). Actual terminations, however, are uncommon. (Dorsey, Tr. 1475).

185.

(REDACTED)

(Neary, Tr. 630; Mendonsa, Tr. 559, *in camera*). For example, Lake Forest Hospital believed that “[m]ost contracts must be terminated to gain enough leverage to increase payment levels from insurance companies.” (RX 987 at FTC-LFH 229).

186.

(REDACTED)

(Ballengee, Tr. 198; Mendonsa, Tr. 560, *in camera*; RX 859; RX 906; RX 919; RX 927; RX 929; RX 950; RX 965; RX 983 at CIG/IL 141819; RX 995, *in camera*; RX 1070, *in camera*; RX 1075 at CIG/IL 200374, *in camera*; RX 1104; RX 1223, *in camera*; RX 1349; RX 1443; RX 1530).

2. System-Wide Contracts Are Gaining Popularity

187.

(REDACTED)

(RX 1223 at UHC 17769, *in camera*; RX 1982 at ALEX 2594-95).

(REDACTED)

(RX 1223 at UHC 17769, *in camera*).

188. Consultants have also advised hospital systems to negotiate as one system. (RX 1982 at ALEX 2594-95). For example, the Tintari Group prepared an assessment of all the active managed care contracts held by Alexian Brothers Health System and recommended that Alexian Brothers “negotiate in the market as one true system,” and “should aggressively negotiate[] using a discount-from-charges pricing methodology.” (RX 1982 at ALEX 2594-95).

189. But some healthcare networks in the Chicago area – including Advocate, Resurrection, Provena and Rush, all with multiple hospitals in their systems – have separate contracts for each hospital. (Foucre, Tr. 890-91; Ballengee, Tr. 163-64).

3. The Contract Negotiation “Pendulum” Is Swinging Back In Favor Of MCOs

190.

(REDACTED)

(RX 1393 at ENHL BW 3683, *in camera*).

191. **(REDACTED)**
(RX 1393 at ENHL BW 3683,
in camera).

192. **(REDACTED)**
(RX 1393 at ENHL BW 3683, *in camera*).

193. **(REDACTED)**
(RX 1393 at ENHL BW 3683, *in camera*).

194. **(REDACTED)** (RX 1393
at ENHL BW 3683, *in camera*).

195. **(REDACTED)** (RX 1393 at ENHL BW
3683, *in camera*).

196. **(REDACTED)** (RX 1393 at
ENHL BW 3683, *in camera*).

III. PRE-MERGER BACKGROUND

197. The Merger should be viewed in a broader factual context. Evanston Hospital and HPH decided to merge only after: (1) the failure of a hospital network in which both parties participated, the Northwestern Healthcare Network (the “Network” or “NHN”); (2) a failed attempt by Evanston Hospital, HPH and another hospital to form a three-way hospital merger (“NH North”); and (3) the failures of several HPH joint ventures and merger negotiations with other hospitals. (Hillebrand, Tr. 1785-86, 1791-92; Neaman, Tr. 1035-36; Spaeth, Tr. 2266). This pre-Merger background – which confirms the pitfalls of loose corporate affiliations short of a full asset merger like the one at issue here as well as the hurdles to merger consummation – is described in more depth below.

A. Northwestern Healthcare Network

198. The Network was a system of hospitals formed in Chicago in the early 1990s. (CX 6306 at 2 (Mecklenburg, Dep.)). The Network was formed pursuant to an affiliation agreement dated October 23, 1989. (RX 22 at NHN 322).

199. The earliest formal discussions concerning the formation of the Network were among a group of hospitals already related to one another through a common affiliation with Northwestern University Medical School. These hospitals included Evanston Hospital, the Rehabilitation Institute of Chicago and Children’s Memorial Medical Center (“Children’s Memorial”). (CX 6306 at 2 (Mecklenburg, Dep.)).

200. Ultimately, the founding members of the Network were Children’s Memorial, Evanston Hospital, Lakeland (HPH’s parent) and Northwestern Memorial. (Neaman, Tr. 963; CX 1780 at 1).

1. Purpose Of The Network

201. The goals and objectives of the Network included:

- (a) creating a vertically and horizontally integrated medical care delivery system for the Chicago metropolitan area;
- (b) developing fully integrated marketplace penetration strategies, including “the development of coordinated Phase I and Phase II systems and processes for managed care contracting”;
- (c) providing leadership in the development of systems for assuring high quality patient care;
- (d) enhancing the financial position of the member institutions through an expanded patient base, diversified health care programs and cost position improvements; and

- (e) strengthening the academic programs at the hospitals and Northwestern University. (CX 1780 at 5-6; CX 6306 at 2-4 (Mecklenburg, Dep.)).

202. The Network hospitals came together to respond to anticipated marketplace behavior in terms of managed care contracting and in terms of exclusive contracting with certain MCOs. (RX 70 at NHN 873; CX 6306 at 4 (Mecklenburg, Dep.)).

203. In particular, the Network was formed, in part, with an eye toward handling the anticipated trend towards capitated contracts, pursuant to which a MCO paid a group of providers a fixed amount of dollars per member per month, thus placing all financial risk on that group of providers. (Neaman, Tr. 1360).

204. While capitated contracts did come to Chicago in the mid-1990s, they never became the major factor many had predicted. (Neaman, Tr. 1361). Thus, one of the driving forces behind the formation of the Network never materialized in the Chicago area marketplace. (RX 584 at ENH JH 2951).

205. Evanston Hospital joined the Network based on its belief that the then-existing Rush, Humana (at that point, Humana owned several hospitals in the Chicago area, including the former Michael Reese Hospital) and Evangelical (a precursor to the Advocate system) systems of ownership of several hospitals in the Chicago area would be the operating model for the future. There was some fear that Evanston Hospital might be left behind if it did not become an integral part of a hospital network. (RX 357 at ENH JH 10385).

206. HPH joined the Network to enhance the hospital's quality of care as well as its perception in the marketplace. (Spaeth, Tr. 2194).

2. Structure And Powers Of The Network

207. Pursuant to the affiliation agreement, the Network became the "sole member" of the member hospitals, in accordance with the Illinois General Not For Profit Corporation Act of 1986, as amended. (RX 22 at NHN 339, 372). The affiliation agreement provided for the creation of a Council of Governors, appointed by the member hospitals, to serve as "Members" of the Network. These "Members" were granted rights under the affiliation agreement and under the Illinois General Not for Profit Corporation Act of 1986. (RX 22 at 340). In addition, the Network had its own executive and its own board of directors. (CX 6306 at 5-6 (Mecklenburg, Dep.); Newton, Tr. 457; Neaman, Tr. 999). There "was a significant effort to integrate the local CEOs into the Network." (CX 6306 at 6 (Mecklenburg, Dep.)).

208. The Network evolved in two phases, Phase I and Phase II. During both Phases I and II, however, the Network had the powers to: (1) approve the member institutions' respective strategic plans; (2) develop a "macro" strategic plan for the entire Network; and (3) approve the member institutions' respective operating and capital budgets. (Neaman, Tr. 967; CX 1780 at 16-17; Newton, Tr. 457-59; CX 6306 at 3 (Mecklenburg, Dep.)).

209. Phase I started when the Network was first approved around 1990. (Neaman, Tr. 967). During Phase I, the Network's governing board and the CEO of each of the member

institutions continued to be nominated, elected and appointed in accordance with the procedures established by each institution. The Network had the reserved power and authority to approve the election and/or appointment of each institution's board members and CEOs. (CX 1780 at 15-16).

210. Phase II started in 1993. (Neaman, Tr. 967). The Network received Hart-Scott-Rodino approval when it moved into this Phase. (Neaman, Tr. 1360).

211. During Phase II, the Network had the reserved power and authority to appoint institution directors and remove directors and the CEOs of the member institutions for cause. (CX 1780 at 15-16; Neaman, Tr. 974-77; CX 1831 at 13; Newton, Tr. 458). The Network also had the additional reserved power to direct asset transfers by the member institutions to the extent necessary to accomplish Network goals and objectives. (CX 1780 at 18).

212. Once Phase II was initiated, there were a number of financial and operating mechanisms that needed the approval of the Network and the Network's Board. (Neaman, Tr. 969-70). For example, hospital budgets were modified as a result of discussions with the Network. (CX 6306 at 6-7 (Mecklenburg, Dep.)).

213. The Network Board reviewed and commented on hospital expansion plans. (CX 6307 at 16-17 (Schelling, Dep.)).

214. Evanston Hospital also submitted budget summaries to the Network. (RX 182 at ENHL HJ 3672-76).

215. The Network reviewed its member hospitals' "keys to success" for each hospital, new programs and network initiatives. (RX 182 at ENHL HJ 3673).

216. The Network also pursued an employee benefits project that would cover the employee benefits for the member institutions and yield millions of dollars in savings. (RX 182 at ENHL HJ 3677-78).

217. Even when the Network did not directly exercise its powers, there was significant discussion about individual hospital actions and decisions at the Network level. (CX 6306 at 8 (Mecklenburg, Dep.)). Gary Mecklenberg, who served as the Network's President and CEO for approximately four years and was the CEO of Northwestern Memorial, did not recall any member that was "not committed to the exercise of the reserved powers." (CX 6306 at 15 (Mecklenburg, Dep.)).

218. Member hospitals invested a great deal of resources in developing the Network. (CX 6306 at 17 (Mecklenburg, Dep.)). In part, these resources were invested through member hospital contributions to the operating budget. (CX 6306 at 17 (Mecklenburg, Dep.)).

3. Managed Care Contracting By The Network

219. The Network negotiated contracts for the provision of hospital services by its member hospitals with the International Brotherhood of Teamsters, Health Network, Great West and MultiPlan. (CX 6307 at 18 (Schelling, Dep.)).

220. The Network also negotiated and entered an agreement with North American Medical Management (“NAMM”), which “set out sort of a baseline of what the downstream documents would be with the local providers.” (CX 6307 at 6 (Schelling, Dep.)). Based on this agreement, each member institution had the option to enter into a direct contract with NAMM. (CX 6307 at 6 (Schelling, Dep.)).

221. The Network also previewed and pre-selected a credentialing firm for use by physicians affiliated with Network member institutions. (CX 6307 at 8 (Schelling, Dep.)).

222. The Network, however, had only relatively minor successes in negotiating with MCOs. (Neaman, Tr. 966). One of the agreements the Network was able to negotiate was a capitated Home Health services agreement with Humana. (CX 6307 at 5 (Schelling, Dep.)).

223. The Network also engaged in extensive discussions with Chicago HMO to negotiate a capitated agreement. (CX 6307 at 5 (Schelling, Dep.)). Although the Network successfully negotiated a base contract, the agreement was never signed. (CX 6307 at 5 (Schelling, Dep.)).

4. Failures And Limitations Of The Network

224. By 1998, the Network had evolved into a “trade association.” (Neaman, Tr. 1008). As a “trade association,” the Network consisted of a general grouping of hospitals designed to support the general well-being of the association. (Neaman, Tr. 1008-09).

225. The Network possessed the power to enforce the principle of unified action among its members, but the Network did not act in accordance with that principle. (Hillebrand, Tr. 1788-89). The Network looked better on paper than it did in real life. (Hillebrand, Tr. 1789).

226. The Network ultimately had limited success negotiating contracts with MCOs, in part, because it could not bring together the members for contract negotiations. (Neaman, Tr. 965-66). Some members were not convinced the Network could get better terms from MCOs and, instead, negotiated independently. (Neaman, Tr. 966). For example, Mecklenburg felt that managed care contracting decisions should be left to the individual member hospitals. (Neaman, Tr. 986). Mecklenburg recognized that there was no evidence in the Chicago area market that large networks would negotiate more favorable prices than smaller individual hospitals. (RX 177 at NHN 115).

227. Similarly, the Network’s inability to get its members to work in a unified fashion rendered it unable to achieve the hoped-for cost reductions. (CX 6306 at 4 (Mecklenburg, Dep.); RX 183 at NHN 81).

228. The Network was formed for a specific purpose and in anticipation of a specific marketplace. But the marketplace did not form as anticipated, and so the Network was not delivering value the way that its members had anticipated that it would. (CX 6306 at 13 (Mecklenburg, Dep.)).

229. The cost of running the Network outweighed the value received from the Network. So the question arose as to whether the Network could generate enough value, whether it was managed care contracting or other activities. (CX 6306 at 12 (Mecklenburg, Dep.)).

230. The Network dissolution agreement was dated December 20, 1999, but went into effect in January 2000. (Neaman, Tr. 1016). All members of the Network voted to dissolve the Network. (Neaman, Tr. 1017).

B. NH North

231. HPH and Evanston Hospital discussed a further collaboration as far back as 1996. (CX 6305 at 7 (Stearns, Dep.); Neaman, Tr. 1017-18). These discussions between HPH and Evanston Hospital were conducted under the auspices of the Network and also involved Northwest Community Hospital. (CX 6305 at 7 (Stearns, Dep.); Neaman, Tr. 1017-18).

232. The entity that would be created as the result of the proposed merger of HPH, Evanston Hospital and Northwest Community would have been called NH North. (Neaman, Tr. 1017-18).

233. One “principle” of NH North was to be “an entity that differentiates its product, its brand and is indispensable to the marketplace.” (CX 395 at 2). The idea behind this branding strategy was to use name-brand to differentiate NH North in such a way that it would make the NH North very distinctive and very desirable in the minds of customers. (Neaman, Tr. 1363-64).

234. An August 1996 planning document for NH North prepared by Neaman and Hillebrand similarly explained that for NH North to achieve “market influence” and “indispensability,” it had to achieve “differentiation” and “cost leadership.” (CX 394 at 13; Neaman, Tr. 1018-19; Hillebrand, Tr. 1790). According to the planning document, “differentiation” was to be achieved through “superior outcomes,” “brand equity” and “best physicians.” (CX 394 at 13; Hillebrand, Tr. 2020). “Cost leadership” was to be achieved through reducing “cost per unit of care,” “develop[ing] pathways” and “hospital & physicians common incentives.” (CX 394 at 13; Hillebrand, Tr. 2020-21).

235. As used in the August 1996 NH North planning document, the word “indispensability” meant that the customer would view NH North as the system of choice for healthcare as a result of NH North having the best outcomes, the best service, the best physicians and the highest valued brand. (Hillebrand, Tr. 2021).

236. Another goal of NH North was to make the NH North brand “stand for the right attributes in consumers’ minds.” (CX 393 at 14).

237. Bain & Company (“Bain”), a consulting firm, was involved in strategizing for NH North. (Neaman, Tr. 1024). Bain listed two “key tactics” that should be used by NH North to “gain incremental market share.” (RX 477 at ENH JH 349). The two “key tactics” were: (1) “improved/coordinated physician recruitment and development”; and (2) “developing and leveraging brand name.” (RX 477 at ENH JH 349).

238. NH North documents make it clear that it was not designed to succeed where the Network was failing. (RX 132 at ENH JH 274). A 1996 document stated: “must identify key linkages (and no duplication to NHN). Example, managed care contracting to be in conjunction with NHN. Everything else at local level.” (RX 132 at ENH JH 274).

239. The three-way discussions between HPH, Evanston Hospital and Northwest Community with regard to the creation of NH North broke down in 1997 as the result of differences over the proposed merged entity’s organization (such as the composition of the board), personality conflicts and a lack of interest on the part of Northwest Community. (CX 6305 at 9 (Stearns, Dep.); Neaman, Tr. 1035; Hillebrand, Tr. 1791-92).

C. Other Failed Merger Negotiations And Failed Joint Ventures Involving HPH

240. HPH started thinking about aligning with another hospital, through a joint venture or otherwise, as early as 1986. (Spaeth, Tr. 2264). During the mid-1980s, HPH discussed the possibility of merging with both Lake Forest Hospital and Condell and also discussed the possibility of linking with the Mayo Clinic. (Spaeth, Tr. 2265). HPH’s merger discussions in the 1980s eventually evolved into HPH joining the Network. (Spaeth, Tr. 2264-65).

241. HPH first considered aligning with other hospitals through joint ventures in the late 1980s and early 1990s. (Spaeth, Tr. 2267). Overall, HPH sought to align with other hospitals because its Board and Spaeth knew that HPH would have a difficult time competing as a stand-alone institution. (Spaeth, Tr. 2266).

242. As the 1990s progressed, bringing capital to HPH became a major factor in seeking to align with another hospital. (Spaeth, Tr. 2266). Had HPH remained independent, it may have had enough capital to survive short-term, but it would have needed to link with another hospital if it ultimately were to thrive and benefit the Highland Park community. (Spaeth, Tr. 2272).

243. During this period, academic affiliation also was a factor in HPH’s consideration of alignments with other hospitals because HPH wanted to give its community something beyond the quality of care provided by a community hospital. (Spaeth, Tr. 2267).

244. To this end, HPH had discussions with Northwestern Memorial concerning a potential merger, but the discussions did not progress beyond the initial stages. Northwestern Memorial was not responsive to HPH’s inquiries. (Spaeth, Tr. 2270-71).

245. Spaeth also spoke with Advocate senior executives about the possibility of linking. But, after initial discussions, HPH determined that Advocate was not the best fit because Advocate's religious affiliation might have affected patient care in the Highland Park community. (Spaeth, Tr. 2271-72).

246. HPH also considered merging with a for-profit hospital, but HPH's board felt very strongly that HPH should remain a community hospital and not become a part of a for-profit corporation. (Spaeth, Tr. 2272).

247. As of May 1997, Spaeth and Neaman had talked about a variety of ways by which HPH and Evanston Hospital might "align," including through joint ventures for oncology and cardiac surgery. (Spaeth, Tr. 2202). Spaeth's general view, however, was that joint ventures suffered from a general lack of commitment. (Spaeth, Tr. 2269). According to Spaeth, "joint ventures' are confusing, lead to mistrust, and are full employment acts for accountants, lawyers, and consultants." (CX 1865 at 6; Spaeth, Tr. 2269).

248. As further explained by HPH's former Vice President of Planning and Marketing, Mark Newton, joint ventures between medical institutions can be problematic because there may not be an alignment of business strategies or cultures. (Newton, Tr. 449). And joint ventures also can be difficult to operationalize. (Newton, Tr. 449).

249. During this same time frame, Mecklenburg likewise expressed his distrust of joint ventures, writing to Spaeth that joint ventures similar to a proposed HPH-Northwestern Memorial oncology program did not have a good history. (CX 1866 at 5; Spaeth, Tr. 2270).

250. See Section IX.B.4 for additional findings concerning HPH's failed joint ventures and merger negotiations.

IV. THE MERGER

A. Merger Negotiations

1. Initial Merger Discussions

251. After the NH North merger discussions broke down in 1997, some members of the Network Board suggested that Evanston Hospital's then-chairman of the Board, Jerry Pearlman, reinitiate discussions with HPH. (CX 6305 at 8 (Stearns, Dep.)). Pursuant to that suggestion, Pearlman contacted Stearns and explained that if HPH were interested and willing to resume linkage discussions, Evanston Hospital likewise would be interested. (CX 6305 at 8 (Stearns, Dep.)). After Pearlman contacted Stearns, Stearns informed the HPH Board, and the Board authorized HPH to enter into exploratory linkage discussions with Evanston Hospital. (CX 6305 at 8 (Stearns, Dep.)).

252. Subsequently, Evanston Hospital and HPH started discussing a merger solely between the two hospitals. (Neaman, Tr. 1035; Spaeth, Tr. 2206).

253. Evanston Hospital and HPH were required under the Network Affiliation Agreement to seek approval from the Network Board of Directors for the proposed merger since both hospitals were members of the Network. (RX 562). Pre-Merger planning documents show that the proposed merger between Evanston Hospital and HPH was not designed to replace the Network. (RX 288 at ENH RS 1031-32; RX 518 at ENH GW 2063; RX 558 at ENH RS 7725). To the contrary, in April 1999, the Evanston Hospital executive committee was informed that one "strategic rationale" for the Merger with HPH was to "strengthen network presence." (RX 518 at ENH GW 2063).

254. On June 29, 1999, HPH sought permission to move forward with the Merger. (RX 562). HPH explained to the Network that the two hospitals were "very excited about the opportunities the merger presents to enhance and expand services for [Evanston Hospital and Highland Park's] respective patient communities." (RX 562).

255. Pearlman, Homer Livingston (Chairman of the ENH Board from 2000 through 2004), Lester Knight III, Mikesell Thomas, William White and Dan Toll represented the Evanston Hospital Board during Merger negotiations. (RX 636 at ENH GW 5701; Styer, Tr. 4965; *see* (CX 6305 at 8 (Stearns, Dep.))).

256. Neele Stearns, Harvey Medvin, Stan Golder and James Styer represented the HPH board during Merger negotiations. (Styer, Tr. 4964; (CX 6305 at 8 (Stearns, Dep.)).

257. Neaman led the Merger discussions from Evanston Hospital's side, while Spaeth led HPH's efforts. (Neaman, Tr. 1320; Spaeth, Tr. 2283).

258. Neaman had overall responsibility for the Merger and the subsequent Merger integration. (Neaman, Tr. 955).

2. Letter Of Intent

259. The Merger discussions resulted in a Letter of Intent, which became effective July 1, 1999. (RX 567; Neaman, Tr. 1328; Spaeth, Tr. 2273-74). The purpose of the Letter of Intent was to identify a series of service enhancements HPH desired for its community – such as a multidisciplinary and comprehensive oncology program, a cardiac surgery program, an academic linkage, and the creation of a community trust, among many others. (Spaeth, Tr. 2274; Styer, Tr. 4968; RX 518 at ENH GW 2084). This Letter of Intent thus emphasized specific commitments by Evanston Hospital to improve the quality of care at HPH for the benefit of the Highland Park community. (Spaeth, Tr. 2274; CX 6305 at 9-10 (Stearns, Dep.)).

260. Specifically, as a condition of HPH agreeing to the Merger, the Letter of Intent required Evanston Hospital to “build a new multi-disciplinary Cancer Center at the HPH campus modeled after the Kellogg Cancer Care Centers at Evanston and Glenbrook.” (RX 567 at ENH MN 1374).

261. The Letter of Intent also required Evanston Hospital to “establish a cardiac surgery program at HPH by extending the cardiovascular surgery program at ENH.” (RX 567 at ENH MN 1376).

262. The Letter of Intent further required Evanston Hospital to commit to create what ultimately became the Healthcare Foundation of Highland Park (“Healthcare Foundation”). (RX 567 at ENH MN 1384-85). Such a separate and independent, community-based foundation would support health and social-related activities in the Highland Park area. (RX 385 at FTC-KHA 2284). HPH and Evanston Hospital agreed to establish the Healthcare Foundation using \$60 million from the old HPH Foundation and another \$40 million from Evanston Hospital. (Styer, Tr. 4969-70). The \$100 million Healthcare Foundation corpus was to be used to support HPH and enhance healthcare in other areas of the community. (Styer, Tr. 4969-70). The creation of the Healthcare Foundation was a critical part of the Merger discussions because HPH wanted to show the Highland Park community that the money the community used to build and fund HPH would remain within the community after the Merger. (Styer, Tr. 4968-69; Kaufman, Tr. 5832-33).

263. The Letter of Intent detailed a series of “key principles and goals established by the Parties as reasons to support and guide the merger.” (RX 567 at ENH MN 1365).

264. These “key principles” included:

- (1) Approach the merger as partners with a common vision;
- (2) Pursue a merger between ENH and LHS for the purpose of best serving the healthcare interests and needs of their respective and combined patient communities;
- (3) Combine the skills and talent of the Parties’ respective organizations so as to enhance the ability to mutually achieve the stated patient care and key goals;
- (4) Develop a coordinated plan between the Parties to achieve growth for the resulting system;
- (5) Improve the existing clinical services

at HPH and develop new specialty services to be rendered on the HPH campus in order to enhance and expand community health, outreach and patient access; (6) Support a plurality of physician practice styles, including the independent practice of medicine as well as the group faculty practice plan, with all current and future physicians being entitled to the same privileges at each site. It is further recognized that physicians, in general, practice primarily at one hospital site, and, hence, a fair and appropriate mechanism will be established on how representation on Committees (including Medical Staff Executive Committee) from physicians practicing primarily at Evanston, Glenbrook, Highland Park Hospitals will occur; (7) Strive to provide quality, cost efficient healthcare services in a manner which promotes and allows local access to the facilities of the Parties and respects a patient's choice of physicians; (8) Use reasonable efforts to see that all employees of the merged entity receive a fair and equitable salary and benefit package; (9) With the exception of Highland Park Hospital Foundation and Highland Park Health Care, Inc., functionally, merge all aspects of the two organizations as much as possible on "day one." Areas not merged "day one" must come together as soon as possible but no later than three years following closing.

(RX 567 at ENH MN 1366).

265. The Letter of Intent further detailed the "key goals" of the merger as follows:

(1) Grow patient volumes through a collective, coordinated effort, particularly in Lake and northern Cook Counties; (2) Increase the quality and value of clinical services to the respective communities by achieving a greater critical mass of patient volume; (3) Implement the "Evanston Northwestern Healthcare" name brand throughout the merged entity in order to enhance the Parties' and the merged entity's reputations and make the resulting healthcare system the provider of choice in the combined healthcare markets. Enhancement of the individual hospital names – "Highland Park Hospital," "Evanston Hospital," and "Glenbrook Hospital" – will also be undertaken; (4) Develop new medical office and ambulatory care sites in locations within the combined service area that have relatively low market share and that bring additional strategic value to the system; (5) Enhance the future viability of the HPH campus by strengthening existing programs and developing new clinical services; (6) Maintain each of HPH, Evanston Hospital and Glenbrook Hospital as a separately licensed, fully accredited hospital with the goal of obtaining one Medicare provider number for all; (7) Assure an effective and coordinated merger of the Medical Staffs so as to maintain the highest level of continuity of patient care services while enhancing patient

volumes, quality and reputation for all physicians; (8) Strive to achieve cost benefits and economies of scale on a system-wide basis; (9) Establish a fully accredited residency training program with ENH and the Northwestern University Medical School at HPH in Family Medicine and/or other disciplines; (10) Allow HPH patients to access specific ENH specialists and services; (11) Ensure that both HPH and ENH will continue to make a significant organizational commitment to enhancing healthcare services in their respective communities.

(RX 567 at ENH MN 1367-68).

266. Evanston Hospital took its commitments in the Letter of Intent seriously. On June 25, 1999, Neaman informed the Evanston Hospital Board of the “requirements” of the Merger. (RX 557 at ENH GW 4252). Neaman explained to the Board that these “requirements” included an “immediate merger of hospital-based physician groups into ENH Medical Group, expansion of Kellogg Cancer Care Center, additional on-site ambulatory care, cardiac surgery and related programs.” (RX 557 at ENH GW 4252-53). Neaman further informed the Evanston Hospital Board on June 25, 1999, that “[a]n investment in marketing support of the ENH name in Lake County and cost improvements in purchasing, systems, ‘overhead,’ and related cost effective measures will be made.” (RX 557 at ENH GW 4253).

267. The provisions of the Letter of Intent discussed above helped put to rest HPH’s fears that Evanston Hospital would merely hang its shingle on HPH’s door, move HPH’s patients to Evanston Hospital and not follow through on the promises to expand services at HPH. (Neaman, Tr. 1329-30; Styer, Tr. 4966-67).

268. Simultaneous with the execution of the Letter of Intent, Evanston Hospital and HPH sent a press release to area employers, elected officials, managed care companies and the press describing the goals of the Merger – specifically, the service enhancements Evanston Hospital planned to make at HPH. (RX 563 at ENH TH 1568-76; Hillebrand, Tr. 1857-58). For example, RX 564 is the copy of the press release sent to Blue Cross Blue Shield. (RX 564).

269. Evanston Hospital did not know how MCOs would react to the Merger. (RX 609 at EY 172). In its merger due diligence, Evanston Hospital wrote: “Until actual negotiations begin, one can only speculate payor reaction to the combined organization.” (RX 609 at EY 172). Evanston Hospital thought that “[a] few payors are likely to take this opportunity to increase downward pressure on rates.” (RX 609 at EY 172).

B. Reasons For The Merger

270. The overriding reason for the Merger, from both parties’ perspectives, was to improve healthcare for the communities surrounding the hospitals by upgrading the HPH facility, enhancing HPH’s quality of care, supporting the respective physician practices and extending academic teaching to HPH. (Spaeth, Tr. 2274, 2297; Neaman, Tr. 1322, 1327; Styer, Tr. 4966; RX 288 at ENH RS 1031; RX 385 at FTC-KHA 2281).

271. Both parties intended for the Merger to expand the breadth and depth of HPH's clinical services by adding services such as cardiac surgery and oncology, as well as by implementing common pathways, protocols and strong physician leadership at all three hospitals. (Styer, Tr. 5027; Neaman, Tr. 1322-23). As discussed below, each party also had its own, additional reasons to merge.

1. HPH's Reasons For The Merger

272. In the late 1990s, the HPH Board concluded that it needed to find a merger partner that would: (1) enhance the hospital's ability to serve the community by bringing new programs to HPH that it could not justify creating as an independent institution; and (2) infuse much-needed capital into the hospital. (CX 6305 at 7, 9-10, 15 (Stearns, Dep.)); RX 288 at ENH RS 1031; RX 384 at ENH RS 7196; RX 385 at FTC-KHA 2282; Spaeth, Tr. 2273; RX 683 at ENH RS 7694). The HPH Board was concerned about what would be necessary to sustain the hospital in the future. (CX 6305 at 4 (Stearns, Dep.)).

273. For the reasons discussed in more depth below, the HPH Board did not believe that the hospital could continue to serve its community in the long run absent a partnership with another institution. (CX 6305 at 11-12 (Stearns, Dep.)).

a. The Merger Would Improve Quality Of Care At HPH And In The Community In General

274. Before the Merger, HPH's continued viability as a critical care facility was in jeopardy. (Styer, Tr. 4965).

275. HPH was not up to Evanston Hospital's quality standards and, therefore, HPH asked for Evanston Hospital's assistance in improving quality of care. (CX 6304 at 4, 8 (Livingston, Dep.)). HPH hoped to improve its quality of care to a level on par with that provided by the Evanston and Glenbrook Hospitals, thus benefiting the community as a whole. (CX 6304 at 8 (Livingston, Dep.)); RX 683 at ENH RS 7694; CX 6305 at 9, 13 (Stearns, Dep.)).

276. One of the written principles of the negotiations regarding the Merger was that "[t]he purpose of the affiliation [with Evanston Hospital was] to assure the availability of the widest range of quality medical services to the North Shore marketplace." (RX 385 at FTC-KHA 2281). "The Highland Park community clearly expect[ed] that one outcome of the affiliation [with Evanston Hospital would be] that local access to medical services would be increased, not diminished." (RX 385 at FTC-KHA 2281).

277. HPH sought a "meaningful relationship" with Evanston Hospital to enhance the quality of care and access for the Northern Cook and Lake County communities. (RX 389 at FTC-KHA 2226). The expectation of the Merger was that it would "lead to a relationship which [would] provide the highest quality comprehensive services to the citizens of northern Cook and Lake Counties." (RX 385 at FTC-KHA 2281).

278. As early as November 1998, HPH had a "high commitment to doing what is right for the community" with respect to whether to combine with Evanston Hospital. (RX 389 at

FTC-KHA 2226). In November 1998, HPH emphasized its goal to “grow clinical services including oncology, heart, orthopedics, [obstetrics] and other medical and surgical specialties” as a result of combining with Evanston Hospital. (RX 389 at FTC-KHA 2226). One of the key goals from the beginning of Merger negotiations was to achieve growth in oncology, cardiology and other services at HPH. (RX 385 at FTC-KHA 2282).

279. At the inception of the Merger negotiations, HPH asked how the Kellogg Cancer Care Center might be developed and implemented at HPH. (RX 389 at FTC-KHA 2227). HPH also highlighted the possibility that both HPH and Evanston Hospital would identify and agree on a level of quality to be met by all providers after the Merger. (RX 389 at FTC-KHA 2227).

280. Other issues pertaining to quality of care at pre-Merger HPH are discussed in more depth in Section VIII.

b. The Merger Would Address HPH’s Deteriorating Financial Condition

281. HPH also sought to merge with Evanston Hospital because HPH’s long-term survival, specifically over the next five to ten years, was in doubt from a financial perspective. (Styer, Tr. 4965; CX 6305 at 2 (Stearns, Dep.); Kaufman, Tr. 5830-31).

282. Financial issues at pre-Merger HPH are discussed in more depth in Section IX.B.

c. The Merger Would Provide A Good “Fit”

283. HPH also decided to merge with Evanston Hospital because there seemed to be a good “fit” between the hospitals. Both were part of the North Shore culture, and many of the hospitals’ physicians knew each other and trained with each other in the same medical schools. (Spaeth, Tr. 2273; RX 288 at ENH RS 1031).

284. Just before the Merger, HPH communicated to its community the types of services the Merger would bring to the hospital. (Spaeth, Tr. 2304). The Highland Park community and area business were thrilled about the proposed merger with Evanston Hospital. (Spaeth, Tr. 2304).

285. Other neighboring hospitals did not provide viable merger opportunities for HPH. HPH approached Lake Forest Hospital from time to time about partnering. But Lake Forest Hospital was not interested, in part, because of its affiliation with Rush Presbyterian. (CX 6305 at 12 (Stearns, Dep.)).

286. In the late 1990s, Condell did not have the financial and clinical wherewithal to be an attractive merger partner to HPH. (CX 6305 at 12 (Stearns, Dep.)).

287. HPH was skeptical that the downtown Chicago hospitals, such as Northwestern Memorial, would commit to delivering the type of quality improvements HPH thought the Highland Park community needed. (Spaeth, Tr. 2270-71).

2. Evanston Hospital's Reasons For The Merger

a. The Merger Would Allow Evanston Hospital To Improve Quality Of Care By Expanding The Volume Of Its Services

288. Evanston Hospital viewed HPH's geography as an attractive opportunity to expand its volume of services because HPH is located in fast-growing Lake County. (Neaman, Tr. 1325).

289. Expanding the volume of services is critically important to support subspecialty practices of medicine because a hospital needs to have enough patient volume to help physicians maintain excellent and up-to-date quality of care. (Neaman, Tr. 1324-25). The ENH 1996-2000 Strategic Plan confirmed this, identifying ways of achieving growth and becoming the "best integrated healthcare delivery system," such as by significantly broadening the portfolio of services through acquisition of, or affiliation with, additional hospitals. (CX 2037 at 9; Neaman, Tr. 1153-54).

290. A hospital also needs to have enough volume of services so that the cost per case, cost per admission and the cost per procedure are all competitive with what the hospital gets paid. (Neaman, Tr. 1325).

b. The Merger Would Allow Evanston Hospital To Improve Quality Of Care By Rationalizing Its Services

291. Evanston Hospital was a space-constrained facility, with only 14 acres of available land. (Neaman, Tr. 1324). Attempts to expand the Evanston Hospital campus failed because of strong protests from the surrounding residential areas. (Neaman, Tr. 1324).

292. Because certain services at Evanston Hospital had reached the limit of that campus' capacity, Evanston Hospital viewed the Merger as an opportunity to allow it to rationalize resources and free-up capacity by moving various services from Evanston Hospital to HPH, thus improving the quality of care at both campuses. (Neaman, Tr. 1323; Hillebrand, Tr. 1798).

293. For example, if patients needed to be relocated because of operating room overcrowding, the Merger would create clinical efficiencies because the merged entity would not have to spend capital to build more operating room capacity. (Newton, Tr. 451).

294. Other clinical services also stood to benefit from centralizing the resources of the multiple hospitals after the Merger. For example, reproductive endocrinology services are better served by the efficiency of a single, rather than multiple, labs. (Newton, Tr. 451-52). Moreover, the Merger was anticipated to create potential synergies in clinical areas such as behavioral health, home health, skilled nursing and pediatrics. (RX 518 at ENH GW 2066).

c. The Merger Would Result In Corporate Efficiencies

295. The Merger presented Evanston Hospital with an opportunity to improve the combined operating margin through: (1) overhead cost reduction, through the consolidation of core central functions like accounting, finance, billing and human resources; (2) the application of benchmarks to those functions to achieve both scale benefit and process redesign; (3) the use of best practices to improve service and cost reduce the on-site functions like care provision, labs, food and environment; and (4) the identification of outsourcing opportunities for cost reduction or service improvement. (RX 477 at ENH JH 326; Hillebrand, Tr. 1798).

296. The Merger was to be a total integration from the outset. The hospitals recognized that cost savings could be realized by improving and merging the core central functions such as accounting, finance, billing, purchasing, information systems, human resources and strategy. (RX 385 at FTC-KHA 2284; RX 518 at ENH GW 2066). Part of Evanston Hospital's strategic rationale for the Merger was to become a low-cost provider by achieving \$2-4 million in estimated cost reduction. (RX 518 at ENH GW 2063, 2066).

d. The Merger Would Provide Evanston Hospital With An Additional Teaching Site

297. Part of Evanston Hospital's strategic rationale for the merger was to provide an additional teaching site for ENH and the Northwestern University Medical School. (RX 518 at ENH GW 2063; RX 704 at ENH HJ 1625).

C. Merger Consummation

298. In August 1999, before the Merger, the FTC Pre-Merger Notification Office notified the Network, Evanston Hospital and Lakeland, the parent company of HPH, that it viewed the Network as already holding the assets of both Evanston Hospital and Lakeland Health Services. (RX 586 at 2).

299. As such, the FTC Pre-Merger Notification Office did not view the Merger between Evanston Hospital and HPH as an acquisition of assets under the HSR Act. (RX 586 at 2). "This conclusion is not altered by the fact that [the Network] will be dissolved and removed as a member of [ENH] following the effective date of the merger. . . . [A]s long as [the Network] exists and holds the reserved power over appointments to the boards of [Evanston Hospital] and [Lakeland] at the time of the merger, the merger will not be reportable." (RX 586 at 2).

300. On or about August 7, 1999, Evanston Hospital received notice from the FTC that Evanston Hospital and HPH did not have to seek Hart-Scott-Rodino approval to proceed with the Merger. (RX 589; RX 586; Neaman, Tr. 1330).

301. On October 29, 1999, the parties entered into the Agreement and Plan of Merger. (RX 651). This Merger agreement enumerated the same key principles and goals as found in the Letter of Intent. (RX 651 at ENH MN 1557-58). The effective date of the Merger was January 1, 2000. (RX 651 at ENH MN 1517).

302. After the Merger, ENH published newsletters informing the community of the achievements of the Merger. (RX 864 at ENH HJ 1781). In the newsletter, ENH advised the community that HPH had undergone a “major turnaround” from the operating losses it had before the Merger. (RX 864 at ENH HJ 1781).

D. Effect Of The Merger On ENH’s Operations

303. To realize the full benefit of the Merger, ENH consolidated all corporate activities at the Evanston Hospital campus and eliminated all corporate functions at HPH – including human resources, purchasing, payor contracting, the business office and information systems. (Hillebrand, Tr. 1839-40; Neaman, Tr. 1345-46).

304. To achieve maximum cost efficiency from the Merger, ENH determined to institute one billing system and one business office. (Hillebrand, Tr. 1839-40).

305. In particular, ENH implemented a coordinated registration, scheduling and charging system throughout its three hospitals. (Hillebrand, Tr. 1840). This system allows any ENH patient to receive the same care at any ENH site and pay the same price for that care at any ENH site. (Hillebrand, Tr. 1840; Chan, Tr. 714).

306. Consequently, after the Merger, HPH physicians became part of the unitary medical staff of Evanston and Glenbrook Hospitals. If a physician had clinical privileges with ENH after the Merger, the clinical privileges were good at any of the three hospital sites. (RX 518 at ENH GW 2082; Hillebrand, Tr. 1840-41).

307. Allowing all ENH physicians to have privileges at all three ENH campuses is a very unique quality measure because ENH’s twelve full-time clinical department chairmen are responsible for quality of care regardless of where it is rendered in the ENH system. (Hillebrand, Tr. 1841-42). No other hospital system in Chicago, besides ENH, allows its physicians to automatically have privileges at all campuses in those systems. (Hillebrand, Tr. 1841-42).

308. ENH’s system of allowing all physicians to have privileges at all three ENH campuses is very difficult to achieve because it requires having hundreds, if not thousands, of physicians successfully working together. (Hillebrand, Tr. 1842). ENH’s decision to coordinate its registration, scheduling and charging systems throughout the three ENH hospitals resulted in the three hospitals having a single chargemaster and a single Medicare ID number. (Hillebrand, Tr. 1840; Neaman, Tr. 1346). This practice was consistent with Evanston Hospital’s prior practice in that Evanston and Glenbrook Hospitals had used the same Medicare ID since Glenbrook opened on April 3, 1977. (Neaman, Tr. 1346; Hillebrand, Tr. 1842). From April 1977, through at least February 2005, no MCO complained about ENH using a single Medicare ID for all campuses in the ENH system. (Hillebrand, Tr. 1843).

309. These post-Merger corporate changes required ENH to renegotiate its MCO contracts. (Hillebrand, Tr. 1839; Neaman, Tr. 1345-46). Merger planning documents explained

that the merged entity “[m]ust have same managed care contracts, pricing, technical/professional fees, etc. so patients/physicians can go to any site.” (RX 402 at ENH MN 2049).

310. Moreover, ENH immediately shut down most of the pre-Merger joint ventures operated by Lakeland Health Ventures under the supervision of Mark Newton, former Vice President of Planning and Marketing at HPH. (Newton, Tr. 449). Newton – who left HPH soon after the Merger to work for a competitor hospital, Swedish Covenant Hospital – did not oversee the quality of clinical services at HPH. (Spaeth, Tr. 2282-83; Newton, Tr. 279). Moreover, Newton had no responsibility for clinical quality at HPH, he was not responsible for information technology at HPH, nor was he tasked with overseeing the credentialing or disciplining of physicians. (Spaeth, Tr. 2283, 2285). The joint ventures Newton operated under Lakeland Health Ventures were losing money when the Merger was consummated. (Newton, Tr. 449).

E. Post-Merger Healthcare Foundation Of Highland Park

311. As a result of the Merger, Evanston Hospital and HPH also created the Healthcare Foundation of Highland Park on January 1, 2000. (Styer, Tr. 4951, 4971; Belsky, Tr. 4894; Spaeth, Tr. 2281). Evanston Hospital and the HPH Foundation signed the agreement creating the Healthcare Foundation of Highland Park in December 1999. (RX 2037; Styer, Tr. 4977-78).

312. The Foundation Agreement establishing the Healthcare Foundation of Highland Park describes the Foundation’s mission to support HPH and healthcare in the general Highland Park community. (RX 2037 at HFHP 1356; Styer, Tr. 4951, 4979; Neaman, Tr. 1373). The creation of the Healthcare Foundation of Highland Park was another means of fulfilling HPH’s primary merger goal of benefiting the Highland Park community. (CX 6305 at 16 (Stearns, Dep.); Neaman, Tr. 1373).

313. The Highland Park Healthcare Foundation provides grants to HPH and other healthcare organizations in the community. (Styer, Tr. 4980-81, 4987-88; RX 2037 at HFHP 1362). The Foundation Agreement also gives the Highland Park Healthcare Foundation the power to notify the Illinois Attorney General of “a material breach by ENH of any of its obligations under the Merger Agreement which substantially undermines or adversely affects the Highland Park community” if ENH and the Healthcare Foundation cannot themselves resolve ENH’s alleged breaches within 90 days. (RX 2037 at HFHP 1364; Styer, Tr. 4971, 4985).

314. See Section IX.C.4 for additional findings on the Highland Park Healthcare Foundation.

V. ANALYTIC FRAMEWORK

A. The Court Should Analyze The Price Increases In The Context Of The Relevant Market

1. All Experts Agree That Price Increases Alone Are Not Anticompetitive

315.

(REDACTED)

(Baker, Tr. 4702, *in camera*; Noether, Tr. 5989; Noether, Tr. 6108, 6114, *in camera*). Even Dr. Haas-Wilson, Complaint Counsel's primary economic expert, admitted that price changes, alone, do not demonstrate the existence of market power. (Haas-Wilson, Tr. 2482).

2. All Experts Agree That One Must Rule Out Viable Alternative Explanations Before Concluding That A Price Increase Is The Result Of Anticompetitive Market Power

316. Before concluding that post-Merger price increases were caused by the gain and exercise of market power, viable alternatives for the price increases must be evaluated and eliminated. (Haas-Wilson, Tr. 2677-78; Noether, Tr. 5903-04).

(REDACTED)

camera; Elzinga, Tr. 2404).

(Baker, Tr. 4649-50, *in*

317.

(REDACTED)

(Haas-Wilson, Tr. 2481-88; Baker, Tr. 4650-53, *in camera*; Elzinga, Tr. 2403-04).

3. Market Definition Provides The Necessary Framework In Which To Evaluate These Alternative Explanations

318.

(REDACTED)

(Baker, Tr. 4702, *in camera*). Market definition is necessary to rule out possible alternative explanations to market power, and when there are alternative explanations – either pre- or post- merger – market definition is necessary in the analysis. (Noether, Tr. 5904).

319.

(REDACTED)

(Baker, Tr. 4701-02, *in camera*).

B. The Court Should Evaluate The Competitive Effects Of The Merger

1. The Court Should Evaluate Price Effects Of The Merger

320. The goal of economic analysis of a merger is to “assess or infer whether combining these two firms will raise market prices *and* reduce industry output.” (Elzinga, Tr. 2360, emphasis added). A merger only harms consumers when both prices go up and output goes down. (Elzinga, Tr. 2403).

321.

(REDACTED)

(Noether, Tr. 5987-88; Baker, Tr. 4620-21, *in camera*).

322. For example, ENH’s price increases can be explained by the fact that it learned more about MCOs’ demand for its services. Just before the Merger, Evanston Hospital learned about HPH’s surprisingly more favorable contract rates with a number of MCOs. (Hillebrand, Tr. 1871; Neaman, Tr. 1344-45; RX 2047 at 10-11 (Ogden, Dep.)). At or about this same time, ENH retained Bain, a consulting firm, to learn more effective negotiation strategies and to help ENH obtain a one-time corrective adjustment in its own negotiated prices. (RX 2047 at 10-11 (Ogden, Dep.))

(REDACTED)

(Noether, Tr. 6060, *in camera*; RX 1912 at 73, *in camera*; Baker, Tr. 4669-71, *in camera* (explaining DX 8046)).

323. Moreover, quality improvements need to be considered in evaluating competitive effects because, if quality improves, the buyer gets more for its money. (Baker, Tr. 4604-06). The quality-adjusted price is a way of accounting for the value of quality improvements. (Baker, Tr. 4604-06). If quality improves, the observed or nominal price could rise, but the quality-adjusted price could stay the same or decline. (Baker, Tr. 4604-08). If the quality-adjusted prices stayed the same or declined, consumers would be better off with the Merger – or at least not worse off – than they would have been had the Merger not occurred. (Baker, Tr. 4606).

2. The Court Should Evaluate Quality Effects Of The Merger As A Pro-Competitive Effect

324. Quality has both clinical and non-clinical aspects. (Noether, Tr. 6016). Clinical quality in healthcare is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with the state of current professional knowledge. (Chassin, Tr. 5141). The non-clinical aspects of quality include: service, amenities and patient convenience. (Noether, Tr. 6016). These non-clinical aspects are economically significant because patients value them. (Noether, Tr. 6018).

325. Quality is important in the analysis of competitive effects because it is one of the dimensions in which hospitals compete. (Noether, Tr. 6011). Patients are made better off when

quality is improved, and they certainly use quality to the extent that they can evaluate it as one of the dimensions by which they choose hospitals. (Noether, Tr. 6011). Quality “certainly affects the competitive strength of the institution as well as the benefits to the consumers.” (Noether, Tr. 6039).

326. Quality improvements should be considered in the analysis of competitive effects regardless of whether outpatient services are included in the relevant product market. (Baker, Tr. 4602, 4608). In this case, improvements in both inpatient and outpatient services should be examined in the analysis of the competitive effects of the Merger. (Baker, Tr. 4608-09).

327. All improvements in the quality of *inpatient* services should be counted because they are improvements that are within the product markets of both Drs. Noether and Haas-Wilson. (Baker, Tr. 4608-09). Similarly, improvements in the quality of *outpatient* services also should be counted in the analysis of the competitive effects of the Merger because they are part of the proper relevant market of all acute care hospital-based services, as defined by Dr. Noether. (Baker, Tr. 4609).

328. Improvements in the quality of outpatient services are relevant even under Dr. Haas-Wilson’s more limited relevant product market, which excludes outpatient services. Outpatient quality improvements should be counted in that circumstance because the benefits of those services accrue to the MCOs, which purchase inpatient and outpatient services in the same contract. Moreover, outpatient services are inextricably linked to quality improvements in inpatient services. (Baker, Tr. 4609).

329. Although Dr. Noether relied on Dr. Chassin for an evaluation of clinical quality, she independently analyzed non-clinical quality. (Noether, Tr. 6016). Dr. Noether concluded, “based on the evidence in the record, that quality [including clinical and non-clinical quality] improved substantially at Highland Park Hospital post-merger.” (Noether, Tr. 5901-02). By contrast, Dr. Haas-Wilson did not do an independent empirical analysis of post-Merger quality changes and, instead, relied on the analysis of Dr. Romano alone to conclude that clinical quality did not improve after the Merger. (Haas-Wilson, Tr. 2446-47, 2586; Noether, Tr. 6018-19). Dr. Haas-Wilson did not evaluate the non-clinical aspects of quality. (Noether, Tr. 6019).

3. The Court Should Take Into Account Other Competitive Effects Considerations

a. The Court Should Evaluate Issues Pertaining To Market Entry And Repositioning

330. Repositioning or entry is “the enhancement of competition either through brand new entry – in a hospital case, it would be a new hospital being constructed and opened – or more modestly, repositioning can imply an existing hospital upgrading its capacity, expanding its capacity, adding new services, updating its physical plant, doing things that essentially make it a more attractive facility to managed care organizations and their enrollees and thereby making it more competitive in the marketplace.” (Noether, Tr. 6023).

331. In evaluating the competitive effects of the Merger, the proper economic analysis compares the actual situation post-Merger to the situation that would have existed during the post-Merger time period if the Merger had not occurred. (Noether, Tr. 6024). Consequently, if hospitals that compete with ENH have become more competitive through repositioning, then it is likely that competition would have increased in this way even absent the Merger. (Noether, Tr. 6024).

332. Repositioning is significant because, in this case, there is substantial evidence that a number of hospitals in the Chicago area – and, most particularly, hospitals around Highland Park – have spent, and are spending, substantial resources to upgrade their facilities and to make themselves competitive in the market place. (Noether, Tr. 6023).

b. The Court Should Evaluate The Financial Condition Of HPH Before The Merger

333. The financial condition of HPH before the Merger is important to take into account in evaluating competitive effects because if HPH were in a weakened financial condition before the Merger, this would have limited HPH's ability to have any competitive significance going forward had it remained independent. (Noether, Tr. 6026).

334. To understand HPH's pre-Merger financial condition, one must weigh HPH's future cash needs against its sources of cash. (Noether, Tr. 6028).

c. The Court Should Evaluate ENH's Not-For-Profit Status

335. Not-for-profit hospitals, like ENH, reinvest their revenue into the hospitals. (CX 6304 at 11-12 (Livingston, Dep.)). Revenue earned by a not-for-profit hospital, like ENH, does not leak out of the hospital system in any way at all. (CX 6304 at 11-12 (Livingston, Dep.)).

336. Economic theory does not necessarily predict that a not-for-profit hospital would try to maximize profits. (Simpson, Tr. 1646). In fact there is expert theory by Drs. William Lynk and Lynette Neumann that "found that non-profit hospitals tended not to exploit market power." (Simpson, Tr. 1626).

337. The decision to open a new service not in the hospital where it would be most profitable, but in the hospital that would best benefit the community, is evidence that the hospital system is not acting like a profit-maximizing firm. (Simpson, Tr. 1633). The provision of more charity care that would benefit the community is another example of how a not-for-profit hospital provides benefits to the community that a for-profit hospital might not. (Simpson, Tr. 1633-34).

338. Complaint Counsel's expert on not-for-profit issues did not testify that ENH used surplus funds in a wasteful manner, or tried to build a prestigious facility that the community would not otherwise need. (Simpson, Tr. 1635, 1648, 1650).

C. ENH's Economist Experts Analyzed The Facts Of The Case In The Context Of This Analytic Framework

1. Dr. Monica Noether

339. Dr. Monica Noether is an economist who specializes in the economics of industrial organization. She has focused on healthcare markets for the past eighteen years. (Noether, Tr. 5889).

340. Dr. Noether received her Bachelor's degree from Wesleyan University in 1974. She received her Masters of Business Administration degree with a specialization in finance from the University of Chicago in 1980. And she received her Ph.D. in Economics from the University of Chicago in 1983. (Noether, Tr. 5890). Dr. Noether lived in Chicago during the time she studied for her MBA and Ph.D. (Noether, Tr. 5890).

341. After receiving her graduate degrees, Dr. Noether worked for the FTC from 1983-1987 as a staff economist, a part-time adviser to one of the Commissioners and, eventually, as the Deputy Assistant Director of the Bureau of Economics. (Noether, Tr. 5892).

342. From 1987-1996, Dr. Noether worked at a policy research and consulting firm called ABT Associates, where she eventually served as managing vice president. (Noether, Tr. 5892).

343. In 1996, Dr. Noether joined Charles River Associates. (Noether, Tr. 5892). Dr. Noether is currently a Vice President at Charles River Associates and, since 2001, she has served as the head of Charles River's Competition Practice. (Noether, Tr. 5889, 5892-93).

344. Dr. Noether has published various papers in peer-reviewed journals. (Noether, Tr. 5891).

345. Dr. Noether has worked on a variety of different hospital mergers, both for the merging parties as well as for the Government, as well as a number of health plan merger cases on behalf of the merging parties generally. (Noether, Tr. 5893).

346. Dr. Noether has testified as an expert in three hospital merger cases on behalf of the Federal Government, including: *FTC v. University Health*, *FTC v. Columbia Hospital Corp.*, *U.S. v. Mercy Health and Finley Health Services*. (Noether, Tr. 5893-94).

347. Dr. Noether was invited to testify twice in the recent FTC/DOJ joint hearings on healthcare competition and policy. (Noether, Tr. 5894).

348. Dr. Noether is the vice-chair of the Antitrust Practice Group of the American Health Lawyers Association, she is a member of the American Bar Association where she participates on the Antitrust Committee and the Health Law Committee, and she is a member of the Association for Health Services Research. (Noether, Tr. 5894).

349. Dr. Noether was retained by ENH to conduct an economic analysis of competitive effects, and to review the work of Complaint Counsel's experts retained in this case. (Noether, Tr. 5895).

350. Dr. Noether performed a comprehensive analysis using the economic principles underlying the Merger Guidelines. (Noether, Tr. 5895). In assessing competitive effects, Dr. Noether considered both price and quality. (Noether, Tr. 5895).

351. Dr. Noether used testimony, documents and data analysis as the basis for her conclusions about the competitive effects of the Merger. (Noether, Tr. 5895-96). Dr. Noether reviewed Investigational Hearing transcripts, deposition transcripts and trial testimony. (Noether, Tr. 5897). The documents that Dr. Noether considered included, among other things: strategic plans, documents prepared by consultants, financial statements of HPH and managed care contracts. (Noether, Tr. 5896).

352. The data used in Dr. Noether's analysis included: (1) claims data provided by some of the relevant MCOs; (2) hospital discharge data provided by the Illinois Hospital Association; and (3) data contained in the Medicare Cost Reports. (Noether, Tr. 5896-97).

2. Professor Jonathan Baker

353. Professor Jonathan Baker is an economist specializing in applied industrial organization. He is employed as a Professor of Law at the Washington College of Law at American University, and is also a Senior Consultant at Charles River Associates, an economics consulting firm. (Baker, Tr. 4588; RX 2036 at 1).

354. Professor Baker worked at the Antitrust Division of the United States Department of Justice from 1990 through 1993, in the Economic Analysis Group, as the Director of Litigation Studies and Special Assistant to the Deputy Assistant Attorney General for Economics, the chief economist at the Antitrust Division. (Baker, Tr. 4592; RX 2036 at 1).

355. While working at the Antitrust Division of the Justice Department, Professor Baker advised the Deputy Assistant Attorney General for Economics on all major merger and non-merger cases that the Antitrust Division was investigating. (Baker, Tr. 4593-94). Professor Baker also helped write the first draft of the 1992 Merger Guidelines. (Baker, Tr. 4593).

356. After leaving the Antitrust Division, Professor Baker was the senior economist for regulation, industrial organization and law at the Council of Economic Advisors in the Executive Office of the President, an organization within the White House that provides dispassionate academic economic advice to the President. He served in that position from June 1993 through April 1995. (Baker, Tr. 4593; RX 2036 at 1).

357. Professor Baker then worked for the FTC, where he was the Director of the Bureau of Economics from April 1995 through December 1998. (Baker, Tr. 4594; RX 2036 at 1).

358. While Bureau Director, Professor Baker advised the Commission on every antitrust and consumer protection matter that the Commission considered, supervised a staff of

around 60 Ph.D. economists, and was a member of the task force of senior FTC and Justice Department officials who drafted the revisions to the efficiency section of the Merger Guidelines. (Baker, Tr. 4594-95). Professor Baker received an award for distinguished service from the FTC in October 1998. (Baker, Tr. 4595; RX 2036 at 1).

359. In 2002, Professor Baker was invited by former FTC Chairman Timothy Muris to be an unpaid consultant to the FTC on merger policy. (Baker, Tr. 4595).

360. Professor Baker worked on hospital merger cases while at the Justice Department and the FTC, has participated in an FTC/DOJ workshop on merger policy and testified in FTC/DOJ hearings on healthcare policy. (Baker, Tr. 4595-96).

361. Professor Baker was the chair of the Antitrust and Economic Regulation Section of the Association of American Law Schools, an organization of law professors. (Baker, Tr. 4596; RX 2036 at 1). Professor Baker currently is a member of the Council of the Section of Antitrust Law of the American Bar Association, and was the editorial chair of Antitrust Law Journal, which is the publication of the American Bar Association's Section of Antitrust Law that publishes legal and economic articles regarding antitrust issues. (Baker, Tr. 4596-97; RX 2036 at 9).

362. Professor Baker has authored several articles involving the application of econometric methods to the measurement of market power, including: "Empirical Methods in Antitrust Litigation: Review and Critique," "Contemporary Empirical Merger Analysis," "Econometric Analysis in FTC Versus Staples," and "Empirical Methods of Identifying and Measuring Market Power." (Baker, Tr. 4597-98; RX 2036 at 2-9).

363. Professor Baker provided trial and deposition testimony on behalf of the merging firms in the case of *FTC v. H.J. Heinz & Co.*, and gave deposition testimony on behalf of the Government in the case of *United States v. Northwest Airlines, Inc.* (Baker, Tr. 4598; RX 2036 at 10).

364. Professor Baker worked on more limited aspects of this case than Dr. Noether. (Baker, Tr. 4600-01). He was retained by ENH to conduct an analysis of the magnitude of the price changes that followed the Merger. In particular, he was asked to determine whether there was a benign explanation for the price change – *i.e.*, whether learning about demand could explain the price change. (Baker, Tr. 4601). Professor Baker also examined the role of quality improvements in the analysis of competitive effects. (Baker, Tr. 4601). Finally, Professor Baker was asked to review the methodology used by Complaint Counsel's experts retained in this case. (Baker, Tr. 4601).

365. Professor Baker analyzed claims data provided by four MCOs; reviewed trial, deposition and investigational transcripts; toured the three ENH hospitals; and interviewed some of ENH's executives. (Baker, Tr. 4601). He also examined all of the expert reports provided by both ENH and Complaint Counsel. (Baker, Tr. 4601). Finally, Professor Baker relied on work performed by Dr. Noether. (Baker, Tr. 4600-01).

VI. RELEVANT MARKET

A. The Relevant Product Market Consists Of All Acute Care Hospital-Based Services

366. To identify the relevant product market, “the [M]erger [G]uidelines instruct that one should look at the product actually being sold to relevant customers.” (Noether, Tr. 5905).

1. The Product At Issue Being Sold Includes All Acute Care Hospital-Based Services

367. The product at issue is acute care hospital-based services. The term “acute care services” refers to services of a “relatively short-term nature” provided “to patients with an acute need” and is “distinguished from more long-term services, such as rehab or sometimes psychiatric care that are applied to more chronically ill patients.” (Noether, Tr. 5905).

368. Hospital services are a differentiated product. (Noether, Tr. 5910; Haas-Wilson, Tr. 2492). Hospital services are differentiated on both product and geographic dimensions. (Noether, Tr. 5911).

2. The Relevant Customers, *i.e.*, MCOs, Purchase All Acute Care Hospital-Based Services Together

a. MCOs Purchase Inpatient And Outpatient Services Together

369. (REDACTED)
(Spaeth, Tr. 2299-2300; Ballengee, Tr. 144-45, 200; Mendonsa, Tr. 556, *in camera*; Hillebrand, Tr. 1862; Foucre, Tr. 1122-23, *in camera*; Holt-Darcy, Tr. 1585, *in camera*).

370. (REDACTED)
(Foucre, Tr. 1122, *in camera*). In addition, Ballengee testified that when entering into a contract with a hospital, she contracts “for the entire set of services at a hospital.” (Ballengee, Tr. 200).

371. (REDACTED)
(Neary, Tr. 590-91; Holt-Darcy, Tr. 1587, *in camera*; Mendonsa, Tr. 557, *in camera*).
(REDACTED) (Neary, Tr. 590-91; Holt-Darcy, Tr. 1586, *in camera*).

372. Moreover, inpatient and outpatient services are intertwined. (Neaman, Tr. 1295). Depending on the patient, some procedures may be done on either an inpatient or an outpatient basis, one example being a laparoscopy. (Neary, Tr. 592-93).

373. Dr. Noether found that in this case, Evanston Hospital and HPH both provided a range of acute care services (inpatient and outpatient services) that they sold as a package to MCOs. (Noether, Tr. 5906).

374. (REDACTED) (Haas-Wilson, Tr. 2891, *in camera*).

375. (REDACTED) (Neaman, Tr. 1295-96; *see also* Foucre, Tr. 1123, *in camera*).

b. MCOs Purchase Primary, Secondary And Tertiary Services Together

376. (REDACTED) (Ballengee, Tr. 200; Mendonsa, Tr. 557, *in camera*; Holt-Darcy, Tr. 1585, *in camera*). MCOs thus essentially purchase all of the services of a particular hospital in one contract when they negotiate prices with that hospital. (Noether, Tr. 5906-08, 5927).

3. Dr. Noether Has Correctly Defined The Relevant Product Market

377. The relevant product market, as defined by Dr. Noether, appropriately includes all acute care hospital-based services sold to MCOs. (Noether, Tr. 5901, 5904). Dr. Noether's product market is consistent with the Complaint, which identified the relevant customer in this case as the MCOs. (Compl. ¶ 16; Noether, Tr. 5906). Moreover, Dr. Noether followed the economic principles underlying the Merger Guidelines in defining her relevant product market. (Noether, Tr. 5905).

378. This relevant product market includes both inpatient and outpatient services. (Noether, Tr. 5904). This market definition, however, does not assume that inpatient and outpatient services are substitutes for each other, just that they are bought together by MCOs. (Noether, Tr. 5908). Individual services, for example, would not be substitutes for each other either. Even Dr. Haas-Wilson lumps all the individual inpatient services together in her market. (Noether, Tr. 5909).

379. Some services in Dr. Noether's product market are provided by providers that are not hospitals. (Noether, Tr. 5923). By defining the product market to include only hospital-based services, Dr. Noether thus does not include as market participants providers that perform some of these services outside the hospital setting (such as outpatient surgery centers). (Noether, Tr. 5923).

380. Dr. Noether also excludes from her product market specialty hospitals that do not provide the full range of services, such as Children's Memorial Hospital. (Noether, Tr. 5924).

4. Dr. Haas-Wilson Has Not Correctly Defined The Relevant Product Market

381. Dr. Haas-Wilson defined the relevant product market as “general acute care *inpatient* hospital services.” (Haas-Wilson, Tr. 2489) (emphasis added). Unlike Dr. Noether, Dr. Haas-Wilson did not follow the Merger Guidelines methodology in defining this relevant product market. (Noether, Tr. 6216).

382. Although Dr. Haas-Wilson includes tertiary services in her relevant product market, she excludes outpatient services. (Haas-Wilson, Tr. 2489-90, 2660). Dr. Haas-Wilson’s decision to exclude outpatient services from the relevant product market makes no economic sense given that the customers at issue are the MCOs, which, as discussed above, purchase both inpatient and outpatient services in the same contract. (Noether, Tr. 5909-10).

B. The Relevant Geographic Market Consists Of Multiple Competitor Hospitals In The Chicago Area

1. The Court Should Consider Patient Preferences And Physician Admitting Patterns When Evaluating The Relevant Geographic Market

383. An appropriate starting point in analyzing the relevant geographic market is to identify the closest competitors of Evanston Hospital and HPH, respectively, from a geographic perspective. (Noether, Tr. 5928). Dr. Noether applied the methodology underlying the Merger Guidelines in defining her minimum geographic market by taking each of the merging hospitals and identifying its closest competitors to build up the markets, an iterative kind of approach. (Noether, Tr. 5958).

384.

(REDACTED)

(Haas-Wilson, Tr. 2902, *in camera*). In fact, it would have been impossible for Dr. Haas-Wilson to define the geographic market as containing only the merged hospitals if she had employed the iterative approach of identifying closest competitors because all of the evidence discussed in the following subsections suggest that Evanston Hospital and HPH were not closest competitors in geographic space. (Noether, Tr. 5959).

a. Patient Preferences Are Relevant To The Geographic Market Analysis

385. **(REDACTED)** (Haas-Wilson, Tr. 2803, *in camera*). This view is supported by the testimony of Foucre (United), Mendonsa (Aetna) and Holt-Darcy (Unicare), all of whom testified that MCOs consider patient preferences. (Noether, Tr. 5937; Foucre, Tr. 885; Mendonsa, Tr. 485; Holt-Darcy, Tr. 1420). Similarly, Ballengee (PHCS) testified that geography and price play roles in what patients

demand from their health care network; in general, patients want to know that they are receiving cost-effective healthcare as well as access to quality health care. (Ballengee, Tr. 152-53).

386. Even though insurance companies may be the purchasers in the first instance of hospital services, they construct hospital networks to create plans that are attractive to their customers, the employers. (Elzinga, Tr. 2407). The employers, in turn, are driven to provide a plan that is attractive to their employees, subject to the constraints of cost, because employees may consider health care benefits in deciding where to accept employment. (Elzinga, Tr. 2407). Therefore, MCOs must take patient preferences into consideration in constructing their hospital networks. (Elzinga, Tr. 2407-08).

i. Geographic Proximity Is Relevant To Patient Preferences

387. Travel distances for employees is a critical component for employers that are evaluating health care benefit plans. (Foucre, Tr. 885). Patients generally want access to a hospital within 30 miles of where they live or work. (Holt-Darcy, Tr. 1420).

(REDACTED) (RX 1912 at 20, *in camera*).

388. (REDACTED)
(RX 1912 at 20, *in camera*). The travel time between the two locations is approximately 25 to 30 minutes. (Spaeth, Tr. 2157). (REDACTED) (RX 1912 at 21, *in camera*).

389. (REDACTED)

(a) (REDACTED)
(Neaman, Tr. 1303; Ballengee, Tr. 212; Ballengee, Tr. 263, *in camera*; RX 1912 at 20-21, *in camera*).

(b) (REDACTED)
(Neaman, Tr. 1302-03; RX 1912 at 20-21, *in camera*; Mendonsa, Tr. 562, *in camera*).

(c) (REDACTED)
(Neaman, Tr. 1297; RX 1912 at 20-21, *in camera*; see also Mendonsa, Tr. 556, *in camera*).
(REDACTED)
(Neaman, Tr. 1301; RX 1912 at 21, *in camera*).

(d) (REDACTED)
(Neaman, Tr. 1303-04; Ballengee, Tr. 263, *in camera*; RX 1912 at 20-21, *in camera*).

(e) (REDACTED)
(Neaman, Tr. 1298; RX 1912 at 20-21, *in camera*).

(f) (REDACTED)
(Neaman, Tr. 1305; RX 1912 at 20-21, *in camera*).

(g) (REDACTED)
(RX 1912 at 20-21, *in camera*)

(h) (REDACTED)
(RX 1912 at 20-21, *in camera*).

(i) (REDACTED)
(RX 1912 at 20-21, *in camera*).

390. (REDACTED) :

(a) (REDACTED) (Neaman, Tr. 1304; Spaeth, Tr. 2240; Mendonsa, Tr. 555, *in camera*).

(REDACTED) (RX 1310 at FTC-LFH 669; RX 1912 at 20-21, *in camera*).

(b) (REDACTED)
(Neaman, Tr. 1304-05; Hillebrand, Tr. 2006; Spaeth, Tr. 2240; Mendonsa, Tr. 555, *in camera*; RX 1912 at 20-21, *in camera*).

(REDACTED)
(RX 1912 at 20-21, *in camera*; Hillebrand, Tr. 2006).

(c) (REDACTED)
(RX 1912 at 20-21, *in camera*).

ii. Travel Patterns Are Relevant To Patient Preferences

391. MCOs also consider patient travel patterns because they recognize that they need to put together provider networks that are going to be attractive to employers. And employers, in turn, are concerned about where their employees want to seek hospital care. (Noether, Tr. 5936-37, 5948). Consequently, to the extent that patients value convenience, there is a derived demand by the MCOs for hospitals that are convenient to their enrollees. (Noether, Tr. 5937).

392. To identify the closest geographic competitors, Dr. Noether started with the location of each merging hospital, and looked to see which hospitals were geographically closest to each of the merging hospitals. (Noether, Tr. 5931). To identify “geographically close” hospitals Dr. Noether looked at the driving times between hospitals, discussed above. (Noether, Tr. 5933). Driving times are a better measure of geographic proximity than driving distances because distances do not account for variations in road and/or traffic patterns that can affect patient preferences. (Noether, Tr. 5933).

393.

(REDACTED)

(Noether, Tr. 5934-35; RX 1912 at 21, *in camera*). Even Northwestern Memorial (26 minutes), located in downtown Chicago, is about the same distance from Evanston Hospital as HPH. (Noether, Tr. 5935).

394.

(REDACTED)

(Noether, Tr. 5935, RX 1912 at 21, *in camera*).

395. To evaluate patient travel patterns, Dr. Noether considered, for all of the merging hospitals and other relevant hospitals, where they drew 80% of their patients. (Noether, Tr. 5938). This analysis showed that Evanston Hospital was drawing 80% of its patients from a reasonably broad area that extended north, included a variety of hospitals, and covered thirty-two zip codes. (Noether, Tr. 5939). Pre-Merger HPH was drawing 80% of its patients from a somewhat smaller area than Evanston Hospital, pulling more from the north than from the south and only covering twenty zip codes. (Noether, Tr. 5941-42). Evanston and Glenbrook Hospitals did not fall within HPH’s pre-Merger 80% service area. (Noether, Tr. 5942).

396. Dr. Noether also considered the overlap of zip codes between Evanston Hospital and HPH’s pre-Merger 80% service areas with the 80% service areas of other hospitals. (Noether, Tr. 5943).

397.

(REDACTED)

(Noether, Tr. 5943-44; RX 1912 at 54, *in camera*).

To the extent patient travel patterns are indicative of patient preferences, this suggests that are several hospitals that are closer substitutes to Evanston Hospital than HPH. (Noether, 5944-45 (*explaining* DX 8120)).

398.

(REDACTED)

(Noether, Tr. 5945; RX 1912 at 54, *in camera*). Advocate Lutheran General had the most overlap with HPH's 80% service area with thirteen out of nineteen zip codes. (Noether, Tr. 5945). Lake Forest Hospital had overlaps in ten out of nineteen zip codes. (Noether, Tr. 5945 (*explaining DX 8119*)).

399. Dr. Noether further looked at the 80% service area for Northwestern Memorial's obstetric services. (Noether, Tr. 5947 (*describing DX 8121*)). This examination revealed that Northwestern Memorial is drawing from a very large geographic area for its obstetrical services. (Noether, Tr. 5947).

400. Hospitals frequently consider patient travel patterns in evaluating competition. (RX 518 at ENH GW 2055-57, 2059; RX 2021 at 3; RX 135 at 4; RX 1361 at 1; RX 1564. According to a Lake Forest Hospital customer survey report, dated November 8, 2001, consumers are willing to travel, on average, up to 16 minutes for emergency care, 28 minutes to a primary care physician for routine care, 31 minutes for outpatient services, and 35 minutes to a hospital for an overnight stay. (RX 1179 at LFH 845).

(REDACTED)

(RX 1912 at 21, *in camera*.)

401. One quarter of consumers in Lake County have left the county for medical services, and 28% of Lake County consumers travel to Chicago. (RX 1179 at LFH 895). Lake Forest Hospital used this information to "provide[] some parameters for determining the potential geographic draw of [Lake Forest] and its medical staff, and for identifying the optimal distance for placing services in outlying areas." (RX 1179 at LFH 845). Lake Forest Hospital recognizes that Northwestern Memorial is one of its competitors because "[p]art of the community goes downtown every day so it is natural for them to use Northwestern." (RX 306 at FTC-LFH 68).

402. Similarly, Condell found that around 31% of Lake County residents left Lake County for hospital services in 2001. (RX 1352 at CMC 20371). Condell runs ads in ENH's area emphasizing Condell's marketing strategy of encouraging patients to use that hospital instead of the downtown hospitals. (Hillebrand, Tr. 2004).

403. ENH, Rush North Shore and Advocate Lutheran General have similar marketing material aimed at patients who use, or are inclined to use, the downtown hospitals by emphasizing that patients can receive quality healthcare in their suburban neighborhoods. (Hillebrand, Tr. 2004).

404. Rush Presbyterian, the University of Chicago, Loyola and the University of Illinois at Chicago – all downtown Chicago hospitals – are within driving range of patients who live in ENH's general service area in northern Illinois. (Neaman, Tr. 1301). This is especially true given that wealthier, more affluent patients (such as those who live in the Chicago North Shore) generally are more willing to travel to receive health care treatment because, among other reasons, they may have the income to supplement what might not be paid for under their health insurance program. (Elzinga, Tr. 2408).

405. An evaluation of patient travel patterns in this context is not an Elzinga-Hogarty analysis “in disguise.” (Noether, Tr. 5947-48). Instead, Dr. Noether was simply using patient travel patterns as one piece of evidence, among other pieces, in considering the likely dimensions of geographic competition. (Noether, Tr. 5948).

b. Physician Admitting Patterns Are Relevant To The Geographic Market Analysis

406. Dr. Noether also considered physician admitting patterns in evaluating geographic competition. (Noether, Tr. 5949). Physician admitting practices are significant “because the physician is the one who is often the most responsible for choosing where a particular patient is going to be admitted to a hospital.” (Noether, Tr. 5949).

407. Lake Forest Hospital conducted a survey of customers in Lake Forest Hospital’s service area in 2001, and found that the customers’ primary care physicians (“PCP”) admitted patients to such hospitals as Lake Forest Hospital, Condell, HPH, Evanston Hospital, Northwest Community and Advocate Lutheran General. (RX 1179 at LFH 857). The survey also found that the most utilized hospitals were Lake Forest Hospital, Condell, HPH, Victory Memorial, Provena St. Therese, Evanston Hospital, Advocate Lutheran General, Good Shepherd, Northwestern Memorial, Glenbrook Hospital and Rush Presbyterian. (RX 1179 at LFH 891).

408. Dr. Noether relied on an internal HPH analysis done in 1999 showing a substantial overlap of admitting physicians between HPH and Lake Forest Hospital. (Noether, Tr. 5950; RX 653). This analysis also reflected that when the Merger was announced there were a number of physicians who had been admitting primarily to HPH and who shifted “a lot” of their patients to Lake Forest Hospital. (Noether, Tr. 5950; RX 653). This analysis suggested that Lake Forest Hospital, not Evanston Hospital, was, in terms of physician admitting patterns, the closest competitor to HPH. (Noether, Tr. 5950).

2. The Court Should Consider The Fact That There Are Multiple Hospitals In The Chicago Area When Evaluating The Relevant Geographic Market

409. A number of hospitals compete for patients within ENH’s core service area. (RX 518 at ENH GW 2057).

410. By way of example, in 1998, over 15,000 patients were admitted to hospitals other than Evanston Hospital or HPH from the combined core service areas. (RX 518 at ENH GW 2059). Rush North Shore attracted 30% of the outmigration from ENH’s core service area. (RX 518 at 18). Advocate Lutheran General represented 16% of the outmigration. (RX 518 at ENH GW 2059). 16% of the outmigration went to the downtown academic hospitals, a trend of increasing “leakage” to the downtown academic hospitals from ENH’s core service area. (RX 518 at ENH GW 2058-59). 15% of the outmigration chose St. Francis Hospital of Evanston. (RX 518 at ENH GW 2059). 6% of the outmigration was to Lake Forest Hospital. (RX 518 at ENH GW 2059). 17% percent of the outmigration selected other hospitals. (RX 518 at ENH GW 2059).

a. Advocate Lutheran General

411.

(REDACTED)

(Neaman, Tr. 1296-97; *see also* Ballengee, Tr. 225, *in camera*; RX 1503 at PHCS 3667, *in camera*; RX 1912 at 60; Mendonsa, Tr. 558, *in camera*).

(REDACTED)

(RX 1053 at AHHC 363, *in camera*; RX 1095 at AHHC 374, *in camera*; RX 1141 at AHHC 385, *in camera*; Mendonsa, Tr. 558, *in camera*).

412. Advocate Lutheran General provides all basic services, cardiac surgery and most everything in between. (Neaman, Tr. 1297). Advocate Lutheran General also has a teaching component with University of Illinois at Chicago Health Services Center. (Neaman, Tr. 1297).

413. Advocate Lutheran General provided 379 diagnosis-related groups (“DRGs”) in 1999. (RX 1912 at 60). DRGs are a system that can be used to categorize inpatients into what are thought to be relatively homogenous groups based on the resources that are used to treat patients on average. (Noether, Tr. 5912)

414.

(REDACTED)

(Haas-Wilson, Tr. 2706, *in camera*).

415. In 1999, Advocate Lutheran General had .36 residents per bed. (RX 1912 at 60).

416. Before the Merger, patients who went to HPH’s or Lake Forest Hospital’s emergency room with a heart attack were referred to Advocate Lutheran General for more advanced care. (Spaeth, Tr. 2241-42).

b. Condell

417.

(REDACTED)

(Neaman, Tr. 1326; Hillebrand, Tr. 2006; Mendonsa, Tr. 562, *in camera*; RX 1912 at 60).

(REDACTED)

(RX 1220 at CIG/IL 120108, *in camera*).

418. As of February 2005, Condell provided a full array of services, including everything from general obstetrics to cardiac surgery. (Neaman, Tr. 1305). Condell is not, however, an academic hospital as in 1999 it had no residents per bed. (RX 1912 at 60).

419. In 1999, Condell provided 292 DRGs. (RX 1912 at 60).

420.

(REDACTED)

RX 1521 at CMC 19875, *in camera*).

421. Condell has a cardiac surgery program that does more open heart procedures per year than HPH. (Hillebrand, Tr. 2005).

422. Condell did a market share study of Lake County residents in 2002 and found that “Evanston & Highland Park show[ed] a drop [in market share] from 14.4% to 13% over the 6 quarters reviewed. In absolute terms, their discharges fell by 249 cases.” (RX 1352 at CMC 20374).

c. Lake Forest Hospital

423.

(REDACTED)

(Hillebrand, Tr. 2005; Holt-Darcy, Tr. 1595, *in camera*; RX 1912 at 60).

424. Lake Forest Hospital is a “very good general hospital” and “nice facility” with a particular strength in obstetrics. (Neaman, Tr. 1304). Lake Forest Hospital does not provide any tertiary care. (Neaman, Tr. 1304).

425. In 1999, Lake Forest Hospital provided 213 DRGs. (RX 1912 at 60).

426. Lake Forest Hospital is not an academic hospital, as in 1999 it had no residents per bed. (RX 1912 at 60).

427. In 2003, Lake Forest Hospital found that there was “an increasingly competitive landscape as Condell Medical Center complete[d] their \$100 million facility replacement, Evanston Northwestern Healthcare invest[ed] \$70 million in the Highland Park facility and Vista Healthcare plan[ed] to close St. Therese and build a new hospital in Lindenhurst.” (RX 1206 at FTC-LFH 2171).

d. Loyola

428. Loyola is a 474-bed tertiary care and academic hospital. (Neaman, Tr. 1300; RX 1912 at 60). Like ENH, Loyola has a faculty practice group. (Neaman, Tr. 1288).

429. Loyola had 405 DRGs in 1999. (RX 1912 at 60).

430. In 1999, Loyola had .60 residents per bed. (RX 1912 at 60).

e. Northwestern Memorial

431. Northwestern Memorial is a tertiary and academic hospital that has more than 700 beds. It provides a full range of inpatient and outpatient services, from general obstetrics to cardiac surgery. (Neaman, Tr. 1298). Northwestern Memorial is affiliated with the

Northwestern Medical School and, in 1999, had .56 residents per bed. (Neaman, Tr. 1299; RX 1912 at 60).

432. In 1999, Northwestern Memorial provided 381 DRGs. (RX 1912 at 60).

433. Northwestern Memorial recognized that, in the Chicago market, there is a “demand for more capacity.” (RX 1296 at NMH 2507). In response to this demand, Northwestern Memorial has invested in growth strategies, including investing in the recruitment of primary care physicians, new technology and equipment, facilities expansion, land holdings and community outreach programs. (RX 1296 at NMH 2508).

434. Northwestern Memorial is the number one provider of obstetrical services in Illinois. (Neaman, Tr. 1298). It has the premier obstetrics brand in Chicago because of its Prentice Women’s Hospital and possesses the largest volume of delivering mothers in the Chicago area, including a large volume of those mothers from ENH’s area. (Hillebrand, Tr. 2003-04). Northwestern Memorial is increasing its obstetrics capabilities, having received approval from the Illinois Health Facilities Planning Board to construct a \$350 million women’s hospital. (Hillebrand, Tr. 2004; D. Jones, Tr. 1681).

f. Rush North Shore And Rush Presbyterian

435. Rush North Shore has 150-200 beds and as of February 2005 it was affiliated with Rush Presbyterian, a major tertiary and academic hospital. The Rush Presbyterian affiliation clearly improved the breadth, quality and the perception of services offered at Rush North Shore. (Neaman, Tr. 1302).

436. In 1999, Rush North Shore provided 245 DRGs. (RX 1912 at 60).

437. In 1999, Rush North Shore had .12 residents per bed. (RX 1912 at 60).

438. Rush Presbyterian has 500-600 beds. (RX 1912 at 60). Like other major academic hospitals, Rush Presbyterian offers everything from general obstetrics through cardiac surgery and performs some transplants as well. (Neaman, Tr. 1299).

439. In 1999, Rush Presbyterian provided 370 DRGs. (RX 1912 at 60).

440. In 1999, Rush Presbyterian had .76 residents per bed. (RX 1912 at 60).

441. Before the Merger, Rush North Shore demonstrated consistent growth in the combined core service areas of HPH and Evanston Hospital. (RX 518 at ENH GW 2058). From 1995 through 1998, Rush North Shore gained 6% market share. (RX 518 at ENH GW 2058).

g. St. Francis

442. St. Francis is a “very good hospital,” with 300-400 beds. As of February 2005, St. Francis was part of the Resurrection System. (Neaman, Tr. 1303). St. Francis’ services range from cardiology and obstetrics all the way to general surgery. (RX 1854 at ENHE F16 426).

443. In 1999, St. Francis provided 312 DRGs. (RX 1912 at 60).

444. St. Francis had .36 residents per bed in 1999. (RX 1912 at 60).

445. The Resurrection system, which owns St. Francis, considers several of Evanston Hospital’s zip codes as a part of St. Francis’ service area. (RX 135 at 12976). As of 1995, Resurrection considered Evanston Hospital the “market leader” in St. Francis’ service area, with an 11.6% share. (RX 135 at 12930).

h. Swedish Covenant

446. As of February 2005, Swedish Covenant had 324 beds. (Newton, Tr. 472). Also as of February 2005, Swedish Covenant had approximately 18 family medicine physicians, 6 critical care physicians, 8 transitional students and a series of other residents. (Newton, Tr. 472).

447. In 1999, Swedish Covenant provided 274 DRGs. (RX 1912 at 60).

448. In 1999, Swedish Covenant had .13 residents per bed. (RX 1912 at 60).

i. University Of Chicago

449. The University of Chicago hospital, a major tertiary and academic hospital, has about 400 beds. (Neaman, Tr. 1299).

450. The University of Chicago provides everything from basic obstetrics to major surgical procedures. The University of Chicago hospital is affiliated with the medical school at the University of Chicago. (Neaman, Tr. 1299-1300).

451. In 1999, the University of Chicago had .79 residents per bed. (RX 1912 at 60).

452. In 1999, the University of Chicago provided 394 DRGs. (RX 1912 at 60).

j. University Of Illinois At Chicago

453. The University of Illinois at Chicago is a tertiary care and academic hospital located in downtown Chicago. (Neaman, Tr. 1300).

3. **The Relevant Geographic Market Broadly Encompasses A Large Number Of Competitor Hospitals In The Chicago Area**

a. **MCO Testimony And Documents Confirm A Broad Geographic Market**

454. The Court heard testimony from five MCOs: United, PHCS, Aetna, Unicare and Great West. All of the private MCO representatives agreed that ENH competes with a broad number of hospitals, including, among others, the hospitals discussed above.

455. The Aetna representative agreed that there are a large number of competing hospitals in the North Shore region of Chicago, including, among others: Rush North Shore, Advocate Lutheran General, St. Francis, Evanston Hospital, Glenbrook Hospital, HPH, Lake Forest Hospital, and Condell. (Mendonsa, Tr. 484).

(REDACTED)

(Mendonsa, Tr. 561-62, *in camera*).

456. According to the United representative,
(REDACTED) (Foucre,
Tr. 1114-15, *in camera*; RX 1208 at UHCENH 3380, *in camera*).

(REDACTED)

(Foucre, Tr. 1115 *in camera*; RX
1208 at UHCENH 3380, *in camera*).

(REDACTED)

(RX 1208 at UHCENH 3380, *in camera*).

457. When PHCS notified its customers about the Merger, PHCS specifically recognized alternatives to ENH in the “same geographical area,” including: “St. Francis Hospital (Evanston, IL), Lake Forest Hospital (Lake Forest, IL), Advocate Lutheran General Hospital (Park Ridge, IL), Rush North Shore Medical Center (Skokie, IL), and Holy Family Medical Center (Des Plaines, IL).” (RX 712 at PHCS 891; Ballengee, Tr. 213-14).

(REDACTED)

(RX 773 at ENH JL 12534, *in camera*).

458. Great West also provided its subscribers with a list of hospitals in its network that were alternatives for the ENH hospitals. (Dorsey, Tr. 1478-79). This list included Lake Forest Hospital, St. Therese and Victory Memorial as alternatives for HPH, and St. Francis and Advocate Lutheran General as alternatives for Evanston Hospital. (Dorsey, Tr. 1479-80). Great West also considered Northwestern Memorial and Condell as alternatives to the ENH hospitals. (Neary, Tr. 631).

459. According to the Unicare representative,

(REDACTED) (Holt-Darcy, Tr. 1596-97, *in camera*). (REDACTED)
(Holt-Darcy, Tr. 1596, *in camera*).
(REDACTED)
(Holt-Darcy, Tr. 1596-98, *in camera*).

460. The Unicare representative testified that Unicare ensures that its “members have access to the hospital within 30 miles of where they live or where they work so that [its plans] have sufficient access.” (Holt-Darcy, Tr. 1420.)

461. In defining the geographic market, Dr. Noether considered this MCO testimony identifying competitors of both HPH and Evanston Hospital. (Noether, Tr. 5951, 6049, *in camera*).

b. Third Party Hospital Documents Confirm A Broad Geographic Market

462. Documents produced from certain of the hospitals discussed above confirm that these hospitals competed with, and were alternative hospitals to, the ENH hospitals.

463. St. Francis viewed Evanston Hospital as its strongest competitor to the north. (RX 531 at 13818).

464.

(REDACTED)
(RX 1205 at FTC-RNSMC 387, *in camera*).
(REDACTED)
(RX 1564 at ENH-RNSMC 1200, 1207, *in camera*).

(REDACTED)
(RX 1564 at ENH-RNSMC 1208, *in camera*).

465. In 2002, Rush North Shore viewed its competitors as Advocate Lutheran General, Evanston Hospital, St. Francis and Swedish Covenant. (Noether, Tr. 5955-56; RX 1314 at A 5896).

466. Condell viewed hospitals such as Evanston Hospital, HPH, Lake Forest Hospital and Advocate Lutheran General as competitors in its primary service area. (RX 997 at CMC 132; RX 1338 at CMC 20375).

467. Indeed, Condell’s market share has grown significantly over the last two decades. For example, from 1985 to 2002, Condell’s market share in Lake County more than doubled from 13.3% to 28.2%. (RX 1329 at CMC 19866; RX 1398 at CMC 19869; RX 1764 at CMC 19920). During the same period, HPH’s Lake County market share actually dropped from

16.5% to 11.8%. (RX 1329 at CMC 19866; RX 1398 at CMC 19869). By late 2002, Condell had become the cardiac surgery leader in Lake County, capturing a 36% share of the Lake County market. (RX 1398 at CMC 19868).

468. Provena Saint Therese Medical Center viewed its major competitors as Condell, Lake Forest Hospital, Victory Memorial Hospital, and HPH. (RX 397 at VIS 71865-66; Noether, Tr. 5956-57).

469. Lake Forest Hospital recognized HPH, Condell, St. Therese, and Victory as other acute care hospitals that operate in its service area. (RX 1310 at FTC-LFH 669). Internal Lake Forest Hospital documents further show that, in the 1990s, HPH was one of Lake Forest Hospital's major competitors for inpatient admissions in Lake County. (RX 394 at FTC-LFH 374-75). Indeed, by late 1997, Lake Forest Hospital had identified HPH as its "number two key competitor." (RX 306 at FTC-LFH 67-68).

470. By late 1997, Lake Forest Hospital also recognized that it competed with Evanston Hospital. (RX 306 at FTC-LFH 67). A market survey that Lake Forest Hospital conducted in late 1997 showed that Evanston Hospital was perceived to be one of Lake Forest Hospital's secondary competitors along with Northwestern Memorial, Victory Memorial and St. Therese hospitals. (RX 306 at FTC-LFH 68). Lake Forest Hospital's 1997 market survey further revealed that Evanston Hospital was "taking some of the outflow from [Lake Forest's] traditional market." (RX 306 at FTC-LFH 68).

471. In 1998, Lake Forest Hospital identified its "key competitors" as Condell and HPH. (Noether, Tr. 5954; RX 306 at FTC-LFH 68).

472. In 1999, Lake Forest Hospital identified its strong competitors as Evanston Hospital, Condell, Victory, the Rush System for Health, the Northwestern Healthcare Network, which it acknowledged was dissolving, the Advocate System and several hospitals in Wisconsin. (Noether, Tr. 5953; RX 703 at FTC-LFH 306-07). In the same document, Lake Forest Hospital acknowledged the impending merger of HPH and Evanston Hospital and expressed the view that the Merger could make HPH a more formidable competitor "depending on how Evanston chooses to manage Highland Park." (Noether, Tr. 5953; RX 703 at FTC-LFH 306).

473.

(REDACTED)

(RX 1292 at SCH 4592, *in camera*; RX 1354 at SCH 4663, 4713, 4721, *in camera*; Newton, Tr. 434).

474. Dr. Noether also considered these hospital documents in defining the geographic market. (Noether, Tr. 5948-49).

c. ENH Testimony And Documents Confirm A Broad Geographic Market

475. ENH and HPH representatives and documents confirm the relevant competitive landscape.

476. According to current and former HPH representatives, pre-Merger, Condell, Rush North Shore, Advocate Lutheran General and Evanston Hospital all competed with HPH because of their “reasonably close” geography and because they all offered comparable or more sophisticated services than HPH. (Spaeth, Tr. 2157, 2239-40). Pre-Merger HPH’s primary competitors were Lake Forest Hospital and Condell. (CX 6305 at 5 (Stearns, Dep.); RX 148 at ENHL TC 7927; Chan, Tr. 730; Krasner, Tr. 3699-3700). MCOs, however, also were able to use Rush North Shore, Evanston Hospital, St. Francis, Advocate Lutheran General and the downtown Chicago hospitals as substitutes for HPH in their networks. (Spaeth, Tr. 2299; Chan, Tr. 730).

477. According to ENH representatives, ENH’s “major competitors” include Advocate Lutheran General, Rush North Shore, St. Francis, Condell, Lake Forest Hospital, Northwestern Memorial, Rush Presbyterian and University of Chicago because all of these hospitals offer a comparable breadth and type of services. (Hillebrand, Tr. 1748-51; Neaman, Tr. 1301). These hospitals target ENH’s service area with advertisements. (Hillebrand, Tr. 2001).

478. ENH documents show that, in 2002, it faces strong competition in its own service area. For example, while ENH had a 16.4% share of its service area, Advocate had a 14.4% share and Resurrection had an even larger share at 17.7%. (RX 1361 at ENHE DL 6610).

479. Other ENH documents confirm that its service area is “defined as 51 zip codes representing the communities where approximately 85% of [ENH’s] patients reside. Fifteen hospitals are located in this 51 zip code service area and provide services to this population.” (RX 1429 at ENHE F16 4561).

480. Evanston Hospital’s and HPH’s respective service areas thus overlapped “a little bit” in the northern tier of Evanston Hospital’s service market. (Neaman, Tr. 1306). HPH competed with Evanston Hospital where the two overlapped to HPH’s south. (Spaeth, Tr. 2088; CX 6305 at 5 (Stearns, Dep.); Newton Tr., 328).

481. Nevertheless, it is important to recognize that, before the Merger, HPH and Evanston Hospital offered very different levels of service. (CX 6305 at 19 (Stearns, Dep.)). For example, pre-Merger HPH did not offer cardiac surgery while Evanston Hospital did. Pre-merger HPH did not have a fully developed oncology program like Evanston’s Kellogg Cancer Care Center. (CX 6305 at 19 (Stearns, Dep.)). Because HPH did not offer cardiac surgery or advanced oncological care, Evanston Hospital did not compete with HPH for these services. (CX 6305 at 19 (Stearns, Dep.); Neaman, Tr. 1306; Spaeth, Tr. 2244). Indeed, HPH’s 1997 bond filings do not include Evanston Hospital as a competitor in its core market. (CX 6321 at 73).

d. Other Third Party Testimony And Documents Confirm A Broad Geographic Market

482. The 10 peer group hospitals used by Deloitte Consulting (“Deloitte”) in 2002 to benchmark ENH’s chargemaster in the marketplace were Loyola, Advocate Lutheran General, Illinois Masonic Medical Center, Resurrection Medical Center, Northwest Community, Northwestern Memorial, University of Chicago, Alexian Brothers, Condell, and Rush Presbyterian. (CX 1846 at 3). *See* Section VI.B.2. They were chosen by Deloitte because they were deemed to be ENH’s chief competitors. (Hillebrand, Tr. 1993).

483. Kaufman Hall & Associates examined the competitive landscape that HPH was facing in the Chicago marketplace as part of its strategic work for the hospital. (Kaufman, Tr. 5836). HPH’s primary competitors were Lake Forest Hospital and Condell. (Kaufman, Tr. 5836). HPH was also feeling competitive pressure from Northwest Community, Advocate Lutheran General, and Northwestern Memorial. (Kaufman, Tr. 5836-37). Northwestern Memorial was constructing a new women’s hospital in downtown Chicago, a construction product that was changing the competitive landscape in a significant way. (Kaufman, Tr. 5837).

484. Moreover, the Illinois Health Facilities Planning Board uses “planning areas” to determine the need for services and beds. Condell and Lake Forest Hospital are in HPH’s planning area. (D. Jones, Tr. at 1685). Significantly, Evanston and HPH are in different planning areas. (D. Jones, Tr. 1670).

e. Dr. Noether Defined A Reasonable Relevant Geographic Market Based On The Evidence Discussed Above

485. Considering all the evidence, including the documents and testimony of market participants discussed above, Dr. Noether concluded that Evanston Hospital and HPH were not each other’s closest geographic substitutes, “rather, each one of them had several other hospitals that were closer competitors.” (Noether, Tr. 5957, 5951-56). As a consequence, it is analytically impossible for Evanston Hospital and HPH to be the only hospitals in the geographic market. (Noether, Tr. 5956).

486. Dr. Noether concluded that Evanston Hospital’s closest geographic competitors were Rush North Shore, St. Francis and Advocate Lutheran General. (Noether, Tr. 5958).

487. Dr. Noether concluded that HPH’s closest geographic competitors were Lake Forest Hospital and Condell. (Noether, Tr. 5959).

488. At a minimum, therefore, Dr. Noether’s geographic market includes, in addition to the merging hospitals, Rush North Shore, St. Francis, Advocate Lutheran General, Resurrection, Lake Forest Hospital and Condell. (Noether, Tr. 5928, 5960).

489. There are some hospitals outside of this minimum market that provide at least some competitive constraint on the hospitals inside the minimum area. (Noether, Tr. 5929). In particular, from a geographic perspective, some of the hospitals that are “quite near” the minimum geographic area provide competitive constraint on the hospitals in the minimum area,

and may even be in the relevant geographic market. (Noether, Tr. 5930). These hospitals include, for example: Holy Family, Swedish Covenant, and Vista. (Noether, Tr. 5930-31).

490. In addition, Northwestern Memorial places “substantial competitive constraint” on ENH and the other hospitals in the minimum geographic market even though it is located in downtown Chicago. (Noether, Tr. 5931).

f. Dr. Haas-Wilson Did Not Define A Reasonable Geographic Market Based On The Evidence Discussed Above

491. Dr. Haas-Wilson defined the relevant geographic market as “the area contiguous to the three hospitals of ENH. So, that would be the campuses of HPH, Evanston Hospital and Glenbrook Hospital.” (Haas-Wilson, Tr. 2667).

492.

(REDACTED)

(Baker, Tr. 4704, *in camera*).

(REDACTED)

(Baker, Tr. 4703, *in camera*).

493. Dr. Noether found additional support for her conclusion that Dr. Haas-Wilson did not follow the Merger Guidelines in her geographic market analysis in the deposition testimony under oath by another expert retained by Complaint Counsel in this litigation, Dr. Gregory Werden.² Complaint Counsel ultimately decided not to call Dr. Werden to testify at trial. (Noether, Tr. 5959-60).

494. Dr. Haas-Wilson’s geographic market only makes sense, under the Merger Guidelines, if Evanston Hospital and HPH were closest competitors in geographic terms. (Noether, Tr. 5932). As discussed above, however, Evanston Hospital and HPH were not each other’s closest geographic competitors. (Noether, Tr. 5932).

495.

(REDACTED) (Baker, Tr. 4704, *in camera*).

(REDACTED)

(Baker, Tr. 4704, *in camera*).

496.

(REDACTED)

(Baker, Tr.

4704-05, *in camera*).

497. As proof that Dr. Haas-Wilson’s proposed relevant geographic market was gerrymandered, she was unwilling and unable to draw a line around her geographic market, or to

² The testimony was elicited for a purpose other than the truth of the matter asserted.

identify the maximum and minimum bounds of her geographic market. (Haas-Wilson, Tr. 2920-21).

498. Indeed, it is possible that Dr. Haas-Wilson's geographic market goes up to the area outside the campus of the next closest hospitals, but not onto or beyond the campuses of those hospitals. (Haas-Wilson, Tr. 2922-23).

C. ENH's Market Share Is Less Than That In Other Hospital Merger Cases

1. ENH's Core Market Consists Of About 20 Zip Codes

499. Core market" is a term of art that ENH uses to describe a subsection of its total market.

500. ENH's "core" market represents about 20 zip codes. (Neaman, Tr. 1055).

501. ENH usually has a 50% market share of the "core" zip codes. (Neaman, Tr. 1056). The 20 zip codes of the "core" are the closest zip codes to ENH in terms of proximity. (Neaman, Tr. 1057).

2. ENH's Service Area Consists Of About 51 Zip Codes

502. At ENH, the term "service area" refers to the 51 zip code area from which 80-85% of ENH's patient come. (RX 1429 at ENHE F16 4561; Hillebrand, Tr. 1996; Spaeth, Tr. 2156; Neaman, Tr. 1055, 1307).

503. ENH's service area has stayed fairly constant at 50-52 zip codes for as long as Hillebrand could recall and extends from the northern tier of the City of Chicago up north to the Wisconsin line, from the lake on the east and out west to various communities such as Arlington Heights, Vernon Hills and Mundelein. (Hillebrand, Tr. 1996; Neaman Tr. 1307). ENH also uses the term "secondary market" to describe the 50-52 zip code market. (Neaman, Tr. 1056-57).

504. Hospital administrators will typically look to their "service area" to determine their respective hospitals' market shares. (Spaeth, Tr. 2156).

505. 20% of ENH's patients come from outside ENH's service area, including such places as the city of Chicago and from around the world. (Hillebrand, Tr. 1998). Patients come from around to world to see ENH's Neurology Department Chairman, who is a widely recognized brain tumor specialist and a professor at Northwestern University Medical School. (Hillebrand, Tr. 1998).

506.

(REDACTED)

(RX 2021 at ENH DL 3443, *in camera*; Neaman, Tr. 1311; Hillebrand, Tr. 1996-98).

507. (REDACTED)
ENH DL 3443, *in camera*; Neaman, Tr. 1311).

(RX 2021 at

3. The Concentration Resulting From The Merger Is Acceptable

508. Given the available data, Dr. Noether was not able to calculate exact market shares. (Noether, Tr. 5961). Dr. Noether did, however, calculate proxy shares using the best available information, contained in the Medicare Cost Reports. (Noether, Tr. 5961). The Medicare Cost reports provide information on total net revenues, both inpatient and outpatient, across all MCOs for each hospital. (Noether, Tr. 5961).

509. Dr. Noether calculated, based on her product market definition and using her minimum geographic market – comprised of Rush North Shore, St. Francis, Advocate Lutheran General, Resurrection, Lake Forest Hospital and Condell – that Evanston Hospital had a pre-Merger share of about 23%. (Noether, Tr. 5962 (*describing* DX 8115)). Dr. Noether calculated that HPH had a pre-Merger share of about 7%. (Noether, Tr. 5962). Consequently, the combined, post-Merger market share was about 30%. (Noether, Tr. 5962).

510. Dr. Noether also calculated Herfindahl-Hirschman Index (“HHI”) statistics based on her product market and using her minimum geographic market. (Noether, Tr. 5962). HHI is a measure suggested by the Merger Guidelines as a way of capturing market concentration to that take into account of all of the players in the market, as opposed to something like a four firm concentration issue, which would only look at the top four, and it takes essentially the shares of each of those firms, squares them and then sums the squared shares. So, HHI is a statistic that can range from zero, in the case of a infinite number of very small players, up to 10,000, which is 100 squared, if there were a single monopolist in the market. (Noether, Tr. 5962-63).

511. The post-Merger HHI for Dr. Noether’s minimum geographic market, treating St. Francis and Resurrection Medical Center as separate hospitals, was slightly greater than 1900, and the change in HHI between pre- and post-Merger was about 300. (Noether, Tr. 5963).

512. St. Francis and Resurrection Medical Center merged in the late 1990’s. (RX 531 at 13916).

(REDACTED)

(Noether, Tr. 6248, *in camera*).

(REDACTED)

(Noether, Tr. 6248, *in camera*).

(REDACTED)

6248-49, *in camera*).

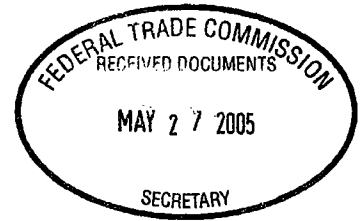
(Noether, Tr.

513. This market is not concentrated relative to the types of transactions that are “typically challenged as likely to cause anti-competitive effects. (Noether, Tr. 5963). Also these shares are conservative because they are calculated only based on hospitals located in Dr. Noether’s minimum geographic market and do not reflect the competitive constraint hospitals

outside Dr. Noether's minimum market may place on those inside the market. (Noether, Tr. 5964).

514. Dr. Noether also calculated shares and concentration, using a proxy, for Complaint Counsel's product market. (Noether, Tr. 5964). Evanston Hospital's pre-Merger share, using Complaint Counsel's product market and Dr. Noether's minimum geographic market, is 21%, and HPH's pre-merger share is 5%. (Noether, Tr. 5965). The post-Merger HHI for this market, treating St. Francis and Resurrection Medical Center as separate hospitals, was 1919, and the change in HHI was 222. (Noether, Tr. 5965; RX 1912 at 58, *in camera*). Again, this level of concentration was not one that generally leads to merger challenges. (Noether, Tr. 5965-66).

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES



_____)
In the matter of _____)
_____)
Evanston Northwestern Healthcare _____)
Corporation, _____)
_____)
_____)

Docket No. 9315
Public Record

RESPONDENT'S PROPOSED POST-TRIAL FINDINGS OF FACT

VOLUME II of IV

WINSTON & STRAWN LLP

35 West Wacker Dr.
Chicago, IL 60601-9703
(312) 558-5764

1700 K Street, N.W.
Washington, DC 20006
(202) 282-5000

TABLE OF CONTENTS

VOLUME I

| | Page |
|--|-------------|
| Abbreviations of Terms | xxxvi |
| | |
| I. THE PARTIES..... | 1 |
| A. Evanston Northwestern Healthcare..... | 1 |
| 1. The Three ENH Hospitals..... | 2 |
| a. Evanston Hospital | 3 |
| b. Glenbrook Hospital | 3 |
| c. HPH..... | 4 |
| 2. ENH Faculty Practice Associates | 4 |
| 3. ENH Research Institute..... | 4 |
| 4. ENH Foundation | 5 |
| B. Evanston Hospital And HPH Before The Merger | 5 |
| 1. Pre-Merger Evanston Hospital..... | 5 |
| 2. HPH Pre-Merger | 6 |
| a. HPH Was A Community Hospital With Limited Services Before The Merger..... | 6 |
| b. HPH Had Financial Problems Before The Merger | 7 |
| c. HPH Had Quality Of Care Problems Before The Merger | 7 |
| | |
| II. DYNAMICS OF MANAGED CARE..... | 9 |
| A. Overview: Interaction Among Relevant Players (Patients, Employers, Private Payors And Providers) | 9 |
| B. Types Of Managed Care Plans | 10 |
| 1. HMO | 10 |
| 2. PPO | 11 |

| | | |
|-------|---|----|
| 3. | POS | 11 |
| 4. | Indemnity | 12 |
| C. | Role Of Outpatient Services | 12 |
| D. | Managed Care Contracting | 12 |
| 1. | Selective Contracting | 12 |
| 2. | Scope Of MCO Contracts | 12 |
| 3. | Reimbursement Methodologies | 13 |
| a. | Discount-Off-Charges Contracts | 13 |
| b. | Per Diem | 14 |
| c. | Case Rates | 15 |
| d. | Capitation..... | 15 |
| E. | Different Type of Hospitals (Academic And Community) | 15 |
| F. | The Impact Of The Balanced Budget Act Of 1997 On Managed Care | 16 |
| G. | Hospitals Have Felt Substantial Pressure To Reduce Costs | 17 |
| H. | Chicago Healthcare Market | 17 |
| a. | Relevant Hospitals | 17 |
| b. | Relevant MCOs..... | 18 |
| i. | Aetna..... | 18 |
| ii. | Blue Cross..... | 18 |
| iii. | CCN | 19 |
| iv. | Cigna..... | 19 |
| v. | Great West | 20 |
| vi. | HFN..... | 20 |
| vii. | Humana | 21 |
| viii. | PHCS | 22 |
| ix. | Unicare..... | 22 |

| | | |
|------|---|----|
| x. | United..... | 23 |
| I. | MCO Negotiating Trends In The Chicago Area Market | 24 |
| 1. | Hospitals Use Termination Letters To Open Negotiations With MCOs..... | 25 |
| 2. | System-Wide Contracts Are Gaining Popularity..... | 25 |
| 3. | The Contract Negotiation “Pendulum” Is Swinging Back In Favor Of MCOs..... | 25 |
| III. | PRE-MERGER BACKGROUND | 27 |
| A. | Northwestern Healthcare Network | 27 |
| 1. | Purpose Of The Network | 27 |
| 2. | Structure And Powers Of The Network..... | 28 |
| 3. | Managed Care Contracting By The Network | 30 |
| 4. | Failures And Limitations Of The Network..... | 30 |
| B. | NH North | 31 |
| C. | Other Failed Merger Negotiations And Failed Joint Ventures Involving HPH | 32 |
| IV. | THE MERGER..... | 34 |
| A. | Merger Negotiations | 34 |
| 1. | Initial Merger Discussions | 34 |
| 2. | Letter Of Intent | 35 |
| B. | Reasons For The Merger..... | 37 |
| 1. | HPH’s Reasons For The Merger..... | 38 |
| a. | The Merger Would Improve Quality Of Care At HPH And In The Community In General..... | 38 |
| b. | The Merger Would Address HPH’s Deteriorating Financial Condition..... | 39 |
| c. | The Merger Would Provide A Good “Fit” | 39 |
| 2. | Evanston Hospital’s Reasons For The Merger | 40 |

| | | |
|----|--|----|
| a. | The Merger Would Allow Evanston Hospital To Improve Quality Of Care By Expanding The Volume Of Its Services..... | 40 |
| b. | The Merger Would Allow Evanston Hospital To Improve Quality Of Care By Rationalizing Its Services | 40 |
| c. | The Merger Would Result In Corporate Efficiencies | 41 |
| d. | The Merger Would Provide Evanston Hospital With An Additional Teaching Site | 41 |
| C. | Merger Consummation | 41 |
| D. | Effect Of The Merger On ENH’s Operations | 42 |
| E. | Post-Merger Healthcare Foundation Of Highland Park..... | 43 |
| V. | ANALYTIC FRAMEWORK | 44 |
| A. | The Court Should Analyze The Price Increases In The Context Of The Relevant Market..... | 44 |
| 1. | All Experts Agree That Price Increases Alone Are Not Anticompetitive..... | 44 |
| 2. | All Experts Agree That One Must Rule Out Viable Alternative Explanations Before Concluding That A Price Increase Is The Result Of Anticompetitive Market Power | 44 |
| 3. | Market Definition Provides The Necessary Framework In Which To Evaluate These Alternative Explanations..... | 44 |
| B. | The Court Should Evaluate The Competitive Effects Of The Merger | 45 |
| 1. | The Court Should Evaluate Price Effects Of The Merger | 45 |
| 2. | The Court Should Evaluate Quality Effects Of The Merger As A Pro-Competitive Effect | 45 |
| 3. | The Court Should Take Into Account Other Competitive Effects Considerations..... | 46 |
| a. | The Court Should Evaluate Issues Pertaining To Market Entry And Repositioning | 46 |
| b. | The Court Should Evaluate The Financial Condition Of HPH Before The Merger | 47 |
| c. | The Court Should Evaluate ENH’s Not-For-Profit Status | 47 |

| | | |
|-----|---|----|
| C. | ENH’s Economist Experts Analyzed The Facts Of The Case In The Context Of This Analytic Framework | 48 |
| 1. | Dr. Monica Noether | 48 |
| 2. | Professor Jonathan Baker..... | 49 |
| VI. | RELEVANT MARKET..... | 51 |
| A. | The Relevant Product Market Consists Of All Acute Care Hospital-Based Services | 51 |
| 1. | The Product At Issue Being Sold Includes All Acute Care Hospital-Based Services | 51 |
| 2. | The Relevant Customers, <i>i.e.</i> , MCOs, Purchase All Acute Care Hospital-Based Services Together | 51 |
| a. | MCOs Purchase Inpatient And Outpatient Services Together | 51 |
| b. | MCOs Purchase Primary, Secondary And Tertiary Services Together | 52 |
| 3. | Dr. Noether Has Correctly Defined The Relevant Product Market..... | 52 |
| 4. | Dr. Haas-Wilson Has Not Correctly Defined The Relevant Product Market | 53 |
| B. | The Relevant Geographic Market Consists Of Multiple Competitor Hospitals In The Chicago Area..... | 53 |
| 1. | The Court Should Consider Patient Preferences And Physician Admitting Patterns When Evaluating The Relevant Geographic Market | 53 |
| a. | Patient Preferences Are Relevant To The Geographic Market Analysis | 53 |
| i. | Geographic Proximity Is Relevant To Patient Preferences | 54 |
| ii. | Travel Patterns Are Relevant To Patient Preferences..... | 55 |
| b. | Physician Admitting Patterns Are Relevant To The Geographic Market Analysis | 58 |
| 2. | The Court Should Consider The Fact That There Are Multiple Hospitals In The Chicago Area When Evaluating The Relevant Geographic Market | 58 |

| | | |
|----|--|----|
| a. | Advocate Lutheran General | 59 |
| b. | Condell | 59 |
| c. | Lake Forest Hospital | 60 |
| d. | Loyola | 60 |
| e. | Northwestern Memorial | 60 |
| f. | Rush North Shore And Rush Presbyterian..... | 61 |
| g. | St. Francis | 62 |
| h. | Swedish Covenant..... | 62 |
| i. | University Of Chicago | 62 |
| j. | University Of Illinois At Chicago..... | 62 |
| 3. | The Relevant Geographic Market Broadly Encompasses A Large Number Of Competitor Hospitals In The Chicago Area | 63 |
| a. | MCO Testimony And Documents Confirm A Broad Geographic Market | 63 |
| b. | Third Party Hospital Documents Confirm A Broad Geographic Market | 64 |
| c. | ENH Testimony And Documents Confirm A Broad Geographic Market | 66 |
| d. | Other Third Party Testimony And Documents Confirm A Broad Geographic Market..... | 67 |
| e. | Dr. Noether Defined A Reasonable Relevant Geographic Market | 67 |
| f. | Dr. Haas-Wilson Did Not Define A Reasonable Geographic Market | 68 |
| C. | ENH's Market Share Is Less Than That In Other Hospital Merger Cases | 69 |
| 1. | ENH's Core Market Consists Of About 20 Zip Codes..... | 69 |
| 2. | ENH's Service Area Consists Of About 51 Zip Codes | 69 |
| 3. | The Concentration Resulting From The Merger Is Acceptable..... | 70 |

VOLUME II

VII. THE MERGER RESULTED IN NO ANTICOMPETITIVE EFFECTS 72

A. The Court Should Consider Various Economic Factors In Its Competitive Effects Analysis 72

1. Dr. Haas-Wilson’s Analysis Is Based On A Bargaining Theory 72

2. The Pertinent Pricing Analysis Under Dr. Haas-Wilson’s Bargaining Theory Has Both Theoretical And Empirical Dimensions 72

a. As A Theoretical Matter, Complaint Counsel Must Show More Than That ENH’s Prices Increased After The Merger 72

i. Price Changes Alone Are Not Evidence Of Market Power 72

ii. Complaint Counsel Must Evaluate And Eliminate Viable Alternative Explanations 73

iii. In Particular, Complaint Counsel Must Rule Out “Learning About Demand” To Show That ENH Exercised Market Power As A Result Of The Merger..... 74

iv. The Court Should Consider Both Price Levels And Price Changes When Evaluating Whether Price Increases Were The Result Of Market Power From The Merger. 74

b. As An Empirical Matter, Complaint Counsel Must Show That ENH’s Post-Merger Prices Increases Were The Result Of Market Power..... 74

3. This Court Also Should Take Into Account Other Competitive Effects Considerations 74

B. The Pre-Merger Competitive Landscape Is Inconsistent With Dr. Haas-Wilson’s Bargaining Theory 76

1. This Case Involves A Differentiated Product 76

2. Evanston Hospital And HPH Were Not Close Substitutes..... 76

a. Evanston And HPH Were Not Close Substitutes From A Product Perspective..... 76

| | | |
|------|---|----|
| i. | Evanston Hospital And HPH Offered A Different Breadth of Services | 76 |
| ii. | Evanston Hospital And HPH Were Hospitals Of Very Different Sizes | 77 |
| iii. | Unlike Evanston Hospital, HPH Had No Teaching Component..... | 78 |
| b. | Evanston Hospital And HPH Were Not Close Substitutes From A Geographic Perspective..... | 78 |
| c. | Evanston Hospital And HPH Had Much Closer Substitutes Than Each Other | 78 |
| i. | Evanston Hospital Had Several Closer Substitutes Than HPH | 79 |
| (1) | Evanston Hospital’s Closest Substitutes From A Product Perspective Were Advocate Lutheran General And Northwestern Memorial | 79 |
| (2) | Evanston Hospital’s Closest Substitutes From A Geographic Perspective Were St. Francis And Rush North Shore..... | 80 |
| ii. | HPH’s Closest Substitutes From Both A Product And Geographic Perspective Were Lake Forest Hospital And Condell | 80 |
| C. | Dr. Haas-Wilson’s Bargaining Theory Does Not Take Into Account The Fact That Evanston Hospital And HPH Had Very Different Negotiating Strategies And Contract Rates Before The Merger | 81 |
| 1. | Evanston Hospital And HPH Had Different Pre-Merger Negotiating Strategies..... | 82 |
| a. | HPH Had An Aggressive Pricing Strategy Before The Merger..... | 82 |
| b. | Evanston Hospital, In Contrast, Did Not Focus On MCO Negotiations Before The Merger | 82 |
| i. | Before 1999, Evanston Hospital Did Not Institute An Aggressive MCO Negotiation Policy | 82 |
| ii. | Evanston Hospital’s Pre-Merger MCO Contract Negotiator Used A Passive Negotiation Style | 83 |

| | | |
|------|---|----|
| (1) | Sirabian Was In Charge Of Evanston Hospital’s Pre-Merger MCO Negotiations | 83 |
| (2) | Sirabian’s Goal Was To Obtain “Win-Win Contracts” | 84 |
| (3) | Sirabian Did Not Threaten Termination As A Means To Obtain Aggressive Rates..... | 84 |
| (4) | Sirabian Let Contracts Lapse And Did Not Intiate Contract Renegotiations..... | 85 |
| iii. | Many Evanston Hospital Contracts Had Not Been Renegotiated In A Number Of Years..... | 85 |
| c. | By The Late 1990’s, Changing Financial Conditions Put Pressure On Evanston Hospital To Focus On MCO Contract Rates..... | 86 |
| i. | Evanston Hospital Realized The Adverse Financial Effect Of The Balanced Budget Act Until In Late 1998 And 1999..... | 86 |
| ii. | Since The Late 1990s, Evanston Hospital/ENH, Along With Other Hospitals, Have Been Under Pressure To Reduce Costs..... | 87 |
| iii. | By The Late 1990s, Evanston Hospital No Longer Could Rely As Heavily On Its Investment Income | 88 |
| 2. | Evanston Hospital And HPH Had Different Negotiated MCO Contract Rates Before The Merger | 89 |
| D. | Dr. Haas-Wilson’s Bargaining Theory Does Not Eliminate All Viable Alternative Explanations For ENH’s Post-Merger Price Increases, Such As Learning About Demand | 89 |
| 1. | “Price” Can Be Defined In Several Ways..... | 89 |
| a. | Charges | 89 |
| b. | Contract Rates..... | 89 |
| c. | Reimbursement Rates | 89 |
| 2. | The Factual Evidence Is Consistent With The Learning About Demand Alternative Explanation For The Price Increases At Issue..... | 90 |

| | | |
|------|---|-----|
| a. | Coincident With The Merger, ENH Learned That It Was “Leaving Money On The Table” Through Proper Due Diligence | 90 |
| b. | At The Time Of The Merger, Evanston Hospital Learned About The Demand For Its Services Through Bain’s Consulting Services | 92 |
| i. | Bain Advised ENH That HPH Had More Favorable MCO Contracts | 92 |
| ii. | Bain Advised ENH That It Had Expired Or Outdated MCO Contracts | 95 |
| iii. | Bain Advised ENH That It Was Under-Market As Compared To Its Peer Academic Hospitals | 96 |
| iv. | Bain Advised ENH On MCO Contract Renegotiations..... | 96 |
| (1) | Bain Advised ENH On A Post-Merger 96Negotiation Schedule | |
| (2) | Bain Advised ENH On Negotiation Tactics | 97 |
| v. | Bain’s Advice Paid Off – But The Successful Contract Renegotiations Were Not Due To The Merger..... | 99 |
| c. | Individual MCO Negotiations Are Consistent With The Learning About Demand Theory | 100 |
| i. | Aetna | 101 |
| (1) | Evanston Hospital’s Pre-Merger Contract Rates With Aetna Were Outdated And Undermarket | 101 |
| (2) | ENH’s Post-Merger Negotiations With Aetna Were Not Anticompetitive | 102 |
| ii. | Blue Cross..... | 103 |
| (1) | Evanston Hospital Pre-Merger Contract Rates Exceeded HPH’s Pre-Merger Contract Rates..... | 103 |
| (2) | ENH’s Post-Merger Negotiations With Blue Cross Were Not Anticompetitive..... | 104 |

| | | |
|-------|---|-----|
| iii. | Cigna..... | 106 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With Cigna Were Outdated And Undermarket | 106 |
| | (2) ENH’s Post-Merger Negotiations With Cigna Were Not Anticompetitive | 106 |
| iv. | CCN..... | 106 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With CCN Were Outdated And Undermarket | 106 |
| | (2) ENH’s Post-Merger Negotiations With CCN Were Not Anticompetitive..... | 107 |
| v. | Great West | 107 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With One Health/Great West Were Outdated And Undermarket..... | 107 |
| | (2) ENH’s Post-Merger Negotiations With Great West Were Not Anticompetitive..... | 108 |
| vi. | HFN..... | 109 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With HFN Were Outdated And Undermarket | 109 |
| | (2) ENH’s Post-Merger Negotiations With HFN Were Not Anticompetitive..... | 110 |
| vii. | Humana | 110 |
| | (1) Before the Merger, Evanston Hospital Acquired Some Humana Physician Office Sites..... | 110 |
| | (2) ENH’s Post-Merger Negotiations With Humana Were Not Anticompetitive | 111 |
| viii. | PHCS..... | 112 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With PHCS Was Outdated And Undermarket | 112 |

| | | | |
|-----|------|--|-----|
| | (2) | ENH’s Post-Merger Negotiations With PHCS Were Not Anticompetitive | 113 |
| ix. | | Preferred Plan..... | 115 |
| | (1) | Evanston Hospital’s Pre-Merger Contract Rates With Preferred Plan Were Outdated And Undermarket..... | 115 |
| | (2) | ENH’s Post-Merger Negotiations With Preferred Plan Were Not Anticompetitive | 115 |
| x. | | Unicare..... | 116 |
| | (1) | Evanston Hospital’s Pre-Merger Contract Rates With Unicare And Rush Prudential Were Outdated And Undermarket | 116 |
| | (2) | ENH’s Post-Merger Negotiations With Unicare Were Not Anticompetitive | 117 |
| xi. | | United..... | 119 |
| | (1) | Evanston Hospital’s Pre-Merger Contract Rates With United Were Outdated And Undermarket | 119 |
| | (2) | ENH’s Post-Merger Negotiations With United Were Not Anticompetitive | 119 |
| | (3) | United And ENH Renegotiated Their 2000 Contract To Accommodate United’s Contracting Goals | 121 |
| d. | | By 2002, ENH Learned That, On A Whole, Its Chargemaster Contained Prices That Were Undermarket | 125 |
| | i. | Description Of A Chargemaster..... | 125 |
| | ii. | ENH Consolidated Its Chargemaster After The Merger..... | 125 |
| | iii. | ENH, With The Assistance Of Deloitte Consulting, Brought Its Chargemaster Up To Market In 2002 | 126 |
| e. | | Factual Evidence Is Inconsistent With Dr. Haas-Wilson’s Bargaining Theory | 130 |
| | i. | Dr. Haas-Wilson’s Bargaining Theory Is Not Grounded In Theory Or Common Sense | 130 |

| | | |
|------|---|-----|
| ii. | Dr. Haas-Wilson’s Bargaining Theory Does Not Apply Here Because MCOs Did Not Play Evanston Hospital And HPH Off Each Other Before The Merger..... | 131 |
| iii. | Dr. Haas-Wilson’s Bargaining Theory Does Not Apply Here Because She Admits That A Network Without ENH Would Still Be Marketable | 133 |
| iv. | Dr. Haas-Wilson’s Bargaining Theory Does Not Apply Here Because There Was Little Selective Contracting In The Chicago Area | 133 |
| v. | Pertinent Documents Do Not Support Dr. Haas-Wilson’s Bargaining Theory | 134 |
| 3. | Empirical Analysis Of Price <i>Changes</i> Does Not Show That The Merger Conferred Market Power..... | 135 |
| a. | Professor Baker Measured The Relative, Non-Quality-Adjusted Post-Merger Price Changes In The Reasonable Range Of 9-12% | 135 |
| b. | Problems With Available Data Render Professor Baker’s Price Estimates Conservative..... | 136 |
| c. | Dr. Haas-Wilson’s Empirical Analysis Fails To Support The Conclusion That Post-Merger Price Changes Are The Result Of Market Power | 137 |
| i. | Dr. Haas-Wilson’s Empirical Theory Is Flawed..... | 137 |
| ii. | Dr. Haas-Wilson’s Methodology Is Flawed | 138 |
| (1) | Dr. Haas-Wilson Measured The Wrong Prices..... | 138 |
| (2) | Dr. Haas-Wilson Did Not Effectively Clean The Data Underlying Her Empirical Analysis..... | 138 |
| (3) | Dr. Haas-Wilson’s Control Groups Are Not An Appropriate Basis For Measuring Relative Price Changes | 139 |
| iii. | Dr. Haas-Wilson’s Empirical Results Are Not Consistent With A Market Power Explanation For The Price Increases At Issue | 141 |

| | | |
|------|---|-----|
| d. | Dr. Haas-Wilson’s Empirical Analysis Fails To Account For Viable Alternative Explanations For The Price Increases At Issue, Such As Learning About Demand | 142 |
| 4. | Empirical Analysis of Price <i>Levels</i> Also Supports Learning About Demand | 144 |
| a. | Dr. Noether’s Control Groups Are An Appropriate Basis To Compare Price Levels..... | 144 |
| i. | The Criteria Used By Dr. Noether To Select Her Control Group Are Appropriate..... | 144 |
| ii. | Dr. Noether’s Characterization Of ENH As A Major Teaching Hospital Is Consistent With MCO Views | 145 |
| iii. | Dr. Haas-Wilson’s Criticisms Of Dr. Noether’s Control Groups Are Unfounded..... | 146 |
| (1) | Dr. Haas-Wilson’s Sum Of Squares Measure Of Breadth Of Service Is Misleading..... | 146 |
| (2) | Dr. Haas-Wilson’s Focus On “Quarternary Services” Is Misguided | 147 |
| (3) | Dr. Haas-Wilson’s Criticisms Of Dr. Noether’s Control Group Based On Differences In Public Perception Are Unfounded..... | 147 |
| b. | Dr. Noether Cleaned Pertinent MCO Data More Effectively Than Dr. Haas-Wilson | 148 |
| c. | Dr. Noether’s Empirical Analysis Confirms That The Learning About Demand Theory Applies In This Case | 150 |
| i. | Aetna | 151 |
| ii. | Blue Cross..... | 151 |
| iii. | Humana | 152 |
| iv. | United..... | 152 |
| d. | Professor Baker’s Empirical Analysis Confirms That The Learning About Demand Theory Applies In This Case | 153 |
| i. | The Results Of Professor Baker’s Analysis Are Consistent With The Learning About Demand Theory | 155 |

| | | |
|-----|--|-----|
| ii. | Professor Baker’s Empirical Analysis Overstates ENH’s Post-Merger Price Increase Because That Analysis Does Not Measure Quality-Adjusted Prices..... | 156 |
|-----|--|-----|

VOLUME III

| | | |
|-------|---|-----|
| VIII. | MERGER IMPACT ON QUALITY | 158 |
| A. | Definition And Measurement Of Healthcare Quality | 158 |
| 1. | Definition Of Quality In Healthcare | 158 |
| 2. | Measuring Healthcare Quality | 158 |
| a. | Strengths And Weaknesses Of Quality Measures | 159 |
| b. | Quality Measures Must Be Valid..... | 161 |
| B. | Dr. Chassin Employed Accepted Methodology For The Study Of Healthcare Quality | 162 |
| C. | Dr. Chassin Has Extensive Experience Evaluating And Assessing Healthcare Quality | 164 |
| D. | Overview Of Changes In Healthcare Quality At HPH As A Result Of The Merger..... | 166 |
| 1. | ENH Corrected Problems With Clinical Practice At HPH That Existed Before The Merger..... | 167 |
| a. | The Merger Improved Quality Of Care In HPH’s Ob/Gyn | 167 |
| i. | Overview..... | 167 |
| ii. | Evanston Hospital Had A Relationship With HPH Before The Merger Through The Illinois Perinatal Network..... | 168 |
| iii. | HPH Ob/Gyn Department Had Serious Problems Before The Merger..... | 169 |
| (1) | HPH Had Insufficient Obstetrician Coverage Before The Merger..... | 170 |
| (2) | HPH’s Ob/Gyn Department Had Poor Nurse/Physician Teamwork Before The Merger..... | 170 |

| | | | |
|-----|-----|---|-----|
| | (3) | HPH Lacked Effective Obstetrical Leadership Before The Merger..... | 171 |
| | (4) | There Were Inappropriate Procedures In HPH's Ob/Gyn Department Before The Merger..... | 172 |
| iv. | | ENH Improved Quality Of Care At HPH's Ob/Gyn Department After The Merger | 173 |
| | (1) | ENH Expanded Obstetrician Coverage At HPH After The Merger | 173 |
| | (2) | ENH Improved HPH's Nurse/Physician Teamwork After The Merger..... | 175 |
| | (3) | ENH Improved HPH's Ob/Gyn Leadership And Quality Assurance Program After The Merger..... | 176 |
| | (4) | ENH Addressed The Inappropriate Procedures In Ob/Gyn At HPH After The Merger..... | 177 |
| | (5) | ENH Implemented Obstetric Committee Practice Protocols At HPH After The Merger..... | 177 |
| | (6) | ENH Introduced The Preoperative Gynecologic Surgical Review Program At HPH After The Merger | 178 |
| v. | | Patient Outcomes In ENH's OB/GYN Services Are Consistent With, Or Better Than, National Benchmarks..... | 180 |
| vi. | | Dr. Romano's Undue Reliance On Administrative Data To Evaluate HPH's Obstetrical Service Is Invalid | 182 |
| b. | | The Merger Improved Quality Of Care In HPH's Nursing Services | 183 |
| | i. | Overview..... | 183 |
| | ii. | HPH's Pre-Merger Nursing Services Needed Improvement..... | 184 |

| | | |
|------|---|-----|
| (1) | HPH Had Issues Concerning Nurse Recruiting, Vacancy And Turnover Rates Before The Merger..... | 184 |
| (2) | HPH Had Issues Concerning Nurse Training Before The Merger..... | 185 |
| (3) | HPH Had Issues Concerning Nurse/Physician Relationships Before The Merger..... | 186 |
| iii. | ENH Improved HPH’s Nursing Services And Culture After The Merger | 188 |
| (1) | ENH Improved HPH’s Nurse Recruiting, Vacancy And Turnover After The Merger | 189 |
| (2) | ENH Improved HPH’s Nurse Training After The Merger..... | 190 |
| (3) | ENH Improved HPH’s Nurse/Physician Relationships After The Merger | 191 |
| c. | The Merger Substantially Improved HPH’s Quality Assurance Program | 192 |
| i. | Overview..... | 192 |
| ii. | HPH’s Quality Assurance Was Inadequate Before The Merger..... | 193 |
| (1) | HPH’s Pre-Merger Organizational Structure Hindered Quality Assurance Activities | 194 |
| (2) | HPH’s Pre-Merger Adverse Event Case Reviews Were Suboptimal..... | 195 |
| (3) | HPH’s Ob/Gyn Department Was Particularly Poor At Disciplining Problem Physicians | 196 |
| iii. | ENH Improved HPH’s Quality Assurance Program Soon After The Merger | 196 |
| (1) | The Merger Improved The Reporting Of Adverse Events At HPH | 197 |

| | | | |
|----|------|--|-----|
| | (2) | ENH’s Addition Of Strong Department Leadership At HPH Helped Correct Problems With Physician Discipline | 197 |
| | (3) | ENH Improved The Process Of Reviewing HPH Physician Credentialing Status | 199 |
| d. | | The Merger Improved HPH’s Quality Improvement Program..... | 199 |
| | i. | HPH’s Pre-Merger QI Program Was Inadequate..... | 200 |
| | ii. | ENH Exported Its Superior Quality Improvement Processes To HPH Soon After The Merger..... | 200 |
| | iii. | Data From HPH’s Pre-Merger Care Maps Cannot Be Used To Assess Quality Improvements At HPH Post-Merger..... | 202 |
| | iv. | Improvements In The Care Of Heart Attack Patients At HPH Demonstrates The Improvement In HPH’s QI Program Post-Merger..... | 202 |
| | (1) | ENH Improved The Provision Of Aspirin To Heart Attack Patients At HPH | 203 |
| | (2) | HPH Improved The Provision Of Beta Blockers To Heart Attack Patients After The Merger..... | 204 |
| | (3) | The Minor Change In Performance On The NRMI Measures Are Based On An Extremely Small Sample..... | 205 |
| | (4) | The Merger Resulted In A Dramatic Improvement In The Care Of Heart Attack Patients At HPH | 206 |
| e. | | ENH Corrected Serious Deficiencies In HPH’s Physical Plant | 206 |
| | i. | Overview..... | 206 |
| | ii. | Before The Merger, HPH Passed The Joint Commission’s Accreditation Inspections, Which Are Not A Comprehensive Assessment Of Hospital Quality, Because It Had Advance Notice Of The Inspections | 207 |

| | | |
|------|---|-----|
| iii. | A 1999 IDPH Survey Uncovered Numerous Physical Plant Deficiencies At HPH That Were Not Identified By The 1999 Joint Commission Accreditation Survey | 208 |
| iv. | Before The Merger, HPH Nearly Lost Its Medicare Accreditation Due To Serious Physical Plant Deficiencies That Threatened Patient Safety | 209 |
| v. | Pre-Merger Due Diligence Performed By ENH Identified Even More Serious Physical Plant Deficiencies | 209 |
| vi. | ENH Remedied The Substantial Deficiencies To HPH's Physical Plant And Made Additional Capital Improvements That Enhanced The Quality Of Care At HPH..... | 211 |
| | (1) ENH Opened A New Open Heart Surgery Suite At HPH | 212 |
| | (2) ENH Opened A New Ambulatory Care Center At HPH..... | 212 |
| | (3) ENH Purchased New Equipment For The Operating Rooms | 212 |
| 2. | ENH Made Additional Improvements To Quality Of Care And Introduced New High Quality Services | 213 |
| a. | ENH Initiated A Cardiac Surgery Program At HPH After The Merger..... | 213 |
| i. | Overview..... | 213 |
| ii. | HPH Was Not Well-Positioned To Begin A Cardiac Surgery Program | 214 |
| iii. | ENH Recruited A Talented Physician Leader For Cardiac Surgery Immediately After The Merger..... | 215 |
| iv. | Evanston Hospital And HPH, Since The Merger, Have An Integrated Cardiac Surgery Program That Shares An Affiliation With Other Hospitals | 216 |
| v. | HPH Had Equal Or Lesser Ability To Accept A New Cardiac Surgery Program Than The ENH-Affiliated Hospitals..... | 218 |

| | | |
|------|--|-----|
| vi. | The Post-Merger, Integrated ENH/HPH Cardiac Surgery Program Provides Excellent Care To Patients | 218 |
| | (1) The Mortality Rate For Cardiac Surgery At HPH Compares Favorably To The Best Surgery Centers In The Country | 218 |
| | (2) HPH Complication Rates For Cardiac Surgery Are Below National Benchmarks..... | 220 |
| vii. | The Merger Was Essential To The Success Of HPH's Cardiac Surgery Program..... | 221 |
| | (1) As A Result Of The Merger HPH Is An Integrated Part Of The ENH Cardiac Surgery Program | 221 |
| | (2) Due To The Level Of Integration Engendered By The Merger, HPH Performs Higher Quality Cardiac Surgery Than Affiliated Hospitals..... | 222 |
| b. | ENH Successfully Established An Interventional Cardiology Program At HPH..... | 224 |
| | i. Overview..... | 224 |
| | ii. Before The Merger, HPH Could Not Treat Heart Attack Patients With Interventional Cardiology Procedures..... | 224 |
| | iii. After The Merger, ENH Established A Successful Interventional Cardiology Program At HPH | 224 |
| | (1) HPH's Interventional Cardiology Program Has Obviated The Need To Transfer Acute Heart Attack Patients To Other Hospitals..... | 225 |
| | (2) The Interventional Cardiology Program At HPH Has Achieved High Quality Outcomes..... | 226 |
| | (3) On-Site Cardiac Surgery At HPH Is Needed To Continue The Interventional Cardiology Program..... | 226 |
| c. | The Merger Substantially Improved HPH's Intensive Care Services | 227 |

| | | |
|------|--|-----|
| i. | Overview..... | 227 |
| ii. | HPH’s ICU Had Gaps In Patient Care Before The Merger..... | 228 |
| iii. | The Addition Of Intensivist Coverage After The Merger Eliminated The Gaps In ICU Patient Care At HPH | 229 |
| (1) | Intensivists Have Broad ICU Responsibilities At HPH | 230 |
| (2) | The Intensivist Program Complemented The Introduction Of Cardiac Surgery At HPH | 231 |
| (3) | The Intensivist Program Improved Nursing Care In The HPH ICU..... | 232 |
| iv. | The Intensivist Program Improved The Overall Quality Of Care For HPH’s Critically Ill Patients | 232 |
| v. | HPH Had No Plans To Adopt An Intensivist Program Before The Merger | 233 |
| d. | The Merger Substantially Improved Oncology Services At ENH | 233 |
| i. | Overview..... | 233 |
| ii. | Pre-Merger Cancer Services At HPH Were Typical Of A Community Hospital..... | 234 |
| (1) | Pre-Merger Cancer Services At HPH Lacked Full Time Employed Oncologists | 234 |
| (2) | Pre-Merger Cancer Support And Ancillary Services At HPH Were Limited..... | 235 |
| (3) | Pre-Merger Cancer Patients At HPH Lacked Access To Specialists..... | 235 |
| (4) | Pre-Merger Cancer Services At HPH Lacked Academic Research And Clinical Trials | 235 |
| (5) | Pre-Merger Cancer Services At HPH Had Inadequate Facilities And Equipment..... | 236 |
| (6) | Pre-Merger Cancer Services At HPH Lacked Quality Assurance | 237 |

| | | |
|------|--|-----|
| iii. | ENH Made Major Improvements To The HPH Oncology Program That Significantly Expanded HPH's Cancer Services And Improved The Quality Of Cancer Care At HPH | 237 |
| | (1) The Kellogg Cancer Center Brought A Multidisciplinary Approach To HPH..... | 237 |
| | (2) ENH Improved Ancillary And Support Services For Cancer Patients After The Merger..... | 239 |
| | (3) ENH Provided More Qualified Staff And An Academic Affiliation To HPH's Cancer Program After The Merger | 240 |
| | (4) ENH Improved Patient Access To Specialists At HPH After The Merger | 240 |
| | (5) ENH Provided Increased Academic Research And Clinical Trials To HPH's Cancer Program After The Merger | 240 |
| | (6) ENH Provided State-Of-The-Art Equipment And Advanced Services To HPH's Cancer Program After The Merger | 241 |
| e. | The Merger Substantially Expanded And Improved Laboratory Services At HPH | 242 |
| | i. Overview..... | 242 |
| | ii. ENH Decided To Close CML Because It Was Inefficient..... | 243 |
| | iii. ENH Found Several Quality Issues When It Took Over The HPH Lab On June 1, 2000..... | 243 |
| | (1) ENH Found That The HPH Lab Had Equipment Issues | 243 |
| | (2) ENH Found That The HPH Lab Had Personnel Issues | 244 |
| | (3) ENH Found That The HPH Lab Had Environmental Controls Issues | 245 |
| | (4) ENH Found That The HPH Lab Had Water Issues..... | 245 |

| | | |
|------|--|-----|
| (5) | ENH Found That The HPH Lab Did Not Have A Histology Laboratory..... | 245 |
| (6) | ENH Found That The HPH Lab Did Not Have A Cytology Laboratory..... | 245 |
| (7) | ENH Found That The HPH Lab Did Not Have Adequate Laboratory Manuals | 246 |
| iv. | ENH Made Numerous Quality Improvements To The HPH Lab | 246 |
| (1) | ENH Improved The HPH Lab’s Equipment..... | 246 |
| (2) | ENH Improved The HPH Lab’s Personnel..... | 247 |
| (3) | ENH Improved The HPH Lab’s Environmental Systems | 247 |
| (4) | ENH Improved The HPH Lab’s Water System..... | 247 |
| (5) | ENH Constructed A Histology Laboratory At The HPH Lab | 247 |
| (6) | ENH Constructed A Cytology Laboratory At The HPH Lab | 247 |
| (7) | ENH Improved The HPH Lab’s Laboratory Manuals..... | 247 |
| (8) | ENH Improved The HPH Lab’s Quality Control | 247 |
| (9) | ENH Improved Microbiology Testing | 248 |
| (10) | ENH Improved Immunology Testing | 248 |
| (11) | ENH Improved Molecular Diagnostic Testing..... | 248 |
| (12) | ENH Improved The HPH Lab’s Computer System..... | 249 |
| (13) | ENH Established Oversight Of The HPH Lab By ENH Specialists | 249 |
| (14) | ENH Established The Rotation Of Pathologists Among The ENH Hospitals | 249 |

VOLUME IV

| | | |
|------|--|-----|
| v. | ENH's Improvements To The HPH Lab Have Improved Quality And/Or Resulted In Efficiencies | 250 |
| (1) | ENH's Improvements To The HPH Lab Dramatically Improved The Turnaround Time For Tests Performed In The HPH Lab | 250 |
| (2) | ENH Brought Its Academic Focus On Pathology To HPH..... | 250 |
| (3) | On-Site Testing Has Substantial Advantages Over Outsourcing..... | 250 |
| (4) | ENH Realized Substantial Cost Savings From The Dissolution of CML | 251 |
| (5) | HPH Pathologists Now Engage in Teaching Activities..... | 252 |
| f. | The Merger Resulted In Structured And Service Improvements To The HPH Emergency Department..... | 251 |
| i. | Overview..... | 251 |
| ii. | HPH's Pre-Merger ED Needed Improvement | 252 |
| (1) | In General, HPH's ED Facilities Were Inadequate Before The Merger | 252 |
| (2) | HPH Had Physician Staffing Problems Before The Merger..... | 252 |
| (3) | HPH's Fast Track Was Inadequate Before The Merger..... | 253 |
| iii. | ENH Significantly Improved The HPH ED After The Merger..... | 254 |
| (1) | ENH Substantially Expanded And Renovated The HPH ED | 254 |
| (a) | Phase I Of The HPH ED Renovation..... | 254 |
| (i) | Patient Rooms Were Redesigned..... | 254 |
| (ii) | Critical Care Rooms Were Updated..... | 255 |

| | | | |
|----|-------|--|-----|
| | (iii) | Isolation Rooms Were Added..... | 255 |
| | (b) | Phase II Of The HPH Renovation | |
| | (i) | The HPH ED Registration Area Was Made More Private..... | 255 |
| | (ii) | The HPH ED Triage Area Was Significantly Expanded..... | 256 |
| | (iii) | The HPH ED Waiting Area Was Remodeled | 256 |
| | (2) | ED Physician Coverage Was Expanded Post-Merger..... | 256 |
| | (i) | Double Coverage At HPH's ED Improved Quality Of Care | 256 |
| | (ii) | The Rotation Of ED Physicians At ENH Improved Quality Of Care..... | 257 |
| | (iii) | Other Staffing Changes At HPH's ED Improved Quality Of Care..... | 258 |
| | (3) | ENH Improved HPH's Fast Track Design And Processes | 258 |
| | (4) | ENH Coordinated HPH's ED And Its Cardiac Services..... | 259 |
| | (5) | ENH Increased Nurse Staffing In HPH's ED | 259 |
| | (6) | ENH Improved HPH's ED In Other Ways As Well | 259 |
| g. | | ENH Improved Pharmacy Services At HPH Post-Merger | 261 |
| | i. | Overview..... | 261 |
| | ii. | ENH Improved Drug Dispensing Services At HPH After The Merger | 261 |
| | (1) | ENH Added A Third-Shift Pharmacist To HPH..... | 261 |
| | (2) | ENH Added An Automated Drug Distribution System (Pyxis) To HPH | 262 |

| | | |
|------|---|-----|
| iii. | ENH Added Clinical Pharmacy Services At HPH After The Merger | 264 |
| iv. | HPH’s Institute For Safe Medication Practices Surveys Confirm That ENH’s Enhancements To HPH’s Pharmacy Services Have Improved Quality Of Care..... | 266 |
| h. | ENH’s Deployment Of EPIC At HPH Has Dramatically Improved The Quality Of Care | 267 |
| i. | Overview | 267 |
| ii. | Epic Integrates All Patient Information Into A Single Data Repository That Is Accessible By All Caregivers And The Patient | 268 |
| iii. | Sources Outside Of ENH, Including The Federal Government, Have Been Calling For The Use Of Electronic Medical Records | 268 |
| iv. | The Sharing Of Information Is Important To Patient Care And Patient Safety | 269 |
| v. | ENH Made A Patient-Centric Integrated Electronic Health Record Its Top Priority And Chose Epic Because It Was Best Suited To Accomplish This Goal..... | 269 |
| vi. | ENH Planned From The Outset To Deploy Epic At HPH And In Affiliate Outpatient Offices | 270 |
| vii. | ENH Aggressively Deployed Epic Throughout The ENH System..... | 270 |
| (1) | Initial Steps | 270 |
| (a) | Workflow Analysis | 270 |
| (b) | Build..... | 271 |
| (c) | Hardware Deployment..... | 271 |
| (d) | Training..... | 271 |
| (e) | Support System | 272 |
| (2) | Deployment..... | 272 |

| | | |
|-------|---|-----|
| viii. | The Deployment And Maintenance Of Epic Requires Tremendous Resources And Manpower..... | 273 |
| ix. | ENH Has Realized Cost Savings Through The Use Of Epic..... | 273 |
| x. | ENH Requires Physicians To Use Epic In The ENH Hospitals | 273 |
| xi. | Epic Allows ENH Clinicians To Access Complete, Up-To-Date Patient Information From Almost Anywhere..... | 274 |
| xii. | Epic Has Dramatically Changed And Improved The Practice Of Medicine | 274 |
| | (1) EPIC Makes Learning A Patient’s Medical History Considerably Easier | 274 |
| | (2) Epic Makes Finding And Reading A Patient’s Medical Information Substantially Easier | 275 |
| | (3) Epic Simplifies And Makes The Ordering Of Medication And Tests More Efficient | 275 |
| | (4) Epic Improves The Process By Which Laboratory Results Are Reported And Accessed | 276 |
| | (5) Epic Has Made Consulting With Other Physicians Much Easier | 277 |
| | (6) Epic Has Substantially Improved Laboratory Services..... | 277 |
| xiii. | Epic Has Numerous Safety Features That Improve The Quality Of Care..... | 277 |
| | (1) Epic Has Health Maintenance Alerts..... | 278 |
| | (2) Epic Has Best Practice Alerts | 278 |
| | (3) Epic Presents Physicians With Order Sets..... | 278 |
| | (4) Epic Facilitates The Use Of Clinical Pathways ... | 278 |
| | (5) Epic Implements A Clinical Decision Support System (“CDSS”)..... | 279 |
| | (6) Epic Improves Patient Access To Their Medical Records | 279 |

| | | |
|--------|--|-----|
| | (7) Epic Improves Quality Of Care When There Are Drug Recalls..... | 279 |
| xiv. | ENH’s Accomplishment In The Deployment Of EPIC Is Unique | 280 |
| xv. | ENH Has Been Recognized By Numerous Outside Sources For Its Successful Deployment Of Epic | 280 |
| xvi. | Other Academic Hospitals In The Chicago Area Are Looking To Learn From ENH’s Successful Deployment Of Epic | 281 |
| xvii. | Epic Has Not Been Implemented By Community Hospitals | 281 |
| xviii. | Epic Is Far Superior To Meditech, The System Used At HPH Before The Merger | 281 |
| i. | The Merger Improved The Quality Of Radiology, Radiation Medicine, And Nuclear Medicine At HPH | 282 |
| | i. Overview..... | 282 |
| | ii. HPH’s Pre-Merger Radiology Equipment Was Antiquated And Productivity Was Lower Than It Should Have Been With Respect To Radiology Services | 282 |
| | iii. ENH Made Substantial Post-Merger Improvements To Radiology And Radiation Medicine Services That Improved The Quality Of Care At HPH..... | 283 |
| | (1) ENH Upgraded The Equipment And Systems At HPH And Extended Its Technology To HPH | 283 |
| | (2) ENH Added Additional Radiology Staff And Improved Access To Specialists At HPH | 284 |
| | (3) HPH Would Not Have Been Able To Make The Improvements In Radiology And Radiation Medicine Without The Merger | 284 |
| | iv. ENH Made Significant Post-Merger Improvements To The Nuclear Medicine Department At HPH | 284 |
| j. | The Medical Staff Integration And Academic Involvement Of Physicians Which Resulted From The Merger Improved The Quality Of Care At HPH..... | 284 |

| | | |
|------|---|-----|
| i. | Overview..... | 284 |
| ii. | HPH Physicians Rotate Through All Three ENH Campuses | 285 |
| iii. | HPH Physicians Take Part In Teaching Activities For Residents And Medical Students At Evanston Hospital | 285 |
| iv. | HPH Physicians Participate In Departmental Conferences That Broaden Their Skills..... | 286 |
| v. | HPH Physicians Have Obtained Faculty Appointments As A Result Of The Merger | 286 |
| vi. | ENH Provides HPH Physicians With A Continuing Medical Education Stipend..... | 287 |
| vii. | HPH Has Gained An Academic Affiliation, Which Has Enabled It To Recruit Better Physicians | 287 |
| k. | The Merger Improved The Quality Of Psychiatric Services At HPH | 287 |
| i. | Overview..... | 287 |
| ii. | Before The Merger, The Adolescent Psychiatry Services Available At Both Highland Park And Evanston Hospitals Were Limited | 288 |
| iii. | HPH’s Adolescent Psychiatry Physical Facility Contained Hazards For Adolescent Patients..... | 288 |
| iv. | Consolidating Adolescent Psychiatric Services At HPH Allowed HPH To Offer New And Expanded Services | 288 |
| v. | ENH Expanded And Remodeled The Adolescent Psychiatry Unit To Make It Safer | 289 |
| vi. | The Improvements Made By ENH In Consolidating And Expanding Psychiatric Services At HPH Improved The Quality Of Care | 289 |
| E. | After The Merger, ENH Continued To Provide High Quality Hospital Services | 290 |
| 1. | ENH Has Been Independently Recognized For Having High Quality Of Care..... | 290 |

| | | |
|----|---|-----|
| a. | ENH Received Solucient’s 100 Top Hospital Award..... | 290 |
| b. | ENH Received Awards From HealthGrades For Clinical Excellence | 290 |
| c. | ENH Received Recognition From The Leapfrog Group | 291 |
| d. | ENH Hospitals Have Received National Recognition For Its Healthcare Quality | 291 |
| e. | US News & World Report Recognized ENH As A Top Hospital | 291 |
| f. | ENH Received The KLAS And Davies Award For Epic | 291 |
| 2. | There Is No Evidence That Quality Deteriorated At Evanston Hospital After The Merger..... | 291 |
| F. | The Programs Or Services ENH Improved And Added At HPH After The Merger Exceed National And State Quality Benchmarks | 292 |
| 1. | HPH’s Post-Merger Performance In Treating Patients With Acute Myocardial Infarction Exceeds The Average In Illinois Hospitals | 292 |
| 2. | HPH’s Post-Merger Cardiac Surgery Outcomes Exceed National Benchmarks..... | 292 |
| 3. | ENH Is A National Leader In The Implementation Of Electronic Medical Records | 292 |
| 4. | ENH Exceeds National Benchmarks For Its Cesarean Section Rate..... | 293 |
| 5. | ENH Exceeds National Benchmarks For Its Operative Vaginal Delivery Rate | 293 |
| 6. | ENH’s Preoperative Gynecologic Surgical Review Program Is Unique..... | 293 |
| 7. | Post-Merger HPH Is A Leader In Terms Of Its Full-Time Internist Program..... | 293 |
| G. | Dr. Romano’s Analysis Did Not Properly Evaluate ENH’s Significant Quality Improvements At HPH | 293 |
| 1. | Dr. Romano Relies Heavily Upon Flawed Administrative Data..... | 294 |
| H. | Dr. Romano Placed Undue Reliance On Patient Satisfaction Surveys..... | 297 |
| a. | Overview..... | 297 |

| | | |
|------|---|-----|
| b. | Dr. Romano Improperly Relied On Unreliable Patient Satisfaction Surveys | 298 |
| i. | Press Ganey Survey Response Rates Are Too Low To Draw Valid Conclusions..... | 298 |
| ii. | Press Ganey’s Rating Scale Has A Ceiling Effect..... | 299 |
| iii. | Press Ganey Uses Mean, Not Percentage, Scores..... | 299 |
| iv. | The Rhea & Kaiser Survey Is Not A Valid Measure Of Patient Satisfaction At HPH | 300 |
| c. | Dr. Romano Improperly Relied On Insufficient Press Ganey Data..... | 300 |
| IX. | OTHER COMPETITIVE EFFECTS CONSIDERATIONS | 302 |
| A. | The Merger Was Not Anticompetitive Because Of Low Barriers To Market Entry And Repositioning By Competitors | 302 |
| 1. | The Illinois CON Law Is Not A Barrier to Entry | 302 |
| a. | Most CON Applications Are Approved | 302 |
| b. | Most CON Applications Are Approved In A Timely Manner | 303 |
| c. | The CON Requirements In Illinois Have Been Revised And, As A Result, Fewer Projects Require CON Approval | 303 |
| d. | ENH’s Competitors Have Been Able To Expand Their Facilities And Services Pursuant To The CON Process | 303 |
| i. | Northwestern Memorial Has Expanded Its Facilities And Services | 303 |
| ii. | Condell Has Expanded Its Facilities And Services..... | 303 |
| iii. | Lake Forest Hospital Has Expanded Its Facilities And Services | 304 |
| B. | The Merger Was Not Anticompetitive Because HPH’s Financial Condition Was Declining Before The Merger..... | 304 |
| 1. | HPH’s Board Of Directors Determined That, Due To The Financial Condition Of HPH, HPH Could No Longer Maintain The Status Quo As An Independent Hospital | 304 |

| | | |
|----|--|-----|
| 2. | The HPH Board Decided That Merging With Evanston Hospital Was The Best Option For The Future Of HPH..... | 306 |
| 3. | HPH’s Financial Condition Was Rapidly Declining | 307 |
| 4. | Evanston Hospital’s Due Diligence Revealed That HPH’s Financials Were On A “Downward Spiral”..... | 309 |
| a. | HPH Was Losing Money And Being Supported With Investment Income..... | 311 |
| b. | HPH’s Debt Capacity Was Severely Constrained | 312 |
| c. | HPH’s Cash And Investments Were Insufficient To Compete In The Marketplace..... | 313 |
| d. | HPH’s Joint Ventures Were Losing Money | 314 |
| e. | HPH Made Insufficient Capital Expenditures | 315 |
| f. | HPH’s Collection Rates/Accounts Receivable Were Declining..... | 316 |
| g. | Due Diligence Revealed That HPH’s Future Financial Projections Were Unrealistic | 317 |
| 5. | Expert Testimony Confirms The Significance Of HPH’s Declining Financial Condition..... | 319 |
| C. | ENH’s Not-For-Profit Status Is Relevant To The Competitive Effects Analysis..... | 320 |
| 1. | Not-For-Profit Status Plays A Role In Hospital Pricing..... | 320 |
| 2. | The Opinions Of Complaint Counsel’s Not-For-Profit Expert Support The Fact That ENH, As A Not-For-Profit Entity, Acts Differently Than A For-Profit Entity | 320 |
| 3. | The Pre-Merger HPH Foundation Is Evidence Of How A Not-For-Profit Hospital Benefits The Community | 321 |
| 4. | The Creation Of The Independent Highland Park Healthcare Foundation As A Result Of The Merger Demonstrates How ENH Acts To Benefit The Community As A Not-For-Profit | 322 |
| a. | The Healthcare Foundation of Highland Park is Required to Monitor the Commitments ENH Made to the Community | 323 |
| b. | The Highland Park Healthcare Foundation Contributes Funds to HPH for the Benefit of the Community | 323 |

| | | |
|----|--|-----|
| c. | The Highland Park Healthcare Foundation Provides Grants To Community Organizations..... | 324 |
| X. | REMEDY..... | 325 |
| A. | Divestiture Is Not A Proper Remedy Because The Merger Was Necessary To Achieve Quality Improvements At HPH..... | 325 |
| 1. | HPH Was Not Capable Of Remediating Its Quality Problems, Implementing New Services, Or Improving Old Ones Without The Merger..... | 325 |
| a. | HPH Lacked The Financial Capacity To Implement Necessary Quality Improvements..... | 325 |
| b. | HPH Lacked The Capacity To Effect Organizational Change | 326 |
| 2. | The Improvements Made By ENH Could Not Have Been Achieved Through Joint Ventures | 327 |
| 3. | The Geographic Proximity Of Evanston Hospital To HPH Was Essential To Improving The Quality At HPH..... | 328 |
| 4. | The Merger Enabled HPH To Make Quality Improvements And Offer Services That Are Not Generally Offered By, And/Or Not Feasible For, Community Hospitals | 328 |
| a. | ENH Upgraded HPH To The Epic System..... | 328 |
| b. | ENH Vastly Improved HPH’s Oncology Services | 329 |
| c. | ENH Improved HPH’s ICU Services By Adding The Services Of Intensivists..... | 329 |
| d. | ENH Provided Much-Needed Improvements To HPH’s Ob/Gyn Services | 330 |
| B. | Divestiture Is Not A Proper Remedy Because It Would Erode Quality Of Care Improvements Resulting From The Merger And Thus Harm Consumers..... | 330 |
| 1. | Divestiture Would Have Adverse Quality Of Care Consequences Pertaining To Cardiac Procedures At HPH | 331 |
| a. | Divestiture Would Result In The Loss Of Cardiac Surgery At HPH..... | 331 |
| b. | Divestiture Would Result In The Loss Of Interventional Cardiology Program at HPH..... | 332 |

| | | |
|------|---|-----|
| c. | Divestiture Would Result In Loss Of Nursing Improvements Resulting From Improved Cardiac Care At HPH After The Merger | 333 |
| d. | Divestiture Would Result In Loss Of ICU Nurse Acuity Gained From The Cardiac Surgery Program | 333 |
| e. | Divestiture Would Result In A Decline In Quality Of Care For Patients With AMI..... | 333 |
| i. | HPH Would Lose Its Capacity To Treat AMI Patients..... | 33 |
| ii. | There Would Be An Increase In Transfers Of Patients With AMI From HPH To Other Hospitals..... | 333 |
| iii. | Delays In Transfer Would Harm Patients..... | 334 |
| 2. | Divestiture Would Result In HPH Returning To A Community Hospital Governance Model | 334 |
| a. | Loss Of Integrated Medical Staffs Would Deprive HPH of Clinical, Academic and Research Activities..... | 335 |
| i. | Divestiture Would Result In HPH’s Loss Of Academic Involvement By HPH Physicians At Evanston Hospital Campus..... | 335 |
| ii. | Divestiture Would Result In HPH’s Loss Of Research Partnerships With Physicians At Evanston Hospital | 335 |
| iii. | Divestiture Would Result In HPH’s Loss Of Department Conferences And Case Consultation..... | 335 |
| 3. | Divestiture Would Result In HPH’s Loss Of ENH Quality Improvement And Quality Assurance Programs | 335 |
| 4. | Divestiture Would Result In HPH’s Loss Of The Benefits Of Epic..... | 336 |
| 5. | Divestiture Would Result In A Diminished Ability By HPH To Recruit High-Caliber Physicians And Hospital Administrators | 337 |
| C. | Divestiture Is Not A Proper Remedy Because ENH Cannot “Unlearn” About Its Demand | 337 |
| D. | Divestiture Is Not A Proper Remedy Because The Merger Was Between Two Members Of An Approved Network..... | 337 |

E. Divestiture Is Not A Proper Remedy Because It Would Undo Efficiencies
Of The Merger338

Exhibit And Demonstrative ListAttachment A

Witness ListAttachment B

VII. THE MERGER RESULTED IN NO ANTICOMPETITIVE EFFECTS

A. The Court Should Consider Various Economic Factors In Its Competitive Effects Analysis

515. The economic principles that underlie the Merger Guidelines provide an appropriate framework for analyzing the Merger. (Noether, Tr. 5900, 5903).

516. The Merger “did not harm competition, neither price or quality; did not lead to the creation of market power for the merged entity; and therefore, there was no exercise of power. To the contrary, consumers benefited from the merger.” (Noether, Tr. 5900).

1. Dr. Haas-Wilson’s Analysis Is Based On A Bargaining Theory

517. (REDACTED)

(Haas-Wilson, Tr. 2756, *in camera*).

(Haas-Wilson Tr. 2757, *in camera*).

518. Dr. Haas-Wilson’s bargaining theory is premised on the notion that the Merger led to a reduction in the number of alternative hospitals available to MCOs for network building. According to Dr. Haas-Wilson’s bargaining theory, a MCO could have excluded Evanston Hospital from a network before the Merger because that MCO could have used HPH, among other hospitals in the area, as alternatives to Evanston Hospital. But after the Merger, Dr. Haas-Wilson surmises, a MCO could not exclude all three ENH hospitals from a network. According to Dr. Haas-Wilson, therefore, ENH gained market power as a result of the Merger. Without considering the full evidentiary context, Dr. Haas-Wilson purports to prove her theory by demonstrating that ENH’s post-Merger prices to MCOs increased more than the prices of competitor hospitals. (Haas-Wilson, Tr. 2472-73; Noether, Tr. 5983).

2. The Pertinent Pricing Analysis Under Dr. Haas-Wilson’s Bargaining Theory Has Both Theoretical And Empirical Dimensions

a. As A Theoretical Matter, Complaint Counsel Must Show More Than That ENH’s Prices Increased After The Merger

i. Price Changes Alone Are Not Evidence Of Market Power

519. (REDACTED)

(Baker, Tr. 4702, 4644, 4649-50, 4653, *in camera*; Haas-Wilson, Tr. 2677 *in camera*; Noether, Tr. 5904).

520. (REDACTED)

(Haas-Wilson, Tr. 2828, *in camera*).

ii. Complaint Counsel Must Evaluate And Eliminate Viable Alternative Explanations

521. Before concluding that post-Merger price increases were caused by the gain and exercise of market power, viable alternatives for the price increases must be evaluated and eliminated. (Haas-Wilson, Tr. 2677-78).

522. If there are credible, benign reasons why prices went up after a merger, then those “explanations would allow you to move forward and conclude that the merger was not anti-competitive, whether you defined a relevant product market or geographic market or not.” (Elzinga, Tr. 2404).

523. There are many potential viable alternative explanations for a post-merger price increase including:

- (a) **(REDACTED)** (Haas-Wilson, Tr. 2642 *in camera*; Haas-Wilson, Tr. 2484; Baker, Tr. 4652-53, *in camera*).
- (b) **(REDACTED)** (Haas-Wilson, Tr. 2482-83; Baker, Tr. 4652, *in camera*).
- (c) Changes in regulations. (Haas-Wilson, Tr. 2483).
- (d) **(REDACTED)**

(Haas-Wilson, Tr. 2681; Baker, Tr. 4652, *in camera*).
- (e) **(REDACTED)** (Baker, Tr. 4653, *in camera*; Haas-Wilson, Tr. 2682).
- (f) **(REDACTED)** (Baker, Tr. 4650-53 (discussing DX 8044), *in camera*).
- (g) Changes in quality at the merging hospitals or other area hospitals. (Haas-Wilson, Tr. 2482-85, 2684). For example, **(REDACTED)**

(Baker, Tr. 4653, *in camera*).
- (h) Changes in the mix of customers. (Haas-Wilson, Tr. 2486).
- (i) **(REDACTED)** (Haas-Wilson, Tr. 2585, *in camera*).
- (j) Decreases in the price of outpatient services. (Haas-Wilson, Tr. 2487).
- (k) Changes in information, also known as “learning about demand.” (Haas-Wilson, Tr. 2488).

- (l) Changes in a hospital's marketing and advertising program. (Haas-Wilson, Tr. 2683).
- (m) Changes in teaching intensity. (Haas-Wilson, Tr. 2486-87).
- (n) Payor specific changes. (Haas-Wilson, Tr. 2687-89).
- (o) Changes in reputation. (Haas-Wilson, Tr. 2682).
- (p) The addition of nicer amenities. (Haas-Wilson, Tr. 2683).

524. (REDACTED)

(Haas-Wilson, Tr. 2744, *in camera*).

525. Dr. Haas-Wilson did not put any probability estimates on any of these potential explanations. (Haas-Wilson, Tr. 2678). Nor did she know how much of a chance there would need to be that an alternative explanation explains a price increase for it to be considered "viable." (Haas-Wilson, Tr. 2680).

526. (REDACTED)

(Haas-Wilson, Tr. 2745-46, 2754, 2755-56, *in camera*).

527. (REDACTED)

(Baker, Tr. 4649-50, *in camera*).

iii. In Particular, Complaint Counsel Must Rule Out "Learning About Demand" To Show That ENH Exercised Market Power As A Result Of The Merger.

528. (REDACTED)

(Baker, Tr. 4654-55, 4699-4700, 4743-44, 4747-48, 4769, *in camera*).

529. (REDACTED)

(Baker, Tr. 4655-56, *in camera*).

530. (REDACTED)

(Baker, Tr. 4757-59, 4761-62, 4812, *in camera*).

531. (REDACTED)

(Noether, Tr. 5970-72; Baker, Tr. 4813-14, *in camera*). In fact, the literature on markets with asymmetric or imperfect information dates back to at least 1961, includes several papers published in well-respected journals, and includes a Nobel Prize in Economics awarded in 2001. (Noether, Tr. 5970-72 (*describing* DX 8108)).

iv. The Court Should Consider Both Price Levels And Price Changes When Evaluating Whether Price Increases Were The Result Of Market Power From The Merger.

532. (REDACTED)

(Noether, Tr. 5989, 5991; Haas-Wilson, Tr. 2823-24, *in camera*).

b. As An Empirical Matter, Complaint Counsel Must Show That ENH's Post-Merger Prices Increases Were The Result Of Market Power

533. (REDACTED)

(Noether, Tr. 6105-06, *in camera*; Baker, Tr. 4671, 4811, *in camera*). This issue is discussed more depth below in Section V.A.2, 3.

3. This Court Also Should Take Into Account Other Competitive Effects Considerations

534. The Court's competitive effects analysis also should take into account: (1) the vast improvements in quality of care after, and as a result of, the Merger (discussed in Section VIII); (2) the limited barriers to entry into the market and the repositioning of existing market participants to foster competition (discussed in Sections V.B.3.b.; IX.A); and (3) the inability of HPH to remain viable in the long-term due to its financial problems (discussed in Sections V.B.3.b.; IX.B.1).

B. The Pre-Merger Competitive Landscape Is Inconsistent With Dr. Haas-Wilson's Bargaining Theory

1. This Case Involves A Differentiated Product

535. As discussed in Section VI, hospital services are a differentiated product. (Noether, Tr. 5910, Haas-Wilson, Tr. 2492). They are differentiated on both product and geographic dimensions. (Noether, Tr. 5911).

536. Product differentiation has a number of dimensions including: (1) breadth of service, measured by number of DRGs; (2) size, measured by number of beds; and (3) teaching intensity, measured by number of residents and interns per bed. (Noether, Tr. 5911-12).

537. In a differentiated product market, firms that are closer substitutes to each other are more likely to constrain each other's competitive behavior. (Noether, Tr. 5911).

2. Evanston Hospital And HPH Were Not Close Substitutes

a. Evanston Hospital And HPH Were Not Close Substitutes From A Product Perspective

538. Evanston Hospital and HPH were not each other's closest substitutes in product space. (Noether, Tr. 5901; Neaman, Tr. 1306; Spaeth, Tr. 2244). Before the Merger, HPH could not possibly have replaced all of Evanston Hospital's services in a MCO's network because Evanston Hospital was a much larger hospital with an academic affiliation and offered a much broader array of services. (Chan, Tr. 706; Neaman, Tr. 1306-07; Spaeth, Tr. 2285).

539. Before the Merger, Evanston Hospital's closest substitutes in product space were other academic/tertiary care facilities such as Dr. Noether's academic control group hospitals. (Noether, Tr. 6160, 6196).

i. Evanston Hospital And HPH Offered A Different Breadth of Services

540. A breadth of service analysis supports Dr. Noether's conclusion that Evanston Hospital and HPH were not "likely to be very close substitutes." (Noether, Tr. 5917).

541. Dr. Noether used the number of DRGs treated by a hospital to analyze "breadth of services." (Noether, Tr. 5913). Dr. Noether considered the number of DRGs treated at twenty hospitals that compete one way or another with at least one of the merging hospitals. (Noether, Tr. 5913-14). **(REDACTED)**

(RX 1912 at 44, *in camera*).

542. In conducting this analysis, Dr. Noether excluded any DRGs in which a particular hospital treated fewer than four cases in a particular year, because she did not want to credit a hospital with DRGs that were either coding errors or the result of a patient coming into the emergency room being treated until stabilized and then transferred out. (Noether, Tr. 5914-15). Dr. Noether used 1999 data to conduct this analysis because she wanted to look at the breadth of

service at the different providers in the market in the period immediately leading up to the Merger. (Noether, Tr. 5913, 5916-17).

543. Evanston Hospital treated the fourth most DRGs out of the twenty hospitals that Dr. Noether considered. (Noether, Tr. 5915).

544. HPH provided the fewest number of DRGs out of the twenty hospitals that Dr. Noether considered, providing a little over half the number of DRGs that Evanston Hospital provided. (Noether, Tr. 5916).

545. Three hospitals – Loyola, University of Chicago and Advocate Northside – had “slightly more DRGs” than Evanston Hospital. (Noether, Tr. 5917).

546. Three hospitals – Northwestern Memorial, Advocate Lutheran General and Rush Presbyterian – had slightly fewer DRGs than Evanston Hospital. (Noether, Tr. 5917).

547. The number of DRGs at HPH was very similar to the number of DRGs at Lake Forest Hospital and the two Vista Hospitals. (Noether, Tr. 5917).

548. **(REDACTED)**

(Noether, Tr. 5986; RX 1912 at 44, *in camera* (describing DX 8113)). **(REDACTED)**

(Noether, Tr. 5986; RX 1912 at 44, *in camera*). **(REDACTED)**

(Noether, Tr. 5986; RX 1912 at 44, *in camera*).

549. The difference in terms of breadth of service between Evanston Hospital and HPH is further evidenced by the fact that Evanston Hospital had tertiary services pre-Merger, while HPH, to a large extent did not. (Haas-Wilson, Tr. 2491). Accordingly, **(REDACTED)** (Haas-Wilson, Tr. 2551-52, *in camera*).

550. In sum, it would have been difficult for MCOs to substitute HPH for Evanston Hospital in their networks before the Merger because HPH did not provide many of the services that Evanston Hospital provided. (Noether, Tr. 5918).

ii. Evanston Hospital And HPH Were Hospitals Of Very Different Sizes

551. Evanston Hospital and HPH were not close substitutes because they were hospitals of very different sizes. (Noether, Tr. 5921).

552. To look at hospital size, Dr. Noether considered the number of staffed beds for the same twenty hospitals considered in the breadth of service analysis. (Noether, Tr. 5918).

553. Staffed beds are different than licensed beds. (Noether, Tr. 5918-19). Each hospital is licensed to have a certain number of beds, and that number serves as the upper bound

on the number of staffed beds. (Noether, Tr. 5919). But often, depending on the demand for their services, hospitals do not actually staff all of the licensed beds. So the staffed beds number is the number of beds that are actually in operation. (Noether, Tr. 5919).

554. Although the Medicare Cost Report data suggests that Advocate Northside had over 650 beds in 1999, based on publicly available information, such as Advocate Northside's website, Dr. Noether concluded that Advocate Northside is really a 507-bed hospital. (Noether, Tr. 5919-20).

555. Evanston Hospital, with 411 staffed beds in 1999, was seventh out of the twenty hospitals that Dr. Noether evaluated in terms of bed size. (Noether, Tr. 5920; RX 1912 at 60).

556. In this regard, Evanston Hospital was most similar to Advocate Lutheran General, Advocate Northside, Rush Presbyterian, Northwestern Memorial, Advocate Lutheran General, University of Chicago and Loyola in terms of bed size. (RX 1912 at 60).

557. In contrast, HPH, with 157 beds in 1999, was nineteenth out of twenty in terms of bed size. (Noether, Tr. 5920; RX 1912 at 60). In that sense, HPH was most like Condell, with 163 beds in 1999, and Lake Forest Hospital, with 142 beds in 1999. (Noether, Tr. 5920; RX 1912 at 60).

iii. Unlike Evanston Hospital, HPH Had No Teaching Component

558. Evanston Hospital and HPH were not particularly close substitutes pre-Merger given that Evanston Hospital was an academic hospital and HPH merely was a community hospital. (Noether, Tr. 5924).

559. MedPAC defines "major teaching hospital" as one that has at least 0.25 medical residents per bed. (Noether, Tr. 5922). The number of residents per bed is an indicator of teaching intensity. (Noether, Tr. 5921). Evanston Hospital, which had .3386 medical residents per bed, satisfied this definition of a major teaching hospital. (Noether, Tr. 5922; RX 1912 at 60). HPH, which had no residents pre-Merger, obviously did not satisfy the definition of a major teaching hospital. (Noether, Tr. 5923; RX 1912 at 60).

b. Evanston Hospital And HPH Were Not Close Substitutes From A Geographic Perspective

560. As discussed in Section VI.B.1, a number of hospitals are closer (both in terms of distance, driving time, service area and physician admission patterns) to Evanston Hospital than HPH. And some hospitals are closer to HPH than Evanston Hospital.

c. Evanston Hospital And HPH Had Much Closer Substitutes Than Each Other

561. The following subsections are intended to supplement the geographic market discussion. (See Section VI.B.)

i. Evanston Hospital Had Several Closer Substitutes Than HPH

562. As far back as 1996, managed care executives believed that Evanston Hospital had many strong competitors and substitutes. (RX 145 at ENH JH 12083).

(1) Evanston Hospital's Closest Substitutes From A Product Perspective Were Advocate Lutheran General And Northwestern Memorial

563. Evanston Hospital's chief competitors were Advocate Lutheran General and Northwestern Memorial. (Chan, Tr. 706).

564. Around the time of the Merger, One Health considered Advocate Lutheran General to be one of the main alternatives to ENH. (Neary, Tr. 630-31; Dorsey, Tr. 1480-81). In addition, One Health considered Northwestern Memorial as an alternative to ENH. (Neary, Tr. 631).

565. The representative from United testified that Evanston Hospital competes with Advocate Lutheran General. (Foucre, Tr. 942). In United's view, as between Advocate Lutheran General, St. Francis, and Rush North Shore, Advocate Lutheran General, which is perceived as one of the highest quality hospitals in Chicago, is the most comparable facility to Evanston Hospital in type of services, quality of services and size of the facility. (Foucre, Tr. 943-44, 947). United also viewed Northwestern Memorial as Evanston Hospital's competitor for certain services. (Foucre, Tr. 946).

566. The PHCS representative viewed Advocate Lutheran General as a significant competitor for Evanston Hospital before the Merger. (Ballengee, Tr. 211). PHCS still considers Advocate Lutheran General a significant competitor for Evanston. (Ballengee, Tr. 211). For purposes of developing its network and deciding which hospitals to include, the PHCS representative viewed the services and quality at Advocate Lutheran General to be comparable to ENH. (Ballengee, Tr. 191).

567. **(REDACTED)** (Holt-Darcy, Tr. 1596, *in camera*). **(REDACTED)**

(Holt-Darcy, Tr. 1596, *in camera*).

568. **(REDACTED)** (Mendonsa, Tr. 561, *in camera*).

569. **(REDACTED)** (RX 1351 at BCBSI-ENH 5230, *in camera*). **(REDACTED)**

(RX 1351 at BCBSI-ENH 5230, *in camera*). **(REDACTED)**

BCBSI-ENH 5182-83, *in camera*). (REDACTED)

(RX 1368 at BCBSI-ENH

5183, *in camera*).

(2) Evanston Hospital's Closest Substitutes From A Geographic Perspective Were St. Francis And Rush North Shore

570. (REDACTED)

(Ballengee, Tr. 212; RX 754 at PHCS 7582, *in camera*; Ballengee, Tr. 263, *in camera*). In addition, PHCS viewed Rush North Shore as a significant competitor to Evanston Hospital. (Ballengee, Tr. 211-12).

571. One Health saw St. Francis as Evanston Hospital's most significant competitor. (Dorsey, Tr. 1472, 1479; Neary, Tr. 631) In addition, One Health believed that Rush North Shore could be a substitute for Evanston Hospital. (Neary, Tr. 624).

572. According to the representative from United, Evanston Hospital competes with St. Francis. (Foucre, Tr. 941). In addition, the United representative agreed that, because of their close proximity, Rush North Shore and Evanston Hospital were competitors. (Foucre, Tr. 941).

573. (REDACTED)

(Mendonsa, Tr. 562, *in camera*).

(Mendonsa, Tr.

562, *in camera*).

574. (REDACTED)

(Holt-Darcy, Tr. 1595-96, *in camera*).

575. A 1996 study conducted by Bain revealed that Blue Cross executives viewed St. Francis as a viable substitute for Evanston Hospital. (RX 145 at ENH JH 012083).

576. (REDACTED)

(RX 1803 at HFN 515, *in*

camera). Indeed, Resurrection documents have recognized Evanston Hospital as a competitor since at least 1995. (RX 119 at 12602, 12631-32).

ii. HPH's Closest Substitutes From Both A Product And Geographic Perspective Were Lake Forest Hospital And Condell

577. (REDACTED)

(Foucre, Tr. 944; Mendonsa, Tr. 562, *in camera*;

Dorsey, Tr. 1472; Ballengee, Tr. 212; Holt-Darcy, Tr. 1595, *in camera*).

578. (REDACTED)

camera). (REDACTED)
7582, *in camera*).

(RX 754 at PHCS 7582, *in*
7582, *in camera*)
(RX 754 at PHCS

579. Terry Chan, who was responsible for managed care contracting for HPH before the Merger and now works for Children's Hospital, viewed Lake Forest Hospital as HPH's closest competitor. (Chan, Tr. 647-48, 652-54, 656-57, 730).

580. Spaeth also confirmed that, before the Merger, HPH's primary competitor was Lake Forest Hospital. (Spaeth, Tr. 2239). Lake Forest Hospital was HPH's primary competitor because of the major overlap between both hospitals' medical staffs. (Spaeth, Tr. 2163). Over 200 of the same physicians were on both HPH's and Lake Forest Hospital's medical staffs. (Spaeth, Tr. 2163).

581. Accordingly, before the Merger, MCOs sometimes played Lake Forest Hospital off of HPH. (Chan, Tr. 747). For instance, certain MCOs offered to exclude Lake Forest Hospital from their networks in exchange for better rates with HPH. (Chan, Tr. 747).

582. Also before the Merger, HPH negotiated restricted contracts with certain MCOs that excluded Lake Forest Hospital and Condell, but never excluded Evanston Hospital. (Chan, Tr. 728).

583. HPH's first contracts with PHCS excluded Lake Forest Hospital. (Chan, Tr. 666-67). And in 1996, HPH's negotiators tried to play themselves off of one of their closest competitors, Condell Hospital, with PHCS. (RX 149 at ENHL TH 141). HPH offered rates to PHCS "contingent on the exclusion of Condell Hospital" from PHCS's network. (RX 149 at ENHL TH 141; RX 148 at ENHL TC 7927).

584. In the 1980s, HPH had an exclusive contract with Blue Cross that excluded Lake Forest Hospital, Condell and Victory Hospital. (Chan, Tr. 737).

585. HPH also had a contract with Humana's Premier plan that excluded Lake Forest Hospital and Condell. (RX 331 at ENH JL 2149; Chan, Tr. 726).

586. HPH agreed to certain discounts with HFN, with the expectation that it would be given a certain degree of exclusivity in HFN's network. (RX 406).

587. Finally, Lake Forest Hospital recognized Condell and HPH as its primary competitors. (RX 306 at FTC-LFH 67-69; RX 789 at LFH 811).

C. Dr. Haas-Wilson's Bargaining Theory Does Not Take Into Account The Fact That Evanston Hospital And HPH Had Very Different Negotiating Strategies And Contract Rates Before The Merger

588. Dr. Haas-Wilson concedes that the personalities of negotiators can impact the outcome of the bargain between hospitals and MCOs. (Haas-Wilson, Tr. 2745-46). Dr. Haas-Wilson, however, did not conduct any analysis to determine whether the personalities of the

negotiators at issue here had an impact on the outcome of negotiations between ENH and MCOs, either before or after the Merger. (Haas-Wilson, Tr. 2745-46).

589. The personalities of the pre-Merger and post-Merger negotiators are relevant to the consideration of the learning about demand theory, as discussed below. (Noether, Tr. 5972-73).

1. Evanston Hospital And HPH Had Different Pre-Merger Negotiating Strategies

a. HPH Had An Aggressive Pricing Strategy Before The Merger

590. HPH analyzed all of its contracts monthly, regardless of payment methodology. (Chan, Tr. 724-25). Before the Merger, HPH negotiated with MCOs on an annual basis. (Spaeth, Tr. 2174).

591. Before the Merger, HPH generally would start out negotiations with MCOs by asking for discount-off-charges arrangements. (Chan, Tr. 665).

592. If a per diem with a particular MCO were generating a discount of 20% to 30%, HPH asked for an increase in the per diem. (Chan, Tr. 676). If the contracted rates were generating a larger discount than 30%, HPH would try to restructure the stop-loss provision to reduce the loss to the hospital, and increase the effective discount. (Chan, Tr. 676). HPH believed that any discount larger than 15% was too large. (Chan, Tr. 670).

593. HPH also sent termination letters to MCOs to make them come to the negotiating table. (Chan, Tr. 734-35). HPH had, at various times before the Merger, threatened to terminate MCOs – including Blue Cross’s PPO plan, Humana’s Premier Plan and HFN’s EPO and PPO networks. (Chan, Tr. 725-26; RX 331 at ENH JL 2150; RX 406). HPH never took seriously the possibility of a MCO actually terminating the contract. (Chan, Tr. 666).

594. (REDACTED)

(Chan, Tr. 780-81, *in camera*).

b. Evanston Hospital, In Contrast, Did Not Focus On MCO Negotiations Before The Merger

i. Before 1999, Evanston Hospital Did Not Institute An Aggressive MCO Negotiation Policy

595. In the 1980s, MCO contracting at Evanston Hospital focused on building relationships. (Hillebrand, Tr. 1832). Because, at the time, Evanston Hospital believed that managed care soon would dominate the market, Evanston Hospital’s goal was to have a relationship with every new player in the marketplace. (Hillebrand, Tr. 1831-32).

596. In the 1980s, Evanston Hospital’s managed care book of business was much smaller. (Hillebrand, Tr. 1832). Consequently, Evanston Hospital did not feel pressured to seek revenue from MCOs during this period. (Hillebrand, Tr. 1832)

597. Before 1999, Evanston Hospital considered having relationships with MCOs to be of greatest importance because ENH did not want any barriers between itself and a patient or a physician. (Hillebrand, Tr. 1834-35). Evanston Hospital's pre-1999 MCO contracting strategy was reflected in Evanston Hospital's negotiating style. (Hillebrand, Tr. 1835). Evanston Hospital took the position that "it was more important to have the relationship [with the MCO] than anything else." (Hillebrand, Tr. 1835).

598. Before 1999, many of Evanston Hospital's MCO contracts were evergreen, meaning that they renewed automatically. (Hillebrand, Tr. 1835). For a variety of reasons, neither Evanston Hospital nor the MCOs sought to change their terms. (Hillebrand, Tr. 1835). That is, before 1999, Evanston Hospital did not negotiate MCO contracts on a yearly basis. (Hillebrand, Tr. 1835).

599. Even MCOs recognized that, before 1999, Evanston Hospital did not employ a confrontational negotiation strategy. (RX 105). For example, Aetna executive Barbara Hill wrote in 1995 to Neaman that "[w]hat went wrong for us with Aetna-Advocate relationship was Advocate's 'take it or leave it' negotiating stance. I know your team at Evanston has a friendlier approach!" (RX 105).

ii. Evanston Hospital's Pre-Merger MCO Contract Negotiator Used A Passive Negotiation Style

(1) Sirabian Was In Charge Of Evanston Hospital's Pre-Merger MCO Negotiations

600. Jack Sirabian, the former Vice President of Business Services, who testified at trial, was responsible for hospital managed care contracting at Evanston Hospital from the time the hospital first got into managed care contracting in approximately 1990 through January 2000. (Sirabian, Tr. 5965, 5697-98).

601. When Sirabian first became responsible for managed care contracting, he did not have any experience in contract negotiations. (Sirabian, Tr. 5697).

602. During the entire 10-year period in which Sirabian was responsible for managed care contracting at Evanston Hospital, he did not have any support staff helping him with that responsibility. (Sirabian, Tr. 5698). And during this period, Sirabian had responsibilities other than managed care contracting. (Sirabian, Tr. 5699). His main responsibilities were managing the hospital and professional business offices, which involved patient billing and customer service for the hospital and physicians. (Sirabian, Tr. 5699-5700). At no time during the 10-year period in which Sirabian was responsible for managed care contracting at Evanston Hospital was managed care contracting his sole responsibility. (Sirabian, Tr. 5701).

603. Sirabian reported to Hillebrand in connection with managed care negotiations, but he did not normally report to him about specific contracts. (Sirabian, Tr. 5701).

604. Hillebrand, however, maintained relationships with some of the very large insurers, such as Blue Cross and Humana. (Hillebrand, Tr. 2012). Hillebrand would get involved with face-to-face negotiations with these larger health plans. (Hillebrand, Tr. 1700).

Accordingly, Sirabian paid closer attention to Evanston Hospital's contracts with these MCOs. (Sirabian, Tr. 5707).

(2) Sirabian's Goal Was To Obtain "Win-Win Contracts"

605. Sirabian's goal in managed care negotiations was to ensure that Evanston Hospital would be included in all of the different MCO networks, and to build those relationships. (Sirabian, Tr. 5700, 5702, 5721).

606. Sirabian's negotiating philosophy was "win-win," *i.e.*, that if both the insurance company and the hospital had a contract then both could benefit from a successful relationship. (Sirabian, Tr. 5702). During negotiations with MCOs, Sirabian told the MCOs he was negotiating with a goal that both sides would benefit from the contract. (Sirabian, Tr. 5702-03; RX 97 at ENHL JL 1093).

607. Consequently, in managed care contract negotiations, Sirabian never attempted to secure aggressive rates from MCOs. (Sirabian, Tr. 5702, 5722, 5733-34). For example, Sirabian wrote to Humana in 1995 that, "[r]ather than counter your proposal with an amount higher than we would expect in order to reach a satisfactory compromise, I will propose a fair and reasonable amount right now which we both can support." (RX 108 at ENHL JL 3173).

608. Although Sirabian used cost information, provided by Evanston Hospital's accounting department, to ensure that the rates being offered exceeded Evanston Hospital's costs, he primarily evaluated whether to accept the rates proposed by a MCO based on gut reaction, and would decide when negotiations were at a point that they could not go any further based on intuition. (Sirabian, Tr. 5704-05)

609. Before the Merger, Evanston Hospital had been worried that taking a tougher stand in negotiations would backfire. (RX 2047 at 34 (Ogden, Dep.)). Part of that was personality; Sirabian was not comfortable taking a tough stand, and "had severely, tragically underestimated how [Evanston Hospital] was positioned in the marketplace to begin with." (RX 2047 at 34 (Ogden Dep.)).

610. Chan, who worked with Sirabian (her Evanston Hospital counterpart) just before and after the Merger, did not believe that Sirabian was a tough negotiator. (Chan, Tr. 740-41). **(REDACTED)**

(Haas-Wilson, Tr. 2820, *in camera*; RX 2030, *in camera*).

(3) Sirabian Did Not Threaten Termination As A Means To Obtain Aggressive Rates

611. During contract negotiations, Sirabian rarely threatened to terminate a contract if a MCO refused to agree to his proposed rate. Again, his primary objective was to be included in the network. (Sirabian, Tr. 5702-03, 5752).

612. For example, during the 1990s, the three most difficult payors to negotiate with were Cigna, Aetna and United because these MCOs were not willing to bring the negotiations to

a conclusion. (Sirabian, Tr. 5710, 5715-16). Nevertheless, Sirabian never threatened to terminate any of these contracts. (Sirabian, Tr. 5763-64).

(4) Sirabian Let Contracts Lapse And Did Not Initiate Contract Renegotiations

613. During the 1990s, Evanston Hospital's contracts with MCOs typically were 12-months in duration. (Sirabian, Tr. 5701, 5705). After the contracts expired, if new rates were not agreed upon, the current contract would continue to exist until a new rate structure was put in place (*i.e.*, an evergreen contract). (Sirabian, Tr. 5705).

614. Generally, contracts had to be renegotiated 2-3 months before the contract expired. (Sirabian, Tr. 5705). Sirabian was usually responsible for initiating the renegotiations. (Sirabian, Tr. 5705-06). Because rates generally increased with renegotiation as a result of increasing costs and other factors, insurers generally had little incentive to initiate renegotiations. (Sirabian, Tr. 5706).

615. Sirabian's practice, however, was not to initiate renegotiations before the contract term expired for those insurers with which Evanston Hospital had low volumes and that represented a small portion of Evanston Hospital's overall business – including Aetna, Cigna and networks such as One Health. (Sirabian, Tr. 5706-07).

iii. Many Evanston Hospital Contracts Had Not Been Renegotiated In A Number Of Years

616. Before the Merger, Evanston Hospital had not negotiated a new contract with Cigna since 1995. (CX 5013 at 6).

617. In a letter to Sirabian, on December 3, 1999, First Health acknowledged that "Evanston and Glenbrook Hospital rates have not been renegotiated for some period." (RX 695 at FH 8575).

618. Before the Merger, Evanston Hospital had not negotiated a new HMO or PPO contract with One Health since 1996. (Neary, Tr. 596; CX-5061; CX-5065).

619. **(REDACTED)**
(Mendonsa, Tr. 563, *in camera*; CX 5007 at 2 (effective date Nov. 1, 1996); Hillebrand, Tr. 1897).

620. **(REDACTED)**
(Holt-Darcy, Tr. 1582, *in camera*; CX 5085 at 1).

621. At the time of the Merger, Bain brought to ENH's attention that its rates with United Healthcare had not been renegotiated since 1994. (Hillebrand, Tr. 1870; RX 684 at BAIN 73).

622. In negotiations with Preferred Plan in 1995, Sirabian recognized that Evanston Hospital's contract had not been renegotiated in 18 months. (RX 100). And as of May 1997, Evanston Hospital had not negotiated a new contract with Preferred Plan for roughly two years. (RX 250).

623. In addition, as seen in Sirabian's June 1995 letter to the Travelers' Insurance Group, a one-year contract was allowed to remain in existence for almost two years without being renegotiated. (RX 98).

c. By The Late 1990's, Changing Financial Conditions Put Pressure On Evanston Hospital To Focus On MCO Contract Rates

624. Evanston Hospital experienced financial pressures in the late 1990s from an operating standpoint. (Neaman, Tr. 1314).

625. Evanston Hospital's key sources of financial pressure in the late 1990s were the Balanced Budget Act of 1997 ("Balanced Budget Act"), declining economic returns and decreased payors reimbursement. (Neaman, Tr. 1314, 962-63; Hillebrand, Tr.1837). The pricing pressures from Medicare and the MCOs were both a significant threat to, and an opportunity for, Evanston Hospital. (Neaman, Tr. 1152; CX 2037 at 3).

626. Kim Ogden of Bain believed that from, 1993 to 1999, pricing pressures on hospitals persisted from managed care and the Balanced Budget Act. (RX 2047 at 8 (Ogden, Dep.)). Providers thus moved to become more efficient and develop higher quality services. (RX 2047 at 8 (Ogden Dep.)).

i. Evanston Hospital Realized The Adverse Financial Effect Of The Balanced Budget Act Until In Late 1998 And 1999.

627. Congress passed the Balanced Budget Act in 1997 as an effort by the federal government to erase the federal budget deficit. (Neaman, Tr. 1314). The original Balanced Budget Act was intended to cut approximately \$100 billion paid to hospitals and doctors through federal programs such as Medicare. (Neaman, Tr. 1314). The Balanced Budget Act and the federal government, however, ultimately reduced payments to hospitals and physicians by \$225 billion. (Neaman, Tr. 1314).

628. Academic medical centers were especially threatened by the cuts in the Balanced Budget Act. (H. Jones, Tr. 4178; RX 528 at ENH RS 5507). For instance, in the Summer of 1999, Mt. Sinai Medical Center in Cleveland discontinued its academic programs, Stanford University Hospital cut 15% of its workforce and Henry Ford Hospital in Detroit had its bond rating reduced. (RX 528 at ENH RS 5507).

629. The Balanced Budget Act affected all hospitals to some extent, but Evanston Hospital was hit harder than most because the Balanced Budget Act disproportionately affected hospitals, like Evanston Hospital, with many clinical service lines, employed physicians, home care, teaching programs and research institutes. (Neaman, Tr. 1315).

630. Beginning in 1998, and for the next five years, the Balanced Budget Act reduced Evanston Hospital's operating revenue by \$16 million per year. (Hillebrand, Tr. 1844). Starting in 1998, and for the next five years, the Balanced Budget Act reduced Evanston Hospital's operating income by a total of \$80 million. (Hillebrand, Tr. 1845, 1837; Neaman, Tr. 1315-6; RX 518 at ENH GW 2044).

631. Evanston Hospital did not realize the full impact of the Balanced Budget Act until late 1998 or early 1999. (Hillebrand, Tr. 1837; RX 462 at ENH RS 5480).

632. By early 1999, HPH was also starting to feel the impact of the Balanced Budget Act's reimbursement cuts. (RX 462 at 2). The impact of the Balanced Budget Act was estimated to be \$15 million over five years for Lakeland Health Services. (RX 518 at ENH GW 2044).

633. The Balanced Budget Act had a significant negative effect on Evanston Hospital's operating income starting in 1998 and 1999, causing operating income to turn from positive to negative. (CX 6304 at 12 (Livingston, Dep.)).

634. Before the Balanced Budget Act was passed, Evanston Hospital's operating income was sufficient to allow Evanston Hospital to avoid using money from its endowment to support its financial well-being. After, and due to, the Balanced Budget Act, however, Evanston Hospital had to use money from its endowment to maintain an acceptable operating income level. (CX 6304 at 12 (Livingston, Dep.)). As of July 2004 (but never before 1998), every year Evanston Hospital would take \$20 million from its endowment and place that \$20 million into its operating earnings category. (CX 6304 at 12 (Livingston, Dep.)).

635. The money in Evanston Hospital's endowment is invested in various stocks and bonds. (Neaman, Tr. 1316). Evanston Hospital/ENH had a policy of not dipping into the principle of its investments but, instead, uses investment income for specific purposes. (Neaman, Tr. 1316-17). For example, as of February 2005, ENH annually used \$20 million of Second Century Fund, an endowment designed to produce investment income, to support free care, research and academic programs. (Hillebrand, Tr. 1843-44). Because the endowment is used to build new business in the absence of operating income, a net decrease in operating income is undesirable. (CX 6304 at 13 (Livingston, Dep.)).

636. The Balanced Budget Act also had an impact on MCO reimbursement because many of the MCOs use Medicare fee schedules as a basis for negotiating rates with hospitals. (Neaman, Tr. 1319). In 1997, Medicare, Blue Cross and Humana instituted significant reductions in reimbursements. (CX 2037 at 2; Neaman., Tr. 1151-52).

ii. Since the late 1990s, Evanston Hospital/ENH, Along With Other Hospitals, Have Been Under Pressure To Reduce Costs

637. In 1998, Evanston Hospital felt more pressure to cut costs and improve revenue. (Neaman, Tr. 963; H. Jones, Tr. 4108). This feeling was not unique to Evanston Hospital/ENH. **(REDACTED)** (RX 1393 at ENHL BW 3681, *in camera*; H. Jones, Tr. 4108).

638. (REDACTED)

(RX 1205 at FTC-RNSMC 361, *in camera*).

(RX 1205 at FTC-RNSMC 361, *in camera*).

639. (REDACTED)

(RX 1393 at ENHL BW 3681, *in camera*).

640. MCOs such as Unicare also recognized that hospitals faced increasing costs caused by increased health care demand and HIPAA. (RX 1189 at ENHL JL 14125).

iii. By The Late 1990s, Evanston Hospital No Longer Could Rely As Heavily On Its Investment Income

641. In 1990, Evanston Hospital created the Second Century Fund, an endowment designed to produce investment income. (Hillebrand, Tr. 1843). From 1990 until the late 1990s, Evanston Hospital did very well in investment income and achieved its targeted financial returns. (Hillebrand, Tr. 1835-36).

642. Before the late 1990s, Evanston Hospital management and the Evanston Hospital Board felt that the managed care pricing levels were sufficient as long as Evanston Hospital was able to get a 2% return from operations over the Medical Consumer Price Index. (Hillebrand, Tr. 1836).

643. In 1990s, investment income grew between 10-20% per year. (Neaman, Tr. 1317). As the 1990s progressed, however, Evanston Hospital was not able to maintain 10-20% annual returns on its investment income. (Neaman, Tr. 1317).

644. Evanston Hospital was experiencing a decline in "Net Non-Operating Revenue," the majority of which is investment income. (H. Jones, Tr. 4107; RX 514 at FTC-KHA 1665). Evanston Hospital's non-operating income decreased from \$71 million in 1997 to \$59 million in 1998 and was projected to level off at approximately \$45 million for the next three years before gradually increasing in 2002-2004. (H. Jones, Tr. 4107-08; RX 514 at FTC-KHA 1665).

645. Although Evanston Hospital initially projected fairly stable non-operating revenue into the future, by the late 1990s, Evanston Hospital suffered significant deterioration in investment returns as Evanston Hospital's income from investments quickly decreased because of poor returns from the stock market. (Hillebrand, Tr. 1837; CX 6304 at 12 (Livingston, Dep.); H. Jones, Tr. 4108; RX 514 at FTC-KHA 1665).

2. Evanston Hospital And HPH Had Different Negotiated MCO Contract Rates Before The Merger

646. As discussed in Section , the different negotiating styles of Evanston Hospital and HPH led to different negotiated MCO contract rates before the Merger.

D. Dr. Haas-Wilson's Bargaining Theory Does Not Eliminate All Viable Alternative Explanations For ENH's Post-Merger Price Increases, Such As Learning About Demand

1. "Price" Can Be Defined In Several Ways

647. There are several different ways to think about price. (Noether, Tr. 5988).

a. Charges

648. Price could be thought of as a hospital's charges. Every hospital or hospital system has a chargemaster, which provides a list price that a hospital charges for each component of the products and services provided by the hospital or hospital system. (Hillebrand, Tr. 1710-11, 1716; Porn, Tr. 5646).

649. In most cases, however, chargemaster prices do not reflect the actual prices paid by patients or MCOs. (Hillebrand, Tr. 1710-11, 1716).

b. Contract Rates

650. Another way to think about price is to consider the rates contained in the contracts between hospitals and MCOs, or "contract rates." (Noether, Tr. 5988).

651. (REDACTED)

, which is discussed in more depth below.
(Baker, Tr. 4807-08, *in camera*).

652. The claims data produced by certain MCOs during discovery include information on the patient, at what hospital the patient received care, the date of admission, the date of discharge, and in many cases the diagnosis, age and gender of the patient. Importantly, this data also includes the amount that the MCO reimbursed the hospital for the care of the patient. (Haas-Wilson, Tr. 2496).

653. (REDACTED)

(Baker, Tr. 4807-08,
in camera; Haas-Wilson, Tr. 2496).

c. Reimbursement Rates

654. Another way to think about "price" is to consider the actual amount paid to a hospital through a managed care contract relationship, or the "reimbursement amount."

(Noether, Tr. 5988). This amount combines the amount paid by the MCO with the amount paid directly by the patient. (Noether, Tr. 5988).

655. It is possible to calculate imperfect reimbursement amounts from some of the claims data provided by the MCOs in discovery. (Noether, Tr. 5988-89).

2. The Factual Evidence Is Consistent With The Learning About Demand Alternative Explanation For The Price Increases At Issue

a. Coincident With The Merger, ENH Learned That It Was “Leaving Money On The Table” Through Proper Due Diligence

656. HPH and Evanston Hospital shared their pre-Merger contract rates during the Merger due diligence. (Chan, Tr. 712).

657. One of Chan’s responsibilities on the contracting team, from HPH’s side, was to compare HPH’s rates with MCOs to Evanston’s rates. (Chan, Tr. 659-60, 714). When Chan first saw Evanston’s charges, she felt they were low as compared to HPH. (Chan, Tr. 739).

658. **(REDACTED)**

(Chan, Tr. 660, 662-63, 711-12; RX 620 at ENHL TC 17809, *in camera*). Chan found that the discounts at Evanston Hospital were substantially larger than HPH’s discounts. (Chan, Tr. 739, 711-13, 715-16). **(REDACTED)**

(RX 620 at ENHL TC 17810, *in camera*; Chan, Tr. 714-17).

659. **(REDACTED)**

(RX 663 at ENHL TC 16939, *in camera*; Chan, Tr. 671; Chan, Tr. 852-53, *in camera*).

660. **(REDACTED)**

(RX 663, at ENHL TC 16939, *in camera*; Chan, Tr. 853-54, *in camera*).

661. **(REDACTED)**

(RX 620 at ENHL TC 17811, *in camera*). **(REDACTED)**

(RX 620 at ENHL TC 17811, *in camera*; Chan, Tr. 716-17).

662. A week after writing her first memo, Chan wrote another memo to Gilbert and Newton on September 30, 1999, comparing the rates of HPH and Evanston Hospital’s contracts on a contract-by-contract basis. (RX 625 at ENH JL 8293).

(Chan, Tr. 825, *in camera*).

663. Chan found that Evanston Hospital's effective discount for inpatient services was 54.11%, while HPH's effective discount was only 38.78%. (RX 625 at ENH JL 8294). HPH would have received over \$5 million less in revenue for inpatient services for the year if it applied Evanston Hospital's rates. (RX 625 at ENH JL 8294; Chan, Tr. 723). For outpatient services, HPH would have received \$2.881 million less in revenue for the year if it applied Evanston Hospital's rates, and just under \$8 million less in revenue for the year overall if inpatient and outpatient services were combined. (RX 625 at ENH JL 8294; Chan, Tr. 722-24). This figure was based on 80% of HPH's managed care contracts. (RX 625 at ENH JL 8294; Chan, Tr. 724). If the remaining 20% of HPH's contracts were also examined, HPH may have lost even more revenue. (Chan, Tr. 724).

664. Chan also examined individual MCO rates with the hospitals, and found that PHCS had a much larger effective discount with Evanston Hospital, 51.98%, than with HPH, 17%. (RX 625 at ENH JL 8294; Chan, Tr. 718-19). Chan also found that there was a significant difference between Evanston Hospital's effective discount with United, 60.59%, and HPH's effective discount with United, 15%. (RX 625 at ENH JL 8294; Chan, Tr. 719-20).

665. In the Highland Park Healthcare Board of Directors meeting on October 22, 1999, Chan and Gilbert reported that "applying ENH's hospital contract rates to [HPH] would reduce [HPH's] annual net revenue from managed care payors by approximately \$8,000,000." (RX 674 at ENHL TC 17915).

666. **(REDACTED)**

(RX 663 at ENHL TC 16939,
in camera).

667. Evanston Hospital's negotiator, Sirabian was surprised to learn that HPH was getting higher rates than Evanston Hospital. (Sirabian, Tr. 5717-18). For example, Sirabian was surprised to learn that HPH had higher rates with United. (Sirabian, Tr. 5763)

668. Sirabian expected all of Evanston Hospital's rates to be higher than HPH's rates because Evanston Hospital was an academic institution and HPH was a community hospital, and the types and quality of care provided by the two organizations were very different. (Sirabian, Tr. 5718).

669. Even Spaeth was surprised to learn that HPH had better rates on the majority of MCO contracts. He assumed that an academic medical center with highly sophisticated care like Evanston Hospital would have better rates than a community hospital like HPH. (Spaeth, Tr. 2297).

b. At The Time Of The Merger, Evanston Hospital Learned About The Demand For Its Services Through Bain's Consulting Services

670. Bain & Co. ("Bain") was a consulting firm hired by Evanston Hospital, in part, to give advice to Evanston Hospital's management regarding contract negotiations. (Chan, Tr. 652). Evanston Hospital specifically engaged Bain for help with the Merger in the Fall of 1999. (Neaman, Tr. 1159). Bain provided advice and analysis pertaining to the Merger and was paid about \$1 million for this work. (Neaman, Tr. 1148; Hillebrand, Tr. 1800).

671. Kim Ogden, an operating Vice President at Bain, was responsible for overseeing the merger related work done by Bain. (RX 2047 at 6 (Ogden, Dep.)). Ogden did not testify live at trial, but portions of her deposition testimony were admitted into evidence. Ogden did not work for Bain at the time of her deposition. Presently, she works in an unpaid position running a non-profit organization. (RX 2047 at 2 (Ogden, Dep.)).

672. Bain examined Evanston Hospital's and HPH's managed care contracts in October and November 1999. (Hillebrand, Tr. 1849, 1851; RX 652).

673. Bain had a kick-off meeting with Evanston Hospital management to talk about what benefits may result from the Merger and where Bain should focus its efforts. As a result of the meeting, two projects became a priority for Bain: (1) a review of Evanston Hospital's service lines became a priority because Evanston Hospital was in the process of planning its capital expenditures; and (2) a review of Evanston Hospital's contracts also became a top priority in light of the discovery that several of Evanston Hospital's contracts had expired. (RX 2047 at 10 (Ogden, Dep.)).

674. Bain believed that the Merger provided Evanston Hospital with opportunities to expand its geographic reach, add new services, consolidate existing services to improve quality, develop centers of excellence, eliminate duplicate costs, engage in benchmarking and relieve Evanston Hospital's capacity constraints through capital investments at HPH. (RX 2047 at 8-9, 14 (Ogden, Dep.)).

675. As to the benchmarking opportunities presented by the Merger, Evanston Hospital believed that HPH was not a well-run hospital, and there was an opportunity to share Evanston Hospital's best practices with HPH to improve both quality and costs. (RX 2047 at 9 (Ogden, Dep.)). The best examples of areas where Evanston Hospital could enhance HPH's capabilities included obstetrics, cardiac care and oncology. (RX 2047 at 14 (Ogden, Dep.)).

676. After Bain completed its "Initial Review," Evanston Hospital organized teams under Hillebrand's guidance to begin the negotiating process with various MCOs. (Hillebrand, Tr. 1851).

i. Bain Advised ENH That HPH Had More Favorable MCO Contracts

677. Until 1999, Evanston Hospital management believed that it was "getting good rates." (RX 2047 at 61 (Ogden, Dep.)). But Bain advised ENH that HPH's contract rates "were

just better.” (RX 2047 at 11 (Ogden, Dep.)). HPH had much higher per diems than Evanston Hospital, and HPH “negotiated structurally better.” (RX 2047 at 11 (Ogden, Dep.)). HPH was doing a much better job than Evanston Hospital on the contracting side.

678. In contrast, Sirabian had a “very loose style,” was not organized and was “not on top of contracting at all.” (RX 2047 at 11 (Ogden, Dep.)). This was “highlighted by what [ENH] learned about Highland Park’s contracting.” (RX 2047 at 11 (Ogden, Dep.)).

679. Strikingly, in 8 out of the 13 contracts that Bain compared in a November 1999 presentation, HPH had more favorable contract terms than Evanston Hospital. (Hillebrand, Tr. 1803; CX 75 at 6). Bain completed a side-by-side comparison of Evanston Hospital’s and HPH’s hospital contracts and found that, “[i]n general, HPH generates more revenue per case on a [case-mix] adjusted basis” and “higher revenue per day on a [case mix] adjusted basis.” (RX 1995 at 8-9).

680. For example, Bain’s analysis revealed that HPH’s United contract was roughly two times more favorable than Evanston Hospital’s United contract. (RX 684 at BAIN 43; Hillebrand, Tr. 1893). From this information, Hillebrand learned that United was paying Evanston roughly 45-50% of what United was paying HPH. (Hillebrand, Tr. 1869; RX 684 at BAIN 43).

681. **(REDACTED)**

(Hillebrand, Tr. 1870; Neaman, Tr. 1340-41; RX 684 at BAIN 73; Haas-Wilson, Tr. 2851-52, *in camera*).
(REDACTED)

(RX 679 at ENHL RG at 4135; Chan Tr. 857-59, *in camera*). Put simply, United was paying Evanston Hospital “less than at a fair rate and less than other comparable institutions.” (Hillebrand, Tr. 1872). **(REDACTED)**

(RX 694 at ENHL TC 8787, *in camera*).

682. Hillebrand was “beyond surprised” by the gap between the rates that HPH was getting from United and what Evanston Hospital was getting from that MCO. (Hillebrand, Tr. 1871). Hillebrand had believed that United was paying Evanston Hospital on par with academic medical centers for many years before 2000. (Hillebrand, Tr. 1871). Up until receiving this advice, Hillebrand believed that Evanston Hospital had better contracts than HPH. (Hillebrand, Tr. 1853).

683. Similarly, Neaman was “shocked that here we were, Evanston, the big . . . teaching place with all of the services running around, and for example, with United, we’re getting half of what a community hospital is.” (Neaman, Tr. 1344-45). Specifically, Neaman was “shocked” to learn that HPH had better rates, particularly on the United contract. (Neaman, Tr. 1342).

684. **(REDACTED)**

(RX 2047 at 61 (Ogden, Dep.); CX 75 at

11; RX 684 at BAIN 48; Neaman, Tr. 1341; Chan, Tr. 860-61, *in camera*). Ogden attended a meeting with United, during which the “woman who was negotiating for United was – seemed very embarrassed when it was raised in the meeting that Highland Park’s rates were so much higher than Evanston’s. You know the United contract itself was from 1994, . . . the rates. So obviously Evanston was extraordinarily behind because it hadn’t been negotiated at all, and she . . . made several comments that suggested she was going to go back and fix this. So there was acknowledgement that . . . some changes need to be made in the rates.” (RX 2047 at 31 (Ogden, Dep.)).

685. Bain also advised Evanston Hospital that HPH had higher reimbursement rates with PHCS. (Hillebrand, Tr. 1892). Bain estimated that PHCS’s rates with HPH were 30-35% higher than Evanston Hospital’s rates. (Hillebrand, Tr. 1893; RX 684 at BAIN 43).

686. **(REDACTED)**

(RX 718 at 6, *in camera*; Chan, Tr. 865-66, *in camera*). **(REDACTED)**

(RX 718 at 6, *in camera*). **(REDACTED)**

(RX 718 at 6, *in camera*).

687.

(REDACTED)

(RX 762 at ENHL TC 9917, 9924 *in camera*;
RX 2047 at 57 (Ogden, Dep.); CX 67 at 39).

688. **In addition, (REDACTED)**

(RX 718 at 6-7, *in camera*).

689. **(REDACTED)**

(RX 762 at ENHL TC
9936, *in camera*).

690. **(REDACTED)**

(RX 762 at ENHL TC 9942, *in camera*). **(REDACTED)**

(RX 762 at ENHL TC 9942, *in camera*).

691. HPH also had higher rates on the Humana PPO/Employers Health contract, but unlike Evanston Hospital, HPH did not have a Humana Staff Medicare or Humana Staff contract. (CX 75 at 6; Hillebrand, Tr. 1804).

692. Evanston Hospital was “not very thoughtful about building in escalators for costs, medical cost increases, et cetera. So I think structurally Highland Park looked like it had just been more thoughtful.” (RX 2074 at 11 (Ogden, Dep.); Hillebrand, Tr. 2043).

693. Evanston Hospital had some contract rates that were more favorable than HPH’s contract rates. For example, Bain discovered that pre-Merger Evanston Hospital’s rates with Blue Cross’ PPO were slightly higher than HPH’s Blue Cross PPO rates. (Hillebrand, Tr. 1803; CX 75 at 6).

ii. Bain Advised ENH That It Had Expired Or Outdated MCO Contracts

694. Based on its evaluation of Evanston Hospital’s contracts, Bain informed Evanston Hospital that it had many expired contracts with terms that varied greatly from contract to contract. (RX 652 at BAIN 9; RX 2047 at 9-11 (Ogden, Dep.)). For example, Bain discovered that the United (Metlife), United (Share), CIGNA PPO and HMO IL/MCNP contracts all had expired. (CX 74 at 20).

695. Neaman and Hillebrand were “just horrified” when they found out that ENH had expired contracts, “so that was absolutely news to them.” (RX 2047 at 19 (Ogden, Dep.)).

696. Hillebrand considered the fact that Evanston Hospital had many expired contracts and no uniform rates among contracts “a call to action” because there seemed to be no apparent rhyme or reason to Evanston Hospital’s contracts and contracting strategy. (Hillebrand, Tr. 1850).

697. (REDACTED)

(RX 762 ENHL TC 924, *in camera*).

698. (REDACTED)

(RX 762 at ENHL TC 9909, *in camera*). (REDACTED)

(RX 762

at ENHL TC 9909, *in camera*). (REDACTED)

(RX 762 at ENHL TC 9909, *in camera*).

699. (REDACTED)

(RX

762 at ENHL TC 9910, *in camera*). (REDACTED)

(RX 762 at ENHL TC 9913, *in camera*). (REDACTED)

(RX 762 at ENHL

TC 9911, *in camera*). (REDACTED)

9913, *in camera*).

(REDACTED)

(RX 705 at ENHL JL 23052; Chan, Tr. 862-863, *in camera*).

700. **(REDACTED)**

(Haas-Wilson, Tr. 2849-51, *in camera*).

iii. Bain Advised ENH That It Was Under-Market As Compared To Its Peer Academic Hospitals

701. According to Bain, Evanston Hospital had a good position in the market before the Merger, but it had not negotiated MCO contract rates based on that position. (RX 2047 at 34 (Ogden, Dep.)). As a result, Evanston Hospital was “very far behind in the marketplace, and that seemed to be supported by the reactions of payors.” (RX 2047 at 31 (Ogden, Dep.)).

702. In a November 1999 presentation by Bain, Evanston Hospital learned, generally speaking, that other academic hospitals similar to Evanston Hospital were getting much higher prices than Evanston Hospital. (Neaman, Tr. 1345).

703. Initially, Hillebrand was skeptical of Bain’s report, but once he was convinced that Bain’s data was accurate, he felt embarrassed to find out ENH was not priced with its peer group of hospitals. (Hillebrand, Tr. 1853-54; RX 2047 at 30 (Ogden, Dep.)). Hillebrand inferred from Bain’s presentation that if ENH was being paid much less than HPH, a community hospital, then ENH had to be faring worse than its peer academic medical centers. (Hillebrand, Tr. 1853-54).

iv. Bain Advised ENH On MCO Contract Renegotiations

(1) Bain Advised ENH On A Post-Merger Negotiation Strategy

704. In the November 1999 presentation, Bain prioritized contracts for renegotiation – dividing them into first and second priorities. (CX 75 at 9). Bain suggested that Evanston Hospital begin renegotiating the expired contracts first. (RX 2047 at 30 (Ogden, Dep.); CX 75 at 9). Bain identified the Humana, United, HMO Illinois and PHCS contracts all as first priority contracts to renegotiated. (CX 75 at 10).

705. Bain’s contracting advice from the Summer of 1999 through 2000 was not tied specifically to the Merger. (Hillebrand, Tr. 1847; RX 2047 at 24-25 (Ogden, Dep.)). Bain advised Evanston Hospital/ENH to seek higher rates regardless of whether the Merger was consummated. (Neaman, Tr. 1347).

706. Nevertheless, Bain advised Evanston Hospital that improvements in the quality of service offered as a result of the Merger, if consummated, would have a positive impact on managed care contracting. (RX 2047 at 15 (Ogden, Dep.)).

707. Bain gave specific recommendations for Evanston Hospital's proposal to United, which was the first health plan in the new round of contract negotiations. (Hillebrand, Tr. 1740, 1868-69; Neaman, Tr. 1339). In particular, Bain recommended a "one-time corrective adjustment" given that Evanston Hospital's rates with United had not been renegotiated since 1994. (Hillebrand, Tr. 1870; RX 684 at BAIN 73; RX 2047 at 45 (Ogden, Dep.); CX 1607 at 4).

708. The intention was to take the rates Evanston Hospital received from United as a benchmark into the subsequent negotiations with other health plans. (Hillebrand, Tr. 1740-41). The discount-off-charges rates negotiated with United were intended to be the benchmark for future negotiations. (Hillebrand, Tr. 1741). For the smaller payors, the rates negotiated with United would be a minimum threshold. (Hillebrand, Tr. 1741).

709. Evanston Hospital began renegotiating its United contract in October 1999. (Hillebrand, Tr. 1851-52, 1868-69). Bain participated directly in the United negotiations. (Hillebrand, Tr. 1734, 1852, 1869; Neaman, Tr. 1339).

(2) Bain Advised ENH On Negotiation Tactics

710. Bain was tasked, in part, with helping post-Merger ENH develop a new contracting approach and philosophy, specifically to bring more rigor and more data to the contracting process. (Hillebrand, Tr. 1846-47).

711. Before 1999, Bain had recommended that Evanston Hospital engage Bain to teach Evanston Hospital employees how to be more aggressive with MCOs in negotiations. (Neaman, Tr. 1149). Evanston Hospital did not engage Bain to consult on managed care contracting until 1999. (Hillebrand, Tr. 1734-35).

712. In late 1999, Bain again approached Evanston Hospital to offer advice about MCO negotiations. This time, however, Neaman engaged Bain to provide such advice. (Neaman, Tr. 1343-44; Hillebrand, Tr. 1854-55). This led to a fairly major shift in Evanston Hospital's negotiating tactics with health plans starting in mid- to late-1999. (Neaman, Tr. 1217).

713. Bain made several recommendations regarding contracting strategy. First, Bain recommended that ENH "start by asking for a percent of charges even though [Bain] had no expectation that [ENH] would end up there, but as an opening bid, that was a way for [MCOs] to then respond to [ENH] with per diems, and [ENH] could understand where they were coming from." (RX 2047 at 62 (Ogden, Dep.); Hillebrand, Tr. 1757, 1854-55; RX 684 at BAIN 53).

714. Bain and ENH never discussed whether to terminate negotiations if it did not get a discount-off-charges arrangement. (RX 2047 at 62 (Ogden, Dep.)). Rather, "[t]he full anticipation was that . . . [ENH] would have per diems, and [its] minimal accepted terms were all in terms of per diems." (RX 2047 at 62 (Ogden, Dep.)).

715. Second, Bain suggested that ENH ask for a price higher than what it might ultimately be satisfied with. (RX 2047 at 62 (Ogden, Dep.)). **(REDACTED)**

(Hillebrand, Tr. 1856; RX 2047 at 31 (Ogden, Dep.); RX 718 at 7,

in camera). (REDACTED)

(RX 718 at 87, *in camera*).

“Targeting 10 percent above the best contract from either hospital” was ENH’s “aggressive goal.” (RX 2047 at 31 (Ogden, Dep.)).

716. Third, Bain encouraged ENH to set minimum contract rate targets. (RX 2047 at 48 (Ogden, Dep.)). (REDACTED)

(RX 718 at 6, *in camera*). (REDACTED)

(CX

5072, at 23, 29, *in camera*; Chan, Tr. 866, *in camera*).

717. Fourth, Bain suggested that ENH adopt a more aggressive, face-to-face negotiating style – including the use of an “internal bad guy” in certain negotiations to demonstrate the seriousness of ENH’s requests. (RX 2047 at 51 (Ogden, Dep.)). For example, Bain gave ENH advice on the steps of the United negotiation such as who was going to talk first and what they were going to say. (RX 2047 at 45 (Ogden, Dep.)). From previous negotiations with Sirabian, United knew that Sirabian was a “pushover.” Therefore, Bain recommended using an “internal bad guy” to “show them [United] that we’re serious and that we’re not just going to take whatever you give us.” (RX 2047 at 51 (Ogden, Dep.)).

718. Finally, Bain advised that ENH should talk about what it can “bring to the table,” something Evanston Hospital had not been doing. (RX 2047 at 31 (Ogden, Dep.)). Bain helped ENH come up with a clear articulation of who ENH “was and had been for five years and just wasn’t getting credit for.” (RX 2047 at 31 (Ogden, Dep.)).

719. In putting together the contracting strategy, Bain analyzed “payer’s economics.” (RX 2047 at 36-37 (Ogden, Dep.); CX 74 at 5). Evanston Hospital had not been “gathering a lot data around what was happening in the marketplace, and we [Bain] believed that that was important to inform, provide a context for these negotiations, . . . we’re looking for a big catch-up here.” (RX 2047 at 36-37 (Ogden, Dep.)). It was important to understand the MCOs’ financial conditions – “[a]re these payers losing money and, therefore, they’re going to be really resistant to it, to what we’re asking which is a big catch up.” (RX 2047 at 37 (Ogden, Dep.)). Bain advised that it was “really just a basic part of any negotiation strategy [to] . . . understand who you are negotiating with, how they are doing.” (RX 2047 at 37 (Ogden, Dep.)).

720. Bain also looked at the “importance of ENH and [HPH] to payers’ position.” (RX 2047 at 37 (Ogden, Dep.); CX 74 at 5). The goal was to understand how likely it was that a particular MCO would “walk away from the table.” (RX 2047 at 37 (Ogden, Dep.)). In “any contract negotiation . . . across any industry, you start with understanding who they are, who you are negotiating with.” (RX 2047 at 37 (Ogden, Dep.)). Bain found that ENH was about the same importance . . . across many different MCOs, and it was one of many hospitals that they negotiated with.” (RX 2047 at 37 (Ogden, Dep.)). Bain also found that HPH was too small to make a difference to MCOs, *i.e.* the importance of Evanston Hospital to a MCO did not differ from the importance of Evanston Hospital and HPH together to a MCO. (RX 2047 at 38 (Ogden, Dep.)).

721. Bain laid out a template for ENH to use in its contract negotiations “that highlighted that they should be doing an annual review, and the data that they should put together before every negotiation, and then some thoughts on how to conduct the negotiation itself.” (RX 2047 at 61 (Ogden, Dep.)). Bain’s role was to help ENH with “some of the analysis of the marketplace that would communicate that we had done our homework.” (RX 2047 at 45 (Ogden, Dep.)).

722. One of the key strengths Bain brought to the Merger project was its data. (Neaman, Tr. 1165-66). Some of the data Bain used with its Merger project came from public sources, some from ENH’s financial books and the rest from Bain’s proprietary data set. (Neaman, Tr. 1219). Because Bain performed work for various insurance companies, the proprietary data set Bain used in connecting with its Merger project contained, in part, information about these companies and their profitability. (Neaman, Tr. 1219).

723. Bain’s advice led to a shift by ENH in its negotiating tactics, including a “willingness to lose contracts.” (Neaman, Tr. 1218). These changes in strategy were a change for Evanston Hospital because its prior strategy had been to maintain, develop and enhance relationships with MCOs. (Hillebrand, Tr. 1854-55).

724. Although Bain’s advice led ENH to change its tactics, ENH’s bargaining position did not change. (Hillebrand, Tr. 1726, 1733). While Bain thought the Merger provided several benefits to ENH, “[w]e weren’t trying to renegotiate based on a changed position because of the merger. We said we need to renegotiate because we don’t have a contract. You haven’t negotiated with us in five years. Here is who Evanston is, and it really was overwhelmingly a focus on Evanston” and what Bain thought was “fair market value.” (RX 2047 at 32 (Ogden, Dep.)).

725. During the course of examining Evanston Hospital/ENH’s contracting tactics in late 1999 and 2000, Neaman expressed his concerns that aggressive tactics might risk losing contracts to the Bain representatives and to ENH’s own negotiators. (Neaman, Tr. 1348). In response to Neaman’s concerns that aggressive negotiating tactics might risk the loss of contracts, Bain put together a contingency plan in the event ENH did lose MCO contracts. (Neaman, Tr. 1349).

v. Bain’s Advice Paid Off – But The Successful Contract Renegotiations Were Not Due To The Merger

726. Some of ENH’s 2000 contract renegotiations resulted in higher prices and, with the exception of one contract, ENH did not lose any contracts as a result of those renegotiations. (Hillebrand, Tr. 1757).

727. ENH’s ability to get better contract terms after the Merger was, in part, dictated by improvements in the capabilities of the contracting team after the Merger as a result of Bain’s recommendations. (RX 2047 at 15 (Ogden, Dep.)).

728. The Merger thus “provided a catalyst, an opportunity to get serious about some of [the things listed in CX 2072] like reducing costs . . . and that was definitely the case on the contracting side.” (RX 2047 at 36 (Ogden, Dep.)). The Merger provided ENH with a good

opportunity to renegotiate its outdated and under-market contracts. (RX 2047 at 30 (Ogden, Dep.)).

729. During these contract negotiations, the Merger was discussed only to the extent that it provided an opening explanation of “why we’re sitting down together and here is who is at the table,” *i.e.* ENH needed a contract that covered all of the hospitals. (RX 2047 at 33 (Ogden, Dep.)). The Merger was not discussed “in the sense of . . . we’re a completely changed entity now.” (RX 2047 at 33 (Ogden, Dep.)).

730. The broader geographic coverage provided by the Merger impacted ENH’s managed care contracting, except in the sense that “[i]t is easier for payers to administer contracts if they have got one contract versus lots and to know that that contract looks pretty much the same. That is a good thing or was a good thing in the payers’ mind.” (RX 2047 at 15 (Ogden, Dep.)). She further believed that if Evanston Hospital would have done exactly what Bain had told them to do even without the Merger, then it “would have had the same rates.” (RX 2047 at 29 (Ogden, Dep.)).

731. HPH was a “tiny hospital” and the Merger did not change ENH’s “position in the marketplace at all.” (RX 2047 at 33 (Ogden, Dep.)). Pre-Merger HPH was able to get better rates because their process was better and they had better people doing the contracting. (RX 2047 at 33 (Ogden, Dep.)). “[T]here was no other reason that they would have had such far superior rates.” (RX 2047 at 33 (Ogden, Dep.)). What ENH did on the contracting side post-Merger was to apply “better people and a better process.” (RX 2047 at 33 (Ogden, Dep.)).

732. The rates that ENH ended up with after the Merger “were not significantly higher . . . than rates that already existed in the market for a lot of other hospitals.” ENH “just played catch up.” (RX 2047 at 34 (Ogden, Dep.)).

733. In the end, “almost all of the upside [in the contract negotiations] – was just from negotiating contracts and doing it in a systematic, data-driven way.” (RX 2047 at 24-25 (Ogden, Dep.)). There was also “value from understanding Highland Park’s contracts and the process they had gone through in negotiating their contracts, the benchmarking.” (RX 2047 at 25 (Ogden, Dep.)). “[A]rmed with that knowledge, . . . Evanston could have absolutely got the same contracting rates they did without Highland Park’s . . . volume” and geographic scope. (RX 2047 at 25 (Ogden, Dep.)). “I think Evanston was just so far behind.” (RX 2047 at 25 (Ogden, Dep.)).

c. Individual MCO Negotiations Are Consistent With The Learning About Demand Theory

734. (REDACTED)

Tr. 6105-06, *in camera*).

(Noether,

735. The individual post-Merger negotiations confirm that the contract rate increases at issue were not anticompetitive. After the Merger, ENH negotiated lower prices than HPH’s

previous discount-off-charges rates for inpatient services at United's PPO/POS plan, PHCS, CCN, Health Network, Preferred Plan and First Health. (RX 871 at ENH JL 3239).

736. ENH also negotiated lower prices than HPH's previous discount-off-charges rates for outpatient services at PHCS, CCN, Health Network, Preferred Plan, First Health, and the State of Illinois. (RX 871 at ENH JL 3239).

737. Since 2000, ENH has seen price increases with some contracts, price decreases with some contracts, and no pricing changes with other contracts. (Hillebrand, Tr. 1710). The primary MCO negotiations at issue are discussed below.

i. Aetna

(1) Evanston Hospital's Pre-Merger Contract Rates With Aetna Were Outdated And Undermarket

738. Aetna's relationship with Evanston Hospital before 2000 was not friendly, and Aetna was perceived in the marketplace as being "anti-provider." (Hillebrand, Tr. 1895).

739. In 1995, Aetna and Evanston Hospital engaged in contract renegotiations. (RX 84 at ENHL JL 1097). **(REDACTED)**

(Mendonsa, Tr. 556, *in camera*).

740. Evanston's negotiator, Sirabian, had an extremely conciliatory approach to the discussions. For example, Sirabian wrote with regard to rates proposed in 1995: "This represents [] a significant adjustment for us and is being offered in recognition of your efforts to satisfy our requirements." (RX 84 at ENHL JL 1097). Sirabian continued by offering to reduce Evanston Hospital's current rates for obstetric services to amounts in place more than two years before the 1995 negotiations. (RX 84 at ENHL JL 1097). Further, Evanston Hospital rolled back its normal delivery and Caesarian section per case rates by 15%. (RX 84 at ENHL JL 1097).

741. Additionally, in 1995 Sirabian proposed to increase the discount-off-charges for non-ambulatory surgery outpatient services from 12% to 15%. (RX 84 at ENHL JL 1097). Sirabian concluded that, "[a]s is evident, this represents a substantial reduction in fees for [Evanston Hospital] especially when you consider that we would, under normal circumstances, be asking for higher rates for next year." (RX 84 at ENHL JL 1097).

742. Even after Sirabian offered these reductions to Aetna, Aetna continued to negotiate aggressively and later retracted an agreement that Evanston Hospital and Aetna had made verbally. (CX 2045 at 1). In response, Sirabian offered further reductions to Aetna in 1995 in search of a "win-win" relationship between Aetna and Evanston Hospital. (CX 2045 at 1).

743. Sirabian offered to reduce existing HMO per diems by 5% and reduce obstetric rates by 10%. (CX 2045 at 1). Further, Sirabian proposed a stop loss provision that was more

favorable to Aetna than the existing contract. (CX 2045 at 1). All of these concessions were aimed towards establishing the “win-win” situation with Aetna. (CX 2045 at 1).

744. (REDACTED)

(Mendonsa, Tr. 563, *in camera*; CX 5001 at 2).

(REDACTED)

(Mendonsa, Tr. 533-34, 563, *in camera*).

745. (REDACTED)

(Noether, Tr. 6095, *in camera*; RX 1912 at 34, *in camera*). (REDACTED)

(Noether, Tr.

6095, *in camera*; RX 1912 at 34, *in camera*). (REDACTED)

(Noether, Tr. 6096,

in camera).

**(2) ENH’s Post-Merger Negotiations With Aetna
Were Not Anticompetitive**

746. (REDACTED)

(RX 769 at ENH JL 2817, *in camera*). Aetna noted that it could not “operationalize” the change in tax identification numbers until new agreements were executed. (RX 779 at 1).

747. (REDACTED)

(RX 769 at ENH JL 2817, *in camera*).

(REDACTED)

(RX 769 at ENH

JL 2818-19, *in camera*).

748. (REDACTED)

(Mendonsa, Tr. 547, *in camera*). (REDACTED)

(Mendonsa, Tr. 547, *in*

camera).

749. (REDACTED)

(CX 123 at 1; Mendonsa, Tr. 546-47, 531, *in camera*).

750. (REDACTED)

(Hillebrand, Tr. 1896; RX 769 at ENH JL 2818-19, *in camera*; CX 5174 at 11-12, *in camera*). Aetna, however, did not agree to that payment methodology. (Hillebrand, Tr. 1896). (REDACTED)

(Mendonsa, Tr. 524, *in camera*).

751. (REDACTED)

(CX 5008 at 5-6, *in camera*; Hillebrand, Tr. 1896).

752. (REDACTED)

(RX 855 at ENHL BW 11393, *in camera*; CX 5007 at 5).

(REDACTED)

(RX 855 at 2, *in camera*).

(REDACTED) (CX 5008 at 7, *in camera*).

753. (REDACTED)

(Mendonsa, Tr. 539, *in camera*; CX 2447, *in camera*; Hillebrand, Tr. 1897; Hillebrand, Tr. 1948, *in camera*). The increase was over a three year period and, after the third year, the rates would remain in place until they are superceded. (Hillebrand, Tr. 1897).

(REDACTED) (Noether, Tr. 6097, *in camera*).

754. (REDACTED)

(Mendonsa, Tr. 533-34, 564, *in camera*;

Noether, Tr. 6096-97, *in camera*). (REDACTED)

(Mendonsa, Tr. 564, *in camera*). (REDACTED)

(Mendonsa, Tr. 530, *in camera*).

755. Overall, the Aetna-ENH negotiations in 2000 were very friendly. (Hillebrand, Tr. 1895-96). (REDACTED)

(Mendonsa, Tr. 537, *in camera*). (REDACTED)

(Mendonsa, Tr. 566, *in camera*).

756. (REDACTED)

(Hillebrand, Tr. 1897;

Mendonsa, Tr. 556, *in camera*).

ii. Blue Cross

(1) Evanston Hospital Pre-Merger Contract Rates Exceeded HPH's Pre-Merger Contract Rates

757. During the 1990s, Sirabian focused most of his attention on the Humana and Blue Cross contracts. (Sirabian, Tr. 5707). Sirabian made sure that the Humana and Blue Cross contracts were always current and up-to-date because the Humana and Blue Cross contracts represented a substantial portion of ENH's managed care business. (Sirabian, Tr. 5707)

758. Since the late 1990s, Evanston Hospital has had an amicable relationship with Blue Cross. (Hillebrand, Tr. 1860). Hillebrand worked closely, and had good relationships, with many of the Blue Cross representatives. (Hillebrand, Tr. 1860).

759. During the 1990s, Blue Cross was always very fair and offered rates such that both sides would mutually benefit. (Sirabian, Tr. 5708).

760. When Sirabian compared Evanston Hospital and HPH's respective contracts with Blue Cross, he learned that Evanston Hospital had better rates with that MCO. (Sirabian, Tr. 5708)

(2) ENH's Post-Merger Negotiations With Blue Cross Were Not Anticompetitive

761. In anticipation of the effective date of the Merger, ENH opened the dialogue with Blue Cross on December 9, 1999. (RX 707). ENH notified Blue Cross that: (1) HPH would be integrated into the same legal entity and tax identification number as ENH; (2) HPH would cease to exist as a separate entity as of the date of the Merger; and, consequently (3) HPH's contract with Blue Cross would be terminated as of December 31, 1999. (RX 707). At the same time, ENH notified Blue Cross that it would initiate efforts to renegotiate the rates and terms of the ENH agreements. (RX 707).

762. Effective January 1, 2000, ENH (including HPH), under its new name, began to provide hospital services to members of HMO Illinois under the rates, terms and conditions of the then-current Provider Agreement between Evanston Hospital and HMO Illinois. (RX 707).

763. In March 2000, ENH initiated a renegotiation with Blue Cross. (Hillebrand, Tr. 1861; RX 707; RX 808 at ENH JL 2019). The contract negotiations were fairly straightforward. (Hillebrand, Tr. 1861).

764. Although ENH notified Blue Cross of its intent to renegotiate its rates under the contract in early December 1999, ENH did not officially open negotiations until March 1, 2000. (RX 707; RX 808 at ENH JL 2019).

765. To ameliorate the risk ENH assumed by proposing per diem and per case rates for HMO Illinois, it proposed a stop loss provision with a \$40,000 threshold at 75% of billed charges. (RX 808 at ENH JL 2021).

766. As a result of proposing per diem and case rate terms, ENH's initial proposal to HMO Illinois included a request for an annual adjustment of the Medical CPI rate to cover ENH's increasing annual costs. (RX 808 at ENH JL 2021). ENH proposed a contract term of three years. (RX 808 at ENH JL 2021).

767. During the 2000 negotiation, Blue Cross and ENH discussed trends in Blue Cross's product evolution and which products would be successful in the marketplace. (Hillebrand, Tr. 1862).

768. The ENH-Blue Cross negotiations began with a focus solely on the HMO product, but evolved into a renegotiation of the entire book of business with Blue Cross. (Hillebrand, Tr. 2019).

769. (REDACTED)

(RX 823 at ENHL TC 18986, *in camera*).

770. (REDACTED)
(RX 823, *in camera*). (REDACTED)

(RX 823 at ENHL TC 18986, *in camera*).

771. (REDACTED)

(RX 823 at ENHL TC 18987, *in camera*).

772. (REDACTED)

(RX 877 at ENH JL 6487, *in camera*).

773. (REDACTED)

(RX 877 at ENH JL 6487, *in camera*).

774. (REDACTED)

(RX 319, *in camera*).

775. (REDACTED)
camera). (REDACTED)

(RX 319, *in*

(RX 319, *in camera*). (REDACTED)

(RX 319, *in camera*).

776. (REDACTED)

(RX 319, *in camera*). (REDACTED)

(RX 319, *in camera*). (REDACTED)

(RX

319, *in camera*). (REDACTED)

(RX 319, *in camera*).

777. (REDACTED)

(RX 319, *in camera*).

(RX 319, *in camera*). (REDACTED)

(RX 319, *in*

camera).

iii. Cigna

**(1) Evanston Hospital's Pre-Merger Contract Rates
With Cigna Were Outdated And Undermarket**

778. As of the Merger, Evanston Hospital had not negotiated a new contract with Cigna since 1995. (CX 5013 at 6).

779. Evanston Hospital's contracted rate with Cigna's PPO and HMO plans for inpatient medical and surgical services was \$1,270. (CX 5013 at 2, 28). Evanston Hospital's contracted rate with Cigna's PPO and HMO plans for outpatient services was a discount-off-charges of 11%. (CX 5013 at 4, 29).

780. HPH had not renegotiated a new contract with Cigna since 1993, but its rates were better than Evanston Hospital's rates before the Merger. (CX 5011 at 4). HPH's contracted rate with Cigna's PPO and HMO plans for inpatient medical and surgical services was \$1,320. (CX 5011 at 1). HPH's contracted rate with Cigna's PPO and HMO plans for outpatient services was 10% off charges. (CX 5011 at 2).

781. Before the Merger, (REDACTED)
(Chan, Tr. 786, *in camera*).

(REDACTED)

(CX 1099 at 12, *in camera*). (REDACTED)

(Chan, Tr. 818, *in camera*).

**(2) ENH's Post-Merger Negotiations With Cigna
Were Not Anticompetitive**

782. After the Merger, ENH signed a three year contract with Cigna. (CX 5015 at 9). The contract provided for no price increase for the second and third years of the contract. (CX 5015 at 24).

783. The post-Merger contract with Cigna used a variety of reimbursement methodologies, including per diem, case rates and discount-off-charges. (CX 5015 at 18-21, 24, 28-30). For Cigna's HMO and "Gatekeeper" products, Cigna negotiated mostly per diem and case rates for inpatient services. (CX 5015 at 18-19, 28-29). For Cigna's PPO product, the parties agreed to a discount-off-charges arrangement for inpatient services. (CX 5015 at 24).

784. On October 9, 2003, ENH and Cigna agreed that the terms and conditions of the post-Merger contract should continue to apply. (RX 1547).

iv. CCN

**(1) Evanston Hospital's Pre-Merger Contract Rates
With CCN Were Outdated And Undermarket**

785. Before the Merger, HPH had a 12% discount-off-charges arrangement for inpatient services and a 5% discount-off-charges arrangement for outpatient services with CCN. (CX 5222 at 1).

786. **(REDACTED)** (RX 757 at ENH JL 9731, *in camera*). **(REDACTED)**
(RX 757 at ENH JL 9731, *in camera*).

(2) ENH's Post-Merger Negotiations With CCN Were Not Anticompetitive

787. Chan and Sirabian wrote a letter to CCN asking it "to assign HPH's Agreement along with its terms and conditions, rights and obligations to ENH." (RX 689 at ENH JL 4138). CCN, however, did not agree to assign its rates with HPH over to ENH. (RX 781 at ENH JL 6304).

788. **(REDACTED)** (RX 757 at ENH JL 9731, *in camera*). **(REDACTED)**
(RX 757 at ENH JL 9731, *in camera*; RX 834 at ENH JL 3943, *in camera*).

789. After four months of negotiations, CCN and ENH agreed to a contract in which CCN received the 20% discount it proposed for inpatient services and a 15% discount for outpatient services. (CX 5235 at 1, *in camera*).

v. Great West

(1) Evanston Hospital's Pre-Merger Contract Rates With One Health/Great West Were Outdated And Undermarket

790. Before the Merger, HPH had a higher rate than Evanston Hospital. (Neary, Tr. 604-05). Accordingly, **(REDACTED)**
(Noether, Tr. 6102, *in camera*; RX 1912 at 34, *in camera*).

791. Evanston Hospital's last pre-Merger contract with Great West was in 1996. (CX 5065 at 4). Evanston Hospital and Great West agreed to a per diem rate of \$1250 and \$1225 for inpatient medical/surgical services on Great West's PPO and POS products. (CX 5065 at 17).

792. Evanston Hospital's pre-Merger contract also did not have a stop loss provision on either its HMO or its PPO products with Great West, meaning that Evanston Hospital bore the risk that the cost of care for a particular patient would exceed the negotiated rate. (Neary, Tr. 632). Moreover, the contract contained a provision that capped Evanston Hospital's reimbursement: "In no event will Company or Payor pay more than the lesser of the Payment Rate or 80% of Hospital's usual billed charges." (CX 5065 at 16).

793. **(REDACTED)**
(Noether, Tr. 6103, *in camera*; RX 1912 at 34, *in camera*; RX 223 at GW 3988-89, *in camera*).

794. HPH also had contracts with Great West before the Merger. (Neary, Tr. 596-97). The PPO/POS contract became effective on September, 1996. (CX 5059 at 4). HPH and Great West agreed to a per diem rate of \$1375 for inpatient medical services and a per diem rate of \$1650 for surgical services, rates that were higher than the rates Evanston Hospital received from Great West at the time. (CX 5059 at 17).

795. **(REDACTED)**

(RX 261 at ENH JL 7994; Noether, Tr. 6103, *in camera*). **(REDACTED)**
(Noether, Tr. 6104, *in camera*).

(2) ENH's Post-Merger Negotiations With Great West Were Not Anticompetitive

796. At or about the time of the Merger, ENH informed Great West that it needed a one-time adjustment to bring its rates up to market. (Neary, Tr. 595, 633). Patrick Neary, formerly of Great West, testified at trial that he "agreed that it had been several years since the contracts had been renegotiated and that it was appropriate to – to increase some of the rates." (Neary, Tr. 608).

797. Kevin Dorsey, another former Great West employee who testified at trial, did not find ENH's initial proposal "that shocking." (Dorsey, Tr. 1437). He explained: "It is not untypical to receive an initial proposal with a provider more or less shooting for the stars of what they would like to receive." (Dorsey, Tr. 1437-38).

798. **(REDACTED)**

(RX 261; RX 837 at ENH JL 4524, *in camera*)

799. Accordingly, on May 23, 2000, ENH sent Great West a notice of termination to become effective on August, 31, 2000. (Neary, Tr. 610-11; CX 5062; RX 848). Great West decided to accept the termination and allow the contract to lapse. (Neary, Tr. 611).

800. Even when Great West was terminated, ENH and Great West had an interim agreement in place. (Hillebrand, Tr. 1898). ENH and Great West negotiated a 10% discount-off-charges interim agreement pertaining to pregnant women in their third trimester. (Neary, Tr. 637).

801. Great West believed it could still have a sellable network after the termination. (Neary, Tr. 615). At the time Great West accepted the termination, Lake Forest Hospital, Northwest Community, Advocate Lutheran General, Rush North Shore and St. Francis were all part of the Great West network. (Neary, Tr. 611).

802. In fact, neither of Complaint Counsel's Great West witnesses could identify a single Great West customer that was lost during the period in which the relationship between Great West and ENH was terminated. (Neary, Tr. 635; Dorsey, Tr. 1469-70, 1481). Neary never saw any letter from any Great West customer complaining about the ENH termination.

(Neary, Tr. 635). And Dorsey could not identify any sales that were lost to any specific customer. (Dorsey, Tr. 1481).

803. Nor could Neary quantify the revenue purportedly lost by Great West as a result of the termination. (Neary, Tr. 635). Neary could not even testify whether the purportedly lost customers were large or small customers. (Neary, Tr. 635). Neary's only knowledge of lost customers from the termination came from the sales manager, Don Manno. (Neary, Tr. 636) Great West actually demoted Manno in 2001 or 2002. (Neary, Tr. 636-39).

804. **(REDACTED)**
(Noether, Tr. 6104, *in camera*). **(REDACTED)**

(Noether, Tr. 6102, *in camera*).

805. ENH called Great West asking to reopen negotiations on October 15, 2000. (RX 993 at ENHL JL 22377). Subsequently, Great West returned to the bargaining table and entered into a contract with ENH. (Hillebrand, Tr. 1898). The contractual discount from the pre-Merger HPH contract to the subsequent post-Merger ENH contract did not change at all. (Hillebrand, Tr. 2031).

806. Great West annoyed ENH in the way it notified customers about the termination. (RX 993 at ENHL JL 22377).

807. As it turned out, Great West could not risk another contentious contract negotiation with ENH. At the same time it was renegotiating with ENH in the Fall of 2000, Great West also faced a difficult negotiation with Lake Forest Hospital, which was assisted by a consulting firm in the negotiation. (Dorsey, Tr. 1484-85). On September 28, 2000, and "[a]fter several months of negotiations," Lake Forest Hospital and its medical group provided Great West with written notice of termination of their contract with Great West effective December 31, 2000. (RX 949; RX 950).

808. It would have been "very problematic" for Great West to have simultaneously lost ENH and Lake Forest Hospital since Lake Forest Hospital was the primary alternative to HPH. (Dorsey, Tr. 1484).

vi. HFN

(1) Evanston Hospital's Pre-Merger Contract Rates With HFN Were Outdated And Undermarket

809. Before the Merger, Evanston Hospital's DRG rate for inpatient medical/surgical services with HFN's EPO plan was \$5,400 under a contract that dated back to 1996. (CX 5215 at 17).

810. HPH's DRG case rate for inpatient medical/surgical services with HFN's EPO plan in 1996 was \$5,700, higher than Evanston Hospital's rates. (CX 5267 at 17). HPH renegotiated its rate in 1999 to \$6,300. (CX 5304 at 2).

811. In 1996, both Evanston Hospital and HPH agreed to a 15% discount with HFN for its EPO outpatient medical/surgical services. (CX 5215 at 17; CX 5267 at 17). HPH, however, renegotiated the rate in 1999 to 10%. (CX 5304 at 2).

812. Before the Merger, Evanston Hospital's DRG case rate for inpatient medical/surgical services with HFN's PPO plan was \$5,800 under a contract that dated back to 1996. (CX 5215 at 17). In contrast, HPH's DRG case rate for inpatient medical/surgical services with HFN's EPO plan was \$7,000. (CX 5304 at 2).

**(2) ENH's Post-Merger Negotiations With HFN
Were Not Anticompetitive**

813. After the Merger, **(REDACTED)**
(CX 5217 at 5, *in camera*).

(REDACTED)

(RX 270 at
ENH-RNSMC 312, *in camera*; RX 281 at NMH 380; RX 1088 at FTC-LFH 1120). Condell negotiated a discount-off-charges contract with HFN in 2002. (RX 1333 at CMC 17620).

vii. Humana

**(1) Before The Merger, Evanston Hospital Acquired
Humana Physician Office Sites**

814. During the 1990s, Humana had the most capitated lives with Evanston Hospital. (Sirabian, Tr. 5709). Evanston Hospital had fair and open discussions with Humana about the requirements of both parties to the contract. (Sirabian, Tr. 5708-09).

815. Until 1998, Evanston Hospital had been reimbursed on per diem, case rate and discount-off-charges arrangements by Humana for hospital services. (Hillebrand, Tr. 1864).

816. In 1998, Evanston Hospital acquired Humana's physician office sites in West Rogers Park, Evanston, Glenview and Buffalo Grove – physician sites adjacent to Evanston Hospital's service area. (Hillebrand, Tr. 1863). Along with the Humana physician offices purchased by Evanston Hospital, ENH Medical Group also acquired about 40 physicians in 1998. (Hillebrand, Tr. 1864).

817. In lieu of paying an acquisition price for the four Humana centers, Evanston Hospital and Humana negotiated a percent-of-premium agreement with Humana. (Hillebrand, Tr. 1864). Under this capitated contract, payment to Evanston Hospital was a percentage of the premium that Humana collected from its subscribers. (Hillebrand, Tr. 1864-65).

818. After 1998, because Evanston Hospital was on a percent-of-premium, as opposed to being paid a rate for services, it had assumed dramatically greater risk. (Hillebrand, Tr. 1865). Evanston Hospital was responsible for the cost of care for their principal products, its HMO products. (Hillebrand, Tr. 1865). This contract left Evanston Hospital fully at risk for the care of Humana's subscribers and was not profitable for Evanston Hospital. (Sirabian, Tr. 5709-10).

819. Evanston Hospital's purchase of the physician sites fundamentally changed its relationship with Humana and played a role in the post-Merger contract negotiations. (Hillebrand, Tr. 1864).

820. Moreover, at the time of Bain's analysis of the managed care contracts, HPH did not participate in all of Humana's products. HPH only participated in Humana's PPO/Employers Health contract. (Hillebrand, Tr. 1804). For that product, HPH had higher pricing than Evanston Hospital. (Hillebrand, Tr. 1804; CX 75 at 6).

821. **(REDACTED)**

(RX 445 at H 17412, *in camera*).

(CX 5764-CX 5771, *in camera*; CX 5775, *in camera*; CX 5020-CX 5028, *in camera*). **(REDACTED)**

(RX 82, *in camera*).

(2) ENH's Post-Merger Negotiations With Humana Were Not Anticompetitive

822. ENH approached Humana in 2000 because the utilization of care was greater than anticipated, and ENH needed to modify the price to account for the increased risk it had assumed. (Hillebrand, Tr. 1865-66).

823. ENH did an analysis of the Humana Medicare population in comparison to its general Medicare populations and found that the Humana patients were, older and sicker. (Hillebrand, Tr. 1865-67). The Humana Medicare population had higher uses of services, but in the reimbursement methodology, ENH was exposed for the risk of providing the care to that patient population. (Hillebrand, Tr. 1866-67).

824. The fixed rate methodology of the Humana Medicare contract was such that ENH was losing significant amounts of money in the order of \$10 million on that contract alone. (Hillebrand, Tr. 1867). As a result, in 2002, ENH approached Humana to exit the Medicare product, but the two sides were able to renegotiate a new contract to both sides' satisfaction. (Hillebrand, Tr. 1866-67).

825. ENH is constantly renegotiating its contract with Humana. (Hillebrand, Tr. 1866). In fact, in 2002, ENH accepted a price decrease on one of its Humana contracts. (Hillebrand, Tr. 1710).

826. **(REDACTED)**

(RX 1308, *in*

camera). **(REDACTED)**

(RX 1308, *in camera*).

(REDACTED) (RX

1308, *in camera*).

viii. PHCS

**(1) Evanston Hospital's Pre-Merger Contract Rates
With PHCS Was Outdated And Undermarket**

827. **(REDACTED)**

(Noether, Tr. 6101, *in camera*; RX 1912 at 34, *in camera*).

828. In 1995, PHCS successfully negotiated significant decreases in rates with Evanston Hospital. (RX 107 at GWL 859). PHCS boasted to its carriers that it had increased its net effective inpatient discount by 10% by limiting rate increases to 3%, freezing medical and surgery per diems and increasing both the lesser of discount and stop loss arrangements. (RX 107 at GWL 859).

829. On the outpatient side, PHCS was equally as successful in squeezing Evanston Hospital's reimbursement. (RX 107 at GWL 859). PHCS bragged to its carriers that it had increased PHCS's net effective discount by 5% through limiting increases in outpatient rates to 3% and changing the lesser of discount provision (described below). (RX 107 at GWL 859).

830. The contract between Evanston Hospital and PHCS used discounts-off-charges for some inpatient services since at least 1995. (RX 107 at GWL 859, 870). PHCS utilized a "lessor of discount or per diem of 23 percent" on its 1995 contract. (RX 107 at GWL 859, 870). For inpatient services, the 1995 contract's payment rate is the lesser of: (1) the negotiated rate (per diem or per case, as set forth in or otherwise specified in the contract); or (2) regular billing rates reduced by 23%. (RX 107 at GWL 870). In the absence of a negotiated rate, the 1995 PHCS rates defaulted to a discount-off-charges. (RX 107 at GWL 870).

831. **(REDACTED)**

(RX 773 at ENH JL 12535, *in camera*).

832. In fact, HPH's pre-Merger rates were noticeably higher than Evanston Hospital's rates for both inpatient and outpatient services. (Ballengee, Tr. 205). **(REDACTED)**

(CX 5070 at 28; CX 5068 at 27, *in camera*). **(REDACTED)**

(Ballengee, Tr. 268, *in camera*; CX 5070 at 28). **(REDACTED)**

(Ballengee, Tr. 269, *in camera*; CX 5068 at 27, *in camera*).

833. **(REDACTED)**

(RX

279, *in camera*). **(REDACTED)**

(RX 308, *in camera*). **(REDACTED)**

(RX 308, *in camera*).

834. (REDACTED)
(RX 279, *in camera*). (REDACTED)
(RX 308, *in camera*).

835. (REDACTED)
(RX 279, *in camera*; RX 308, *in camera*). (REDACTED)
(RX 279, *in camera*; RX 308, *in camera*). (REDACTED)

(RX 279, *in camera*; RX 308, *in camera*). (REDACTED)

(Ballengee, Tr. 265-66, *in camera*; RX 805, *in camera*).

836. (REDACTED)
(RX 279, *in camera*; RX 308, *in camera*). (REDACTED)
(RX 279, *in camera*). (REDACTED)
(RX 308, *in camera*).

837. (REDACTED)
(RX 279, *in camera*; RX 308, *in camera*).
(REDACTED)
(RX 279, *in camera*). (REDACTED)
(RX 308, *in camera*).

838. (REDACTED)
(CX 5070 at 9; RX 718 at 7, *in camera*).

(2) ENH's Post-Merger Negotiations With PHCS Were Not Anticompetitive

839. Upon learning of the Merger, PHCS drafted a "significant network change memo" to advise its customers. (RX 712). In this memo, PHCS anticipated ENH's decision to provide notice of termination during contract renegotiation. (RX 712 at PHCS 891). In addition, PHCS advised its customers that it did not anticipate terminating the agreement with ENH, but the potential for termination existed if the parties could not reach mutually acceptable terms. (Ballengee, Tr. 213; RX 712 at PHCS 891).

840. On December 1, 1999, Chan sent a letter to Jane Ballengee, who testified at trial, notifying PHCS that HPH would be integrated into the same legal entity and tax identification number as ENH. (CX 171 at 1). Consequently, ENH wanted to assign the contract and rates between PHCS and HPH to the post-Merger entity. (Ballengee, Tr. 174-75; CX 171 at 1-2). ENH was seeking one set of rates for the entire system. (Ballengee, Tr. 176)

841. (REDACTED)

(Ballengee, Tr. 232-33, *in camera*; CX 1539 at 2, *in camera*; RX 711). PHCS requested to “begin discussions” regarding the renegotiation of rates that were already two years old at HPH. (RX 711; CX 171 at 5).

842. PHCS notified its customers of ENH’s intent to assign HPH’s rates on December 14, 1999. (RX 712 at PHCS 891).

843. Negotiations between ENH and PHCS then lasted a number of months, from December 1999 through February or March of 2000. (Ballengee, Tr. 173). (REDACTED)

(Ballengee, Tr. 175; RX 718 at 2-5, *in camera*; CX 113 at 1, *in camera*; RX 773 at ENH JL 12536-38, *in camera*; CX 116 at 2, *in camera*; CX 176 at 2, *in camera*).

844. Ballengee offered, in general terms, to exclude certain hospitals from PHCS’s network during the contract negotiations with ENH. (Hillebrand, Tr. 1745-47, 1894). However, since PPOs do not have the ability to steer business, Hillebrand was skeptical of that offer. (Hillebrand, Tr. 1746, 1894). Hillebrand later learned that Ballengee did not even have the authority to make such an offer because that approach was not supported by the decision-makers at PHCS. (Hillebrand, Tr. 1894).

845. (REDACTED)
(CX 116 at 1, *in camera*). (REDACTED)

(CX 116 at 1, *in camera*).

846. ENH did not negotiate a “take it or leave it” contract with (REDACTED).
(REDACTED) (CX 116 at 2, *in camera*; CX 5072
at 23, 29, *in camera*). (REDACTED)

(CX 116 at 2, *in camera*; CX 5072 at 23, *in camera*). (REDACTED)
. (CX 5072 at 23, *in camera*; Ballengee, Tr. 258-60, *in camera*).

847. (REDACTED) (CX 116 at 2, *in camera*; CX 5072 at 29, *in camera*). (REDACTED)
(CX 116 at 2, *in camera*; CX 5072 at 29, *in camera*). (REDACTED)

(Ballengee, Tr. 260, *in camera*; Hillebrand, Tr. 1893; Hillebrand, Tr. 1937, *in camera*; CX 5072 at 18).

(REDACTED) (Ballengee, Tr. 260-61, *in camera*; CX 5072 at 18). (REDACTED) (Ballengee, Tr. 260-61, *in camera*; CX 5072 at 18). The escalator clause also required ENH to notify PHCS each year regarding its chargemaster prices. (Hillebrand, Tr. 1995-96). (REDACTED) (Ballengee, Tr. 261, *in camera*). ENH adhered to the terms of its contract with PHCS. (Hillebrand, Tr. 1995-96).

848. PHCS calculated that ENH received a post-Merger price increase of 60%. (Ballengee, Tr. 196). That calculation was based on modeling the old and new contracts using data from the PHCS claims database. (Ballengee, Tr. 196). (REDACTED) (Ballengee, Tr. 261-62, *in camera*). (REDACTED) (Ballengee, Tr. 262, *in camera*).

(REDACTED) (Ballengee, Tr. 262, *in camera*).

ix. Preferred Plan

(1) Evanston Hospital's Pre-Merger Contract Rates With Preferred Plan Were Outdated And Undermarket

849. Before the Merger, Evanston Hospital had a mixed per diem and discount-off-charges arrangement with Preferred Plan, granting Preferred Plan medical/surgical per diems of \$1,397.25, but also including discount-off-charges arrangements for inpatient services at 20% and outpatient services at 15%. (CX 5199 at 2).

850. Before the Merger, HPH had a 15% discount-off-charges arrangement for inpatient services and an 8% discount-off-charges arrangement for outpatient services with Preferred Plan. (CX 5183 at 2).

(2) ENH's Post-Merger Negotiations With Preferred Plan Were Not Anticompetitive

851. After the Merger, Preferred Plan agreed to assign HPH's rates to ENH – again, a 15% discount-off-charges for inpatient services and an 8% discount-off-charges for outpatient services. (RX 781 at ENH JL 6304, 6310).

852. On May 1, 2000, Preferred Plan and ENH agreed to a new contract that benefited Preferred Plan. This contract included a 20% discount for inpatient services and a 12% discount for outpatient services – discounts that were larger than those Preferred Plan assigned to ENH from HPH after the Merger. (CX 5200 at 2).

x. Unicare

(1) Evanston Hospital's Pre-Merger Contract Rates With Unicare And Rush Prudential Were Outdated And Undermarket

853. Wellpoint, the parent of Unicare, purchased Rush Prudential in 2000. (CX 124 at 1).

854. In September 1999, Evanston Hospital characterized its contract with Rush Prudential as "horrible." (RX 617). Evanston Hospital also noted that it was "very painful working" with Rush Prudential's administrative staff. (RX 617).

855. **(REDACTED)**

(Holt-Darcy, Tr. 1570-71, *in camera*). **(REDACTED)**
(Holt-Darcy, Tr. 1600, *in camera*).

856. Evanston Hospital had an HMO contract with Unicare dating back to 1994. (CX 5085). This contract expired on May 30, 1995, but was renewed annually. (CX 5085 at 2; CX 5091 at 2).

857. **(REDACTED)**

(Holt-Darcy, Tr. 1599, 1605, *in camera*; CX 216 at 12, *in camera*).
(REDACTED) (Holt-Darcy, Tr. 1605, *in camera*).

(REDACTED) (Holt-Darcy, Tr. 1548, 1599-1600, *in camera*).
(REDACTED) (Holt-Darcy, Tr. 1549, *in camera*).

858. **(REDACTED)**

(CX 216 at 1, 12, *in camera*). And the contract was only scheduled to be in effect for one year. (CX 216 at 9). Accordingly, Evanston Hospital and Unicare would have had to begin negotiations prior to the Summer of 2000 even without the Merger. (CX 216 at 9).

859. HPH had a PPO contract with Rush Prudential dating back to May 1, 1994. (CX 215 at 1; CX 5076 at 1-2). This contract with Rush Prudential expired on April 30, 1995, but had been successively renewed per the terms of the contract. (CX 215 at 1).

860. In 1998, Rush Prudential sought to contract HPH into its HMO plan. (RX 392). But HPH refused to accept Rush Prudential's "standard terms of the contract." (RX 392).

861. HPH had no contract with Unicare before the Merger. (CX 114 at 1). Unicare accessed HPH using the CCN or Healthstar Network. (CX 114 at 1). HPH did not sign a contract with Unicare because Unicare was not willing to offer rates comparable to those offered by CCN and Healthstar. (CX 114 at 1).

(2) ENH's Post-Merger Negotiations With Unicare Were Not Anticompetitive

862. On March 24, 2000, ENH opened contract renegotiations with Unicare. (CX 124 at 1). The contracts had to be renegotiated in part because two mergers took place in early 2000: ENH's merger with HPH and Wellpoint's acquisition of Rush Prudential. (CX 124 at 1).

863. (REDACTED) (Holt-Darcy, Tr. 1503, *in camera*). (REDACTED) (Holt-Darcy, Tr. 1503, *in camera*).

864. (REDACTED) (Holt-Darcy, Tr. 1579, *in camera*; CX 129 at 1).

865. (REDACTED) (Holt-Darcy, Tr. 1527-28, *in camera*; CX 124 at 2, *in camera*). (REDACTED) (Holt-Darcy, Tr. 1527-28, *in camera*; CX 124 at 2). (REDACTED) (Holt-Darcy, Tr. 1527, *in camera*).

866. In response to Unicare's counteroffer, on June 14, 2000, ENH provided notice of termination of the Unicare hospital contract. (CX 2063 at 1; RX 881). ENH wrote, "[a]s much as we want to continue our contractual relationship with Unicare, we cannot accept the rates as proposed [by Unicare]." (CX 2063 at 1).

867. (REDACTED) (Holt-Darcy, Tr. 1602, *in camera*). (REDACTED) (Holt-Darcy, Tr. 1552, *in camera*). (REDACTED)

(Holt-Darcy, Tr. 1540, 1551, *in camera*). (REDACTED) (Holt-Darcy, Tr. 1552, *in camera*).

868. (REDACTED) (Holt-Darcy, Tr. 1567-68, *in camera*). (REDACTED) (Holt-Darcy, Tr. 1567, *in camera*).

869. (REDACTED) (CX 5075, *in camera*).

870. (REDACTED) (Holt-Darcy, Tr. 1535, *in camera*). (REDACTED) (Holt-Darcy, Tr. 1542, *in camera*).

871. (REDACTED)

(Holt-Darcy, Tr. 1582-83, *in camera*; CX 5085 at 1; CX 5075 at 17, *in camera*). (REDACTED)
(Holt-Darcy, Tr. 1582, *in camera*; CX 5085 at 1,).

(REDACTED)
(Holt-Darcy, Tr. 1582, *in camera*; CX 5075 at 17, *in camera*).

872.

(Holt-Darcy, Tr. 1581, *in camera*). (REDACTED)

(Holt-Darcy, Tr. 1581, *in camera*). (REDACTED)

(Holt-Darcy, Tr. 1581, *in camera*). (REDACTED)

(Holt-Darcy, Tr. 1581, *in camera*; CX 5075 at 18, *in camera*).

873. When compared against Rush Prudential contracts, Unicare also enjoyed improved outpatient rates. The outpatient rates under the 1994 Rush Prudential contracts with HPH were at a 12% discount-off-charges. (CX 5076 at 10; CX 215 at 1). The pre-Merger outpatient discount at Evanston Hospital was 8% off charges. (CX 5085 at 1; CX 5091 at 1).

(REDACTED)

(CX 5075 at 17, *in camera*).

874. (REDACTED)

in camera). (REDACTED)

(Noether, Tr. 6104,

Darcy, Tr. 1570-71, *in camera*).

(Noether, Tr. 6104, *in camera*; Holt-

875. (REDACTED)

(Holt-Darcy, Tr. 1562-64, *in camera*).

876. (REDACTED)

64, *in camera*).

(REDACTED)

(Holt-Darcy, Tr. 1563-

(Holt-Darcy, Tr. 1564, *in camera*). (REDACTED)

(Holt-Darcy, Tr. 1564, *in camera*).

**(1) Evanston Hospital's Pre-Merger Contract Rates
With United Were Outdated And Undermarket**

877. At the time of the Merger, Evanston Hospital's rates with United had been in place for about five years, they were below Evanston Hospital's costs, and they were much lower than Evanston Hospital's rates with other MCOs. (Sirabian, Tr. 5711-12).

878. The United contract with Evanston Hospital in effect at the time of the Merger expired in the mid-1990s. (Sirabian, Tr. 5711). During the 1990s, United was not willing to work with Evanston Hospital in a fair, honest and open way. United was uncompromising, and Evanston Hospital had a very difficult time trying to present its position to them. (Sirabian, Tr. 5710-11; 5714-15; Hillebrand, Tr. 1868).

879. Evanston Hospital had claims issues with United in the mid- to late-1990s that made reimbursement a "mess." (Hillebrand, Tr. 1870-71). Evanston Hospital was commonly paid under the wrong contract terms, by the wrong system, and for the wrong product. (Hillebrand, Tr. 1871). Evanston Hospital's business office literally had people dedicated to claims adjudication and resolution of United claims. (Hillebrand, Tr. 1871). Eventually, Evanston Hospital had to purchase additional software to attempt to resolve those issues. (Hillebrand, Tr. 1871).

880. Before the Merger, United acquired a variety of companies, including Share, Chicago HMO, MetLife and Travelers, each of which had separate payment systems. (Hillebrand, Tr. 1870-71). In July 1998, United requested to consolidate the four hospital agreements in place with Evanston Hospital. (RX 355; Hillebrand, Tr. 1724).

881. Evanston Hospital agreed that the United contracts should be consolidated in July 1998. (RX 356). However, the proposed rate structure was not acceptable and Evanston Hospital presented a counter-proposal. (RX 356). New agreements, however, were not reached during these negotiations, as indicated by the 2000 contract which includes an introductory paragraph consolidating and superceding the existing contracts held by Share Health Plan, Chicago HMO and Chicago Health Multi Option Insurance. (CX 5174 at 1-2).

882. As early as December 1994, HPH had negotiated discount-off-charges of 15% for nearly all inpatient services with Metropolitan Life Insurance Company, which was acquired by United Healthcare. (CX 5141 at 1-4). HPH had the same contract until the Merger. (CX 5141). For outpatient services under the pre-Merger HPH contract, the percentage of billed charges was 92.5%. (CX 5141 at 5). Emergency room visits were also paid at 92.5% of billed charges. (CX 5141 at 4).

**(2) ENH's Post-Merger Negotiations With United
Were Not Anticompetitive**

883. **(REDACTED)**
(Noether, Tr. 6086-87, *in camera*; RX 1912 at 34, *in camera*).

(REDACTED) (Noether, Tr.
6086-87, *in camera*; RX 1912 at 34, *in camera*).

884. **(REDACTED)**
(Noether, Tr. 6088, *in camera*). **(REDACTED)**

(Noether, Tr. 6088-89, *in camera*).

(REDACTED)
(Noether, Tr. 6093, *in camera*; Hillebrand, Tr. 1870; Neaman, Tr. 1340-41; RX 684 at BAIN 73; Haas-Wilson, Tr. 2851-52, *in camera*).

885. After ENH saw HPH's rates with United, Hillebrand felt that United's negotiators had lied to him by giving him the impression that Evanston Hospital was being fairly and appropriately compensated. (Hillebrand, Tr. 1874).

886. Jack Sirabian, from ENH, and Ogden, from Bain, handled the 1999 negotiations with United. (Hillebrand, Tr. 1873-74). Jack Gilbert (HPH's former CFO) also participated in the conversations. (Hillebrand, Tr. 1874).

887. Jim Watson was the principal contact for United Healthcare during the 1999-2000 negotiations. (Hillebrand, Tr. 1900). **(REDACTED)**

(Foucre, Tr. 1118, *in camera*). **(REDACTED)**

(Foucre, Tr. 1118, *in camera*).

888. In December 1999, United proposed that the parties use the better of the two contracts, either Evanston Hospital's or HPH's, as the basis for the new, post-Merger ENH agreement. (Hillebrand, Tr. 1900-01; CX 111 at 1). HPH's previous contract with United was much better than Evanston Hospital's, at 85% of charges for inpatient services. (CX 5141). Evanston Hospital had per diem contracts before the Merger. (Foucre, Tr. 890).

889. **(REDACTED)** (Foucre, Tr. 1118, *in camera*; CX 5174 at 11-12, *in camera*). **(REDACTED)**
(CX 5174 at 11-12; *in camera*).

890. **(REDACTED)** (CX 5174 at 11-12, *in camera*).

(REDACTED)
(Foucre, Tr. 1118-19, *in camera*; CX 5174 at 12, *in camera*).

891. ENH proposed the duration of the agreement to be three years. (Hillebrand, Tr. 1901; CX 111 at 4). However, United Healthcare negotiated the initial term to be two years, renewing automatically for successive year terms thereafter. (CX 5174 at 7).

892. **(REDACTED)**

(CX 5174 at 7; Foucre, Tr. 1087, *in camera*). United, therefore, had foreseen the possibility that ENH's charges could rise and specifically negotiated an appropriate remedy in that event: termination of the contract. (CX 5174 at 7).

893. (REDACTED)

1208 at UHCENH 3378, *in camera*). (REDACTED)

(RX

UHCENH 3378, *in camera*). (REDACTED)

(RX 1208 at

(RX 1208 at UHCENH 3378, *in camera*). (REDACTED)

(RX 1208 at

UHCENH 3378, *in camera*).

(3) United And ENH Renegotiated Their 2000 Contract To Accommodate United's Contracting Goals

894. At the end of 2002, United was free to terminate its existing contract with ENH. (Foucre, Tr. 899; CX 5174 at 7). In August 2002, United and ENH began re-negotiations that lasted for nearly two years. (Foucre, Tr. 882; Hillebrand, Tr. 1875).

895. The renegotiations with ENH began with a meeting in August 2002 between Ms. Foucre and Bill Moeller, CEO of United, conferring with Hillebrand, Joe Golbus, and Jodi Levine. (Foucre, Tr. 892; Hillebrand, Tr. 1875-76). United presented its broad objectives for the negotiations. (Foucre, Tr. 892). ENH discussed its perspective that moving away from discount-off-charges shifts risk to the hospitals and that ENH's view was that United should be responsible for taking risk. (Foucre, Tr. 893).

896. When United entered renegotiation talks in August 2002, its objectives were: (1) to move ENH onto its new contract template; (2) to significantly improve the level of fixed rate pricing; and (3) to achieve an overall reduction in the total reimbursement under the contract. (Foucre, Tr. 892). United sent its initial proposal to ENH in October 2002. (Foucre, Tr. 894).

897. The two sides met in October 2002. (Foucre, Tr. 894). Present on behalf of United was Foucre, Bill Moeller, Tom Kniery (Vice President of Network Management) and perhaps others. (Foucre, Tr. 894-95; Hillebrand, Tr. 1878). For ENH, Hillebrand, Dr. Golbus and Levine were present. (Hillebrand, Tr. 1878; Foucre, Tr. 895).

898. United shaped the conversation relating to a decrease by asking for reimbursement rates similar to its primary competitor, Blue Cross. (Foucre, Tr. 893).

(REDACTED)

(Foucre, Tr. 894; Foucre, Tr. 1107, *in camera*; CX 2381, *in camera*).

899. ENH did not know how United had derived its data for Blue Cross. (Hillebrand, Tr. 1880). United never provided ENH with the formula it used to make the calculations. (Hillebrand, Tr. 1880).

900. United assumed that ENH had a 30% margin on its business with Blue Cross. (Hillebrand, Tr. 1880-81). But United's calculations in that regard simply did not make any sense. (Hillebrand, Tr. 1881).

901. United sought a 40% reduction in the reimbursement to be paid to ENH, by proposing a price reduction of \$20 million on a book of business at ENH of only \$50 million. (Hillebrand, Tr. 1878).

902. Hillebrand felt that United's proposal was demeaning and did not recognize the services and level of care ENH delivered to its patients. (Hillebrand, Tr. 1878). Hillebrand had never before and has never since been presented with a demand of that type. (Hillebrand, Tr. 1878-79).

903. During the meeting in October 2002, United prepared a document estimating ENH's margin on United's business as compared against other commercial and government payors. (Foucre, Tr. 895-96). United reviewed ENH's financial data, bond filings and other publicly available information in its analysis. (Foucre, Tr. 895). United also used its claims data to assess the performance of the contract. (Foucre, Tr. 896).

904. ENH analyzed the data presented by United and found that the data was "nonsensical," invalid, extremely flawed and "junior graduate school level work." (Hillebrand, Tr. 1879, 1881-82; Foucre, Tr. 896). United's data was based on its calculation of revenue and expense profitability for their contract, Medicare, Medicaid and Blue Cross. (Hillebrand, Tr. 1879). The conclusions that United reached, and the basis upon which it did the analysis, simply did not make any sense. (Hillebrand, Tr. 1879). **(REDACTED)**
(Foucre, Tr. 1107, *in camera*).

905. For example, United used the wrong case-mix indicator in its data. (Hillebrand, Tr. 1879). United indicated that ENH's case-mix was below 1.0 when, in fact, it was approximately 1.4 at the time. (Hillebrand, Tr. 1879-80). **(REDACTED)**
(RX 424 at UHCENH 3324, *in camera*).

(REDACTED)
(CX 2381 at 4, *in camera*). United's presentation to ENH also used the wrong average length of stay. (Hillebrand, Tr. 1881).

906. After ENH contested the validity and pointed out the inaccuracies of United Healthcare's data, the data never again resurfaced during the contract negotiation. (Hillebrand, Tr. 1882).

907. Before May 2003, United eased its negotiating position to focus on moving to fixed rate pricing rather than asking for a reduction. (Foucre, Tr. 907-08).
(REDACTED)

(Foucre, Tr. 1117-18, *in camera*; RX 1208 at UHCENH 3378, *in camera*).

908. **(REDACTED)**

(RX 424 at UHCENH 3324, *in camera*).

(RX 424 at UHCENH 3324, *in camera*; RX 1208 at UHCENH 3378, *in camera*). (REDACTED)

(RX 424 at UHCENH 3324). (REDACTED)

(RX 1208 at UHCENH 3378, *in camera*).

909. In January 2003, United identified its self-funded customers that had the largest number of dollars flowing through ENH. (Foucre, Tr. 903). Foucre met with those customers to describe to them the concerns she had regarding the progress of the ENH negotiations. (Foucre, Tr. 903-04). Foucre met with Kraft, LaSalle Bank, Allstate, American Airlines, SBC Communications, WW Grainger and AT&T. (Foucre, Tr. 904). But none of these employers felt adversely affected by the Merger. (Foucre, Tr. 948).

910. ENH hired Brian Washa as its contract negotiator in June 2003, and this changed the tone of the negotiations. (Hillebrand, Tr. 1885; Foucre, Tr. 912). Washa was now involved in the negotiations from ENH and Kurt Janavitz replaced Greg Mylin from United. (Foucre, Tr. 912; Hillebrand, Tr. 1886). Washa and Janavitz worked together and knew each other from previous experience, and the negotiations took on a different tone. (Foucre, Tr. 912). A fair amount of negotiations occurred between the Summer of 2003 and April of 2004. (Hillebrand, Tr. 1889).

911. In fact, ENH was considering changing its employee plan to United in July or August 2003. (Foucre, Tr. 913). ENH was looking for alternatives to provide employee benefits to its employees and families. (Foucre, Tr. 914).

912. (REDACTED)

(RX 1319 at 1, *in camera*).

(REDACTED)

(RX 1319 at UHCENH

3511, *in camera*). (REDACTED)

(RX 1319 at UHCENH 3511, *in camera*).

(REDACTED)

(RX

1527, *in camera*).

913. (REDACTED)

(RX 1527, *in camera*). (REDACTED)

(RX 1527, *in camera*). (REDACTED)

(RX 1527, *in camera*). (REDACTED)

(RX 1527, *in camera*).

914. Since the start of negotiations in 2002, ENH and United had been negotiating one price for all products. (Hillebrand, Tr. 1889-90). However, in January 2004, United asked ENH to develop two prices for the contract. (Hillebrand, Tr. 1889-90). As a result, the parties had to start over again with negotiations in January 2004. (Hillebrand, Tr. 1889).

915. At about the time that ENH began to recast the pricing into two different structures, ENH became aware that United had terminated with the largest hospital system in Chicago, the Advocate Health System. (Hillebrand, Tr. 1891). The termination was widely covered in the press. (Hillebrand, Tr. 1891).

916. In addition, throughout the early 2000s, the entire Rush System for Health was not in United's network. (Hillebrand, Tr. 1891). Rush North Shore Hospital was added to United's network later, but it was a fairly new relationship between United and Rush North Shore as of January 2004. (Hillebrand, Tr. 1891).

917. **(REDACTED)**

(Foucre, Tr. 1105-06, *in camera*; CX 5176 at 1). **(REDACTED)**

(Foucre, Tr. 1106, *in camera*).

(REDACTED)

(Foucre, Tr. 882, 887-88; CX 5176, *in camera*).

918. Foucre testified that United did not get everything it wanted in the 2004 contract. (Foucre, Tr. 930). **(REDACTED)**

(Foucre, Tr. 1101-02, *in camera*).

919. **(REDACTED)**

(Hillebrand, Tr. 1890; CX 5176 at 12; Foucre, Tr. 1106, *in camera*). In fact, ENH was the first provider in the United States to sign United's new template contract. (Hillebrand, Tr. 1890).

920. **(REDACTED)**

(Foucre, Tr. 1102 *in camera*).

(REDACTED) (Foucre, Tr. 1102 *in camera*). The 2004 ENH contract with United Healthcare was not a discount-off-charges contract. (Hillebrand, Tr. 2028). Almost all of the rates in the contract are per diems and case rates. (Hillebrand, Tr. 2028).

921. **(REDACTED)**

(Hillebrand, Tr. 1924, *in camera*).

(REDACTED)

(Foucre, Tr. 1106, *in camera*; CX 5176 at 32-36, *in camera*; Hillebrand, Tr. 1890). **(REDACTED)**

(Foucre, Tr. 1130, *in camera*; CX 5176 at 33, *in camera*). **(REDACTED)**

Foucre, Tr. 1130, *in camera*; CX 5176 at

35-36, *in camera*). **(REDACTED)**
(Foucre, Tr. 1106, *in camera*; CX 5176 at 32-36, *in camera*).

922. United was quite pleased with the results of the new contract with ENH in 2004. (Hillebrand, Tr. 1890-91). ENH also felt that the 2004 contract with United was a fair deal. (Hillebrand, Tr. 1891). Throughout the entire contract process, no one at ENH ever made statements regarding perceiving themselves as having market power. (Foucre, Tr. 948).

923. A few months after the contract became effective in June 2004, ENH discovered that United's national template contract had a significant payment compliance issue resulting in underpaid claims and administrative difficulty. (RX 1725 at 1). United was obligated to analyze all of the past claims, identify any underpayments and calculate a prospective remedy to ENH for the mistake. (RX 1725 at 2-3).

d. By 2002, ENH Learned That, On A Whole, Its Chargemaster Contained Prices That Were Undermarket

i. Description Of A Chargemaster

924. A charge description master, also known as a CDM or chargemaster, is a line-by-line listing of all of the clinical activities performed at a hospital. (Neaman, Tr. 1349; Porn, Tr. 5638). The chargemaster contains all services provided at a hospital – including inpatient and outpatient services. (Porn, Tr. 5646).

925. The chargemaster represents the list price and not necessarily what will be paid by payors and other customers. (Hillebrand, Tr. 1710-11, 1716; Porn, Tr. 5646). A chargemaster contains thousands of lines of codes, depending on the complexity of the services provided at a hospital. (Porn, Tr. 5647). A hospital that offers complex services would have around 15,000 lines of chargemaster codes, while a community hospital would have fewer. (Porn, Tr. 5647).

926. ENH's chargemaster has 15,000-20,000 line items. (Neaman, Tr. 1349; RX 641 at ENH KG 00627).

927. The chargemaster is a fluid document. (Hillebrand, Tr. 1712). Roughly a hundred changes are made to the chargemaster every month as Medicare issues new codes for new services and changes the terminology for existing services, and as ENH initiates its own new clinical services. (Hillebrand, Tr. 1712, 1989).

ii. ENH Consolidated Its Chargemaster After The Merger

928. To maximize Merger-related cost efficiencies, ENH consolidated its chargemaster with HPH's so the merged entity could have a singular billing system and a singular process for patient registration and other activities. (Hillebrand, Tr. 1710, 1990; RX 864 at ENH HG 1781). A consolidated chargemaster is the best practice for a hospital system. (Porn, Tr. 5646-47).

929. ENH did not hire outside consultants to merge its chargemaster with HPH's chargemaster. (Hillebrand, Tr. 1990). ENH had had an internal chargemaster transition team, which Hillebrand headed. (CX 2239; Hillebrand, Tr. 1713, 1990).

930. ENH's "goal" of the 2000 chargemaster transition was to "equalize charges at all three sites." (CX 2239). However, ENH did not increase its chargemaster prices in 2000 above the pre-Merger Evanston Hospital and HPH prices. (Hillebrand, Tr. 1712).

931. ENH also consolidated the chargemasters by taking the chargemaster list price for an item that existed at one hospital and transferred it over to the other hospital. (CX 2240 at 11; Hillebrand, Tr. 1715). Further, ENH "cleaned up" and streamlined the terminology used both chargemasters. (Hillebrand, Tr. 1711-12).

iii. ENH, With The Assistance Of Deloitte Consulting, Brought Its Chargemaster Up To Market In 2002

932. ENH retained Deloitte Consulting ("Deloitte") to reexamine its chargemaster in the Spring of 2002. (Hillebrand, Tr. 1716; Neaman, Tr. 1349-50).

933. In late 2000, ENH initially hired Deloitte to assist with a revenue cycle analysis of ENH's physician practices. (Hillebrand, Tr. 1990; Porn, Tr. 5641-42). In 2001 and early 2002, Deloitte assisted ENH with a revenue cycle analysis of its hospitals. (Hillebrand, Tr. 1990-91). The last activity Deloitte performed as part of ENH's revenue cycle analysis was to review ENH's chargemaster. (Hillebrand, Tr. 1716, 1990-91; Porn, Tr. 5641).

934. A revenue cycle project involves refining all steps involved in the collection of revenue at a hospital – from scheduling a patient, admitting the patient to the hospital, providing the service, recording the charge, billing the third-party payor and collecting the proper amount. (Porn, Tr. 5638; Hillebrand, Tr. 1991).

935. ENH's hospital chargemaster needed to be updated even without a merger. There were 1901 unique Current Procedural Terminology ("CPT") codes, *i.e.*, the procedures at a hospital, of which 1383 were active. (RX 641 at ENH KG 267; Porn, Tr. 5646-47, 5658). Of the 1901 unique CPT codes, 78 of them were invalid in October 13, 1999. (RX 641 at ENH KG 267). Twenty of the 1383 active unique CPT codes were invalid as of October 13, 1999. (RX 641 at ENH KG 267).

936. In 1999, half of the 1383 active unique CPT codes had multiple pricing points. (RX 641 at ENH KG 267, 271).

937. On its October 13, 1999 preliminary chargemaster review, Deloitte discovered that there were 2010 line items within the hospital chargemaster with a \$0 charge. (RX 641 at ENH KG 267). There were 384 unique, active CPTs which carried a \$0 charge. (RX 641 at ENH KG 267).

938. Deloitte advised that the "organizational structure and processes related to CDM update and maintenance are not well defined and controlled" in 2001. (RX 1138 at DC 605).

Deloitte noted that there was no annual chargemaster review nor a regular, annual review of the hospital fee schedule. (RX 1155 at DC 1982).

939. While ENH “somewhat” had a pricing methodology, it was applied inconsistently and was not tied to market benchmarks. (RX 1155 at DC 1982). Under- and over-pricing were thought to be commonplace within the fee schedule. (RX 1155 at DC 1985). In fact, the majority of prices had not been reviewed in years. (RX 1155 at DC 1985).

940. A chargemaster project involves updating a hospital’s chargemaster to include the most current services available at the hospital. (Porn, Tr. 5638). It is important that a chargemaster properly describe and list the service codes that are provided at a hospital. (Porn, Tr. 5643). The codes are used for billing and cost accounting at a hospital. (Porn, Tr. 5643).

941. Medicare produces annual and quarterly updates which are required to be input into a chargemaster. (Porn, Tr. 5644). In addition, a hospital will regularly add new physicians and new services that need to be accounted for in the chargemaster. (Porn, Tr. 5644).

942. As part of a chargemaster project, Deloitte compares a client hospital’s chargemaster to a master list developed by Deloitte over the course of prior engagements, and determines what services need to be added to the chargemaster. (Porn, Tr. 5638). Deloitte has performed chargemaster projects for number of clients. (Porn, Tr. 5638-39).

943. A parallel project Deloitte performs on a chargemaster for its clients all across the country on a regular basis is a chargemaster pricing project. (Porn, Tr. 5645-47). The purpose of a pricing project is to increase a hospital’s prices to be competitive in the marketplace. (Porn, Tr. 5645).

944. Deloitte compares the prices from a client’s chargemaster to comparable institutions in the marketplace. (Porn, Tr. 5646). Deloitte’s selection of comparable hospitals is “somewhat subjective.” (Porn, Tr. 5647). Deloitte consults with the clinical departments in a hospital to make sure that the chargemaster definitions being compared with other hospitals are consistent. (Porn, Tr. 5646). Deloitte also determines the overall effect the price changes will have on the institution. (Porn, Tr. 5646).

945. To compare a client’s chargemaster prices, Deloitte obtains information from a third-party information clearing house that gathers publicly available pricing information. (Porn, Tr. 5647). The pricing information available from the clearinghouse represents the hospitals’ list price – *i.e.*, Deloitte does not have access to the actual prices that may have been paid by MCOs. (Porn, Tr. 5666-67). Deloitte compares the client hospital’s chargemaster prices with those from the comparable institutions on a line-by-line basis. (Porn, Tr. 5647).

946. After comparing a client’s chargemaster to comparable hospitals, Deloitte will identify those charges that it believes are “under priced” and work with the clinical departments to make sure the comparisons are accurate. (Porn, Tr. 5647-48). Deloitte provides the client hospital with a line-by-line list of the under priced charges and will ultimately suggest that certain prices be increased. (Porn, Tr. 5648).

947. In 2001, Deloitte advised ENH that the 2000 chargemaster consolidation could be improved by cleaning up redundancies and errors in the chargemaster. (Porn, Tr. 5643-45; Hillebrand, Tr. 1991). Deloitte advised ENH that it should develop a more rigorous process to better manage the monthly changes that are made to the chargemaster. (Hillebrand, Tr. 1991).

948. During Deloitte's initial projects at the hospital, it identified that ENH's chargemaster was "not up to date." (Porn, Tr. 5643). Deloitte discovered that the ENH chargemaster did not reflect a number of services that were performed at ENH as well as a number of expired or non-current codes. (Porn, Tr. 5641). The chargemaster codes needed to be updated based on annual and quarterly updates that are provided by Medicare. (Porn, Tr. 5643-44).

949. During Deloitte's initial chargemaster update work, it identified that ENH's prices were below market. (Porn, Tr. 5648). Deloitte proposed its pricing project to ENH. (Porn, Tr. 5648). At first, ENH believed that its prices were already competitive and did not see any opportunity from the project. (Porn, Tr. 5648-49). However, after Deloitte presented ENH with its initial findings, ENH agreed to engage Deloitte to perform the pricing project. (Porn, Tr. 5650; RX 1244).

950. The purpose of Deloitte's pricing project at ENH was to "increase prices to be competitive in the marketplace." (Porn, Tr. 5645). ENH officially engaged Deloitte to perform the pricing project on March 8, 2002, and the project was completed in approximately 12 weeks. (Porn, Tr. 5650, 5652; RX 1244 at ENH JH 7109). Hillebrand was primarily responsible for hiring Deloitte to work on ENH's chargemaster in 2002. (Neaman, Tr. 1350). Harry Jones, a member of ENH's finance department, worked on the 2002 chargemaster initiative. (Neaman, Tr. 1350; Hillebrand, Tr. 1716; H. Jones, Tr. 4143). Lou Porn, who specializes in providing consulting services to healthcare providers, led the Deloitte team. (Hillebrand, Tr. 1716; Porn, Tr. 5637).

951. Porn's engagements for healthcare providers – including for ENH, Advocate, Children's Memorial and other Chicago area hospitals – involve revenue cycle projects, chargemaster updates, pricing projects, accounts receivable projects and others. (Porn, Tr. 5637-39).

952. Deloitte used a proprietary database to compare ENH's list prices to list prices of other hospitals in the Chicago area. (Hillebrand, Tr. 1716). Deloitte examined ENH's ancillary and diagnostic services, but did not examine routine charges such as room rates. (Hillebrand, Tr. 1994). Deloitte also met with personnel from each of ENH's clinical departments and then compared the prices for individual ancillary and diagnostic services to those of ENH's peer hospital group's prices. (Hillebrand, Tr. 1994).

953. Deloitte selected 10 hospitals as comparable to ENH for purposes of its chargemaster pricing project. (Porn, Tr. 5653-54). The 10-hospital peer group that Deloitte identified included: Loyola University, Advocate Lutheran General, Advocate Illinois Masonic, Resurrection, Northwestern Community, Northwestern Memorial, University of Chicago, Alexian Brothers, Condell and Rush-Presbyterian. (Porn, Tr. 5654; RX 1283 at DC 7). In selecting its peer group, Deloitte performed a subjective evaluation of what it thought were

comparable hospitals based on service mix and reputation in the marketplace. (Porn, Tr. 5654-55; Hillebrand, Tr. 1993). Deloitte believed that ENH was comparable to other academic medical centers in the marketplace. (Porn, Tr. 5655).

954. The initial list of peer hospitals that Deloitte proposed to ENH included Rush North Shore and St. Francis and omitted Rush Presbyterian and Loyola University. (Porn, Tr. 5654-55). ENH modified the proposed list by exchanging Rush North Shore with Rush Presbyterian, and St. Francis with Loyola University. (Porn, Tr. 5655). Porn believed the exchange was made because Rush Presbyterian and Loyola are more comparable due to their status as academic medical centers. (Porn, Tr. 5655).

955. Deloitte's peer group list also included some non-academic hospitals that offer high-level services, but Deloitte did not perform a technical review of the peer hospitals' case-mix index. (Porn, Tr. 5656). Deloitte also did not know the prices at the peer group hospitals before selecting the list. (Porn, Tr. 5656). Deloitte's selection of the peer hospitals was a subjective selection based on its knowledge of the marketplace. (Porn, Tr. 5657).

956. Deloitte discovered during its chargemaster update project that a number of ENH's "prices were well below the marketplace." (Porn, Tr. 5651, 5653; Hillebrand, Tr. 1993). On average, Deloitte found that ENH's prices were at the 63rd percentile of comparable hospitals, while some charges were below the 50th percentile. (Porn, Tr. 5653; Hillebrand, Tr. 1717, 1993; RX 1244; RX 1283). The percentile is calculated on a line-by-line basis for each code or procedure within the chargemaster. (Porn, Tr. 5658).

957. ENH was surprised at Deloitte's findings because ENH believed that it was competitive in the marketplace. (Porn, Tr. 5658-59). After determining that ENH's prices had a weighted average in the 63rd percentile, Deloitte recommended that ENH increase its prices. (Porn, Tr. 5658).

958. Deloitte recognized that "small across-the-board increases will not recapture the value of the [highly underpriced] services." (RX 1170 at DC 2008). Instead, Deloitte emphasized that a "one-time 'catch-up' adjustment" was required on ENH's chargemaster. (RX 1170 at DC 2008). The main objective of the pricing project was to bring ENH's undervalued hospital prices up to the common-market-based rate. (RX 1244 at ENH JH 7105).

959. Deloitte's 2002 chargemaster study concluded that an overall 11% increase in ENH's prices was warranted to bring ENH's prices in line with the market. (Hillebrand, Tr. 1993). Thus, Deloitte recommended that ENH move its list prices to either the 80th, 90th or 95th percentile. (Hillebrand, Tr. 1994; Porn, Tr. 5657). In consultation with Deloitte, ENH decided to move its chargemaster prices to the 90th percentile in the market as calculated by Deloitte. (Hillebrand, Tr. 1717, 1994; Porn, Tr. 5657-60). Porn believed that the selection of the 90th percentile was reasonable based on ENH's reputation and prestige. (Porn, Tr. 5657).

960. Out of the 14,000 to 15,000 codes within the chargemaster, Deloitte only reviewed approximately 2,400 for possible price increases. (Porn, Tr. 5660; RX 1283 at DC 15). Deloitte did not review increasing pricing on room and board and other related charges. (Porn, Tr. 5660).

961. Of the 2,400 charges that Deloitte reviewed, only approximately 2,000 charges were actually increased. (Porn, Tr. 5660-61; RX 1283 at DC 15). Deloitte assisted ENH with implementing the price increases on the identified line items. (Porn, Tr. 5660). As a result of implementing the Deloitte recommended chargemaster price increases, ENH's chargemaster was increased a total of 8.5%. (Porn, Tr. 5664).

962. To Hillebrand's knowledge, MCOs have never requested to see ENH's chargemaster. (Hillebrand, Tr. 1995). Thus, Hillebrand did not anticipate any resistance from the payors to the chargemaster pricing changes because he never before had a conversation with a payor about the chargemaster, and he did not believe that ENH's chargemaster prices were a relevant matter to the payors. (Hillebrand, Tr. 1995). Deloitte also was not aware of any MCO that had issues with the prices increases in the chargemaster. (Porn, Tr. 5665).

963. ENH's 2002 chargemaster initiative had no impact on Medicare reimbursements, and had no relationship to ENH's 2000 MCO contract renegotiations. (Hillebrand, Tr. 1721, 1996).

964. Deloitte would have made the same pricing recommendation to ENH even absent the Merger. (Porn, Tr. 5661).

e. Factual Evidence Is Inconsistent With Dr. Haas-Wilson's Bargaining Theory

i. Dr. Haas-Wilson's Bargaining Theory Is Not Grounded In Theory Or Common Sense

965. Dr. Haas-Wilson's theory of competitive harm is based on bargaining theory in general. She opines that (REDACTED) (Haas-Wilson, Tr. 2469; Haas-Wilson, Tr. 2759-60, *in camera*). Dr. Haas-Wilson, however, did not provide any real details of her bargaining model. (Noether, Tr. 5979).

966. When explaining her bargaining theory, Dr. Haas-Wilson relied on an article by Town and Vistnes, which suggested that a "hospital's incremental value to the plan is a function of the plan's opportunity cost of turning to the next-best alternative network that excludes the hospital." (Noether, Tr. 5984; Haas-Wilson, Tr. 2475-76). This embodies the concept that "closeness of substitution of different networks with and without a particular hospital in question are important in informing about the bargaining leverage that each party brings to the table." (Noether, Tr. 5984).

967. The Town and Vistnes article is inconsistent with Dr. Haas-Wilson's claim that her bargaining theory does not require that Evanston Hospital and HPH to be each other's closest competitors before the Merger from the perspective of either patients or MCOs. (Haas-Wilson, Tr. 2476). Dr. Noether explained that HPH and Evanston Hospital each had much closer hospital competitors, thus establishing that the combination of Evanston Hospital and HPH would have little effect on MCO bargaining dynamics. (Noether, Tr. 5985).

(REDACTED) (Haas-Wilson, Tr. 2778, *in camera*). As discussed below, however, the record evidence does not corroborate Ballengee's testimony.

975. PHCS did not play Evanston Hospital off HPH during negotiations before the Merger. (Ballengee, Tr. 170). (REDACTED)

(Haas-Wilson, Tr. 2780-81, *in camera*; Ballengee, Tr. 170).

976. (REDACTED) (Haas-Wilson, Tr. 2817, *in camera*; RX 2030, *in camera*).

977. (REDACTED) (Mendonsa, Tr. 562-63, *in camera*).
(REDACTED) (Mendonsa, Tr. 568, *in camera*).

978. (REDACTED) (Holt-Darcy, Tr. 1594, *in camera*).
(Holt-Darcy, Tr. 1593-94, *in camera*). (REDACTED) (Holt-Darcy, Tr. 1513, *in camera*).

979. Great West also did not play one hospital off another to get better rates. (Dorsey, Tr. 1470-71). That has "never been a negotiating strategy" during Dorsey's tenure at the company, and he never approved that strategy for anyone on his team. (Dorsey, Tr. 1470-71).

980. (REDACTED) (Haas-Wilson, Tr. 2788-89, 2793, *in camera*).

981. (REDACTED) (Haas-Wilson, 2796-98, *in camera*).

982. Moreover, before the Merger, HPH had contracts with virtually all MCOs, with perhaps one or two exceptions. (Newton, Tr. 457). And HPH was never excluded from managed care contracts because of Evanston Hospital (other than Humana's Staff model product). (Newton, Tr. 457).

983. Evanston Hospital's presence, or the presence of any other hospital, in a MCO's network did not make it more difficult for HPH to gain price increases from that MCO before the Merger. (Spaeth, Tr. 2176). If a MCO decided not to accept HPH's price proposals, HPH simply would either lower its prices or walk away from the MCO. (Spaeth, Tr. 2176).

iii. Dr. Haas-Wilson's Bargaining Theory Does Not Apply Here Because She Admits That A Network Without ENH Would Still Be Marketable

984. (REDACTED)

(Haas-Wilson, Tr. 2762, *in camera*).

985. (REDACTED)

(Haas-Wilson, Tr. 2762, *in camera*).

(REDACTED) (Haas-Wilson, Tr. 2763-64, *in camera*).

986. (REDACTED)

(Haas-Wilson, Tr. 2765-66, *in camera*).

(REDACTED) (Haas-Wilson, Tr. 2766, *in camera*).

987. (REDACTED)

(Haas-Wilson, Tr. 2766, *in camera*).

(REDACTED)

(Haas-Wilson, Tr. 2768, *in camera*).

(REDACTED) (Haas-Wilson, Tr. 2769-70, *in camera*).

988. (REDACTED)

(Haas-Wilson,

Tr. 2773, *in camera*). (REDACTED)

(Haas-

Wilson, Tr. 2773, *in camera*).

iv. Dr. Haas-Wilson's Bargaining Theory Does Not Apply Here Because There Was Little Selective Contracting In The Chicago Area

989. Dr. Haas-Wilson's bargaining theory is based on the concept of selective contracting. (Haas-Wilson, Tr. 2457-59). Selective contracting is where MCOs contract with a limited number of hospitals rather than all the hospitals in an area and use their bargaining ability to steer volume to the contracted hospitals, thus inducing price competition among hospitals. (Noether, Tr. 5980-81).

990. In the absence of selective contracting, a MCO attempts to have all hospitals in their networks and, as a consequence, the MCO would not have the same bargaining leverage it would have had if it engaged in selective contracting. (Noether, Tr. 5981).

991. There was never much selective contracting in the Chicago area. (Noether, Tr. 5981). An analysis of the size of various managed care networks in the Chicago area shows that all MCO networks are very large and fairly inclusive. This supports the conclusion that MCOs

contract with the vast majority of hospitals in the Chicago area. (Noether, Tr. 5982 (*describing* DX 7045)).

992. This analysis further indicates that, in the Chicago area, HMO and PPO networks are about the same size. (Noether, Tr. 5982). For example, (Holt-Darcy, Tr. 1584-85, *in camera*). Traditionally, in a market where there was more selective contracting, HMOs would be smaller than PPOs. (Noether, Tr. 5982).

993. There are 80 to 90 hospitals in the Chicago area, excluding VA hospitals, pediatric hospitals and private psychological institutions. (Ballengee, Tr. 154). PHCS has 75 of these hospitals in its network in the Chicago area. (Ballengee, Tr. 154).

994. **(REDACTED)**
(Holt-Darcy, Tr. 1583-84, *in camera*). In fact, **(REDACTED)** (Holt-Darcy, Tr. 1584, *in camera*).

v. Pertinent Documents Do Not Support Dr. Haas-Wilson's Bargaining Theory

995. Complaint Counsel may rely on documents from the files of ENH and Bain that refer to the term "leverage" to support Dr. Haas-Wilson's bargaining theory.

996. Bain used the term "leverage" in some of its consulting materials. The word "leverage" as used in the Bain documents means "position." (RX 2047 at 34, 39 (Ogden, Dep.); CX 74 at 22; RX 1786 at BAIN 17641). **(REDACTED)** (RX 2047 at 29 (Ogden, Dep.); CX 1991 at 2, *in camera*). Bain advised ENH that it "should recognize its position and not be afraid to ask to be paid fair market value" for its services. (RX 2047 at 39-40 (Ogden, Dep.)).

997. **(REDACTED)** (Noether, Tr. 6106-07, *in camera*). **(REDACTED)**
(Noether, Tr. 6107, *in camera*).

998. **(REDACTED)**

(RX 2047 at 65 (Ogden, Dep.); RX 1786 at BAIN 17641; Hillebrand Tr. 2014-15; Noether, Tr. 6107, *in camera*). After the Merger integration project was completed, Bain worked on a cost reduction project for ENH. (RX 2047 at 62 (Ogden, Dep.)). Bain discovered that ENH was not good at negotiating contracts across the board, and developed a "vendor strategy," which recommended that ENH approach vendor contracting in a systematic way. (RX 2047 at 62-63 (Ogden, Dep.)). Bain examined ENH's contracts with large national suppliers of medical products, and found that ENH's contracting practices in this area were "haphazard." (RX 2047 at 63 (Ogden, Dep.)). Bain's advice "looked very much like what we said on the contracting side: to be more systematic about it, to do our homework, to get everybody together in a room, we laid out a process for them going forward." (RX 2047 at 63-66 (Ogden, Dep.); RX

1786; Hillebrand, Tr. 2016-17). Bain thus advised that ENH look at its “leverage” and hospital suppliers’ “leverage” when entering negotiations with the hospital suppliers. (RX 1786 at BAIN 17641). Hillebrand understood that Bain was using “leverage” to mean “strengthen the position” to purchase supplies. (RX 1786 at BAIN 17641; Hillebrand, Tr. 2016-17).

999. Bain did not advise ENH that the Merger resulted in market power. HPH was really a non-issue to MCOs. So the “leverage” that ENH had with MCOs after the Merger was a function of where they had been paid before the Merger, and ENH’s position as a major-sized hospital (even without HPH). (RX 2047 at 41 (Ogden, Dep.)).

1000. Similarly, the term “leverage” as used in ENH documents does not mean market power. Neaman defined his use of the term “leverage” to mean the “ability to succeed.” (Neaman, Tr. 958).

1001. Complaint Counsel also places undue reliance on the term “indispensable” used in some ENH documents. HPH hoped to become “indispensable” to the market by improving its quality of care, not from a market power perspective. (RX 367 at ENH DR 4205). For example, the Lakeland Finance Committee’s August 18, 1998, Managed Care Review stated that one of HPH’s goals was to “[i]ncrease patient satisfaction and patient loyalty to the hospital and the physicians making [Highland Park Healthcare, Inc.] indispensable to any major player in the managed care market.” (RX 367 at ENH DR 4205).

1002. **(REDACTED)**

(Noether, Tr. 6107-08, *in camera*; CX 7, 8, 9 and 10). **(REDACTED)**

(Noether, Tr. 6107, *in camera*). As Hillebrand explained, ENH achieved the price increases noted in these documents precisely because in 1999-2000 Evanston Hospital/ ENH realized it was not being fairly compensated by many purchasers of care for its clinical services. (Hillebrand, Tr. 2026).

3. Empirical Analysis Of Price Changes Does Not Show That The Merger Conferred Market Power

a. Professor Baker Measured The Relative, Non-Quality-Adjusted Post-Merger Price Changes In The Reasonable Range Of 9-12%

1003. **(REDACTED)**

(Baker, Tr. 4617-19, 4795-96, *in camera*).

1004. **(REDACTED)**

(Baker, Tr. 4619-20, 4646, 4795-96, *in camera*; Haas-Wilson, Tr. 2637, *in camera*).

1005. (REDACTED)

(Baker, Tr. 4631, *in camera*). (REDACTED)

(Baker, Tr. 4631, *in camera*).

1006. (REDACTED)

(Baker, Tr. 4642, *in camera*).

(REDACTED)

(Baker, Tr. 4642-43, *in camera*).

1007. (REDACTED)

(Baker, Tr. 4621, 4740, *in camera*). (REDACTED)

(Baker, Tr. 4637-38, 4755, *in camera*).

1008. (REDACTED)

(Baker, Tr. 4628-29, *in camera*).

1009. (REDACTED)

(Baker, Tr. 4633, *in camera*). (REDACTED)

(Baker, Tr. 4633, *in camera*).

1010. (REDACTED)

(Baker, Tr. 4635, *in camera*).

(REDACTED)

(Baker, Tr. 4635, *in camera*).

1011. (REDACTED)

(Baker, Tr. 4648, *in camera*).

b. Problems With Available Data Render Professor Baker's Price Estimates Conservative

1012. (REDACTED)

(Baker, Tr. 4621-22, *in camera*).

(REDACTED)

(Baker, Tr. 4622, *in camera*).

1013. (REDACTED)

(Baker, Tr. 4625-26, *in camera*).

(REDACTED)

(Baker, Tr. 4628, *in camera*).

1014. (REDACTED)

(Baker, Tr. 4806-07, *in camera*).

(REDACTED)

(Baker, Tr. 4807, *in camera*).

1015. (REDACTED)

(Baker, Tr. 4627-28, *in camera*).

1016. (REDACTED)

(Baker, Tr. 4645-46, *in camera*).

(REDACTED)

(Baker, Tr. 4646-47, *in camera*).

c. Dr. Haas-Wilson's Empirical Analysis Fails To Support The Conclusion That Post-Merger Price Changes Are The Result Of Market Power

1017. Dr. Haas-Wilson admitted that she did not use the Merger Guidelines as the theoretical basis for her empirical work in this matter. (Haas-Wilson, Tr. 2467-68).

1018. Dr. Haas-Wilson further admitted that she did not write her rebuttal report. (Haas-Wilson, Tr. 2449-50, 2671). Moreover, Dr. Haas-Wilson did not know who wrote the first draft of her rebuttal report. (Haas-Wilson, Tr. 2671-72). Dr. Haas-Wilson only taught one course at Smith College and was doing no other consulting work during the Fall semester, when her rebuttal report was written. (Haas-Wilson, Tr. 2672)

1019. Prior the filing of the Complaint in this matter, Dr. Haas-Wilson told the FTC they "had a strong case." (Haas-Wilson, Tr. 2673).

1020. Dr. Haas-Wilson reached this conclusion before doing any analysis of the claims data, and before reviewing deposition transcripts. (Haas-Wilson Tr. 2674-75).

i. Dr. Haas-Wilson's Empirical Theory Is Flawed

1021. (REDACTED)

(Haas-Wilson, Tr. 2745-46, *in camera*). For example, as described in paragraphs 894-923 above, the personalities of the

negotiators at ENH and United greatly affected the inability to reach agreement and when these personalities changed, an agreement was reached.

1022. (REDACTED)

(Haas-Wilson, Tr. 2755, *in camera*).

1023. (REDACTED)

(Haas-Wilson, Tr. 2545-46, *in camera*). For example, Dr. Haas-Wilson did not consider the impact of mergers between MCOs on post-Merger price increases. (Haas-Wilson, Tr. 2688-89). (REDACTED)

(Haas-Wilson, Tr. 2743, *in camera*; see Section VII.D.2.c.vii).

ii. Dr. Haas-Wilson's Methodology Is Flawed

(1) Dr. Haas-Wilson Measured The Wrong Prices

1024. (REDACTED)

(Haas-Wilson, Tr. 2853, *in camera*; Mendonsa, Tr. 557; Holt-Darcy, Tr. 1541, 1586-87; Hillebrand, Tr. 1861-62, 2019; RX 844 at ENH JL 2023).

(REDACTED)

(Haas-Wilson, Tr. 2510, *in camera*).

1025. (REDACTED)

(Noether, Tr. 6113, *in camera*).

1026. (REDACTED)

(Baker, Tr. 4631-32, *in camera*). (REDACTED)

(Baker, Tr. 4632, *in camera*). (REDACTED)

(CX 6279 at 4-

5).

1027. (REDACTED)

(Haas-Wilson, Tr. 2514, *in camera*). (REDACTED)

(Haas-Wilson, Tr. 2839-40, *in camera*).

(2) Dr. Haas-Wilson Did Not Effectively Clean The Data Underlying Her Empirical Analysis

1028. (REDACTED)

(Haas-Wilson, Tr. 2511, *in camera*; Baker, Tr. 4635-36, *in camera*). (REDACTED)

(Baker, Tr. 4636-37, *in camera*).

1029. (REDACTED)

(Haas-Wilson, Tr. 2853, *in camera*).

1030. (REDACTED)

(Haas-Wilson, Tr. 3038, *in camera*).

(REDACTED)
3038-39, *in camera*).

(Haas-Wilson, Tr.

(REDACTED)
(Haas-Wilson, Tr. 3039, *in camera*). (REDACTED)
(Haas-Wilson, Tr. 3039, *in camera*).

(3) Dr. Haas-Wilson's Control Groups Are Not An Appropriate Basis For Measuring Relative Price Changes

1031. (REDACTED)

(Haas-Wilson, Tr. 2697, *in camera*).

This was the case here. (Noether, Tr. 5989-90).

1032. (REDACTED)

(Haas-Wilson, Tr. 2548, *in camera*; Noether, Tr. 5997).

1033. (REDACTED)

(Haas-Wilson, Tr. 2858-59, *in camera*). (REDACTED)

(Haas-Wilson, Tr. 2859, *in camera*).

1034. (REDACTED)

(Haas-Wilson, Tr. 2857, *in camera*).

1035. (REDACTED)

(Haas-Wilson, Tr. 2859, *in camera*).

1036. (REDACTED)
(Haas-Wilson, Tr. 2860, *in camera*). Generally, however, under-inclusion is safer than over-inclusion because the larger the control group, the greater the risk of having hospitals that are not good comparisons. (Noether, Tr. 5997-98).

1037. (REDACTED)

(Haas-Wilson, Tr. 2548-49, *in camera*).

1038. (REDACTED)
(Noether, Tr. 5989; Noether, Tr. 6109, *in camera*).

(REDACTED)
(Baker, Tr. 4647, *in camera*). (REDACTED)
(Baker, Tr. 4647, *in camera*).

1039. (REDACTED)
(Noether, Tr. 6109, *in camera*).

(REDACTED)
(Noether, Tr. 6110, *in camera*).
(REDACTED)
(Noether, Tr. 6112-13, *in camera*).

1040. (REDACTED)
(Haas-Wilson, Tr. 2862, *in camera*). (REDACTED)
(Haas-Wilson, Tr. 2862, *in camera*).
(REDACTED)
(Haas-Wilson, Tr. 2865, *in camera*).

1041. (REDACTED)
(Haas-Wilson, Tr. 2864-65, *in camera*).

1042. (REDACTED)
(Haas-Wilson, Tr. 2871, *in camera*).

1043. (REDACTED)
(Haas-Wilson, Tr. 2871-72, *in camera*).

(REDACTED)

(Haas-Wilson, Tr. 2873-74, *in camera*).
2875, *in camera*).

(REDACTED)

(Haas-Wilson, Tr.

1044. **(REDACTED)**

(Haas-Wilson, Tr. 2869-70, *in camera*; Noether, Tr. 6110-11, *in camera*).
(REDACTED)

(Noether, Tr. 6110-11, *in camera*).

1045. **(REDACTED)**

(Haas-Wilson, Tr. 2870,
in camera). **(REDACTED)**
(Haas-Wilson, Tr. 2870, *in camera*).

iii. Dr. Haas-Wilson's Empirical Results Are Not Consistent With A Market Power Explanation For The Price Increases At Issue

1046. **(REDACTED)**

(Baker, Tr. 4694-95, *in camera*).

(REDACTED)

(Baker, Tr. 4696, *in camera*).

1047. **(REDACTED)**

(Baker, Tr. 4697, *in camera*).

1048. **(REDACTED)**

(Haas-Wilson, Tr. 2746-47, *in camera*).

1049. **(REDACTED)**

(Baker, Tr. 4695-96, *in camera*).

(REDACTED)

(Baker, Tr. 4695-96, 4742-43, *in camera*).

1050. **(REDACTED)**

(REDACTED)

(Haas-

Wilson, Tr. 2747, *in camera*).

(REDACTED)

(Haas-Wilson, Tr. 2746, *in camera*).

1051. (REDACTED)

(Haas-Wilson, Tr. 2749-50, *in camera*).

1052. (REDACTED)

(Haas-Wilson, Tr. 2754, *in camera*; Haas-Wilson, Tr. 2748-54, *in camera*).
4696, *in camera*).

(REDACTED)

(Baker, Tr.

d. Dr. Haas-Wilson’s Empirical Analysis Fails To Account For Viable Alternative Explanations For The Price Increases At Issue, Such As Learning About Demand

1053. Dr. Haas-Wilson’s difference-in-differences analyses do not necessarily show that the merger resulted in market power. (Noether, 5989, 5991).

1054. (REDACTED)

(Haas-Wilson, Tr. 2545-46 *in camera*).

(REDACTED)

(Haas-Wilson, Tr. 2546-47, *in camera*).

(REDACTED)

(Haas-Wilson, Tr. 2547 *in camera*).

(REDACTED)

(Haas-Wilson, Tr. 2547 *in camera*).

1055. (REDACTED)

(Haas-Wilson, Tr. 2552, *in camera*).

1056. (REDACTED)

(Haas-Wilson, Tr. 2615-16, *in camera*).

1057. (REDACTED)

(Haas-Wilson, Tr. 2822, *in camera*).

(REDACTED)

(Haas-

Wilson, Tr. 2823, *in camera*).

(REDACTED) (Haas-Wilson, Tr. 2823-24, *in camera*).

1058. (REDACTED) (Haas-Wilson, Tr. 2830, 2832-33, *in camera*). (REDACTED)

(Haas-Wilson, Tr. 2832-33, *in camera*).

1059. One would have expected ENH's negotiated prices to rise above competitive levels if those prices were the result of market power from the Merger. (Noether, Tr. 5991). If, however, learning about demand explained the post-Merger price increases, one would expect ENH's prices to rise to competitive levels. (Noether, Tr. 5991). The evidence showed that, in fact, ENH's price level is "comparable to the average of several of the major teaching hospitals in the Chicago area," thus confirming the learning about demand theory. (Noether, Tr. 5992).

1060. Significantly, both Dr. Haas-Wilson's theory of enhancement and exercise of market power and the learning about demand theory predict that the merged entity will have larger price *increases* than comparison hospitals. (Noether, Tr. 5989). But Dr. Haas-Wilson, who relies exclusively on an empirical analysis of price changes, assumes that all the hospitals used in her empirical analysis, including the merging hospitals, "were in equilibrium in terms of pricing relative to what the demand for their services was based on reasonably complete information." (Noether, Tr. 5987, 5990).

1061. If the learning about demand theory were the explanation for the post-Merger price increases, then all hospitals, in particular the merging hospitals, would not have been in equilibrium before the Merger. (Noether, Tr. 5990-91).

1062. Consequently, without considering price *levels*, it would be impossible to reject the learning about demand theory. (Noether, Tr. 5989). An analysis of price levels allows differentiation between market power and learning about demand. (Noether, Tr. 5991).

(REDACTED) (Baker, Tr. 4621, *in camera*).

1063. (REDACTED)

(Haas-Wilson, Tr. 2834-35, *in camera*).

(REDACTED)

(Haas-Wilson, Tr. 2835-36, *in camera*).

1064. (REDACTED)

(Haas-Wilson, Tr. 2835, *in camera*; Noether, Tr. 5990).

4. Empirical Analysis of Price Levels Supports Learning About Demand

a. Dr. Noether's Control Groups Are An Appropriate Basis To Compare Price Levels

i. The Criteria Used By Dr. Noether To Select Her Control Group Are Appropriate

1065. In general, Dr. Noether compared Evanston Hospital's prices before the Merger to the prices of her control group of academic control group hospitals, and then compared ENH's prices after the Merger to that same control group of academic hospitals. (Noether, Tr. 5993).

(REDACTED)

(Baker, Tr. 4638, *in camera*).

1066. Dr. Noether developed her control groups by looking at various characteristics of the 18 hospitals she selected based on a review of the evidence. (Noether, Tr. 6149). Dr. Noether identified her academic control group by considering the same characteristics she considered in terms of product differentiation: (1) breadth of service; (2) size; and (3) teaching intensity. (Noether, Tr. 5993).

1067. She elected to base her control group selection on three measures because any single measure could be subject to bias. (Noether, 6213). Several hospitals (Alexian Brothers, Louis Weiss, Northwest Community, Resurrection and St. Francis) met only one of Dr. Noether's criteria. (Noether, Tr. 6214). Case-mix index alone would not have been an effective way to select academic control group hospitals. (Noether, Tr. 6212).

1068. Dr. Noether used the number of DRGs to measure the breadth of service. (Noether, Tr. 5994). Breadth of service is important because the range of services that hospital affects the demand for its services. (Noether, Tr. 5994). In defining her academic control group, Dr. Noether used 370 DRGs as the cut-off for measuring breadth of service. (Noether, Tr. 5994). This cut-off included the top-third of the number of DRGs list as meeting the criteria for academic hospitals. (Noether, Tr. 6164-65).

1069. Dr. Noether used the number of staffed beds to measure the size of the hospitals. (Noether, Tr. 5995). Size can reflect underlying breadth of service, it is readily observable and it is an indicator that consumers consider. (Noether, Tr. 5995-96). Dr. Noether used a cutoff of 300 beds to define an academic hospital. (Noether, Tr. 5996). Similarly, Solucient uses size, as measured by the number of beds, as one measure of a major teaching hospital. (Noether, Tr. 5996).

1070. Dr. Noether used the ratio of residents to bed to measure teaching intensity. (Noether, Tr. 5994-95). Teaching intensity is a proxy for higher quality and more sophisticated services. (Noether, Tr. 5995). Patients use teaching intensity as an indicator of desirable hospitals. (Noether, Tr. 5995). In addition, teaching hospitals generally have higher costs associated with treating patients. (Noether, Tr. 5995). Dr. Noether used a cut-off of .25 residents per bed. (Noether, Tr. 5995). **(REDACTED)**

(Noether, Tr. 6111, *in camera*).

1071. A hospital had to meet all three of Dr. Noether's criteria to be included in her academic control group. (Noether, Tr. 5999). Six hospitals, in addition to Evanston Hospital, met all three criteria. (Noether, 6000). These hospitals are: Advocate Lutheran General, Advocate Northside, Northwestern Memorial, Rush Presbyterian, Loyola and University of Chicago. (Noether, 6000).

1072. Dr. Noether classified those hospitals that did not meet all three criteria as "community hospitals." (Noether, Tr. 6000). Twelve hospitals did not meet these three criteria. (Noether, Tr. 6000).

1073. Dr. Noether also considered the views of the hospitals themselves, the views of the MCOs and the views of consultants in characterizing her control group hospitals. (Noether, Tr. 5997). Dr. Noether found that these views were consistent with her control group definition. (Noether, Tr. 6007-08).

1074. In a 2002 Competitive Assessment document, Northwestern Memorial identified two types of competitors: tertiary/academic hospitals and "community hospitals. (Noether, Tr. 6008-09; RX 1316 at NMH 9392). Northwestern Memorial included Christ, Cook County Hospital, ENH, Loyola, Advocate Lutheran General, Northwest Community, Rush, University of Chicago and University of Illinois in the tertiary hospital or academic medical center group. (Noether, Tr. 6009; RX 1316 at NMH 9392).

1075. Dr. Noether did not attempt to make her control groups inclusive of all possible comparison hospitals. (Noether, Tr. 5997, 6150). (REDACTED) (Baker, Tr. 4780-81, *in camera*).

1076. (REDACTED) (Haas-Wilson, Tr. 2868, *in camera*).
(REDACTED) (Haas-Wilson, Tr. 2869, *in camera*).

1077. Dr. Noether did not know the prices of the various hospitals before selecting her control group hospitals. (Noether, Tr. 6210).

ii. Dr. Noether's Characterization Of ENH As A Major Teaching Hospital Is Consistent With MCO Views

1078. A document authored by Ballengee at PHCS as far back as August 28, 1995, identified the Evanston Hospital Corporation, which included Glenbrook Hospital, as an "advanced teaching" hospital. (*Compare* Ballengee, Tr. 189 *with* RX 107 at GWL 859).

(REDACTED) (RX 773 at ENH JL 12535, *in camera*).

1079. (REDACTED) (Foucre, Tr. 1114, *in camera*; RX 1208 at UHCENH 3380, *in camera*; Ballengee, Tr. 212).

iii. Dr. Haas-Wilson's Criticisms Of Dr. Noether's Control Groups Are Unfounded

1080. Dr. Haas-Wilson considers Evanston Hospital to be a teaching hospital. (Haas-Wilson, Tr. 2943). (REDACTED)

(Haas-Wilson, Tr. 2697-98, *in camera*) Her criticisms are addressed below.

(1) Dr. Haas-Wilson's Sum Of Squares Measure Of Breadth Of Service Is Misleading

1081. Dr. Haas-Wilson criticized Dr. Noether's use of the number of DRGs to measure breadth of service in creating the academic control group. (Noether, Tr. 6001). Dr. Haas-Wilson proposed an alternative measure of breadth of service based on a sum of squares calculation. (Noether, Tr. 6003).

1082. (REDACTED) (Haas-Wilson, Tr. 2704-05, *in camera*). (REDACTED) (Haas-Wilson, Tr. 2704-05, *in camera*).

(REDACTED) (Haas-Wilson, Tr. 2704-05, *in camera*).

(REDACTED)

(Haas-Wilson, 2706 *in camera*).

1083. Dr. Haas-Wilson's measure is misleading because it places undue weight on high volume DRGs such as obstetrics. (Noether, Tr. 6004). With particular reference to obstetrics, this analysis also double-counts each obstetric encounter because Dr. Haas-Wilson counts both mother and baby. (Noether, Tr. 6004). In addition, by squaring the sums of the differences, Dr. Haas-Wilson augments the differences across hospitals. (Noether, Tr. 6005).

1084. To illustrate this mischaracterization, Dr. Noether specifically considered the sum of squared differences for both ENH and Northwestern Memorial. (Noether, Tr. 6006). Based on this analysis, Dr. Noether found that 94% of Dr. Haas-Wilson's measure of the difference between ENH and Northwestern Memorial was attributable to obstetrics patients. (Noether, Tr. 6006). Although obstetric services account for only 22 DRGs out of 520, Dr. Haas-Wilson's measure is dominated by this services line. (Noether, Tr. 6006-07). In essence, Dr. Haas-Wilson's measure really reflects the size of the obstetrics programs at various hospitals. (Noether, Tr. 6007).

1085. (REDACTED)

(Haas-Wilson, Tr. 2706, *in camera*).

(2) Dr. Haas-Wilson's Focus On "Quaternary Services" Is Misguided

1086. Dr. Haas-Wilson also criticizes Dr. Noether's academic control group on the ground that some of the hospitals in Dr. Noether's academic control provided "quaternary services" that are not provided by ENH. (Noether, Tr. 6001).

1087. (REDACTED)

(Noether, Tr. 6001; Haas-Wilson, Tr. 2876, *in camera*). This definition, however, conflicts with the Complaint, which

(REDACTED)

(Haas-Wilson, Tr. 2876, *in camera*) (emphasis added). (REDACTED)

(Haas-Wilson, Tr. 2882, *in*

camera). (REDACTED)

(Haas-Wilson, Tr. 2879-80, *in camera*).

1088. In any event, solid organ transplants and extensive burn treatments are a very small portion – .8 of 1% – of the total number of services provided at any of the academic control group hospitals. (Noether, Tr. 6002).

1089. For example, as a percentage of total discharges, organ transplants at the University of Illinois may account for as little as eight-tenths of 1%. (Dorsey, Tr. 1473)

1090. Finally, Evanston Hospital at one point did provide extensive burn services, but elected to terminate that program because demand for these types of services was significantly lessened by the widespread use of fire detectors. (Noether, Tr. 6002-03; Hillebrand, Tr. 2009-10).

(3) Dr. Haas-Wilson's Criticisms Of Dr. Noether's Control Group Based On Differences In Public Perception Are Unfounded

1091. (REDACTED)

(Haas-Wilson, Tr. 2709, *in camera*). In part, she relied on one year of US News & World Report rankings to highlight alleged differences in public perception. (Haas-Wilson, Tr. 2930-31).

1092. Although Dr. Haas-Wilson was aware that US News & World Report ranks hospitals based on reputation, structure and mortality, she was not aware that the reputational score was determined based solely on a survey of 150 physicians in a given specialty rather than on surveys of consumers. (Haas-Wilson, Tr. 2930.)

1093. Dr. Haas-Wilson was familiar with Health Grades, but she did not know that Health Grades listed ENH as a distinguished hospital for clinical excellence in 2003, 2004 and 2005. (Haas-Wilson, Tr. 2931).

1094. Dr. Haas-Wilson was not familiar with the Davies Award for Excellence in the Implementation of an Electronic Health Record, and was not aware that ENH had received this award. (Haas-Wilson, Tr. 2931-32).

1095. Dr. Haas-Wilson was familiar with a group called Solucient, and was aware of the top 100 hospital list published by Solucient. (Haas-Wilson, Tr. 2932). And she admitted that Solucient rankings would be relevant to public perception. (Haas-Wilson, Tr. 2932). But she was not aware that Solucient had classified ENH as a major teaching hospital in its rankings, or that ENH had been named to Solucient's Top100 list for the tenth time in 2005. (Haas-Wilson, Tr. 2932).

1096. Dr. Haas-Wilson was familiar with Leapfrog, but she was not aware that Leapfrog had recognized ENH for the implementation of a medical records system and for staffing its ICU with intensivists. (Haas-Wilson, Tr. 2932-33).

b. Dr. Noether Cleaned Pertinent MCO Data More Effectively Than Dr. Haas-Wilson.

1097. (REDACTED) (Noether, Tr. 6049-50, *in camera*).

1098. (REDACTED) (Noether, Tr. 6050, *in camera*).

(REDACTED) (Noether, Tr. 6050).

1099. (REDACTED) (Noether, Tr. 6050-51, *in camera*).

1100. (REDACTED) (Noether, Tr. 6051, *in camera*).

1101. (REDACTED) (Noether, Tr. 6051, *in camera*).

1102. (REDACTED) (Noether, Tr. 6052-53, *in camera*).

(REDACTED) (Noether, Tr. 6053, *in camera*).

1103. (REDACTED) (Noether, Tr. 6053, *in camera*).
 (REDACTED) (Noether, Tr. 6053, *in camera*).
 (REDACTED) (Noether, Tr. 6054, *in camera*).
 (REDACTED) (Noether, Tr. 6054, *in camera*).
 (REDACTED) (Noether, Tr. 6054-55, *in camera*).
 (REDACTED) (Noether, Tr. 6055, *in camera*).
1104. (REDACTED) (Noether, Tr. 6099, *in camera*).
1105. (REDACTED) (Noether, Tr. 6099, *in camera*). (REDACTED)
 (Noether, Tr. 6099, *in camera*).
 (REDACTED) (Noether, Tr. 6099-6100, *in camera*).
1106. (REDACTED) (Noether, Tr. 6052, *in camera*).
1107. (REDACTED) (Noether, Tr. 6056-6057, *in camera*).
1108. (REDACTED) (Noether, Tr. 6057, *in camera*).
 (REDACTED) (Noether, Tr. 6057, *in camera*).
 (REDACTED)
1109. (REDACTED) (Noether, Tr. 6058-59, *in camera*).

c. **Dr. Noether's Empirical Analysis Confirms That The Learning About Demand Theory Applies In This Case**

1110. **(REDACTED)**

(Noether, Tr. 6060, *in camera*; RX 1912 at 73, *in camera*).

1111. **(REDACTED)**

(Noether, Tr. 6060, *in camera*; RX 1912 at 73, *in camera*).

(REDACTED)
camera; RX 1912 at 73, *in camera*).

(Noether, Tr. 6060, *in*

1112. **(REDACTED)**

(Noether, Tr. 6060, *in camera*; RX 1912 at 73, *in camera*).

1113. **(REDACTED)**

camera; RX 1912 at 74, *in camera*).

(REDACTED)

(Noether, Tr. 6062, *in*

(Noether, Tr. 6062, *in camera*; RX 1912 at 74, *in camera*).

(REDACTED) (Noether, Tr. 6062-63, *in camera*; RX 1912 at 74, *in camera*).

(REDACTED)

(Noether, Tr. 6062, *in camera*).

1114. **(REDACTED)**

(Noether, Tr. 6063-64, *in camera*; RX 1912 at 75, *in camera*).

(REDACTED)

(Noether, Tr. 6063, *in camera*; RX 1912 at 75, *in camera*).

(REDACTED)

(Noether, Tr. 6063, *in camera*; RX 1912 at 75, *in camera*).

1115. **(REDACTED)**

in camera).
(REDACTED)

(Noether, Tr. 6065, *in camera*; RX 1912 at 147, *in camera*).

(REDACTED)

in camera).

(REDACTED)

Tr. 6065, *in camera*; RX 1912 at 147, *in camera*).

(Noether, Tr. 6065, *in camera*; RX 1912 at 147,

(Noether,

(REDACTED)

(Noether, Tr. 6065, *in camera*; RX 1912 at 147, *in camera*).

1116. (REDACTED)

(Noether, Tr. 6065-66, *in camera*; RX 1912

at 147, *in camera*).

(REDACTED)

(Noether, Tr. 6067, *in camera*; RX 1912 at 150, *in camera*).

(REDACTED)

(Noether, Tr. 6067, *in camera*; RX 1912 at 150, *in camera*).

(REDACTED) (Noether, Tr. 6066-67, *in camera*; RX 1912 at 150, *in camera*).

1117. (REDACTED)

(Noether, Tr. 6070). Dr. Noether's empirical findings on a payor-by-payor basis are summarized below.

i. Aetna

1118. (REDACTED)

(Noether, Tr. 6094, *in camera*; RX 1912 at 70, *in camera*).

1119. (REDACTED)

(Noether, Tr. 6094, *in camera*; RX 1912 at 70, *in camera*).

(REDACTED)

(Noether, Tr. 6095, *in camera*; RX 1912 at 70, *in camera*).

ii. Blue Cross

1120. (REDACTED)

(Noether, Tr. 6070-71, *in camera*; RX 1912 at 62, *in camera*).

1121. (REDACTED)

(Noether, Tr. 6071, 6074, *in camera*).

1122. (REDACTED)

(Noether, Tr. 6072-73, *in camera*; RX 1912 at 34, *in camera*).

(REDACTED)

(Noether, Tr. 6073, *in camera*; RX 1912 at 34, *in camera*).

1123. (REDACTED)

(Noether, Tr. 6073, *in camera*).

1124. (REDACTED) (Noether, Tr. 6074, *in camera*; Sirabian, Tr. 5707).

(REDACTED) (Noether, Tr. 6074, *in camera*).

iii. Humana

1125. (REDACTED) (Noether, Tr. 6075, *in camera*; RX 1912 at 65, *in camera*).

1126. (REDACTED) (Noether, Tr. 6075, *in camera*; RX 1912 at 65, *in camera*).

1127. (REDACTED) (Noether, Tr. 6075, *in camera*; RX 1912 at 65, *in camera*).

1128. (REDACTED)

(Noether, Tr. 6076-77).

(REDACTED)
(Noether, Tr. 6076, *in camera*).

1129. (REDACTED)

(Noether, Tr. 6078, *in camera*).

(REDACTED)

(Noether, Tr. 6078-79, *in camera*).

1130. (REDACTED)
(Noether, Tr. 6079, *in camera*).

(REDACTED)
(Noether, Tr. 6080, *in camera*; RX 1912 at 34, *in camera*).

iv. United

1131. (REDACTED) (Noether, Tr. 6081, *in camera*; RX 1912 at 68, *in camera*).

1132. (REDACTED)

(Noether, Tr. 6081, *in*

camera; RX 1912 at 68, *in camera*).

1133. (REDACTED)

(Noether, Tr. 6081, *in camera*).

(REDACTED)

(Noether, Tr. 6082, *in camera*).

(REDACTED)

(Noether,

Tr. 6082-83, *in camera*; RX 1912 at 129, *in camera*).

(REDACTED)

(Noether, Tr. 6082-83, *in camera*; RX 1912 at 129, *in camera*).

1134. (REDACTED)

(Noether, Tr. 6084, *in camera*; RX 1912 at 69, *in camera*).

(REDACTED)

(Noether, Tr. 6084, *in camera*; RX 1912 at 69, *in camera*).

1135. (REDACTED)

(Noether,

Tr. 6085, *in camera*; RX 1912 at 128, *in camera*).

(REDACTED)

(Noether, Tr. 6085, *in camera*; RX 1912 at 128, *in camera*).

1136. (REDACTED)

(Noether, Tr. 6093, *in camera*).

(REDACTED)

(Noether,

Tr. 6093-94, 6098, *in camera*).

d. Professor Baker's Empirical Analysis Confirms That The Learning About Demand Theory Applies In This Case

1137. (REDACTED)

(Baker, Tr. 4638-39, 4662, *in camera*).

1138. (REDACTED)

(Baker, Tr. 4656-57, *in camera*).

(REDACTED)

(Baker, Tr. 4657-58, *in camera*).

(REDACTED) (Baker, Tr. 4660, *in camera*).

1147. **(REDACTED)**

(Baker, Tr. 4666-67, *in camera*).

i. The Results Of Professor Baker's Analysis Are Consistent With The Learning About Demand Theory

1148. **(REDACTED)**

(Baker, Tr. 4669-71, *in camera*).

1149. **(REDACTED)**

(REDACTED) (Baker, Tr. 4810-11, *in camera*).

1150. **(REDACTED)**

(REDACTED) (Baker, Tr. 4677-4800, (*explaining DX 8047*), *in camera*; Haas-Wilson, Tr. 2706, *in camera*).

(Baker, Tr. 4680 (*explaining DX 8047*), *in camera*).

1151. **(REDACTED)**

(REDACTED) (Baker, Tr. 4674, 4681, *in camera*).

1152. **(REDACTED)**

(Baker, Tr. 4674, 4681-82, 4699, *in camera*).

1153. **(REDACTED)**

(REDACTED) (Baker, Tr. 4674, *in camera*).

1154. **(REDACTED)**

(Baker, Tr. 4684, *in camera*).

(REDACTED)
(Baker, Tr. 4810-11, *in camera*).

(REDACTED)
Tr. 4674, *in camera*).

(Baker,

1155. (REDACTED)
(Baker, Tr. 4671, 4811, *in camera*). (REDACTED)
(Baker, Tr. 4658, *in camera*).

ii. **Professor Baker's Empirical Analysis Overstates ENH's Post-Merger Price Increase Because That Analysis Does Not Measure Quality-Adjusted Prices**

1156. (REDACTED)

30, 4799, *in camera*).

(Baker, Tr. 4629-

1157. Quality improvements need to be considered in evaluating competitive effects because if quality improves, the quality-adjusted price – a way of accounting for the value of quality improvements – declines. That is, a buyer gets more for its money. (Baker, Tr. 4604-06).

1158. Since ENH's quality improved after the Merger, the quality-adjusted price did not rise as much as the observed price. (Baker, Tr. 4606). If the quality-adjusted prices stayed the same or declined, consumers would be better off with the Merger – or at least not worse off – than they would have been had the Merger not happened. (Baker, Tr. 4606).

1159. (REDACTED)
(Baker, Tr. 4804-05, *in camera*).

1160. It is appropriate to quality-adjust the prices even if MCOs did not know that quality went up at ENH, because the MCOs are objectively better off. (Baker, Tr. 4607).

1161. The prices that are observed in this case, when looking at how prices changed coincident with the Merger, could not be quality-adjusted. (REDACTED)

(Baker, Tr. 4658, 4663-64, 4667-68, *in camera*).

(REDACTED) (Baker, Tr.
4658-61, 4663-64, 4667-68, *in camera*).

(REDACTED)
(Baker, Tr. 4663-64, *in camera*).

1162. Dr. Haas-Wilson did not adjust the price changes that she calculated for changes in quality. Accordingly, she provided no way for this Court to determine whether the quality-adjusted price rose, even if the observed price rose. (Baker, Tr. 4607-08).

1163. (REDACTED)

(Baker, Tr. 4651, 4653, *in camera*).

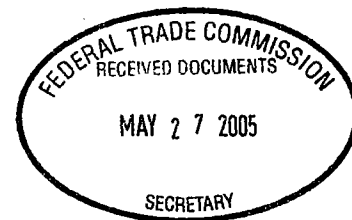
(REDACTED)

(Baker, Tr. 4811, *in camera*).

1164. Moreover, there is evidence that output at ENH increased after the Merger. Evidence of increased price and increased output post-Merger is consistent with an increase in quality rather than an increase in market power as a result of the Merger. (Noether, Tr. 6217-18).



UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES



In the matter of)
)
)

Evanston Northwestern Healthcare)
Corporation,)
)
_____)

Docket No. 9315

Public Record

RESPONDENT'S PROPOSED POST-TRIAL FINDINGS OF FACT

VOLUME III of IV

WINSTON & STRAWN LLP

35 West Wacker Dr.
Chicago, IL 60601-9703
(312) 558-5764

1700 K Street, N.W.
Washington, DC 20006
(202) 282-5000

TABLE OF CONTENTS

VOLUME I

| | Page |
|--|-------------|
| Abbreviations of Terms | xxxvi |
| | |
| I. THE PARTIES..... | 1 |
| A. Evanston Northwestern Healthcare..... | 1 |
| 1. The Three ENH Hospitals..... | 2 |
| a. Evanston Hospital | 3 |
| b. Glenbrook Hospital..... | 3 |
| c. HPH..... | 4 |
| 2. ENH Faculty Practice Associates | 4 |
| 3. ENH Research Institute..... | 4 |
| 4. ENH Foundation | 5 |
| B. Evanston Hospital And HPH Before The Merger | 5 |
| 1. Pre-Merger Evanston Hospital..... | 5 |
| 2. HPH Pre-Merger | 6 |
| a. HPH Was A Community Hospital With Limited Services Before The Merger..... | 6 |
| b. HPH Had Financial Problems Before The Merger..... | 7 |
| c. HPH Had Quality Of Care Problems Before The Merger | 7 |
| | |
| II. DYNAMICS OF MANAGED CARE..... | 9 |
| A. Overview: Interaction Among Relevant Players (Patients, Employers, Private Payors And Providers) | 9 |
| B. Types Of Managed Care Plans | 10 |
| 1. HMO | 10 |
| 2. PPO | 11 |

| | | |
|-------|---|----|
| 3. | POS | 11 |
| 4. | Indemnity | 12 |
| C. | Role Of Outpatient Services | 12 |
| D. | Managed Care Contracting | 12 |
| 1. | Selective Contracting | 12 |
| 2. | Scope Of MCO Contracts | 12 |
| 3. | Reimbursement Methodologies | 13 |
| a. | Discount-Off-Charges Contracts | 13 |
| b. | Per Diem | 14 |
| c. | Case Rates | 15 |
| d. | Capitation | 15 |
| E. | Different Type of Hospitals (Academic And Community) | 15 |
| F. | The Impact Of The Balanced Budget Act Of 1997 On Managed Care | 16 |
| G. | Hospitals Have Felt Substantial Pressure To Reduce Costs | 17 |
| H. | Chicago Healthcare Market | 17 |
| a. | Relevant Hospitals | 17 |
| b. | Relevant MCOs | 18 |
| i. | Aetna | 18 |
| ii. | Blue Cross | 18 |
| iii. | CCN | 19 |
| iv. | Cigna | 19 |
| v. | Great West | 20 |
| vi. | HFN | 20 |
| vii. | Humana | 21 |
| viii. | PHCS | 22 |
| ix. | Unicare | 22 |

| | | |
|------|---|----|
| x. | United..... | 23 |
| I. | MCO Negotiating Trends In The Chicago Area Market | 24 |
| 1. | Hospitals Use Termination Letters To Open Negotiations With MCOs..... | 25 |
| 2. | System-Wide Contracts Are Gaining Popularity..... | 25 |
| 3. | The Contract Negotiation “Pendulum” Is Swinging Back In Favor Of MCOs..... | 25 |
| III. | PRE-MERGER BACKGROUND | 27 |
| A. | Northwestern Healthcare Network | 27 |
| 1. | Purpose Of The Network | 27 |
| 2. | Structure And Powers Of The Network..... | 28 |
| 3. | Managed Care Contracting By The Network | 30 |
| 4. | Failures And Limitations Of The Network..... | 30 |
| B. | NH North | 31 |
| C. | Other Failed Merger Negotiations And Failed Joint Ventures Involving HPH | 32 |
| IV. | THE MERGER | 34 |
| A. | Merger Negotiations | 34 |
| 1. | Initial Merger Discussions | 34 |
| 2. | Letter Of Intent | 35 |
| B. | Reasons For The Merger..... | 37 |
| 1. | HPH’s Reasons For The Merger..... | 38 |
| a. | The Merger Would Improve Quality Of Care At HPH And In The Community In General..... | 38 |
| b. | The Merger Would Address HPH’s Deteriorating Financial Condition..... | 39 |
| c. | The Merger Would Provide A Good “Fit” | 39 |
| 2. | Evanston Hospital’s Reasons For The Merger | 40 |

| | | |
|----|--|----|
| a. | The Merger Would Allow Evanston Hospital To Improve Quality Of Care By Expanding The Volume Of Its Services | 40 |
| b. | The Merger Would Allow Evanston Hospital To Improve Quality Of Care By Rationalizing Its Services | 40 |
| c. | The Merger Would Result In Corporate Efficiencies | 41 |
| d. | The Merger Would Provide Evanston Hospital With An Additional Teaching Site | 41 |
| C. | Merger Consummation | 41 |
| D. | Effect Of The Merger On ENH’s Operations | 42 |
| E. | Post-Merger Healthcare Foundation Of Highland Park..... | 43 |
| V. | ANALYTIC FRAMEWORK..... | 44 |
| A. | The Court Should Analyze The Price Increases In The Context Of The Relevant Market..... | 44 |
| 1. | All Experts Agree That Price Increases Alone Are Not Anticompetitive..... | 44 |
| 2. | All Experts Agree That One Must Rule Out Viable Alternative Explanations Before Concluding That A Price Increase Is The Result Of Anticompetitive Market Power | 44 |
| 3. | Market Definition Provides The Necessary Framework In Which To Evaluate These Alternative Explanations..... | 44 |
| B. | The Court Should Evaluate The Competitive Effects Of The Merger | 45 |
| 1. | The Court Should Evaluate Price Effects Of The Merger | 45 |
| 2. | The Court Should Evaluate Quality Effects Of The Merger As A Pro-Competitive Effect | 45 |
| 3. | The Court Should Take Into Account Other Competitive Effects Considerations..... | 46 |
| a. | The Court Should Evaluate Issues Pertaining To Market Entry And Repositioning | 46 |
| b. | The Court Should Evaluate The Financial Condition Of HPH Before The Merger | 47 |
| c. | The Court Should Evaluate ENH’s Not-For-Profit Status | 47 |

| | | |
|-----|---|----|
| C. | ENH’s Economist Experts Analyzed The Facts Of The Case In The Context Of This Analytic Framework | 48 |
| 1. | Dr. Monica Noether | 48 |
| 2. | Professor Jonathan Baker..... | 49 |
| VI. | RELEVANT MARKET..... | 51 |
| A. | The Relevant Product Market Consists Of All Acute Care Hospital-Based Services | 51 |
| 1. | The Product At Issue Being Sold Includes All Acute Care Hospital-Based Services | 51 |
| 2. | The Relevant Customers, <i>i.e.</i> , MCOs, Purchase All Acute Care Hospital-Based Services Together..... | 51 |
| a. | MCOs Purchase Inpatient And Outpatient Services Together | 51 |
| b. | MCOs Purchase Primary, Secondary And Tertiary Services Together | 52 |
| 3. | Dr. Noether Has Correctly Defined The Relevant Product Market..... | 52 |
| 4. | Dr. Haas-Wilson Has Not Correctly Defined The Relevant Product Market | 53 |
| B. | The Relevant Geographic Market Consists Of Multiple Competitor Hospitals In The Chicago Area..... | 53 |
| 1. | The Court Should Consider Patient Preferences And Physician Admitting Patterns When Evaluating The Relevant Geographic Market | 53 |
| a. | Patient Preferences Are Relevant To The Geographic Market Analysis..... | 53 |
| i. | Geographic Proximity Is Relevant To Patient Preferences..... | 54 |
| ii. | Travel Patterns Are Relevant To Patient Preferences..... | 55 |
| b. | Physician Admitting Patterns Are Relevant To The Geographic Market Analysis | 58 |
| 2. | The Court Should Consider The Fact That There Are Multiple Hospitals In The Chicago Area When Evaluating The Relevant Geographic Market | 58 |

| | | |
|----|--|----|
| a. | Advocate Lutheran General | 59 |
| b. | Condell..... | 59 |
| c. | Lake Forest Hospital | 60 |
| d. | Loyola | 60 |
| e. | Northwestern Memorial | 60 |
| f. | Rush North Shore And Rush Presbyterian..... | 61 |
| g. | St. Francis | 62 |
| h. | Swedish Covenant..... | 62 |
| i. | University Of Chicago | 62 |
| j. | University Of Illinois At Chicago | 62 |
| 3. | The Relevant Geographic Market Broadly Encompasses A Large Number Of Competitor Hospitals In The Chicago Area | 63 |
| a. | MCO Testimony And Documents Confirm A Broad Geographic Market | 63 |
| b. | Third Party Hospital Documents Confirm A Broad Geographic Market | 64 |
| c. | ENH Testimony And Documents Confirm A Broad Geographic Market | 66 |
| d. | Other Third Party Testimony And Documents Confirm A Broad Geographic Market..... | 67 |
| e. | Dr. Noether Defined A Reasonable Relevant Geographic Market..... | 67 |
| f. | Dr. Haas-Wilson Did Not Define A Reasonable Geographic Market | 68 |
| C. | ENH's Market Share Is Less Than That In Other Hospital Merger Cases..... | 69 |
| 1. | ENH's Core Market Consists Of About 20 Zip Codes..... | 69 |
| 2. | ENH's Service Area Consists Of About 51 Zip Codes | 69 |
| 3. | The Concentration Resulting From The Merger Is Acceptable..... | 70 |

VOLUME II

VII. THE MERGER RESULTED IN NO ANTICOMPETITIVE EFFECTS 72

A. The Court Should Consider Various Economic Factors In Its Competitive Effects Analysis 72

1. Dr. Haas-Wilson’s Analysis Is Based On A Bargaining Theory..... 72

2. The Pertinent Pricing Analysis Under Dr. Haas-Wilson’s Bargaining Theory Has Both Theoretical And Empirical Dimensions 72

a. As A Theoretical Matter, Complaint Counsel Must Show More Than That ENH’s Prices Increased After The Merger 72

i. Price Changes Alone Are Not Evidence Of Market Power 72

ii. Complaint Counsel Must Evaluate And Eliminate Viable Alternative Explanations 73

iii. In Particular, Complaint Counsel Must Rule Out “Learning About Demand” To Show That ENH Exercised Market Power As A Result Of The Merger..... 74

iv. The Court Should Consider Both Price Levels And Price Changes When Evaluating Whether Price Increases Were The Result Of Market Power From The Merger. 74

b. As An Empirical Matter, Complaint Counsel Must Show That ENH’s Post-Merger Prices Increases Were The Result Of Market Power..... 74

3. This Court Also Should Take Into Account Other Competitive Effects Considerations 74

B. The Pre-Merger Competitive Landscape Is Inconsistent With Dr. Haas-Wilson’s Bargaining Theory 76

1. This Case Involves A Differentiated Product..... 76

2. Evanston Hospital And HPH Were Not Close Substitutes..... 76

a. Evanston And HPH Were Not Close Substitutes From A Product Perspective..... 76

| | | |
|------|---|----|
| i. | Evanston Hospital And HPH Offered A Different Breadth of Services | 76 |
| ii. | Evanston Hospital And HPH Were Hospitals Of Very Different Sizes | 77 |
| iii. | Unlike Evanston Hospital, HPH Had No Teaching Component..... | 78 |
| b. | Evanston Hospital And HPH Were Not Close Substitutes From A Geographic Perspective..... | 78 |
| c. | Evanston Hospital And HPH Had Much Closer Substitutes Than Each Other | 78 |
| i. | Evanston Hospital Had Several Closer Substitutes Than HPH | 79 |
| (1) | Evanston Hospital’s Closest Substitutes From A Product Perspective Were Advocate Lutheran General And Northwestern Memorial | 79 |
| (2) | Evanston Hospital’s Closest Substitutes From A Geographic Perspective Were St. Francis And Rush North Shore..... | 80 |
| ii. | HPH’s Closest Substitutes From Both A Product And Geographic Perspective Were Lake Forest Hospital And Condell | 80 |
| C. | Dr. Haas-Wilson’s Bargaining Theory Does Not Take Into Account The Fact That Evanston Hospital And HPH Had Very Different Negotiating Strategies And Contract Rates Before The Merger | 81 |
| 1. | Evanston Hospital And HPH Had Different Pre-Merger Negotiating Strategies..... | 82 |
| a. | HPH Had An Aggressive Pricing Strategy Before The Merger..... | 82 |
| b. | Evanston Hospital, In Contrast, Did Not Focus On MCO Negotiations Before The Merger | 82 |
| i. | Before 1999, Evanston Hospital Did Not Institute An Aggressive MCO Negotiation Policy | 82 |
| ii. | Evanston Hospital’s Pre-Merger MCO Contract Negotiator Used A Passive Negotiation Style | 83 |

| | | |
|------|---|----|
| (1) | Sirabian Was In Charge Of Evanston Hospital’s Pre-Merger MCO Negotiations | 83 |
| (2) | Sirabian’s Goal Was To Obtain “Win-Win Contracts” | 84 |
| (3) | Sirabian Did Not Threaten Termination As A Means To Obtain Aggressive Rates..... | 84 |
| (4) | Sirabian Let Contracts Lapse And Did Not Intiate Contract Renegotiations..... | 85 |
| iii. | Many Evanston Hospital Contracts Had Not Been Renegotiated In A Number Of Years..... | 85 |
| c. | By The Late 1990’s, Changing Financial Conditions Put Pressure On Evanston Hospital To Focus On MCO Contract Rates..... | 86 |
| i. | Evanston Hospital Realized The Adverse Financial Effect Of The Balanced Budget Act Until In Late 1998 And 1999..... | 86 |
| ii. | Since The Late 1990s, Evanston Hospital/ENH, Along With Other Hospitals, Have Been Under Pressure To Reduce Costs..... | 87 |
| iii. | By The Late 1990s, Evanston Hospital No Longer Could Rely As Heavily On Its Investment Income | 88 |
| 2. | Evanston Hospital And HPH Had Different Negotiated MCO Contract Rates Before The Merger | 89 |
| D. | Dr. Haas-Wilson’s Bargaining Theory Does Not Eliminate All Viable Alternative Explanations For ENH’s Post-Merger Price Increases, Such As Learning About Demand | 89 |
| 1. | “Price” Can Be Defined In Several Ways..... | 89 |
| a. | Charges | 89 |
| b. | Contract Rates | 89 |
| c. | Reimbursement Rates | 89 |
| 2. | The Factual Evidence Is Consistent With The Learning About Demand Alternative Explanation For The Price Increases At Issue..... | 90 |

| | | |
|------|---|-----|
| a. | Coincident With The Merger, ENH Learned That It Was “Leaving Money On The Table” Through Proper Due Diligence | 90 |
| b. | At The Time Of The Merger, Evanston Hospital Learned About The Demand For Its Services Through Bain’s Consulting Services | 92 |
| i. | Bain Advised ENH That HPH Had More Favorable MCO Contracts | 92 |
| ii. | Bain Advised ENH That It Had Expired Or Outdated MCO Contracts | 95 |
| iii. | Bain Advised ENH That It Was Under-Market As Compared To Its Peer Academic Hospitals | 96 |
| iv. | Bain Advised ENH On MCO Contract Renegotiations..... | 96 |
| (1) | Bain Advised ENH On A Post-Merger 96Negotiation Schedule | |
| (2) | Bain Advised ENH On Negotiation Tactics | 97 |
| v. | Bain’s Advice Paid Off – But The Successful Contract Renegotiations Were Not Due To The Merger..... | 99 |
| c. | Individual MCO Negotiations Are Consistent With The Learning About Demand Theory | 100 |
| i. | Aetna..... | 101 |
| (1) | Evanston Hospital’s Pre-Merger Contract Rates With Aetna Were Outdated And Undermarket | 101 |
| (2) | ENH’s Post-Merger Negotiations With Aetna Were Not Anticompetitive | 102 |
| ii. | Blue Cross..... | 103 |
| (1) | Evanston Hospital Pre-Merger Contract Rates Exceeded HPH’s Pre-Merger Contract Rates..... | 103 |
| (2) | ENH’s Post-Merger Negotiations With Blue Cross Were Not Anticompetitive..... | 104 |

| | | |
|-------|---|-----|
| iii. | Cigna..... | 106 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With Cigna Were Outdated And Undermarket | 106 |
| | (2) ENH’s Post-Merger Negotiations With Cigna Were Not Anticompetitive | 106 |
| iv. | CCN..... | 106 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With CCN Were Outdated And Undermarket | 106 |
| | (2) ENH’s Post-Merger Negotiations With CCN Were Not Anticompetitive..... | 107 |
| v. | Great West | 107 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With One Health/Great West Were Outdated And Undermarket..... | 107 |
| | (2) ENH’s Post-Merger Negotiations With Great West Were Not Anticompetitive..... | 108 |
| vi. | HFN..... | 109 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With HFN Were Outdated And Undermarket | 109 |
| | (2) ENH’s Post-Merger Negotiations With HFN Were Not Anticompetitive..... | 110 |
| vii. | Humana..... | 110 |
| | (1) Before the Merger, Evanston Hospital Acquired Some Humana Physician Office Sites..... | 110 |
| | (2) ENH’s Post-Merger Negotiations With Humana Were Not Anticompetitive | 111 |
| viii. | PHCS..... | 112 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With PHCS Was Outdated And Undermarket | 112 |

| | | | |
|-----|------|--|-----|
| | (2) | ENH’s Post-Merger Negotiations With PHCS Were Not Anticompetitive..... | 113 |
| ix. | | Preferred Plan..... | 115 |
| | (1) | Evanston Hospital’s Pre-Merger Contract Rates With Preferred Plan Were Outdated And Undermarket..... | 115 |
| | (2) | ENH’s Post-Merger Negotiations With Preferred Plan Were Not Anticompetitive..... | 115 |
| x. | | Unicare..... | 116 |
| | (1) | Evanston Hospital’s Pre-Merger Contract Rates With Unicare And Rush Prudential Were Outdated And Undermarket | 116 |
| | (2) | ENH’s Post-Merger Negotiations With Unicare Were Not Anticompetitive | 117 |
| xi. | | United..... | 119 |
| | (1) | Evanston Hospital’s Pre-Merger Contract Rates With United Were Outdated And Undermarket | 119 |
| | (2) | ENH’s Post-Merger Negotiations With United Were Not Anticompetitive..... | 119 |
| | (3) | United And ENH Renegotiated Their 2000 Contract To Accommodate United’s Contracting Goals | 121 |
| d. | | By 2002, ENH Learned That, On A Whole, Its Chargemaster Contained Prices That Were Undermarket | 125 |
| | i. | Description Of A Chargemaster..... | 125 |
| | ii. | ENH Consolidated Its Chargemaster After The Merger..... | 125 |
| | iii. | ENH, With The Assistance Of Deloitte Consulting, Brought Its Chargemaster Up To Market In 2002 | 126 |
| e. | | Factual Evidence Is Inconsistent With Dr. Haas-Wilson’s Bargaining Theory | 130 |
| | i. | Dr. Haas-Wilson’s Bargaining Theory Is Not Grounded In Theory Or Common Sense | 130 |

| | | |
|------|---|-----|
| ii. | Dr. Haas-Wilson’s Bargaining Theory Does Not Apply Here Because MCOs Did Not Play Evanston Hospital And HPH Off Each Other Before The Merger..... | 131 |
| iii. | Dr. Haas-Wilson’s Bargaining Theory Does Not Apply Here Because She Admits That A Network Without ENH Would Still Be Marketable | 133 |
| iv. | Dr. Haas-Wilson’s Bargaining Theory Does Not Apply Here Because There Was Little Selective Contracting In The Chicago Area | 133 |
| v. | Pertinent Documents Do Not Support Dr. Haas-Wilson’s Bargaining Theory..... | 134 |
| 3. | Empirical Analysis Of Price <i>Changes</i> Does Not Show That The Merger Conferred Market Power | 135 |
| a. | Professor Baker Measured The Relative, Non-Quality-Adjusted Post-Merger Price Changes In The Reasonable Range Of 9-12% | 135 |
| b. | Problems With Available Data Render Professor Baker’s Price Estimates Conservative..... | 136 |
| c. | Dr. Haas-Wilson’s Empirical Analysis Fails To Support The Conclusion That Post-Merger Price Changes Are The Result Of Market Power | 137 |
| i. | Dr. Haas-Wilson’s Empirical Theory Is Flawed..... | 137 |
| ii. | Dr. Haas-Wilson’s Methodology Is Flawed | 138 |
| (1) | Dr. Haas-Wilson Measured The Wrong Prices..... | 138 |
| (2) | Dr. Haas-Wilson Did Not Effectively Clean The Data Underlying Her Empirical Analysis..... | 138 |
| (3) | Dr. Haas-Wilson’s Control Groups Are Not An Appropriate Basis For Measuring Relative Price Changes | 139 |
| iii. | Dr. Haas-Wilson’s Empirical Results Are Not Consistent With A Market Power Explanation For The Price Increases At Issue | 141 |

| | | |
|------|--|-----|
| d. | Dr. Haas-Wilson’s Empirical Analysis Fails To Account For Viable Alternative Explanations For The Price Increases At Issue, Such As Learning About Demand..... | 142 |
| 4. | Empirical Analysis of Price <i>Levels</i> Also Supports Learning About Demand..... | 144 |
| a. | Dr. Noether’s Control Groups Are An Appropriate Basis To Compare Price Levels..... | 144 |
| i. | The Criteria Used By Dr. Noether To Select Her Control Group Are Appropriate..... | 144 |
| ii. | Dr. Noether’s Characterization Of ENH As A Major Teaching Hospital Is Consistent With MCO Views..... | 145 |
| iii. | Dr. Haas-Wilson’s Criticisms Of Dr. Noether’s Control Groups Are Unfounded..... | 146 |
| (1) | Dr. Haas-Wilson’s Sum Of Squares Measure Of Breadth Of Service Is Misleading..... | 146 |
| (2) | Dr. Haas-Wilson’s Focus On “Quarternary Services” Is Misguided..... | 147 |
| (3) | Dr. Haas-Wilson’s Criticisms Of Dr. Noether’s Control Group Based On Differences In Public Perception Are Unfounded..... | 147 |
| b. | Dr. Noether Cleaned Pertinent MCO Data More Effectively Than Dr. Haas-Wilson..... | 148 |
| c. | Dr. Noether’s Empirical Analysis Confirms That The Learning About Demand Theory Applies In This Case..... | 150 |
| i. | Aetna..... | 151 |
| ii. | Blue Cross..... | 151 |
| iii. | Humana..... | 152 |
| iv. | United..... | 152 |
| d. | Professor Baker’s Empirical Analysis Confirms That The Learning About Demand Theory Applies In This Case..... | 153 |
| i. | The Results Of Professor Baker’s Analysis Are Consistent With The Learning About Demand Theory..... | 155 |

| | | |
|-----|--|-----|
| ii. | Professor Baker’s Empirical Analysis Overstates ENH’s Post-Merger Price Increase Because That Analysis Does Not Measure Quality-Adjusted Prices..... | 156 |
|-----|--|-----|

VOLUME III

| | | |
|-------|---|-----|
| VIII. | MERGER IMPACT ON QUALITY | 158 |
| A. | Definition And Measurement Of Healthcare Quality..... | 158 |
| 1. | Definition Of Quality In Healthcare | 158 |
| 2. | Measuring Healthcare Quality | 158 |
| a. | Strengths And Weaknesses Of Quality Measures | 159 |
| b. | Quality Measures Must Be Valid..... | 161 |
| B. | Dr. Chassin Employed Accepted Methodology For The Study Of Healthcare Quality | 162 |
| C. | Dr. Chassin Has Extensive Experience Evaluating And Assessing Healthcare Quality | 164 |
| D. | Overview Of Changes In Healthcare Quality At HPH As A Result Of The Merger..... | 166 |
| 1. | ENH Corrected Problems With Clinical Practice At HPH That Existed Before The Merger..... | 167 |
| a. | The Merger Improved Quality Of Care In HPH’s Ob/Gyn | 167 |
| i. | Overview | 167 |
| ii. | Evanston Hospital Had A Relationship With HPH Before The Merger Through The Illinois Perinatal Network..... | 168 |
| iii. | HPH Ob/Gyn Department Had Serious Problems Before The Merger..... | 169 |
| (1) | HPH Had Insufficient Obstetrician Coverage Before The Merger..... | 170 |
| (2) | HPH’s Ob/Gyn Department Had Poor Nurse/Physician Teamwork Before The Merger..... | 170 |

| | | | |
|------|-----|---|-----|
| | (1) | HPH Had Issues Concerning Nurse Recruiting, Vacancy And Turnover Rates Before The Merger..... | 184 |
| | (2) | HPH Had Issues Concerning Nurse Training Before The Merger..... | 185 |
| | (3) | HPH Had Issues Concerning Nurse/Physician Relationships Before The Merger..... | 186 |
| iii. | | ENH Improved HPH’s Nursing Services And Culture After The Merger | 188 |
| | (1) | ENH Improved HPH’s Nurse Recruiting, Vacancy And Turnover After The Merger | 189 |
| | (2) | ENH Improved HPH’s Nurse Training After The Merger..... | 190 |
| | (3) | ENH Improved HPH’s Nurse/Physician Relationships After The Merger | 191 |
| c. | | The Merger Substantially Improved HPH’s Quality Assurance Program | 192 |
| | i. | Overview..... | 192 |
| | ii. | HPH’s Quality Assurance Was Inadequate Before The Merger..... | 193 |
| | (1) | HPH’s Pre-Merger Organizational Structure Hindered Quality Assurance Activities | 194 |
| | (2) | HPH’s Pre-Merger Adverse Event Case Reviews Were Suboptimal..... | 195 |
| | (3) | HPH’s Ob/Gyn Department Was Particularly Poor At Disciplining Problem Physicians | 196 |
| iii. | | ENH Improved HPH’s Quality Assurance Program Soon After The Merger | 196 |
| | (1) | The Merger Improved The Reporting Of Adverse Events At HPH | 197 |

| | | | |
|----|------|--|-----|
| | (2) | ENH's Addition Of Strong Department Leadership At HPH Helped Correct Problems With Physician Discipline | 197 |
| | (3) | ENH Improved The Process Of Reviewing HPH Physician Credentialing Status | 199 |
| d. | | The Merger Improved HPH's Quality Improvement Program..... | 199 |
| | i. | HPH's Pre-Merger QI Program Was Inadequate..... | 200 |
| | ii. | ENH Exported Its Superior Quality Improvement Processes To HPH Soon After The Merger..... | 200 |
| | iii. | Data From HPH's Pre-Merger Care Maps Cannot Be Used To Assess Quality Improvements At HPH Post-Merger..... | 202 |
| | iv. | Improvements In The Care Of Heart Attack Patients At HPH Demonstrates The Improvement In HPH's QI Program Post-Merger..... | 202 |
| | (1) | ENH Improved The Provision Of Aspirin To Heart Attack Patients At HPH | 203 |
| | (2) | HPH Improved The Provision Of Beta Blockers To Heart Attack Patients After The Merger..... | 204 |
| | (3) | The Minor Change In Performance On The NRMI Measures Are Based On An Extremely Small Sample..... | 205 |
| | (4) | The Merger Resulted In A Dramatic Improvement In The Care Of Heart Attack Patients At HPH | 206 |
| e. | | ENH Corrected Serious Deficiencies In HPH's Physical Plant | 206 |
| | i. | Overview..... | 206 |
| | ii. | Before The Merger, HPH Passed The Joint Commission's Accreditation Inspections, Which Are Not A Comprehensive Assessment Of Hospital Quality, Because It Had Advance Notice Of The Inspections | 207 |

| | | |
|------|---|-----|
| iii. | A 1999 IDPH Survey Uncovered Numerous Physical Plant Deficiencies At HPH That Were Not Identified By The 1999 Joint Commission Accreditation Survey | 208 |
| iv. | Before The Merger, HPH Nearly Lost Its Medicare Accreditation Due To Serious Physical Plant Deficiencies That Threatened Patient Safety | 209 |
| v. | Pre-Merger Due Diligence Performed By ENH Identified Even More Serious Physical Plant Deficiencies | 209 |
| vi. | ENH Remedied The Substantial Deficiencies To HPH's Physical Plant And Made Additional Capital Improvements That Enhanced The Quality Of Care At HPH..... | 211 |
| | (1) ENH Opened A New Open Heart Surgery Suite At HPH | 212 |
| | (2) ENH Opened A New Ambulatory Care Center At HPH..... | 212 |
| | (3) ENH Purchased New Equipment For The Operating Rooms | 212 |
| 2. | ENH Made Additional Improvements To Quality Of Care And Introduced New High Quality Services | 213 |
| a. | ENH Initiated A Cardiac Surgery Program At HPH After The Merger..... | 213 |
| i. | Overview..... | 213 |
| ii. | HPH Was Not Well-Positioned To Begin A Cardiac Surgery Program | 214 |
| iii. | ENH Recruited A Talented Physician Leader For Cardiac Surgery Immediately After The Merger..... | 215 |
| iv. | Evanston Hospital And HPH, Since The Merger, Have An Integrated Cardiac Surgery Program That Shares An Affiliation With Other Hospitals | 216 |
| v. | HPH Had Equal Or Lesser Ability To Accept A New Cardiac Surgery Program Than The ENH-Affiliated Hospitals..... | 218 |

| | | |
|------|--|-----|
| vi. | The Post-Merger, Integrated ENH/HPH Cardiac Surgery Program Provides Excellent Care To Patients | 218 |
| | (1) The Mortality Rate For Cardiac Surgery At HPH Compares Favorably To The Best Surgery Centers In The Country | 218 |
| | (2) HPH Complication Rates For Cardiac Surgery Are Below National Benchmarks..... | 220 |
| vii. | The Merger Was Essential To The Success Of HPH’s Cardiac Surgery Program..... | 221 |
| | (1) As A Result Of The Merger HPH Is An Integrated Part Of The ENH Cardiac Surgery Program | 221 |
| | (2) Due To The Level Of Integration Engendered By The Merger, HPH Performs Higher Quality Cardiac Surgery Than Affiliated Hospitals..... | 222 |
| b. | ENH Successfully Established An Interventional Cardiology Program At HPH..... | 224 |
| | i. Overview..... | 224 |
| | ii. Before The Merger, HPH Could Not Treat Heart Attack Patients With Interventional Cardiology Procedures..... | 224 |
| | iii. After The Merger, ENH Established A Successful Interventional Cardiology Program At HPH | 224 |
| | (1) HPH’s Interventional Cardiology Program Has Obviated The Need To Transfer Acute Heart Attack Patients To Other Hospitals..... | 225 |
| | (2) The Interventional Cardiology Program At HPH Has Achieved High Quality Outcomes..... | 226 |
| | (3) On-Site Cardiac Surgery At HPH Is Needed To Continue The Interventional Cardiology Program..... | 226 |
| c. | The Merger Substantially Improved HPH’s Intensive Care Services..... | 227 |

| | | |
|------|--|-----|
| i. | Overview..... | 227 |
| ii. | HPH’s ICU Had Gaps In Patient Care Before The Merger..... | 228 |
| iii. | The Addition Of Intensivist Coverage After The Merger Eliminated The Gaps In ICU Patient Care At HPH | 229 |
| (1) | Intensivists Have Broad ICU Responsibilities At HPH | 230 |
| (2) | The Intensivist Program Complemented The Introduction Of Cardiac Surgery At HPH | 231 |
| (3) | The Intensivist Program Improved Nursing Care In The HPH ICU..... | 232 |
| iv. | The Intensivist Program Improved The Overall Quality Of Care For HPH’s Critically Ill Patients | 232 |
| v. | HPH Had No Plans To Adopt An Intensivist Program Before The Merger | 233 |
| d. | The Merger Substantially Improved Oncology Services At ENH | 233 |
| i. | Overview..... | 233 |
| ii. | Pre-Merger Cancer Services At HPH Were Typical Of A Community Hospital..... | 234 |
| (1) | Pre-Merger Cancer Services At HPH Lacked Full Time Employed Oncologists | 234 |
| (2) | Pre-Merger Cancer Support And Ancillary Services At HPH Were Limited..... | 235 |
| (3) | Pre-Merger Cancer Patients At HPH Lacked Access To Specialists..... | 235 |
| (4) | Pre-Merger Cancer Services At HPH Lacked Academic Research And Clinical Trials | 235 |
| (5) | Pre-Merger Cancer Services At HPH Had Inadequate Facilities And Equipment..... | 236 |
| (6) | Pre-Merger Cancer Services At HPH Lacked Quality Assurance | 237 |

| | | |
|------|---|-----|
| iii. | ENH Made Major Improvements To The HPH Oncology Program That Significantly Expanded HPH's Cancer Services And Improved The Quality Of Cancer Care At HPH | 237 |
| | (1) The Kellogg Cancer Center Brought A Multidisciplinary Approach To HPH..... | 237 |
| | (2) ENH Improved Ancillary And Support Services For Cancer Patients After The Merger..... | 239 |
| | (3) ENH Provided More Qualified Staff And An Academic Affiliation To HPH's Cancer Program After The Merger | 240 |
| | (4) ENH Improved Patient Access To Specialists At HPH After The Merger | 240 |
| | (5) ENH Provided Increased Academic Research And Clinical Trials To HPH's Cancer Program After The Merger | 240 |
| | (6) ENH Provided State-Of-The-Art Equipment And Advanced Services To HPH's Cancer Program After The Merger | 241 |
| e. | The Merger Substantially Expanded And Improved Laboratory Services At HPH | 242 |
| | i. Overview..... | 242 |
| | ii. ENH Decided To Close CML Because It Was Inefficient..... | 243 |
| | iii. ENH Found Several Quality Issues When It Took Over The HPH Lab On June 1, 2000 | 243 |
| | (1) ENH Found That The HPH Lab Had Equipment Issues | 243 |
| | (2) ENH Found That The HPH Lab Had Personnel Issues | 244 |
| | (3) ENH Found That The HPH Lab Had Environmental Controls Issues | 245 |
| | (4) ENH Found That The HPH Lab Had Water Issues..... | 245 |

| | | | |
|-----|------|--|-----|
| | (5) | ENH Found That The HPH Lab Did Not Have A Histology Laboratory..... | 245 |
| | (6) | ENH Found That The HPH Lab Did Not Have A Cytology Laboratory..... | 245 |
| | (7) | ENH Found That The HPH Lab Did Not Have Adequate Laboratory Manuals | 246 |
| iv. | | ENH Made Numerous Quality Improvements To The HPH Lab | 246 |
| | (1) | ENH Improved The HPH Lab’s Equipment..... | 246 |
| | (2) | ENH Improved The HPH Lab’s Personnel..... | 247 |
| | (3) | ENH Improved The HPH Lab’s Environmental Systems | 247 |
| | (4) | ENH Improved The HPH Lab’s Water System..... | 247 |
| | (5) | ENH Constructed A Histology Laboratory At The HPH Lab | 247 |
| | (6) | ENH Constructed A Cytology Laboratory At The HPH Lab | 247 |
| | (7) | ENH Improved The HPH Lab’s Laboratory Manuals..... | 247 |
| | (8) | ENH Improved The HPH Lab’s Quality Control | 247 |
| | (9) | ENH Improved Microbiology Testing | 248 |
| | (10) | ENH Improved Immunology Testing..... | 248 |
| | (11) | ENH Improved Molecular Diagnostic Testing..... | 248 |
| | (12) | ENH Improved The HPH Lab’s Computer System..... | 249 |
| | (13) | ENH Established Oversight Of The HPH Lab By ENH Specialists | 249 |
| | (14) | ENH Established The Rotation Of Pathologists Among The ENH Hospitals | 249 |

VOLUME IV

- v. ENH’s Improvements To The HPH Lab Have Improved Quality And/Or Resulted In Efficiencies250
 - (1) ENH’s Improvements To The HPH Lab Dramatically Improved The Turnaround Time For Tests Performed In The HPH Lab250
 - (2) ENH Brought Its Academic Focus On Pathology To HPH250
 - (3) On-Site Testing Has Substantial Advantages Over Outsourcing.....250
 - (4) ENH Realized Substantial Cost Savings From The Dissolution of CML251
 - (5) HPH Pathologists Now Engage in Teaching Activities252

- f. The Merger Resulted In Structured And Service Improvements To The HPH Emergency Department.....251
 - i. Overview.....251
 - ii. HPH’s Pre-Merger ED Needed Improvement252
 - (1) In General, HPH’s ED Facilities Were Inadequate Before The Merger252
 - (2) HPH Had Physician Staffing Problems Before The Merger.....252
 - (3) HPH’s Fast Track Was Inadequate Before The Merger.....253
 - iii. ENH Significantly Improved The HPH ED After The Merger.....254
 - (1) ENH Substantially Expanded And Renovated The HPH ED.....254
 - (a) Phase I Of The HPH ED Renovation.....254
 - (i) Patient Rooms Were Redesigned254
 - (ii) Critical Care Rooms Were Updated.....255

| | | | |
|----|-------|--|-----|
| | (iii) | Isolation Rooms Were Added..... | 255 |
| | (b) | Phase II Of The HPH Renovation | |
| | (i) | The HPH ED Registration Area Was Made More Private..... | 255 |
| | (ii) | The HPH ED Triage Area Was Significantly Expanded..... | 256 |
| | (iii) | The HPH ED Waiting Area Was Remodeled | 256 |
| | (2) | ED Physician Coverage Was Expanded Post-Merger..... | 256 |
| | (i) | Double Coverage At HPH's ED Improved Quality Of Care | 256 |
| | (ii) | The Rotation Of ED Physicians At ENH Improved Quality Of Care..... | 257 |
| | (iii) | Other Staffing Changes At HPH's ED Improved Quality Of Care..... | 258 |
| | (3) | ENH Improved HPH's Fast Track Design And Processes | 258 |
| | (4) | ENH Coordinated HPH's ED And Its Cardiac Services..... | 259 |
| | (5) | ENH Increased Nurse Staffing In HPH's ED | 259 |
| | (6) | ENH Improved HPH's ED In Other Ways As Well | 259 |
| g. | | ENH Improved Pharmacy Services At HPH Post-Merger | 261 |
| | i. | Overview..... | 261 |
| | ii. | ENH Improved Drug Dispensing Services At HPH After The Merger | 261 |
| | (1) | ENH Added A Third-Shift Pharmacist To HPH..... | 261 |
| | (2) | ENH Added An Automated Drug Distribution System (Pyxis) To HPH | 262 |

| | | |
|------|---|-----|
| iii. | ENH Added Clinical Pharmacy Services At HPH After The Merger | 264 |
| iv. | HPH’s Institute For Safe Medication Practices Surveys Confirm That ENH’s Enhancements To HPH’s Pharmacy Services Have Improved Quality Of Care..... | 266 |
| h. | ENH’s Deployment Of EPIC At HPH Has Dramatically Improved The Quality Of Care | 267 |
| i. | Overview..... | 267 |
| ii. | Epic Integrates All Patient Information Into A Single Data Repository That Is Accessible By All Caregivers And The Patient | 268 |
| iii. | Sources Outside Of ENH, Including The Federal Government, Have Been Calling For The Use Of Electronic Medical Records..... | 268 |
| iv. | The Sharing Of Information Is Important To Patient Care And Patient Safety..... | 269 |
| v. | ENH Made A Patient-Centric Integrated Electronic Health Record Its Top Priority And Chose Epic Because It Was Best Suited To Accomplish This Goal..... | 269 |
| vi. | ENH Planned From The Outset To Deploy Epic At HPH And In Affiliate Outpatient Offices | 270 |
| vii. | ENH Aggressively Deployed Epic Throughout The ENH System..... | 270 |
| (1) | Initial Steps | 270 |
| (a) | Workflow Analysis | 270 |
| (b) | Build..... | 271 |
| (c) | Hardware Deployment..... | 271 |
| (d) | Training..... | 271 |
| (e) | Support System | 272 |
| (2) | Deployment..... | 272 |

| | | |
|-------|---|-----|
| viii. | The Deployment And Maintenance Of Epic Requires Tremendous Resources And Manpower..... | 273 |
| ix. | ENH Has Realized Cost Savings Through The Use Of Epic..... | 273 |
| x. | ENH Requires Physicians To Use Epic In The ENH Hospitals | 273 |
| xi. | Epic Allows ENH Clinicians To Access Complete, Up-To-Date Patient Information From Almost Anywhere..... | 274 |
| xii. | Epic Has Dramatically Changed And Improved The Practice Of Medicine | 274 |
| | (1) EPIC Makes Learning A Patient’s Medical History Considerably Easier | 274 |
| | (2) Epic Makes Finding And Reading A Patient’s Medical Information Substantially Easier | 275 |
| | (3) Epic Simplifies And Makes The Ordering Of Medication And Tests More Efficient | 275 |
| | (4) Epic Improves The Process By Which Laboratory Results Are Reported And Accessed | 276 |
| | (5) Epic Has Made Consulting With Other Physicians Much Easier | 277 |
| | (6) Epic Has Substantially Improved Laboratory Services | 277 |
| xiii. | Epic Has Numerous Safety Features That Improve The Quality Of Care..... | 277 |
| | (1) Epic Has Health Maintenance Alerts..... | 278 |
| | (2) Epic Has Best Practice Alerts | 278 |
| | (3) Epic Presents Physicians With Order Sets..... | 278 |
| | (4) Epic Facilitates The Use Of Clinical Pathways ... | 278 |
| | (5) Epic Implements A Clinical Decision Support System (“CDSS”)..... | 279 |
| | (6) Epic Improves Patient Access To Their Medical Records | 279 |

| | | |
|--------|---|-----|
| | (7) Epic Improves Quality Of Care When There Are Drug Recalls..... | 279 |
| xiv. | ENH’s Accomplishment In The Deployment Of EPIC Is Unique | 280 |
| xv. | ENH Has Been Recognized By Numerous Outside Sources For Its Successful Deployment Of Epic | 280 |
| xvi. | Other Academic Hospitals In The Chicago Area Are Looking To Learn From ENH’s Successful Deployment Of Epic | 281 |
| xvii. | Epic Has Not Been Implemented By Community Hospitals | 281 |
| xviii. | Epic Is Far Superior To Meditech, The System Used At HPH Before The Merger | 281 |
| i. | The Merger Improved The Quality Of Radiology, Radiation Medicine, And Nuclear Medicine At HPH | 282 |
| | i. Overview..... | 282 |
| | ii. HPH’s Pre-Merger Radiology Equipment Was Antiquated And Productivity Was Lower Than It Should Have Been With Respect To Radiology Services..... | 282 |
| | iii. ENH Made Substantial Post-Merger Improvements To Radiology And Radiation Medicine Services That Improved The Quality Of Care At HPH..... | 283 |
| | (1) ENH Upgraded The Equipment And Systems At HPH And Extended Its Technology To HPH..... | 283 |
| | (2) ENH Added Additional Radiology Staff And Improved Access To Specialists At HPH..... | 284 |
| | (3) HPH Would Not Have Been Able To Make The Improvements In Radiology And Radiation Medicine Without The Merger | 284 |
| | iv. ENH Made Significant Post-Merger Improvements To The Nuclear Medicine Department At HPH | 284 |
| j. | The Medical Staff Integration And Academic Involvement Of Physicians Which Resulted From The Merger Improved The Quality Of Care At HPH..... | 284 |

| | | |
|------|--|-----|
| i. | Overview..... | 284 |
| ii. | HPH Physicians Rotate Through All Three ENH Campuses..... | 285 |
| iii. | HPH Physicians Take Part In Teaching Activities For Residents And Medical Students At Evanston Hospital..... | 285 |
| iv. | HPH Physicians Participate In Departmental Conferences That Broaden Their Skills..... | 286 |
| v. | HPH Physicians Have Obtained Faculty Appointments As A Result Of The Merger..... | 286 |
| vi. | ENH Provides HPH Physicians With A Continuing Medical Education Stipend..... | 287 |
| vii. | HPH Has Gained An Academic Affiliation, Which Has Enabled It To Recruit Better Physicians..... | 287 |
| k. | The Merger Improved The Quality Of Psychiatric Services At HPH..... | 287 |
| i. | Overview..... | 287 |
| ii. | Before The Merger, The Adolescent Psychiatry Services Available At Both Highland Park And Evanston Hospitals Were Limited..... | 288 |
| iii. | HPH’s Adolescent Psychiatry Physical Facility Contained Hazards For Adolescent Patients..... | 288 |
| iv. | Consolidating Adolescent Psychiatric Services At HPH Allowed HPH To Offer New And Expanded Services..... | 288 |
| v. | ENH Expanded And Remodeled The Adolescent Psychiatry Unit To Make It Safer..... | 289 |
| vi. | The Improvements Made By ENH In Consolidating And Expanding Psychiatric Services At HPH Improved The Quality Of Care..... | 289 |
| E. | After The Merger, ENH Continued To Provide High Quality Hospital Services..... | 290 |
| 1. | ENH Has Been Independently Recognized For Having High Quality Of Care..... | 290 |

| | | |
|----|---|-----|
| a. | ENH Received Solucient’s 100 Top Hospital Award..... | 290 |
| b. | ENH Received Awards From HealthGrades For Clinical Excellence | 290 |
| c. | ENH Received Recognition From The Leapfrog Group | 291 |
| d. | ENH Hospitals Have Received National Recognition For Its Healthcare Quality | 291 |
| e. | US News & World Report Recognized ENH As A Top Hospital..... | 291 |
| f. | ENH Received The KLAS And Davies Award For Epic..... | 291 |
| 2. | There Is No Evidence That Quality Deteriorated At Evanston Hospital After The Merger..... | 291 |
| F. | The Programs Or Services ENH Improved And Added At HPH After The Merger Exceed National And State Quality Benchmarks | 292 |
| 1. | HPH’s Post-Merger Performance In Treating Patients With Acute Myocardial Infarction Exceeds The Average In Illinois Hospitals | 292 |
| 2. | HPH’s Post-Merger Cardiac Surgery Outcomes Exceed National Benchmarks..... | 292 |
| 3. | ENH Is A National Leader In The Implementation Of Electronic Medical Records | 292 |
| 4. | ENH Exceeds National Benchmarks For Its Cesarean Section Rate..... | 293 |
| 5. | ENH Exceeds National Benchmarks For Its Operative Vaginal Delivery Rate | 293 |
| 6. | ENH’s Preoperative Gynecologic Surgical Review Program Is Unique..... | 293 |
| 7. | Post-Merger HPH Is A Leader In Terms Of Its Full-Time Internist Program..... | 293 |
| G. | Dr. Romano’s Analysis Did Not Properly Evaluate ENH’s Significant Quality Improvements At HPH | 293 |
| 1. | Dr. Romano Relies Heavily Upon Flawed Administrative Data..... | 294 |
| H. | Dr. Romano Placed Undue Reliance On Patient Satisfaction Surveys..... | 297 |
| a. | Overview..... | 297 |

| | | |
|------|---|-----|
| b. | Dr. Romano Improperly Relied On Unreliable Patient Satisfaction Surveys | 298 |
| i. | Press Ganey Survey Response Rates Are Too Low To Draw Valid Conclusions..... | 298 |
| ii. | Press Ganey’s Rating Scale Has A Ceiling Effect..... | 299 |
| iii. | Press Ganey Uses Mean, Not Percentage, Scores..... | 299 |
| iv. | The Rhea & Kaiser Survey Is Not A Valid Measure Of Patient Satisfaction At HPH | 300 |
| c. | Dr. Romano Improperly Relied On Insufficient Press Ganey Data..... | 300 |
| IX. | OTHER COMPETITIVE EFFECTS CONSIDERATIONS | 302 |
| A. | The Merger Was Not Anticompetitive Because Of Low Barriers To Market Entry And Repositioning By Competitors | 302 |
| 1. | The Illinois CON Law Is Not A Barrier to Entry | 302 |
| a. | Most CON Applications Are Approved | 302 |
| b. | Most CON Applications Are Approved In A Timely Manner | 303 |
| c. | The CON Requirements In Illinois Have Been Revised And, As A Result, Fewer Projects Require CON Approval..... | 303 |
| d. | ENH’s Competitors Have Been Able To Expand Their Facilities And Services Pursuant To The CON Process | 303 |
| i. | Northwestern Memorial Has Expanded Its Facilities And Services | 303 |
| ii. | Condell Has Expanded Its Facilities And Services..... | 303 |
| iii. | Lake Forest Hospital Has Expanded Its Facilities And Services | 304 |
| B. | The Merger Was Not Anticompetitive Because HPH’s Financial Condition Was Declining Before The Merger..... | 304 |
| 1. | HPH’s Board Of Directors Determined That, Due To The Financial Condition Of HPH, HPH Could No Longer Maintain The Status Quo As An Independent Hospital | 304 |

| | | |
|----|--|-----|
| 2. | The HPH Board Decided That Merging With Evanston Hospital Was The Best Option For The Future Of HPH..... | 306 |
| 3. | HPH’s Financial Condition Was Rapidly Declining | 307 |
| 4. | Evanston Hospital’s Due Diligence Revealed That HPH’s Financials Were On A “Downward Spiral” | 309 |
| a. | HPH Was Losing Money And Being Supported With Investment Income..... | 311 |
| b. | HPH’s Debt Capacity Was Severely Constrained | 312 |
| c. | HPH’s Cash And Investments Were Insufficient To Compete In The Marketplace..... | 313 |
| d. | HPH’s Joint Ventures Were Losing Money | 314 |
| e. | HPH Made Insufficient Capital Expenditures | 315 |
| f. | HPH’s Collection Rates/Accounts Receivable Were Declining..... | 316 |
| g. | Due Diligence Revealed That HPH’s Future Financial Projections Were Unrealistic | 317 |
| 5. | Expert Testimony Confirms The Significance Of HPH’s Declining Financial Condition..... | 319 |
| C. | ENH’s Not-For-Profit Status Is Relevant To The Competitive Effects Analysis..... | 320 |
| 1. | Not-For-Profit Status Plays A Role In Hospital Pricing..... | 320 |
| 2. | The Opinions Of Complaint Counsel’s Not-For-Profit Expert Support The Fact That ENH, As A Not-For-Profit Entity, Acts Differently Than A For-Profit Entity..... | 320 |
| 3. | The Pre-Merger HPH Foundation Is Evidence Of How A Not-For-Profit Hospital Benefits The Community | 321 |
| 4. | The Creation Of The Independent Highland Park Healthcare Foundation As A Result Of The Merger Demonstrates How ENH Acts To Benefit The Community As A Not-For-Profit | 322 |
| a. | The Healthcare Foundation of Highland Park is Required to Monitor the Commitments ENH Made to the Community | 323 |
| b. | The Highland Park Healthcare Foundation Contributes Funds to HPH for the Benefit of the Community | 323 |

| | | |
|------|--|-----|
| c. | Divestiture Would Result In Loss Of Nursing Improvements Resulting From Improved Cardiac Care At HPH After The Merger | 333 |
| d. | Divestiture Would Result In Loss Of ICU Nurse Acuity Gained From The Cardiac Surgery Program | 333 |
| e. | Divestiture Would Result In A Decline In Quality Of Care For Patients With AMI..... | 333 |
| i. | HPH Would Lose Its Capacity To Treat AMI Patients..... | 33 |
| ii. | There Would Be An Increase In Transfers Of Patients With AMI From HPH To Other Hospitals..... | 333 |
| iii. | Delays In Transfer Would Harm Patients..... | 334 |
| 2. | Divestiture Would Result In HPH Returning To A Community Hospital Governance Model | 334 |
| a. | Loss Of Integrated Medical Staffs Would Deprive HPH of Clinical, Academic and Research Activities..... | 335 |
| i. | Divestiture Would Result In HPH’s Loss Of Academic Involvement By HPH Physicians At Evanston Hospital Campus..... | 335 |
| ii. | Divestiture Would Result In HPH’s Loss Of Research Partnerships With Physicians At Evanston Hospital..... | 335 |
| iii. | Divestiture Would Result In HPH’s Loss Of Department Conferences And Case Consultation..... | 335 |
| 3. | Divestiture Would Result In HPH’s Loss Of ENH Quality Improvement And Quality Assurance Programs | 335 |
| 4. | Divestiture Would Result In HPH’s Loss Of The Benefits Of Epic..... | 336 |
| 5. | Divestiture Would Result In A Diminished Ability By HPH To Recruit High-Caliber Physicians And Hospital Administrators | 337 |
| C. | Divestiture Is Not A Proper Remedy Because ENH Cannot “Unlearn” About Its Demand..... | 337 |
| D. | Divestiture Is Not A Proper Remedy Because The Merger Was Between Two Members Of An Approved Network..... | 337 |

E. Divestiture Is Not A Proper Remedy Because It Would Undo Efficiencies
Of The Merger338

Exhibit And Demonstrative ListAttachment A

Witness ListAttachment B

VIII. MERGER IMPACT ON QUALITY

A. Definition And Measurement Of Healthcare Quality

1. Definition Of Quality In Healthcare

1165. Quality in healthcare is defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with the state of current professional knowledge. (Chassin, Tr. 5141; Romano, Tr. 3250-51).

1166. This definition was promulgated by the Institute of Medicine (“IOM”) in 1990. (Chassin, Tr. 5142; Romano, Tr. 3250). The IOM is a component of the National Academy of Sciences, and it is charged by Congress with undertaking studies in specific areas relevant to health and medicine. (Romano, Tr. 2998-99).

1167. This definition is generally accepted by experts as the most authoritative definition of quality. Accordingly, this definition was specifically accepted as the definition of healthcare quality by the experts for both parties in this case. (Chassin, Tr. 5143; Romano, Tr. 3251). Before IOM came up with this definition, there was no other classification that was as widely accepted as authoritative in the study of the quality of medical care. (Chassin, Tr. 5142-43).

1168. ENH’s healthcare quality expert, Dr. Mark Chassin, was a member of the IOM committee that created and adopted the definition of quality in healthcare per a directive from Congress. (Chassin, Tr. 5142). Dr. Chassin was actively engaged in that subcommittee that debated the issues surrounding this definition and part of the committee that ultimately sanctioned the definition. (Chassin, Tr. 5142).

1169. The heart of the quality definition is the phrase “increase the likelihood of desired health outcomes.” (Chassin, Tr. 5143). Quality is about reducing the risk of bad things happening, or increasing the likelihood of good things happening. (Chassin, Tr. 5143-44).

1170. But, “Quality” is not the same as good outcomes because, despite the best medical care, bad outcomes frequently happen to patients. (Chassin, Tr. 5144). Similarly, good outcomes may result from poor quality care, as patients are often resilient to mistakes or errors made by providers. The definition of healthcare quality reflects the balance that must be made when evaluating quality of healthcare; that is, whether the structure, process, or other means of delivering care is likely to increase the probability of good outcomes. (Chassin, Tr. 5144).

2. Measuring Healthcare Quality

1171. Experts in the field of healthcare quality assessment investigate three different classes of quality measures to determine if there has been a quality improvement. The three different categories of health care quality measurement are structure, process and outcomes. (Chassin, Tr. 5144-45; Romano, Tr. 3251).

1172. Structural measures reflect specific characteristics or features of a healthcare delivery organization. Structural factors are enabling factors. They set the background. They

provide the conditions under which care is delivered. (Romano, Tr. 2988). Structural measures include the physical resources put in place to deliver the processes of care – such as the beds that are available, the equipment, laboratory facilities, radiology facilities, and so forth. Structural measures also include the human resources, the specific training and the expertise of the professionals put in place to deliver the processes of care. (Romano, Tr. 2986-87, 3251; Chassin, Tr. 5145). For example, the expansion of obstetrician coverage to include nighttime coverage, even in the absence of outcome data, is a structural quality improvement. (Romano, Tr. 3251-52).

1173. Processes are all the things providers do when they treat patients. Process measures reflect what health professionals actually do to diagnose and treat disease – including prescribing medications, diagnostic testing and surgical procedures. These are all parts of process in care. (Chassin, Tr. 5155; Romano, Tr. 2987).

1174. Outcome measures reflect what ultimately happens to patients as a result of the care process: Do they leave the hospital alive? Are they disabled? Is their functional status optimized? Are they satisfied? (Romano, Tr. 2987).

a. Strengths And Weaknesses Of Quality Measures

1175. Each one of the classes of measures described above has its uses, its strengths and its weaknesses. (Chassin, Tr. 5152).

1176. In the case of structural measures, there are typically many of them, and they are easy to gather information about. One can easily lookup the number of beds in the hospital and research the amount of training the physicians have undergone. However, structural measures are often remote from the actual outcomes. (Chassin, Tr. 5152).

1177. Process measures are readily understandable to clinicians and are very usable in quality improvement. They also have the advantage of not needing comparative data. For example, if it were known that treating hypertension is a valid measure of quality and produces good outcomes, then all of a hospital's hypertensive patients would have to be treated to their target goals. That particular hospital would not need to know how it compared to other institutions; the organization would know its goal was 100% compliance. (Chassin, Tr. 5152-53). But there are weaknesses with process measures. Clinical information in these areas are not readily available in automated data systems or routine reports. (Chassin, Tr. 5153).

1178. Outcome measures are very attractive, but they too have their strengths and weaknesses. The most attractive part of looking at outcome measures is that, by definition, an outcome is the end result – what patients and providers care about. (Chassin, Tr. 5153). The other advantage is that at least the occurrence of outcomes is readily available in some automated data systems. (Chassin, Tr. 5153). Nevertheless, despite the attractiveness of outcomes, when making a determination as to whether there has been a quality improvement, it is not always necessary to have outcome information. (Chassin, Tr. 5145). In fact, there are limitations to using outcomes in assessing healthcare quality, and outcome measures sometimes suffer from severe problems that may interfere with their usefulness in identifying the effects of hospital Mergers. (Romano, Tr. 3253).

1179. The problems with outcome measures are quite serious and quite severe, especially when they are used to measure the quality of care at an individual hospital. (Chassin, Tr. 5153-54). Accordingly, it is necessary to have comparative data to know whether a particular outcome is good, bad, or indifferent. For example, in contrast to knowing that a hospital should treat all its hypertensive patients according to a standard, we do not know if 3% is a good mortality rate for a given procedure, or if 6% is a bad rate for another procedure when these procedures are measured in isolation. (Chassin, Tr. 5154).

1180. Another limitation of using outcome data to measure hospital quality is that some outcomes occur so rarely that they are not useful as quality measures. (Romano, Tr. 3254). For example, the occurrence of neonatal mortality at a low-risk delivery service such as HPH is so rare that it would not be meaningful to compare changes in that outcome over time to evaluate quality improvements in that area. (Chassin, Tr. 5597). Further, some outcomes of medical treatment are so delayed after treatment is given that it is impossible to use them in deciding whether quality changes happened as a result of a merger. (Romano, Tr. 3254). For example, for some procedures there are so few deaths that in-hospital mortality, which is an outcome measure, is not a useful measure of quality. (Romano, Tr. 3254).

1181. Another important aspect in trying to use outcomes to assess hospital quality is the need to risk-adjust them. (Chassin, Tr. 5156). Risk-adjustment is the process by which all the other factors that influence patient outcomes that are independent of the treatment – such as the severity of a patient’s disease, or other conditions a patient presents with – are taken into account. (Chassin, Tr. 5156; Romano, Tr. 3273).

1182. Risk-adjustment is very difficult to do. It requires extremely detailed clinical information about precisely how sick the patient is and what other conditions the patient brings with him or her to the hospital. Without this information, one cannot tell whether that hospital’s care has contributed to improving the outcome. (Chassin, Tr. 5156).

1183. Finally, another important weakness of outcome measures is that – unlike processes or structures, which are, by and large, under the control of the provider giving care – outcomes are susceptible to a lot of influences, and many of the influences that produce certain outcomes are not under a provider’s control. (Chassin, Tr. 5154; Romano, Tr. 3253-54). Therefore, it is important to sort out what part of the outcome is the responsibility of, and under the control of, the provider. (Chassin, Tr. 5154).

1184. The difficulty in relying on outcome measures is also recognized by leading third-party organizations in the field of healthcare quality. The Joint Commission for the Accreditation of Healthcare Organizations (“Joint Commission” or “JCAHO”) does not attach any weight to outcome measures of quality in the accreditation process for hospitals. (Chassin, Tr. 5156).

1185. JCAHO is the entity responsible for accrediting hospitals and certain other types of healthcare organizations in the United States. It convenes a series of expert panels to help identify appropriate quality measures for use in the accreditation process. (Romano, Tr. 2969).

1193. There are different types of evidence that may be used to establish the validity of structure, process and outcome measures. To establish a relationship between processes and outcomes, evidence from research based on randomized trials typically is required. (Chassin, Tr. 5149-50).

1194. To establish a relationship between structural measures, several other considerations must be weighed. It is always desirable to have clinical research evidence that structural measures are valid. However, such evidence is not always available. (Chassin, Tr. 5150). In fact, Dr. Romano concedes that there are structural aspects of quality of care that could not be tested in a randomized intervention because of ethical concerns with doing so. (Romano, Tr. 3332-33).

1195. For example, a defective defibrillator would never be installed in an emergency department as part of a randomized trial to prove that you need effective defibrillators to have quality of care in delivering shocks to the heart. (Chassin, Tr. 5150-51; Romano, Tr. 3333). Further, it would be unethical to conduct a clinical study to determine if someone who is trained as a general surgeon would conduct neurosurgery worse than someone who was trained as a neurosurgeon. Therefore, for many training and equipment issues, which are structural measures of quality, judgments must be made in the absence of outcome data generated by research. (Chassin, Tr. 5151).

B. Dr. Chassin Employed Accepted Methodology For The Study Of Healthcare Quality

1196. Dr. Chassin employed a multi-faceted strategy to measure the changes in structures, processes and outcomes at HPH and ENH in this case. (Chassin, Tr. 5158-59). The elements of Dr. Chassin's methodology are utilized by significant third-party organizations and state governing bodies in the field of healthcare quality. (Chassin, Tr. 5169-70, 5190-91).

1197. Dr. Chassin's strategy in approaching his assessment of whether quality of care improved at HPH in connection with the Merger was to use a variety of different sources for information, and then to prioritize areas of concern that might exist for a hospital like Evanston Hospital in preparing to merge with a community hospital like HPH. (Chassin, Tr. 5158-59). He then looked at exactly what Evanston Hospital did during the course of the Merger and thereafter. Next, he assessed the impact of all of Evanston Hospital's interventions on the quality of care that had existed before the Merger at HPH. (Chassin, Tr. 5159).

1198. Further, to the extent Dr. Romano raised any questions in his reports about quality issues at Evanston Hospital, Dr. Chassin looked at those issues in his own assessment. (Chassin, Tr. 5579). In looking at those issues, Dr. Chassin could not find any declines in quality at Evanston Hospital pre-Merger. (Chassin, Tr. 5276, 5579).

1199. Dr. Chassin's review focused on the Merger's impact on the quality of HPH's clinical services. (Chassin, Tr. 5580). In making his assessment, Dr. Chassin considered and analyzed data from a variety of sources, including: (1) site visits made to both Evanston Hospital and HPH; (2) formal and informal interviews; (3) contemporaneous documents; (4)

available outcome data, including both clinical and administrative data; and, finally (5) quantitative and qualitative analyses. (Chassin, Tr. 5159).

1200. Dr. Chassin was assisted in his assessment by Dr. Elizabeth Howell, a board-certified obstetrician/gynecologist and a faculty member of the Department of Health Policy at Mount Sinai. (Chassin, Tr. 5160). Dr. Howell reviewed documents, performed literature searches, assisted with the interviews and helped to compile some of the data used in Dr. Chassin's analyses. (Chassin, Tr. 5160).

1201. Dr. Howell began the review of contemporaneous documents by identifying quality-related documents in the 36 boxes of documents produced early in discovery. (Chassin, Tr. 5160). Dr. Chassin then reviewed all of those quality-related documents and began the site visit and interviewing processes. (Chassin, Tr. 5160). This review led to an iterative process through which Dr. Chassin made further specific requests for more documents and data and conducted additional interviews and another site visit. (Chassin, Tr. 5160-61).

1202. Dr. Chassin reviewed at least a dozen deposition transcripts before writing his expert report. (Chassin, Tr. 5161). Since writing his report, he also reviewed transcripts of physicians and witnesses, including Dr. Romano, who testified about quality issues in this case. (Chassin, Tr. 5161).

1203. Dr. Chassin conducted two, two-day site visits at HPH and ENH in June and August of 2004. (Chassin, Tr. 5169). The Joint Commission, state health departments, and professional organizations like the American College of Obstetricians and Gynecologists ("ACOG") conduct site visits as part of their assessments of hospital quality. (Chassin, Tr. 5170; Romano, Tr. 3245). Yet Dr. Romano, who admitted that site visits would have been ideal, did not conduct a site visit in this case of any relevant hospital. (Romano, Tr. 3245).

1204. Dr. Chassin also conducted 34 formal interviews of key physicians, nurses and administrative leaders who were present at HPH or Evanston Hospital either before or after the Merger or, in some cases, both. (Chassin, Tr. 5161-62).

1205. Dr. Chassin also interviewed a number of other individuals informally during his site visits, including physicians and nurses in such areas as the adolescent psychiatric unit, the ambulatory surgery unit, the cardiac catheterization lab, the emergency department ("ED") and the intensive care unit ("ICU"). (Chassin, Tr. 5162).

1206. Dr. Chassin selected all of the interview subjects. (Chassin, Tr. 5584). During his site visits, Dr. Chassin conducted informal interviews with people he met when there were no lawyers or administrators present. (Chassin, Tr. 5584).

1207. The interviews consisted of a series of structured questions that were directed at a particular topic. (Chassin, Tr. 5163). The individuals Dr. Chassin interviewed were able to clearly describe their experiences with providing care and doing their jobs, both at the time of the interview and previously. (Chassin, Tr. 5164).

1208. Interviews are important in trying to gather a full picture of how a hospital functions, both currently and previously. (Chassin, Tr. 5164). Dr. Chassin utilized the

interviews to determine whether there was consistency among all the different sources of information he was considering. (Chassin, Tr. 5165).

1209. The Joint Commission, state health departments and professional organizations like ACOG, conduct site interviews as part of their assessments of hospital quality. (Chassin, Tr. 5170; Romano, Tr. 3246-47). Nevertheless, Dr. Romano did not personally conduct any interviews of physicians or administrators relevant to the case. (Romano, Tr. 3247).

1210. When possible, Dr. Chassin utilized different sources in his analysis – including interviews, document review, examination of data and site visits – to determine whether there was consistency among all the sources of information he was considering and to see if those sources pointed in the same direction in terms of the quality assessment he was conducting. (Chassin, Tr. 5164-65, 5233). This broad range of sources led Dr. Chassin to conclude in a number of areas, for example, Ob/Gyn and nursing, that quality improved. (Chassin, Tr. 5159, 5192-93, 5233, 5236).

1211. The methods used by Dr. Chassin to conduct his assessment in the changes in quality at HPH after the Merger were entirely consistent with the methods used by Dr. Chassin when he was Commissioner of Health in the State of New York. (Chassin, Tr. 5190-91).

C. Dr. Chassin Has Extensive Experience Evaluating And Assessing Healthcare Quality

1212. Dr. Chassin is an expert in the fields of measuring, assessing and improving quality of healthcare as well as in health services and health policy research. (Chassin, Tr. 5131)

1213. Dr. Chassin is a physician employed by the Mount Sinai School of Medicine in New York City. (Chassin, Tr. 5119). He is the Edmond A. Guggenheim Professor of Health Policy, Chairman of the Department of Health Policy of the Mount Sinai Medical School, and Executive Vice President for Excellence in Patient Care at Mount Sinai Medical Center. (Chassin, Tr. 5119).

1214. As professor and chairman of the Department of Health Policy, Dr. Chassin is responsible for leading the expansion of the program in health services and health policy research. (Chassin, Tr. 5119).

1215. As the Executive Vice President, Dr. Chassin is responsible for leading clinical quality improvement throughout the medical center. (Chassin, Tr. 5120). Several medical center functions report to Dr. Chassin in his Executive Vice President role. (Chassin, Tr. 5120).

1216. The Mount Sinai Survey Center, the entity that conducts patient satisfaction surveys for inpatients and outpatients at Mount Sinai Hospital, is led by Dr. Chassin. The Six Sigma Quality Improvement Program – the vehicle that Mount Sinai uses for organizational improvement and cultural change, as well as improving business, administrative and clinical processes of care – reports to Dr. Chassin. The Cullman Institute for Patient Care, a trustee-endowed entity that focuses on improving nursing care, is overseen by Dr. Chassin. And Dr. Chassin directs the Excellence in Patient Care Initiative at Mount Sinai. (Chassin, Tr. 5120).

1217. At Mount Sinai, Dr. Chassin serves as co-chair of the quality control committee and is an elected member of the executive faculty, which is the governing body of the faculty of the medical school. (Chassin, Tr. 5120-21).

1218. Dr. Chassin completed his undergraduate studies, graduate studies and medical school studies at Harvard College. (Chassin, Tr. 5122; RX 1910 at 1). While in medical school, Dr. Chassin also attended the Kennedy School of Government at Harvard and earned a Master's degree in Public Policy. (Chassin, Tr. 5122). After medical school, Dr. Chassin completed residency training in internal medicine at Harvard General Hospital in Los Angeles, a fellowship in health services research at the Robert Wood Johnson Foundation Clinical Scholars Program at UCLA, and then earned a Master's degree in Public Health from UCLA. (Chassin, Tr. 5122).

1219. Dr. Chassin practiced emergency medicine for 12 years. (Chassin, Tr. 5122). He is board-certified in internal medicine. (Chassin, Tr. 5123).

1220. After his research fellowship, Dr. Chassin worked for the Healthcare Finance Administration ("HCFA"), then went to the Office of Policy Analysis at HCFA, and subsequently became the Deputy Director of the Office of Professional Standards Review Organizations. (Chassin, Tr. 5123). Dr. Chassin then went to RAND Corporation, where he conducted health services research for almost ten years. (Chassin, Tr. 5123-24). After RAND, Dr. Chassin co-founded a private sector firm, Value Health Sciences, in an attempt to take some of the research methods and turn them into commercial tools to measure quality. (Chassin, Tr. 5124).

1221. From 1992-1994, Dr. Chassin was appointed by the Governor of New York as the Commissioner of Health for New York State. (Chassin, Tr. 5124). As Commissioner, he was responsible for protecting the public health, regulating and licensing delivery systems, quality investigations and investigations of physician misconduct. (Chassin, Tr. 5124-25).

1222. Over a 20-year period, Dr. Chassin has published about 90 articles in peer-reviewed literature. (Chassin, Tr. 5125). Dr. Chassin regularly reviews manuscripts for journals such as the New England Journal of Medicine and the Journal of the American Medical Association. (Chassin, Tr. 5126). Dr. Chassin lectures widely and makes presentations in the area of healthcare quality both in and outside the United States. (Chassin, Tr. 5127).

1223. Dr. Chassin was admitted into the first class of the National Academies of Science. He received the Founder's Award from the American College of Medical Quality, the Laureate Award from the American College of Physicians and the Ellwood Award from the Foundation for Accountability. (Chassin, Tr. 5127).

1224. Dr. Chassin is an elected member of the IOM. He has worked with the IOM for more than 15 years on a variety of quality of care issues. (Chassin, Tr. 5128).

1225. Dr. Chassin was retained by ENH to evaluate the effects of the Merger between Evanston and HPH, to evaluate whether any improvements that might have occurred could have occurred absent the Merger, to evaluate what would happen in the event of divestiture and to review the reports and testimony of Dr. Patrick Romano. (Chassin, Tr. 5130-31).

D. Overview Of Changes In Healthcare Quality At HPH As A Result Of The Merger

1226. Dr. Chassin's multi-faceted review of the quality of care at HPH and ENH led to several unmistakable, and important, conclusions. First, based on the interviews, site visits, clinical data, and documents that Dr. Chassin reviewed, a methodology utilized by third-party organizations such as the Joint Commission, the State of New York and experts in the field of health care quality, he concluded that HPH had several significant quality problems that existed before the Merger in several different service areas. (Chassin, Tr. 5138, 5169-70, 5191; Romano, Tr. 3245-47).

1227. ENH addressed those problems successfully during the course of, and after, the Merger. (Chassin, Tr. 5138). Specifically, pre-Merger HPH had significant issues, including: dysfunctional obstetrics and gynecology ("Ob/Gyn") services; ineffective quality assurance programs; dysfunctional nursing culture; weak quality improvement programs; and a series of deficiencies in the physical plant that affected patient safety. (Chassin, Tr. 5191-92).

1228. Second, in addition to remedying deficiencies, ENH also made substantial improvements in quality in a number of other clinical service areas after the Merger. (Chassin, Tr. 5138). Most of those improvements required ENH to integrate its clinical and management systems and import or export its collaborative multidisciplinary culture to change the way clinical care was delivered at HPH. (Chassin, Tr. 5138-29). The vast majority of those improvements could not have been achieved without a Merger. (Chassin, Tr. 5139).

1229. The sixteen areas in which there were substantial quality improvements include: (1) Ob/Gyn; (2) quality assurance; (3) nursing; (4) quality improvement; (5) physical plant; (6) cardiac surgery; (7) interventional cardiology; (8) intensive care; (9) emergency care; (10) psychiatry; (11) laboratory medicine/pathology; (12) pharmacy; (13) radiology and radiation medicine; (14) electronic medical records (Epic); (15) oncology; and (16) the skills of the physician staff, as a result of the medical integration with ENH and its academic programs. (Chassin, Tr. 5140-41).

1230. Many of these improvements were brought about through a substantial infusion of capital to upgrade aging, defective and outmoded equipment and facilities, and to increase accessibility to expanded clinical services delivered in key areas. Specifically, ENH allocated more than \$165 million in capital funds to be invested in the infrastructure and health care delivery systems at HPH. (Hillebrand, Tr. 1976-77; Neaman, Tr. 1250).

1231. **(REDACTED)**

(Romano, Tr. 3332-33, 3390-93,

3327, 3308-09, 3317-18; Romano Tr. 3067-68, 3109-11, 3160-61, 3178-79, 3194-98, 3228-29, *in camera*).

1232. Finally, as discussed in more depth in Section X.A., any divestiture of HPH would erode a number of the quality improvements achieved through the Merger. (Chassin, Tr. 5139).

1. ENH Corrected Problems With Clinical Practice At HPH That Existed Before The Merger.

a. The Merger Improved Quality Of Care In HPH's Ob/Gyn Department

i. Overview

1233. One of the quality problem areas that existed at HPH before the Merger was Ob/Gyn services. (Chassin, Tr. 5191; Spaeth, Tr. 2249). ENH's improvements to HPH's Department of Ob/Gyn – including new obstetric practice protocols, improved physician discipline, physician and nurse teamwork – are all quality improvements at HPH resulting from the Merger. (Chassin, Tr. 5208).

1234. ENH improved these Ob/Gyn services after the Merger at a cost of more than \$750,000, annually. (Silver, Tr. 3782-83, 3848-49).

1235. Evanston Hospital is the high-risk obstetric center within ENH, meaning that the vast majority of at-risk mothers-to-be are cared for at Evanston Hospital. (Silver, Tr. 3771; Krasner, Tr. 3695-96). Obstetric services are provided at Evanston Hospital and HPH, while the gynecologic services are available at all three ENH hospital campuses. (Silver, Tr. 3770).

1236. HPH generally cares for less risky obstetric patients, both before and after the Merger. (Silver, Tr. 3773; Krasner, Tr. 3695-96). ENH obstetricians generally admit their higher risk obstetric patients directly to Evanston Hospital. (Silver, Tr. 3773-74).

1237. Obstetrical care was (and is) delivered at HPH through the Family Birthing Center. The HPH Family Birthing Center is a Labor, Delivery, Recovery and Postpartum ("LDRP") unit. (Krasner, Tr. 3695, 3698). In this unit, mothers in labor are admitted to a room and remain in that room throughout their hospital stay until discharged. (Krasner, Tr. 3698). Typically, LDRP is only used at community hospitals that have a volume of fewer than 2,500 deliveries per year. (Krasner, Tr. 3698).

1238. Evanston Hospital does not have a LDRP area due to the fact that its delivery volume is far too large and the physical space required to operate as an LDRP unit on that scale is enormous. (Krasner, Tr. 3698). Moreover, because Evanston Hospital was and is a Level Three hospital, which cares for the most complex obstetrical cases, using LDRP would not be an effective utilization of staff, as care for complex cases requires highly specialized staffing not used in the LDRP setting. (Krasner, Tr. 3698-99). LDRP does not affect quality of care. It is a marketing tool that is simply a choice made by the hospital for a model of care. (Krasner, Tr.

3699). That said, it was not a good marketing tool at HPH. It did not increase birth volume at all at HPH. (Krasner, Tr. 3699-700).

1239. Dr. Chassin's assessment of improvements in HPH's labor and delivery services since the Merger was based on interviews of physicians and nursing staff, as well as a 1998 contemporaneous review by an external body, ACOG, that codified and collated the problems that existed in the obstetrical service. (Chassin, Tr. 5192-93). In addition, Dr. Chassin interviewed several physicians, including Drs. Hirsch and Hansfield as well as nurses Heidi Krasner and Karen Mayer concerning the Ob/Gyn services at HPH pre-Merger. (Chassin, Tr. 5194). Dr. Chassin's review was also based upon his site visit to HPH. (Chassin, Tr. 5159).

1240. Dr. Chassin also relied on the trial testimony of Dr. Silver, who is the ENH Chairman of the Department of Ob/Gyn. (Chassin, Tr. 5161; Silver, Tr. 3767). Dr. Silver attended medical school at Northwestern University and completed his residency and fellowship training in Ob/Gyn and maternal fetal medicine, respectively. Dr. Silver is Board certified in Ob/Gyn with a subspecialty certification in maternal fetal medicine. (Silver, Tr. 3759-60). Dr. Silver began working at Evanston Hospital in 1987, and has been employed by Evanston Hospital and, subsequently, ENH, continually since that time. (Silver, Tr. 3760-61). He became the Director of the Division of Maternal/Fetal Medicine from 1994 through 2001, which involves the care and consultation of the high-risk obstetric patient, for example, women with multiple or complex pregnancies. (Silver, Tr. 3763-64).

1241. As Department Chairman, Dr. Silver is responsible for the provision of clinical care in the department, the academic activities of the department and the conduct of the professional staff who work in the department. (Silver, Tr. 3768). In addition, he is responsible for quality improvement activities that relate to physicians in the department. (Silver, Tr. 3769).

1242. In addition, as Chairman of the ENH Ob/Gyn Department, Dr. Silver is directly responsible for the review of physician practice and reacting to and adjudicating any quality assurance issues that arise. Before the Merger, however, he would not have had any such responsibility for obstetricians at HPH. (Silver, Tr. 3776).

1243. Dr. Silver's time as Department Chairman is divided among clinical responsibilities, teaching activities and administrative duties. (Silver, Tr. 3762-63). He has a clinical practice, performs consultations, delivers babies and supervises residents and students in the delivery and care of patients. (Silver, Tr. 3764). Dr. Silver also is a member of the Ob/Gyn Department's executive committee, which is comprised of a mixture of employed and independent physicians. (Silver, Tr. 3764-65).

ii. Evanston Hospital Had A Relationship With HPH Before The Merger Through The Illinois Perinatal Network

1244. Although Dr. Silver did not work at HPH before the Merger, he became familiar with HPH's pre-Merger Ob/Gyn practice through Evanston Hospital's involvement in the Illinois Perinatal Network, through which regional hospitals are required to transfer their high-risk mothers to Evanston Hospital for care. (Silver, Tr. 3771, 3774; Krasner, Tr. 3696).

1245. The State of Illinois has organized the provision of perinatal care based upon a system of central hospitals with services that are matched to the acuity of the patients they serve, such that high-risk expectant mothers are cared for at hospitals with that capability, including Evanston Hospital. (Silver, Tr. 3772). Other Chicago hospitals designated by the state as high-risk centers include Loyola, University of Chicago, Northwestern Memorial and Advocate Lutheran General. (Krasner, Tr. 3696).

1246. Dr. Silver, as the Division Director of Maternal Fetal Medicine at Evanston Hospital before the Merger, got to know a majority of the practitioners at HPH through the Illinois Perinatal Network. (Silver, Tr. 3774). The relationship through the Illinois Perinatal Network, before the Merger, was extremely circumscribed, however, and it was limited to quarterly state-mandated meetings to review select obstetric cases, as well as limited consultation on high-risk cases referred to Evanston Hospital. (Silver, Tr. 3774-75). **(REDACTED)**

(RX 324 at ENHL PK 29714, *in camera*).

1247. Before the Merger, therefore, Dr. Silver was not responsible for the conduct of the professional staff at HPH. He had no obligation through the Illinois Perinatal Network to oversee the quality assurance with respect to obstetricians in practice at HPH. (Silver, Tr. 3775-76).

1248. There was never any formal affiliation or joint venture between ENH or HPH before the Merger with respect to obstetrical services. (Krasner, Tr. 3697). The only relationship between Evanston Hospital and HPH before the Merger was that Evanston Hospital was a state-designated Regional Perinatal Center for HPH. As a Level Two hospital, HPH sent its high-risk expectant mothers to Evanston Hospital, a Level Three hospital, for care. That relationship continues today. (Krasner, Tr. 3696-97).

iii. HPH Ob/Gyn Department Had Serious Problems Before The Merger

1249. **(REDACTED)**

(Chassin, Tr. 5196; RX 324 at ENHL PK 29708-11, *in camera*; Silver, Tr. 3782).

1250. The obstetrics area at HPH before the Merger stood out as a major problem area because a third of all admissions to HPH pre-Merger were admissions of women about to have a delivery. (Chassin, Tr. 5196). The pre-Merger problems with this service combined to create unsafe situations in a critical care area, labor and delivery, that placed mothers and babies at risk of adverse outcomes because they were unable to function in a highly effective way. (Chassin, Tr. 5197).

1251. Because HPH's Ob/Gyn leadership and department were not able to resolve internally the problems with the hospital's Ob/Gyn care, HPH asked ACOG experts to come to HPH and help implement the appropriate standards of care. (Spaeth, Tr. 2114-15, 2249).

1252. **(REDACTED)**

(Chassin, Tr. 5221; RX 324 at ENHL PK 29708, *in camera*; RX 208 at ENHL PK 17285). See Section VIII.D.1.c.ii.

1253. The ACOG report was a thoroughly done, top to bottom, east to west review by expert Ob/Gyns looking at every aspect of the Ob/Gyn services at HPH. (Chassin, Tr. 5193).

1254. **(REDACTED)**

(Romano, Tr. 3390; RX 324, *in camera* at ENHL PK 29709).

1255. The information in the ACOG report was corroborated by other sources of information. (Chassin, Tr. 5198; RX 208 at ENHL PK 17285). ACOG also identified problems with interpretation of fetal monitoring strips as an area for improvement. (RX 1770 at ENHL PK 55180).

(1) HPH Had Insufficient Obstetrician Coverage Before The Merger

1256. A lack of in-house nighttime coverage at HPH before the Merger clearly constituted inadequate labor and delivery service. (Silver, Tr. 3782). The lack of such coverage was an issue with regard to quality of care because physicians were not always able to respond to emergencies as quickly as necessary. HPH had to rely on a good Samaritan act by a physician who happened to be in the area if nighttime coverage were needed in the labor and delivery unit. (Krasner, Tr. 3737).

(2) HPH's Ob/Gyn Department Had Poor Nurse/Physician Teamwork Before The Merger

1257. **(REDACTED)**

(Chassin, Tr. 5197; RX 324 at ENHL PK 29773, *in camera*). **(REDACTED)**

(Chassin, Tr. 5197-98; RX 324 at ENHL PK 29773, *in camera*).

1258. **(REDACTED)**

(RX 324 at ENHL PK 29754, *in camera*). **(REDACTED)**

(RX 324 at ENHL PK 29754, *in camera*).

1259. **(REDACTED)**

(Chassin, Tr. 5198; RX 324 at ENHL PK 29773, *in camera*). This constituted evidence of dysfunction in Ob/Gyn services at HPH. (Chassin, Tr. 5198).

1260. The characteristics of the Ob/Gyn services at HPH pre-Merger directly related to patient safety because effective teamwork is essential on the labor and delivery unit to provide safe care to patients. (Chassin, Tr. 5200). When communication processes are poor, sharing of critical information often is delayed and, in labor and delivery minutes, this can mean the difference between a healthy baby and an unhealthy baby. (Chassin, Tr. 5200).

1261. The Joint Commission has published information for hospitals detailing how communication problems were the major root cause of infant injury and, in hospitals experiencing these problems, bad organizational culture, ineffective communication and teamwork, as well as intimidating behavior of the kind described by Heidi Krasner were important causes of those adverse events. (Chassin, Tr. 5202). *See* Section VIII.D.1.b.ii, *supra*.

1262. **(REDACTED)**

(RX 324 at ENHL PK 29710, *in camera*).

(3) HPH Lacked Effective Obstetrical Leadership Before The Merger

1263. Effective hospital leadership is essential to improving quality of care, use of clinical practice guidelines, teaching and coaching staff as well as supporting quality patient care, treatment and services. (RX 2006 at 251).

1264. The Joint Commission includes several dimensions of hospital leadership as part of the standards upon which hospitals are judged. (RX 2006 at 251-54). HPH lacked effective nurse and physician leadership in obstetrics pre-Merger under the Joint Commission Standards. (Chassin, Tr. 5202-03).

1265. The lack of an effective chain of command – an identified leadership structure – was one of the biggest problems that was not solved until Dr. Silver was able to partner with Krasner to create an effective chain of command. (Chassin, Tr. 5603). **(REDACTED)**

(Romano, Tr. 3157, *in camera*). The chain of command at HPH pre-Merger was rarely utilized and did not work. (Krasner, Tr. 3708-10). **(REDACTED)**

(Romano, Tr. 3157; RX 324 at ENHL PK 29769-70, *in camera*).

1266. Dr. Chassin also reviewed a 1999 report of HPH's obstetrical service by the Chicago Risk Pooling Project ("CHRPP"), HPH's malpractice carrier. (Chassin, Tr. 5193). In contrast to the ACOG report, the CHRPP report was an attempt by the malpractice carrier to look

at certain areas related to malpractice risk. (Chassin, Tr. 5193). There were no physicians on CHRPP's review team and it was a much more superficial review, and was carried out for very different purposes, than the ACOG review. (Chassin, Tr. 5194).

1267. While the CHRPP report acknowledged the existence of a chain of command policy at HPH, it did not, however, comment on the degree to which HPH's chain of command policy was, in fact, implemented or working effectively such that it was actually protecting patients. (Chassin, Tr. 5602-03).

1268. The ACOG report contains statements addressing the professional relationships between nurses and physicians, indicating that they were "likely to improve." (RX 324 at ENHL PK 29773). However, following that statement is a recommendation for the exertion of effective leadership on the department chairman and the nurse manager to create a functioning obstetrics unit. (Chassin, Tr. 5588). But that did not happen until after the Merger with the emergence of Dr. Silver as an effective physician leader partner for the obstetrics nursing service. (Chassin, Tr. 5588).

(4) There Were Inappropriate Procedures In HPH's Ob/Gyn Department Before The Merger

1269. **(REDACTED)**

(Chassin, Tr. 5203; RX 324 at ENHL PK 29730-47, *in camera*).

1270. In addition, there were problems with respect to two categories of inappropriate procedures in labor and delivery at HPH before the Merger. (Krasner, Tr. 3714-16). One was termination of pregnancy at inappropriately late stages of pregnancy, and the other concerned inductions of labor. (Silver, Tr. 3797-98; Krasner, Tr. 3714-16).

1271. Before the Merger, physicians at HPH performed a procedure in the emergency room called a Dilation and Curettage, which is performed in response to a failing pregnancy. (Silver, Tr. 3793-94; Krasner, Tr. 3715-16). An emergency room is an inappropriate location to perform this procedure because there is inadequate pain relief from anesthesiologists, an inadequate level of patient privacy and a lack of maternal support services that would otherwise be available in the operating room setting. (Silver, Tr. 3793).

1272. For the second trimester abortions, there was a concern that the physician involved in this practice was misleading the staff by giving incorrect gestational age of the fetus and performing abortions beyond the point at which one would condone a pregnancy termination. (Silver, Tr. 3798-99). The concern regarding this issue has many dimensions, not the least of which was that the procedure may not have been proper from a medical perspective. (Silver, Tr. 3799).

1273. The fact that physicians performed tubal ligations or inductions for no medical reason at HPH before the Merger was memorialized in the 1999 CHRPP report."". In November 1999, CHRPP cited HPH for use of slang language in its medical records. (Krasner, Tr. 3717-19; RX 657 at ENHL PK 29821). Specifically, CHRPP cited HPH for the term "gestaphobia," which it found in HPH's medical records. (Krasner, Tr. 3717-19; RX 657 at ENHL PK 29821).

“Gestaphobia” was a term that a physician at HPH used before the Merger as a reason to schedule an induction. (Krasner, Tr. 3719-20). The non-medical slang term was known to mean that the patient no longer wished to be pregnant. (Krasner, Tr. 3719-20). Inductions, however, should only be performed for a medically valid reason, and “gestaphobia” is not a proper justification. Moreover, it is unquestioned that slang terminology should not be found in patients’ medical charts. Nevertheless, the term “gestaphobia” was frequently used in medical charts and the physician who used it was never disciplined at HPH before the Merger. Indeed, the problem continued up and until the Merger. (Krasner, Tr. 3719-20).

1274. Another concern was the practice of inducing labor based on social or personal factors, rather than a medical indication. (Silver, Tr. 3800-01). This practice may have resulted in unnecessary complications. For example, babies who had to be admitted to special care nurseries or transferred because of respiratory distress might not have had to undergo these procedures if the induction were properly-timed or not performed altogether. (Silver, Tr. 3801).

1275. This practice of inappropriate inductions existed at HPH before the Merger, and Dr. Silver was aware of it because he was contacted about this issue at Evanston Hospital through his role in the Illinois Perinatal Network. (Silver, Tr. 3801). Before the Merger, however, Dr. Silver could not take any action against this practice because he had no authority over HPH physicians. (Silver, Tr. 3802).

iv. ENH Improved Quality Of Care At HPH’s Ob/Gyn Department After The Merger

(1) ENH Expanded Obstetrician Coverage At HPH After The Merger

1276. In 2001, shortly after becoming Chairman of the Ob/Gyn Department, Dr. Silver made a definitive response to the problem of inadequate nighttime obstetrician coverage in HPH’s labor and delivery unit. (Silver, Tr. 3779).

1277. ENH, under Dr. Silver’s leadership, implemented in-house nighttime and weekend coverage by obstetricians at HPH. (Chassin, Tr. 5204). The expanded obstetrician coverage at HPH improved quality of Ob/Gyn care by having trained physicians in the hospital at night and on weekends to respond to emergencies on the labor and delivery floor. (Chassin, Tr. 5204). In-house obstetric coverage was a substantial improvement over the pre-Merger coverage by physicians at HPH who lived nearby. (Chassin, Tr. 5586).

1278. ENH implemented the in-house coverage program at the HPH campus because it was an issue of safety for women. (Silver, Tr. 3785).

1279. To effectuate this change, Dr. Silver made presentations to the Department’s members, to the Department Executive Committee and, eventually, to the ENH administration for its support. (Silver, Tr. 3782-83). Dr. Silver had to obtain financial support from the ENH administration to enact the obstetrician coverage, an investment of \$150,000 annually. (Silver, Tr. 3783; RX 988). This money was to be used for an additional stipend to be paid to participating physicians. (Silver, Tr. 3779-80).

1280. The in-house coverage is provided by a full-time attending obstetrician who is physically present at HPH from 10:00 p.m. to 7:00 a.m. during the weekdays. (Silver, Tr. 3783; Krasner, Tr. 3736-37). Some regional hospitals staff their in-house obstetrician coverage with residents in training, but ENH provides coverage with attendings, who have finished their medical training and who are more experienced than residents. (Silver, Tr. 3783-85). During the weekends, the obstetrician is in-house at HPH 24 hours a day. (Silver, Tr. 3784).

1281. The nighttime obstetrician is available to respond in the case of an emergency, to perform an emergency Caesarean section and to provide consultations to nursing staff for any patient emergency. (Silver, Tr. 3783). Evanston Hospital had a similar in-house physician coverage program before the Merger. (Silver, Tr. 3784-86). In addition, some of the obstetricians based at Evanston Hospital have taken part in the in-house coverage at the HPH campus since the Merger. (Silver, Tr. 3784).

1282. The obstetrician coverage at Evanston Hospital is 24 hours per day, 7 days per week, in part, because there is an obligation to train the medical students and residents who take part in the teaching program there. (Silver, Tr. 3785-86). For as long as Dr. Silver has worked at Evanston Hospital it has had in-house obstetrician coverage. (Silver, Tr. 3786).

1283. The obstetrician coverage program at HPH after the Merger was not typical of a community hospital at the time that program was instituted. (Silver, Tr. 3786). Indeed, HPH was the first hospital in Lake County to have in-house obstetrician coverage. (Silver, Tr. 3791). ENH implemented in-house coverage at HPH before Lake Forest, Condell and Victory Memorial Hospitals established their respective in-house coverage programs. (Silver, Tr. 3791).

1284. The in-house obstetrician program has been very successful and has benefited many patients. (Silver, Tr. 3787). ENH compiles statistics on the utilization of the in-house coverage program and, for calendar year 2004, approximately 200 women at both HPH and Evanston Hospital had urgent or emergent care provided by the in-house obstetrician. (Silver, Tr. 3787). In addition, those are not the only documented uses of in-house coverage, there are many other instances when the in-house obstetrician has been contacted by nursing personnel for consultations on fetal heart tracings and other things. (Silver, Tr. 3787).

1285. In addition, the data that ENH has concerning this program is objective evidence of improvements in quality of care for Ob/Gyn patients at HPH. (Silver, Tr. 3866-67). The fact that, for 2004, 200 women whose deliveries would have gone unattended by an attending physician were, in fact, attended – some at HPH, some at Evanston Hospital – is objective data that quality of care has been improved. (Silver, Tr. 3854).

1286. Emergencies occur in the delivery process and having in-house physician coverage for that service is critical to patient care. The obstetrician coverage provided by physicians who live nearby HPH was inferior to the in-house coverage currently in place at that campus. (Silver, Tr. 3788).

1287. (REDACTED)

(Chassin, Tr. 5585; RX

657 at ENHL PK 29812, *in camera*; RX 324 at ENHL PK 29709, *in camera*).

(REDACTED)

(RX 657 at ENHL PK 29812, *in camera*; Chassin, Tr. 5585; Romano, Tr. 3390).

1288. **(REDACTED)**

(Chassin, Tr. 5585; RX 658 at ENH RS 7482, *in camera*). These CHRPP bonuses are done by category so that it is possible to get a bonus or premium reduction in one category but not in others. (Chassin, Tr. 5585). **(REDACTED)**

(Chassin, Tr. 5585-86; RX 658 at ENH RS 7482).

1289. **(REDACTED)**

(RX 657 at ENHL

PK 29809, *in camera*). **(REDACTED)**

(RX 657 at ENHL PK 29809, *in camera*).

(REDACTED)

(RX 324 at ENHL PK 29709, *in camera*).

1290. The implementation of in-house coverage had a positive influence on the nursing staff at HPH by helping them to be more confident in providing patient care. In addition, nurses had the opportunity to consult with physicians who were present in the hospital during the nighttime. (Silver, Tr. 3790).

1291. The lack of available nighttime obstetrical coverage increases the risk of adverse outcomes, which is, by definition, a quality problem. (Chassin, Tr. 5586).

1292. Dr. Romano concedes that the expansion of obstetrician coverage to include in-house coverage during the nighttime would be a structural quality improvement. (Romano, Tr. 3389-90). Dr. Romano could reach the conclusion that nighttime obstetrician coverage was a structural quality improvement even in the absence of outcome data. (Romano, Tr. 3390).

(2) ENH Improved HPH's Nurse/Physician Teamwork After The Merger

1293. After the Merger, and through ENH's addition of full-time clinical department chairman, ENH corrected the problems of inadequate physician leadership in HPH's labor and delivery unit and, as a result, improved the nurse and physician teamwork. (Chassin, Tr. 5204-05). *See* Section VIII.D.1.a.iv, *infra*.

1294. An important improvement to HPH's Ob/Gyn was the creation of multidisciplinary clinical care, which physicians, nurses and all of the participants in the obstetric service worked together as a team to reduce the risks of the adverse outcomes that existed before the Merger. (Chassin, Tr. 5206). Reducing the risk of an adverse outcome is a quality improvement. (Chassin, Tr. 5206).

(3) ENH Improved HPH's Ob/Gyn Leadership And Quality Assurance Program After The Merger

1295. Dr. Silver, as Chairman of the Ob/Gyn Department, is responsible for quality assurance activities, in addition to being responsible for the quality of care provided by physicians within the department. (Silver, Tr. 3792). Dr. Silver's quality of care responsibilities include looking at trends and patterns within the department for specific outcomes, both in obstetrics and gynecology. (Silver, Tr. 3821). In addition, he speaks regularly with members of the department so that they feel at ease discussing quality of care issues. (Silver, Tr. 3821). *See* Section VIII.D.1.a.iv., *supra*.

1296. Before the Merger, the department of obstetrics at HPH was particularly weak in disciplining problem physicians. (Chassin, Tr. 5207). ENH remedied this deficiency by enacting effective physician discipline to address repeated patterns of behavior that could really only be dealt with by discipline, and that was corrected after the Merger by Dr. Silver. (Chassin, Tr. 5207).

1297. **(REDACTED)**

(Romano, Tr. 3393-94; 3450, *in camera*). **(REDACTED)**

(Romano, Tr. 3450, *in camera*).

1298. Dr. Silver became Department Chairman in 2001, following an extensive national search, lasting nine months. (Silver, Tr. 3842-43). Thus, there was a short transitional period in Ob/Gyn after the Merger and before Dr. Silver's appointment. (Silver, Tr. 3842-43). However, directly after becoming Chairman, Dr. Silver implemented several improvements, including the change in expanded obstetrician coverage. (Silver, Tr. 3842).

1299. It was not until after the Merger when Krasner had the partnership with a strong physician leader like Dr. Silver and a strong administration that the full conversion to an effective nursing culture and effective teamwork could be created in Ob/Gyn. (Chassin, Tr. 5207). **(REDACTED)**

(Romano, Tr. 3450-51, *in camera*). **(REDACTED)**

(Romano, Tr. 3451, *in camera*).

1300. By installing a full-time department chair, ENH corrected the problem of lack of physician leadership in obstetrics that had plagued HPH before the Merger, enabling much more evidence-based protocols to be created, a much better system of physician discipline, and Ms. Krasner then had a physician partner to work with to really create full teamwork between nurses and physicians. (Chassin, Tr. 5204-05; RX 1416 at ENHL PK 54591).

**(4) ENH Addressed The Inappropriate Procedures
In Ob/Gyn At HPH After The Merger**

1301. After the Merger, ENH made a policy and a procedural change to require that: (1) the inappropriate Ob/Gyn procedures described above be performed in an outpatient operating room (as opposed to the emergency room); and (2) HPH make available perinatal support staff, consisting of psychologists and work workers to assist with such procedures, that was not available to patients before the Merger. (Silver, Tr. 3795).

1302. Soon after becoming the Ob/Gyn Department Chairman, Dr. Silver, in consultation with other HPH physicians, put an end to the practice of physicians using the emergency room at HPH to perform Dilation and Curettage. (Silver, Tr. 3778, 3781). The physicians at HPH appreciated this change and, in addition, patients benefited from this change as they were no longer subject to having this procedure performed in an inappropriate location with inappropriate support. (Silver, Tr. 3794).

1303. Similarly, after the Merger, Dr. Silver, as Department Chairman, dealt directly with physicians performing inappropriate inductions of labor and stopped that practice from occurring. (Silver, Tr. 3802, 3808). Dr. Silver relied on one of the committees in his department, the obstetrics practice committee, to develop a protocol for labor induction that would be acceptable to the department based on evidence in the literature and best practice. (Silver, Tr. 3802; RX 1416 at ENHL PK 54592-94). Further, the protocol is clear that inductions performed for purely social reasons or convenience are, as a rule, not appropriate at any gestational age. (RX 1416 at ENHL PK 54592).

**(5) ENH Implemented Obstetric Committee
Practice Protocols At HPH After The Merger**

1304. Dr. Silver created the obstetrics practice committee, which had broad membership to foster collegiality. This committee included nurses, certified nurse-midwives and physicians from all campuses. (Silver, Tr. 3802-03). Broad membership was important so that everyone in the department had a sense of ownership about the protocols and, further, so that it was not just a small hierarchy making decisions about critical aspects of patient care. (Silver, Tr. 3802-03). The protocols are designed to address a condition or subject area and develop a consensus on that subject based on the best randomized clinical trials in the literature, the standards from societies like ACOG and input from local practitioners. (Silver, Tr. 3804; RX 1416 at ENHL PK 54594).

1305. Before the Merger, HPH may have had separate nurse and physician protocols, but they were not as comprehensive as those created by ENH's obstetric practice committee. For example, the pre-Merger HPH protocols would not have included as exhaustive a review of the literature, and they would not have been created with input from as broad a group of participants. (Silver, Tr. 3804-05). The post-Merger protocols were designed so that everyone who was involved in a patient's care had a say in the nature of the obstetric practice at the ENH campuses. (Silver, Tr. 3805).

1306. ENH also developed a protocol on chain of command that was unique to the department of Ob/Gyn. (Silver, Tr. 3809; RX 1416 at ENHL PK 54612-14). This was done in

response to nursing concerns as well as some physicians' concerns that the chain of command was not clear-cut for some of the services provided. (Silver, Tr. 3810).

1307. This protocol was developed to ensure that the input of all personnel received appropriate attention while respecting the authority of the responsible care providers. (RX 1416 at ENHL PK 54612). Dr. Silver could recall at least one instance when the chain of command was utilized and a nurse at the HPH campus contacted him concerning an inappropriate induction of labor. (Silver, Tr. 3810). Dr. Silver determined that the care was inappropriate, contacted the physician directly to ensure that he changed his plan and provided support to the nurse. (Silver, Tr. 3810-11).

1308. The research and drafting involved in each obstetric committee practice protocol is labor-intensive, and each such protocol takes a significant amount of time to prepare. (Silver, Tr. 3865-66).

1309. To address nurse/physician collaboration, ENH, under Dr. Silver's leadership as chairman of the ENH Department of Ob/Gyn, implemented a series of obstetric committee practice protocols, including a chain of command policy that was designed, in part, to facilitate communication about "clinically significant observations" among nurses and physicians. (Silver, Tr. 3809-10; RX 1416 at ENHL PK 54612-14). **(REDACTED)**

(Chassin, Tr. 5207; RX 324 at ENHL PK 29709, *in camera*). Before the Merger, HPH's obstetric protocols were outdated and did not reflect the best current thinking about obstetrical care. (Chassin, Tr. 5208).

1310. In addition, HPH's obstetric protocols pre-Merger permitted procedures to be done in unsafe, inappropriate locations, such as abortions in the ED. (Chassin, Tr. 5208). The programs did not uncover the pattern of inappropriate gynecologic surgery pre-Merger that was effectively dealt with after the Merger. (Chassin, Tr. 5208). ENH's evidence-based, multidisciplinary protocols helped get rid of that problem after the Merger and standardize care in a very high quality way. (Chassin, Tr. 5208; RX 1416).

(6) ENH Introduced The Preoperative Gynecologic Surgical Review Program At HPH After The Merger

1311. **(REDACTED)**
(Silver, Tr. 3889, *in camera*). **(REDACTED)**

(Silver, Tr. 3889, *in camera*). **(REDACTED)**
(Silver, Tr. 3889,

in camera).

1312. **(REDACTED)**

(RX 1768 at ENHL RSL 3, *in camera*). **(REDACTED)**
(Silver, Tr. 3889, *in camera*; RX 1768 at ENHL RSL 4, *in camera*).

1313. **(REDACTED)**
(Silver, Tr. 3890, *in camera*). **(REDACTED)**

(Silver, Tr. 3891, *in camera*). **(REDACTED)**
(Silver, Tr. 3895, *in camera*).

1314. **(REDACTED)**
(Silver, Tr. 3889-90, *in camera*). **(REDACTED)**
(Silver, Tr. 3890, *in camera*).

1315. **(REDACTED)**
(Silver, Tr. 3893, *in camera*; RX 1768 at ENHL RSL 8, *in camera*).
(REDACTED)

(Silver, Tr. 3835-36; RX 1768 at
ENHL RSL 8, *in camera*). **(REDACTED)**

(Silver, Tr. 3895, *in camera*).

1316. **(REDACTED)**
(Silver, Tr. 3894-95, *in camera*; RX 1768 at ENHL RSL 4, *in camera*). **(REDACTED)**
(Silver, Tr. 3895, *in camera*).

1317. **(REDACTED)**
(Silver, Tr. 3836-37; Silver, Tr. 3298, *in camera*). **(REDACTED)**

(Silver, Tr. 3898, 3917-18, *in camera*; RX 2033, *in camera*; RX 2034, *in camera*). There were no other examples in the Department of Ob/Gyn in which gynecologic surgery was done inappropriately. (Silver, Tr. 3837). *See* Section VIII.D.1.c.iii., *supra*.

1318. The preoperative surgical review program unambiguously improves quality of patient care. (Silver, Tr. 3852). **(REDACTED)**

(RX 1768 at ENHL RSL 16, *in camera*). **(REDACTED)**

(Silver, Tr. 3923-24, *in camera*).

1319. Dr. Silver's addition of the preoperative gynecologic surgical review program is a major quality improvement because it prevents inappropriate surgery or premature surgery before a complete workup has been provided and that was an important improvement after the Merger. (Chassin, Tr. 5206; RX 1768; RX 1769 at ENHL PK 5876).

1320. Dr. Romano agreed that the preoperative gynecologic review program instituted at HPH after the Merger would be a quality improvement if there had been evidence of such a problem before the Merger. (Romano, Tr. 3392). Dr. Romano, however, found documentary evidence that inappropriate gynecologic surgeries had been performed at HPH before the Merger. (Romano, Tr. 3392-93). Further, Dr. Romano agrees that ENH took steps to put an end to those inappropriate gynecologic surgeries at HPH after the Merger. (Romano, Tr. 3393).

v. Patient Outcomes In ENH's Ob/Gyn Services Are Consistent With, Or Better Than, National Benchmarks

1321. **(REDACTED)**

(Silver, Tr. 3825; Chassin, Tr. 5419, *in camera*). **(REDACTED)**

(Silver, Tr. 3821-22; Chassin, Tr. 5413, *in camera*).

1322. There are three ways in which babies are delivered: (1) a spontaneous vaginal delivery; (2) a Cesarean delivery; and (3) an operative vaginal delivery, all of which are a kind of patient outcome. (Silver, Tr. 3811-12).

1323. **(REDACTED)**

(Chassin, Tr. 5416, *in camera*; Silver, Tr. 3814-15). **(REDACTED)**

(Chassin, Tr. 5416-17, *in camera*; Silver, Tr. 3812-14; RX 1416 at ENHL PK 54656).

1324. ENH implemented an operative vaginal delivery protocol, which was important to help obstetricians at ENH select the appropriate delivery method – forceps or vacuum when performing an operative vaginal delivery. (Silver, Tr. 3815; RX 1416 at ENHL PK 54656-60).

1325. Having a successful vaginal delivery is more common with forceps than with vacuum methods and, thus, the associated Cesarean section rate would be lower. (Silver, Tr. 3814). A lower Cesarean section rate benefits patients at ENH because it decreases their risk of complications and of maternal death. (Silver, Tr. 3824).

1326. **(REDACTED)**

(Chassin, Tr. 5418, *in camera*; Silver, Tr. 3823-24 (*discussing* DX 7037-001). Both before and after the Merger, ENH has been very consistent in its performance on the Cesarean section rate, having a rate that is lower than the national trend throughout the pre- and post-Merger period. (Silver, Tr. 3824 (*discussing* DX 7037-001)).

1327. **(REDACTED)**

(Chassin, Tr. 5418, *in camera*). **(REDACTED)**

(Silver, Tr. 3825; Chassin, Tr. 5419, *in camera* (*discussing* DX 7037-002)). Physicians in the department are appropriately very selective of which patients undergo an operative vaginal delivery. (Silver, Tr. 3826).

1328. **(REDACTED)**

(Chassin, Tr. 5419, *in camera*). **(REDACTED)**

(Chassin, Tr. 5419, *in camera*; Silver, Tr. 3825-26). **(REDACTED)**

(Chassin, Tr. 5420, *in camera*).

1329. **(REDACTED)**

(RX 1769 at ENHL PK 5873, *in camera*). **(REDACTED)**

(RX 1769 at ENHL PK 5873, *in camera*). **(REDACTED)**

(RX 1769 at ENHL PK 5873, *in camera*).

1330. **(REDACTED)**

(Romano, Tr. 3228-29, *in camera*). **(REDACTED)**

(Romano, Tr. 3228, *in camera*).

1331. **(REDACTED)**

(Romano, Tr. 3189, *in camera* (DX 7037 at 6-9)).

1332. Dr. Romano also found that perineal tear rates declined at ENH from the pre- and post-Merger periods significantly more than at ENH peer group hospitals. (Romano, Tr. 3397).

1333. **(REDACTED)**

(Chassin, Tr. 5419-20, *in camera*). **(REDACTED)**

(Chassin, Tr. 5420-21, *in camera*). **(REDACTED)**

(Chassin, Tr. 5420-21, *in camera*).

vi. Dr. Romano's Undue Reliance On Administrative Data To Evaluate HPH's Obstetrical Service Is Invalid

1334. The indicators that Dr. Romano used to analyze obstetrical services at the ENH hospitals were not comprehensive. (Romano, Tr. 3395). Dr. Romano conceded that the indicators for birth trauma, third and fourth degree perineal lacerations, neonatal mortality and vaginal birth after a Cesarean section ("VBAC") rates are not comprehensive and overlook many important processes of care. (Romano, Tr. 3396).

1335. {In addition, Dr. Romano's analysis of the NPIC data was not complete because it is based upon administrative data, and looking at each measure is not sufficient to judge the overall quality of obstetrical care.} (Chassin, Tr. 5414, *in camera*). {The data that Dr. Romano examined concerning vaginal lacerations – which are based on administrative data processed in different ways – and result in opposite conclusions about the rate of vaginal lacerations.} (Chassin, Tr. 5414-15, *in camera* (*discussing* DX 7034A at 9-10)).

1336. **(REDACTED)**

(Chassin, Tr. 5416, *in camera*). **(REDACTED)**

(Chassin, Tr. 5417, *in camera*).

1337. Dr. Chassin did not examine neonatal mortality because he did not find risk-adjusted data that would have allowed him to track quality in a meaningful way pre- and post-Merger. (Chassin, Tr. 5596). To obtain meaningful data would have required a large-scale chart review because administrative data by themselves do not allow one to make such judgments.

(Chassin, Tr. 5596-97). Even if risk-adjusted data on neonatal mortality were available, that outcome would be very rare in a low-risk obstetric service like HPH's. Accordingly, it would be questionable whether one could make meaningful comparisons on this point pre- and post-Merger. (Chassin, Tr. 5597).

b. The Merger Improved Quality Of Care In HPH's Nursing Services

i. Overview

1338. Nursing services are absolutely critical to patient care because of the increasing complexity and severity of illnesses of hospitalized patients. (Chassin, Tr. 5230).

1339. Effective nursing services have exemplary leadership, are focused on developing autonomous nursing practices and encourage collaborative participation with physicians and other clinicians. (Chassin, Tr. 5231). Literature dating back 15 to 20 years in nursing health services research has evaluated these qualities of effective nursing and has shown that when they are present, the mortality and morbidity rates of patients are lower than in those hospitals with dysfunctional nursing services. (Chassin, Tr. 5231).

1340. ENH positively transformed the nursing service at HPH after the Merger. Nursing services improved through enhanced training, improvements in physician/nurse relationships, critical thinking and assessment skills, and improved safety. (Chassin, Tr. 5239-43; Ankin, Tr. 5070).

1341. Heidi Krasner, who testified at trial concerning these improvements, has been a registered nurse for 18 years. (Krasner, Tr. 3688-89). Krasner is the Clinical Coordinator for the Nursing Resource Team, the Staffing Office and IV Therapy Team for HPH. (Krasner, Tr. 3688). She has held this position since August 2004. (Krasner, Tr. 3688). Krasner, who has practiced at several hospitals across the Chicago area, was hired at HPH as the Clinical Nurse Manager for the Family Birthing Center in 1997. She was manager of the family birthing center from 1997-2001. (Krasner, Tr. 3689-91).

1342. As the Clinical Nurse Manager for the Family Birthing Center, Krasner was responsible for the day-to-day operations of the Birthing Center, prenatal education for parents, lactation services, nurse staffing and training for labor and delivery, and oversight of nurse-physician relationships. She was also responsible for the financial condition of the Birthing Center and the Lactation Center at HPH. She managed a total of 60 people in this capacity. (Krasner, Tr. 3691-92).

1343. Despite the fact that Krasner is no longer the Nurse Manager of the Family Birthing Center at HPH, she is still very familiar with the state of care in that unit. Her familiarity is based upon the fact that the nurses she oversees on the resource team serve in the Family Birthing Center, as well as throughout the hospital, and she maintains oversight for all of the finances of the Birthing Center. Moreover, Krasner gathers all of the health-related statistics regarding deliveries and patients who are admitted, re-admitted, or discharged from the Family Birthing Center. (Krasner, Tr. 3694-95).

ii. HPH's Pre-Merger Nursing Services Needed Improvement

1344. Key elements of effective nursing were absent from HPH before the Merger. (Chassin, Tr. 5232).

1345. Leadership did not support active involvement of nursing in multidisciplinary care. (Chassin, Tr. 5232).

1346. Analysis performed by health care providers at the time of, and before, the Merger also confirmed that the nursing culture at HPH was passive, and the nurses simply carried out physician orders instead of being partners in care. (Chassin, Tr. 5232; RX 925 at ENHL PK 51687).

1347. Before the Merger, nursing problems were memorialized in an August 23, 2000, memorandum from Peggy King, Assistant Vice President, to Mary O'Brien, Senior Vice President. (RX 925). King identified concerns about passive nursing, the failure of nurses to practice autonomously, a punitive nursing atmosphere that inhibited accident investigation, a lack of nurse leadership support and nursing competency. (Chassin, Tr. 5235; RX 925 at ENHL PK 51687).

1348. Moreover, the Family Birthing Center at HPH had several major nursing service issues that paralleled the nursing problems in the rest of the hospital. (Chassin, Tr. 5232-39). The problem areas for nursing in the Family Birthing Center were focused in the areas of staffing, training and nurse-physician relationships. (Krasner, Tr. 3701).

1349. The issues concerning HPH nursing before the Merger are explored in more depth below.

(1) HPH Had Issues Concerning Nurse Recruiting, Vacancy And Turnover Rates Before The Merger

1350. **(REDACTED)** (Spaeth, Tr. 2247; RX 442 at ENH RS 4660, *in camera*). Specifically, pre-Merger HPH had a 13-15% nurse vacancy rate and had to fill the vacancies with temporary nurses from agencies. (Spaeth, Tr. 2247; O'Brien, Tr. 3533-34).

1351. In 1997, there were several vacant nursing positions in the Family Birthing Center. Specifically, HPH had 7.9 Full Time Equivalent positions that were vacant and were not even posted for hire. (Krasner, Tr. 3701-02).

1352. Physicians were concerned about the nurse vacancy rate. (O'Brien, Tr. 3531, 3533-34; RX 938 at ENHE F35 317).

1353. To decrease nurse vacancy, HPH needed to recruit and hire new nurses. However, economic realities at HPH before the Merger restricted the ability of HPH to compete in the market for nursing salaries and benefits packages. (RX 450 at ENH DR 3478). Starting

salaries for Registered Nurses and Operating Room Techs were 4.8% and 7.5% below their respective markets in 1999 at HPH. (RX 450 at ENH DR 3478). And there was no merit-based reward system for nurses at HPH. (Krasner, Tr. 3702).

1354. Krasner could not cure any issues of compensation before the Merger. (Krasner, Tr. 3722). Contemporaneous documents confirm this statement was true for all of HPH nursing. (RX 450 at ENH DR 3478).

1355. **(REDACTED)**

(Krasner, Tr. 3702; Newton, Tr. 513-14, *in camera*). But agency nurses are not as effective with respect to patient care as nurses who are on staff. Because agency nurses are temporary, they lack institutional familiarity with the hospital, its policies, or its physicians. (Krasner, Tr. 3702-03; RX 657 at ENHL PK 029811). Further, the skill set and abilities of agency nurses are unknown before they are brought in to staff the hospital because there is no interview process in their selection. They are simply provided to the hospital through an outside temporary nursing agency. (Krasner, Tr. 3702-03).

1356. Hiring agency nurses is expensive, and they are difficult to find. The trend of increased reliance on agency nurses at HPH before the Merger increased the financial resources of the hospital that had to be dedicated to finding and retaining the temporary employees. For example, in 1998, the total agency nurse cost was \$26,833 at HPH. However, the following year the cost increased dramatically. In just one month, January 1999, HPH spent \$14,679 on agency nurse costs. (RX 450 at ENH DR 3478).

1357. Moreover, before the Merger, there was constant turnover of nurses in the Family Birthing Center at HPH. (Krasner, Tr. 3702, 3721-22). This constant turnover caused vacancy rates to be an ongoing problem at HPH. (Krasner, Tr. 3755).

1358. The turnover rate was high and getting worse at HPH pre-Merger. Specifically, in 1998, Staff Nurse turnover was 19.4% higher than the average staff turnover in 1996 and 1997 at HPH. (RX 450 at ENH DR 3478).

1359. The considerable turnover over time resulted in concerns regarding nurse staffing and issues regarding the quality of services being afforded to patients. (RX 938 at ENHE F35 317).

(2) HPH Had Issues Concerning Nurse Training Before The Merger

1360. Overall, the proper training of nurses is critical with respect to the quality of care given to patients. Anytime a nurse is not properly trained it puts patients at risk and compromises the safety of care provided at a hospital. (Krasner, Tr. 3705).

1361. Nurses also must have critical thinking skills to be active and engaged and function at a high level when caring for patients. (Chassin, Tr. 5237). When nurses do not possess these important skills, it creates an environment in which they cannot alert physicians when adverse events are about to happen, such as when patients are starting to deteriorate. Put

simply, nurses have to have critical thinking skills to function as part of an effective care-giving team. (Chassin, Tr. 5237).

1362. Nurses were not well-trained at HPH before the Merger. There were nurses without CPR certification, there was no nurse orientation program, there was no nurse training for delivering care to high-risk patients and nurses were not cross-trained. (Krasner, Tr. 3703-05).

1363. According to documented evidence, physician leaders, quality improvement personnel and nursing leaders all commented that once the Merger occurred it became apparent that HPH nurses lacked the skills necessary to implement the collaborative treatment pathways that HPH was exposed to by ENH. (Chassin, Tr. 5236-37; RX 925 at ENHL PK 51687).

1364. Despite the critical need for adequate training, pre-Merger HPH's nurses lacked effective skills to handle modern aspects of patient care. There also was a lack of professionalism among the nurses in that HPH nurses did not have input into the plans for, and care given to, patients within the scope of their practice. (Chassin, Tr. 5232-33; RX 925 at ENHL PK 51688).

1365. Specifically, for Labor and Delivery at HPH to function properly, the nurses need to be able to care for the mother both in labor and in post-delivery. Cross-training allows nurses to be educated to deliver care both in labor and post-delivery. Pre-Merger, patient care was compromised because nurses were not cross-trained and HPH employed the LDRP model. (Krasner, Tr. 3704-05).

1366. There were several physician concerns regarding nurse training at HPH. (O'Brien, Tr. 3533). Physicians were concerned about nurse competency and skills in general. (O'Brien, Tr. 3533-34). Physicians did not feel that the nurses were acting as the eyes and ears for them when the physicians were away from the hospital. (O'Brien, Tr. 3534). Physicians also felt there was a lack of critical thinking and accountability among the nurses. (O'Brien, Tr. 3534).

1367. Physicians also were skeptical that pre-Merger HPH's nurses possessed the necessary clinical skills or competencies. Physicians stated that, as a result, nurses were unable to participate in ENH's collaborative pathway process that HPH was exposed to after the Merger. (Chassin, Tr. 5237; RX 925 at ENHL PK 51688).

(3) HPH Had Issues Concerning Nurse/Physician Relationships Before The Merger

1368. HPH had problems before the Merger with nurse/physician relationships. (Chassin, Tr. 5233).

1369. ACOG, which sets guidelines for care of Ob/Gyn patients, made a site visit to HPH before the Merger in September 1997 and published its findings concerning nurse/physician relationships, among other issues, in a report submitted to the hospital. (Krasner, Tr. 3732-74). This report, as well as other documents, identified problems with pre-Merger HPH nurse/physician relationships, as did interviews Dr. Chassin conducted with

physicians, nurses, and employees who practiced at HPH before and/or after the Merger. (Chassin, Tr. 5233, 5236).

1370. **(REDACTED)**

(RX 324 at ENHL PK 29710, *in camera*). According to Krasner, this was an understatement. (Krasner, Tr. 3738).

1371. **(REDACTED)**

(Krasner, Tr. 3738; RX 324 at ENHL PK 29710, *in camera*). **(REDACTED)**

(RX 324 at ENHL PK 29754, *in camera*).

1372. Drs. Alexander, Ankin, Harris and Rosengart as well as Krasner, Mayer and O'Brien all confirmed at trial that nurse/physician relationships were not good before the Merger and improved as a result of the Merger. (Chassin, Tr. 5233; O'Brien, Tr. 3533-34; Krasner, Tr. 3705-07; RX 1445 at ENHL PK 51621).

1373. The nursing culture at HPH was passive in that the nurses simply carried out physician orders instead of being partners in care. This passive behavior and lack of professionalism displayed by nurses at HPH before the Merger stemmed from a destructive culture and negative nurse/physician relationships. (Krasner, Tr. 3706-07).

1374. The punitive manner in which incidents were investigated by physicians and administration also damaged nurse/physician relationships. That punitive culture acted as a barrier to incident reporting. (Chassin, Tr. 5232-35; RX 925 at ENHL PK 51687).

1375. Typically, physicians did not listen to or rely upon nurses judgments before the Merger. Nurses had no recourse when confronting a physician who was providing care in an unsafe manner. (Krasner, Tr. 3708-10).

1376. Before the Merger, the nurses and physicians in the Family Birthing Center at HPH did not work together as a team. There were no collegial relationships and no mutual respect. Physicians verbally abused nurses and had no confidence in nurses' clinical skills to manage their patients. (Krasner, Tr. 3705-06).

1377. There were no processes developed to ensure access to dispute resolution and there were no mechanisms in place for disciplinary actions. (Krasner, Tr. 3740). The HPH Department Chairs were private practitioners who were not paid by HPH. (Krasner, Tr. 3728).

1378. Physicians placed their own convenience above patient safety before the Merger. (Krasner, Tr. 3706).

1379. Sometimes physicians' treatment of nurses at HPH was extreme. In 1998, there was a case where a nurse was being cross-trained to scrub in the labor and delivery operating room for a Cesarean section. The nurse being trained was not moving fast enough for an HPH

physician during the procedure and the physician threw the patient's placenta at the nurse. This type of behavior was typical at HPH before the Merger. (Krasner, Tr. 3713-14).

1380. Physicians' conduct towards labor and delivery nurses at HPH was not typical of other hospitals such as Evanston Hospital, Lake Forest Hospital or Rush University Medical Center. It was very different from those institutions and extremely dysfunctional. (Krasner, Tr. 3689-90, 3711-12). Yet, before the Merger, there was no significant effort made in the HPH Family Birthing Center to repair nurse/physician relationships. (Krasner, Tr. 3739-40).

1381. As a result, nurses in labor and delivery were very passive at HPH in the pre-Merger period. They did not have critical thinking skills and lacked professionalism. Nurses did not have enough confidence in their own skills to question a physician's judgment when they might know something was improper. All of this meant nurses were not advocating for their patients before the Merger. (Krasner, Tr. 3706-07).

1382. This destructive nursing culture at HPH hindered teamwork critical to the quality delivery of medicines to patients in the hospital. And patient care was affected by the dysfunctional nursing culture pre-Merger. Patients are put at risk whenever nurses do not think for themselves and do not act as a patient advocate. (Krasner, Tr. 3707-08).

1383. For example, before the Merger, the HPH pharmacy had a procedure under which certain medications were automatically stopped after a fixed period of days, and if nurses and physicians did not take immediate action, the medication no longer would be delivered. The passive and unprofessional culture for nurses and the lack of teamwork between nurses, physicians and pharmacists caused the stop order practice to lead to a number of adverse events during the pre-Merger period. These events were grave compromises of good medical care and included: (1) unrecognized, inappropriate stop orders for medications leading to morbidity and transfer to specialized care; (2) wrong IV administrations; (3) inconsistency in the security of narcotics in the hospital; and (4) multiple instances of administering one patient's medications to another patient. (Chassin, Tr. 5235-36; RX 925 at ENHL PK 15687-88).

1384. Krasner was not able to solve the nurse/physician relationship issues before the Merger. (Krasner, Tr. 3722). The issues could not be solved pre-Merger because there was not a culture – throughout the hospital, through administration, or through physician leadership – that promoted positive nurse/physician relationships. (Krasner, Tr. 3739). Solving the cultural issues at HPH with respect to nursing required a change of the hospital systems, administration and physician leadership; the support for cultural change had to be pervasive throughout the organization. (Krasner, Tr. 3739).

iii. ENH Improved HPH's Nursing Services And Culture After The Merger

1385. The quality of nursing has dramatically improved at HPH since the Merger. (Ankin, Tr. 5070).

1386. ENH completely transformed the nursing service at HPH. Nursing services improved through enhanced training, improvements in nurse/physician relationships, critical thinking and assessment skills, and improved safety. (Chassin, Tr. 5239-43). The nursing

service changed from one with a passive culture into a much more active, professional culture that learned to be full partners with physicians in providing multidisciplinary, effective care. (Chassin, Tr. 5239).

1387. The changes in nursing culture, however, took some time to develop. (O'Brien, Tr. 3536). There were some initial improvements in the first two years after the Merger. (O'Brien, Tr. 3537; RX 900 at ENH GW 528; RX 913; RX 915; RX 916). But the significant changes in the nursing culture at HPH were instituted in the period from 2002 to 2004. (O'Brien, Tr. 3536).

1388. For example, a 2003 memo to Mary O'Brien, President of HPH, regarding the state of inpatient nursing services at HPH details improvements in critical thinking and assessment skills, improved patient safety, reduced rates of patient misidentification and a series of other nursing improvements. (Chassin, Tr. 5242; RX 1445).

**(1) ENH Improved HPH's Nurse Recruiting,
Vacancy And Turnover Rates After The Merger**

1389. ENH immediately provided several nurse pay increases to address high turnover and vacancy rates at HPH. (Krasner, Tr. 3722; O'Brien, Tr. 3534; RX 822 at ENH GW 296). ENH made market adjustments for nurses at the time of the Merger, and again in October of 2000. (O'Brien, Tr. 3535).

1390. ENH instituted a merit-based pay system called Levels of Practice. (RX 900 at ENH GW 529). This merit-based performance system allowed nurses to receive increases in pay for a greater commitment to the hospital and to the unit in which they worked. For example, nurses were incented for precepting and teaching, obtaining certification and performing at a higher skill level. (Krasner, Tr. 3722).

1391. ENH also implemented a strategy to retain good nurses at HPH called a clinical ladder system. (O'Brien, Tr. 3536). The clinical ladder system elevates nurses with special certifications or skills to higher pay areas. (O'Brien, Tr. 3536).

1392. There was no centralized Nursing Resource team at HPH before the Merger. (Krasner, Tr. 3702, 3724). Accordingly, ENH developed a Nurse Resource Team to address staffing issues at HPH. The resource team was also on a merit-based pay system, and that system allowed the resource team to grow tremendously. Certain members of the HPH Nurse Resource Team staffs at all three hospitals in the ENH system. (Krasner, Tr. 3723-24).

1393. Today, HPH uses its extensive Nurse Resource Team and staffing office to minimize its reliance on agency nurses. The larger the resource team, the fewer agency nurses need to be used. Moreover, those nurses on the resource team are better qualified nurses to take care of patients at HPH. (Krasner, Tr. 3694).

1394. The ENH Nurse Staffing Office manages all the nursing resource teams throughout HPH. This office supplies and deploys nurses to all of the units throughout the hospital to assist managers in providing adequate staffing to care for patients. (Krasner, Tr. 3693-94).

1395. As a result of the changes in compensation, staffing and the Nurse Resource Team, the nursing staff in the HPH Birthing Center is more satisfied. This enables HPH to retain more easily and recruit nurses than before the Merger. (Krasner, Tr. 3724).

1396. **(REDACTED)**

(O'Brien, Tr. 3672, *in camera*). In addition, by February 2, 2001, the nurse vacancy rate at HPH dropped to 5.8%. (RX 1032 at ENH GW 471). **(REDACTED)**

(O'Brien, Tr. 3672, *in camera*).

(2) ENH Improved HPH's Nurse Training After The Merger

1397. ENH implemented widespread additional training for nurses across the entire HPH hospital, on regular floors and in the ICU and operating room, thus allowing the nurses to be more active and more effective clinical caregivers. (Chassin, Tr. 5239). Since the Merger, the nurses at Evanston Hospital/HPH have been under the same umbrella of nursing leadership and have been free to train throughout the system. (Rosengart, Tr. 4466).

1398. Before the Merger, nurses at HPH were very infrequently trained at Evanston Hospital. (Krasner, Tr. 3727).

1399. ENH also put in place a rotation system for HPH nurse managers to rotate through all three hospital campuses. (O'Brien, Tr. 3535). The rotation system helped the nurse managers gain critical skills. (O'Brien, Tr. 3535; RX 1445 at ENHL PK 51620).

1400. After the Merger, nurses at HPH had the ability to be trained for extended periods of time at Evanston Hospital. Extended training allowed HPH nurses to build their high-risk nursery skills in Evanston Hospital's high-risk nursery. By training for extended periods at Evanston Hospital, HPH nurses could receive very focused training, be exposed to a higher volume of deliveries, attend to more complex cases and see things they could not see at HPH. HPH nurses could not build these skills by training at the lower risk HPH Family Birthing Center. (Krasner, Tr. 3725-26).

1401. An example of the enhanced training opportunities brought about by the Merger occurred when ENH hired a new Clinical Coordinator for the HPH Family Birthing Center. After the Merger, the new Clinical Coordinator was able to receive focused training for several months at Evanston Hospital. Before the Merger, HPH might have been able to send the coordinator to Evanston Hospital's nursery for two or three days as part of the perinatal center agreement, but beyond that, an extended opportunity was not available. (Krasner, Tr. 3725-27).

1402. Nurses at all levels at HPH were trained to prepare for and begin the cardiac surgery program at HPH. (RX 822 at ENH GW 296). The addition of the cardiac surgery program at HPH added considerable value to each of the nurses in the ICU. (Ankin, Tr. 5065). For example, the increased abilities of HPH nurses gained from caring for critically ill heart patients also translated to care they provide to other patients in the ICU. (Rosengart, Tr. 4483-84).

1403. Specifically, nurses at HPH that participated in the cardiac surgery program were sent to Evanston Hospital for additional training on caring for open heart patients. (Ankin, Tr. 5064-65). In addition, all of the nurses in the HPH ICU completed an orientation to the cardiac surgery program. (RX 1445 at ENHL PK 51621).

1404. ENH provided the ICU team with two additional nurse educators, including an advanced practice nurse whose sole job is to educate the nurses on the proper use of ICU equipment. (Ankin, Tr. 5068). In addition, the intensivists have an active role in educating the nursing staff at HPH, both during patient rounds and during the intensivist's 12-hour shift. (Ankin, Tr. 5068; RX 1084 at ENHL MA 5). *See* Section VIII.D.2.c.

1405. The advanced practice nurses in the ICU at HPH provide education to other nurses daily on the proper use of medical equipment, medications and wound care. (Ankin, Tr. 5068-69). Advanced practice nurses are nurses with additional training to complete clinical assessments and writing orders. (Ankin, Tr. 5069). HPH did not have advanced practice nurses before the Merger. (Ankin, Tr. 5069). Since the Merger, ENH has added two advanced practice nurses to the HPH ICU. (Ankin, Tr. 5069-70).

1406. One of the advanced practice nurses in the HPH ICU is a clinical advanced practice nurse who is extremely well trained in critically ill patients who is present in the HPH for 40 hours each week. (Ankin, Tr. 5070). The clinical advanced practice nurse enables the intensivists to provide better care to all patients in the HPH ICU. (Ankin, Tr. 5070).

1407. As of 2003, ENH physicians praised ICU nurses and the quality of care they provided to cardiac surgery patients in the ICU. (Chassin, Tr. 5242; RX 1445 at ENHL PK 51621). Further, improved critical thinking and practice of nurses at HPH were noted by physicians in the State of Nursing Inpatient Department Report. (RX 1445). For example, Dr. Rosengart was cited stating that “[p]rior complaints about quality of care to CV surgery patients now resolved.” Dr. Rosengart went on to praise the nursing staff for “improved critical thinking and practice evidenced by quality assessment and resuscitation of patient on night shift.” (RX 1445 at ENHL PK 51621).

(3) ENH Improved HPH's Nurse/Physician Relationships After The Merger

1408. In contrast to the pre-Merger HPH nurse/physician relationships, the nurse/physician relationships at Evanston Hospital were very collaborative. (O'Brien, Tr. 3533). Nurses were confident in their skills and physicians were confident in the nurses' skills. (O'Brien, Tr. 3533). The nurse/physician relationships at pre-Merger HPH were more of an order giver/order taker relationship, and it was difficult for nurses and physicians to interrelate. (O'Brien, Tr. 3534; Spaeth, Tr. 2291).

1409. Vital to the improvements in nursing services at HPH was the improved nurse/physician relationships that were enhanced in terms of communication and teamwork. HPH would not have achieved a quality improvement in nursing unless nurses were able to work collaboratively as partners with physicians and teams in the ICU, surgery, cardiology, cardiac

surgery and other areas. There was a great improvement in teamwork after the Merger. (Chassin, Tr. 5239-40).

1410. ENH changed the culture at HPH by altering the leadership structures in the hospital. ENH installed full-time, paid department chairs who are responsible for managing physicians within their department and addressing nurse/physician relationships, among other issues. (Krasner, Tr. 3727).

1411. The Department Chairmen attend departmental meetings at HPH and are at HPH each week. Further, ENH installed Vice-Chairmen with offices at HPH. Vice-Chairs are also paid for their service in that position. (Krasner, Tr. 3730-31).

1412. ENH also made changes in nursing leadership at HPH after the Merger. (O'Brien, Tr. 3537; Neaman, Tr. 1354). For example, a new Vice President of Nursing was hired. (O'Brien, Tr. 3537).

1413. As a result of changes made by ENH, HPH nurses and physicians now have a collegial relationship. ENH addressed the nurse/physician relationships by putting in place an ethics committee where they worked together. (O'Brien, Tr. 3535). Nurses' opinions are respected by physicians and HPH, under ENH ownership, does not tolerate physician abuse of nurses. (Krasner Tr. 3727).

c. The Merger Substantially Improved HPH's Quality Assurance Program

i. Overview

1414. **(REDACTED)**
(Romano, Tr. 3449, *in camera*).

1415. Hospitals are responsible for operating quality assurance programs: (1) to identify and appropriately discipline poorly performing physicians, and (2) to carefully investigate adverse events and close calls to identify opportunities for improvement in hospital systems and policies for reducing the likelihood of those adverse events recurring. (Chassin, Tr. 5209-10).

1416. The pre-Merger quality assurance program at HPH was inadequate in both respects. (Chassin, Tr. 5210-11 RX 417 at ENHL PK 17695). It had a very weak structure within each of the clinical departments for performing effective peer review and identifying problem physicians, and it lacked an adequate process to discipline those physicians. (Chassin, Tr. 5210-11).

1417. Because of these structural issues, the Merger was necessary to make effective improvements to HPH's quality assurance program. (Chassin, Tr. 5389). After the Merger, ENH transformed the leadership structure at HPH, thus allowing ENH to export its superior quality assurance processes to HPH. (Chassin, Tr. 5389-90).

1424. There is no evidence that HPH took any formal disciplinary actions against HPH physicians before the Merger despite several clear examples of pre-Merger physician behavior at HPH that clearly merited such action. (Chassin, Tr. 5225-26).

1425. **(REDACTED)**

(Harris, Tr. 4420-23, *in camera*; RX 368 at ENH RS 7055, *in camera*). **(REDACTED)**

(Harris, Tr. 4420-21, *in camera*; RX 346 at ENHL PK 24708, *in camera*). **(REDACTED)**

(Harris, Tr. 4420, *in camera*). **(REDACTED)**

(Harris, Tr. 4420, *in camera*).

1426. **(REDACTED)**

(Harris, Tr. 4421, *in camera*).
(REDACTED) (Harris, Tr. 4421, *in camera*; RX 346 at ENHL PK 24709, *in camera*).

1427. **(REDACTED)**
(REDACTED)

(Harris, Tr. 4423, *in camera*).

(Harris, Tr. 4423, *in camera*). **(REDACTED)**
(Harris, Tr. 4423, *in camera*).

1428. This pattern of ineffective adverse event case reviews was widespread throughout HPH. (Chassin, Tr. 5223).

(1) **HPH's Pre-Merger Organizational Structure Hindered Quality Assurance Activities**

1429. Hospital governance plays a critical role in setting the tone for effective quality assurance. (Chassin, Tr. 5211). Effective peer review and quality assurance starts with the leadership at all levels. (Chassin, Tr. 5211). For peer review and quality assurance to work well, the Board of Trustees must have a role in hearing about, encouraging, and then enforcing discipline. (Chassin, Tr. 5211). The hospital's leadership, the administrative leadership and the nursing and physician leadership must play similar roles. (Chassin, Tr. 5211).

1430. Before the Merger, there was a lack of effective hospital and Board leadership at HPH that prevented physician leaders from being able to enforce and evaluate conduct by other physicians. (Chassin, Tr. 5389-90). There was a lack of overarching goals set from the top down. (RX 417 at ENHL PK 17696).

1431. Before the Merger, HPH had a hospital culture of keeping adverse event discussions away from the Board of Trustees. (Chassin, Tr. 5216-17). As a result, the Board rarely, if ever, was involved either in analyzing the adverse events or helping to solve them. (Chassin, Tr. 5212, 5216-17). The documentary evidence of HPH's Board of Trustee meetings

confirms an absence of sufficient discussion of quality assurance problems at the hospital Board level. (Chassin, Tr. 5212).

1432. Additionally, clinical department chairmen were the primary authority for evaluating and correcting physician discipline and quality assurance problems within their clinical spheres. (Chassin, Tr. 5217; Spaeth, Tr. 2253). All of the department chairmen were private practicing physicians. This arrangement placed department chairmen in the role of judging the behavior of physicians in their department with whom they worked or had a competing financial stake. (Chassin, Tr. 5218-19; Spaeth, Tr. 2252). This structure created conflicts that prevented the members of the quality assurance committee from effective peer review because, in part, they did not want to be responsible for someone losing their privileges and livelihood. (Chassin, Tr. 5219; RX 324 at ENHL PK 29713).

1433. The incentive to discipline fellow physicians was further reduced by the possibility that the disciplined physician might be elected as a department head the following year. (Spaeth, Tr. 2252). **(REDACTED)**

(Chassin, Tr. 5218-19; RX 324 at ENHL PK 29708, *in camera*).

(REDACTED)

(Chassin, Tr. 5218; RX 324 at ENHL PK 29708, *in camera*).

1434. A further problem at HPH before the Merger was that the physicians in leadership roles practiced at other hospitals, and HPH sometimes had trouble finding physicians to accept positions as department chairman. (Spaeth, Tr. 2251-52). For example, HPH's pre-Merger head of surgery, Dr. Sobinsky, practiced primarily at Lake Forest Hospital. (Spaeth, Tr. 2251).

(2) HPH's Pre-Merger Adverse Event Case Reviews Were Suboptimal

1435. Hospital quality assurance programs look carefully at adverse events, errors and close calls that do not result in adverse events to learn as much as possible about how the organization can prevent those unsafe situations or bad outcomes from recurring. (Chassin, Tr. 5219-20). HPH had no systematic method of quality assurance before the Merger, and there were several substantial barriers to clinical quality reform. (Chassin, Tr. 5220; RX 417 at ENHL PK 17695).

1436. Numerous records and contemporaneous documents dated before the Merger identify inappropriate practices and physician misbehavior that was not dealt with and further demonstrate that HPH's pre-Merger culture prevented physicians from taking effective disciplinary action. (Chassin, Tr. 5217-18; RX 417 at ENHL PK 17696-97).

1437. **(REDACTED)**

(RX 324 at ENHL PK 29754, *in camera*).

(REDACTED)

(Chassin, Tr. 5221-22; RX 2006 at 103; Harris, Tr. 4418, *in camera*; RX 365 at ENH RS 3454, *in camera*). **(REDACTED)**

(Harris, Tr. 4418-19, in camera). Because HPH was required to do an adverse event case review by the Joint Commission as a result of the 1998 esophageal obstruction case, it does not reveal very much about the strengths or weaknesses of HPH's pre-Merger quality assurance program. (Chassin, Tr. 5620-21).

1438. **(REDACTED)**

(Harris, Tr. 4421, *in camera*;
RX 365 at ENH RS 3454, *in camera*). **(REDACTED)**

(Harris, Tr. 4421, *in camera*).

1439. **(REDACTED)**

(Chassin, Tr. 5221; RX 324 at ENHL PK 29708, *in camera*; RX 208 at ENHL PK 17285). In fact, the ACOG report states that ACOG was called in to do the review because a member of the HPH board of trustees was upset by a 1997 newspaper publication regarding a malpractice verdict against HPH for an incident that occurred four years earlier. (Chassin, Tr. 5587). **(REDACTED)**

(Chassin, Tr. 5221; RX 324 at ENHL PK 29710, *in camera*).

1440. The fact that the 1998 ACOG site visit was voluntarily requested is not, by itself, a reflection of a good QA or QI process at HPH before the Merger. (Chassin, Tr. 5586-87, 5221).

(3) HPH's Ob/Gyn Department Was Particularly Poor At Disciplining Problem Physicians

1441. Before the Merger, the Department of Ob/Gyn at HPH was particularly weak in disciplining physicians who had demonstrated the kinds of repeated patterns of behavior that could really only be dealt with by discipline. (Chassin, Tr. 5206-07).

iii. ENH Improved HPH's Quality Assurance Program Soon After The Merger

1442. After the Merger, ENH completely changed the structure of physician oversight at HPH. (Chassin, Tr. 5224). ENH replaced the part-time and private practicing physician chairs with full-time clinical chairmen, and integrated the medical staffs in each department. (Chassin, Tr. 5224-25; Neaman, Tr. 1354; Spaeth, Tr. 2253-54). The clinical chairmen are responsible for the integrated departments and physicians at HPH. (Spaeth, Tr. 2253-54).

1443. The clinical chairmen are no longer elected. Rather, they are selected following a national search and employed by ENH. (Spaeth, Tr. 2252-53). As such, they are unencumbered

by the conflicts-of-interest facing the private practicing physician leaders at HPH before the Merger. (Chassin, Tr. 5391).

(1) The Merger Improved The Reporting Of Adverse Events At HPH

1444. Before the Merger, Evanston Hospital's organizational culture encouraged the reporting of hospital errors for learning purposes. (Chassin, Tr. 5227). That culture was exported to HPH after the Merger, and over time, resulted in a positive change at HPH in the reporting of errors. (Chassin, Tr. 5227-28).

1445. Contemporaneous documents from the quality assurance meetings at HPH show that HPH became more proactive in identifying and reporting errors after the Merger. (Chassin, Tr. 5228; RX 889 at ENHL PK 16485). As early as June 2000, the quality assurance committee meetings at HPH reflect HPH's new efforts to discuss and encourage the reporting of medical errors and close calls. (Chassin, Tr. 5229-30; RX 889 at ENHL PK 16485).

(2) ENH's Addition Of Strong Department Leadership At HPH Helped Correct Problems With Physician Discipline

1446. **(REDACTED)**

(Chassin, Tr. 5225; RX 2033, *in camera*; RX 2034, *in camera*). **(REDACTED)**
(RX 2034 at ENHL PL 1301, *in camera*).

1447. ENH's addition of department chairmen was an important step in improving the system of physician discipline at HPH, and it improved the quality in the Department of Ob/Gyn at HPH. (Chassin, Tr. 5204-05).

1448. Dr. Silver, the chairman of the Department of Ob/Gyn at HPH, fixed the weak disciplinary structure within the department. (Chassin, Tr. 5206-07).

1449. **(REDACTED)**

(Silver, Tr. 3880-89, 3896-3916, *in camera*).

1450. **(REDACTED)**

(Silver, Tr. 3880-82, *in camera*). **(REDACTED)**
(Silver, Tr. 3881, *in camera*). **(REDACTED)**

(Silver, Tr. 3882-83, *in camera*). **(REDACTED)**
(Silver, Tr. 3884, *in camera*)

1451. **(REDACTED)** (Silver, Tr. 3886, *in camera*). **(REDACTED)**

(Silver, Tr. 3886-87, *in camera*). **(REDACTED)**
(Silver, Tr. 3888-89, *in camera*).

1452. **(REDACTED)**
(Silver, Tr. 3906-07, *in camera*). **(REDACTED)**

(Silver, Tr. 3898, 3917, *in camera*; RX 2033, *in camera*; RX 2034, *in camera*). **(REDACTED)**
(Silver, Tr. 3913-14, *in camera*).

(Silver, Tr. 3900-01, *in camera*).

1453. **(REDACTED)**
(Silver, Tr. 3916, *in camera*). **(REDACTED)**

(Silver, Tr. 3901-02, *in camera*). **(REDACTED)**
(Silver, Tr. 3902, *in camera*).

1454. **(REDACTED)** (Silver, Tr. 3903-04, *in camera*;
RX 2033, *in camera*). **(REDACTED)**

(RX 2033, *in camera*). **(REDACTED)** (Silver,
Tr. 3907, *in camera*).

1455. **(REDACTED)** (Silver, Tr. 3908, *in camera*; RX 2034,
in camera.) **(REDACTED)**

(Silver, Tr. 3908-10, *in camera*; Jones, Tr.
4191, *in camera*). **(REDACTED)**

(Jones, Tr. 4191-92, *in camera*).

1456. (REDACTED)

(Jones, Tr. 4192, *in camera*).

(REDACTED)

(Jones, Tr. 4192, *in camera*). (REDACTED)

(Jones, Tr. 4192, *in camera*).

1457. (REDACTED)

(Silver, Tr. 3926, *in camera*).

(3) ENH Improved The Process Of Reviewing HPH Physician Credentialing Status

1458. After the Merger, ENH introduced a periodic re-credentialing process in which HPH physicians underwent a review of their practices under which they were required to meet the credentialing requirements that have been established to maintain clinical privileges by the appropriate department chairman. (Chassin, Tr. 5226; Neaman, Tr. 1354; RX 651 at ENH MN 1536). After the Merger, several physicians at HPH were not granted re-appointment during the periodic re-credentialing process because of their failures to respond while on call. (Chassin, Tr. 5227).

1459. (REDACTED)

(Chassin, Tr. 5227; RX 324 at ENHL PK 29709, *in camera*; RX 346 at ENHL PK 24708, *in camera*).

d. The Merger Improved HPH's Quality Improvement Program

1460. Quality improvement ("QI") is directed toward improving the quality of service across a wide variety of measures. (Chassin, Tr. 5252). Hospitals must have QI programs that are directed proactively using data-driven methods to improve their services over time. (Chassin, Tr. 5252).

1461. To be effective, a QI program has to involve multidisciplinary approaches, which requires input from all different clinical perspectives – including physicians, nurses, pharmacists and all of the other perspectives of care. (Chassin, Tr. 5252). The QI program must also be data-driven, which requires the identification of specific measures that are valid and focus on improving those measures. (Chassin, Tr. 5252). Further, the QI program must be proactive, identifying the best opportunities for improvement across the services that the hospital offers. (Chassin, Tr. 5252-53).

1462. In the months immediately following the Merger, ENH made major improvements in HPH's QI program by exporting its QI program to HPH. (Chassin, Tr. 5257). (REDACTED)

(Romano, Tr. 3451-52, *in camera*).

1463. These QI program improvements dramatically improved the quality of patient care at HPH. (Chassin, Tr. 5257-58; Ankin, Tr. 5055).

i. HPH's Pre-Merger QI Program Was Inadequate

1464. HPH's pre-Merger QI program suffered from several weaknesses: (1) it included several indicators that were not valid quality measures and did not use data from sources outside HPH to determine where its performance was on the scale of good, bad, or indifferent; (2) there was a lack of benchmarking and use of best demonstrated practices; (3) HPH used a care map process that was very simplistic and deficient as a means of improving care; and (4) HPH's approach to improvement was extremely limited in that it did not use evidence from adverse event investigations, or a multidisciplinary process, and had very few indicators. (Chassin, Tr. 5253-54; RX 417 at ENHL PK 17694).

1465. (REDACTED)

(Chassin, Tr. 5254-55; RX 216 at ENHL PK 36980, *in camera*).

1466. HPH also had an extremely limited process for attempting to proactively improve quality of care pre-Merger. This process failed to identify the places where care needed to be improved. (Chassin, Tr. 5255; RX 417 at ENHL PK 17695). In addition, there was evidence of wide variations in applying practice standards in the treatment of certain diseases, resulting in variation in patient outcomes at HPH before the Merger. (RX 417 at ENHL PK 17695).

1467. (REDACTED)

(Chassin, Tr. 5255; RX 216, *in camera*). HPH's pre-Merger care maps lacked valid process measures of quality, such as which medications and treatment procedures should be used, and did not result from a multidisciplinary process that included physicians and nurses developing a best approach to patient care. (Chassin, Tr. 5255-56).

1468. Even though HPH recognized some of the limitations in its QI efforts toward the end of the pre-Merger period, there is no evidence that HPH actually improved its QI process before the Merger. (Chassin, Tr. 5256; RX 417 at ENHL PK 17695).

ii. ENH Exported Its Superior Quality Improvement Processes To HPH Soon After The Merger

1469. At the time of the Merger, a team of people from the QI departments at Evanston Hospital and HPH conducted an assessment of the QI activities at HPH. (O'Brien, Tr. 3526). The team determined that there was some effort at HPH to use best practices and to make investigations of some adverse events. (O'Brien, Tr. 3526). However, the Evanston Hospital best practices were more comprehensive and contained an established set of criteria for determining when an investigation should take place after a near miss or an adverse event. (O'Brien, Tr. 3526-27).

1470. After the Merger, ENH rapidly exported its quality assurance and QI systems to HPH by involving a large cohort of physicians in quality improvement committees and activities.

(Chassin, Tr. 5375; O'Brien, Tr. 3524). The first committee was the Professional Staff Quality Improvement Committee, which is physician-led and hears reports from physician leaders related to critical pathways or other outcomes. (O'Brien, Tr. 3525). Critical pathways are best practice techniques designed to improve the efficiency of care and minimize omission and the cost of services. (Ankin, Tr. 5054-55).

1471. The second committee was the Subcommittee on Quality Improvement of the Board of Directors, which is responsible for setting the priorities for quality initiatives for a particular year. (O'Brien, Tr. 3524-25).

1472. Physicians at HPH were invited to participate on both committees at the invitation of the chairman of the department. (O'Brien, Tr. 3525). Through this participation, HPH physicians began to set some of the priorities for quality improvement for all of ENH. (O'Brien, Tr. 3525).

1473. Through their involvement in the development of critical pathways and review of literature to determine up-to-date treatment plans, the physicians upgraded their skills. (Chassin, Tr. 5375). These upgraded skills resulted in improved quality for patients because physician training is a structural issue that improved processes used to take care of patients. (Chassin, Tr. 5375).

1474. After the Merger, the nurses in ENH's QI Department also collected data and communicated with physicians at HPH so that the physicians could make decisions about changing practices. (O'Brien, Tr. 3527).

1475. (REDACTED)

(Chassin, Tr. 5257; RX 869; RX 1776; RX 348 at 2, *in camera*). Further, ENH's critical pathways contain numerous process measures of quality designed to improve patient outcomes, and they employ many best practices from other sources to generate a proactive approach to quality improvement. (Chassin, Tr. 5257). (REDACTED)

(Chassin, Tr. 5258; RX 1326 at ENHE JG 15730, *in camera*).

1476. One of the priorities of the Subcommittee on Quality Improvement of the Board of Directors at ENH in the year 2000 was to align HPH care maps with ENH's clinical pathways, with input from physicians at all three ENH hospitals. (O'Brien, Tr. 3528; RX 869). An example of such alignment can be seen in the area of acute myocardial infarction. (O'Brien, Tr. 3528).

1477. In 2000, Evanston Hospital had 57 multidisciplinary critical pathways, and it formulated a very detailed plan for rolling those out in such a way that would teach HPH its multidisciplinary model of QI. (Chassin, Tr. 5257-58; RX 869; RX 1775; RX 1776; RX 1683). The action plan set forth a strategy for identifying interdisciplinary team members, educating staff and establishing a support system for implementation. (RX 1776).

1478. ENH implemented the first critical pathways at HPH as early as March 2000. (RX 889 at ENHL PK 16483). Between January 2000 and October 2001, ENH implemented 15

new pathways. (RX 1357 at ENHE F42 21020-21). By August 2002, ENH had introduced a total of 33 new critical pathways to HPH. (RX 1357 at ENHE F42 21020-21).

1479. The intensivists at HPH also implemented critical care pathways at HPH post-Merger. (Ankin, Tr. 5054-55; RX 1084 at ENHL MA 5). Before the Merger, HPH had three pathways used in intensive care. (Ankin, Tr. 5055). Since the Merger, the development of pathways has been greatly increased, and it is easier for the intensivist team to develop new pathways. (Ankin, Tr. 5055).

1480. The new critical pathway guidelines implemented by ENH after the Merger contain information that was lacking in the HPH care maps, including a variance-tracking tool, a physician ordering sheet, a documentation tool and an educational piece with options delineated for physicians. (RX 869).

iii. Data From HPH's Pre-Merger Care Maps Cannot Be Used To Assess Quality Improvements At HPH Post-Merger

1481. It is not possible to learn anything about changes in quality of care at HPH after the Merger by comparing the pre-Merger data available through HPH's care maps with the available data from critical pathways at Evanston Hospital because length of stay and cost per case are not particularly related to quality of care. (Chassin, Tr. 5258-59). For example, data related to the pathway integration project – which reported number of cases, average length of stay, variable cost per case, case mix index and age across procedures and conditions – would not be useful in drawing any conclusions about changes in quality of care at HPH before and after the Merger. (Chassin, Tr. 5259-63).

iv. Improvements In The Care Of Heart Attack Patients At HPH Demonstrates The Improvement In HPH's QI Program Post-Merger

1482. Dr. Chassin reviewed data from the treatment of acute myocardial infarction to determine whether Evanston Hospital had a better QI program pre-Merger, whether it was successfully able to export that to HPH at the time of the Merger, and whether improvements in performance at HPH reflected those changes in a positive way. (Chassin, Tr. 5263).

(REDACTED)

(Chassin, Tr. 5263-64; RX 2043; RX 1985, *in camera*).

1483. Dr. Chassin looked at NRMI data for beta blockers and aspirin both pre- and post-Merger at ENH, HPH and Illinois hospitals. (Chassin, Tr. 5595-96). Dr. Chassin selected data from the State of Illinois because it was the only data available on the NRMI clinical process measures. (Chassin, Tr. 5279). This data existed because Medicare did a study of every state in the nation looking at medical records of Medicare patients to extract this very complicated clinical data set, which is comparable to the NRMI measures on process that was available for Evanston and HPH. (Chassin, Tr. 5279).

1484. The strengths of the NRMI data were that this data set was continuously available to both hospitals, both hospitals subscribed to it from at least 1997 through 2003 and, thus, both

hospitals submitted clinical data from the records of their patients as they were being treated on processes of care. (Chassin, Tr. 5264). In addition, the NRMI data contain four highly valid process measures of care, the validity of which was entirely consistent over the pre- and post-Merger time period. (Chassin, Tr. 5264). **(REDACTED)**

(Chassin, Tr. 5265; RX 2043; RX 1985, *in camera*).

1485. Aspirin and beta blockers are some of the most effective medications in the treatment of heart attacks. (Chassin, Tr. 5267-68). If used within the first 24 hours of arrival and through the hospitalization, they have an effect on immediate survival and function. (Chassin, Tr. 5268). Additionally, if these medications are continued after discharge, the effect is even greater on reducing mortality six months, a year, and two years later. (Chassin, Tr. 5268). **(REDACTED)**

(Romano, Tr. 3082, *in camera*).

1486. The administration of aspirin and beta blockers to heart attack patients are critical process measures of the effectiveness of treating heart attack patients. (Chassin, Tr. 5268). For example, aspirin or beta blockers on discharge from the hospital are measures of the long-term treatment of patients with acute myocardial infarction. (Chassin, Tr. 5270). Hospitals that have high rates of performance on such measures have better survival rates for their patients. (Chassin, Tr. 5271).

1487. One of the first critical pathways that ENH exported to HPH after the Merger was the myocardial infarction critical pathway, which emphasized improving performance on aspirin and beta blockers. (Chassin, Tr. 5266-67; RX 869; RX 1775).

1488. The NRMI data thus was an ideal way to test the relative effectiveness of Evanston Hospital's and HPH's QI programs. (Chassin, Tr. 5264).

(1) ENH Improved The Provision Of Aspirin To Heart Attack Patients At HPH

1489. **(REDACTED)**

(Romano, Tr. 3080, *in camera*).

1490. **(REDACTED)**

(Chassin, Tr. 5281-82; RX 2043; RX 1985, *in camera*).

1491. "Aspirin on arrival" refers to administering aspirin to patients within the first 24 hours of arrival to the hospital with a heart attack. (Chassin, Tr. 5267).

1492. **(REDACTED)**

(Chassin, Tr. 5265; RX 2043; RX 1985, *in camera*). **(REDACTED)**

(Chassin, Tr. 5265; RX 2043; RX 1985, *in camera*; Romano, Tr. 3081, *in camera*).

1493. (REDACTED)

(Romano, Tr. 3081, *in camera*).

(REDACTED)

(RX 2043; RX 1985, *in camera*).

1494. (REDACTED)

(Chassin, Tr. 5267; RX 2043; RX 1985, *in camera*). (REDACTED)

(RX 2043; RX 1985, *in*

camera). (REDACTED)

(RX 2043; RX 1985, *in*

camera).

1495. HPH's change in performance for aspirin on arrival was statistically significant at a P value less than 0.0001 level. (Chassin, Tr. 5279). This means that if the pre- and post-Merger measures of HPH's performance are equal, the chance of observing this big a difference due to chance, rather than the Merger, would be less than one in 10,000. (Chassin, Tr. 5279-80 (*discussing DX 8079*)).

1496. (REDACTED)

(Chassin, Tr. 5270;

RX 2043; RX 1985, *in camera*). (REDACTED)

(Chassin, Tr. 5282; RX 2043; RX 1985, *in camera*).

1497. (REDACTED)

(Romano, Tr.

3085, *in camera*). (REDACTED)

(Chassin, Tr. 5271; RX 2043; RX 1985, *in camera*).

(REDACTED)

(Chassin, Tr. 5271; RX 2043; RX

1985, *in camera*).

1498. (REDACTED)

(Chassin, Tr. 5282; RX 2043; RX 1985, *in camera*).

(2) **HPH Improved The Provision Of Beta Blockers To Heart Attack Patients After The Merger**

1499. (REDACTED)

(Chassin, Tr. 5282-83; RX 2043; RX 1985, *in camera*).

1500. (REDACTED)

(Chassin, Tr. 5269; RX 2043; RX 1985, *in camera*).

(REDACTED)

(Chassin, Tr. 5280-81; RX 2043; RX 1985, *in camera*).

1501. **(REDACTED)**

(Chassin, Tr. 5269; RX 2043; RX 1985, *in camera*).

(REDACTED)

(Chasen, Tr. 5281 RX 2043;

RX 1985, *in camera*).

1502. **(REDACTED)**

(Chassin, Tr. 5272; RX 2043; RX 1985, *in camera*). **(REDACTED)**

Chassin, Tr. 5272; RX 2043; RX 1985, *in camera*).

1503. **(REDACTED)**

(Chassin, Tr. 5282-53; RX 2043; RX 1985, *in camera*).

1504. **(REDACTED)**

(Chassin, Tr. 5272; RX 2043; RX 1985, *in camera*). **(REDACTED)**

(Chassin, Tr. 5272, 5282-83; RX

2043; RX 1985, *in camera*).

(3) The Minor Change In Performance On The NRMI Measures Are Based On An Extremely Small Sample

1505. In the year 2000 NRMI data, there was a slight dip in the performance of Evanston Hospital. Dr. Chassin attributed this dip in performance to a major revision in the NRMI data set between NRMI-III and NRMI-IV. (Chassin, Tr. 5273-74). For example, there were only 26 cases reported from Evanston Hospital in the NRMI data in year 2000 when there should have been 150 based upon the volume of heart attack cases in the years just before and after 2000. (Chassin, Tr. 5275). **(REDACTED)**

(RX 2043; RX 1985; *in camera*).

1506. Dr. Chassin found that the slight dip in NRMI data at Evanston Hospital in 2000 was not the result of any diversion of resources from Evanston to HPH around the time of the Merger. (Chassin, Tr. 5275). Further, Dr. Chassin found no evidence to support Dr. Romano's hypothesis that quality at Evanston declined because resources were purportedly diverted from Evanston Hospital to HPH. Nor did Dr. Romano cite any such evidence in support of this hypothesis. (Chassin, Tr. 5276).

1507. In 2001 and 2003, HPH was virtually identical to the like hospitals, meaning that under an accepted standard used to measure door-to-dilation time of 120 minutes, there were

differences of only two to five minutes. These differences are not clinically significant. (Chassin, Tr. 5592-93). The 120-minute standard comes from the Joint Commission, Medicare and a variety of other organizations. (Chassin, Tr. 5593).

1508. Overall, assuming Dr. Romano's data are correct, HPH was within the acceptable time frames for door-to-dilation time in 2001 and 2003, and in 2002, HPH was only slightly over that based on just 16 cases. (Chassin, Tr. 5593-94). However, because the sample size for 2002 is so low – 16 total patients – it is very difficult to draw any generalized conclusions about that quality measure for that particular year. (Chassin, Tr. 5595).

(4) The Merger Resulted In A Dramatic Improvement In The Care Of Heart Attack Patients At HPH

1509. **(REDACTED)**

(Chassin,
Tr. 5277-78, 5281-83; RX 2043; RX 1985; *in camera*).

1510. Thus, ENH's exportation to HPH of a much more effective QI program after the Merger produced very rapid and very substantial quality improvements at HPH in highly valid process measures of care (e.g., aspirin and beta blockers). (Chassin, Tr. 5283-84).

1511. The trends in the NRM data for HPH and Evanston Hospital with respect to administration of aspirin and beta blockers, both on admission and on discharge, are significant because they allow one to determine the effect of the Merger. (Chassin, Tr. 5273). **(REDACTED)**

(Chassin, Tr. 5273; RX 2043; RX 1985, *in camera*).

e. ENH Corrected Serious Deficiencies In HPH's Physical Plant

i. Overview

1512. Before the Merger, HPH had significant deficiencies in its physical plant that limited HPH's capacity to render adequate care and ensure the health and safety of its patients. (Chassin, Tr. 5285-86; RX 545 at ENH JH 11578).

1513. These deficiencies, which required substantial investment to remedy, were sufficiently serious that HPH nearly lost its Medicare accreditation as a result. (RX 545 at ENH JH 11578; RX 1379 at ENH JH 11544; RX 1380 at ENH JH 11480).

1514. Additionally, pre-Merger due diligence determined that the physical facilities at HPH needed immediate, and numerous, life safety and code compliance improvements that would require a \$14-19 million investment. (RX 635 at ENH JH 4002; Neaman, Tr. 1336). These physical plant deficiencies were far more serious than those that nearly cost HPH its Medicare accreditation in that they increased the risk of adverse events at HPH. (Chassin, Tr. 5285-86, 5590).

1515. Shortly after the Merger, ENH addressed all 144 of the life safety and code compliance issues with the HPH physical plant, as well as items that could present such problems if not addressed. (Chassin, Tr. 5287-88; RX 1379 at ENH JH 11544-45).

1516. In addition to correcting the problems with HPH's physical plant, ENH also made changes to the plant that constituted improvements in quality of care. (Chassin, Tr. 5288; RX 1377 at ENH JH 11478). These improvements included building a new ambulatory care center ("ACC") that housed modern radiation equipment, a new cardiac catheterization lab to support the interventional cardiology program, renovating and expanding the ED and psychiatry units, expanding the radiology department and adding modern equipment to a variety of areas. (Chassin, Tr. 5288-89; RX 1377 at ENH JH 11478). These additions were substantial improvements to the structure of care that increased HPH's ability to deliver high quality care, thereby increasing the likelihood of desired outcomes. (Chassin, Tr. 5289).

1517. As of February 2005, ENH had completed most of the capital improvements at HPH that it started after the Merger. (Hillebrand, Tr. 1982). It is continuing to remodel HPH's radiation department and HPH's medical/surgical units, and it started construction of a new ICU. (Hillebrand, Tr. 1982). In addition to new construction of patient care areas within the hospital, ENH spent approximately \$27 million in capital improvements to the HPH campus, including a new parking structure and power plant. (O'Brien, Tr. 3514-15).

1518. Overall, ENH spent \$120 million on capital improvements at HPH. (Hillebrand, Tr. 1977; Neaman, Tr. 1250). Moreover, ENH has committed to spend an additional \$45 million at HPH in the future. (Hillebrand, Tr. 1977)

ii. Before The Merger, HPH Passed The Joint Commission's Accreditation Inspections, Which Are Not A Comprehensive Assessment Of Hospital Quality, Because It Had Advance Notice Of The Inspections

1519. Joint Commission accreditation is a necessary requirement for getting Medicare payments. (Neaman, Tr. 1367; Spaeth, Tr. 2154; RX 545 at ENH JH 11578). Joint Commission accreditation is a minimum standard. (Holt-Darcy, Tr. 1421). Additionally, some MCOs have followed the government and require Joint Commission accreditation before doing business with a provider. (Neaman, Tr. 1367; Spaeth, Tr. 2154).

1520. The primary reason for the Joint Commission inspections was to ensure that hospitals were maintaining minimum standards for hospital accreditation. (Styer, Tr. 5024-25, 5030).

1521. The vast majority of hospitals in the United States receive Joint Commission accreditation. (Newton, Tr. 460-61). Further, it is common for hospitals to receive Joint Commission scores around 95. (Spaeth, Tr. 2122). For example, in April 1999, the HPH Board knew that Chicago hospitals in general received Joint Commission scores in the mid-90s. (Spaeth, Tr. 2148-49).

1522. In 1999, Joint Commission announced to hospitals in advance that it would be surveying the hospital. (Newton, Tr. 461). It was fairly easy to hire a consultant to put the

paperwork together to pass inspection. (Chassin, Tr. 5588). Accordingly, HPH's pre-Merger Joint Commission scores were not necessarily a reflection of the hospital's quality. (RX 462 at ENH RS 5482).

1523. The Joint Commission conducted an inspection of HPH in early 1999, before the April 1999 visit by the IDPH, which was performing a look behind survey following the Joint Commission's visit. (RX 1379 at ENH JH 11544; RX 545 at ENH JH 11578).

1524. Before the Merger, HPH had advance notice of when Joint Commission would conduct a site visit. (Newton, Tr. 461). In the six weeks before Joint Commission inspections, HPH "turned itself upside down" to make sure it would meet the Joint Commission's standards. (Styer, Tr. 5030).

1525. Over the last three to four years, Joint Commission has dramatically changed its standards. (Spaeth, Tr. 2256-57). As of February 2005, Joint Commission looks more specifically at the quality of care provided at hospitals. (Spaeth, Tr. 2256-57). In the last two years, Joint Commission completely revised its survey and accreditation process to include unscheduled hospital visits. (Chassin, Tr. 5589; Newton, Tr. 461). At the time HPH received a score of 96 before the Merger, however, the Joint Commission was still conducting scheduled visits. (Chassin, Tr. 5589).

iii. A 1999 IDPH Survey Uncovered Numerous Physical Plant Deficiencies At HPH That Were Not Identified By The 1999 Joint Commission Accreditation Survey

1526. In April 1999, the Illinois Department of Public Health ("IDPH"), on behalf of HCFA, conducted a "look back" survey at HPH to inspect HPH's facilities and record any deficiencies after the early 1999 Joint Commission inspection. (Hillebrand, Tr. 1773-74; Newton, Tr. 461-62; RX 528 at ENH RS 5508; RX 525). The survey team consisted of registered nurses, dieticians, sanitarians and architects who spent three days checking a variety of areas. (RX 528 at ENH RS 5508).

1527. The IDPH inspection found 144 deficiencies that were not identified during the Joint Commission inspection in early 1999. (RX 1379 at ENH JH 11544; RX 545 at ENH JH 11578).

1528. The IDPH inspectors focused on life and fire safety deficiencies. (Hillebrand, Tr. 1774). Accordingly, the deficiencies they discovered included items such as insufficient fire resistance and lack of sprinklers. (RX 523 at ENH JH 11552-53).

1529. The IDPH inspectors did not examine or assess the HPH medical staff, patient outcomes, the quality of the medical procedures, or the medical equipment. (Hillebrand, Tr. 1775).

iv. Before The Merger, HPH Nearly Lost Its Medicare Accreditation Due To Serious Physical Plant Deficiencies That Threatened Patient Safety

1530. A hospital must be accredited to be eligible for Medicare payments. (RX 545 at ENH JH 11578). The Joint Commission accreditation survey is one way to be deemed to have meet Medicare's conditions. (RX 545 at ENH JH 11578). That survey, however, may be validated by state agencies such as the IDPH, as happened in 1999 with respect to HPH. (RX 545 at ENH JH 11578).

1531. On July 14, 1999, Peter Friend, HPH's COO, received a letter from the Department of Health and Human Services ("HHS letter") informing HPH of numerous problems with its physical plant. (RX 545 at ENH JH 11578; Spaeth, Tr. 2257-58). The HHS letter stated that HHS had "determined that the deficiencies [at HPH] are significant and limit your hospital's capacity to render adequate care and ensure the health and safety of your patients." (RX 545 at ENH JH 11578; Chassin, Tr. 5285-86). The structural problems identified were based upon the April 1999 IDPH review. (RX 545 at ENH JH 11578).

1532. The HHS letter threatened to pull HPH's Medicare accreditation, stating "based on the determination that your hospital does not comply with the above Condition and that significant deficiencies exist, your hospital is no longer deemed to meet the Medicare Conditions of Participation. In addition, we must terminate your Medicare agreement. The date on which your agreement terminates is July 15, 1999." (RX 545 at ENH JH 11579).

1533. If HPH had lost its Medicare accreditation, it would have lost close to 50% of its revenue. (Spaeth, Tr. 2258).

1534. **(REDACTED)** (Spaeth, Tr. 2258-59; Newton, Tr. 464; RX 658 at ENH RS 7481, *in camera*).

1535. ENH ultimately corrected HPH's physical plant deficiencies identified by IDPH after the Merger. (Hillebrand, Tr. 1771). Both ENH and HPH spent roughly \$1 million to correct HPH's Medicare deficiencies. (Hillebrand, Tr. 1771).

v. Pre-Merger Due Diligence Performed By ENH Identified Even More Serious Physical Plant Deficiencies

1536. In 1999, Hillebrand asked an architect to lead the pre-Merger due diligence review of HPH's facilities. (Hillebrand, Tr. 1906). The architect was assisted by a group of contractors, mechanical and electrical engineers, and others. (Hillebrand, Tr. 1906).

1537. The architects determined that HPH's facility problems were "high risk." (RX 635 at ENH JH 4002; Hillebrand, Tr. 1906-07). These problems included problems with the ventilation system, maintaining pressures in the isolation rooms, problems with the air handling system, maintenance of emergency power, and asbestos issues – problems that were far more serious than those identified by HHS. (Chassin, Tr. 5285-86).

1538. The architects further noted that facilities consultants used by HPH the year before were in the process of making a number of the same recommendations “that were not disclosed to ENH until recently.” (RX 635 at ENH JH 4002; Hillebrand, Tr. 1906-07).

1539. On October 7, 1999, the architect issued a Final Due Diligence Report listing a series of “critical facility upgrades” and the cost of those upgrades. (RX 635 at ENH JH 4012-13). “Critical facility upgrades” referred to items identified by the architects as necessary for code compliance or the reliable operation of the facility. (Chassin, Tr. 5286; RX 635 at ENH JH 4002). Items on the critical upgrade list were a direct threat to patient safety. (Chassin, Tr. 5287).

1540. The architect estimated the cost of the critical upgrades to be \$9.77 million. (Chassin, Tr. 5287; RX 635 at ENH JH 4013). The critical facility upgrades included \$1.5 million for “asbestos abatement,” \$600,000 for “added boiler capacity,” \$1.8 million for “Emergency Power System Upgrades” and \$1 million for “electrical issues.” (RX 635 at ENH JH 4012-13).

1541. The Final Due Diligence Report identified a second category of deficiencies called priority upgrades. (Chassin, Tr. 5287). Priority upgrades were items that could or would affect operations and could become code issues if they were not addressed. (Chassin, Tr. 5287). The architect estimated the cost of the priority upgrades to be \$5 million. (Chassin, Tr. 5287; RX 635 at ENH JH 4016).

1542. Before the Merger, HPH failed to encapsulate asbestos insulation around pipes and in ductwork. This resulted in the air conditioning system blowing asbestos into labor and delivery suites at the hospital. (Hillebrand, Tr. 1908).

1543. At the time of the Merger, HPH had only one boiler because the backup boiler had previously failed. (Hillebrand, Tr. 1908-09). Consequently, if that boiler had, HPH would have been without heat and hot water. (Hillebrand, Tr. 1908-09).

1544. Before the Merger, HPH’s facilities revealed that HPH’s emergency power system was inadequate due to problems with the distribution system and the size of the generator. (Hillebrand, Tr. 1909). If forced to switch to emergency power, HPH risked losing all power. (Hillebrand, Tr. 1909).

1545. HPH’s ED also did not have an adequate supply of emergency power for the most critically ill patients, and HPH did not properly designate emergency power outlets in critical areas such as the ICU. (Hillebrand, Tr. 1909-10).

1546. Other facility problems at HPH before the Merger included a lack of isolation rooms on the patient units, patient rooms that lacked bathrooms and cardiac monitors, showers that lacked hot water and even problems with cafeteria tray lines. (Spaeth, Tr. 2287; O’Brien, Tr. 3511).

1547. Before the Merger, HPH had inadequate parking for patients, visitors and physicians. (Hillebrand, Tr. 1978-79; O’Brien, Tr. 3513). Patients parked on community streets

instead of hospital lots. (O'Brien, Tr. 3513). Given the size of the existing lot, the only solution was to build a new parking structure. (Hillebrand, Tr. 1978-79; O'Brien, Tr. 3513-14).

1548. HPH's facilities problems were not resolved before the Merger. (Neaman, Tr. 1259; RX 1380 at ENH JH 11480). The Final Due Diligence Report recommended that ENH "aggressively remedy critical facility needs." (RX 635 at ENH JH 4002; Neaman, Tr. 1333).

vi. ENH Remedied The Substantial Deficiencies To HPH's Physical Plant And Made Additional Capital Improvements That Enhanced The Quality Of Care At HPH

1549. It was important for ENH to resolve HPH's physical plant deficiencies to protect the welfare of patients at HPH and also to protect the reputation of HPH. (Neaman, Tr. 1337). ENH made significant capital improvements to the HPH campus after the Merger. (Hillebrand, Tr. 1976). These improvements were overseen by Hillebrand. (Hillebrand, Tr. 1976).

1550. After the Merger, ENH replaced the HPH patient care buildings' entire electrical distribution and ventilation systems, plumbing and waste pipes. (Hillebrand, Tr. 1982).

1551. ENH also built a completely new central plant at HPH, including a new power plant that houses utilities such as electrical generators, backup generators, boilers and air ventilation equipment. (Hillebrand, Tr. 1979; O'Brien, Tr. 3514-15; CX 6304 at 14-15 (Livingston, Dep.)).

1552. One of ENH's principles has always been to have redundant critical life safety systems. (Hillebrand, Tr. 1979-80). Accordingly, after the Merger, ENH added two boilers instead of one, put in new air handlers for the ventilation system, replaced the emergency electrical generator and added a second emergency electrical generator. (Hillebrand, Tr. 1979). Consistent with its principle of having redundant critical life safety systems, after the Merger, ENH also installed at HPH two sources of water, two sources of electricity and two sources of natural gas. (Hillebrand, Tr. 1980).

1553. In December 2003, HPH began remodeling all of its patient units. (O'Brien, Tr. 3511). Patient rooms in the first unit were gutted, and showers were installed in each room. (O'Brien, Tr. 3512; Neaman, Tr. 1351-52). Each patient room now has a cardiac monitoring unit. (O'Brien, Tr. 3512; Neaman, Tr. 1351-52). ENH also installed a central cardiac monitoring unit in the nursing station. (O'Brien, Tr. 3512; Neaman, Tr. 1351-52). The total cost of remodeling the rooms in the first unit was \$5.6 million. (O'Brien, Tr. 3513).

1554. Additionally, ENH added isolation rooms to the new unit, including a positive and negative air flow room, which are used for the treatment of infectious or immunosuppressed patients. (O'Brien, Tr. 3512-13).

1555. ENH currently is in the process of remodeling patient rooms in the second unit. (O'Brien, Tr. 3513).

1556. **(REDACTED)**

(Hillebrand, Tr. 1920-21, *in camera*). ENH also remodeled the registration areas to make it more private in satisfaction of the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”) regulations. (O’Brien, Tr. 3515). **(REDACTED)**

(O’Brien, Tr. 3515; Hillebrand, Tr. 1920-21, *in camera*).

1557. Immediately after the Merger, ENH added complimentary valet parking at HPH. (O’Brien, Tr. 3514). ENH also added a new four-floor garage and remodeled the remaining parking around HPH. (O’Brien, Tr. 3513-14; CX 6304 at 14 (Livingston, Dep.)).

(1) ENH Opened A New Open Heart Surgery Suite At HPH

1558. In April of 2000, ENH opened a new open heart surgery suite at HPH. (O’Brien, Tr. 3504). Coronary artery bypass grafts (“CABG”) and open heart surgery are performed in the suite. (O’Brien, Tr. 3504-05). The cost of the open heart surgery suite was \$1.3 million. (O’Brien, Tr. 3505).

(2) ENH Opened A New Ambulatory Care Center At HPH

1559. ENH began construction of the ACC at HPH in December 2003. (O’Brien, Tr. 3498; Hillebrand, Tr. 1981). The 67,000 square foot building has four floors. (O’Brien, Tr. 3498).

1560. Outpatients go to the ACC for diagnostic testing. (O’Brien, Tr. 3497). Four hospital services are housed in the ACC: radiation medicine, nuclear medicine, the Kellogg Cancer Care Center and the breast imaging center. (O’Brien, Tr. 3497).

1561. The ACC opened its doors in February of 2005. (O’Brien, Tr. 3498; Hillebrand, Tr. 1981). The building cost \$19.5 million, and the equipment cost an additional \$5.3 million. (O’Brien, Tr. 3499).

(3) ENH Purchased New Equipment For The Operating Rooms

1562. After the Merger, ENH purchased additional equipment for to the operating rooms. (O’Brien, Tr. 3505). This included equipment to enhance retina surgery, bariatric surgery, plastic surgery, neurosurgery and orthopedic surgery. (O’Brien, Tr. 3505-06). The cost of the equipment upgrades was slightly over \$2 million. (O’Brien, Tr. 3506).

1563. The additional equipment helped attract physicians and cases from Evanston Hospital and Glenbrook Hospital to HPH. (O’Brien, Tr. 3506).

2. ENH Made Additional Improvements To Quality Of Care And Introduced New High Quality Services

1564. After the Merger, ENH enhanced HPH's clinical services, including adding cardiac surgery, adding academic oncology through the Kellogg Cancer Center, involving academic physicians, introducing residents and interns through an academic family medicine program, doubling the staffing at the ER and introducing full-time intensivists to the ICU. (Hillebrand, Tr. 1983-84). In short, ENH honored every commitment to the community spelled out in the Letter of Intent. (Spaeth, Tr. 2274-75).

a. ENH Initiated A Cardiac Surgery Program At HPH After The Merger

i. Overview

1565. In June 2000, after the Merger, HPH became the first hospital in Lake County to perform open-heart surgery. (RX 879 at ENH GW 3252). At HPH, cardiac surgery is the most complex and highly technical care given to patients. (Chassin, Tr. 5603). The opening of the cardiac surgery program at HPH was a quality improvement in the care given to HPH patients. (Chassin, Tr. 5289).

1566. Before the Merger, HPH did not have cardiac surgery or interventional cardiology, such as the capability to perform angioplasty or utilize stent technology. (Newton, Tr. 465-66; Spaeth, Tr. 2275). Dr. Romano concedes that the extension of the cardiac surgery program to HPH improved access to CABG procedures to residents of Lake County and reduced geographic disparities within the Chicago Metropolitan Statistical Area. (Romano, Tr. 3275).

1567. As a general matter, cardiac surgery is an important quality enhancement for several reasons. First and foremost, cardiac surgery provides immediate life-saving treatment to patients with cardiac surgical emergencies. Cardiac surgery can also provide long-lasting benefits when patients who need cardiac surgery undergo it. (Chassin, Tr. 5290).

1568. For example, if a patient presents in the HPH emergency room today with a torn aorta that closes off blood supply to the brain, that person needs immediate cardiac surgery. This has occurred recently at HPH, and the hospital was able to repair the tear in the patient's aorta and restore blood flow to the brain. Before the Merger, HPH would have had to transfer that patient by ambulance to another hospital where the patient would have to be re-evaluated and then sent to the transferee hospital's operating room for surgery. When a person has had blood flow cut off from the brain, that person has mere minutes or, at the most, hours to receive the necessary life-saving treatment. Therefore, cardiac surgery is a very important, and often life-saving, procedure. (Rosengart, Tr. 4457-58).

1569. Second, cardiac surgery is a necessary component of a full-service cardiology program and must be present to begin such a program at a given hospital. (Chassin, Tr. 5290).

1570. Open-heart or cardiac surgery procedures include CABG (CABG technically stands for coronary artery bypass grafting), valve procedures, and surgery on the aorta. (Rosengart, Tr. 4452).

1571. The term “isolated CABG” means that only a bypass surgery was performed and no other procedure. (Rosengart, Tr. 4453). Isolated CABG surgery is performed to prevent heart attacks or myocardial infarctions and primarily to prolong life. It is also performed for patients who have symptoms of angina or chest pain, which can often be debilitating but is a life saving-operation. (Rosengart, Tr. 4454-55).

1572. Heart valve procedures are also an important part of cardiac surgery. Cardiac surgeons often repair or replace patient heart valves that no longer function properly. This operation involves surgery inside the heart, as opposed to CABG surgery where surgery is performed on the surface of the heart. Valve surgeries are performed under life-threatening circumstances. (Rosengart, Tr. 4455).

1573. Sometimes valve and CABG surgeries are performed at the same time and these surgeries would not be considered isolated CABG surgeries. (Rosengart, Tr. 4455-56).

1574. When evaluating the importance of a cardiac surgery program, one must include all of the different cardiac surgeries that are performed on patients. Isolated CABG surgeries account for only 50-70% of open heart surgery procedures performed at HPH. Overall, the percent of isolated CABG surgeries is decreasing and more valve surgeries are being performed. (Rosengart, Tr. 4458).

1575. After, and as a result of, the Merger, ENH brought to HPH a “superb” cardiac surgery program and an enhanced cardiac catheterization lab. (Spaeth, Tr. 2275).

ii. HPH Was Not Well-Positioned To Begin A Cardiac Surgery Program

1576. **(REDACTED)**

(Romano, Tr. 3059-60, *in camera*).

1577. Before the Merger, HPH, as a community hospital, did not implement a cardiac surgery program. (CX 6305 at 4 (Stearns, Dep.)).

1578. After studying the issue, pre-Merger HPH concluded that a cardiac surgery program was not an appropriate investment to make at the hospital. (CX 6305 at 4 (Stearns, Dep.)). HPH could not justify starting a cardiac surgery program as a stand-alone hospital in light of several hurdles to such a program. (CX 6305 at 9 (Stearns, Dep.)).

1579. **(REDACTED)**

(Rosengart, Tr. 4462; Romano, Tr. 3058-59, *in camera*). All of these individuals play an important role in the success or failure of an open heart surgery program, in fact, the weakest link in the chain of personnel really defines how successful a program can become. (Rosengart, Tr. 4462).

1580. Nurses are a critical component of an open heart surgery team. ICU nurses take care of critically ill patients right after surgery. They are specially trained to run ventilators, supply multiple medications, and other tasks critical to cardiac patient care in the ICU. (Rosengart, Tr. 4463-64). Floor nurses monitor vital signs, take care of daily living activities, monitor breathing and circulation, as well as other tasks for cardiac surgery patients. (Rosengart, Tr. 4464).

1581. HPH also needed approval from the state of Illinois to offer a cardiac surgery program. (Spaeth, Tr. 2247-48).

1582. In light of these hurdles, HPH was far from prepared to begin a cardiac surgery program before the Merger. As of November 1999, there was a very rudimentary ICU. There was negligible physician supervision. There was little nursing experience in terms of open heart surgery. There was essentially no OR nursing experience for doing open heart surgery. Basically, there was a self perception throughout the hospital that “we’re not ready to do open heart surgery here” and, in fact, that perception was correct. (Rosengart, Tr. 4481).

1583. HPH’s OR, ICU and step-down nurses had little experience or leadership capacity before the Merger. After the Merger, in contrast, nurses at HPH began a series of in-service programs at Evanston Hospital where they spent weeks or a month being trained in the Evanston Hospital ICU and OR to work with cardiac surgery patients. (Rosengart, Tr. 4482-83).

1584. The entire ICU at HPH also did not have much experience or a positive track record taking care of critically ill patients. In fact, before the Merger, HPH did not have any physician leadership to help nurses take care of critically ill patients. As a result, ENH created an intensivist program after the Merger in the HPH ICU, a program that was critical in upgrading the ability of nurses to identify and treat emergent problems and heart surgery patients. *See* Section VIII.D.2.c., *supra*. The corollary of the increased abilities of ICU nurses gained from caring for critically ill heart patients is that their newly acquired training also translates to care they provide to other patients in the ICU. (Rosengart, Tr. 4483-84).

1585. Moreover, the administration at HPH did not facilitate the opening of the cardiac surgery program at HPH. Eventually, these administrators were removed by ENH, and ENH had to start from the ground up to install the open heart program at HPH. (Rosengart, Tr. 4484-85). There also was trepidation and an inferiority complex throughout HPH with respect to beginning the open heart program. (Rosengart, Tr. 4485-86).

iii. ENH Recruited A Talented Physician Leader For Cardiac Surgery Immediately After The Merger

1586. In late 1999 or early 2000, ENH expanded its cardiac surgery capabilities and added cardiac medical genetic procedures, in part, by recruiting Dr. Todd Rosengart, an experienced cardiac surgeon who testified at trial concerning how the addition of cardiac surgery at HPH after the Merger improved quality of care at that hospital and benefited its community. (Neaman, Tr. 1381; Rosengart, Tr. 4439-40).

1587. Dr. Rosengart is a cardiac surgeon. (Rosengart, Tr. 4436). He was recruited to ENH as the head of the Division of Cardiothoracic Surgery. His responsibilities in this position

extend to each hospital within ENH, including HPH. (Rosengart, Tr. 4439-40). Dr. Rosengart is also the medical director of cardiac surgery at Weiss Hospital and Swedish Covenant Hospital in Chicago. (Rosengart Tr. 4442-43).

1588. Dr. Rosengart attended medical school at Northwestern University. (Rosengart, Tr. 4436). He completed his residency at NYU in 1989, and spent two years at the National Institute of Health. He also completed a fellowship at Cornell, New York Hospital. (Rosengart, Tr. 4436-37). Dr. Rosengart has been Board-certified in cardiac and thoracic surgery since 1990 and 1992 respectively. (Rosengart, Tr. 4437). He is licensed to practice surgery in Illinois and New York state. (Rosengart, Tr. 4437-38).

1589. Dr. Rosengart has practiced at several hospitals in New York including New York Hospital, Jamaica Hospital, and United Hospital in West Chester. (Rosengart, Tr. 4438-39).

1590. Dr. Rosengart is a member of the several academic and professional societies with respect to cardiothoracic surgery. For example, he is a member of the American College of Cardiac Surgeons, Society of Thoracic Surgery ("STS") and American Heart Association ("AHA"). In the STS, Dr. Rosengart is on the health policies committee, which develops guidelines for the practice of cardiac surgery and sets direction for it. (Rosengart, Tr. 4447-48). Dr. Rosengart also founded the Chicago Cardiothoracic Society and the 21st Century Cardiac Surgery Society. (Rosengart, Tr. 4448-49).

iv. Evanston Hospital And HPH, Since The Merger, Have An Integrated Cardiac Surgery Program That Shares An Affiliation With Other Hospitals

1591. The Merger provided the necessary infrastructure support to remedy the clear inability of HPH to implement a cardiac surgery program. (Rosengart, Tr. 4486-87).

1592. Today, the practice of cardiac surgery at HPH is indistinguishable from the cardiac surgery practice at Evanston Hospital. What is being done at both campuses is state-of-the-art with respect to complexity of surgical techniques and cases, and cutting edge research. (Rosengart, Tr. 4492).

1593. ENH did everything that a high quality hospital would do to open a cardiac surgery program of the highest quality when it began the program at HPH. (Chassin, Tr. 5291). To begin the cardiac surgery program, ENH had to acquire a Certificate of Need ("CON") from the State of Illinois. The CON is a document from the State in which the State and the hospital agree to conditions that suggest that the cardiac surgery program to be opened is of a certain quality that it should be sanctioned by the State. The State of Illinois placed various conditions on the performance of the new cardiac surgery program at HPH during the beginning years of its operation. At the conclusion of the evaluation period, ENH received unanimous approval after the review of the CON Board for the cardiac surgery program at HPH. (Rosengart, Tr. 4471-72).

1594. The ENH cardiac surgeons practice at four different sites, including two non-ENH hospitals. The sites are Evanston Hospital, HPH, Swedish Covenant Hospital and Weiss Hospital. (Rosengart, Tr. 4442).

1595. Four physicians currently perform cardiac surgery at ENH and other affiliated hospitals under the direction of Dr. Rosengart. Within the ENH Medical Group, Dr. Ronald Curran and Dr. Edward Chedrawy both practice under Dr. Rosengart. Outside the Medical Group, but on staff at ENH, Dr. Michael Frank practices primarily at Evanston Hospital. (Rosengart, Tr. 4440-41).

1596. Under the protocols required by the state of Illinois for approval of the program the affiliates and HPH must be within 30 minutes travel time for physicians. The close location of these affiliated programs allows ENH physicians to meet that requirement. (Rosengart, Tr. 4475).

1597. It is important for physicians to be in close proximity to the hospital where they perform cardiac surgery because patients suffering from acute heart attacks or emergency cardiac situations need attention quickly or may die. In fact, the State of Illinois required that at least one HPH cardiothoracic surgeon should reside within 30 minutes travel time from HPH. (Rosengart, Tr. 4545; RX 901 at ENH JH 11513).

1598. The ENH open heart surgery program is an adult cardiac surgery program with a volume between 500 and 600 open heart procedures per year.

1599. The cardiac surgery that takes place at Evanston Hospital and HPH is part of a single program, the ENH cardiac surgery program, and both locations involve very intensive reporting and monitoring. (Rosengart, Tr. 4452-53). In other words, the program at HPH is not a stand-alone cardiac surgery program. It functions as one program with Evanston Hospital. Specifically, Dr. Rosengart sees the ENH program as having two operating rooms that are several miles away instead of 50 feet apart. (Rosengart, Tr. 4498).

1600. Neither Weiss Hospital nor Swedish Covenant Hospital are hospitals owned or operated by ENH. Accordingly, ENH cardiac surgeons practice at these two sites only via an affiliation agreement. (Rosengart, Tr. 4443).

1601. The affiliation agreements in place ensure that Weiss Hospital and Swedish Covenant Hospital are independent from ENH; those hospitals basically run their own programs. (Rosengart, Tr. 4444). The Weiss Hospital and Swedish Covenant Hospital affiliation agreements are modeled very closely after each other. (Rosengart, Tr. 4489). Essentially, these agreements allow the ENH team of surgeons to practice cardiac surgery at the affiliated hospitals. (Rosengart, Tr. 4443-44).

1602. The only other individuals covered under the affiliation agreements are the ENH perfusionists, or the people who run the heart/lung machine during surgery. A heart/lung machine takes over the function of the heart beating and the lungs working for a patient undergoing cardiac surgery. The perfusionist runs the machine and is literally in complete control of the patient's vital heart and lung function. (Rosengart, Tr. 4464-65). ENH provides the perfusionists for the open heart programs at these hospitals. (Rosengart, Tr. 4500-01, 4461-62).

v. HPH Had Equal Or Lesser Ability To Accept A New Cardiac Surgery Program Than The ENH-Affiliated Hospitals

1603. Swedish Covenant Hospital was much better prepared than HPH to accept a new cardiac surgery program before the beginning of the HPH open heart program. (Rosengart, Tr. 4487-88). Specifically, Swedish Covenant Hospital had its own nurses in place. Swedish Covenant Hospital already had advanced practice nurses with significant cardiac surgery experience, the hospital already had intensive care unit physician coverage, and the hospital already had an administration that understood what it would take to run a cardiac surgery program. (Rosengart, Tr. 4487-88).

1604. Weiss Hospital was more like HPH than Swedish Covenant Hospital in its ability to accept a cardiac surgery program. Weiss Hospital had (and still has) depleted infrastructure and capital resources. There were deficiencies in teaching, administration and nursing. (Rosengart, Tr. 4469, 4490).

1605. Having a strong hospital administration is critical to the operation of an open heart surgery program. There are constant needs and demands placed on a program of this type and, as a result, many things about the program have to be continually modified and upgraded by the hospital administration for the program to function well over time. (Rosengart, Tr. 4466-67). For example, the operating room lights at Weiss Hospital are substandard and the Weiss administration has been slow to respond to fix them. (Rosengart, Tr. 4469).

vi. The Post-Merger, Integrated ENH/HPH Cardiac Surgery Program Provides Excellent Care To Patients

1606. Evanston Hospital clearly recognized the complexities of the challenges it was undertaking with respect to implementing cardiac surgery at HPH. The roll-out plan for HPH called for careful initial patient selection. In the first six to nine months the cases selected to be done at HPH were not high risk. As systems were perfected and the surgeons became more comfortable with the skill level of the cardiac surgery teams, the acuity of cases were increased. (Rosengart, Tr. 4491).

1607. In-depth analyses of HPH's cardiac surgery program, described in more detail below, indicate that the program has been implemented successfully and is run through very high quality structures and processes. In addition, the conclusion that the structures and processes dedicated to cardiac surgery at HPH are of the highest quality is supported by the fact that the mortality and major complication rates at HPH for cardiac surgery have been better than or equal to national benchmarks for an extended period of time. (Chassin, Tr. 5299-300).

(1) The Mortality Rate For Cardiac Surgery At HPH Compares Favorably To The Best Surgery Centers In The Country

1608. The most overwhelming outcome measure when evaluating the performance of a cardiac surgery program is mortality. (Rosengart, Tr. 4521-22). It is the "gold standard" of

outcome measures used to measure the quality of open heart surgery programs. (Rosengart, Tr. 4522-23).

1609. The mortality rate at HPH compares favorably to the best cardiac surgery centers in the country. (Rosengart, Tr. 4522-24).

1610. **(REDACTED)**

(Chassin, Tr. 5294; RX 1400 at ENHL PK 54798-806, *in camera*).

1611. **(REDACTED)**

(Rosengart, Tr. 4523; Chassin, Tr. 5295; RX 1400 ENHL PK 54214-15, *in camera*).

1612. **(REDACTED)**

(Romano, Tr. 3053, *in camera*).

1613. ENH is very diligent in the way it reports all data to STS. STS is a voluntary registry that enables health care providers to compare the results of cardiac surgery at different institutions across the country. (Rosengart, Tr. 4511-12).

(RX 1411 at ENHL PK 51119, *in camera*; Romano, Tr. 3046, *in camera*).

1614. **(REDACTED)**

(RX 1411 at ENHL PK 51180, *in camera*).

Moreover, HPH is lower than the benchmark for cardiac surgery programs in New York State, which is also 2.3%. (Chassin, Tr. 5294).

1615. **(REDACTED)**

(Romano, Tr. 3059, *in camera*). Further, the State of Illinois during the CON process stipulated that the HPH cardiac surgery program must have an annual a mortality rate of no more than 5%. (Rosengart, Tr. 4477-78).

1616. The mortality rate for each cardiothoracic surgeon performing isolated bypass or CABG surgery at HPH in the initial year of the program at or below 3%. Dr. Votapka's mortality rate was .6%, Dr. Rosengart's mortality rate was 1.4%, and Dr. Frank's mortality rate was 3.1%. (Rosengart, Tr. 4477-78; RX 1371 at ENH JH 11538).

**(2) HPH Complication Rates For Cardiac Surgery
Are Below National Benchmarks**

1617. Complications can be grouped into at least two categories, major and minor. Major complications are life threatening. They include stroke, sternal wound infection, renal failure, or significant bleeding. (Rosengart, Tr. 4510). Minor complications are not life threatening and include things like leg wound infections. (Rosengart, Tr. 4510).

1618. Major Complication rates are important measurements in the quality of a cardiac surgery program. This is true because cardiac surgery must be performed with very low complication rates if it is to provide long-term benefits of prolonged life, improved functioning and reduced pain. (Chassin, Tr. 5293).

1619. The commonly accepted major complications of cardiac surgery include re-operations, permanent stroke that causes cerebral damage, damage to the brain, kidney failure and deep sternal wound infections. (Chassin, Tr. 5298).

1620. In general, patient outcomes measured when evaluating the performance of a cardiac surgery program include major complications, minor complications, length of stay and mortality. (Rosengart, Tr. 4508-09, 4521-22). Complications are an adverse event that may or may not be influenced by a practice pattern. (Rosengart, Tr. 4509).

1621. The data regarding measurement of major complication rates associated with HPH's cardiac surgery program amplify the conclusion drawn from the low mortality rate in patients who undergo isolated CABG at HPH. Both of these seminal indicators show that the roll-out of the cardiac surgery program at HPH by ENH was done in an extremely high-quality way with outcomes that were equal to or better than national standards. (Chassin, Tr. 5299).

1622. Overall, the rate of major complications accepted as measures of quality for cardiac surgery were lower at HPH than national benchmarks established by STS. HPH's rate of re-operation was about 1.8%, while the accepted national benchmark published by STS is much higher, approximately 5.3%. The rate of permanent stroke at HPH was equal to the STS national benchmark at 1.54%. The rate of kidney failure at HPH was much lower at 1.16%, as compared to 3.48% nationally. Finally, the rate of deep sternal wound infection was about equal at less than 1% to national benchmarks. (Chassin, Tr. 5299; RX 1571 at ENHL PK 52193).

1623. **(REDACTED)**

(Romano, Tr. 3053-55, *in camera*).

1624. The more minor a complication is, the less accurate its reporting in the STS database. (Rosengart, Tr. 4513-14). However, the rates of minor complications at ENH have been very good and are evidence of good performance. (Rosengart, Tr. 4515).

1625. Certain complications, such as atrial fibrillation, which is an abnormal heart beat, are not useful in evaluating the performance of a cardiac surgery program. Atrial fibrillation is also an outcome. Outcomes like atrial fibrillation are not useful to measure performance because their occurrence is not influenced by whether any aspect of care is changed. In other words, it is

not a benchmark for bad performance because no change in care is known to prevent it. (Rosengart, Tr. 4508-09).

1626. Leg wound infections are a minor complication of cardiac surgery. Overall, the leg wound infection rate is low at ENH. Literature and medical research in cardiac surgery show leg wound infection rates within 30 days of surgery to be occur within 10-20% of patients nationally. (Rosengart, Tr. 4514-16).

1627. The leg wound infection rate at ENH when compared to STS national benchmarks may have increased due to a difference in practice patterns. For example, at ENH the way referral patterns are set up, all of the patients essentially come back to ENH with any complication they may have. In comparison, a New York City hospital may get referrals from 20 or 30 miles away and frequently will see patients of surgery and not see them for any follow-up. So if a leg wound infection occurred within the 30 day window measured by STS it would not be voluntarily reported at the city hospital and the city hospital's performance would look better than a hospital like ENH that sees the same patients over and over again. (Rosengart, Tr. 4512, 4514-15).

vii. The Merger Was Essential To The Success Of HPH's Cardiac Surgery Program

1628. The Merger was necessary to produce the extremely high quality cardiac surgery program at HPH today. This is true because cardiac surgery is a highly complex and team-dependant service. In fact, cardiac surgery is probably the most complex and team-dependant service that exists at HPH post-Merger. The close collaboration of all team members, from the perfusionist to the surgeon to the physician's assistant to the ICU or OR nurses is absolutely necessary to the performance of high quality cardiac surgery. This collaborative culture did not exist at HPH before the Merger. (Chassin, Tr. 5392).

1629. If the cardiac surgery program at HPH had been launched without the Merger, the program would have been of significantly lesser quality. It is likely that the level of cardiac surgery would be similar to that practiced at Weiss Hospital or Swedish Covenant Hospital. (Chassin, Tr. 5392-93).

(1) As A Result Of The Merger, HPH Is An Integrated Part Of The ENH Cardiac Surgery Program

1630. As discussed above, neither Weiss Hospital nor Swedish Covenant Hospital are hospitals owned or operated by ENH. ENH cardiac surgeons practice at these two sites only via an affiliation agreement. (Rosengart, Tr. 4443). Swedish Covenant Hospital functions as a stand-alone cardiac surgery program. No overlap extends between the programs other than the fact that ENH surgeons and perfusionists work there at Swedish Covenant Hospital under the affiliation agreement. (Rosengart, Tr. 4500-01).

1631. Weiss Hospital's cardiac program similarly functions independently from ENH. (Rosengart, Tr. 4444, 4489).

1632. At HPH and Evanston Hospital, the same team of OR nurses rotates between the two sites. In contrast, Swedish Covenant Hospital and Weiss Hospital have their own OR nurses, nurse practitioners, and physicians' assistants. (Rosengart, Tr. 4465-66).

1633. ICU and Floor nurses utilized in the cardiac surgery program are specific to each site. The nurses at Evanston Hospital/HPH, however, are under the same umbrella of nursing leadership and are free to train throughout the system. (Rosengart, Tr. 4466).

1634. The quality assurance program in place at Evanston Hospital with respect to cardiac surgery extends to HPH, but not to the affiliated hospitals. (Rosengart Tr. 4467-68; 4550).

1635. Aside from the surgeons, the only individuals covered under the affiliation agreements with Weiss Hospital and Swedish Covenant Hospital are the ENH perfusionists, or the people who run the heart/lung machine during surgery. (Rosengart, Tr. 4444, 4489, 4500-01, 4461-62).

**(2) Due To The Level Of Integration Engendered By
The Merger, HPH Performs Higher Quality
Cardiac Surgery Than Affiliated Hospitals**

1636. Overall, the quality of cardiac surgery performed at ENH (Evanston Hospital and HPH) is higher than the quality of cardiac surgery performed at the affiliated sites, Swedish Covenant Hospital and Weiss Hospital. (Rosengart, Tr. 4504).

1637. First, as a result of the integrated relationship between Evanston Hospital and HPH, and the more attenuated affiliation between ENH and Weiss Hospital and Swedish Covenant Hospital, there are a number of cardiac surgery procedures only done at HPH and Evanston Hospital that are not performed at Weiss Hospital or Swedish Covenant Hospital. These cutting-edge procedures are being done at few other places in Chicago, Illinois, or even nationally. (Rosengart, Tr. 4492-93).

1638. As Dr. Rosengart put it: "We are not doing [advanced surgical techniques] at either Swedish or Weiss. I wouldn't feel comfortable. It really involves a lot of integration of anesthesia, nursing, equipment, resources and things like that, and by virtue of not having that sort of commonality of the team, probably would not – certainly no in – not in the near future do it at either of those sites." (Rosengart, Tr. 4493).

1639. Operating Weiss Hospital's cardiac program via affiliation does not afford complete control of the cardiac surgery program there by ENH. (Rosengart, Tr. 4444). While Dr. Rosengart ensures that the surgical team under his control provides the requisite high-quality care, Swedish Covenant and Weiss Hospitals, as affiliate programs, have a great deal of independence and, thus, ENH does not control all aspects of care that potentially affect patient outcomes. (Rosengart, Tr. 4444). As a result, the performance of cardiac surgery at Weiss Hospital is not satisfactory. Issues with administration, resources, and the ability to upgrade have not been able to be dealt with within the affiliation relationship between ENH and Weiss Hospital. Surgeries performed at Weiss Hospital are kept more basic and patients with complex

cases are transferred to Evanston Hospital due to the level of comfort ENH surgeons have with the infrastructure in place at Weiss Hospital. (Rosengart, Tr. 4503-04).

1640. For example, vein harvesting techniques using periscopes through a one inch incision are done at Evanston Hospital and HPH and not at Swedish Covenant Hospital or Weiss Hospital. Moreover, bloodless surgery, which is cardiac surgery performed without blood transfusions, is performed at HPH and Evanston Hospital, but not at Swedish Covenant Hospital or Weiss Hospital. Only a handful of hospitals in the country are doing bloodless surgery. (Rosengart, Tr. 4494-96).

1641. Second, private and government funded research take place at Evanston Hospital and HPH, but not at Swedish Covenant Hospital or Weiss Hospital. Research is not performed at Swedish Covenant Hospital or Weiss Hospital because under the affiliation agreement they maintain separate infrastructure, separate Institutional Review Boards, and separate contracting practices. (Rosengart, Tr. 4496-97).

1642. Another specific example of the benefit of the integration achieved through the Merger involves the use of new stenting technology. Two years ago, a new kind of stent came out that cardiologists use. That was something that Evanston Hospital and HPH were able to adopt simultaneously and far ahead of other cardiac programs in Chicago. This took place because of the common structure between HPH and Evanston Hospital, and the adoption of the new stent technology is a benefit to patients. (Rosengart, Tr. 4496-97).

1643. Third, outcome data confirms that the quality of cardiac surgery performed at HPH since the Merger is of a higher quality than that done by hospitals with cardiac surgery programs opened through affiliation with ENH. Specifically, although the mortality rates at Swedish Covenant Hospital are within acceptable limits, HPH has had much better outcomes with 0 mortality for CABG patients in the last two and a half years. (Rosengart, Tr. 4502-05).

1644. Moreover, the length of stay for cardiac surgery patients is longer at Swedish Covenant Hospital than at HPH. As a result, patients who receive cardiac surgery at Swedish Covenant Hospital stay in the hospital longer for recovery and the costs incurred by the hospitals to perform cardiac surgery are also higher at Swedish Covenant Hospital than at HPH. (Rosengart, Tr. 4501-02).

1645. Finally, due to the Merger, the current HPH cardiac surgery program staff has access to ENH's state-of-the-art medical technology. (Rosengart, Tr. 4566).

1646. At the end of the day, it is likely that if cardiac surgery at HPH had been installed via affiliation absent the Merger, such affiliation would have resulted in a program no better than that at Swedish Covenant Hospital or Weiss Hospital. (Chassin, Tr. 5392-93).

b. ENH Successfully Established An Interventional Cardiology Program At HPH

i. Overview

1647. (REDACTED)

(Chassin, Tr. 5303; Romano, Tr. 3067, *in camera*). HPH did not have an interventional cardiology program before the Merger. (Chassin, Tr. 5303).

1648. An interventional cardiology program benefits patient care in several ways: (1) patients with acute myocardial infarctions (heart attacks) can be effectively treated by applying interventional procedures to open up their blocked coronary arteries immediately within a few hours of their arrival; (2) patients already admitted to the hospital who have heart attacks requiring emergency treatment can be treated at the same hospital rather than having to be transferred to another hospital; and (3) patients with chronic heart disease may be treated closer to their homes, which is more convenient for the patient. (Chassin, Tr. 5303-04).

1649. After the Merger, ENH established an interventional cardiology at HPH that improved the quality of care available to patients. (Chassin, Tr. 5304-05).

ii. Before The Merger, HPH Could Not Treat Heart Attack Patients With Interventional Cardiology Procedures

1650. Before the Merger, HPH had a diagnostic catheterization laboratory that performed only diagnostic catheterizations. (Chassin, Tr. 5304; O'Brien, Tr. 3489; Hillebrand, Tr. 1980). Diagnostic catheterizations allow a physician to determine the degree of blockage in a vessel, but do not cure that problem or treat it. (Chassin, Tr. 5304; O'Brien, Tr. 3489).

1651. Interventional cardiology, on the other hand, treats or cures blockage in vessels. (Chassin, Tr. 5304; O'Brien, Tr. 3489). Before the Merger, HPH did not have an interventional cardiology laboratory. (Chassin, Tr. 5304). Accordingly, emergent (emergency) or other procedures to cure coronary blockages could not be performed at HPH. (Chassin, Tr. 5304). Thus, before the Merger, many patients with acute myocardial infarction (heart attack) were transferred out of HPH. (Chassin, Tr. 5316; RX 2042).

1652. Additionally, HPH's pre-Merger cardiac catheterization lab was a converted x-ray room, and the equipment in the lab was purchased in 1988. (Hillebrand, Tr. 1980; O'Brien, Tr. 3488). At the time of the Merger, HPH was having difficulty with its cardiac catheterization lab. (Spaeth, Tr. 2290).

iii. After The Merger, ENH Established A Successful Interventional Cardiology Program At HPH

1653. After the Merger, and in conjunction with the introduction of cardiac surgery at HPH, ENH built a new cardiac catheterization lab at HPH that performed both diagnostic and

interventional procedures such as angioplasties. (Hillebrand, Tr. 1980). The new cardiac catheterization lab was completed in March of 2002 at a cost of over \$2.5 million. (O'Brien, Tr. 3490).

1654. The new cardiac catheterization lab has three suites and affords enhanced training for HPH's cardiologists. (Hillebrand, Tr. 1980; Spaeth, Tr. 2275). The lab equipment is brand new, and it is capable of enhancing images from the older piece of equipment. (O'Brien, Tr. 3490). It also has broadcasting capabilities, which gives physicians at other campuses the ability to view a case taking place at HPH or vice versa. (O'Brien, Tr. 3490).

(1) HPH's Interventional Cardiology Program Has Obviated The Need To Transfer Acute Heart Attack Patients To Other Hospitals

1655. The enhanced cardiac services at HPH are a "fabulous" upgrade for the Highland Park community because they allow a patient to move from the HPH ED to the catheterization lab for a stent, all without having to leave the HPH campus. (Spaeth, Tr. 2275). Indeed, after the Merger, HPH ceased transferring patients with acute heart attacks outside of HPH. (Chassin, Tr. 5316; RX 2042).

1656. **(REDACTED)**

(Chassin, Tr. 5317-18; RX 2042; RX 2044, *in camera*; RX 1985, *in camera*). **(REDACTED)**

(Chassin, Tr. 5318-19; RX 2042; RX 1985, *in camera*). **(REDACTED)**

(Chassin, Tr. 5319; RX 2042; RX 2044, *in camera*; RX 1985, *in camera*).

1657. **(REDACTED)**

(RX 2044, *in camera*; RX 1985, *in camera*). **(REDACTED)**
(Chassin, Tr. 5319;

RX 2042; RX 2044, *in camera*; RX 1985, *in camera*). **(REDACTED)**

(Chassin, Tr. 5319; RX 2042; RX 1985, *in camera*). **(REDACTED)**

(Chassin, Tr. 5319; RX 2042; RX 1985, *in camera*).

1658. This reduction in heart attack patients being transferred from HPH is a substantial quality improvement because there is a medical risk when transferring a patient in the middle of an acute heart attack. (Chassin, Tr. 5319-20).

1659. **(REDACTED)**

(Romano, Tr. 3069-70, *in camera*).

1660. The quality of HPH's interventional cardiology program has been recognized by other physicians and hospitals in the region. (Chassin, Tr. 5320). **(REDACTED)**

(Chassin, Tr. 5319-20; RX 2042; RX 2044, *in camera*; RX 1985, *in camera*).

(2) The Interventional Cardiology Program At HPH Has Achieved High Quality Outcomes

1661. ENH conceived, launched and implemented the interventional cardiology program at HPH in a very high quality way. (Chassin, Tr. 5307). As a result, the interventional cardiology program represents a major quality improvement for HPH. (Chassin, Tr. 5307).

1662. This conclusion is based on the very low mortality rate from elective percutaneous coronary interventions ("PCIs"), the acceptable mortality rate for emergent PCIs, the achievement of reasonable volumes, the implementation of the ability to treat acute heart attack patients on site emergently with PCI and the effect of the entire program on treatment patterns for patients with acute heart attacks. (Chassin, Tr. 5308).

1663. Elective PCIs are procedures that can be scheduled in advance for patients who are not critically ill, who have chronic disease and who do not need the procedure within minutes or hours. (Chassin, Tr. 5306).

1664. HPH has performed about 350 PCI cases per year every since the first full year of the program's operation in 2001. (Chassin, Tr. 5308). The mortality rate for the elective PCI program is 0.6%, which is very comparable to national benchmarks. (Chassin, Tr. 5308).

(3) On-Site Cardiac Surgery At HPH Is Needed To Continue The Interventional Cardiology Program

1665. ENH took several steps to implement the interventional cardiology program at HPH, including: (1) establishing a cardiac surgery program; (2) identifying experienced interventional cardiologists that were part of the cardiology group at HPH but performing interventions elsewhere and bringing them onto the HPH staff as interventionalists; (3) training the nursing staff and technicians, and (4) installing quality assurance/quality improvement programs that would be overseen by the chief of cardiology at ENH. (Chassin, Tr. 5305-06).

1666. Shortly after the Merger, ENH also implemented a number of educational initiatives to prepare HPH physicians to perform elective PTCA (angioplasty)/stent procedures. (RX 984 at ENHL PK 51618-19).

1667. **(REDACTED)**

(Chassin, Tr. 5306-07; Romano, Tr. 3068, *in camera*).

1668. The American College of Cardiology (“ACC”) and the American Heart Association (“AHA”) strongly recommend that elective PCI programs always be backed up by cardiac surgery. (Chassin, Tr. 5307). Further, the state of Illinois and the ACC/AHA guidelines require that an elective interventional cardiology program must have cardiac surgery backup within the hospital. (Rosengart, Tr. 4506-07).

1669. Cardiac surgical backup is also desirable in emergent PCI procedures. (Chassin, Tr. 5323).

1670. Moreover, HPH, which performs only 50 or 60 emergent PCI cases annually, does not have a high enough volume to support a stand-alone emergent PCI program (without cardiac surgery). (Chassin, Tr. 5323, 5325). A hospital cannot employ a full-time physician based on upon 50 or 60 cases a year and, therefore, without cardiac surgery, HPH would have to contract with an interventional cardiologist based at another hospital. (Chassin, Tr. 5324-25).

1671. **(REDACTED)**

(Romano, Tr. 3067-68, *in camera*).

c. The Merger Substantially Improved HPH’s Intensive Care Services

i. Overview

1672. ENH added an intensivist program to HPH after the Merger, an improvement that enhanced quality of care in HPH’s ICU. (Ankin, Tr. 5041; RX 1099 at ENHE F35 340; O’Brien, Tr. 3528-29; Chassin, Tr. 5328).

1673. An intensivist program is a program that tasks the intensivists with supervising all clinical activity in the care of critically ill patients in the ICU and being available upon request to assist primary care physicians in the care of their patients. (Ankin, Tr. 5039). Most of the patients in the ICU are critically ill, injured or unstable patients with cardiac failure or respiratory failure. (Ankin, Tr. 5035).

1674. An intensivist is a physician who specializes in the care of intensive care patients and, as a result, has more experience dealing with the complications of those critically ill people and is less prone to make mistakes. (Ankin, Tr. 5035-36; O’Brien, Tr. 3529). Intensivists also have an administrative role in overseeing and coordinating the medical and nursing staff that provide care to critically ill patients in the ICU. (Ankin, Tr. 5036). An intensivist is empowered by the hospital’s administration to make judgments about when patients should be transferred out of the ICU. (Ankin, Tr. 5036-37).

1675. Physicians have acted as intensivists for a long time, although it is relatively new as an established field in medicine. (Ankin, Tr. 5038).

1676. Dr. Ankin, who is a board-certified physician in internal and pulmonary medicine, testified about HPH’s post-Merger intensivist program at trial. (Ankin, Tr. 5033). Dr. Ankin is

President of a private practice organization called Pulmonary Physicians of the North Shore (“PPONS”). (Ankin, Tr. 5033). He has been practicing as a pulmonologist in the Chicago North Shore for over 25 years, and he has been admitting patients to HPH during this entire period. (Ankin, Tr. 5033). Dr. Ankin is an independent practitioner with admitting privileges at several hospitals – including HPH, Lake Forest, Rush North Shore and Condell. (Ankin, Tr. 5034).

ii. HPH’s ICU Had Gaps In Patient Care Before The Merger

1677. HPH did not have an intensivist program before the Merger. (Ankin, Tr. 5045; Spaeth, Tr. 2278; Newton, Tr. 470-71).

1678. **(REDACTED)**

(Ankin, Tr. 5046; RX 989 at ENHL MO 7123, *in camera*).

1679. Before the Merger, HPH provided physician coverage of its ICU in the manner similar to most other community hospitals – meaning that the attending physician would come to the ICU, see his or her patient, finish rounds and return to his or her office. (Ankin, Tr. 5046). **(REDACTED)**

(Ankin, Tr. 5046; RX 989 at ENHL MO 7123, *in camera*).

1680. **(REDACTED)**

(Ankin, Tr. 5047-48, 5057-58; RX 989 at ENHL MO 7123, *in camera*). **(REDACTED)**

(Ankin, Tr. 5047; RX 989 at ENHL MO 7123, *in camera*; Chassin, Tr. 5326).

1681. **(REDACTED)**

(RX 989 at ENHL MO 7123, *in camera*). **(REDACTED)** (RX 989 at ENHL MO 7123, *in camera*).

1682. Before the Merger, the HPH emergency room physician was responsible for responding to all code blues – which occurs when a patient in the hospital has an emergency medical condition requiring an immediate response – unless another physician happened to be in the hospital at the time and could help out with the emergency. (Ankin, Tr. 5057). **(REDACTED)**

(Ankin, Tr. 5057; O’Brien, Tr. 3530; RX 989 at ENHL MO 7123, *in camera*).

1683. Moreover, before the Merger, if a patient on a general medical floor at HPH required intensive care services in a short time-frame, hospital personnel generally would have to contact the attending physician at home or the office. (Ankin, Tr. 5060-61). The attending physician would then make arrangements to come to the hospital to see that patient whose condition had worsened. (Ankin, Tr. 5061). Not having an intensivist available during the day

to respond to such urgent requests for consultations led to delays in caring for a critically ill patient. (Ankin, Tr. 5061-62).

1684. The faster a critically ill patient receives an intervention, the more likely it is that patient will recover. (Ankin, Tr. 5061). Being able to respond to critically ill patients within five minutes is much preferable to assessing that patient within thirty minutes. (Ankin, Tr. 5061-62). A delay of 25 minutes without therapy and a medical intervention may be fatal to many patients. (Ankin, Tr. 5060-62). Accordingly, the ICU arrangement at HPH before the Merger – where there was no staff physician in charge of taking care of critically ill and unstable patients – put critically ill patients at risk. (Chassin, Tr. 5326).

1685. **(REDACTED)**

(Ankin, Tr. 5037; RX 989 at ENHL MO 7123, *in camera*). **(REDACTED)**

(RX 989 at ENHL
MO 7123, *in camera*).

**iii. The Addition Of Intensivist Coverage After The Merger
Eliminated The Gaps In ICU Patient Care At HPH**

1686. **(REDACTED)**

(Ankin, Tr. 5050-51; O'Brien, Tr. 3530; RX 989 at ENHL MO 7123, *in camera*).

1687. A number of studies have been published showing that having intensivists improves outcomes in ICUs. (Romano, Tr. 3003). Having patients in ICUs managed by physicians who specialize in such care leads to better outcomes for patients. (Romano, Tr. 3003).

1688. In particular, studies done by a variety of different institutions have shown that intensivist programs reduce mortality by 10-15%. (Ankin, Tr. 5039). Intensivist programs also decrease the length of a patient's stay in the ICU, decrease infection rates as well as increase nurse satisfaction and nurse retention. (Ankin, Tr. 5039; RX 1111 at ENH GW 276).

1689. **(REDACTED)**

(Ankin, Tr. 5040; RX 1031 at ENH GW
283; Romano, Tr. 3113, *in camera*).

1690. ENH implemented the intensivist program at HPH in 2001 by contracting with PPONS. (Ankin, Tr. 5041; RX 1099 at ENHE F35 340; O'Brien, Tr. 3528-29). **(REDACTED)**
(Ankin, Tr. 5063; RX
1084 at ENHL MA, *in camera*; O'Brien, Tr. 3530-31).

(1) Intensivists Have Broad ICU Responsibilities At HPH

1691. The intensivist program at HPH, headed by Dr. Ankin, is an effective collaboration with the private medical staff at HPH. (RX 1111 at ENH GW 277; RX 1099 at ENHE F35 340). The intensivists from PPONS are responsible for directing the care of patients in HPH's ICU to improve patient care and patient safety. (Ankin, Tr. 5042-43; RX 1084 at ENHL MA 4-5).

1692. Dr. Ankin and six physicians from PPONS are responsible for being physically present at HPH, primarily in the ICU, and providing intensivist services on a 12-hour-a-day basis for five days a week. (Ankin, Tr. 5041; 5048; RX 1084 at ENHL MA 5; Spaeth, Tr. 2278; O'Brien, Tr. 3528-29; RX 1099 at ENHE F35 340; Chassin, Tr. 5326).

1693. In general, intensivists at HPH are involved in several activities, including: multidisciplinary ICU teaching, critical care evaluation, utilization of ICU beds, critical care pathway establishment, emergency-code response hospital-wide, urgent evaluations and monitoring clinical care of patients in the step-down unit (a unit providing a lesser intensity of care than the ICU). (RX 1111 at ENH GW 277; RX 1084 at ENHL MA 5; Ankin, Tr. 5041-43).

1694. In particular, there are daily patient rounds in the ICU at HPH starting at 9:00 a.m., with a group of individuals involved in the patient's care, including the intensivist, nurses, a dietician, a physical therapist, a social worker, a chaplain and a discharge planner – all of whom meet to discuss the needs of each patient in the ICU. (Ankin, Tr. 5054; RX 1099 at ENHE F35 340; Chassin, Tr. 5327). The purpose of these multidisciplinary rounds is to improve patient care by anticipating patient needs ahead of time so that there are no gaps in care. (Ankin, Tr. 5054; Chassin, Tr. 5327, 5331). HPH did not have multidisciplinary rounds before the Merger. (Ankin, Tr. 5054; Chassin, Tr. 5331).

1695. **(REDACTED)**

(Ankin, Tr. 5037; RX 989 at ENHL MO 7123, *in camera*; RX 1084 at ENHL MA 5; Ankin, Tr. 5043-44).

1696. The intensivists at HPH are also responsible for responding to patient emergencies in other areas of the hospital, in addition to the ICU. (Ankin, Tr. 5056; RX 1099 at ENHE F35 340; O'Brien, Tr. 3530). **(REDACTED)**

(RX 989 at ENHL MO 7124, *in camera*; RX 1084 ENHL MA 5). More importantly, the intensivists are available to see patients anywhere in the hospital who are rapidly deteriorating and who require intensive care services within a short period of time. (Ankin, Tr. 5056-57; Chassin, Tr. 5329). This additional physician coverage was a quality of care improvement. (Chassin, Tr. 5328).

1697. Dr. Ankin's practice also has monthly meetings with the Evanston and Glenbrook intensivists to coordinate care in the ICUs of all three ENH hospitals, discuss process and performance improvement and to discuss research projects and care paths. (Ankin, Tr. 5051). The meetings are an occasion to discuss research projects that are carried out at the ENH hospitals. (Ankin, Tr. 5052).

1698. In addition, Dr. Ankin's group has coordinated with the intensivists at both Glenbrook and Evanston Hospitals to develop a variety of new critical pathways, including ventilator management and diabetic sugar control. (Ankin, Tr. 5052).

1699. Dr. Ankin's group has worked on research projects with intensivists at Evanston and Glenbrook Hospitals involving medications for sepsis and medications to reduce the need for blood transfusions. (Ankin, Tr. 5052).

1700. The HPH intensivists, who are responsible for all of the patients in the ICU, have the opportunity to consult with the primary care physicians for each of those patients. (Ankin, Tr. 5043). Further, intensivists at HPH have the ability to discuss a patient's care with family members and help coordinate patient care for ICU patients through all of the physicians and specialists. (Ankin, Tr. 5043).

1701. After the Merger, ENH also added a physician in training as a fellow to the intensivist team to supplement intensivist coverage. (Ankin, Tr. 5058). Currently, the fellow – or house physician – arrives each night at 6:00 p.m., consults with the attending intensivist about particular patients in the ICU and is responsible for evaluating and caring for ICU patients until the intensivist returns in the morning. (Ankin, Tr. 5058-59).

1702. The intensivists at HPH are on call during evening hours and on weekends to respond to patient emergencies in the ICU, if necessary, come to the hospital during the evening hours to respond to a patient who was unstable. (Ankin, Tr. 5058-60). In addition, the intensivists at HPH respond to consultation requests by a physician or nurse for patients whose condition is rapidly deteriorating. (Ankin, Tr. 5060; RX 1084 at ENHL MA 5; RX 1099 at ENHE F35 340).

1703. Dr. Ankin has, over the past four years, frequently received such consultation requests for deteriorating patients, usually for patients admitted to a general medical floor outside the ICU. (Ankin, Tr. 5060).

(2) The Intensivist Program Complemented The Introduction Of Cardiac Surgery At HPH

1704. The addition of cardiac surgery at HPH after the Merger changed the ICU by requiring that ICU personnel learn to care for cardiac surgery patients after their surgery. (Ankin, Tr. 5063-64). Cardiac surgery patients are often sick and unstable patients and go directly from the operating room to the ICU, and their post-operative care requires sophisticated machinery, medications and medical care. (Ankin, Tr. 5064). Caring for cardiac surgery patients in the ICU requires a high degree of intelligence and focus. (Ankin, Tr. 5064).

1705. There are situations in which a patient in the ICU is so sick and unstable that he or she cannot be safely transferred to another hospital by ambulance. (Ankin, Tr. 5066). One of the problems for a community hospital that does not have a cardiac surgery program is that patients who come to the hospital with a heart attack may be too unstable to transfer to a hospital with cardiac surgery capabilities. (Ankin, Tr. 5066).

1706. Dr. Ankin had a patient in the HPH ICU a few months ago who had a heart attack and was too unstable to transfer. But because of HPH's cardiac surgery program instituted after the Merger, this patient was evaluated by the cardiac surgeons, operated on and discharged in better condition from HPH. (Ankin, Tr. 5066). This patient could not have had her cardiac surgery procedure at HPH before the Merger. (Ankin, Tr. 5066). In contrast, before the Merger, HPH patients who needed to be transferred but were too unstable to transfer died. (Ankin, Tr. 5068).

1707. Finally, there is a relationship between the quality of ICU services at a hospital and the maintenance of a cardiac surgery program. (Chassin, Tr. 5604). At HPH, the ICU serves as the joint cardiac surgery and other critical care areas for the hospital. (Chassin, Tr. 5604). Once the nurses are trained to handle the complicated cardiac surgery cases, those skills spill over into their ability to care for other critically ill patients in the ICU for other medical reasons. (Chassin, Tr. 5604).

(3) The Intensivist Program Improved Nursing Care In The HPH ICU

1708. The intensivists have an active role in educating the nursing staff at HPH, both during patient rounds and during the intensivist's 12-hour shift. (Ankin, Tr. 5068; RX 1084 at ENHL MA 5).

1709. As part of the roll-out of the cardiac surgical program, ENH brought the HPH ICU nurses to Evanston Hospital for intensive training. (Chassin, Tr. 5330). Those nurses returned to HPH and both cardiac and ICU patients benefited from improved care. (Chassin, Tr. 5330). The improved nurse staffing in the HPH ICU enhanced the ability of the intensivists to care for patients in the ICU. (Ankin, Tr. 5069-70).

1710. Moreover, a nurse practitioner was added to the ICU staff at HPH after the Merger, and this addition increased the capacity of the ICU to provide excellent care. (Chassin, Tr. 5328; RX 1445 ENHL PK 51621).

iv. The Intensivist Program Improved The Overall Quality Of Care For HPH's Critically Ill Patients

1711. ENH improved the quality of care in HPH's ICU by adding an intensivist program, by instituting a program to train ICU nurses to handle more complicated patients and by bringing a more sophisticated style of care to ICU patients. (Chassin, Tr. 5326-27).

1712. The intensivist program at HPH was an improvement in quality of care because full-time intensivists improve mortality and reduce complications. (Chassin, Tr. 5328.) The changes ENH made to the HPH ICU, including providing full-time intensivist coverage and adding pharmacists to the multi-disciplinary rounds in the ICU, are improvements in the quality of ICU care. (Chassin, Tr. 5328).

1713. Dr. Romano concedes that the implementation of the intensivist program at HPH was likely to improve patient outcomes, reduce mortality in the ICU and lead to improvements in quality of care. (Romano, Tr. 3318).

v. HPH Had No Plans To Adopt An Intensivist Program Before The Merger

1714. There is no record evidence that HPH had any plan to adopt an intensivist program before the Merger. (Ankin, Tr. 5045)

1715. Before the Merger, neither Dr. Ankin nor his private practice, PPONS, had any contractual relationship with HPH to direct the critical care of patients in the ICU. (Ankin, Tr. 5045).

1716. Before the Merger, nobody from HPH ever approached Dr. Ankin to request that he initiate an intensivist program. (Ankin, Tr. 5045).

1717. One year after the HPH intensivist program started, and due to the success of that program, Dr. Ankin, in his capacity as a Board member of Lake Forest Hospital, suggested to that hospital's Board and its administration that the hospital begin an intensivist program. (Ankin, Tr. 5072-73). The Lake Forest Board of Directors initiated an intensivist program because it saw the advantages to patient care and patient safety of having such a program. (Ankin, Tr. 5073).

1718. Lake Forest had no intent to adopt an intensivist program before Dr. Ankin made this suggestion based on his positive experiences with HPH's post-Merger intensivist program. (Ankin, Tr. 5073-74).

1719. The intensivist program at Lake Forest is only eight hours each day, rather than 12 hours at HPH. (Ankin, Tr. 5074). Lake Forest Hospital has only eight hours of intensivist coverage because it could not afford a 12-hour per day program. (Ankin, Tr. 5074).

1720. Dr. Ankin also recommended to Rush North Shore that it begin an intensivist program. Nevertheless, that hospital did not institute such a program because it could not afford it. (Ankin, Tr. 5074).

1721. Intensivist programs, such as the one instituted at HPH after the Merger, are not common in community hospitals (such as HPH before the Merger). (Chassin, Tr. 5329). The Leapfrog Group conducted a survey that tallied the number of hospitals reporting intensivist programs. (Chassin, Tr. 5329-30). Only six out of 37 hospitals reporting to LeapFrog in Illinois had intensivist programs, and three of those six hospitals were the ENH hospitals. (Chassin, Tr. 5330; Romano, Tr. 3324). The Leapfrog Group survey ranked the ENH hospitals as the top hospital system in the State of Illinois in 2005. (Neaman, Tr. 1291).

d. The Merger Substantially Improved Oncology Services At ENH

i. Overview

1722. Before the Merger, HPH's oncology program was designated by the American College of Surgeons, a national organization charged with certifying cancer programs at community and academic hospitals and academic institutions, as a community oncology

program. (Dragon, Tr. 4320-21). The level of care provided for oncology patients was very typical of an average community hospital. (Dragon, Tr. 4309).

1723. For example, as was typical in community hospitals, necessary support services such as pharmacy services, psychology, and nutritionists were not coordinated in a central location, thus requiring sick patients to travel to multiple locations to receive these important services. (Dragon, Tr. 4318-19; Chassin, Tr. 5369). Also, as was typical in community hospitals, HPH did not have any specialty oncologists before the Merger. (Dragon, Tr. 4315-17).

1724. ENH made two major improvements to oncology services at ENH after the Merger: (1) it brought a multidisciplinary approach to cancer care through the extension of the Kellogg Cancer Center to HPH, and (2) it introduced subspecialty oncologists to HPH. (Chassin, Tr. 5369, 5371).

1725. ENH also built an entirely new facility for oncology services at HPH, purchased new and additional equipment that typically would not be found in a community hospital and improved access to research trials. (Dragon, Tr. 4370-71; Chassin 5371).

1726. As a result of these post-Merger improvements, the American College of Surgeons changed its designation of HPH's oncology program from a community oncology program to an academic hospital cancer center. (Dragon, Tr. 4360). These post-Merger improvements represent substantial quality improvements for cancer patients at HPH. (Chassin, Tr. 5369).

1727. Dr. Leon Dragon, a practicing physician, medical oncologist, and medical director of the Kellogg Cancer Center at HPH since 2002, testified at trial about HPH's oncology services pre- and post-Merger. (Dragon, Tr. 4300, 4306). Dr. Dragon has practiced medicine for 27 years and is familiar with the different oncology practices in the Chicago area. (Dragon, Tr. 4303). He first began practicing medicine at HPH in 1999 and spent about half of his time at HPH by the time of the Merger or earlier. (Dragon, Tr. 4309-10).

1728. As the medical director of the Kellogg Cancer Center at HPH, Dr. Dragon was charged with developing the cancer program at HPH and integrating it with the services then organized and available at Evanston and Glenbrook Hospitals to create a freestanding facility at HPH that would offer both the clinical services and clinical research services available at the other two sites. (Dragon, Tr. 4306-07).

ii. Pre-Merger Cancer Services At HPH Were Typical Of A Community Hospital

(1) Pre-Merger Cancer Services At HPH Lacked Full Time Employed Oncologists

1729. Before the Merger, all of the oncologists practicing at HPH were private practitioners. (Dragon, Tr. 4310). HPH employed two full-time equivalent oncologists, but 90% of the care rendered by those physicians and their group was office-based. (Dragon, Tr. 4310). Two other oncologists who were based at Lake Forest Hospital had privileges at HPH, but they

primarily saw outpatient referrals for physicians on staff at HPH in their office at Lake Forest Hospital. (Dragon, Tr. 4309-10).

1730. The services generally provided by private practice oncologists are based on their ability to generate revenue. (Dragon, Tr. 4311-12).

(2) Pre-Merger Cancer Support And Ancillary Services At HPH Were Limited

1731. Oncology support or ancillary services for cancer patients generally include psycho-social counseling, specialized pharmacy, blood transfusions, and dietary services. (Dragon, Tr. 4312-13, 4317). Oncology patients utilize these services to address important health issues attendant to cancer care. (Dragon, Tr. 4317). For example, cancer patients require dietary services because such patients have problems with gastrointestinal function, appetite, and weight loss. (Dragon, Tr. 4317). Additionally, specialized pharmacy services are needed to deal with chemotherapy drugs, the adjustment of pain medication, narcotics, and anti-nausea medication or anti-emetics. (Dragon, Tr. 4317).

1732. Typically, private practice oncologists do not provide ancillary or support services for oncology patients because they generally lose money providing such services. (Dragon, Tr. 4312-13).

1733. Before the Merger, cancer patients at HPH were referred to social workers or psychiatrists outside of the oncology physicians' practices and outside HPH. (Dragon, Tr. 4318). Many of the support services were not covered by health insurance, so patients had to pay for them out of pocket. (Dragon, Tr. 4318). Even if their insurance carrier covered the costs, however, the cancer patients still had to get the services on their own elsewhere in the community. (Dragon, Tr. 4318). This uncoordinated approach made it more difficult for chronically-ill patients who were undergoing cancer treatments to get needed services on their own. (Dragon, Tr. 4318-19).

(3) Pre-Merger Cancer Patients At HPH Lacked Access To Specialists

1734. All of the medical oncologists caring for patients at HPH before the Merger were generalists. (Dragon, Tr. 4315).

1735. Many HPH oncology patients who needed to see a specialist before the Merger went to either the University of Chicago or Northwestern Memorial, both of which are located 25 to 35 miles south of HPH. (Dragon, Tr. 4349).

(4) Pre-Merger Cancer Services At HPH Lacked Academic Research And Clinical Trials

1736. Before the Merger, the HPH oncology program did not have an academic orientation. (Dragon, Tr. 4322). Few physicians had academic appointments to any teaching or research institutions, and aside from putting the occasional patient put on clinical trials, no teaching was done. (Dragon, Tr. 4322; Spaeth, Tr. 2294).

1737. HPH had a small clinical trial program before the Merger. (Dragon, Tr. 4322). Immediately before the Merger, HPH was engaged in only one clinical trial – a national study looking at breast cancer prevention run through HPH. (Dragon, Tr. 4322, 4331-32).

1738. Academic research in oncology is usually performed via clinical trials. (Dragon, Tr. 4325). There are three different types of clinical trials: (1) cooperative group trials; (2) industry-based trials; and (3) institutional-based or Phase II trials. (Dragon, Tr. 4325-26).

1739. Cooperative group trials are National Cancer Institute sponsored trials that cooperatively tie together a number of groups nationally and hundreds of institutions to research the effectiveness of cancer treatments. (Dragon, Tr. 4327). Initially, there were a relatively small number of cooperative group trials at HPH. (Dragon, Tr. 4328). Before the Merger, however, these trials were taken away from HPH. (Dragon, Tr. 4328-30).

1740. Before the Merger, HPH had an Institutional Review Board (“IRB”) in place to review potential clinical trials or studies involving human subjects or materials. (Dragon, Tr. 4331). IRBs ensure that the utilization of human subjects or materials in a hospital is reviewed at the community or institutional level for appropriateness and ethical standards. (Dragon, Tr. 4331-32).

1741. Once the cooperative group trials were taken out of HPH, all review of studies in which HPH patients were participating was done by a freestanding IRB that was not part of the hospital. (Dragon, Tr. 4332). As a result, the community and HPH had no ability to weigh in on the ethical or organizational elements of those studies. (Dragon, Tr. 4332-33).

(5) Pre-Merger Cancer Services At HPH Had Inadequate Facilities And Equipment

1742. Before the Merger, the only site at HPH offering organized chemotherapy services was Dr. Dragon’s office. (Dragon, Tr. 4333). His office contained a communal or open room with nine treatment chairs with some curtains. (Dragon, Tr. 4333).

1743. Additionally, HPH did not own any equipment or facilities dedicated to treating oncology patients. (Dragon, Tr. 4333-34). For instance, the linear accelerator at HPH was not owned by HPH, but by an independent practice. (Newton, Tr. 469). A linear accelerator is a piece of equipment used to provide radiation therapy. (Dragon, Tr. 4334). Specifically, a linear accelerator generates electrons at a high level of intensity to treat a localized part of a patient’s body. (Dragon, Tr. 4334-35).

1744. Moreover, the linear accelerator at HPH pre-Merger was very antiquated and outdated. (Dragon, Tr. 4334). It was two generations beyond what would be considered modern at the time, and below what typical community hospitals in Chicago would have had at that time. (Dragon, Tr. 4336-37). Specifically, the linear accelerator was incapable of giving modern radiation therapy voltage, was incapable of giving intensity-modulated radiotherapy, and the energy was lower than was needed to give effective treatment for specific curative therapies. (Dragon, Tr. 4338-39).

1745. Additionally, the linear accelerator was housed in a shielded vault in the basement of the professional office building at HPH, a place constructed for that particular linear accelerator and too small for a new one. (Dragon, Tr. 4336-37; Newton, Tr. 469).

1746. Because HPH did not own the linear accelerator (it was owned by a private practice) or have space for a new one, HPH could not upgrade the linear accelerator. (Dragon, Tr. 4336-37; Newton, Tr. 469).

1747. Before the Merger, the radiation equipment used to treat cancer patients also was antiquated and not owned by the HPH, but by private practice physicians. (Dragon, Tr. 4334). Radiation equipment is used to treat local sites of tumors. (Dragon, Tr. 4335). The equipment can be used for curative purposes or to palliate symptoms, like pain. (Dragon, Tr. 4335). Radiation oncology and radiation therapy are an integral part of the modern day management of cancer. (Dragon, Tr. 4335-36).

1748. Some physicians used every opportunity to refer patients to other radiation therapy facilities. (Dragon, Tr. 4340).

(6) Pre-Merger Cancer Services At HPH Lacked Quality Assurance

1749. Before the Merger, there were no quality assurance programs in place with respect to oncology at HPH. (Dragon, Tr. 4341).

iii. ENH Made Major Improvements To The HPH Oncology Program That Significantly Expanded HPH's Cancer Services And Improved The Quality Of Cancer Care At HPH

1750. After the Merger, ENH made major improvements to the oncology program at HPH by exporting its multidisciplinary approach to HPH and introducing subspecialty oncologists to HPH. (Chassin, Tr. 5369-70).

(1) The Kellogg Cancer Center Brought A Multidisciplinary Approach To HPH

1751. The Kellogg Cancer Care Center is a Center of Excellence. (Spaeth, Tr. 2237-38). A Center of Excellence is a clinical program that seeks to care for the patient's specific disease through the support of various clinical, research and social services all targeted toward that specific disease. (Spaeth, Tr. 2237-38).

1752. The Kellogg Cancer Center was started at Evanston Hospital more than 20 years ago. (Dragon, Tr. 4342).

1753. Today the Kellogg Cancer Center consists of three ambulatory or outpatient cancer centers: one at Evanston Hospital, one at Glenbrook Hospital, and one at HPH. (Dragon, Tr. 4342; Neaman, Tr. 1352).

1754. The Kellogg Cancer Center outpatient center at HPH is managed by physician leaders at HPH, but the management and administration of the HPH unit reports to a central management at Evanston Hospital. (Dragon, Tr. 4343).

1755. The Kellogg Cancer Center was first opened at HPH as a temporary facility in the Summer of 2000. (Dragon, Tr. 4342; (CX 6304 at 14 (Livingston, Dep.)). Between its opening in June 2000 and September 2002, the HPH branch of the Kellogg Cancer Center recorded more than 1,500 patient visits. (RX 1341 at ENHE TH 975).

1756. By extending the Kellogg Cancer Center to HPH after the Merger, HPH became a multidisciplinary academic oncology center that combines both medical oncology, radiation therapy and breast cancer centers. (Dragon, Tr. 4343-44; Neaman, Tr. 1352; Spaeth, Tr. 2276). Patients are cared for by a team consisting of the physician oncologist, nurse, pharmacist, psychologist, social worker, and nutritionist. (Chassin, Tr. 5369).

1757. Moreover, after HPH's oncology program was merged with ENH, all of the oncology patients at HPH were included in weekly multidisciplinary site-specific care conferences. (Dragon, Tr. 4322). These conferences include discussions about cases involving breast cancer, thoracic cancers, hematologic malignancies, gynecological cancers, sarcomas and melanomas, and gastrointestinal cancer. (Dragon, Tr. 4322-23).

1758. During these conferences a number of physicians from different disciplines, including medical oncologists, surgeons, radiation oncologists, diagnostic radiologists, and pathologists discuss the treatment of each patient. (Dragon, Tr. 4324-25). This interaction is critical because it assures the most up-to-date and modern thoughts and treatment are applied to each case presented at the conference. (Dragon, Tr. 4323-25).

1759. Multidisciplinary site-specific oncology conferences are generally performed by academic hospitals. (Dragon, Tr. 4325). Community hospitals in the Chicago area do not have conferences like these to discuss their patients. (Dragon, Tr. 4325). Typically, a community hospital like HPH would only have a weekly tumor board, which is a general conference at which two or three patients might be presented from the whole institution. (Dragon, Tr. 4363).

1760. ENH recently opened a brand new Ambulatory Care Center ("ACC") at HPH that houses Medical Oncology, the Cardiac Stress Center, the new Breast Imaging Center, and the departments of Nuclear Medicine, Rehabilitation Medicine, and Radiation Therapy. (Dragon, Tr. 4367). The Kellogg Cancer Center occupies an entire floor of the ACC and is outfitted with private treatment rooms for patients who receive chemotherapy. (Hillebrand, Tr. 1981; O'Brien, Tr. 3503).

1761. With the construction of a new ACC at HPH, HPH now has a comprehensive community-based ambulatory facility to provide multidisciplinary cancer care – including medical oncology, radiation oncology and ancillary services – under one roof. (Dragon, Tr. 4346).

1762. Community hospitals typically do not have centers similar to the Kellogg Cancer Center. (Neaman, Tr. 1352). In fact, no service similar to the Kellogg Cancer Center was available at HPH before the Merger. (Spaeth, Tr. 2276).

**(2) ENH Improved Ancillary And Support Services
For Cancer Patients After The Merger**

1763. Ancillary services for cancer patients are not merely changes for the sake of convenience. (Dragon, Tr. 4356). These services are very important to the day-to-day quality of life of cancer patients. (Dragon, Tr. 4356).

1764. Today, HPH offers a host of ancillary and support services to cancer patients directly on-site – including social services, psycho-social support, oncology pharmacy services and dietary services. (Dragon, Tr. 4352). These services are all provided by trained professionals who are members of the staff at the Kellogg Cancer Center. (Dragon, Tr. 4352).

1765. For example, licensed clinical social workers are available to cancer patients at HPH. (Dragon, Tr. 4354). They not only counsel patients and families, but also help with placement issues, arrange for home care and organize many of the complicated issues related to the management of chronic care illness at home. (Dragon, Tr. 4354).

1766. Trained and licensed psychologists are also available on-site to cancer patients at HPH. (Dragon, Tr. 4354). The psychologists who care for patients at HPH and the Kellogg Cancer Center specialize in oncology-related psychology issues. (Dragon, Tr. 4354). Psychological care is very important to establish good quality of life for oncology patients. (Dragon, Tr. 4354-55).

1767. The Kellogg Cancer Center at HPH has registered pharmacists who are specifically trained in oncology pharmacy services. (Dragon, Tr. 4355). One or two pharmacists and often a technician are available at any time to help prepare medications. (Dragon, Tr. 4355). The specialized oncology pharmacists are able to help coordinate the management of pain medication and anti-nausea medication for cancer patients. (Dragon, Tr. 4355). Before the Merger, nurses mixed the drugs. (Dragon, Tr. 4355).

1768. Trained and licensed nutritionists and dieticians are also available to cancer patients at HPH directly through the Kellogg Cancer Center. (Dragon, Tr. 4353). Cancer patients suffer from changes in appetite, weight loss and bowel function and often require fairly complicated changes in dietary support to keep from losing weight. (Dragon, Tr. 4353). These services are important for the physical well-being of patients. (Dragon, Tr. 4353-54).

1769. Finally, there is a collaborative nurse system at the Kellogg Cancer Center where all clinicians have a nurse that works with that physician's group of patients and is available to those patients for counseling, discussion of test scheduling and clinical problems. (Dragon, Tr. 4359-60).

1770. These support services at HPH are part of the ongoing cancer management at HPH. (Dragon, Tr. 4353). Patients are often able to receive ancillary services at HPH while they are undergoing their chemotherapy treatments. (Dragon, Tr. 4353). Moreover, the providers of support services at HPH seamlessly share patient records with the oncologists providing patient care. (Dragon, Tr. 4358).

1771. The coordinated provision of support services at HPH today is typically only seen in academic hospitals. (Dragon, Tr. 4359).

(3) ENH Provided More Qualified Staff And An Academic Affiliation To HPH's Cancer Program After The Merger

1772. The Kellogg Cancer Center at HPH has 10 practicing oncologists, none of whom is a private practitioner. (Dragon, Tr. 4347). Every physician at the Kellogg Cancer Center at HPH is an employed member of the Division of Hematology/Oncology of ENH. (Dragon, Tr. 4347).

1773. Additionally, all oncologists at HPH and the Kellogg Cancer Center are Board-certified and on the faculty of Northwestern University Medical School, and nurses and pharmacists also maintain oncology certification. (RX 1341 at ENHE TH 975; Dragon, Tr. 4361).

(4) ENH Improved Patient Access To Specialists At HPH After The Merger

1774. After the Merger, subspecialty oncologists were available to HPH patients. (Chassin, Tr. 5370). The Kellogg Cancer Center at HPH has a broad range of sub-specialist oncologists – including sub-specialists in breast oncology, thoracic oncology, hematologic malignancies, melanoma, head and neck cancer, and sarcoma. (Dragon, Tr. 4347-48).

1775. The level of expertise by specialized practitioners who are focused in one academic area far exceeds the expertise general oncologists could expect to attain. (Dragon, Tr. 4350).

1776. Before the Merger, none of the physicians on staff at HPH had sub-specialties. (Dragon, Tr. 4348). Accordingly, patients had to leave the community to get access to the oncology specialists who are at HPH today, often traveling long distances for such consultations. (Dragon, Tr. 4350-51; Chassin, Tr. 5370). When a patient is dealing with a chronic debilitating illness, it is far superior from a quality of life standpoint to get health care treatment near home. (Dragon, Tr. 4350-51).

1777. The availability of the sub-specialists provides HPH physicians with learning opportunities in the form of consultations and conferences. (Chassin, Tr. 5370).

1778. The kind of sub-specialty care ENH brought to HPH after the Merger is typical of the care provided at academic medical centers. (Chassin, Tr. 5371).

(5) ENH Provided Increased Academic Research And Clinical Trials To HPH's Cancer Program After The Merger

1779. Another improvement ENH brought to HPH that improved the quality of care in oncology at HPH was increased access to research trials. (Chassin, Tr. 5371). Research trials

are important to patients and physicians because they give physicians the opportunity to be involved in new treatments and to keep abreast of new developments. (Chassin, Tr. 5371).

1780. After the Merger, cancer patients at the HPH branch of the Kellogg Cancer Center had access to at least 78 clinical trials administered directly through the Kellogg Cancer Center. (RX 1723).

1781. Moreover, the National Cancer Institute has recognized the Kellogg Cancer Center, and HPH as a unit of the Kellogg Cancer Center, as a Community Clinical Oncology Program (“CCOP”). (Dragon, Tr. 4344). The National Cancer Institute is a federally funded research organization based in Bethesda, Maryland that is responsible for research funded at institutions nationally. (Dragon, Tr. 4344). The Kellogg Cancer Center is one of 50 Community Clinical Oncology Programs that are funded nationally by the National Cancer Institute. (Dragon, Tr. 4344). The designation of HPH as a CCOP means that the Kellogg Cancer Center is funded to be active in areas of clinical research and prevention of cancer. (Dragon, Tr. 4345). The level of research that is required to have funding for this program is extraordinary for a community hospital, and it gives patients at HPH access to a broad range of treatment and prevention trials. (Dragon, Tr. 4344-45; RX 1341 at ENE TH 975).

1782. HPH was not a CCOP before the Merger. (Dragon, Tr. 4345). Generally, community hospitals would not be designated CCOPs because the resources needed to obtain the funding and the breadth of care are beyond the scope of a relatively small community hospital. (Dragon, Tr. 4345-46).

1783. HPH and ENH now have a single IRB, which is composed of a diverse group of people – including physicians, attorneys, and community representatives. (Dragon, Tr. 4364). Clinical trials at HPH, Evanston Hospital, or Glenbrook Hospital must be presented and formally sanctioned by the IRB. (Dragon, Tr. 4364). The IRB makes decisions on clinical trials based on what the Board feels to be ethically and scientifically acceptable. (Dragon, Tr. 4364-65).

1784. Moreover, academic institutions typically do not allow patients to be on clinical trials outside the purview of its IRB because patient interests require that the hospital be involved in assessing the ethical and scientific bases for research on patients under the hospital’s care. (Dragon, Tr. 4365-66).

**(6) ENH Provided State-Of-The-Art Equipment
And Advanced Services To HPH’s Cancer
Program After The Merger**

1785. Diagnostic equipment is very important in the treatment of cancer patients. (Dragon, Tr. 4367). Diagnostic equipment is used to assess the activity of disease and a patient’s response to treatment. (Dragon, Tr. 4367). It is essential to correctly diagnose a patient’s cancer in order to treat it. (Dragon, Tr. 4366-67).

1786. The ACC at HPH houses a new linear accelerator. (Dragon, Tr. 4369). The linear accelerator gives state-of-the-art treatment, including intensity modulated radiotherapy, which is a type of localizing therapy to treat smaller areas of disease without injuring healthy tissue around them. (Dragon, Tr. 4369-70).

1787. After the Merger, ENH purchased a CT/PET scan for HPH that is used to treat oncology patients. (Dragon, Tr. 4370). A CT/PET scan is the latest generation of positive emission tomography scanning device. (Dragon, Tr. 4370-71). Before the Merger, HPH and Evanston Hospital did not have a CT/PET scan machine. (Dragon, Tr. 4371). CT/PET scan machines are rarely found in community hospitals. (Dragon, Tr. 4372).

1788. Today, complex procedures and treatments, such as interventional radiology, thermal ablation and endoscopic ultrasound, are available to cancer patients at HPH. (Dragon, Tr. 4377). Services such as these would not be available in a typical community hospital and would almost always be done in an academic hospital. (Dragon, Tr. 4376-78).

1789. The changes in radiology and the new equipment purchased by ENH for HPH constitute improvements in quality of care. (Chassin, Tr. 5372).

e. The Merger Substantially Expanded And Improved Laboratory Services At HPH

i. Overview

1790. It is estimated that 70% of medical decisions are based on the results that come from the laboratory. (Victor, Tr. 3636). Pathology is the study and diagnosis of disease using clinical laboratory techniques. (Victor, Tr. 3583).

1791. Laboratory services at HPH before the Merger and after the Merger until June 1, 2001, were provided by two laboratories: (1) an immediate response or “stat” laboratory within HPH (“HPH Lab”); and (2) Consolidated Medical Labs (“CML”), which provided comprehensive laboratory services, located ten miles away. (O’Brien, Tr. 3507-08).

1792. An immediate response laboratory provides urgent results. (Victor, Tr. 3598). The tests performed in an immediate response laboratory are generally far less complex than the tests performed in a full service laboratory. (Victor, Tr. 3598).

1793. CML was a joint venture between Lake Forest Hospital and HPH. (Victor, Tr. 3599; O’Brien, Tr. 3507). Before the Merger, HPH outsourced laboratory testing to CML. (Victor, Tr. 3599).

1794. ENH took over the HPH Lab on June 1, 2000. (Victor, Tr. 3600). It did not take over the HPH Lab immediately after the Merger because the joint venture between Lake Forest Hospital and HPH had to be unraveled first. (Victor, Tr. 3600).

1795. When ENH took over the HPH Lab on June 1, 2000, there were numerous problems at the HPH Lab. (Victor, Tr. 3602). ENH fixed these problems and converted the HPH Lab from an immediate response laboratory to a full service laboratory. (Victor, Tr. 3600-01, 3615-20). Additionally, ENH brought all of the microbiology, immunologic, and molecular diagnostic testing to Evanston Hospital, where there are specialists in each field, and brought specialist oversight and an academic focus to the HPH Lab. (Victor, Tr. 3621-26, 3628-29, 3634-35).

1796. The changes made by ENH post-Merger improved quality in the HPH Lab. (Chassin, Tr. 5349). The costs of these quality improvements exceeded a \$1,000,000. (Victor, Tr. 3617).

1797. Dr. Thomas A. Victor, the Chairman of the Department of Pathology at ENH since 1995 and a board certified pathologist, testified about the quality issues he observed when ENH took over the HPH Lab on June 1, 2000, the steps ENH took to remedy the problems, and other changes made by ENH to expand and improve laboratory services at ENH. (Victor, Tr. 3582-83, 3587). Dr. Victor was in charge of converting the HPH Lab to a full service laboratory. (Victor, Tr. at 3600-01).

ii. ENH Decided To Close CML Because It Was Inefficient

1798. At the time of the Merger, under the direction of Dr. Victor and the pathologists, ENH had a team of 20 people review the services provided at the HPH Lab. (O'Brien, Tr. 3507). The review team also took into account the views of physicians who utilized the laboratories. (O'Brien, Tr. 3507-09).

1799. The assessment concluded that the equipment in the stat laboratory was old, that the operating costs of CML were much higher than the operating costs of the laboratory unit at Evanston and Glenbrook Hospitals and that turnaround times were cause for concern. (O'Brien, Tr. 3508).

1800. As a result of the assessment, ENH dissolved the CML arrangement before June 1, 2001. (O'Brien, Tr. 3509). The laboratory services CML previously provided were divided between Evanston Hospital and HPH. (O'Brien, Tr. 3509; RX 888 at ENHE TV 1262).

iii. ENH Found Several Quality Issues When It Took Over The HPH Lab On June 1, 2000

1801. When ENH took over the HPH Lab on June 1, 2000, there were problems with the equipment, the personnel, the environmental controls, and the water, as well as with the policies and procedures at the HPH Lab. (Victor, Tr. 3602; Chassin, Tr. 5350).

(1) ENH Found That The HPH Lab Had Equipment Issues

1802. There were five problems areas with respect to the automated instrumentation at the HPH Lab when ENH took over on June 1, 2000: (1) Hitachi analyzer, (2) Cell Dye hematology analyzer, (3) blood gas machines, (4) coag machine, and (5) cardiac markers. (Victor, Tr. 3602-03).

1803. In general, automated instruments are preferred to manual testing because automated instruments provide a more rapid turnaround time and use established and standardized methodologies. (Victor, Tr. 3593).

1804. The Hitachi analyzer, used to perform chemistry tests in the HPH Lab, was not consistent in its performance. (Victor, Tr. 3603). It is important to have a properly functioning

Hitachi analyzer because many of the tests required by the clinical staff to manage their patients are chemistry tests, many of which are also stat tests. (Victor, Tr. 3603). Nevertheless, the HPH Lab's Hitachi analyzer broke down frequently and had problems with certain test results, including potassiums and bilirubin. (Victor, Tr. 3603).

1805. HPH Lab personnel were not capable of fixing the problems with the Hitachi analyzer. (Victor, Tr. 3604). Accordingly, if the Hitachi analyzer in the HPH Lab broke down, the HPH Lab personnel would have to wait until somebody came from CML to repair the instrument. (Victor, Tr. 3604). If the delay in repairing the instrument were long enough, the HPH Lab would have to send the tests to CML to be performed. (Victor, Tr. 3604).

1806. The HPH Lab had only one good hematology analyzer that was not capable of performing a five-part differential, a test used to look at the different percentage of cells and the types of cells that are circulating in the blood. (Victor, Tr. 3605). Additionally, the HPH Lab did not have a backup hematology analyzer. (Victor, Tr. 3605).

1807. The HPH Lab's blood gas machines could not be properly calibrated, were not functioning properly and were not giving proper results. (Victor, Tr. 3606-07).

1808. The HPH Lab had only one coag analyzer, which is used to measure the clotting capability of an individual's blood. (Victor, Tr. 3607). The coag analyzer was incapable of doing multiple specimens at the same time, thus causing problems with respect to turnaround time of the needed results. (Victor, Tr. 3607).

1809. The HPH Lab used an Axsym device for cardiac markers that required a lot of time for preparation of the sample. (Victor, Tr. 3608). This was problematic because the pathology laboratories at ENH are often asked to perform tests for cardiac markers by the emergency department, and it is very important to get the result back as quickly as possible. (Victor, Tr. 3608).

1810. Nor did the HPH Lab have the full panel of cardiac markers they should have had. (Victor, Tr. 3608).

1811. Finally, the equipment in the HPH Lab was not state-of-the-art. (Victor, Tr. 3614). To the contrary, the equipment in the HPH stat laboratory was purchased, on average, five to ten years earlier than the equipment in the laboratories of Evanston and Glenbrook Hospitals. (O'Brien, Tr. 3508).

(2) ENH Found That The HPH Lab Had Personnel Issues

1812. The HPH Lab had few certified medical technologists. (Victor, Tr. 3608).

1813. Additionally, the HPH Lab used several personnel who were part-time, many of whom had only just been trained on the job, and many of whom had fewer than three or four months of training. (Victor, Tr. 3608).

1814. Part-time staff are a problem because there is no continuity with regard to their performing tests in the laboratory, and they usually are not well-trained and cannot handle problems as they arise while performing tests. (Victor, Tr. 3609). Moreover, some of the individuals in the HPH Lab had criminal records. (Victor, Tr. 3609).

1815. In addition, pathologists at the HPH Lab were generalists. (Chassin, Tr. 5352). Nor did CML have specialists in each different field of pathology overseeing the testing that was performed there. (Victor, Tr. 3628-29). Rather, CML had eight pathologists whose major function was anatomic pathology – diagnosing surgical specimens – that also covered clinical pathology. (Victor, Tr. 3629).

(3) ENH Found That The HPH Lab Had Environmental Controls Issues

1816. The temperature in a laboratory must be kept at a constant level for the machines in the laboratory to function properly. (Victor, Tr. 3609).

1817. Before the Merger, it was not possible to control the temperature in the laboratory so that it could remain at a constant value. (Victor, Tr. 3609).

(4) ENH Found That The HPH Lab Had Water Issues

1818. The water in the HPH Lab was contaminated and had material floating in it. (Victor, Tr. 3609).

(5) ENH Found That The HPH Lab Did Not Have A Histology Laboratory

1819. A histology laboratory is a laboratory in which tissues are received and prepared for microscopic study. (Victor, Tr. 3610; O'Brien, Tr. 3507).

1820. It is important to have a histology laboratory on site because: (1) it allows the pathologist to work back and forth with the technician to make sure that he or she gets an optimal section to make a diagnosis; (2) the histologist can more conveniently change the way he or she is producing a section when necessary; and (3) staining quality can be controlled. (Victor, Tr. 3610-11).

1821. The HPH Lab did not have a histology laboratory on site before the Merger. (RX 850).

(6) ENH Found That The HPH Lab Did Not Have A Cytology Laboratory

1822. A cytology laboratory is a laboratory in which cell specimens are prepared, usually from fluids and sometimes from needle aspirates, to be read by the pathologist to make a diagnosis. (Victor, Tr. 3611).

1823. It is important to have a cytology laboratory on site because it is important for the pathologist and cytologist to be present together at the same time so that the pathologist can look at the cytology specimen and evaluate the quality of the preparation. (Victor, Tr. 3611).

1824. The HPH Lab did not have a cytology laboratory on site. (RX 850).

(7) ENH Found That The HPH Lab Did Not Have Adequate Laboratory Manuals

1825. The HPH Lab did not have laboratory manuals for all of the tests it was running. (Victor, Tr. 3611-12). It is important to have laboratory manuals: (1) because they are required for approval by regulatory agencies; and (2) in the event a technologist needs to look at the way a procedure has to be done. (Victor, Tr. 3612).

1826. The HPH Lab did not have safety manuals or quality control manuals. (Victor, Tr. 3612). The lack of quality control manuals was an issue because, without them, it is not possible for the technician to ensure that the instrumentation is functioning properly. (Victor, Tr. 3613).

iv. ENH Made Numerous Quality Improvements To The HPH Lab

1827. Following the Merger, ENH made improvements in the laboratory at HPH, including expanding and upgrading the defective equipment, hiring and training qualified personnel, building a new histology and cytology laboratory at HPH, and changing procedures with respect to proficiency and quality testing in machinery. (Chassin, Tr. 5350-51). These improvements all improved the quality of care rendered at HPH. (Chassin, Tr. 5351).

(1) ENH Improved The HPH Lab's Equipment

1828. Over the course of the Summer of 2000, ENH replaced the outdated equipment in the HPH Lab with new equipment that was state of the art. (Victor, Tr. 3616-17).

1829. Specifically, ENH: (1) replaced the existing blood gas machines with state-of-the-art blood gas machines (Radiometers); (2) replaced the Hitachi analyzer with a Beckmann LX 20, which is a state-of-the-art chemical analyzer; (3) purchased a Beckmann CX-9 as a backup analyzer; (4) replaced the coagulation machines with two machines that could do more than one test at a time and handle emergencies; (5) replaced the Axsym cardiac marker equipment with a Stratus, which did comprehensive cardiac markers; and (6) upgraded the hematology instrumentation so that it would be able to do a full automated differential and added a backup for the hematology analyzer. (Victor, Tr. 3615-16).

1830. The new laboratory equipment installed by ENH at the HPH Lab in the Summer of 2000 cost over \$1 million. (Victor, Tr. 3717).

(2) ENH Improved The HPH Lab's Personnel

1831. ENH brought the laboratory manager from Glenbrook Hospital to HPH. (Victor, Tr. 3617). It also replaced all of the personnel who were not registered medical technologists with registered medical technologists. (Victor, Tr. 3617-18). All of the personnel currently in the HPH Lab are registered medical technologists. (Victor, Tr. 3617-18).

1832. To provide appropriate coverage of clinical pathology at the HPH Lab, Dr. Robert Rosecrans, a clinical laboratory scientist who specializes in clinical chemistry, was placed full time at the HPH Lab in the Fall of 2000. (Victor, Tr. 3618; RX 943)

(3) ENH Improved The HPH Lab's Environmental Systems

1833. ENH modified the temperature control in the HPH Lab so that it would achieve the appropriate temperatures for the instrumentation. (Victor, Tr. 3618-19).

(4) ENH Improved The HPH Lab's Water System

1834. ENH changed the HPH Lab water system by putting in new piping and a new filtration system. (Victor, Tr. 3619).

(5) ENH Constructed A Histology Laboratory At The HPH Lab

1835. ENH built a new histology laboratory at HPH over the Summer, Fall and Winter of 2000. (Victor, Tr. 3619). The cost of the new histology laboratory was about \$600,000. (O'Brien, Tr. 3510).

(6) ENH Constructed A Cytology Laboratory At The HPH Lab

1836. ENH built a new cytology laboratory at HPH over the Summer, Fall and Winter of 2000. (Victor, Tr. 3619).

(7) ENH Improved The HPH Lab's Laboratory Manuals

1837. ENH immediately created procedure manuals for the tests performed in the HPH Lab. (Victor, Tr. 3619-20). ENH also developed quality control and safety manuals. (Victor, Tr. 3619-20).

(8) ENH Improved The HPH Lab's Quality Control

1838. ENH monitored quality control data on every HPH Lab shift and over periods of time to make sure that the tests were yielding accurate results. (Victor, Tr. 3620). ENH also implemented proficiency testing at the HPH Lab. (Victor, Tr. 3620).

1839. ENH obtains samples from and gives its test results on those samples to the College of American Pathologists to ensure that ENH benchmarks with every other laboratory in the country that participates in that College of American Pathologists' program. (Victor, Tr. 3620). ENH participates in this survey program so that every two years the Pathology Department at HPH is reviewed to make sure that it is meeting all of the laboratory standards. (Victor, Tr. 3621).

1840. ENH implemented competency training at the HPH Lab, periodically testing the technologists to make sure that they are competent and know how to perform the testing for which they are responsible. (Victor, Tr. 3620).

1841. ENH measured turnaround times at the HPH Lab to make sure it was meeting standards. (Victor, Tr. 3620-21).

(9) ENH Improved Microbiology Testing

1842. Microbiology tests are used to identify organisms causing an infection. (Victor, Tr. 3622).

1843. ENH transferred all of the microbiology testing at HPH to Evanston Hospital. (Victor, Tr. 3621).

1844. Evanston Hospital has three specialists in microbiology. (Victor, Tr. 3622). Before the Merger, CML did not have any specialists in microbiology. (Victor, Tr. 3622).

1845. Additionally, ENH has instituted at least two programs at HPH to control nosocomial infections – *i.e.*, infections that are acquired in the hospital. (Victor, Tr. 3623).

(10) ENH Improved Immunology Testing

1846. ENH brought all of the immunology testing at the HPH Lab to Evanston Hospital. (Victor, Tr. 3624). Evanston Hospital has a nationally recognized specialist in immunology. (Victor, Tr. 3625).

(11) ENH Improved Molecular Diagnostic Testing

1847. Molecular diagnostic testing is used to identify genetic diseases or proclivity to diseases that are caused by specific gene expressions. (Victor, Tr. 3625-26).

1848. ENH brought all of the molecular diagnostic testing at the HPH Lab to Evanston Hospital. (Victor, Tr. 3625).

1849. Evanston Hospital has specialists in molecular diagnostics. (Victor, Tr. 3626). Before the Merger, CML was not able to perform molecular diagnostic testing. (Victor, Tr. 3626).

(12) ENH Improved The HPH Lab's Computer System

1850. On June 1, 2000, ENH installed a new computer system at the HPH Lab. (Victor, Tr. 3627-28; RX 850; RX 888 at ENHE TV 1262). As a result of the Merger, and the integration of HPH's site into ENH's multi-site laboratory system, it was necessary to install a new laboratory information system that was capable of handling a multi-site laboratory. (RX 888 at ENHE TV 1262). The implementation was accomplished in a mere two and a half months, something which ordinarily would have required between nine and twelve months to complete. (RX 888 at ENHE TV 1262).

1851. The new system dramatically improved results reporting and laboratory information availability and was further improved by the later addition of and integration with Epic. (Chassin, Tr. 5352; Victor, Tr. 3627; RX 888 at ENHE TV 1262). This new laboratory information system improved the quality of care at HPH. (Chassin, Tr. 5352).

(13) ENH Established Oversight Of The HPH Lab By ENH Specialists

1852. After ENH took over the HPH Lab on June 1, 2000, the clinical laboratory directors at ENH immediately became responsible for the laboratory at HPH. (Victor, Tr. 3628). The clinical laboratory directors at ENH are all specialists in one subspecialty of clinical pathology and are each board certified in their respective specialties. (Victor, Tr. 3628).

1853. Access to subspecialty pathologists improved the quality of care at HPH. (Chassin, Tr. 5352). Specialists are up to date on all of the technology and thinking that involves their area of specialization and are better equipped to choose the appropriate testing systems for their specialties. Further, specialists are well equipped to offer consultation to any of the clinical staff who need to understand the results they are producing in the laboratory and to obtain consultative information with regard to the care of their patients. (Victor, Tr. 3629).

(14) ENH Established The Rotation Of Pathologists Among The ENH Hospitals

1854. The ENH Pathology Department has 19 faculty members. (Victor, Tr. 3588.) These 19 faculty members rotate through the laboratories at Glenbrook Hospital, Evanston Hospital and HPH. (Victor, Tr. 3588-89).

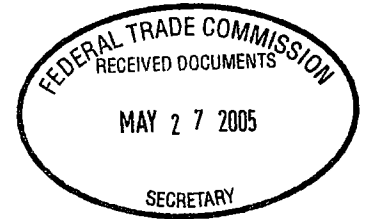
1855. Additionally, immediately after ENH took over the HPH Lab, pathologists from HPH began rotating to Evanston Hospital, and pathologists from Evanston Hospital began rotating to the HPH Lab. (Victor, Tr. 3629-30). This was done because the pathologists at Evanston Hospital see more complex specimens, and it allowed pathologists to stay abreast of all of the modern thinking and modern technologies relating to the practice of pathology. (Victor, Tr. 3589).

○

○

○

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES



_____)
In the matter of)
)
Evanston Northwestern Healthcare) Docket No. 9315
Corporation,) **Public Record**
)
_____)

RESPONDENT'S PROPOSED POST-TRIAL FINDINGS OF FACT

VOLUME IV of IV

WINSTON & STRAWN LLP

35 West Wacker Dr.
Chicago, IL 60601-9703
(312) 558-5764

1700 K Street, N.W.
Washington, DC 20006
(202) 282-5000

TABLE OF CONTENTS

VOLUME I

| | Page |
|--|-------|
| Abbreviations of Terms | xxxvi |
| | |
| I. THE PARTIES..... | 1 |
| A. Evanston Northwestern Healthcare..... | 1 |
| 1. The Three ENH Hospitals..... | 2 |
| a. Evanston Hospital | 3 |
| b. Glenbrook Hospital..... | 3 |
| c. HPH..... | 4 |
| 2. ENH Faculty Practice Associates | 4 |
| 3. ENH Research Institute..... | 4 |
| 4. ENH Foundation..... | 5 |
| B. Evanston Hospital And HPH Before The Merger | 5 |
| 1. Pre-Merger Evanston Hospital..... | 5 |
| 2. HPH Pre-Merger | 6 |
| a. HPH Was A Community Hospital With Limited Services Before The Merger..... | 6 |
| b. HPH Had Financial Problems Before The Merger..... | 7 |
| c. HPH Had Quality Of Care Problems Before The Merger | 7 |
| | |
| II. DYNAMICS OF MANAGED CARE..... | 9 |
| A. Overview: Interaction Among Relevant Players (Patients, Employers, Private Payors And Providers) | 9 |
| B. Types Of Managed Care Plans | 10 |
| 1. HMO | 10 |
| 2. PPO | 11 |

| | | |
|-------|---|----|
| 3. | POS | 11 |
| 4. | Indemnity | 12 |
| C. | Role Of Outpatient Services | 12 |
| D. | Managed Care Contracting | 12 |
| 1. | Selective Contracting | 12 |
| 2. | Scope Of MCO Contracts | 12 |
| 3. | Reimbursement Methodologies | 13 |
| a. | Discount-Off-Charges Contracts | 13 |
| b. | Per Diem | 14 |
| c. | Case Rates | 15 |
| d. | Capitation | 15 |
| E. | Different Type of Hospitals (Academic And Community) | 15 |
| F. | The Impact Of The Balanced Budget Act Of 1997 On Managed Care | 16 |
| G. | Hospitals Have Felt Substantial Pressure To Reduce Costs | 17 |
| H. | Chicago Healthcare Market | 17 |
| a. | Relevant Hospitals | 17 |
| b. | Relevant MCOs | 18 |
| i. | Aetna | 18 |
| ii. | Blue Cross | 18 |
| iii. | CCN | 19 |
| iv. | Cigna | 19 |
| v. | Great West | 20 |
| vi. | HFN | 20 |
| vii. | Humana | 21 |
| viii. | PHCS | 22 |
| ix. | Unicare | 22 |

| | | |
|------|---|----|
| x. | United..... | 23 |
| I. | MCO Negotiating Trends In The Chicago Area Market | 24 |
| 1. | Hospitals Use Termination Letters To Open Negotiations With MCOs..... | 25 |
| 2. | System-Wide Contracts Are Gaining Popularity..... | 25 |
| 3. | The Contract Negotiation “Pendulum” Is Swinging Back In Favor Of MCOs..... | 25 |
| III. | PRE-MERGER BACKGROUND | 27 |
| A. | Northwestern Healthcare Network | 27 |
| 1. | Purpose Of The Network | 27 |
| 2. | Structure And Powers Of The Network..... | 28 |
| 3. | Managed Care Contracting By The Network | 30 |
| 4. | Failures And Limitations Of The Network..... | 30 |
| B. | NH North | 31 |
| C. | Other Failed Merger Negotiations And Failed Joint Ventures Involving HPH | 32 |
| IV. | THE MERGER..... | 34 |
| A. | Merger Negotiations | 34 |
| 1. | Initial Merger Discussions | 34 |
| 2. | Letter Of Intent | 35 |
| B. | Reasons For The Merger..... | 37 |
| 1. | HPH’s Reasons For The Merger..... | 38 |
| a. | The Merger Would Improve Quality Of Care At HPH And In The Community In General..... | 38 |
| b. | The Merger Would Address HPH’s Deteriorating Financial Condition..... | 39 |
| c. | The Merger Would Provide A Good “Fit” | 39 |
| 2. | Evanston Hospital’s Reasons For The Merger | 40 |

| | | |
|----|--|----|
| a. | The Merger Would Allow Evanston Hospital To Improve Quality Of Care By Expanding The Volume Of Its Services | 40 |
| b. | The Merger Would Allow Evanston Hospital To Improve Quality Of Care By Rationalizing Its Services | 40 |
| c. | The Merger Would Result In Corporate Efficiencies | 41 |
| d. | The Merger Would Provide Evanston Hospital With An Additional Teaching Site | 41 |
| C. | Merger Consummation | 41 |
| D. | Effect Of The Merger On ENH’s Operations | 42 |
| E. | Post-Merger Healthcare Foundation Of Highland Park..... | 43 |
| V. | ANALYTIC FRAMEWORK | 44 |
| A. | The Court Should Analyze The Price Increases In The Context Of The Relevant Market..... | 44 |
| 1. | All Experts Agree That Price Increases Alone Are Not Anticompetitive..... | 44 |
| 2. | All Experts Agree That One Must Rule Out Viable Alternative Explanations Before Concluding That A Price Increase Is The Result Of Anticompetitive Market Power | 44 |
| 3. | Market Definition Provides The Necessary Framework In Which To Evaluate These Alternative Explanations..... | 44 |
| B. | The Court Should Evaluate The Competitive Effects Of The Merger | 45 |
| 1. | The Court Should Evaluate Price Effects Of The Merger | 45 |
| 2. | The Court Should Evaluate Quality Effects Of The Merger As A Pro-Competitive Effect | 45 |
| 3. | The Court Should Take Into Account Other Competitive Effects Considerations..... | 46 |
| a. | The Court Should Evaluate Issues Pertaining To Market Entry And Repositioning | 46 |
| b. | The Court Should Evaluate The Financial Condition Of HPH Before The Merger | 47 |
| c. | The Court Should Evaluate ENH’s Not-For-Profit Status | 47 |

| | | |
|-----|---|----|
| C. | ENH’s Economist Experts Analyzed The Facts Of The Case In The Context Of This Analytic Framework | 48 |
| 1. | Dr. Monica Noether | 48 |
| 2. | Professor Jonathan Baker..... | 49 |
| VI. | RELEVANT MARKET..... | 51 |
| A. | The Relevant Product Market Consists Of All Acute Care Hospital-Based Services | 51 |
| 1. | The Product At Issue Being Sold Includes All Acute Care Hospital-Based Services | 51 |
| 2. | The Relevant Customers, <i>i.e.</i> , MCOs, Purchase All Acute Care Hospital-Based Services Together..... | 51 |
| a. | MCOs Purchase Inpatient And Outpatient Services Together | 51 |
| b. | MCOs Purchase Primary, Secondary And Tertiary Services Together | 52 |
| 3. | Dr. Noether Has Correctly Defined The Relevant Product Market..... | 52 |
| 4. | Dr. Haas-Wilson Has Not Correctly Defined The Relevant Product Market | 53 |
| B. | The Relevant Geographic Market Consists Of Multiple Competitor Hospitals In The Chicago Area..... | 53 |
| 1. | The Court Should Consider Patient Preferences And Physician Admitting Patterns When Evaluating The Relevant Geographic Market | 53 |
| a. | Patient Preferences Are Relevant To The Geographic Market Analysis | 53 |
| i. | Geographic Proximity Is Relevant To Patient Preferences..... | 54 |
| ii. | Travel Patterns Are Relevant To Patient Preferences..... | 55 |
| b. | Physician Admitting Patterns Are Relevant To The Geographic Market Analysis | 58 |
| 2. | The Court Should Consider The Fact That There Are Multiple Hospitals In The Chicago Area When Evaluating The Relevant Geographic Market | 58 |

| | | |
|----|--|----|
| a. | Advocate Lutheran General | 59 |
| b. | Condell..... | 59 |
| c. | Lake Forest Hospital | 60 |
| d. | Loyola | 60 |
| e. | Northwestern Memorial | 60 |
| f. | Rush North Shore And Rush Presbyterian..... | 61 |
| g. | St. Francis | 62 |
| h. | Swedish Covenant..... | 62 |
| i. | University Of Chicago | 62 |
| j. | University Of Illinois At Chicago..... | 62 |
| 3. | The Relevant Geographic Market Broadly Encompasses A Large Number Of Competitor Hospitals In The Chicago Area | 63 |
| a. | MCO Testimony And Documents Confirm A Broad Geographic Market | 63 |
| b. | Third Party Hospital Documents Confirm A Broad Geographic Market | 64 |
| c. | ENH Testimony And Documents Confirm A Broad Geographic Market | 66 |
| d. | Other Third Party Testimony And Documents Confirm A Broad Geographic Market..... | 67 |
| e. | Dr. Noether Defined A Reasonable Relevant Geographic Market | 67 |
| f. | Dr. Haas-Wilson Did Not Define A Reasonable Geographic Market | 68 |
| C. | ENH's Market Share Is Less Than That In Other Hospital Merger Cases..... | 69 |
| 1. | ENH's Core Market Consists Of About 20 Zip Codes..... | 69 |
| 2. | ENH's Service Area Consists Of About 51 Zip Codes | 69 |
| 3. | The Concentration Resulting From The Merger Is Acceptable..... | 70 |

VOLUME II

VII. THE MERGER RESULTED IN NO ANTICOMPETITIVE EFFECTS 72

A. The Court Should Consider Various Economic Factors In Its Competitive Effects Analysis 72

1. Dr. Haas-Wilson’s Analysis Is Based On A Bargaining Theory 72

2. The Pertinent Pricing Analysis Under Dr. Haas-Wilson’s Bargaining Theory Has Both Theoretical And Empirical Dimensions 72

a. As A Theoretical Matter, Complaint Counsel Must Show More Than That ENH’s Prices Increased After The Merger 72

i. Price Changes Alone Are Not Evidence Of Market Power 72

ii. Complaint Counsel Must Evaluate And Eliminate Viable Alternative Explanations 73

iii. In Particular, Complaint Counsel Must Rule Out “Learning About Demand” To Show That ENH Exercised Market Power As A Result Of The Merger..... 74

iv. The Court Should Consider Both Price Levels And Price Changes When Evaluating Whether Price Increases Were The Result Of Market Power From The Merger. 74

b. As An Empirical Matter, Complaint Counsel Must Show That ENH’s Post-Merger Prices Increases Were The Result Of Market Power..... 74

3. This Court Also Should Take Into Account Other Competitive Effects Considerations 74

B. The Pre-Merger Competitive Landscape Is Inconsistent With Dr. Haas-Wilson’s Bargaining Theory 76

1. This Case Involves A Differentiated Product 76

2. Evanston Hospital And HPH Were Not Close Substitutes..... 76

a. Evanston And HPH Were Not Close Substitutes From A Product Perspective..... 76

| | | |
|------|---|----|
| i. | Evanston Hospital And HPH Offered A Different Breadth of Services | 76 |
| ii. | Evanston Hospital And HPH Were Hospitals Of Very Different Sizes | 77 |
| iii. | Unlike Evanston Hospital, HPH Had No Teaching Component..... | 78 |
| b. | Evanston Hospital And HPH Were Not Close Substitutes From A Geographic Perspective..... | 78 |
| c. | Evanston Hospital And HPH Had Much Closer Substitutes Than Each Other | 78 |
| i. | Evanston Hospital Had Several Closer Substitutes Than HPH | 79 |
| (1) | Evanston Hospital’s Closest Substitutes From A Product Perspective Were Advocate Lutheran General And Northwestern Memorial | 79 |
| (2) | Evanston Hospital’s Closest Substitutes From A Geographic Perspective Were St. Francis And Rush North Shore..... | 80 |
| ii. | HPH’s Closest Substitutes From Both A Product And Geographic Perspective Were Lake Forest Hospital And Condell | 80 |
| C. | Dr. Haas-Wilson’s Bargaining Theory Does Not Take Into Account The Fact That Evanston Hospital And HPH Had Very Different Negotiating Strategies And Contract Rates Before The Merger | 81 |
| 1. | Evanston Hospital And HPH Had Different Pre-Merger Negotiating Strategies..... | 82 |
| a. | HPH Had An Aggressive Pricing Strategy Before The Merger..... | 82 |
| b. | Evanston Hospital, In Contrast, Did Not Focus On MCO Negotiations Before The Merger | 82 |
| i. | Before 1999, Evanston Hospital Did Not Institute An Aggressive MCO Negotiation Policy | 82 |
| ii. | Evanston Hospital’s Pre-Merger MCO Contract Negotiator Used A Passive Negotiation Style | 83 |

| | | |
|------|---|----|
| (1) | Sirabian Was In Charge Of Evanston Hospital’s Pre-Merger MCO Negotiations | 83 |
| (2) | Sirabian’s Goal Was To Obtain “Win-Win Contracts” | 84 |
| (3) | Sirabian Did Not Threaten Termination As A Means To Obtain Aggressive Rates..... | 84 |
| (4) | Sirabian Let Contracts Lapse And Did Not Intiate Contract Renegotiations..... | 85 |
| iii. | Many Evanston Hospital Contracts Had Not Been Renegotiated In A Number Of Years..... | 85 |
| c. | By The Late 1990’s, Changing Financial Conditions Put Pressure On Evanston Hospital To Focus On MCO Contract Rates..... | 86 |
| i. | Evanston Hospital Realized The Adverse Financial Effect Of The Balanced Budget Act Until In Late 1998 And 1999..... | 86 |
| ii. | Since The Late 1990s, Evanston Hospital/ENH, Along With Other Hospitals, Have Been Under Pressure To Reduce Costs..... | 87 |
| iii. | By The Late 1990s, Evanston Hospital No Longer Could Rely As Heavily On Its Investment Income | 88 |
| 2. | Evanston Hospital And HPH Had Different Negotiated MCO Contract Rates Before The Merger | 89 |
| D. | Dr. Haas-Wilson’s Bargaining Theory Does Not Eliminate All Viable Alternative Explanations For ENH’s Post-Merger Price Increases, Such As Learning About Demand | 89 |
| 1. | “Price” Can Be Defined In Several Ways..... | 89 |
| a. | Charges | 89 |
| b. | Contract Rates..... | 89 |
| c. | Reimbursement Rates | 89 |
| 2. | The Factual Evidence Is Consistent With The Learning About Demand Alternative Explanation For The Price Increases At Issue..... | 90 |

| | | |
|----|---|-----|
| a. | Coincident With The Merger, ENH Learned That It Was “Leaving Money On The Table” Through Proper Due Diligence | 90 |
| b. | At The Time Of The Merger, Evanston Hospital Learned About The Demand For Its Services Through Bain’s Consulting Services | 92 |
| | i. Bain Advised ENH That HPH Had More Favorable MCO Contracts | 92 |
| | ii. Bain Advised ENH That It Had Expired Or Outdated MCO Contracts | 95 |
| | iii. Bain Advised ENH That It Was Under-Market As Compared To Its Peer Academic Hospitals | 96 |
| | iv. Bain Advised ENH On MCO Contract Renegotiations..... | 96 |
| | (1) Bain Advised ENH On A Post-Merger Negotiation Schedule | |
| | (2) Bain Advised ENH On Negotiation Tactics | 97 |
| | v. Bain’s Advice Paid Off – But The Successful Contract Renegotiations Were Not Due To The Merger..... | 99 |
| c. | Individual MCO Negotiations Are Consistent With The Learning About Demand Theory | 100 |
| | i. Aetna..... | 101 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With Aetna Were Outdated And Undermarket | 101 |
| | (2) ENH’s Post-Merger Negotiations With Aetna Were Not Anticompetitive | 102 |
| | ii. Blue Cross..... | 103 |
| | (1) Evanston Hospital Pre-Merger Contract Rates Exceeded HPH’s Pre-Merger Contract Rates..... | 103 |
| | (2) ENH’s Post-Merger Negotiations With Blue Cross Were Not Anticompetitive..... | 104 |

| | | |
|-------|---|-----|
| iii. | Cigna..... | 106 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With Cigna Were Outdated And Undermarket | 106 |
| | (2) ENH’s Post-Merger Negotiations With Cigna Were Not Anticompetitive | 106 |
| iv. | CCN | 106 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With CCN Were Outdated And Undermarket | 106 |
| | (2) ENH’s Post-Merger Negotiations With CCN Were Not Anticompetitive..... | 107 |
| v. | Great West | 107 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With One Health/Great West Were Outdated And Undermarket..... | 107 |
| | (2) ENH’s Post-Merger Negotiations With Great West Were Not Anticompetitive..... | 108 |
| vi. | HFN..... | 109 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With HFN Were Outdated And Undermarket | 109 |
| | (2) ENH’s Post-Merger Negotiations With HFN Were Not Anticompetitive..... | 110 |
| vii. | Humana..... | 110 |
| | (1) Before the Merger, Evanston Hospital Acquired Some Humana Physician Office Sites..... | 110 |
| | (2) ENH’s Post-Merger Negotiations With Humana Were Not Anticompetitive | 111 |
| viii. | PHCS..... | 112 |
| | (1) Evanston Hospital’s Pre-Merger Contract Rates With PHCS Was Outdated And Undermarket | 112 |

| | | | |
|-----|------|--|-----|
| | (2) | ENH’s Post-Merger Negotiations With PHCS Were Not Anticompetitive..... | 113 |
| ix. | | Preferred Plan..... | 115 |
| | (1) | Evanston Hospital’s Pre-Merger Contract Rates With Preferred Plan Were Outdated And Undermarket..... | 115 |
| | (2) | ENH’s Post-Merger Negotiations With Preferred Plan Were Not Anticompetitive..... | 115 |
| x. | | Unicare..... | 116 |
| | (1) | Evanston Hospital’s Pre-Merger Contract Rates With Unicare And Rush Prudential Were Outdated And Undermarket | 116 |
| | (2) | ENH’s Post-Merger Negotiations With Unicare Were Not Anticompetitive | 117 |
| xi. | | United..... | 119 |
| | (1) | Evanston Hospital’s Pre-Merger Contract Rates With United Were Outdated And Undermarket | 119 |
| | (2) | ENH’s Post-Merger Negotiations With United Were Not Anticompetitive..... | 119 |
| | (3) | United And ENH Renegotiated Their 2000 Contract To Accommodate United’s Contracting Goals | 121 |
| d. | | By 2002, ENH Learned That, On A Whole, Its Chargemaster Contained Prices That Were Undermarket | 125 |
| | i. | Description Of A Chargemaster..... | 125 |
| | ii. | ENH Consolidated Its Chargemaster After The Merger..... | 125 |
| | iii. | ENH, With The Assistance Of Deloitte Consulting, Brought Its Chargemaster Up To Market In 2002 | 126 |
| e. | | Factual Evidence Is Inconsistent With Dr. Haas-Wilson’s Bargaining Theory | 130 |
| | i. | Dr. Haas-Wilson’s Bargaining Theory Is Not Grounded In Theory Or Common Sense | 130 |

| | | |
|------|---|-----|
| ii. | Dr. Haas-Wilson’s Bargaining Theory Does Not Apply Here Because MCOs Did Not Play Evanston Hospital And HPH Off Each Other Before The Merger..... | 131 |
| iii. | Dr. Haas-Wilson’s Bargaining Theory Does Not Apply Here Because She Admits That A Network Without ENH Would Still Be Marketable..... | 133 |
| iv. | Dr. Haas-Wilson’s Bargaining Theory Does Not Apply Here Because There Was Little Selective Contracting In The Chicago Area..... | 133 |
| v. | Pertinent Documents Do Not Support Dr. Haas-Wilson’s Bargaining Theory..... | 134 |
| 3. | Empirical Analysis Of Price <i>Changes</i> Does Not Show That The Merger Conferred Market Power..... | 135 |
| a. | Professor Baker Measured The Relative, Non-Quality-Adjusted Post-Merger Price Changes In The Reasonable Range Of 9-12% | 135 |
| b. | Problems With Available Data Render Professor Baker’s Price Estimates Conservative..... | 136 |
| c. | Dr. Haas-Wilson’s Empirical Analysis Fails To Support The Conclusion That Post-Merger Price Changes Are The Result Of Market Power | 137 |
| i. | Dr. Haas-Wilson’s Empirical Theory Is Flawed..... | 137 |
| ii. | Dr. Haas-Wilson’s Methodology Is Flawed | 138 |
| (1) | Dr. Haas-Wilson Measured The Wrong Prices..... | 138 |
| (2) | Dr. Haas-Wilson Did Not Effectively Clean The Data Underlying Her Empirical Analysis..... | 138 |
| (3) | Dr. Haas-Wilson’s Control Groups Are Not An Appropriate Basis For Measuring Relative Price Changes | 139 |
| iii. | Dr. Haas-Wilson’s Empirical Results Are Not Consistent With A Market Power Explanation For The Price Increases At Issue..... | 141 |

| | | |
|------|---|-----|
| d. | Dr. Haas-Wilson’s Empirical Analysis Fails To Account For Viable Alternative Explanations For The Price Increases At Issue, Such As Learning About Demand | 142 |
| 4. | Empirical Analysis of Price <i>Levels</i> Also Supports Learning About Demand | 144 |
| a. | Dr. Noether’s Control Groups Are An Appropriate Basis To Compare Price Levels..... | 144 |
| i. | The Criteria Used By Dr. Noether To Select Her Control Group Are Appropriate..... | 144 |
| ii. | Dr. Noether’s Characterization Of ENH As A Major Teaching Hospital Is Consistent With MCO Views | 145 |
| iii. | Dr. Haas-Wilson’s Criticisms Of Dr. Noether’s Control Groups Are Unfounded..... | 146 |
| (1) | Dr. Haas-Wilson’s Sum Of Squares Measure Of Breadth Of Service Is Misleading..... | 146 |
| (2) | Dr. Haas-Wilson’s Focus On “Quarternary Services” Is Misguided | 147 |
| (3) | Dr. Haas-Wilson’s Criticisms Of Dr. Noether’s Control Group Based On Differences In Public Perception Are Unfounded..... | 147 |
| b. | Dr. Noether Cleaned Pertinent MCO Data More Effectively Than Dr. Haas-Wilson | 148 |
| c. | Dr. Noether’s Empirical Analysis Confirms That The Learning About Demand Theory Applies In This Case | 150 |
| i. | Aetna..... | 151 |
| ii. | Blue Cross..... | 151 |
| iii. | Humana..... | 152 |
| iv. | United..... | 152 |
| d. | Professor Baker’s Empirical Analysis Confirms That The Learning About Demand Theory Applies In This Case | 153 |
| i. | The Results Of Professor Baker’s Analysis Are Consistent With The Learning About Demand Theory..... | 155 |

| | | |
|-----|--|-----|
| ii. | Professor Baker’s Empirical Analysis Overstates ENH’s Post-Merger Price Increase Because That Analysis Does Not Measure Quality-Adjusted Prices..... | 156 |
|-----|--|-----|

VOLUME III

| | | |
|-------|---|-----|
| VIII. | MERGER IMPACT ON QUALITY | 158 |
| A. | Definition And Measurement Of Healthcare Quality..... | 158 |
| 1. | Definition Of Quality In Healthcare | 158 |
| 2. | Measuring Healthcare Quality | 158 |
| a. | Strengths And Weaknesses Of Quality Measures | 159 |
| b. | Quality Measures Must Be Valid..... | 161 |
| B. | Dr. Chassin Employed Accepted Methodology For The Study Of Healthcare Quality | 162 |
| C. | Dr. Chassin Has Extensive Experience Evaluating And Assessing Healthcare Quality | 164 |
| D. | Overview Of Changes In Healthcare Quality At HPH As A Result Of The Merger..... | 166 |
| 1. | ENH Corrected Problems With Clinical Practice At HPH That Existed Before The Merger..... | 167 |
| a. | The Merger Improved Quality Of Care In HPH’s Ob/Gyn | 167 |
| i. | Overview..... | 167 |
| ii. | Evanston Hospital Had A Relationship With HPH Before The Merger Through The Illinois Perinatal Network..... | 168 |
| iii. | HPH Ob/Gyn Department Had Serious Problems Before The Merger..... | 169 |
| (1) | HPH Had Insufficient Obstetrician Coverage Before The Merger..... | 170 |
| (2) | HPH’s Ob/Gyn Department Had Poor Nurse/Physician Teamwork Before The Merger..... | 170 |

| | | | |
|-----|-----|---|-----|
| | (3) | HPH Lacked Effective Obstetrical Leadership Before The Merger | 171 |
| | (4) | There Were Inappropriate Procedures In HPH's Ob/Gyn Department Before The Merger | 172 |
| iv. | | ENH Improved Quality Of Care At HPH's Ob/Gyn Department After The Merger | 173 |
| | (1) | ENH Expanded Obstetrician Coverage At HPH After The Merger | 173 |
| | (2) | ENH Improved HPH's Nurse/Physician Teamwork After The Merger | 175 |
| | (3) | ENH Improved HPH's Ob/Gyn Leadership And Quality Assurance Program After The Merger | 176 |
| | (4) | ENH Addressed The Inappropriate Procedures In Ob/Gyn At HPH After The Merger | 177 |
| | (5) | ENH Implemented Obstetric Committee Practice Protocols At HPH After The Merger | 177 |
| | (6) | ENH Introduced The Preoperative Gynecologic Surgical Review Program At HPH After The Merger | 178 |
| v. | | Patient Outcomes In ENH's OB/GYN Services Are Consistent With, Or Better Than, National Benchmarks | 180 |
| vi. | | Dr. Romano's Undue Reliance On Administrative Data To Evaluate HPH's Obstetrical Service Is Invalid | 182 |
| b. | | The Merger Improved Quality Of Care In HPH's Nursing Services | 183 |
| | i. | Overview | 183 |
| | ii. | HPH's Pre-Merger Nursing Services Needed Improvement | 184 |

| | | |
|------|---|-----|
| (1) | HPH Had Issues Concerning Nurse Recruiting, Vacancy And Turnover Rates Before The Merger..... | 184 |
| (2) | HPH Had Issues Concerning Nurse Training Before The Merger..... | 185 |
| (3) | HPH Had Issues Concerning Nurse/Physician Relationships Before The Merger..... | 186 |
| iii. | ENH Improved HPH’s Nursing Services And Culture After The Merger | 188 |
| (1) | ENH Improved HPH’s Nurse Recruiting, Vacancy And Turnover After The Merger | 189 |
| (2) | ENH Improved HPH’s Nurse Training After The Merger..... | 190 |
| (3) | ENH Improved HPH’s Nurse/Physician Relationships After The Merger | 191 |
| c. | The Merger Substantially Improved HPH’s Quality Assurance Program | 192 |
| i. | Overview..... | 192 |
| ii. | HPH’s Quality Assurance Was Inadequate Before The Merger..... | 193 |
| (1) | HPH’s Pre-Merger Organizational Structure Hindered Quality Assurance Activities | 194 |
| (2) | HPH’s Pre-Merger Adverse Event Case Reviews Were Suboptimal..... | 195 |
| (3) | HPH’s Ob/Gyn Department Was Particularly Poor At Disciplining Problem Physicians | 196 |
| iii. | ENH Improved HPH’s Quality Assurance Program Soon After The Merger..... | 196 |
| (1) | The Merger Improved The Reporting Of Adverse Events At HPH | 197 |

| | | | |
|----|------|--|-----|
| | (2) | ENH’s Addition Of Strong Department Leadership At HPH Helped Correct Problems With Physician Discipline | 197 |
| | (3) | ENH Improved The Process Of Reviewing HPH Physician Credentialing Status | 199 |
| d. | | The Merger Improved HPH’s Quality Improvement Program..... | 199 |
| | i. | HPH’s Pre-Merger QI Program Was Inadequate..... | 200 |
| | ii. | ENH Exported Its Superior Quality Improvement Processes To HPH Soon After The Merger | 200 |
| | iii. | Data From HPH’s Pre-Merger Care Maps Cannot Be Used To Assess Quality Improvements At HPH Post-Merger..... | 202 |
| | iv. | Improvements In The Care Of Heart Attack Patients At HPH Demonstrates The Improvement In HPH’s QI Program Post-Merger..... | 202 |
| | (1) | ENH Improved The Provision Of Aspirin To Heart Attack Patients At HPH | 203 |
| | (2) | HPH Improved The Provision Of Beta Blockers To Heart Attack Patients After The Merger..... | 204 |
| | (3) | The Minor Change In Performance On The NRMI Measures Are Based On An Extremely Small Sample..... | 205 |
| | (4) | The Merger Resulted In A Dramatic Improvement In The Care Of Heart Attack Patients At HPH | 206 |
| e. | | ENH Corrected Serious Deficiencies In HPH’s Physical Plant | 206 |
| | i. | Overview..... | 206 |
| | ii. | Before The Merger, HPH Passed The Joint Commission’s Accreditation Inspections, Which Are Not A Comprehensive Assessment Of Hospital Quality, Because It Had Advance Notice Of The Inspections | 207 |

| | | |
|------|---|-----|
| iii. | A 1999 IDPH Survey Uncovered Numerous Physical Plant Deficiencies At HPH That Were Not Identified By The 1999 Joint Commission Accreditation Survey | 208 |
| iv. | Before The Merger, HPH Nearly Lost Its Medicare Accreditation Due To Serious Physical Plant Deficiencies That Threatened Patient Safety | 209 |
| v. | Pre-Merger Due Diligence Performed By ENH Identified Even More Serious Physical Plant Deficiencies | 209 |
| vi. | ENH Remedied The Substantial Deficiencies To HPH's Physical Plant And Made Additional Capital Improvements That Enhanced The Quality Of Care At HPH..... | 211 |
| | (1) ENH Opened A New Open Heart Surgery Suite At HPH | 212 |
| | (2) ENH Opened A New Ambulatory Care Center At HPH..... | 212 |
| | (3) ENH Purchased New Equipment For The Operating Rooms | 212 |
| 2. | ENH Made Additional Improvements To Quality Of Care And Introduced New High Quality Services | 213 |
| a. | ENH Initiated A Cardiac Surgery Program At HPH After The Merger..... | 213 |
| i. | Overview..... | 213 |
| ii. | HPH Was Not Well-Positioned To Begin A Cardiac Surgery Program | 214 |
| iii. | ENH Recruited A Talented Physician Leader For Cardiac Surgery Immediately After The Merger..... | 215 |
| iv. | Evanston Hospital And HPH, Since The Merger, Have An Integrated Cardiac Surgery Program That Shares An Affiliation With Other Hospitals | 216 |
| v. | HPH Had Equal Or Lesser Ability To Accept A New Cardiac Surgery Program Than The ENH-Affiliated Hospitals..... | 218 |

| | | |
|------|--|-----|
| vi. | The Post-Merger, Integrated ENH/HPH Cardiac Surgery Program Provides Excellent Care To Patients | 218 |
| | (1) The Mortality Rate For Cardiac Surgery At HPH Compares Favorably To The Best Surgery Centers In The Country | 218 |
| | (2) HPH Complication Rates For Cardiac Surgery Are Below National Benchmarks..... | 220 |
| vii. | The Merger Was Essential To The Success Of HPH's Cardiac Surgery Program..... | 221 |
| | (1) As A Result Of The Merger HPH Is An Integrated Part Of The ENH Cardiac Surgery Program | 221 |
| | (2) Due To The Level Of Integration Engendered By The Merger, HPH Performs Higher Quality Cardiac Surgery Than Affiliated Hospitals..... | 222 |
| b. | ENH Successfully Established An Interventional Cardiology Program At HPH..... | 224 |
| | i. Overview..... | 224 |
| | ii. Before The Merger, HPH Could Not Treat Heart Attack Patients With Interventional Cardiology Procedures..... | 224 |
| | iii. After The Merger, ENH Established A Successful Interventional Cardiology Program At HPH | 224 |
| | (1) HPH's Interventional Cardiology Program Has Obviated The Need To Transfer Acute Heart Attack Patients To Other Hospitals..... | 225 |
| | (2) The Interventional Cardiology Program At HPH Has Achieved High Quality Outcomes..... | 226 |
| | (3) On-Site Cardiac Surgery At HPH Is Needed To Continue The Interventional Cardiology Program..... | 226 |
| c. | The Merger Substantially Improved HPH's Intensive Care Services | 227 |

| | | |
|------|--|-----|
| i. | Overview..... | 227 |
| ii. | HPH’s ICU Had Gaps In Patient Care Before The Merger..... | 228 |
| iii. | The Addition Of Intensivist Coverage After The Merger Eliminated The Gaps In ICU Patient Care At HPH | 229 |
| (1) | Intensivists Have Broad ICU Responsibilities At HPH | 230 |
| (2) | The Intensivist Program Complemented The Introduction Of Cardiac Surgery At HPH | 231 |
| (3) | The Intensivist Program Improved Nursing Care In The HPH ICU..... | 232 |
| iv. | The Intensivist Program Improved The Overall Quality Of Care For HPH’s Critically Ill Patients | 232 |
| v. | HPH Had No Plans To Adopt An Intensivist Program Before The Merger | 233 |
| d. | The Merger Substantially Improved Oncology Services At ENH | 233 |
| i. | Overview..... | 233 |
| ii. | Pre-Merger Cancer Services At HPH Were Typical Of A Community Hospital..... | 234 |
| (1) | Pre-Merger Cancer Services At HPH Lacked Full Time Employed Oncologists | 234 |
| (2) | Pre-Merger Cancer Support And Ancillary Services At HPH Were Limited..... | 235 |
| (3) | Pre-Merger Cancer Patients At HPH Lacked Access To Specialists..... | 235 |
| (4) | Pre-Merger Cancer Services At HPH Lacked Academic Research And Clinical Trials | 235 |
| (5) | Pre-Merger Cancer Services At HPH Had Inadequate Facilities And Equipment..... | 236 |
| (6) | Pre-Merger Cancer Services At HPH Lacked Quality Assurance | 237 |

| | | |
|------|--|-----|
| iii. | ENH Made Major Improvements To The HPH Oncology Program That Significantly Expanded HPH’s Cancer Services And Improved The Quality Of Cancer Care At HPH | 237 |
| | (1) The Kellogg Cancer Center Brought A Multidisciplinary Approach To HPH..... | 237 |
| | (2) ENH Improved Ancillary And Support Services For Cancer Patients After The Merger..... | 239 |
| | (3) ENH Provided More Qualified Staff And An Academic Affiliation To HPH’s Cancer Program After The Merger | 240 |
| | (4) ENH Improved Patient Access To Specialists At HPH After The Merger | 240 |
| | (5) ENH Provided Increased Academic Research And Clinical Trials To HPH’s Cancer Program After The Merger | 240 |
| | (6) ENH Provided State-Of-The-Art Equipment And Advanced Services To HPH’s Cancer Program After The Merger | 241 |
| e. | The Merger Substantially Expanded And Improved Laboratory Services At HPH | 242 |
| | i. Overview..... | 242 |
| | ii. ENH Decided To Close CML Because It Was Inefficient..... | 243 |
| | iii. ENH Found Several Quality Issues When It Took Over The HPH Lab On June 1, 2000..... | 243 |
| | (1) ENH Found That The HPH Lab Had Equipment Issues | 243 |
| | (2) ENH Found That The HPH Lab Had Personnel Issues..... | 244 |
| | (3) ENH Found That The HPH Lab Had Environmental Controls Issues | 245 |
| | (4) ENH Found That The HPH Lab Had Water Issues..... | 245 |

| | | | |
|-----|------|--|-----|
| | (5) | ENH Found That The HPH Lab Did Not Have A Histology Laboratory..... | 245 |
| | (6) | ENH Found That The HPH Lab Did Not Have A Cytology Laboratory..... | 245 |
| | (7) | ENH Found That The HPH Lab Did Not Have Adequate Laboratory Manuals | 246 |
| iv. | | ENH Made Numerous Quality Improvements To The HPH Lab | 246 |
| | (1) | ENH Improved The HPH Lab’s Equipment..... | 246 |
| | (2) | ENH Improved The HPH Lab’s Personnel..... | 247 |
| | (3) | ENH Improved The HPH Lab’s Environmental Systems | 247 |
| | (4) | ENH Improved The HPH Lab’s Water System..... | 247 |
| | (5) | ENH Constructed A Histology Laboratory At The HPH Lab | 247 |
| | (6) | ENH Constructed A Cytology Laboratory At The HPH Lab | 247 |
| | (7) | ENH Improved The HPH Lab’s Laboratory Manuals..... | 247 |
| | (8) | ENH Improved The HPH Lab’s Quality Control | 247 |
| | (9) | ENH Improved Microbiology Testing | 248 |
| | (10) | ENH Improved Immunology Testing | 248 |
| | (11) | ENH Improved Molecular Diagnostic Testing..... | 248 |
| | (12) | ENH Improved The HPH Lab’s Computer System..... | 249 |
| | (13) | ENH Established Oversight Of The HPH Lab By ENH Specialists | 249 |
| | (14) | ENH Established The Rotation Of Pathologists Among The ENH Hospitals | 249 |

VOLUME IV

| | | |
|------|--|-----|
| v. | ENH's Improvements To The HPH Lab Have Improved Quality And/Or Resulted In Efficiencies | 250 |
| (1) | ENH's Improvements To The HPH Lab Dramatically Improved The Turnaround Time For Tests Performed In The HPH Lab | 250 |
| (2) | ENH Brought Its Academic Focus On Pathology To HPH..... | 250 |
| (3) | On-Site Testing Has Substantial Advantages Over Outsourcing..... | 250 |
| (4) | ENH Realized Substantial Cost Savings From The Dissolution of CML | 251 |
| (5) | HPH Pathologists Now Engage in Teaching Activities..... | 252 |
| f. | The Merger Resulted In Structured And Service Improvements To The HPH Emergency Department..... | 251 |
| i. | Overview..... | 251 |
| ii. | HPH's Pre-Merger ED Needed Improvement | 252 |
| (1) | In General, HPH's ED Facilities Were Inadequate Before The Merger | 252 |
| (2) | HPH Had Physician Staffing Problems Before The Merger..... | 252 |
| (3) | HPH's Fast Track Was Inadequate Before The Merger..... | 253 |
| iii. | ENH Significantly Improved The HPH ED After The Merger..... | 254 |
| (1) | ENH Substantially Expanded And Renovated The HPH ED..... | 254 |
| (a) | Phase I Of The HPH ED Renovation..... | 254 |
| (i) | Patient Rooms Were Redesigned..... | 254 |
| (ii) | Critical Care Rooms Were Updated | 255 |

| | | | |
|----|-------|--|-----|
| | (iii) | Isolation Rooms Were Added..... | 255 |
| | (b) | Phase II Of The HPH Renovation | |
| | (i) | The HPH ED Registration Area Was Made More Private..... | 255 |
| | (ii) | The HPH ED Triage Area Was Significantly Expanded..... | 256 |
| | (iii) | The HPH ED Waiting Area Was Remodeled | 256 |
| | (2) | ED Physician Coverage Was Expanded Post-Merger..... | 256 |
| | (i) | Double Coverage At HPH’s ED Improved Quality Of Care..... | 256 |
| | (ii) | The Rotation Of ED Physicians At ENH Improved Quality Of Care..... | 257 |
| | (iii) | Other Staffing Changes At HPH’s ED Improved Quality Of Care..... | 258 |
| | (3) | ENH Improved HPH’s Fast Track Design And Processes | 258 |
| | (4) | ENH Coordinated HPH’s ED And Its Cardiac Services..... | 259 |
| | (5) | ENH Increased Nurse Staffing In HPH’s ED | 259 |
| | (6) | ENH Improved HPH’s ED In Other Ways As Well | 259 |
| g. | | ENH Improved Pharmacy Services At HPH Post-Merger | 261 |
| | i. | Overview..... | 261 |
| | ii. | ENH Improved Drug Dispensing Services At HPH After The Merger | 261 |
| | (1) | ENH Added A Third-Shift Pharmacist To HPH..... | 261 |
| | (2) | ENH Added An Automated Drug Distribution System (Pyxis) To HPH | 262 |

| | | |
|------|--|-----|
| iii. | ENH Added Clinical Pharmacy Services At HPH After The Merger | 264 |
| iv. | HPH’s Institute For Safe Medication Practices Surveys Confirm That ENH’s Enhancements To HPH’s Pharmacy Services Have Improved Quality Of Care..... | 266 |
| h. | ENH’s Deployment Of EPIC At HPH Has Dramatically Improved The Quality Of Care | 267 |
| i. | Overview..... | 267 |
| ii. | Epic Integrates All Patient Information Into A Single Data Repository That Is Accessible By All Caregivers And The Patient | 268 |
| iii. | Sources Outside Of ENH, Including The Federal Government, Have Been Calling For The Use Of Electronic Medical Records..... | 268 |
| iv. | The Sharing Of Information Is Important To Patient Care And Patient Safety..... | 269 |
| v. | ENH Made A Patient-Centric Integrated Electronic Health Record Its Top Priority And Chose Epic Because It Was Best Suited To Accomplish This Goal..... | 269 |
| vi. | ENH Planned From The Outset To Deploy Epic At HPH And In Affiliate Outpatient Offices | 270 |
| vii. | ENH Aggressively Deployed Epic Throughout The ENH System..... | 270 |
| | (1) Initial Steps | 270 |
| | (a) Workflow Analysis | 270 |
| | (b) Build..... | 271 |
| | (c) Hardware Deployment | 271 |
| | (d) Training..... | 271 |
| | (e) Support System | 272 |
| | (2) Deployment..... | 272 |

| | | |
|-------|---|-----|
| viii. | The Deployment And Maintenance Of Epic Requires Tremendous Resources And Manpower | 273 |
| ix. | ENH Has Realized Cost Savings Through The Use Of Epic | 273 |
| x. | ENH Requires Physicians To Use Epic In The ENH Hospitals | 273 |
| xi. | Epic Allows ENH Clinicians To Access Complete, Up-To-Date Patient Information From Almost Anywhere..... | 274 |
| xii. | Epic Has Dramatically Changed And Improved The Practice Of Medicine | 274 |
| | (1) EPIC Makes Learning A Patient’s Medical History Considerably Easier | 274 |
| | (2) Epic Makes Finding And Reading A Patient’s Medical Information Substantially Easier | 275 |
| | (3) Epic Simplifies And Makes The Ordering Of Medication And Tests More Efficient | 275 |
| | (4) Epic Improves The Process By Which Laboratory Results Are Reported And Accessed | 276 |
| | (5) Epic Has Made Consulting With Other Physicians Much Easier | 277 |
| | (6) Epic Has Substantially Improved Laboratory Services | 277 |
| xiii. | Epic Has Numerous Safety Features That Improve The Quality Of Care..... | 277 |
| | (1) Epic Has Health Maintenance Alerts | 278 |
| | (2) Epic Has Best Practice Alerts | 278 |
| | (3) Epic Presents Physicians With Order Sets..... | 278 |
| | (4) Epic Facilitates The Use Of Clinical Pathways ... | 278 |
| | (5) Epic Implements A Clinical Decision Support System (“CDSS”)..... | 279 |
| | (6) Epic Improves Patient Access To Their Medical Records | 279 |

| | | |
|--------|--|-----|
| | (7) Epic Improves Quality Of Care When There Are Drug Recalls..... | 279 |
| xiv. | ENH’s Accomplishment In The Deployment of EPIC Is Unique | 280 |
| xv. | ENH Has Been Recognized By Numerous Outside Sources For Its Successful Deployment Of Epic | 280 |
| xvi. | Other Academic Hospitals In The Chicago Area Are Looking To Learn From ENH’s Successful Deployment Of Epic | 281 |
| xvii. | Epic Has Not Been Implemented By Community Hospitals | 281 |
| xviii. | Epic Is Far Superior To Meditech, The System Used At HPH Before The Merger | 281 |
| i. | The Merger Improved The Quality Of Radiology, Radiation Medicine, And Nuclear Medicine At HPH | 282 |
| | i. Overview | 282 |
| | ii. HPH’s Pre-Merger Radiology Equipment Was Antiquated And Productivity Was Lower Than It Should Have Been With Respect To Radiology Services | 282 |
| | iii. ENH Made Substantial Post-Merger Improvements To Radiology And Radiation Medicine Services That Improved The Quality Of Care At HPH..... | 283 |
| | (1) ENH Upgraded The Equipment And Systems At HPH And Extended Its Technology To HPH..... | 283 |
| | (2) ENH Added Additional Radiology Staff And Improved Access To Specialists At HPH | 284 |
| | (3) HPH Would Not Have Been Able To Make The Improvements In Radiology And Radiation Medicine Without The Merger | 284 |
| | iv. ENH Made Significant Post-Merger Improvements To The Nuclear Medicine Department At HPH | 284 |
| j. | The Medical Staff Integration And Academic Involvement Of Physicians Which Resulted From The Merger Improved The Quality Of Care At HPH..... | 284 |

| | | |
|------|---|-----|
| i. | Overview | 284 |
| ii. | HPH Physicians Rotate Through All Three ENH Campuses | 285 |
| iii. | HPH Physicians Take Part In Teaching Activities For Residents And Medical Students At Evanston Hospital | 285 |
| iv. | HPH Physicians Participate In Departmental Conferences That Broaden Their Skills..... | 286 |
| v. | HPH Physicians Have Obtained Faculty Appointments As A Result Of The Merger | 286 |
| vi. | ENH Provides HPH Physicians With A Continuing Medical Education Stipend | 287 |
| vii. | HPH Has Gained An Academic Affiliation, Which Has Enabled It To Recruit Better Physicians | 287 |
| k. | The Merger Improved The Quality Of Psychiatric Services At HPH | 287 |
| i. | Overview..... | 287 |
| ii. | Before The Merger, The Adolescent Psychiatry Services Available At Both Highland Park And Evanston Hospitals Were Limited | 288 |
| iii. | HPH’s Adolescent Psychiatry Physical Facility Contained Hazards For Adolescent Patients..... | 288 |
| iv. | Consolidating Adolescent Psychiatric Services At HPH Allowed HPH To Offer New And Expanded Services | 288 |
| v. | ENH Expanded And Remodeled The Adolescent Psychiatry Unit To Make It Safer | 289 |
| vi. | The Improvements Made By ENH In Consolidating And Expanding Psychiatric Services At HPH Improved The Quality Of Care..... | 289 |
| E. | After The Merger, ENH Continued To Provide High Quality Hospital Services | 290 |
| 1. | ENH Has Been Independently Recognized For Having High Quality Of Care..... | 290 |

| | | |
|----|---|-----|
| a. | ENH Received Solucient’s 100 Top Hospital Award..... | 290 |
| b. | ENH Received Awards From HealthGrades For Clinical Excellence..... | 290 |
| c. | ENH Received Recognition From The Leapfrog Group | 291 |
| d. | ENH Hospitals Have Received National Recognition For Its Healthcare Quality | 291 |
| e. | US News & World Report Recognized ENH As A Top Hospital..... | 291 |
| f. | ENH Received The KLAS And Davies Award For Epic..... | 291 |
| 2. | There Is No Evidence That Quality Deteriorated At Evanston Hospital After The Merger..... | 291 |
| F. | The Programs Or Services ENH Improved And Added At HPH After The Merger Exceed National And State Quality Benchmarks | 292 |
| 1. | HPH’s Post-Merger Performance In Treating Patients With Acute Myocardial Infarction Exceeds The Average In Illinois Hospitals | 292 |
| 2. | HPH’s Post-Merger Cardiac Surgery Outcomes Exceed National Benchmarks..... | 292 |
| 3. | ENH Is A National Leader In The Implementation Of Electronic Medical Records | 292 |
| 4. | ENH Exceeds National Benchmarks For Its Cesarean Section Rate..... | 293 |
| 5. | ENH Exceeds National Benchmarks For Its Operative Vaginal Delivery Rate | 293 |
| 6. | ENH’s Preoperative Gynecologic Surgical Review Program Is Unique..... | 293 |
| 7. | Post-Merger HPH Is A Leader In Terms Of Its Full-Time Internist Program..... | 293 |
| G. | Dr. Romano’s Analysis Did Not Properly Evaluate ENH’s Significant Quality Improvements At HPH | 293 |
| 1. | Dr. Romano Relies Heavily Upon Flawed Administrative Data..... | 294 |
| H. | Dr. Romano Placed Undue Reliance On Patient Satisfaction Surveys..... | 297 |
| a. | Overview..... | 297 |

| | | |
|------|---|-----|
| b. | Dr. Romano Improperly Relied On Unreliable Patient Satisfaction Surveys | 298 |
| i. | Press Ganey Survey Response Rates Are Too Low To Draw Valid Conclusions..... | 298 |
| ii. | Press Ganey’s Rating Scale Has A Ceiling Effect..... | 299 |
| iii. | Press Ganey Uses Mean, Not Percentage, Scores..... | 299 |
| iv. | The Rhea & Kaiser Survey Is Not A Valid Measure Of Patient Satisfaction At HPH | 300 |
| c. | Dr. Romano Improperly Relied On Insufficient Press Ganey Data..... | 300 |
| IX. | OTHER COMPETITIVE EFFECTS CONSIDERATIONS | 302 |
| A. | The Merger Was Not Anticompetitive Because Of Low Barriers To Market Entry And Repositioning By Competitors | 302 |
| 1. | The Illinois CON Law Is Not A Barrier to Entry | 302 |
| a. | Most CON Applications Are Approved | 302 |
| b. | Most CON Applications Are Approved In A Timely Manner | 303 |
| c. | The CON Requirements In Illinois Have Been Revised And, As A Result, Fewer Projects Require CON Approval | 303 |
| d. | ENH’s Competitors Have Been Able To Expand Their Facilities And Services Pursuant To The CON Process | 303 |
| i. | Northwestern Memorial Has Expanded Its Facilities And Services | 303 |
| ii. | Condell Has Expanded Its Facilities And Services..... | 303 |
| iii. | Lake Forest Hospital Has Expanded Its Facilities And Services | 304 |
| B. | The Merger Was Not Anticompetitive Because HPH’s Financial Condition Was Declining Before The Merger..... | 304 |
| 1. | HPH’s Board Of Directors Determined That, Due To The Financial Condition Of HPH, HPH Could No Longer Maintain The Status Quo As An Independent Hospital | 304 |

| | | |
|----|--|-----|
| 2. | The HPH Board Decided That Merging With Evanston Hospital Was The Best Option For The Future Of HPH..... | 306 |
| 3. | HPH’s Financial Condition Was Rapidly Declining | 307 |
| 4. | Evanston Hospital’s Due Diligence Revealed That HPH’s Financials Were On A “Downward Spiral” | 309 |
| a. | HPH Was Losing Money And Being Supported With Investment Income..... | 311 |
| b. | HPH’s Debt Capacity Was Severely Constrained | 312 |
| c. | HPH’s Cash And Investments Were Insufficient To Compete In The Marketplace..... | 313 |
| d. | HPH’s Joint Ventures Were Losing Money | 314 |
| e. | HPH Made Insufficient Capital Expenditures | 315 |
| f. | HPH’s Collection Rates/Accounts Receivable Were Declining..... | 316 |
| g. | Due Diligence Revealed That HPH’s Future Financial Projections Were Unrealistic | 317 |
| 5. | Expert Testimony Confirms The Significance Of HPH’s Declining Financial Condition..... | 319 |
| C. | ENH’s Not-For-Profit Status Is Relevant To The Competitive Effects Analysis..... | 320 |
| 1. | Not-For-Profit Status Plays A Role In Hospital Pricing..... | 320 |
| 2. | The Opinions Of Complaint Counsel’s Not-For-Profit Expert Support The Fact That ENH, As A Not-For-Profit Entity, Acts Differently Than A For-Profit Entity..... | 320 |
| 3. | The Pre-Merger HPH Foundation Is Evidence Of How A Not-For-Profit Hospital Benefits The Community | 321 |
| 4. | The Creation Of The Independent Highland Park Healthcare Foundation As A Result Of The Merger Demonstrates How ENH Acts To Benefit The Community As A Not-For-Profit | 322 |
| a. | The Healthcare Foundation of Highland Park is Required to Monitor the Commitments ENH Made to the Community | 323 |
| b. | The Highland Park Healthcare Foundation Contributes Funds to HPH for the Benefit of the Community | 323 |

| | | |
|----|--|-----|
| c. | The Highland Park Healthcare Foundation Provides Grants To Community Organizations..... | 324 |
| X. | REMEDY..... | 325 |
| A. | Divestiture Is Not A Proper Remedy Because The Merger Was Necessary To Achieve Quality Improvements At HPH..... | 325 |
| 1. | HPH Was Not Capable Of Remediating Its Quality Problems, Implementing New Services, Or Improving Old Ones Without The Merger..... | 325 |
| a. | HPH Lacked The Financial Capacity To Implement Necessary Quality Improvements | 325 |
| b. | HPH Lacked The Capacity To Effect Organizational Change | 326 |
| 2. | The Improvements Made By ENH Could Not Have Been Achieved Through Joint Ventures | 327 |
| 3. | The Geographic Proximity Of Evanston Hospital To HPH Was Essential To Improving The Quality At HPH..... | 328 |
| 4. | The Merger Enabled HPH To Make Quality Improvements And Offer Services That Are Not Generally Offered By, And/Or Not Feasible For, Community Hospitals | 328 |
| a. | ENH Upgraded HPH To The Epic System..... | 328 |
| b. | ENH Vastly Improved HPH’s Oncology Services | 329 |
| c. | ENH Improved HPH’s ICU Services By Adding The Services Of Intensivists..... | 329 |
| d. | ENH Provided Much-Needed Improvements To HPH’s Ob/Gyn Services | 330 |
| B. | Divestiture Is Not A Proper Remedy Because It Would Erode Quality Of Care Improvements Resulting From The Merger And Thus Harm Consumers..... | 330 |
| 1. | Divestiture Would Have Adverse Quality Of Care Consequences Pertaining To Cardiac Procedures At HPH | 331 |
| a. | Divestiture Would Result In The Loss Of Cardiac Surgery At HPH..... | 331 |
| b. | Divestiture Would Result In The Loss Of Interventional Cardiology Program at HPH..... | 332 |

| | | |
|------|--|-----|
| c. | Divestiture Would Result In Loss Of Nursing Improvements Resulting From Improved Cardiac Care At HPH After The Merger | 333 |
| d. | Divestiture Would Result In Loss Of ICU Nurse Acuity Gained From The Cardiac Surgery Program | 333 |
| e. | Divestiture Would Result In A Decline In Quality Of Care For Patients With AMI..... | 333 |
| i. | HPH Would Lose Its Capacity To Treat AMI Patients..... | 33 |
| ii. | There Would Be An Increase In Transfers Of Patients With AMI From HPH To Other Hospitals..... | 333 |
| iii. | Delays In Transfer Would Harm Patients..... | 334 |
| 2. | Divestiture Would Result In HPH Returning To A Community Hospital Governance Model | 334 |
| a. | Loss Of Integrated Medical Staffs Would Deprive HPH of Clinical, Academic and Research Activities..... | 335 |
| i. | Divestiture Would Result In HPH’s Loss Of Academic Involvement By HPH Physicians At Evanston Hospital Campus | 335 |
| ii. | Divestiture Would Result In HPH’s Loss Of Research Partnerships With Physicians At Evanston Hospital..... | 335 |
| iii. | Divestiture Would Result In HPH’s Loss Of Department Conferences And Case Consultation..... | 335 |
| 3. | Divestiture Would Result In HPH’s Loss Of ENH Quality Improvement And Quality Assurance Programs | 335 |
| 4. | Divestiture Would Result In HPH’s Loss Of The Benefits Of Epic..... | 336 |
| 5. | Divestiture Would Result In A Diminished Ability By HPH To Recruit High-Caliber Physicians And Hospital Administrators | 337 |
| C. | Divestiture Is Not A Proper Remedy Because ENH Cannot “Unlearn” About Its Demand..... | 337 |
| D. | Divestiture Is Not A Proper Remedy Because The Merger Was Between Two Members Of An Approved Network | 337 |

E. Divestiture Is Not A Proper Remedy Because It Would Undo Efficiencies
Of The Merger338

Exhibit And Demonstrative ListAttachment A

Witness ListAttachment B

v. ENH's Improvements To The HPH Lab Have Improved Quality And/Or Resulted In Efficiencies

(1) ENH's Improvements To The HPH Lab Dramatically Improved The Turnaround Time For Tests Performed In The HPH Lab

1856. Turnaround time is the time it takes to do a test. (Victor, Tr. 3643). Turnaround times at the HPH Lab decreased dramatically after ENH took over the HPH Lab, as a result of the improvements ENH made to the HPH Lab. (Victor, Tr. 3632-34; Chassin, Tr. 5353).

1857. For example, in 2000-2001, the turnaround time for a basic metabolic pathway testing system decreased from 40 minutes to 30 minutes. (Victor, Tr. 3633). Also, in 2000-2001, the turnaround time for a CBC coming into the laboratory decreased from 80 minutes to 20 minutes. (Victor, Tr. 3633). The decreased turnaround times resulted in improved quality of care. (Chassin, Tr. 5353).

1858. Additionally, ENH has improved the manner in which specimens at HPH are transported to the laboratory at HPH. (Victor, Tr. 3634). ENH has implemented a pneumatic tube system which allows specimens to be transported from the Kellogg Cancer Center directly to the hospital laboratory, and this system allows for a much faster turnaround time. (Victor, Tr. 3634).

(2) ENH Brought Its Academic Focus On Pathology To HPH

1859. As an academic hospital, Evanston Hospital brings an academic focus to pathology. (Victor, Tr. 3634). Before the Merger, HPH did not have an academic focus. (Victor, Tr. 3635).

1860. An academic focus is beneficial to pathology because those doing the teaching maintain their expertise and their knowledge in a field of specialization, and it requires individuals who are committed to only one specialty. (Victor, Tr. 3635).

1861. The academic focus at Evanston Hospital benefits the laboratory work done at HPH because the laboratory directors at Evanston Hospital provide their specialized expertise for laboratory testing and also provide expertise when consulting with physicians. (Victor, Tr. 3635).

(3) On-Site Testing Has Substantial Advantages Over Outsourcing

1862. Performing tests on-site rather than outsourcing them has at least two advantages with respect to quality of care: (1) turnaround times are improved and routine results can be provided to physicians or placed in the patient's chart more rapidly; and (2) clinicians can have direct conversations with people in the laboratory about results that are coming from the laboratory. (Victor, Tr. 3599). It is important for clinicians to communicate with the laboratory

staff in situations where it is necessary to correlate the clinical situation that the physician is facing with the laboratory result. (Victor, Tr. 3599-600).

(4) ENH Realized Substantial Cost Savings From The Dissolution of CML

1863. As a result of closing down the CML laboratory, HPH had a savings in operating costs of \$2.5 million. (O'Brien, Tr. 3510). HPH continued to see roughly a \$2 million savings annually from the dissolution. (O'Brien, Tr. 3510).

1864. Before ENH took over the HPH Lab, HPH's cost per test was approximately \$18. (Victor, Tr. 3637). ENH lowered HPH's cost per test to approximately \$10 per test. (Victor, Tr. 3637).

(5) HPH Pathologists Now Engage in Teaching Activities

1865. Pathologists at HPH are responsible for teaching residents at Evanston Hospital. (Victor, Tr. 3589-90). Pathologists at HPH also give didactic lectures – lectures which are focused on a specific topic – to the residents at Evanston Hospital. (Victor, Tr. 3590).

f. The Merger Resulted In Structural And Service Improvements To The HPH Emergency Department

i. Overview

1866. ENH improved both the physical layout and service components of HPH's ED after the Merger. (Chassin, Tr. 5333).

1867. The total cost of the structural changes in the ED was \$5.3 million. (O'Brien, Tr. 3488). The ED staffing changes cost well over a million dollars. (Harris, Tr. 4234).

1868. Emergency medicine is the area of medicine that deals with acute episodic care. (Harris, Tr. 4201). Approximately 20-30% of HPH's ED patients are admitted to the hospital. (Harris, Tr. 4213).

1869. Responsibility for monitoring quality of care in the ED at HPH before the Merger rested with Dr. Bruce Harris, the nursing director, the quality improvement department, and administration. (Harris, Tr. 4208-09).

1870. Dr. Harris, who testified at trial, is the HPH ED Medical Director and is employed by the ENH Medical Group as an emergency medicine physician at ENH. (Harris, Tr. 4201-02). Dr. Harris is a staff physician and has served as the HPH Medical Director since 1997. (Harris, Tr. 4202). Dr. Harris has practiced continually at HPH since 1985 and has been an emergency physician for almost 20 years. (Harris, Tr. 4213).

1871. Dr. Harris monitored quality of care at HPH's ED through conversations with patients and nurses, by handling complaints, by being physically present in the ED on a daily

basis and by tracking several indicators. (Harris, Tr. 4208). Quality in the HPH ED was monitored to determine whether HPH was performing at a level that was acceptable for internal standards as well as any area-wide standards. (Harris, Tr. 4209, 4266).

ii. HPH's Pre-Merger ED Needed Improvement

(1) HPH's ED Facilities Were Inadequate Before The Merger

1872. Before the Merger, HPH's ED was cluttered, cramped, non-private, non-ergonomic, poorly laid out and unattractive. (Harris, Tr. 4214).

1873. These negative characteristics affected ED patient care in several ways. (Harris, Tr. 4214). First, in the pre-Merger ED, physicians had difficulty observing patient rooms, an important aspect of their job, because their backs were to the patients. (Harris, Tr. 4214).

1874. Second, the layout of the ED raised privacy concerns. (Harris, Tr. 4215). The pre-Merger patient treatment rooms were separated by thin curtains and divided into bays, making privacy basically nonexistent for patients and their families. (Harris, Tr. 4215; O'Brien, Tr. 3484). Physicians were concerned that patients may withhold responses to sensitive questions because they were afraid someone might hear their responses. (Harris, Tr. 4221).

1875. Third, the registration area consisted only of a desk jutting out into a hall. (Harris, Tr. 4226). This area could only accommodate one patient or family group at a time and it did not afford any privacy. (Harris, Tr. 4226).

1876. From a clinical standpoint, before the Merger, HPH did not have a decontamination room or an isolation room for patients who may have been exposed to biohazards. (O'Brien, Tr. 3484). Nor did HPH's ED have any critical care capability. (Hillebrand, Tr. 1980-81).

1877. Before the Merger, Dr. Harris recommended to HPH management that physical improvements needed to be made to the ED. (Harris, Tr. 4248). No actions were taken or changes made pre-Merger. (Harris, Tr. 4248-49).

(2) HPH Had Physician Staffing Problems Before The Merger

1878. Before the Merger, only one physician covered the ED. (Harris, Tr. 4230). This arrangement was inadequate during busy times. (Harris, Tr. 4230).

1879. At most, HPH used moonlighting senior residents to achieve double coverage on weekends. (Harris, Tr. 4279-80). Double coverage is a period of time when there are two emergency physicians scheduled to staff the ED. (Harris, Tr. 4232).

1880. Dr. Harris tried to get double physician coverage in the HPH ED before the Merger. (Harris, Tr. 4230). Despite Dr. Harris's efforts, HPH never had double physician coverage before the Merger. (Harris, Tr. 4232).

1881. Under HPH's pre-Merger physician staffing arrangement, if there were two critically ill patients in the HPH ED at the same time, the emergency physician had to split his or her time between both patients. (Harris, Tr. 4235).

1882. In addition, before the Merger, the HPH ED was responsible for responding to code blues that occurred anywhere in the hospital. (Harris, Tr. 4236). A code blue means that a patient has suffered a cardiac or a cardiopulmonary arrest. (Harris, Tr. 4236). When a physician left the ED to respond to a code blue, only the nurses were left to monitor the ED. (Harris, Tr. 4236).

1883. There was an incident before the Merger in the ED involving a "near miss" as a result of the lack of double coverage. (Harris, Tr. 4236-37). Dr. Harris was finishing his shift and the physician on the next shift happened to arrive a little early. (Harris, Tr. 4237). A code blue was called in the ICU. (Harris, Tr. 4237). While Dr. Harris was responding to that code, a patient entered the ED and went into cardiac arrest. (Harris, Tr. 4237). The physician who, by chance, arrived early was able to successfully defibrillate the patient. (Harris, Tr. 4237).

(3) HPH's Fast Track Was Inadequate Before The Merger

1884. HPH had a Fast Track program pre-Merger. (Harris, Tr. 4246; RX 466 at ENH RS 5318). Fast Track is a program in the HPH ED designed to care for patients with minor injury or illness in a rapid manner. (Harris, Tr. 4245). This arrangement frees up the rest of the ED to care for sicker patients. (Harris, Tr. 4246).

1885. HPH's pre-Merger Fast Track consisted of a couple of beds in a room sub-divided by curtains in the Fast Track area, an area that used to be HPH's grieving room. (Harris, Tr. 4247). A storage room was converted into another patient room. (Harris, Tr. 4247).

1886. To staff Fast Track before the Merger, HPH hired physician assistants, also called mid-level practitioners. (Harris, Tr. 4246).

1887. The addition of the pre-Merger Fast Track was met with mixed satisfaction. (Harris, Tr. 4247). HPH was better off with it, but there were some major problems with the Fast Track program. (Harris, Tr. 4247).

1888. First, the pre-Merger HPH Fast Track area had physical limitations due to its small size. (Harris, Tr. 4247).

1889. Second, the HPH Fast Track left HPH with no grieving room. (Harris, Tr. 4247). A grieving room is an area where the families of critically ill or deceased patients are brought so the physician can deliver bad news. (Harris, Tr. 4249). Before the Merger, physicians would have to conduct such meetings in any room they could find – e.g., the nurse manager's office, the cardiac catheterization lab, or the paramedic room. (Harris, Tr. 4249).

1890. Third, it was possible for patients to come into the HPH ED, be seen by a physician assistant, and leave the ED without being seen by a physician. (Harris, Tr. 4247-48).

Physician assistants are good care providers, but they lack the experience of a physician. (Harris, Tr. 4248).

iii. ENH Significantly Improved The HPH ED After The Merger

1891. ENH improved quality in the HPH ED after the Merger. (Chassin, Tr. 5332). In particular, there were a number of improvements to HPH's ED after the Merger including: major facility expansion, improved physician and nurse staffing, enhancements to fast track and other improvements. (Harris, Tr. 4213-14; Newton, Tr. 470; Hillebrand, Tr. 1980-81).

(1) ENH Substantially Expanded And Renovated The HPH ED

1892. The ED was gutted, expanded, and renovated after the Merger because the facility was extremely inadequate. (Harris, Tr. 4216; Chassin, Tr. 5333; CX 6304 at 14-15 (Livingston, Dep.)).

1893. The "2001-2003 Capital Expenditure and Cash Flow Projections" called for spending \$3 million to upgrade HPH's ED after the Merger. (CX 591 at 7). Construction began in or about December of 2000. (Harris, Tr. 4216; O'Brien, Tr. 3483).

1894. The first capital improvement ENH made at HPH was the reconstruction of the HPH ED, including the addition of an entrance for walk-in patients separate from the ambulance traffic. (Hillebrand, Tr. 1976).

1895. Moreover, the overall square footage of the HPH ED increased from about 7,500 square feet pre-Merger to 11,000 square feet post-Merger. (Harris, Tr. 4217). Coincident with these major improvements and expansion to the HPH ED, there was an 11.5% increase in the volume of patients seen and treated at the ED, which is further evidence that the added capacity was utilized by, and benefited, a significant number of patients at HPH. (Chassin, Tr. 5336).

(a) Phase I Of The HPH ED Renovation

1896. The ENH Healthcare Services Committee was a hospital Board Committee. (Harris, Tr. 4218). The Committee's primary purpose was to report on and oversee the overall clinical services at the hospital. (Harris, Tr. 4218). Dr. Harris attended committee meetings by invitation and was present at the September 14, 2001, meeting. (Harris, Tr. 4218).

1897. At the meeting, Dr. Harris reviewed for the Committee the enhancements and new construction in the ED at HPH. (Harris, Tr. 4218-19; RX 1148 at ENH GW 271-72). Phase I of the construction, completed in September 2001, involved renovations to the major clinical areas of the ED. (Harris, Tr. 4219).

(i) Patient Rooms Were Redesigned

1898. State-of-the-art, patient-focused rooms were constructed as part of the Phase I renovations. (Harris, Tr. 4219-20; RX 1148 at ENH GW 271-72). HPH went from 12 to 14

beds plus an Ear, Nose and Throat (“ENT”) room, and every patient room is now private, more spacious and separated by walls. (Harris, Tr. 4217, 4225; O’Brien, Tr. 3485). This redesign is important for privacy and confidentiality reasons and to meet HIPPA regulations. (O’Brien, Tr. 3485).

1899. Patient observation by physicians and the nurses at the central station in the ED is easier because the patient treatment rooms have glass doors with curtains that can be pulled open when necessary. (Harris, Tr. 4217, 4220; O’Brien, Tr. 3485).

(ii) Critical Care Rooms Were Updated

1900. Critical care rooms are much larger than the old rooms, and this allows for a variety of personnel to be at a bedside during a procedure. (Harris, Tr. 4221; Hillebrand, Tr. 1980-81). The new rooms have oxygen, suction, and cardiac monitoring equipment placed in a logical location rather than scattered around the room. (Harris, Tr. 4222).

1901. The critical care rooms are also visually more attractive and are designed to have the ability to take care of critical patients during a resuscitation. (Harris, Tr. 4221). Resuscitations are performed on patients with no heart rate or on those patients who are not breathing. (Harris, Tr. 4221-22).

(iii) Isolation Rooms Were Added

1902. Isolation rooms are designed for both positive and negative air flow. (Harris, Tr. 4222). Negative air flow is used to try to prevent a patient who has an infectious disease from spreading that disease to another patient, caregiver or family member. (Harris, Tr. 4222-23). So when the door opens, air rushes in so that potential infection cannot escape from the room. (O’Brien, Tr. 3486-87). Positive air flow is used to treat patients who have low immunity who need to be protected from germs. (Harris, Tr. 4223).

1903. One room at HPH had been retrofitted with negative flow before the Merger. (Harris, Tr. 4223). A positive flow isolation room was installed after the Merger. (Harris, Tr. 4223; O’Brien, Tr. 3486).

1904. Also, a decontamination room was added, and this room is accessible from the ambulance bay and has a shower. (O’Brien, Tr. 3486-87).

(b) Phase II Of The HPH Renovation

1905. Phase II of the ED construction involved the non-clinical functions of the department, including the registration area, the triage room and the waiting room. (Harris, Tr. 4226; RX 1148 at ENH GW 271). Phase II was completed on or before December of 2001. (Harris, Tr. 4226).

(i) The HPH ED Registration Area Was Made More Private

1906. After the Merger, the registration area was remodeled so that it could accommodate up to three patients or families at once. (Harris, Tr. 4226).

1907. Privacy screens were installed so that patient information could not be overheard by bystanders. (Harris, Tr. 4226). The new registration area was more compliant with HIPPA. (Harris, Tr. 4227).

(ii) The HPH ED Triage Area Was Significantly Expanded

1908. Post-Merger, the triage area was substantially expanded in square footage by about 300%. (Harris, Tr. 4227). New equipment was brought into the triage area, including a scale. (Harris, Tr. 4228).

1909. Before the Merger, the first person to see a patient walking into the ED was the registration person or a security guard and not a clinical person. (Harris, Tr. 4228). For example, before the Merger, if a patient crumpled (*i.e.*, suffered a subarachnoid hemorrhage in the brain) in the registration area, there would be a delay in treatment because clinical personnel had to be called in to take care of the patient. (Harris, Tr. 4286). After the Merger, in contrast, the area was glass-windowed in, giving the triage nurse direct visual observation of both the registration areas and the waiting room areas. (Harris, Tr. 4227).

(iii) The HPH ED Waiting Area Was Remodeled

1910. The waiting room areas became more pleasant and roomy post-Merger. (Harris, Tr. 4228). There is now a fish tank in the area, thus providing a pleasant diversion for small children who may be waiting. (Harris, Tr. 4228-29).

(2) ED Physician Coverage Was Expanded Post-Merger

(i) Double Coverage At HPH's ED Improved Quality Of Care

1911. In July 2001, ENH instituted double physician coverage at HPH. (Harris, Tr. 4231, 4279). Dr. Harris was involved with this plan and met with Dr. Jeffrey Graf, the Chief of the Division of Emergency Medicine for ENH, and nursing administration about recruiting and training new physicians. (Harris, Tr. 4231).

1912. Since July 2001, because of the Merger and for the first time in HPH's history, HPH has had enhanced physician coverage with expansion to double shifts, ten hours a day. (Harris, Tr. 4229; Spaeth, Tr. 2277; Chassin, Tr. 5333).

1913. This change allowed for responses to emergencies outside the ED as well as higher quality, more efficient care for patients in the ED. (Chassin, Tr. 5333).

1914. The new shift covers 11 a.m. to 9 p.m., historically the busiest hours in the HPH ED. (Harris, Tr. 4232). The double coverage cost ENH a couple million dollars. (Harris, Tr. 4233-34).

1915. Double coverage allows for collaboration between physicians. (Harris, Tr. 4232-33). Collaboration among physicians also occurs at conferences and educational offerings available at ENH and through the side-by-side work the physicians perform. (Harris, Tr. 4212).

1916. Double coverage had a positive impact on the staff physicians. (Harris, Tr. 4234). Having a second physician staffed cuts down the patient workload of each physician by 50%. (Harris, Tr. 4234). This allows each physician to spend more time with each patient and with speaking to, counseling, and educating the families. (Harris, Tr. 4234). The double coverage also allows physicians the time to do a better job of documenting their cases. (Harris, Tr. 4234).

1917. Double coverage also improved turn-around times in the HPH ED. (Harris, Tr. 4235).

1918. Dr. Harris treated a patient who personally benefited from the double coverage. (Harris, Tr. 4233). The patient needed intubation (insertion of a tube into the windpipe to assist with breathing). (Harris, Tr. 4233). After sedation and paralysis of the patient, Dr. Harris was unable to insert the tube and called the other physician staffed in the ED to assist him with the procedure. (Harris, Tr. 4233).

1919. Dr. Harris has not had any “near misses” since the Merger. (Harris, Tr. 4237). HPH ED physicians rarely respond to codes outside the ED post-Merger. (Harris, Tr. 4237). Instead, the hospital now has an intensivist, a physician specially trained in critical care medicine, who responds to the code blues. (Harris, Tr. 4238).

**(ii) The Rotation Of ED Physicians At
ENH Improved Quality Of Care**

1920. ENH ED physicians now rotate among the three ENH hospitals. (Harris, Tr. 4210; Chassin, Tr. 5334). Rotation allows for the physicians and nurses to collaborate with a larger number of people and to keep their skills sharp. (Harris, Tr. 4210; Chassin, Tr. 5334). This is a considerable improvement in quality of care. (Chassin, Tr. 5334-35).

1921. Another important result of rotation is that physicians broaden their clinical acumen because each hospital is unique. (Harris, Tr. 4211). For example, Glenbrook has a high geriatric population, Evanston Hospital has a concentration of patients who are medically or socially indigent and HPH has a heavier pediatric emphasis. (Harris, Tr. 4211).

**(iii) Other Staffing Changes At HPH's
ED Improved Quality Of Care**

1922. Changes were also made in other staffing areas. (O'Brien, Tr. 3487). An extra ED physician was added for peak hours. (O'Brien, Tr. 3488). A family medicine resident was added to rotate through the ED. (O'Brien, Tr. 3488).

1923. Pediatrician coverage in the ED improved post-Merger. (Chassin, Tr. 5336). Pre-Merger, HPH had fellows in training covering pediatrics and post-Merger there were practicing pediatricians covering the ED. (Chassin, Tr. 5336-37; RX 204, *in camera*).

1924. HPH now has a toxicologist on staff who is available to the ED 24 hours a day, seven days a week. (Harris, Tr. 4260). A toxicologist is a medical specialist who deals with adverse effects in patients from drugs and physical substances. (Harris, Tr. 4260). HPH did not have a toxicologist before the Merger. (Harris, Tr. 4260). The toxicologist physically sees patients, which frees up the ED physicians from having to do research on toxicology issues. (Harris, Tr. 4261).

1925. The toxicologist also brought new ideas into HPH. (Harris, Tr. 4261). For example, he discovered that in Europe, physicians were using a certain antidote to treat Tylenol and Acetaminophen overdoses that was not widely used in the United States at that time. (Harris, Tr. 4261). The toxicologist initiated use of this drug, N-acetylcysteine, at HPH. (Harris, Tr. 4261).

1926. Moreover, ENH implemented a crisis intervention service at HPH after the Merger. (Harris, Tr. 4262). This service provides a specially trained social worker at the hospital to assess patients with acute behavioral emergencies. (Harris, Tr. 4262; O'Brien, Tr. 3487-88). Before the Merger, the ED physician was responsible for the psychological evaluations. (Harris, Tr. 4262-63).

**(3) ENH Improved HPH's Fast Track Design And
Processes**

1927. After the Merger, ENH immediately made changes to improve the HPH ED Fast Track program. (Harris, Tr. 4249; O'Brien, Tr. 3484-86).

1928. ENH upgraded the Fast Track program by putting it in proximity to the ED. (Chassin, Tr. 5334). Three private patient rooms were constructed for Fast Track patients that were larger than the pre-Merger rooms. (Harris, Tr. 4250; Chassin, Tr. 5333). ENH created more efficient traffic patterns with triage in Fast Track. (Chassin, Tr. 5333).

1929. An x-ray viewing area was added near the patient rooms. (Harris, Tr. 4250). In contrast, before the Merger, physicians had to walk all the way across the ED to the old view box to look at x-rays, thus wasting physician time. (Harris, Tr. 4250).

1930. In addition, ENH ensured that patients were always seen by a physician. (Harris, Tr. 4249).

(4) ENH Coordinated HPH's ED And Its Cardiac Services

1931. The HPH ED coordinates with cardiovascular services to provide emergency angioplasty. (Harris, Tr. 4240; RX 1148 at ENH GW 272). This coordination allows interventional cardiologists to perform angioplasties on patients with heart attacks. (Harris, Tr. 4240). The ability to do these cardiovascular procedures completely changed HPH's approach to treating heart attack patients. (Harris, Tr. 4240).

1932. If HPH patients needed an angioplasty or open heart surgery before the Merger, they were transferred to a hospital with that service. (Harris, Tr. 4240-41). The first problem with the transfer situation was the delay in treatment time to a patient with a clot in an artery preventing the flow of oxygen to the heart. (Harris, Tr. 4241). The second problem was that the level of care the patient received while being transferred in an ambulance was lower than the care they received in the ED or ICU. (Harris, Tr. 4242).

1933. Since the Merger, there have not been any situations where an HPH patient who started out in the HPH ED was transferred to another hospital because of a need for angioplasty or open heart surgery. (Harris, Tr. 4243-44).

(5) ENH Increased Nurse Staffing In HPH's ED

1934. ENH increased nurse staffing by hiring new nurses for the ED, and this improved the efficiency and speed of caring for patients. (Chassin, Tr. 5334; Harris, Tr. 4244).

1935. A new triage nurse position was created in the HPH ED. (Harris, Tr. 4244). The triage nurse is the first clinical person to see a patient when they present to the HPH ED. (Harris, Tr. 4244). The triage nurse's primary responsibility is to determine which patients need to be seen immediately. (Harris, Tr. 4244).

1936. The addition of the triage nurse increased the nursing services available to physicians at the bedside. (Harris, Tr. 4245). The more nurses available, the more rapidly patients are processed and observed. (Harris, Tr. 4245).

1937. ENH also hired a nurse practitioner, who is supervised by ED physicians, to attend to patients in Fast Track so they can be treated quickly and released. (O'Brien, Tr. 3486).

1938. Some of the nurses received special training and were certified in pediatric emergency care. (O'Brien, Tr. 3487).

(6) ENH Improved HPH's ED In Other Ways As Well

1939. ENH also improved technology in the HPH ED. (Harris, Tr. 4253-54). The addition of the cardiac monitoring system, a Pictorial Archiving Communication System ("PACS") and Epic to the ED were significant improvements. (Harris, Tr. 4254).

1940. Each patient room has been equipped with a standard cardiac monitoring system that is centrally monitored from the nurses' station. (O'Brien, Tr. 3487). The new cardiac monitors allow for more sophisticated measurements. (Harris, Tr. 4224). In addition, a central station at the nurses' work area allows physicians and nurses to monitor patient rhythms and vital signs from one screen in a remote area versus having to physically be in a patient room to do so. (Harris, Tr. 4223-24).

1941. PACS is a digital x-ray system through which an ED physician can immediately see an image that was taken in radiology of an ED patient. (O'Brien, Tr. 3487). The patient does not even have to make it physically back to the ED before the physician actually sees the image. (O'Brien, Tr. 3487). PACS improved the turnaround time for making images available to HPH ED physicians. (Harris, Tr. 4254). Images are available almost immediately because they are digital. (Harris, Tr. 4255). PACS also allows physicians to pull up multiple studies to do comparisons. (Harris, Tr. 4255).

1942. The computerized physician order entry component of Epic (described in more depth in Section VIII.D.2.h.) has decreased transcription and dosing errors. (Harris, Tr. 4256). The system provides a warning screen if a patient has a drug allergy or there is a potential drug interaction with something the physician was going to prescribe. (Harris, Tr. 4257).

1943. Before Epic was installed at HPH, a physician would have to check a patient chart or ask the patient about allergies if the patient was conscious. (Harris, Tr. 4257). A physician had to rely on his own mental database to prevent drug interactions. (Harris, Tr. 4257).

1944. The addition of Epic also eliminated the handwriting legibility issue since everything is now electronic. (Harris, Tr. 4257-58). It also allows an ED physician to rapidly access prior clinical patient information within seconds. (Harris, Tr. 4258).

1945. Today, the HPH ED uses a specific module of Epic that pertains to emergency medicine. (Harris, Tr. 4259). The HPH system went live with the ED module in December of 2003. (Harris, Tr. 4259). Two ENH physicians, Dr. Mike Gillam and Dr. George del Castillo, were involved in creating that module. (Harris, Tr. 4259). HPH was the first hospital to use the ED module. (Harris, Tr. 4258-59).

1946. Patients' clinical outcomes have been better with the addition of Epic. (Harris, Tr. 4288). For example, pre-Merger, there was a pediatric ED patient who had an abscess that needed to be drained. (Harris, Tr. 4294). A verbal order for ketamine, a sedative agent, was given by the physician. (Harris, Tr. 4294-95). The nurse inadvertently administered a substantially higher dose than what was ordered and the child was sedated more than necessary for the procedure. (Harris, Tr. 4295).

1947. Epic automatically calculates a weight-appropriate dose. (Harris, Tr. 4295). If a physician attempts to pull out a dose that is inappropriate, Epic gives a warning, and the physician has to actively bypass the warning to administer such a dose. (Harris, Tr. 4295).

1948. Before the Merger, Dr. Harris was not aware of any plans by HPH to purchase PACS or Epic. (Harris, Tr. 4258-59).

1949. Finally, a pneumatic tube was added to the ED and connected with the pharmacy and the laboratory after the Merger. (O'Brien, Tr. 3485). The tube expedited getting specimens and medications across the hospital. (O'Brien, Tr. 3485-86).

g. ENH Improved Pharmacy Services At HPH Post-Merger

i. Overview

1950. ENH improved HPH's drug dispensing and clinical pharmacy services after the Merger, and these improvements had a direct impact on patient safety. (Kent, Tr. 4844; Chassin, Tr. 5354). These improvements cost at least \$775,000. (Kent, Tr. 4850, 4861).

1951. Drug dispensing at a hospital is part of the "medication use process," which refers to the entire process of using medications in patients. This process begins with a physician writing a prescription, drug dispensing by a pharmacist, nurse administration of the medication and, finally, monitoring the effect of the drug in the patient. (Kent, Tr. 4844-45).

1952. Clinical pharmacy services consist of monitoring drug therapy, assuring that doses of medications are appropriate, and making sure that patients are responding to drug therapy as the physician intended. (Kent, Tr. 4862).

1953. Stan Kent, who testified at trial concerning the post-Merger drug dispensing and clinical pharmacy improvements at HPH, is the Assistant Vice President for Pharmacy Services at ENH. (Kent, Tr. 4839). Kent is the senior pharmacy officer in ENH and is responsible for all day-to-day operations in all pharmacy areas, as well as financial management, personnel management and the quality of pharmacy services. (Kent, Tr. 4839-40). Kent has a Master's Degree in hospital pharmacy and completed a two-year residency in hospital pharmacy administration. (Kent, Tr. 4841-42).

ii. ENH Improved Drug Dispensing Services At HPH After The Merger

1954. The two most important improvements in drug dispensing services at HPH since the Merger are the addition of overnight pharmacy services and the implementation of Pyxis. (Kent, Tr. 4846; RX 1697 at ENHL PK 51635).

(1) ENH Added A Third-Shift Pharmacist To HPH

1955. At the time of the Merger, both Evanston Hospital and Glenbrook Hospital had hired a third (or night) shift pharmacist for at least the past 15-20 years. (Kent, Tr. 4849).

1956. HPH, however, did not have a third shift pharmacist at the time of the Merger. (Kent, Tr. 4847). **(REDACTED)**

(Kent, Tr. 4942, *in camera*). Kent was concerned with pharmacist staffing at HPH at the time of the Merger because such staffing did not meet contemporary practice standards. (Kent, Tr. 4848).

1957. This was a problem because nurses do not have the training required for proper drug preparation and dispensing, and there was a potential for patient harm. (Kent, Tr. 4848). Pharmacists, not nurses or physicians, should dispense drugs because pharmacists have specialized training in that activity. (Kent, Tr. 4845).

1958. ENH initially took steps to correct this problem at HPH by establishing a system whereby the nurses who were procuring medications from the pharmacy at night would have access to the night pharmacists at Evanston Hospital or Glenbrook Hospital if they had questions or needed help with a specific medication order or drug preparation. (Kent, Tr. 4848).

1959. **(REDACTED)**

(Kent, Tr. 4942, *in camera*).

1960. ENH ultimately added two third-shift pharmacists to the HPH pharmacy in 2003 at a cost of about \$250,000 per year. (Kent, Tr. 4848-50).

1961. ENH waited until 2003 to hire a third-shift pharmacist because such staffing is a substantial expense, costing ENH \$120,000-130,000 per year, per pharmacist. (Kent, Tr. 4849-50).

1962. Currently, there are three shifts at the HPH pharmacy, including nighttime coverage between the hours of 11:00 p.m. and 7:00 a.m. (Kent, Tr. 4846). ENH now has 24-hour a day on-site pharmacists at all three hospitals. (Chassin, Tr. 5355).

1963. Adding the third-shift pharmacist to HPH helped improve the quality of care there because it relieved the nurse supervisor from those responsibilities, provided a pharmacist professional onsite to provide pharmacy and dispensing services, and further relieved the pharmacists at Evanston Hospital and Glenbrook Hospitals from having to deal with any medication issues arising at HPH during the third shift. (Kent, Tr. 4850).

(2) ENH Added An Automated Drug Distribution System (Pyxis) To HPH

1964. At the time of the Merger, HPH used a traditional unit dose cart exchange system to distribute medications. Under this system, medication cards that hold cassettes of 15 to 20 drawers, each drawer being labeled for an individual patient, were filled in the pharmacy with a supply of medications to last 24-hours. (Kent, Tr. 4856). The drawers in these units are supposed to be locked, but often they were not. (Kent, Tr. 4856).

1965. During the time the cart exchange system was in place at HPH, there were problems with doses being lost and not making it to that patient's drawer, and there were problems with patients missing doses as well. (Kent, Tr. 4859).

1966. The traditional unit dose cart exchange system in place at HPH at the time of the Merger was inefficient, in that many of the drug doses had to be returned to the pharmacy, credited back to patients' accounts and then re-shelved. (Kent, Tr. 4857).

1967. In terms of patient care, this older distribution system was a concern because discontinued medications continued to reside in the cart and there was a chance that nurses could accidentally administer a medication that was no longer current for a particular patient. (Kent, Tr. 4857-58).

1968. At the time of the Merger, the medication use process at HPH required physicians to handwrite orders on paper. (Kent, Tr. 4858). Those orders would typically be faxed to the pharmacy and would sometimes get lost, which would require pharmacist time to locate the order. (Kent, Tr. 4858). A pharmacist then would have to enter the order, generate a label and a technician, in turn, would have to procure the medication, label it, and manually deliver it to the floor for administration by the nurse. (Kent, Tr. 4858-59). This HPH medication use process at the time of the Merger took between two to four hours. (Kent, Tr. 4859).

1969. While investigating the state of pharmacy services at HPH at the time of Merger, Kent expected that HPH would have made more extensive use of automation in the drug distribution process. (Kent, Tr. 4859). Kent's expectations about the level of pharmacy services that should have been in place at HPH at the time of the Merger were based upon his experience with pharmacy practice standards, which he has become familiar with through his membership in the American Society of Health System Pharmacists ("ASHP") and from visiting hospitals throughout the country, including community hospitals. (Kent, Tr. 4859).

1970. Since 1998, Evanston and Glenbrook Hospitals had been using an automated drug distribution product called Pyxis, which is a machine that interfaces with pharmacies. (Kent, Tr. 4860).

1971. Pyxis is an automated drug dispensing system, and each unit contains locked drawers with medications that are accessible via a touch screen. (Kent, Tr. 4851). Pyxis machines improve the efficiency and safety of drug distribution and overall help to improve care for patients. (Kent, Tr. 4851; Chassin, Tr. 5355-56). Specifically, Pyxis gives hospitals more control of medications because they are stored in an electronically accessible device and, in addition, provide medications in a more timely manner than traditional dispensing systems. (Kent, Tr. 4851-52).

1972. Kent was involved in the decision to install Pyxis at Evanston and Glenbrook Hospitals in 1998, a decision that was made to improve the manner in which medications were distributed and dispensed. (Kent, Tr. 4860).

1973. ENH decided to install Pyxis machines at HPH after the Merger for those same reasons. (Kent, Tr. 4860-61).

1974. ENH installed approximately twenty Pyxis machines at HPH in the first year of the Merger, 2000. (Kent, Tr. 4854-55). Pyxis machines were installed at HPH in all of the inpatient care units where there was any substantial medication use, as well as some ancillary areas. (Kent, Tr. 4855).

1975. About 85% of medication doses used on patients at ENH are currently available from Pyxis machines. (Kent, Tr. 4852).

1976. Pyxis helps ENH prevent potential medication errors insofar as it only makes available to nurses medications that have been ordered specifically for that patient. (Kent, Tr. 4852). In addition, the implementation of Pyxis machines gave ENH better control of medications, and medications are now available in a more timely fashion. (Kent, Tr. 4861).

1977. Since the installation of Pyxis machines at HPH, the medication use process begins with a physician ordering a medication through Epic (discussed in Section VIII.D.2.h), the order is then sent to the pharmacy, and finally, an electronic message is sent to the relevant Pyxis machine to authorize the distribution of particular medication for a particular patient. (Kent, Tr. 4853-54). A nurse then signs into a Pyxis machine using a bio-identification – in the form of a fingerprint – to authorize access to the Pyxis unit and retrieve the medication for distribution to the patient. (Kent, Tr. 4854). The entire medication use process using Epic and Pyxis machines takes only a few minutes. (Kent, Tr. 4854).

1978. Installing Pyxis drug dispensing machines across an entire hospital would cost \$1-2 million. (Spaeth, Tr. 2292).

iii. ENH Added Clinical Pharmacy Services At HPH After The Merger

1979. At the time of the Merger, there were not any clinical pharmacy services provided to patients at HPH in any organized or substantive way. (Kent, Tr. 4863). Services were purely reactive to a physician who might call with a question about drug therapy. (Kent, Tr. 4863). Moreover, at the time of the Merger, pharmacists at HPH were not really involved in patient care. (Kent, Tr. 4864).

1980. After the Merger, ENH changed this practice by substantively involving pharmacists in clinical activities at HPH. (Kent, Tr. 4864-65; RX 1697 at ENHL PK 51636). For example, ENH implemented decentralized pharmacists, pharmacist clinical rounds, pharmacokinetic drug monitoring, and also added an ICU pharmacist, an infectious disease pharmacist, and a medication safety pharmacist, all at HPH. (Kent, Tr. 4864-65).

1981. Decentralized pharmacists are pharmacists who practice at the patient care unit level and thus are in a position to directly answer questions by physicians and nurses, to educate patients, and to more closely monitor drug therapy. (Kent, Tr. 4865). Decentralized pharmacists at HPH also provide the following services to medical and surgical units at HPH including: medication verification; computer order entry; monitoring of efficacy and toxicity of high-risk medications; dose checking renal eliminated medication; providing drug information services; evaluating medication distribution issues; and providing education services. (RX 1099 at ENHE F35 341).

1982. The decentralization of pharmacists at HPH allowed them to more closely manage drug therapy, teach nurses about how to monitor the patients and help patients learn about their medications. (Kent, Tr. 4865-66).

1983. The pharmacists at HPH were not decentralized at the time of the Merger, and ENH added this improvement by the end of 2000. (Kent, Tr. 4865).

1984. Pharmacists also took part in clinical rounds, which involve a multidisciplinary team going on rounds from one patient's room to another, a process that greatly improves drug therapy for patients. (Kent, Tr. 4866). Pharmacist involvement in multidisciplinary rounds began towards the end of 2000 at HPH. (Kent, Tr. 4866; RX 1697 at ENHL PK 51635-36). It has been proven in medical literature that adding pharmacists to the multi-disciplinary rounds in the ICU dramatically reduces medication errors and reduces preventable injuries from medications. (Chassin, Tr. 5328, 5356).

1985. ENH also implemented an ICU pharmacist at HPH. (Kent, Tr. 4866). An ICU pharmacist is a specialized, decentralized pharmacist focusing on intensive care patients. (Kent, Tr. 4866-67; RX 1697 at ENHL PK 51635). HPH did not have an ICU pharmacist at the time of the Merger. (Kent, Tr. 4866-67). ENH implemented the ICU pharmacist position at HPH toward the end of 2000. (Kent, Tr. 4867).

1986. ENH also implemented pharmacokinetic drug monitoring at HPH after the Merger. (Kent, Tr. 4867; RX 1697 at ENHL PK 51635). Pharmacokinetics involves the study of serum levels in the blood. (Kent, Tr. 4867). This is important because, for certain medications, if a serum level gets too high, it could cause toxicity or other problems or, if the serum level is too low, the drug may not be effective. (Kent, Tr. 4867). The addition of pharmacokinetic drug monitoring has improved pharmacy services at HPH because now physicians can rely on pharmacists to help come up with the most appropriate dose of medication for patients. (Kent, Tr. 4867-68). HPH did not have pharmacokinetic drug monitoring at the time of the Merger. (Kent, Tr. 4867).

1987. ENH also added an infectious disease pharmacist at HPH after the Merger. (Kent, Tr. 4868; RX 1697 at ENHL PK 51635). An infectious disease pharmacist is someone who has specialized training and experience in the proper use of antibiotics and who monitors laboratory and microbiology reports on a daily basis to ensure that all the patients are on the correct antibiotic for their infection. (Kent, Tr. 4868). HPH did not have an infectious disease pharmacist at the time of the Merger, which is when ENH began that service at HPH. (Kent, Tr. 4868).

1988. ENH also added a medication safety (adverse drug event) pharmacist to HPH. (Kent, Tr. 4868; RX 1697 at ENHL PK 51635). A medication safety pharmacist is a specialized position that focuses solely on making sure that medications are used safely throughout the corporation. (Kent, Tr. 4869). HPH did not have a medication safety pharmacist at the time of the Merger, which is when ENH implemented that position at HPH. (Kent, Tr. 4869).

1989. Another improvement was ENH's addition of two oncology pharmacists to work in the outpatient oncology cancer center at HPH. (Kent, Tr. 4869-70; RX 1697 at ENHL PK 51636). It is important that pharmacists are involved in evaluating and treating oncology patients because chemotherapy is a class of drugs that has great potential for curing cancer, but also has the potential for harming patients if not dosed, prepared, and administered properly. (Kent, Tr. 4869). HPH did not have oncology pharmacists at the time of the Merger. (Kent, Tr. 4869-70).

1990. ENH also implemented a code team pharmacist at HPH after the Merger. (Kent, Tr. 4870; RX 1697 at ENHL PK 51636). A code team pharmacist assists with preparing and administering medications on the floor when a patient codes (*i.e.*, has an emergency). (Kent, Tr. 4870). HPH did not have a code team pharmacist at the time of the Merger. (Kent, Tr. 4870).

1991. Currently, there are 14 pharmacists at HPH compared to 10 pharmacists at the time of the Merger. (Kent, Tr. 4871).

iv. HPH's Institute For Safe Medication Practices Surveys Confirm That ENH's Enhancements To HPH's Pharmacy Services Have Improved Quality Of Care

1992. ENH conducted a medication safety assessment survey at HPH in 2000 that was prepared by the Institute for Safe Medication Practices ("ISMP"). (Kent, Tr. 4871). The ISMP is the premier organization promulgating patient safety with respect to medication errors. (Chassin, Tr. 5356). The organization is a non-profit entity founded more than 20 years ago and is the leading authority in how to provide medication safely in hospitals. (Chassin, Tr. 5356-57).

1993. ISMP administered the survey, containing about 200 items, by sending questionnaires to all hospitals, who then completed and returned the surveys to ISMP. (Kent, Tr. 4871-72). The purpose of the survey was to provide hospitals with a checklist that they could use to assess the extent to which they were employing the safe medication practices that ISMP had compiled over time from research and literature to protect patients from medication errors. (Kent, Tr. 4872; Chassin, Tr. 5357). The survey results were a quantitative measure that gave hospitals a chance to know where they were on the spectrum of safety as of 2000. (Chassin, Tr. 5357).

1994. There have been two ISMP surveys, one in 2000 and the second in 2004. (Kent, Tr. 4871-72; Chassin, Tr. 5357). The responses to the ISMP surveys are submitted electronically and then the ISMP staff compiles the results to arrive at a rating. (Kent, Tr. 4873). Kent assembled a group of pharmacists and nurses at ENH to determine their compliance with each item on the ISMP survey. (Kent, Tr. 4873).

1995. ENH sought to be 100% accurate when completing the survey because the ISMP survey was to be used as a tool to make improvements in the medication use process. (Kent, Tr. 4873).

1996. The results of the 2000 ISMP survey were that Evanston and Glenbrook Hospitals had achieved 80% and 81% compliance ratings, respectively, or scores in the top two ratings in the survey while, in contrast, HPH had a rating of 70%. (Kent, Tr. 4875; RX 1029 at ENHL PK 51640). Indeed, in July 2000, barely 50% of the ISMP's recommended safe medication practices were fully implemented in all units of HPH. (Chassin, Tr. 5358). The 2000 ISMP survey thus revealed that there was room to make improvements in pharmacy services at HPH. (Kent, Tr. 4875).

1997. By 2004, HPH was almost 90% compliant with all the items identified in the ISMP survey, a rating that was consistent with ratings for both Evanston and Glenbrook Hospitals during the same period. (Kent, Tr. 4876; RX 1029 at ENHL PK 51638).

1998. The ISMP surveys reflect a substantial improvement in compliance with ISMP's medication safety recommendations, most notably at HPH. (Kent, Tr. 4876; RX 1029 at ENHL PK 51638). This is a dramatic quantified improvement in the quality of medication safety. (Chassin, Tr. 5358)

h. ENH's Deployment Of Epic At HPH Dramatically Improved The Quality Of Care

i. Overview

1999. According to the Institute of Medicine ("IOM"), the development of an information technology ("IT") infrastructure has enormous potential to improve the safety, quality and efficiency of health care in the United States. (RX 1423 at 6). The availability of complete patient health information at the point of care delivery, together with clinical decision support systems ("CDSS") such as those for medication order entry, can prevent many errors and events from occurring. (RX 1423 at 6).

2000. The Federal Government has endorsed and expanded this view, establishing a national initiative to develop a universally accessible electronic healthcare record for all citizens within 10 years. (Wagner, Tr. 3957).

2001. In 2001, the President of ENH made ENH's top priority the implementation of a paperless, patient-centric health record with true computerized physician order entry ("CPOE"). (RX 1425 at ENHE F22 1394; RX 1839 at ENH GW 3520). ENH selected Epic in June 2001 as the system most able to meet this goal, and ENH began the long process of implementing Epic in all three of its hospitals, its faculty practice medical group outpatient offices and all affiliated physician offices that wished to participate. (Wagner, Tr. 3965-66, 3968-74).

2002. Epic was first deployed in January 2003 and was fully implemented across all ENH sites and all ENH faculty practice outpatient offices by April 2004. (Wagner Tr. 3976; Neaman, Tr. 1251).

2003. (REDACTED)

(Romano, Tr. 3160, *in camera*). It ties all of the campuses and their inpatient and outpatient services together with a single electronic health repository and is critically important for communicating health information. (Chassin, Tr. 5364). (REDACTED)

(Romano, Tr. 3160, *in camera*).

2004. ENH's roll-out of Epic at HPH constituted a major improvement in quality of care. (Chassin, Tr. 5363). It is a major improvement in the structure of care at ENH that increases the likelihood of desired health outcomes when the physician uses the information in ways that improve care. (Romano, Tr. 3327-29).

2005. In fact, Complaint Counsel's quality expert uses Epic at the University of California at Davis ("U.C. Davis") and advocated for the implementation of Epic because he believed it would result in an improvement in quality. (Romano, Tr. 3326-28).

2006. ENH has spent approximately \$42 million on Epic to date. (Wagner, Tr. 3987-88; Neaman, Tr. 1251; Hillebrand, Tr. 1984). Approximately \$14 million of the \$42 million was spent to implement Epic at HPH. (Hillebrand, Tr. 1984; Neaman, Tr. 1355; O'Brien, Tr. 3523).

ii. Epic Integrates All Patient Information Into A Single Data Repository That Is Accessible By All Caregivers And The Patient

2007. Epic is an integrated, longitudinal health record. (Wagner, Tr. 3945). An “integrated” record is a single repository for all of the clinical information that is necessary for patient care, including physician office visits, hospital encounters, laboratory information, x-ray images, and other ancillary information that may be necessary for patient care. (Wagner, Tr. 3945-46). A “longitudinal health record” serves as a repository of information that follows the patient through his or her life. (Wagner, Tr. 3946). The term “health record” means that the patient can access and contribute to the patient’s own information. (Wagner, Tr. 3945-46).

2008. Epic allows all caregivers to have access to clinical information about a patient – including hospital admissions, office visits, laboratory studies, imaging studies and information generated by other caregivers – that is secure, current, complete, legible, organized and instantly accessible. (RX 1425 at ENHE F22 1392; RX 1636 at ENHE DL 1721; RX 1677 at ENHE DL 10002-03).

2009. Epic, as deployed at ENH, includes a patient portal that allows patients to review their health record, including their test results, office visits, hospital visits and communicate securely with their physician. (Wagner, Tr. 3959-60).

2010. In contrast to Epic, a nonintegrated electronic medical record gives electronic access to pieces of a patient’s clinical information and different data repositories, such as a hospital laboratory repository or a radiology data repository, but the data repositories cannot talk to each other. (Wagner, Tr. 3946).

iii. Sources Outside Of ENH, Including The Federal Government, Have Been Calling For The Use Of Electronic Medical Records

2011. In the early 1990s, the Institute of Medicine (“IOM”) issued a report identifying electronic medical records as an essential ingredient to modern healthcare. (Wagner, Tr. 3955).

2012. In the middle and late 1990s, the IOM issued a report entitled “To Err is Human,” identifying unnecessary patient deaths in hospitals as a result of poor order transmission or misinterpretation. (Wagner, Tr. 3955).

2013. The IOM issued another report about two years later entitled “Crossing the Quality Chasm,” which further identified the electronic medical record as an essential ingredient to raising quality and making the quality of healthcare more uniform across the country. (Wagner, Tr. 3955-56).

2014. In the 1990s, an organization called Leapfrog, a collection of large industry employers – *i.e.*, purchasers of healthcare – identified CPOE as an indicator of excellence in healthcare institutions. (Wagner, Tr. 3956).

2015. More recently, the Federal Government has established a national initiative to develop a universally accessible electronic healthcare record for all citizens within 10 years. (Wagner, Tr. 3957). The goal is to improve the safety, quality, and efficiency of healthcare in every area of this country. (RX 1701 at 1-2). President Bush, in the January 2004 State of the Union Address, called for the widespread adoption of computerized health records to avoid dangerous medical mistakes, reduce costs and improve care. (RX 1635 at 99; RX 1677 at ENHE DL 10002)

2016. To accomplish the goal of a universally accessible electronic medical record, in April 2004, President Bush created an Office of National Healthcare Information Technology, which is headed by Dr. David Brailer. (Wagner, Tr. 3957; RX 1701 at 1).

2017. The Federal Government’s initiative expands the Leapfrog vision from CPOE to a patient-focused electronic medical record that includes all of the patients’ medical records in one place and is accessible by all providers and the patients themselves. (Wagner, Tr. 3958).

iv. The Sharing Of Information Is Important To Patient Care And Patient Safety

2018. The sharing of patient information is important because no single physician is the repository of all the knowledge it takes to manage a patient’s well-being. (Wagner, Tr. 3960). Patients see different physicians for different needs, and all of these physicians contribute to the patient’s overall health. (Wagner, Tr. 3960).

2019. Patient safety is enhanced when all physicians can contribute to the same body of knowledge and access the same body of knowledge, affording them complete and current information about the patient. (Wagner, Tr. 3960).

v. ENH Made A Patient-Centric Integrated Electronic Health Record Its Top Priority And Chose Epic Because It Was Best Suited To Accomplish This Goal

2020. Initially, ENH was interested in order transmission, recovery, and result review. (Wagner, Tr. 3958). Over time, ENH’s focus changed to an integrated longitudinal health record. (Wagner, Tr. 3961; RX 1839 at ENHE GW 3520).

2021. Before Epic, ENH had elements of a medical record in place through a vendor called McKesson HBOC, but the record was not integrated. (Wagner, Tr. 3962).

2022. The McKesson HBOC system was insufficient to accomplish ENH’s goal because: (1) in the late 1990s, McKesson discontinued its physician documentation and order transmission capability; and (2) the McKesson HBOC system did not include support for the ambulatory world. (Wagner, Tr. 3962). The bulk of healthcare happens outside of the hospital in what is termed the ambulatory world, which includes physician offices. (Wagner, Tr. 3962).

2023. In 2001, Neaman established as ENH's number one priority the implementation of a paperless, patient-centric electronic health record with true CPOE. (RX 1425 at ENHE F22 1394; RX 1839 at ENH GW 3520). Accordingly, in February 2001, ENH began aggressively searching for a different clinical electronic medical record system. (Wagner, Tr. 3964). ENH chose Epic in June 2001 because Epic was best suited to meet ENH's ambulatory needs, and Epic had an excellent track record in dealing with physicians and responding to physicians' needs for software development and evolution. (Wagner, Tr. 3965-66; Hillebrand, Tr. 1985).

2024. ENH purchased the following software packages from Epic: patient registration, scheduling, central data repository, inpatient documentation and order entry, outpatient documentation and order entry, a reporting engine, and a patient portal. (Wagner, Tr. 3966-67). The inpatient and outpatient packages use the same central data repository. (Wagner, Tr. 3967).

2025. The Epic project is focused on creating a body of information that follows and surrounds the patient. (Wagner, Tr. 3951). The goals of the Epic project include: (1) improving patient safety by eliminating problems associated with illegible orders and medication errors; (2) ensuring that physicians, clinicians, and administrators have access to the right patient data at the right time; (3) ensuring the accuracy of the information and data in the record; and (4) simplifying processes and making them consistent across the organization. (RX 1425 at ENHE F22 1394).

vi. ENH Planned From The Outset To Deploy Epic At HPH And In Affiliate Outpatient Offices

2026. When ENH signed the contract with Epic in 2001, it decided that Epic would be deployed at all three ENH hospitals, at ENH's full time faculty practice medical group outpatient offices, and all of the affiliate outpatient physician offices that were willing to participate. (Wagner, Tr. 3967).

vii. ENH Aggressively Deployed Epic Throughout The ENH System

(1) Initial Steps

2027. ENH was required to take several steps before deploying Epic, including workflow analysis, build, hardware deployment, training, and creating a support system. (Wagner, Tr. 3968). Moreover, all of these steps had to be taken before deploying Epic in the ENH hospitals and then repeated for each physician office that installed Epic. (Wagner, Tr. 3975-76).

(a) Workflow Analysis

2028. A workflow is an understanding of how knowledge is captured, shared, stored, and retrieved. (Wagner, Tr. 3968). Workflows are the blueprints used in designing and building Epic. (Wagner, Tr. 3970).

2029. The workflow analysis phase, which included workflow analysis for all three ENH hospitals, began in November 2001 and lasted through April 2002. (Wagner, Tr. 3972).

(b) Build

2030. Building Epic involved configuring it with items including lists, documentation tools, orders sets, best practice alerts and health maintenance alerts. (Wagner, Tr. 3968).

2031. The build phase, which included the build for all three ENH hospitals, began in April 2002 and continued aggressively until November 2002. (Wagner, Tr. 3972-73). Elements of the build that were unique to each hospital were built more proximate to the time in which each hospital went live on Epic. (Wagner, Tr. 3973). ENH continues to build Epic through the present. (Wagner, Tr. 3972-73).

(c) Hardware Deployment

2032. The hardware deployment process for all three hospitals and ambulatory offices took place in 2002. (Wagner, Tr. 3973-74). To run Epic, ENH had to purchase a new central processor and a new network infrastructure. (Wagner, Tr. 3973). The network infrastructure required the purchase and install of multiple access points. (Wagner, Tr. 3973). As part of the hardware deployment, ENH purchased new equipment for HPH. (Wagner, Tr. 3974).

(d) Training

2033. Training is required before a person is allowed to use Epic at ENH. (Wagner, Tr. 3986). For example, ENH physicians cannot admit, consult, or perform surgery unless they have completed 16 hours of Epic training. (Wagner, Tr. 3987; O'Brien, Tr. 3522). Physicians who use EPIC in their office must also take an additional four hours of training. (Wagner, Tr. 3987).

2034. ENH physicians underwent Epic training that was more extensive than the training conducted by other institutions, such as U.C. Davis, because ENH has implemented more features of Epic. (Romano, Tr. 3335).

2035. The Human Resources Division, Training Division, of ENH set up a classroom environment and performed the training. (Wagner, Tr. 3986-87). The cost of Epic training was paid by ENH. (Wagner, Tr. 3987).

2036. ENH trained almost 8,000 people to use Epic over the course of 119,352 training hours. (RX 1425 at ENHE F22 1402). This included 1,500 physicians and staff at HPH. (O'Brien, Tr. 3522).

2037. Physicians, nurses, and clinicians were trained in an impeccable way to use the system, which has been a failing in many other implementations. (Chassin, Tr. 5364).

2038. Epic training is role-specific. (Wagner, Tr. 3986). There is different training, for example, for physicians and nurses. (Wagner, Tr. 3986). ENH has developed and used 51 different training courses. (Wagner, Tr. 3986).

2039. Formal Epic training began in October 2002 and continued aggressively through December 2003. (Wagner, Tr. 3974). Training continues through the present. (Wagner, Tr.

3974). New physician arrivals, new nurse arrivals, new house staff arrivals and rotating medical students must be trained to use Epic. (Wagner, Tr. 3974).

2040. Training in the proper use of an electronic medical record is important and a big part of the cost of such systems. (Romano, Tr. 3329). ENH has spent \$7 million to date on Epic training. (Wagner, Tr. 3987-88). Moreover, when new physicians and other personnel join ENH, ENH pays for the cost of their training. (Wagner, Tr. 3987).

(e) Support System

2041. ENH's support system for Epic, which supports Epic in all three hospitals, was developed contemporaneously with the installation of Epic and it is ongoing. (Wagner, Tr. 3975).

2042. As part of Epic support, ENH maintains Epic's mechanics and clinical structure, trains personnel and provides user support, and builds new order sets, practice alerts and other quality related features in Epic. (Wagner, Tr. 3975).

(2) Deployment

2043. Epic was first deployed in a faculty practice internal medicine office in January 2003. (Wagner, Tr. 3976). The faculty practice group consists of physicians who are employed by ENH. (Wagner, Tr. 3976). Epic is mandatory for the faculty practice physicians. (Wagner, Tr. 3977).

2044. Epic was deployed at Glenbrook Hospital in March 2003, Evanston Hospital in June 2003, and HPH in December 2003. (Wagner, Tr. 3976-77).

2045. The deployment of Epic at HPH was a two step process. (O'Brien, Tr. 3521). In December 2003, ENH implemented progress notes, nursing notes and other items that were documented in a patient's chart. (O'Brien, Tr. 3521-22). In April 2004, ENH implemented CPOE across all of the inpatient and outpatient services at HPH. (O'Brien, Tr. 3522).

2046. Epic was deployed in three to five faculty practice physician offices during months when there was no hospital "go live." (Wagner, Tr. 3977).

2047. Epic was first deployed in an affiliate office in June 2004. (Wagner, Tr. 3977).

2048. Three affiliated practices currently have Epic in their offices. (Wagner, Tr. 3978). ENH is continuing to expand Epic into the offices of affiliated physicians. (Hillebrand, Tr. 1984).

2049. Use of Epic is mandatory for affiliated physicians in the ENH hospitals. (Wagner, Tr. 3978).

2050. ENH has offered incentives for affiliates to adopt Epic in their offices by waiving the \$12,000 license fee. (Wagner, Tr. 3980-81).

viii. The Deployment And Maintenance Of Epic Requires Tremendous Resources And Manpower

2051. Approximately 200 people at ENH were involved in the deployment of Epic. (Wagner, Tr. 3985).

2052. The Epic system requires continuous maintenance. (Wagner, Tr. 3985). The activities required to maintain Epic include understanding, configuring, building, and training employees to use and deploy upgrades from Epic twice a year, and satisfying requests from departments and divisions for new best practice alerts, order sets, order set reminders, and care plans. (Wagner, Tr. 3985-86). ENH currently employs 75 people to maintain Epic. (Wagner, Tr. 3986).

ix. ENH Has Realized Cost Savings Through The Use Of Epic

2053. Epic produces both clinical and administrative cost savings. (Wagner, Tr. 3988). Clinical cost savings result from the reduction in duplication of tests (because the information is easily obtainable when needed) and the avoidance of adverse medication and procedural outcomes that are diminished through Epic's quality and patient safety features. (Wagner, Tr. 3988).

2054. Administrative savings result from the cost savings in personnel required to manage paper records and the reduction in the cost of dictation or transcription. (Wagner, Tr. 3988-89). Epic has generated additional efficiencies by reducing the amount of time physicians spend looking for charts, reducing dictation costs. (RX 1698 at ENHE TH 1206).

x. ENH Requires Physicians To Use Epic In The ENH Hospitals

2055. It is critically important that all physicians who have privileges at HPH use Epic. (Chassin, Tr. 5366). Physician use of Epic is the linchpin of achieving the full benefit of integrated electronic health records. (Chassin, Tr. 5366).

2056. Accordingly, ENH has mandated that a physician cannot practice medicine at any ENH hospital, including HPH, without using Epic. (Wagner, Tr. 3982). A physician cannot enter an order at any ENH hospital without using Epic. (Wagner, Tr. 3982).

2057. Additionally, a physician cannot obtain or renew privileges at any ENH hospital without being trained to use Epic. (Wagner, Tr. 3982). ENH re-credentials one-quarter of its professional staff every six months. (Wagner, Tr. 3982-83).

2058. The adoption of CPOE improved in the quality of care at HPH because it reduces a large number of categories of medication errors. (Chassin, Tr. 5364). It is well-documented in outcome studies that the use of CPOE reduces medication errors and injuries as a result of medications, particularly when coupled with CDSS, as it was in ENH's case. (Chassin, Tr. 5364).

xi. Epic Allows ENH Clinicians To Access Complete, Up-To-Date Patient Information From Almost Anywhere

2059. In the ENH hospitals, Epic can be accessed from anywhere there is an access terminal, including nurses stations, patient rooms, administration areas and mobile carts that can be taken into patient rooms. (Wagner, Tr. 3982).

2060. Outside of the hospital, Epic can be accessed from anywhere there is a hard connection, such as in a physician's office, or broadband Internet. (Wagner, Tr. 3983).

2061. An ENH physician may access Epic via the Internet using a security code generated by a key fob. (Wagner, Tr. 3983). Almost 1,100 physicians at ENH have key fobs. (Wagner, Tr. 3983).

2062. Once a physician has gained access to Epic, whether in the hospital or through the Internet, he or she sees the entire patient record – including all hospital care, laboratory care, radiology images and office visits. (Wagner, Tr. 3983-84). There is no difference between the information a physician may view accessing Epic via the Internet compared to accessing Epic in the ENH hospitals. (Wagner, Tr. 3984).

2063. Affiliated physicians who do not have Epic in their offices can still access the Epic system using the Internet. (Wagner, Tr. 3984). Through the Internet, they can see the patient's entire health record, including the patient's hospital visits, office visits to Epic-enabled practices, laboratory images and ancillary services. (Wagner, Tr.3984).

2064. ENH physicians currently access Epic via the Internet up to 60 times a month. (Wagner, Tr. 3984-85).

xii. Epic Has Dramatically Changed And Improved The Practice Of Medicine

2065. As a result of Epic, paper patient charts are no longer used in the ENH hospitals or in those physician's full time faculty practice and affiliate offices that have adopted Epic. (RX 1425 at ENHE F22 1404, 1406).

(1) Epic Makes Learning A Patient's Medical History Considerably Easier

2066. Before Epic, a physician would learn a patient's medical history by asking the patient. (Wagner, Tr. 4002). Patients, however, often have imperfect memory of their health history, medications and allergies. (Wagner, Tr. 4002).

2067. Epic relieves patients of having to remember and repeat their medical information to different caregivers. (RX 1677 at ENHE DL 10004). Epic provides an organized means of keeping, retaining and reviewing a patient's medical history, family history, medication history, allergies, prior surgeries, prior office visits and prior hospitalizations. (Wagner, Tr. 4002). Moreover, the patient's medical history is current, and information is available as soon as it is entered. (Wagner, Tr. 4032).

2068. Patients appreciate physicians having access to their complete medical information. (Wagner, Tr. 4033).

(2) Epic Makes Finding And Reading A Patient's Medical Information Substantially Easier

2069. Before Epic, physicians in the ENH system were not required to record or keep information in their files in any standardized manner. (Wagner, Tr. 4002-03). A patient's medical record was generally handwritten. (Wagner, Tr. 4003; RX 1466). Moreover, there was no standard form of shorthand that physicians used to record information in their charts. (Wagner, Tr. 4005).

2070. Epic has made information recorded in the patient's medical record easier to read because it is all typecast. (Wagner, Tr. 4003-04; RX 1466).

2071. Before the installation of Epic, a patient's medical record could span more than one volume. (Wagner, Tr. 4003). Additionally, different physicians who treated a patient would keep separate medical charts. (Wagner, Tr. 4005). As a result, the patient's health record was fragmented, and different parts were maintained at different sites of care. (Wagner, Tr. 4005-06).

2072. Epic has changed the way in which medical files are organized. (Wagner, Tr. 4003). It aggregates all of the patient's information in one location so that all caregivers can review and have access to all of the necessary information, and it presents information to the physician as he or she has a need to use it. (Wagner, Tr. 4003, 4006). Moreover, Epic causes the physician to capture and report information in specific locations where it is easily retrievable. (Wagner, Tr. 4003).

2073. The improved availability of information at the point of care such that physicians no longer need to spend as much time looking for information in consultation and prior visits is an improvement in the quality of care. (Romano, Tr. 3327).

(3) Epic Simplifies And Makes The Ordering Of Medication And Tests More Efficient

2074. Before Epic, in the hospital setting, physicians would order medication and tests by going to the nurses' stations, finding the patient's chart, recording on paper the order to be accomplished and flagging the chart. (Wagner, Tr. 4006). In contrast, Epic allows the physician to order medication and tests by placing the order during the course of caring for the patient. (Wagner, Tr. 4008).

2075. In the hospital setting, before the arrival of Epic, nurses would know when a medication or test was ordered for a patient by seeing the flag on the patient's chart when he or she walked past the nursing station, or the unit secretary may have noted the flagged chart, pulled it, and asked the nurse to come and sign off on the order. (Wagner, Tr. 4007-08; RX 1466). In Epic, nurses learn about new orders immediately by an icon that shows up in the new orders column on their patient list on the mobile terminal the nurse carries with her. (Wagner, Tr. 4008; RX 1466).

2076. In physician offices, before the implementation of Epic, medications would be ordered on written prescriptions, which would be given to the patient. (Wagner, Tr. 4006-07). In Epic, prescriptions may be printed on a piece of paper to be taken by the patient to the pharmacy or may be transmitted directly to the pharmacy so that they are filled by the time the patient arrives. (Wagner, Tr. 4008-09).

2077. Before Epic, a physician would learn the medications a patient was taking or had taken in the past by asking the patient and/or calling the patient's other physicians. (Wagner, Tr. 4007). In Epic, a physician learns the medications the patient is taking or had taken in the past by looking in the medications section of Epic, which maintains a record of current and historic medications. (Wagner, Tr. 4009).

2078. Before Epic, the detection of drug interactions and drug allergies depended on: (1) the prescribing physician having complete and accurate information as to what medications the patient was taking or may have taken in the past; and (2) the prescribing physician's knowledge of potential drug interactions. (Wagner, Tr. 4007). In Epic, at the time a prescription is written, Epic runs a check on drug interactions, drug/allergy interactions, drug/disease interactions, and drug/food interactions, and it presents alerts to the physician if there is an interaction. (Wagner, Tr. 4009).

(4) Epic Improves The Process By Which Laboratory Results Are Reported And Accessed

2079. Before Epic, in the hospital setting, the laboratory would batch and print all of that day's laboratory output and deliver it to the nursing stations. (Wagner, Tr. 4009-10). Test and laboratory results typically would be received the next morning. (Wagner, Tr. 4011). Mail reports took a week or two to be received by the physician's office. (Wagner, Tr. 4011).

2080. Before Epic, for tests or labs ordered in a physician's office, results would be communicated to that office either by mail or fax or a printer connected to the laboratory by modem (if the physician's office had one), which would run a print job in the middle of the night on the laboratory work that was done the previous day. (Wagner, Tr. 4010).

2081. In Epic, test and laboratory results are available as soon as they are resulted. (Wagner, Tr. 4012; Victor, Tr. 3593; RX 1636 at ENHE DL 1721). Before Epic, in the hospital setting, test and laboratory results were stored in the patient's paper record or in the laboratory database. (Wagner, Tr. 4011). In a physician's office, test and lab results were stored in a paper record and in the performing laboratory's database before the installation of Epic at ENH. (Wagner, Tr. 4012).

2082. Before Epic, if a physician were neither in the hospital nor in his or her office, the physician would access test and lab results either by calling the office and asking that the patient's chart be pulled or calling the performing laboratory to have the results read to the physician. (Wagner, Tr. 4010). There was no way for physicians at HPH to access test and laboratory results through the Internet. (Wagner, Tr. 4011). In Epic, test and laboratory results can be accessed from wherever a person has Epic access – either in the hospital, the physician's office, or anywhere there is Internet access. (Wagner, Tr. 4012-13; Victor, Tr. 3594-95; RX

1636 at ENHE DL 1721). Moreover, any clinician who has secure access to Epic can access test and laboratory results. (Wagner, Tr. 4013).

2083. Before the installation of Epic, if a patient who had a test performed at a physician's office required hospital treatment, the hospital would not have knowledge of the results of the test that was performed in the physician's office. (Wagner, Tr. 4012). Similarly, if a patient who had a test performed in the hospital later saw a physician at her office, the physician would not have knowledge of the results of the test performed in the hospital. (Wagner, Tr. 4012). In Epic, both the hospital and the physician would have knowledge of those test results. (Wagner, Tr. 4013).

(5) Epic Has Made Consulting With Other Physicians Much Easier

2084. Epic has changed the way physicians consult with each other by allowing the referring physician to speak with the consulting physician live and simultaneously view the same information. (Wagner, Tr. 4013).

(6) Epic Has Substantially Improved Laboratory Services

2085. Epic is an improvement over the previous method of reporting laboratory results because: (1) the laboratory results go into the chart virtually immediately and are immediately available to the physicians and staff treating the patient; (2) the information is stored in the same location and easily found when needed; and (3) physicians may review test results at home and make clinical decisions without having to travel to the hospital. (Victor, Tr. 3595-96).

2086. Epic allows laboratory results to be compared more easily to previous results because everything is present on one chart as opposed to multiple charts. (Victor, Tr. 3596).

2087. Additionally, to make a diagnosis, pathologists often have to look at information contained in the patient's medical record. (Victor, Tr. 3597). Before Epic, to get information about a patient's medical record, ENH pathologists would have to call physicians or members of the clinical staff to obtain the information they needed to make a diagnosis. (Victor, Tr. 3598). Epic benefits ENH pathologists because they can look up information in a patient's medical record, including a patient's medical history, x-ray data, and prior test results, without having to find the physician who treated the patient. (Victor, Tr. 3597).

xiii. Epic Has Numerous Safety Features That Improve The Quality Of Care

2088. Epic improves quality of care and patient safety: (1) by giving complete access to information wherever the physician needs it; and (2) through the use of built-in alerts, including health maintenance alerts, order sets, best practice alerts and clinical pathways. (Wagner, Tr. 4015-16).

(1) Epic Has Health Maintenance Alerts

2089. A health maintenance alert is a reminder of tests a physician may want to perform that are based on a person's age, gender and disease state, such as pap smear or a mammogram. (Wagner, Tr. 4016-17). Epic alerts the physician when the patient is due for a health maintenance test. (Wagner, Tr. 4017).

2090. Expert bodies within ENH determine what health maintenance alerts will be put into Epic based on national guidelines, and are continually adding new alerts. (Wagner, Tr. 4017).

(2) Epic Has Best Practice Alerts

2091. Best practice alerts are alerts of avoidable risks or risks that can be diminished by an appropriate course of care. (Wagner, Tr. 4017). Epic presents a best practice alert to the physician when avoidable risks or risks that can be diminished by an appropriate course of care are detected. (Wagner, Tr. 4018).

2092. Expert bodies within the departments and divisions of the ENH hospitals determine what best practice alerts are added to Epic based on national guidelines and standards, and continue to add such alerts into Epic. (Wagner, Tr. 4018).

(3) Epic Presents Physicians With Order Sets

2093. Order sets are collections of tests, medications and procedures that are appropriate for the management, treatment and diagnosis of a given problem. (Wagner, Tr. 4018-19). When a patient's chief complaint is entered into Epic, Epic presents the physician with order sets recommended for that chief complaint. (Wagner, Tr. 4019).

2094. Expert bodies within ENH determine what order sets are added to Epic based on national guidelines and standards. (Wagner, Tr. 4019). There are over 1,000 order sets built into Epic today, and ENH is continuing to add more. (Wagner, Tr. 4019; RX 1425 at ENHE F22 1419).

(4) Epic Facilitates The Use Of Clinical Pathways

2095. A clinical pathway is a collection of activities that need to be accomplished to handle an episode of care for a specific diagnosis in an optimal, safe manner. (Wagner, Tr. 4019). Epic facilitates the use of clinical pathways by presenting the physician with elements of the appropriate clinical pathway for the patient's diagnosis or complaint. (Wagner, Tr. 4020).

2096. Multidisciplinary bodies composed of physicians, nurses, pharmacists and therapists determine which pathways are programmed into Epic. (Wagner, Tr. 4020). There are currently more than 50 pathways in place in Epic. (Wagner, Tr. 4020; RX 1425 at ENHE F22 1418).

(5) Epic Implements A Clinical Decision Support System

2097. A Clinical Decision Support System (“CDSS”) is a broad category that refers to uses of automated data, typically to bring in information from different sources to help physicians make better decisions about prescribing medication and ordering lab tests while providing care to patients. (Chassin, Tr. 5365).

2098. There is a body of literature in the field of quality improvement that addresses CDSS systems as they relate to medication errors and improving outcomes. (Chassin, Tr. 5366). Those studies indicate that when CDSS systems are added to CPOE systems, the combination is even more effective at preventing injury from medications and medication errors than either system by itself. (Chassin, Tr. 5366).

2099. CDSS has been implemented in Epic through health maintenance alerts, best practice alerts, order sets and clinical pathways. (Wagner, Tr. 4021; Chassin, Tr. 5365). Other examples of clinical decision support in Epic include not allowing X-rays to be taken of female patients under a certain age unless they are first asked if they are pregnant, and not allowing medication orders to be placed if the patient’s allergies have not been verified within the last year. (RX 1425 at ENHE F22 1415).

2100. ENH is developing and rolling out additional CDSS functions through Epic that are state-of-the-art. (Chassin, Tr. 5365).

(6) Epic Improves Patient Access To Their Medical Records

2101. Giving patients access to their medical records allows them to be more knowledgeable about their health problems and what medications they are on, and it is one of the Government’s and Dr. Brailer’s four principal goals. (Wagner, Tr. 4056-57).

2102. Patients can print the information from their medical records, including their current medications and laboratory results, from ENH’s patient portal and take it with them when they visit physicians who may not be on the Epic system. (Wagner, Tr. 4056-57).

(7) Epic Improves Quality Of Care When There Are Drug Recalls

2103. When the drug Vioxx was recalled, within four hours ENH was able to identify and give to caregivers lists of their patients who were on or who had been on Vioxx. (Wagner, Tr. 4021).

2104. Before Epic, when there was a drug recall, it took one physician office six months to review all patient charts for patients who had taken the drug, and the physician was not certain he had identified all of his patients who had taken that drug. (Wagner, Tr. 4021-22).

xiv. ENH's Accomplishment In The Deployment of EPIC Is Unique

2105. No hospital system other than ENH has both employed and affiliated physicians on the same integrated electronic medical record system. (Wagner, Tr. 3985).

2106. Dr. Ankin, for example, does not practice at any other hospital that has an electronic medical record system such as Epic. (Ankin, Tr. 5071). He recommended to Lake Forest Hospital that it adopt Epic three to four years before the Merger, but the hospital could not afford it. (Ankin, Tr. 5071-72).

2107. ENH is the only institution in the Chicago area that has brought live 100% physician use of inpatient clinician order entry, documentation, and result review and ambulatory and inpatient use simultaneously, while also giving patients access to their own information. (Wagner, Tr. 4082).

2108. ENH is the only institution in the Chicago area and in the country that has accomplished a broad and successful deployment of an integrated electronic medical record. (Wagner, Tr. 4082).

2109. The typical roll-out of an electronic medical record like Epic would require at least two to three years. (Romano, Tr. 3334). The depth and speed with which ENH was able to completely engage their three campuses, including both physicians and non-physicians, in the roll-out of Epic produced a much greater improvement in quality in a much shorter period of time than most, if not all, other implementations of a full electronic medical record. (Chassin, Tr. 5368).

xv. ENH Has Been Recognized By Numerous Outside Sources For Its Successful Deployment Of Epic

2110. Epic Systems has used the implementation of Epic at ENH as a model and has referred other institutions to ENH. (Romano, Tr. 3329).

2111. In 2004, ENH achieved the "Highest Value Rating" from KLAS CPOE Digest. (RX 1666; RX 1677 at ENHE DL 10003; RX 1580). This meant that based upon physician and nurse data collected during the winter of 2003-04, ENH achieved the overall highest value for physician and nurse use across all KLAS measurements. (RX 1666).

2112. Also in 2004, ENH received the Nicholas Davies Award from the Health Information Management Specialists Society for being the only institution that has universally accepted inpatient physician order entry, physician documentation, and nurse documentation by employed and non-employed physicians; has extended this capability to the ambulatory world; and has an integrated medical record. (Wagner, Tr. 3996-97; RX 1733 at 1).

2113. In November 2004, Dr. Brailer visited ENH to recognize ENH on its achievement of having a fully deployed and integrated electronic health record universally throughout the three ENH hospitals that was used by all physicians and patient accessible. (Wagner, Tr. 3959).

xvi. Other Academic Hospitals In The Chicago Area Are Looking To Learn From ENH's Successful Deployment Of Epic

2114. The ENH information systems staff gives presentations on ENH's deployment of Epic to other hospitals in the Chicago area, including Loyola, the University of Chicago, Northwestern Memorial, Children's Memorial Hospital, and Advocate Health System. (Wagner, Tr. 3997). Those presentations are generally made at the request of the other hospitals because they want to understand how ENH accomplished the successful deployment of Epic in such a short time. (Wagner, Tr. 3997-98).

2115. Other hospitals in the Chicago area, including the University of Chicago, Loyola, Northwestern Memorial, and Children's Memorial have made site visits to ENH to study its deployment of Epic. (Wagner, Tr. 3998).

2116. A representative of the U.C., Davis has made a site visit to ENH to study ENH's deployment of Epic. (Wagner, Tr. 3998).

2117. ENH provided its Epic training materials to Loyola. (Wagner, Tr. 3999). Loyola sought to purchase ENH's Epic training materials because it is a huge effort to create the training materials, and Loyola felt they would benefit from having available to them materials that had been demonstrated to be successful. (Wagner, Tr. 3999).

xvii. Epic Has Not Been Implemented By Community Hospitals

2118. (REDACTED)

(Romano, Tr. 3162, *in camera*).

2119. Indeed, no community hospital has deployed an enterprise grade electronic medical record system such as Epic. (Wagner, Tr. 3999-4000). Those hospitals smaller than HPH that are installing Epic are part of a larger hospital system. (Wagner, Tr. 4000-01).

2120. Moreover, the majority of community hospitals today do not have an electronic medical record that includes CPOE systems. (Romano, Tr. 3334).

xviii. Epic Is Far Superior To Meditech, The System Used At HPH Before The Merger

2121. Before the Merger and through February 2001, HPH used elements of an electronic medical record system called Meditech. (Wagner, Tr. 4058; O'Brien, Tr. 3520-21). Meditech integrated billing and registration functions, as well as pharmacy, lab and radiology functions. (O'Brien, Tr. 3520).

2122. The capabilities of Meditech as deployed at HPH pre-Merger were essentially the same as those that were available at ENH in 1985. (Wagner, Tr. 4060).

2123. Meditech could not be accessed remotely outside HPH, so it was used in conjunction with paper charts. (O'Brien, Tr. 3521). Meditech did not operate as the primary patient chart. (O'Brien, Tr. 3521).

2124. Meditech, as deployed at HPH, did not allow for CPOE. (Wagner, Tr. 4061). Without CPOE, it is not possible to have the clinical decision support, such as alerts and reminders, that is present in Epic as deployed by ENH. (Wagner, Tr. 4061).

2125. Meditech, as deployed at HPH, did not have any ambulatory or outpatient capability. (Wagner, Tr. 4061). It also did not allow patients to access their own medical records. (Wagner, Tr. 4062).

2126. Before the Merger, if a patient who was discharged from HPH wanted to obtain information relating to her hospitalization, including the medications she was given during the hospital visit, she would have to request that the record be sent, and it would have taken a week or longer for the patient to receive it. (Wagner, Tr. 4062).

2127. Meditech, as deployed by HPH, was not a patient-focused, community-based, multi-hospital, multi-office, comprehensive, longitudinal health record. (Wagner, Tr. 4062).

i. The Merger Improved The Quality Of Radiology, Radiation Medicine And Nuclear Medicine At HPH

i. Overview

2128. Radiation medicine is a therapeutic department that provides very focused radiation to targeted areas. (O'Brien, Tr. 3498). Nuclear medicine is a diagnostic department that tracks isotopes injected into a patient to pick up the affinity between the radiation and things such as tumors. (O'Brien, Tr. 3498).

ii. HPH's Pre-Merger Radiology Equipment Was Antiquated And Productivity Was Lower Than It Should Have Been With Respect To Radiology Services

2129. At the time of the Merger, equipment in the Radiology Department at HPH was antiquated, had limited radiation capacity and needed to be replaced. (O'Brien, Tr. 3491; Chassin, Tr. 5359).

2130. For example, HPH had an old linear accelerator, which was purchased in the mid-1980s and located in the basement of the medical office building adjacent to the hospital. (O'Brien, Tr. 3499-500). The old accelerator had no trade-in value, and ENH had to pay to have it removed. (O'Brien, Tr. 3500-01).

2131. The equipment was so antiquated that, before the Merger, physicians did not send their patients to HPH for radiology services. (Chassin, Tr. 5362-63).

2132. At the time of the Merger, HPH performed fewer radiology exams than Glenbrook Hospital even though Glenbrook Hospital had one CT scan and HPH had two. (O'Brien, Tr. 3492-93).

iii. ENH Made Substantial Post-Merger Improvements To Radiology And Radiation Medicine Services That Improved The Quality Of Care At HPH

(1) ENH Upgraded The Equipment And Systems At HPH And Extended Its Technology To HPH

2133. After the Merger, ENH purchased a new linear accelerator for HPH. (O'Brien, Tr. 3500). It also added two new CT scanners in HPH's radiology department, upgraded the radiation therapy equipment, and purchased a simulator. (O'Brien, Tr. 3496, 3501; Chassin, Tr. 5362-63; RX 1896 at ENHL MO 7109). A simulator is an instrument in radiation medicine that maps the location and doses for delivering radiation. (O'Brien, Tr. 3502).

2134. ENH added \$2.3 million of new equipment to the radiology and radiation medicine departments in 2000 and 2001, and another \$4.1 million of upgraded equipment between 2002 and 2004. (O'Brien, Tr. 3496-97).

2135. In February of 2001, ENH extended RADNET, a radiology information system that provides access to patient reports from anywhere in the ENH system, to HPH. (O'Brien, Tr. 3494). The installation of RADNET and Epic at HPH cost about \$2.1 million. (O'Brien, Tr. 3496).

2136. In February or March of 2001, ENH improved the quality of HPH's radiology department by extending PACS, its radiology imaging system, to HPH. (O'Brien, Tr. 3494; Chassin, Tr. 5360; Spaeth, Tr. 2277, 2293). PACS is a new way of taking x-rays that does not involve film. (Chassin, Tr. 5360). As a result, the radiology department became almost filmless, reducing the chance for lost images. (O'Brien, Tr. 3495-96; RX 1233 at ENH GW 267). Additionally, turnaround time was reduced, and the images became instantly available for viewing to HPH physicians from their home, office, or anywhere they have Internet access. (O'Brien, Tr. 3495; Chassin, Tr. 5360-61; RX 1233 at ENH GW 266-267).

2137. As of February 15, 2002, there were 70 PACS workstations in use throughout the ENH system. (RX 1233 at ENH GW 267).

2138. The IOM has determined that more immediate access to computer-based clinical information, such as laboratory and radiology results, can reduce redundancy and improve quality. (RX 1423 at 6).

2139. After the Merger, ENH also added a call center for radiology at HPH to allow patients in need of radiology tests to call into the corporate system and schedule the first appointment available at any ENH hospital. (O'Brien, Tr. 3493-94). Before the Merger, the appointment scheduling system at HPH was a paper-based system. (Chassin, Tr. 5359).

(2) ENH Added Additional Radiology Staff And Improved Access To Specialists At HPH

2140. After the Merger, HPH added radiologists to improve turnaround times for reading radiology reports. (O'Brien, Tr. 3493).

2141. Moreover, additional staff were added to the HPH Radiology Department, and weekend and evening hours were extended. (O'Brien, Tr. 3493).

2142. Before the Merger, the radiologists at HPH were generalists. (Chassin, Tr. 5362). At the time of the Merger, the radiology departments at all three campuses combined to create one department. (Chassin, Tr. 5361). All of the HPH radiologists were required to adopt a specialty, and those that did not ceased practicing at ENH. (Chassin, Tr. 5362).

2143. After the Merger, HPH patients had access to specialists in MRI reading, neuroradiology specialists, and specialists who only did interventional procedures in radiology. (Chassin, Tr. 5362). The addition of specialists was an important quality improvement at HPH. (Chassin, Tr. 5361-32).

(3) HPH Would Not Have Been Able To Make The Improvements In Radiology And Radiation Medicine Without The Merger

2144. Because the cost of installing PACS was roughly \$9 million, HPH would not have been able to install the system before the Merger. (Spaeth, Tr. 2293).

iv. ENH Made Significant Post-Merger Improvements To The Nuclear Medicine Department At HPH

2145. After the Merger, ENH purchased a CT pet for the nuclear medicine department. (O'Brien, Tr. 3496, 3501; Chassin, Tr. 5362-63; RX 1896 at ENHL MO 7109). A CT pet is a diagnostic tool in nuclear medicine used to detect things like tumors or Alzheimer's. (O'Brien, Tr. 3502). HPH did not have a CT pet, which is not commonly found in community hospitals, before the Merger. (O'Brien, Tr. 3502-03).

j. The Medical Staff Integration And Academic Involvement Of Physicians That Resulted From The Merger Improved The Quality Of Care At HPH

i. Overview

2146. After the Merger, Evanston Hospital merged the clinical staffs at Evanston Hospital and HPH. (Chassin, Tr. 5373). HPH physicians now rotate regularly through all three ENH campuses. (Chassin, Tr. 5598).

2147. The integration of the clinical staffs provided HPH physicians the opportunity to upgrade their skills by becoming part of an academic enterprise that challenged them to teach residents, participate in more educational conferences and keep up with the latest developments

in healthcare. (Chassin, Tr. 5373-74). Physicians' skills become impaired and begin to stagnate if they do not have access to a continuous influx of academic information. (Chassin, Tr. 5400-01).

2148. The upgrade in physician skills and the access to academic practice are structural changes that improved the quality of the HPH staff. (Chassin, Tr. 5377).

2149. As a result of the integration of the medical staffs and the academic focus that ENH brought to HPH, the quality of care improved at HPH. (Chassin, Tr. 5373).

ii. HPH Physicians Rotate Through All Three ENH Campuses

2150. Since the Merger, physicians in pathology, radiology, emergency medicine, cardiology, cardiac surgery and anesthesiology rotate through all three campuses. (Chassin, Tr. 5598). These physicians did not rotate before the Merger. (Chassin, Tr. 5598). With the exception of emergency medicine, all of the rotating physicians are specialists. (Chassin, Tr. 5598).

2151. In pathology, for example, the 19 faculty members rotate through the laboratories at Glenbrook Hospital, Evanston Hospital and HPH. (Victor, Tr. 3588-89). Additionally, the pathologists in the HPH and Evanston Hospital laboratories rotate back and forth. (Victor, Tr. 3629-30). The pathologists at Evanston Hospital see more complex specimens, and rotating allows the pathologists to stay abreast of all of the modern thinking and modern technologies relating to the practice of pathology. (Victor, Tr. 3589).

2152. Physicians in the Department of Ob/Gyn also regularly work at all three ENH hospital campuses. (Silver, Tr. 3770).

iii. HPH Physicians Take Part In Teaching Activities For Residents And Medical Students At Evanston Hospital

2153. Teaching forces physicians to keep up with medical literature, answer questions they may not have considered, and generally keeps them sharp. (Chassin, Tr. 5376-77).

2154. After the Merger, a number of HPH physicians became involved in teaching at Evanston Hospital. (O'Brien, Tr. 3539). These academic instructors rotate between Evanston Hospital, Glenbrook Hospital and HPH. (O'Brien, Tr. 3541).

2155. Dr. Harris teaches emergency medicine at Evanston Hospital, which includes clinical bedside instruction of residents and medical students. (Harris, Tr. 4251-52). In addition, Dr. Harris delivers talks and lectures as part of the ongoing, biweekly clinical conferences for the residents and attending physicians. (Harris, Tr. 4252). Most of the ED physicians are involved in the residency program at Evanston Hospital. (Harris, Tr. 4252.) This academic and teaching experience keeps physicians sharp by forcing them to research answers to questions, and by providing them with a venue for the exchange of new ideas. (Harris, Tr. 4252).

2156. Dr. Silver has a faculty appointment as a professor in the Medical School of Northwestern University. (Silver, Tr. 3762). The ENH Department of Ob/Gyn holds teaching activities for residents and medical students at ENH. (Silver, Tr. 3762-63). Further, the department holds weekly teaching conferences regarding high-risk obstetrics and a combined conference with the departments of pathology and pediatrics. Departmental physicians participate in teaching rounds, which take place at all three hospital campuses. (Silver, Tr. 3767-68). The participation of HPH obstetricians and gynecologists in teaching activities at ENH improved the quality of Ob/Gyn at HPH. (Chassin, Tr. 5380).

2157. Pathologists at HPH are responsible for teaching residents at Evanston Hospital. (Victor, Tr. 3589-90). Pathologists at HPH also give didactic lectures – lectures that are focused on a specific topic – to the residents at Evanston Hospital. (Victor, Tr. 3589-90).

2158. Since ENH brought its family medicine program to HPH after the Merger, the HPH family medicine program has included residents from Northwestern University. (O'Brien, Tr. 3539; Chassin, Tr. 5380). The participation of these residents in formal academic programs in family medicine at HPH is a quality improvement. (Chassin, Tr. 5380).

2159. In addition to traditional teaching opportunities, ENH physicians are now able to participate in grand rounds, which involve the bedside teaching of residents, that are run at Evanston. (Harris, Tr. 4253). For example, there are grand rounds for all physicians every Thursday in the Department of Ob/Gyn. (Silver, Tr. 3767).

iv. HPH Physicians Participate In Departmental Conferences That Broaden Their Skills

2160. ENH routinely holds conferences for ENH physicians only. These conferences are multidisciplinary and focus on treatment plans for individual patients and on quality assurance issues that involve specific ENH cases. (Chassin, Tr. 5599).

2161. More information is shared at educational and academic conferences among physicians within the same hospital compared to conferences that include physicians from different hospitals. (Chassin, Tr. 5599). In the latter type of conferences, the lectures and seminars are usually straightforward. (Chassin, Tr. 5599).

2162. Additionally, HPH physicians who are generalists are able to interact with the subspecialists at these conferences and during patient care consultation sessions, thereby improving their skills. (Chassin, Tr. 5378).

v. HPH Physicians Have Obtained Faculty Appointments As A Result Of The Merger

2163. Following the Merger, about 60 HPH physicians who did not have academic appointments were able to obtain appointments at Northwestern Medical School. (Chassin, Tr. 5376; O'Brien, Tr. 3540). These faculty positions allow the HPH physicians to pursue research and drew many physicians into teaching roles in the residency program operated by ENH. (Chassin, Tr. 5376; Harris, Tr. 4252).

2164. Before the Merger, these appointments were not frequently granted to HPH physicians. (Chassin, Tr. 5376).

vi. ENH Provides HPH Physicians With A Continuing Medical Education Stipend

2165. ENH provides HPH physicians with a \$4,000 continuing medical education stipend. (Harris, Tr. 4253). No such stipend was available pre-Merger. (Harris, Tr. 4253).

vii. HPH Has Gained An Academic Affiliation, Which Has Enabled It To Recruit Better Physicians

2166. An academic medical center is defined as a teaching hospital that is owned or operated or affiliated with a medical school. (O'Brien, Tr. 3542). Before the Merger, HPH did not have an academic affiliation. (Spaeth, Tr. 2239).

2167. In contrast, ENH is an academic medical center through its affiliation with Northwestern University Medical School. (O'Brien, Tr. 3542).

2168. Additionally, the Medicare Payment Advisory Commission ("MedPac"), a federal body that defines academic medical center and major academic hospital categories, characterizes an academic hospital as a hospital that has at least a 0.25 resident-to-bed ratio. (O'Brien, Tr. 3541-42). ENH has a 0.29 ratio. (O'Brien, Tr. 3542).

2169. A hospital's status as an academic medical center has a substantial impact on its ability to recruit the highest quality physicians and administrators. (Chassin, Tr. 5600). Before the Merger, HPH had a major problem recruiting physicians. (Harris, Tr. 4251). After the Merger, HPH had an improved ability to hire quality residents due to its new affiliation with the Northwestern Medical School. (Harris, Tr. 4251; RX 1148).

2170. During his time as HPH's CEO, Spaeth and HPH could not recruit subspecialty physicians to the hospital. (Spaeth, Tr. 2246-47). HPH had trouble recruiting physicians because its community hospital environment did not offer academic and research opportunities and did not offer a high complexity of cases. (Spaeth, Tr. 2247).

2171. During his time as HPH's CEO, Spaeth and HPH were able to recruit and hire some primary care physicians and one or two radiologists and oncologists. (Spaeth, Tr. 2246-47). Pre-Merger HPH was able to recruit only a single physician from a university setting, Dr. Leon Dragon, who became HPH's director of radiology. (Spaeth, Tr. 2309).

k. The Merger Improved The Quality Of Psychiatric Services At HPH

i. Overview

2172. Before the Merger and through the Spring of 2001, HPH and Evanston Hospital each had separate inpatient psychiatric units that treated both adult and adolescent patients. (O'Brien, Tr. 3516; RX 1754 at ENH RS 3086). In the Spring of 2001, however, ENH

consolidated the adolescent inpatient services at HPH and the adult inpatient services at Evanston Hospital. (O'Brien, Tr. 3517; Chassin, Tr. 5339; Neaman, Tr. 1358-59; RX 1080 at ENHL PK 55405).

2173. ENH also spent about \$1.2 million (excluding additional staffing costs) to make facility and program improvements to the HPH psychiatric unit. (O'Brien, Tr. 3519). In addition, the State conducted a full certificate of need review of the rationalization of psychiatric services at ENH before it was completed. (Chassin, Tr. 5340-41).

2174. Rationalization of clinical services is the process of enhancing the quality and cost efficiency of clinical services by determining at what location in a hospital system clinical services should be rendered. (Hillebrand, Tr. 1986). Rationalization of clinical services takes into account the best ways to improve the quality and cost efficiencies of the clinical services. (Hillebrand, Tr. 1986).

ii. Before The Merger, The Adolescent Psychiatry Services Available At Both HPH And Evanston Hospital Were Limited

2175. Before the Merger, the adolescent population at both HPH and Evanston Hospital was not large enough to provide the full complement of services for inpatient psychiatric care in terms of group therapy, intermittent therapy and other combinations of treatment plans. (Chassin, Tr. 5341; RX 1754 at ENH RS 3092).

2176. Additionally, before the Merger, psychiatric consultations in the ED were sought from either a private practice psychiatrist or the ED physicians. (Chassin, Tr. 5345). Patients presenting with psychiatric emergencies, however, often require specialized assessment that is beyond the scope of most ED physicians' capacity. (Chassin, Tr. 5342-43; RX 1111 at ENH GW 278).

iii. HPH's Adolescent Psychiatry Physical Facility Contained Hazards For Adolescent Patients

2177. Before the Merger, the physical facility that housed the HPH adolescent psychiatry unit contained many hazards for both the patients and the staff. (Chassin, Tr. 5341). For example, adolescents could hide from staff in the hallways, presenting unsafe situations. (Chassin, Tr. 5342; O'Brien, Tr. 3519).

iv. Consolidating Adolescent Psychiatric Services At HPH Allowed HPH To Offer New And Expanded Services

2178. After the Merger, HPH was able to offer a broader variety of treatment options for adolescent patients. (Chassin, Tr. 5339). One of the new services HPH opened after the Merger was a crisis intervention team that was dedicated to providing psychological counseling and evaluation to ED patients. (Chassin, Tr. 5339).

2179. ENH also created a consultation service at HPH to address patients with chemical dependency problems. (Chassin, Tr. 5344-45; RX 1066; RX 1754 at ENH RS 3092).

2180. Additionally, ENH added a Ph.D. in education to the HPH staff to work with adolescent issues. (O'Brien, Tr. 3517). Adolescents can be in the unit for five to ten days and away from their school work for that period of time. (O'Brien, Tr. 3517-18). The Ph.D. provides a curriculum for students while they are in the unit and helps to transition the adolescents back to school. (O'Brien, Tr. 3517).

2181. ENH also added a full-time psychiatrist to provide consultation to HPH inpatients who were hospitalized for medical or surgical conditions but also had psychiatric problems. (Chassin, Tr. 5339). This specialty service allows psychiatrists who understand the relationship between the psychiatric illness and the medical or surgical illness to consult on patients and recommend an overall plan of care. (Chassin, Tr. 5344; RX 1781 at ENHL PK 55286). This service was not available pre-Merger. (Chassin, Tr. 5344).

2182. After the Merger, ENH extended the range of adolescents who could be treated in the unit from 12-18 years old to 24 years of age. (O'Brien, Tr. 3517; RX 1250).

2183. ENH also hired several adolescent psychiatrists to staff the HPH adolescent unit. (O'Brien, Tr. 3518).

v. ENH Expanded And Remodeled The Adolescent Psychiatry Unit To Make It Safer

2184. The HPH adolescent psychiatric unit was remodeled and opened in December of 2003. (O'Brien, Tr. 3518). Before the reconstruction, the rooms were semi-private. (O'Brien, Tr. 3518-19). Today, the unit today has ten private patient rooms. (O'Brien, Tr. 3518).

2185. ENH added a keyless entry system with voice and sight recognition. (O'Brien, Tr. 3518). Furniture was also grounded and attached to the floor for patient safety reasons. (O'Brien, Tr. 3519). There are no drawers or cabinets so that contraband can be easily monitored. (O'Brien, Tr. 3519).

vi. The Improvements Made By ENH In Consolidating And Expanding Psychiatric Services At HPH Improved The Quality Of Care

2186. All of the changes that ENH brought to HPH's psychiatric services after the Merger improved the quality of care. (Chassin, Tr. 5347).

2187. To familiarize himself with psychiatric services, Dr. Chassin spoke to people in the facility, reviewed contemporaneous documents, interviewed the Chairman of psychiatry, and made a site visit to the facility at HPH. (Chassin, Tr. 5342).

2188. In contrast, Dr. Romano used Press Ganey data to evaluate psychiatric services both pre- and post-Merger. This is not a valid way of evaluating patient satisfaction. (Chassin, Tr. 5348). Further, the Press Ganey data Dr. Romano used in his evaluation were inpatient data. (Chassin, Tr. 5348). In addition to all of the other problems with these data, they measure different services offered by completely different programs – the pre-Merger mixed adult/adolescent unit compared to completely separate post-Merger units. (Chassin, Tr. 5349).

E. After The Merger, ENH Continued To Provide High Quality Hospital Services

1. ENH Has Been Independently Recognized For Having High Quality Of Care

a. ENH Received Solucient's 100 Top Hospital Award

2189. The Solucient Top 100 Hospital Award is a form of recognition given to hospitals once a year based on criteria chosen with a proprietary risk-adjustment program. (O'Brien, Tr. 3544). ENH does not subscribe, or pay money, to Solucient. (O'Brien, Tr. 3545). Solucient is a company that provides consulting and healthcare data analysis services to hospitals and other healthcare organizations and is a source of data that Dr. Romano has relied upon in his work in the healthcare quality field. (Romano, Tr. 2995-96). Solucient compares ENH's performance against the median performance of benchmarked hospitals for quality related issues, such as risk-adjusted mortality, complications and patient safety. (RX 2032 at 5). In addition, Solucient also looks at financial performance. (RX 2032 at 5).

2190. ENH has received the Top 100 Award from Solucient for ten years in the major teaching hospital category. (O'Brien, Tr. 3544-45). The most recent year was 2004. (O'Brien, Tr. 3544; RX 2032 at 6). There are 147 hospitals in the major teaching hospital category, 15 of which are selected for the Top 100 award in that category. (O'Brien, Tr. 3545).

2191. Solucient uses data from MedPar, the Agency for Healthcare Research and Quality ("AHRQ") and its own hospital database. (O'Brien, Tr. 3546). (REDACTED) (O'Brien, Tr. 3667, *in camera*). With respect to the risk-adjusted patient safety index, ENH has a favorable rating of 11.4 percent, which means that ENH out-performed more than just similar hospitals, but instead outperformed the elite Top 100 Hospitals in its peer group hospitals by 11.4 percent for this category. ENH's performance with respect to risk-adjusted mortality improved from -18.0 percent in the 2001 survey, to -0.38 percent in the 2004 Solucient Top 100 Hospital survey, a substantial decrease in risk-adjusted mortality during that period. (RX 2032 at 5-7; CX 1947; Romano, Tr. 3405).

2192. Since 1999, ENH has received on multiple occasions both the Top 15 Teaching Hospital Award and the Top 100 Hospital Award. (Neaman, Tr. 1290-91).

2193. Dr. Romano agreed that ENH was ranked by Solucient in the top 100 hospitals based, in part, upon a quality assessment. (Romano, Tr. 3398-3400). While, ENH's profitability score decreased during the same period, significantly, its quality related scores for risk-adjusted mortality and patient safety index either improved or remained favorable. (RX 2032 at 7; CX 1947 at 15).

b. ENH Received Awards From HealthGrades For Clinical Excellence

2194. HealthGrades, which is a proprietary data analysis firm that sponsors a website that includes information about hospital and physician quality, has identified ENH as a

2204. Further, there was no evidence to support Dr. Romano's hypothesis that quality declined at Evanston Hospital as a result of a diversion of resources from Evanston Hospital to HPH after the Merger. (Chassin, Tr. 5275-76). *See* Section VIII.D.1. d.iv., , *supra*.

F. The Programs Or Services ENH Improved And Added At HPH After The Merger Exceed National And State Quality Benchmarks

1. HPH's Post-Merger Performance In Treating Patients With Acute Myocardial Infarction Exceeds The Average In Illinois Hospitals

2205. HPH's use of highly valid process measures for the treatment of heart attack patients – the administration of aspirin and beta blockers upon arrival and discharge – has exceeded the Illinois hospital average during the post-Merger period. (Chassin, Tr. 5278-83; RX 2043). Before the Merger, HPH was consistently below the Illinois hospital average for almost all of these process measures and below Evanston Hospital for all four process measures. (RX 2043). Evanston Hospital's performance on these same measures was also superior to that of all other Illinois hospitals during both the pre- and post-Merger time periods. (Chassin, Tr. 5278; RX 2043). *See* Section VIII. D.1.d.iv.

2. HPH's Post-Merger Cardiac Surgery Outcomes Exceed National Benchmarks

2206. HPH's post-Merger mortality rate for cardiac surgery is lower than the national benchmark taken from data submitted to the Society of Thoracic Surgeons ("STS"). (Chassin, Tr. 5294). Moreover, HPH is also lower than the benchmark for cardiac surgery programs in New York State. (Chassin, Tr. 5294).

2207. HPH's post-Merger major complication rate was also lower than national benchmarks established by STS. (Chassin, Tr. 5299). For example, HPH's post-Merger re-operation rate was about 1.8%, which is well under the accepted national benchmark published by STS of approximately 5.3%. (Chassin, Tr. 5299). HPH's post-Merger kidney failure rate of 1.2% was also much lower than the 3% national benchmark. (Chassin, Tr. 5299). *See* Section VIII.D.2.a.vi., *supra*.

3. ENH Is A National Leader In The Implementation Of Electronic Medical Records

2208. Independent groups such as KLAS and Davies have recognized ENH as the national leader in electronic medical record implementation because of its uniquely successful implementation of the Epic system. (RX 1666; Neaman, Tr. 1356; Wagner, Tr. 3996-97; RX 1733). The Davies Award singled out ENH for being the only institution that has universally accepted inpatient physician order entry, physician documentation, and nurse documentation by employed and non-employed physicians; has extended this capability to the ambulatory world; and has an integrated medical record. (Wagner, Tr. 3996-97; RX 1733).

2209. Additionally, Dr. Brailer, who was appointed by President Bush as the head of the Office of National Healthcare Information Technology, personally visited ENH to recognize its achievement of having a fully deployed and integrated electronic health record universally

affect the care of every single patient at HPH and, as a result, HPH takes a very integrated and broad multidisciplinary approach to the care of its patients. Evanston Hospital, as an academic medical center, has brought a great deal of clinical expertise and training to physicians throughout HPH. (Chassin, Tr. 5400-04).

2218. Further, the improvements that ENH has made are interconnected. (Chassin, Tr. 5404). For example, the establishment of cardiac surgery has required that the skills of physicians, nurses and technicians throughout the hospital be enhanced and maintained at a high-level. (Chassin, Tr. 5401; Rosengart, Tr. 4463-64, 4483-84; Ankin, Tr. 5064-65, 5068-69 ; RX 1445 at ENHL PK 51621).

2219. **(REDACTED)**

(Romano, Tr. 3308-09, 3317-18, 3327, 3332-33, 3390-93; Romano, Tr. 3067-68, 3109-11, 3160, 3178-79, 3194-98, 3228-29, *in camera*). Although he discounts the significance and relevance of those improvements, Dr. Romano admittedly was not comprehensive in his analysis. (Romano, Tr. 3244). In fact, he relied on incomplete and, in many cases, inappropriate data and methodologies to draw his conclusions. (Chassin, Tr. 5139).

2220. Specifically, as discussed in more depth below, Dr. Romano inappropriately relied on administrative data and patient satisfaction survey results. (Romano, Tr. 3255; Chassin, Tr. 5251).

1. Dr. Romano Relies Heavily Upon Flawed Administrative Data

2221. According to Dr. Romano a significant portion of his analysis in this case turns on his use of administrative data. (Romano, Tr. 3255).

2222. Administrative data include very limited sets of information, typically diagnosis and procedure codes, that are collected in the course of a hospital's administrative processes, as opposed to clinical processes. (Chassin, Tr. 5172-73). Administrative data are mostly intended for billing purposes and reporting to regulatory agencies. (Chassin, Tr. 5172-73). This definition is widely accepted in the field of hospital quality analysis. (Chassin, Tr. 5172-73).

2223. AHRQ, with which Dr. Romano is associated, publishes guidelines regarding administrative data. (Romano, Tr. 3255-56). AHRQ is the leading federal agency for quality of care. (Romano, Tr. 3270). In published guidelines, AHRQ avers that administrative data "should not be used as a definitive source of information on quality of health care." (Romano, Tr. 3255-56; RX 2004 at 29).

2224. **(REDACTED)**

(Romano, Tr. 3207-08, *in camera*; Romano, Tr. 3256-57; Chassin, Tr. 5175-82).

2225. First, administrative data contain few valid measures of process or structure. (Chassin, Tr. 5176). To account for improvements in those areas one would have to use other sources. (Chassin, Tr. 5176). The only useful information that can be taken from administrative data for this case is some information on outcomes. (Chassin, Tr. 5176).

2226. Second, few, if any, outcome measures compiled from administrative data are valid. (Chassin, Tr. 5176).

2227. Finally, to compare one hospital to another one must use a very exact method of risk-adjustment. (Chassin, Tr. 5176). Risk-adjustment must be done because patient populations of different hospitals are different. (Chassin, Tr. 5176). This fact must be taken into account when assessing changes in hospital quality. (Chassin, Tr. 5176).

2228. There are three important deficiencies in using administrative data for risk adjustment. (Chassin, Tr. 5176-77).

2229. First, administrative data lacks the depth of clinical detail for use in quality measurement. (Romano, Tr. 3257-58; Chassin, Tr. 5177). **(REDACTED)**

(Romano, Tr. 3205-08, *in camera*).

2230. Specifically, administrative data do not contain the vast majority of clinical data that are known to affect risk. (Chassin, Tr. 5177). This is a significant problem because the most important factors that need to be accounted for in risk-adjustment do not appear in billing data. (Chassin, Tr. 5177).

2231. This limitation is recognized by more than just Drs. Romano and Chassin. In fact, AHRQ has specifically published that AHRQ patient safety indicators based on administrative data must be cautiously used because the administrative data they are based on are not collected for research purposes and for measuring quality but, rather, for billing purposes only. (RX 2004 at 29; Romano, Tr. 3256-57).

2232. Second, the coding of administrative data are unreliable because they suffer from variation and inaccuracy in coding among different hospitals. (Chassin, Tr. 5177). Therefore, even when clinical information is present one cannot rely on it to be accurately coded. (Chassin, Tr. 5177; Romano, Tr. 3264-65, 3272-74).

2233. The fact that administrative data are unreliably coded may lead to erroneous estimates associated with co-morbid disease (described below) and bias risk-adjusted models used to compare outcomes. (Romano, Tr. 3259).

2234. **(REDACTED)**

Romano, Tr. 3207, *in camera*).

(REDACTED)

(Romano, Tr. 3207, *in camera*).

2235. That said, administrative data generally under-reports most co-morbid conditions that could be important risk factors for adverse outcomes or complications. (Romano, Tr. 3259). In fact, according to Dr. Romano, roughly half of post-operative complications go unreported in

administrative data because of poor documentation, errors, or restrictive coding practices. (Romano, Tr. 3264).

2236. Finally, administrative data fail to account for the difference between co-morbid conditions that a patient has before they come to a hospital and complications suffered after they begin to receive care. (Chassin, Tr. 5177). As a result, the data are often poorly risk-adjusted. (Romano, Tr. 3259-65, 3272-74; Chassin, Tr. 5177-79).

2237. Co-morbid conditions are complications that patients suffer from before they come to the hospital and are not indicative of the quality of care given to the patient after they are admitted to the hospital. (Chassin, Tr. 5177; Romano, Tr. 3273). On the other hand, complications that occur after the patient is admitted to the hospital can be the direct result of bad quality. (Chassin, Tr. 5177). The key failing of administrative data is that the data does not account for any difference in many complications that occur before and after admission. (Chassin, Tr. 5177). Proper risk-adjustment always avoids including complications that occur after admission. (Chassin, Tr. 5177). Therefore, administrative data cannot be accurately risk-adjusted to measure real changes in quality. (Chassin, Tr. 5177-78; Romano, Tr. 3273).

2238. One should consider all of these failings in the reliability of administrative data when attempting to conduct proper quality of care analyses. (Chassin, Tr. 5178-79; Romano, Tr. 3263-65). In fact, according to survey work done by Dr. Romano, hospital leaders remain skeptical about the usefulness and validity of outcome comparisons based on administrative data. (Romano, Tr. 3264-65).

2239. In sum, the best use of administrative data, because it compiles so many records, is to look for large, global trends among large groups of hospitals. (Chassin, Tr. 5179). At that global level, differences between patient populations tend to cancel out. (Chassin, Tr. 5179). Nevertheless, one cannot reliably make judgments about an individual hospital's quality, as Dr. Romano has done in this case, by looking at the particular characteristics of patients admitted to individual hospitals based on administrative data. (Chassin, Tr. 5179). As stated above, administrative data at this particularized level are replete with significant errors. (Chassin, Tr. 5178-79).

2240. Accordingly, in contrast to Dr. Romano, Dr. Chassin relied on a different type of data collected for healthcare quality in this case. (Chassin, Tr. 5171). Dr. Chassin relied heavily on clinical data in forming his opinions. (Chassin, Tr. 5171).

2241. Clinical data are the detailed measures of severity of illness and physiologic functioning, and are collected during the course of providing care to patients. (Chassin, Tr. 5171). Clinical data are found in the medical records of patients. (Chassin, Tr. 5171). As a result, clinical data are the primary data used by hospitals and third-party organizations to monitor quality assessment and quality assurance. (Chassin, Tr. 5171-72).

2242. Most of the clinical data used in this case came from clinical data registries that are maintained by third-parties to which hospitals contribute clinical data as part of their quality assessment and quality assurance programs. (Chassin, Tr. 5172). For example, the kind of data collected and published by the Society For Thoracic Surgeons ("STS") in its registry is clinical

data. (Chassin, Tr. 5172). STS data complies and tracks more clinical detail than administrative data. (Romano, Tr. 3259).

2243. Dr. Chassin also endeavored to collect clinical data from ENH and HPH that the hospitals had collected themselves to track their own clinical performance. (Chassin, Tr. 5171-72).

2244. Administrative data lacks clinical details that could be important in predicting the risk of death in a patient with heart disease. (Romano, Tr. 3261-62). In fact, the State of California and State of New York require that clinical data, not administrative data, be submitted regarding cardiac bypass surgery or CABG. (Romano, Tr. 3263).

2245. Not only did Dr. Romano utilize highly suspect administrative data, but the significant majority of outcome measures Dr. Romano relied on are themselves invalid irrespective of the data used to calculate them. Specifically, Dr. Romano utilized administrative data when he employed several different categories of outcome measures promulgated by the United States Agency on Healthcare Quality (“AHRQ”). (Romano, Tr. 3127-28). Dr. Romano used these measures to posit that quality of care did not improve at HPH. (Romano, Tr. 3127-28, 3217-31, 3255, 6273-74). There are more than 46 measures proffered by AHRQ and, according to the guidelines published by AHRQ for its own measures, only six are defined as valid regardless of the kind of data on which they are based. (Chassin, Tr. 5583; RX 2004 at 27-30; RX 2010 at 19-23).

2246. In fact, AHRQ itself cautions that its indicators were designed, in part, to identify hospital areas for further analysis and, “as a result, the [AHRQ] indicators were not intended as definitive measures of quality problems, but rather as screens for use in quality improvement. As screening tools, these indicators would serve as a first-round flag of potential quality problems, which should be investigated further by other methods, such as chart review.” (RX 2007 at 26).

2247. Moreover, Dr. Romano’s analysis of almost all of these AHRQ and Joint Commission indicators are not statistically significant at the level that he states is the standard statistical threshold. (Romano, Tr. 3093, 3211-12, 3216-34). Dr. Romano admits that 17 of the 18 AHRQ and Joint Commission indicators that he employed in this case are not statistically significant. (Romano, Tr. 3093, 3211-12, 3216-34). The traditional threshold of statistical significance means that there is less than a 5% chance of finding an effect if, in fact, there were no deterioration, or improvement in performance. (Romano, Tr. 3213, 3221). Thus, Dr. Romano relied on indicators of quality, many of which were lacking in validity and, in addition, the analysis of almost all of those indicators did not reveal any statistically significant findings. (Chassin, Tr. 5582-83; Romano, Tr. 3093, 3211-12, 3216-34).

2. Dr. Romano Placed Undue Reliance On Patient Satisfaction Surveys

a. Overview

2248. Dr. Romano improperly relied on patient satisfaction surveys from Press Ganey, Associates, Inc. (“Press Ganey”) and the Rhea & Kaiser marketing survey in an effort to show that patient satisfaction has not improved at ENH since the Merger. (Chassin, Tr. 5250-51).

2249. Press Ganey surveys patients on a number of items related to aspects of appearance, comfort and convenience – so-called amenities – that are not themselves measures of clinical quality. (Romano, Tr. 3337-39). Several of the questions from Press Ganey that Dr. Romano reviewed concerned such amenities having nothing to do with clinical quality. (Romano, Tr. 3339-40). For example, Press Ganey measures such things as courtesy of custodial staff; hospital food quality; and physicians' cordiality. (Spaeth, Tr. 2093-94; Romano, Tr. 3340). The deficiencies with the Press Ganey survey instrument include low response rates, a poorly-designed response scale, and the use of a mean score. (Chassin, Tr. 5244-46).

2250. ENH uses patient satisfaction surveys such as Press Ganey, in part, because the JCAHO requires them to do so. (Neaman, Tr. 1366). Although it is important for hospitals to have a general understanding of how patients perceive the hospital's service, patient satisfaction surveys do not reflect real clinical care or clinical outcomes. (Neaman, Tr. 1366).

2251. The Rhea & Kaiser survey was a marketing survey done on a small number of patients who self-identified themselves as patients at HPH. (Chassin, Tr. 5249-50; RX 2031 at ENH DL 6549). The Rhea & Kaiser survey also is misleading and invalid as a measure of patient satisfaction. (Chassin, Tr. 5249; RX 2031).

2252. Consistent with recognized scientific methods for evaluating surveys, Dr. Chassin did not rely on Press Ganey data or the Rhea & Kaiser marketing survey in assessing whether quality of care changed at HPH after the Merger. (Chassin, Tr. 5243, 5249). Dr. Chassin did not make use of patient satisfaction data in his analysis because there were no reliable data available. (Chassin, Tr. 5468). This explains why Dr. Chassin also does not use Press Ganey scores at Mount Sinai, where the Patient Satisfaction Survey Center reports to him. (Chassin, Tr. 5244-45).

2253. Finally, there are other, methodologically stronger patient satisfaction surveys, such as H-CAHPS, which is a federally funded effort that will likely supercede the weaker Press Ganey survey that ENH uses. (Romano, Tr. 3346-47).

b. Dr. Romano Improperly Relied On Unreliable Patient Satisfaction Surveys

2254. Press Ganey does not measure patient satisfaction or experience with care in a valid manner because of deficiencies in the survey assessment. (Chassin, Tr. 5243). The same conclusion applies to the Rhea & Kaiser survey. (Chassin, Tr. 5249).

2255. The problems discussed below associated with the Press Ganey surveys and the Rhea & Kaiser survey apply to all of the services evaluated at HPH. (Chassin, Tr. 5250-51).

i. Press Ganey Survey Response Rates Are Too Low To Draw Valid Conclusions

2256. The first problem with the Press Ganey surveys is that the proportion of patients who respond to the surveys is incredibly low. (Chassin, Tr. 5244). Survey response rates are important in assessing how much weight to accord to a survey analysis. (Romano, Tr. 3344).

Dr. Romano, however, did not even know the response rates for the Press Ganey surveys he analyzed. (Romano, Tr. 3344-45).

2257. Press Ganey has about a 20% response rate, a rate that is too low to draw valid conclusions. (Chassin, Tr. 5244). To determine the response rate, Dr. Chassin compared the number of patients who were discharged from HPH who received a survey with the number of surveys that were returned to HPH. (Chassin, Tr. 5247-48). HPH's practice was to survey every patient who had been hospitalized for a specific period of time. (Chassin, Tr. 5248). Once HPH received the surveys back from the patients, HPH sent them on to Press Ganey. (Chassin, Tr. 5248).

2258. The 20% Press Ganey response rate means that only 20% of the patients who were sent the survey returned a completed (or at least partially completed) survey. (Chassin, Tr. 5247). This 20% response rate is suboptimal because the lower response rate increases the possibility of bias due to differences between the survey's respondents and the non-respondents. (Romano, Tr. 3346).

2259. Indeed, the 20% response rate does not deal with how completely all the survey questions were answered. (Chassin, Tr. 5247). Press Ganey did not report the results where fewer than 40% of the patients actually responded to a particular question. (Chassin, Tr. 5249). So it is possible that only 40% of the 20% who returned the surveys might have answered a particular question. (Chassin, Tr. 5249).

2260. Hospitals that do well in assessing patient satisfaction typically have much higher response rates – in the 45-50% range. (Chassin, Tr. 5244).

2261. In fact, Dr. Romano acknowledged that he has not published articles in peer-reviewed journals drawing conclusions on quality of care based upon unrepresentative samples from patient satisfaction surveys. (Romano, Tr. 3343-44).

ii. Press Ganey's Rating Scale Has A Ceiling Effect

2262. The second problem is the design of the Press Ganey survey responses, which vary from very good at the high end to good, fair, poor and very poor. (Chassin, Tr. 5245). There is no "excellent" category on the Press Ganey surveys that Dr. Romano reviewed and, as a result, patients who wanted to express a score of excellent could not do so. (Romano, Tr. 3351).

2263. In the patient satisfaction field, patients tend to rate their experience with care highly, so scores are clustered at the high end of the scale. (Chassin, Tr. 5245; Romano, Tr. 3350). Thus, if an improvement were made that resulted in superb care, a patient would be unable to express that because the top end of the scale is only "very good," a phenomenon described as the "ceiling effect." (Chassin, Tr. 5245; Romano, Tr. 3350-51).

iii. Press Ganey Uses Mean, Not Percentage, Scores

2264. The third problem with Press Ganey scores is the use of mean, as opposed to percentage, scores. (Chassin, Tr. 5245-46).

2265. In patient satisfaction assessment, surveyors usually want to look at patient scores that are very high (so they can determine how to get more people in that category), and patient scores that are very low (so they can learn what drives dissatisfaction). (Chassin, Tr. 5246). Press Ganey has constructed a score that weights those ratings and puts them all together in a mean score. (Chassin, Tr. 5246).

2266. Press Ganey data could not be used to assess patient satisfaction to compare the changes in quality of care at HPH during the pre-Merger to the post-Merger period. (Chassin, Tr. 5246-47).

2267. Dr. Romano's testimony on Press Ganey scores actually reported the mean scores for the Press Ganey surveys, rather than the percentage of patients giving good and very good ratings. (Romano, Tr. 3356-57). The mean score on the Press Ganey surveys often was lower than the percentage score, which combined the good and very good ratings. (Romano, Tr. 3356-57).

2268. In Dr. Chassin's experience, particularly at Mount Sinai, he does not use mean scores in patient satisfaction surveys. (Chassin, Tr. 5246).

iv. The Rhea & Kaiser Survey Is Not A Valid Measure Of Patient Satisfaction At HPH

2269. Dr. Romano concedes that the Rhea & Kaiser should be used cautiously because it is based upon a small sample size. (Romano, Tr. 3361).

2270. The actual survey methods were not described in the Rhea & Kaiser survey summary, including how patients were selected and their responses obtained. (Chassin, Tr. 5250; RX 2031 at ENH DL 6550). The proportion of patients who answered questions about their impressions of improvement in specific services was very small including, for example, only 26 patients using HPH's oncology services and 24 patients using HPH's maternity service. (Chassin, Tr. 5250; Romano, Tr. 3361; RX 2031 at ENH DL 6566).

2271. Moreover, the Rhea & Kaiser survey asked patients about their perceptions of care that occurred up to two years prior. (Chassin, Tr. 5250; RX 2031 at ENH DL 6549-50). It is well established in patient satisfaction literature that patients' impressions of their care experience must be taken within a few weeks of that experience, otherwise their recollection deteriorates and changes dramatically. (Chassin, Tr. 5250).

c. Dr. Romano Improperly Relied On Insufficient Press Ganey Data

2272. Dr. Romano examined Press Ganey data for inpatient use of HPH's emergency services and the Kellogg Cancer Care Center only, thus omitting important information for HPH's outpatient services. (Romano, Tr. 3365-66; Chassin, Tr. 5372-73).

2273. Roughly 80% of patients who use HPH's emergency room are treated on an outpatient basis and, as a result, their experiences were not included in Dr. Romano's analysis of patient satisfaction at HPH. (Romano, Tr. 3365; Harris, Tr. 4213).

2274. Moreover, the inpatient Press Ganey data relied on by Dr. Romano pertaining to emergency services was limited to only one quarter post-Merger. (Romano, Tr. 3365). More data would be required before reaching conclusions on patient satisfaction with emergency services. (Romano, Tr. 3364-65).

2275. Similarly, many patients use HPH's Kellogg Cancer Care Center on an outpatient basis, and their experiences also were not reflected in Dr. Romano's analysis of patient satisfaction at HPH. (Romano, Tr. 3366-67; Chassin, Tr. 5373).

2276. For the reasons discussed above, Dr. Romano improperly relied on Press Ganey data to reach conclusions concerning the effect of the Merger on the quality of nursing care. (Chassin, Tr. 5251).

2277. Finally, Dr. Chassin's opinion with respect to Dr. Romano's reliance on the Rhea & Kaiser survey or the Press Ganey surveys for HPH's oncology service is the same as his opinion with respect to those surveys in other areas of improvements. (Chassin, Tr. 5373).

IX. OTHER COMPETITIVE EFFECTS CONSIDERATIONS

A. The Merger Was Not Anticompetitive Because Of Low Barriers To Market Entry And Repositioning By Competitors

2278. In evaluating the effects of the Merger, the proper economic analysis compares the actual situation post-Merger to the situation that would have existed during the post-Merger time period if the Merger had not occurred. (Noether, Tr. 6024). Consequently, the relevant question is whether HPH would have been a viable independent competitor since hospitals that compete with it have become more competitive through repositioning in the time since the Merger. (Noether, Tr. 6024).

2279. Repositioning or entry is “the enhancement of competition either through brand new entry – in a hospital case, it would be a new hospital being constructed and opened – or more modestly, repositioning can imply an existing hospital upgrading its capacity, expanding its capacity, adding new services, updating its physical plant, doing things that essentially make it a more attractive facility to managed care organizations and their enrollees and thereby making it more competitive in the marketplace.” (Noether, Tr. 6023).

1. The Illinois CON Law Will Not Be A Barrier to Entry

2280. Certain transactions that are proposed by healthcare facilities in Illinois require approval from the Illinois Health Facilities Planning Board. (D. Jones, Tr. 1653). The applications for transactions requiring approval from the Illinois Health Facilities Planning Board are commonly referred to as Certificate of Need, or CON applications. (D. Jones, Tr. 1653). The Illinois Health Facilities Planning Board reviews CON applications and Certificate of Exemption applications in Illinois. (D. Jones, Tr. 1652).

2281. The Illinois CON laws are scheduled to be repealed on July 1, 2006. (D. Jones, Tr. 1685). Unless the Illinois CON laws are extended or new laws are enacted, the CON process will cease to exist in July 2006. (D. Jones, Tr. 1685).

2282. If the CON statute expires and there is no replacement and/or similar statute enacted, all of the regulatory barriers would be removed. (D. Jones, Tr. 1685-86). This legal change will likely make entry and expansion much easier. (Noether, Tr. 6025).

a. Most CON Applications Are Approved

2283. From 1999 to mid-2004, 88% of the CON applications in Illinois were approved. (D. Jones, Tr. 1671-72).

2284. From 1999 to mid-2004, 427 projects were approved in Illinois pursuant to CON applications. (D. Jones, Tr. 1672).

b. Most CON Applications Are Approved In A Timely Manner

2285. In late 2002, early 2003, the Illinois Health Facilities Planning Board determined that it took an average of 75 calendar days from when a CON application was received by the agency until the permit was issued. (D. Jones, Tr. 1672).

2286. From 1999 to mid-2004, the average time from when a CON application was deemed complete to the date the permit was issued was 68 business days. (D. Jones, Tr. 1672-73).

c. The CON Requirements In Illinois Have Been Revised And, As A Result, Fewer Projects Require CON Approval

2287. In 2000, Illinois increased the minimum capital expenditure threshold for a permit to be required from the Illinois Health Facilities Planning Board from \$2 million to \$6 million. (D. Jones, Tr. 1673). The threshold amount required for a permit prior to the acquisition of major medical equipment was also increased from \$1 million to \$6 million. (D. Jones, Tr. 1673-74)

2288. As a result of the increases in the minimum capital expenditure and acquisition of major medical equipment thresholds, some projects that previously required a CON approval no longer require such approval. (D. Jones, Tr. 1674)

d. ENH's Competitors Have Been Able To Expand Their Facilities And Services Pursuant To The CON Process

2289. Repositioning is significant because, "in this case, there is substantial evidence that a number of hospitals in the Chicago area and most particularly hospitals around Highland Park [are] spending substantial resources to upgrade their facilities and thereby mak[ing] themselves competitive in the market place." (Noether, Tr. 6023).

i. Northwestern Memorial Has Expanded Its Facilities And Services

2290. In 2003, the Illinois Health Facilities Planning Board granted Northwestern Memorial a permit to build a new women's hospital. (D. Jones, Tr. 1681).

2291. Northwestern Memorial, which already draws obstetrics patients from a very large area, is in the process of constructing a new women's hospital "designed to make it an even bigger player in that field." (Noether, Tr. 6025; RX 1296 at NMH 2508, 2510, 2512, 2520).

ii. Condell Has Expanded Its Facilities And Services

2292. In 2000, Condell filed a Certificate of Need application for a major modernization and expansion of its hospital facilities, including its inpatient, ancillary and support services. (RX 755 at CMC 5974). This expansion provided four new obstetrics beds, three new ICU beds, a new Women's Center, an expanded and consolidated Surgery-Recovery-GI/Endo Department, an expanded Emergency Department, an expanded Radiology/Nuclear Medicine Department,

and an expanded administrative and support space. (RX 755 at CMC 5974). The construction began in 2001 and continued until late 2003. (RX 997 at CMC 135; RX 1556 at CMC 6071).

2293. In late 2002, the Illinois Health Facilities Planning Board granted Condell Medical Center a permit to increase its medical/surgical beds by 10 beds. (D. Jones, Tr. 1684).

2294. In 2004, the Illinois Health Facilities Planning Board granted a permit to Condell to add eight ICU beds. (D. Jones, Tr. 1683). The Condell CON permit increased the total number of ICU beds at Condell by almost 33%. (D. Jones, Tr. 1683).

2295. In late 2003, the Illinois Health Facilities Planning Board allowed Condell to alter its permit for obstetric beds to increase the number of obstetric beds by 10 beds. (D. Jones, Tr. 1684). The 2003 permit increased Condell's total number of obstetric beds by almost 40%. (D. Jones, Tr. 1684).

2296. In 2004, the Illinois Health Facilities Planning Board granted Condell a permit to add another 10 medical/surgical beds. (D. Jones, Tr. 1684).

iii. Lake Forest Hospital Has Expanded Its Facilities And Services

2297. In 2003, the Illinois Health Facilities Planning Board granted Lake Forest a permit to increase the number of medical/surgical beds by 10 beds. (D. Jones, Tr. 1684).

B. The Merger Was Not Anticompetitive Because HPH's Financial Condition Was Declining Before The Merger

1. HPH's Board Of Directors Determined That, Due To The Financial Condition Of HPH, HPH Could No Longer Maintain The Status Quo As An Independent Hospital

2298. The HPH Board of Directors was concerned about the long term-future of HPH. (Kaufman, Tr. 5781). The Board was concerned about the financial capability of the organization and the quality of services that were being offered at HPH. (Kaufman, Tr. 5781-82). The Board believed that the quality of care at the hospital did not meet the demands of the community the hospital served. (Kaufman, Tr. 5819).

2299. The Board was concerned about HPH's ability to compete effectively in the Chicago marketplace in light of its financial situation. (Kaufman, Tr. 5781-82). The HPH Board believed that it had a fiduciary obligation to HPH to take a close look at the hospital and chart out a course for the future. (Kaufman, Tr. 5781-82).

2300. HPH's declining operating income was discussed at HPH Board meetings. (CX 6305 at 3 (Stearns, Dep.)). The Board was concerned about the hospital's declining operating income. (CX 6305 at 3 (Stearns, Dep.)). The Board also was concerned about being able to perpetuate the existence of the hospital as the 1990s progressed. (CX 6305 at 4 (Stearns, Dep.)).

2301. The HPH Board hired Kaufman Hall & Associates (“Kaufman Hall”) to evaluate the future of the hospital from a third party perspective. (Kaufman, Tr. 5782). Kaufman Hall began working for HPH in the late 1980s. (Kaufman, Tr. 5778; Spaeth, Tr. 2266-67). During the two decades that Kenneth Kaufman of Kaufman Hall worked with HPH, he became very familiar with the finances of the hospital as well as the available strategic options. (Kaufman, Tr. 5778-79; Spaeth, Tr. 2266; Newton, Tr. 437).

2302. Kaufman Hall is an independent consulting firm that provides financial and capital advisory services to not-for-profit hospitals. (Kaufman, Tr. 5773). Kaufman Hall has provided financial consulting services to over 100 hospital mergers and acquisitions. (Kaufman, Tr. 5776).

2303. In the Chicago healthcare market, Kaufman Hall has provided financial consulting services to many mergers and acquisitions – such as the sale of St. Francis Hospital in Evanston to Resurrection Healthcare, the sale of St. Joseph’s Hospital to Resurrection Healthcare and the sale of West Suburban Hospital to Oak Park. (Kaufman, Tr. 5777).

2304. Kaufman, who testified at trial, is a well-recognized and preeminent consultant on financial matters in the Chicago healthcare market. (Newton, Tr. 436-37). Kaufman has an exceptional reputation in the healthcare field. (Spaeth, Tr. 2141).

2305. In November of 1996, Kaufman Hall was hired by HPH to “take a very detailed look at what the best future of HPH could be, and [] to evaluate the different options that were” available to the hospital. (Kaufman, Tr. 5780, 5818-19, RX 198). Kaufman Hall’s strategic project for HPH began on November 18, 1996, and concluded with the signing of the letter of intent on June 30, 1999. (Kaufman, Tr. 5789; RX 198; RX 567). Kaufman Hall was the only third party consultant hired by HPH to assist the hospital in evaluating its future options. (Kaufman, Tr. 5783).

2306. The HPH Board was focused on three primary criteria for the future of HPH: (1) an increase in capital capacity; (2) an increase in quality; and (3) the retention of local control. (Kaufman, Tr. 5786-87; 5817). The HPH Board’s first criteria was focused on insuring that HPH obtain the capital capacity to make long-term investments in the hospital to provide first-class services to the Highland Park Community. (Kaufman, Tr. 5786-87). The HPH Board also sought to address concerns about the overall quality of the hospital and to find a way to improve quality at the hospital. (Kaufman, Tr. 5786-87). The HPH Board’s third criteria was to maintain local control of the hospital for the benefit of the Highland Park community. (Kaufman, Tr. 5786-87).

2307. Kaufman Hall’s analysis determined that HPH could not maintain the status quo as an independently operated hospital because of the hospital’s financial situation. (Kaufman, Tr. 5811, 5818). The financial needs of HPH outweighed the capital capacity of the hospital. (Kaufman, Tr. 5828). As a result of the financial needs of HPH and the competitive pressures of the Chicago marketplace, Kaufman Hall concluded that HPH would be unable to maintain the status quo of the hospital. (Kaufman, Tr. 5819-20, 5828).

2. **The HPH Board Decided That Merging With Evanston Hospital Was The Best Option For The Future Of HPH**

2308. The HPH Board considered numerous options, but believed that a full asset merger was the best option to improve the future of HPH. (Kaufman, Tr. 5820-21). The Board wanted to merge the hospital into a “stronger healthcare company that could bring much stronger services over the long term to the Highland Park community.” (Kaufman, Tr. 5821-22).

2309. The Board did not feel that HPH could continue to serve its community in the long-run absent a partnership with another institution. (CX 6305 at 11 (Stearns, Dep.)). The Board concluded that HPH needed to find a partner that would enhance HPH’s ability to serve the community by bringing new programs to HPH – programs that HPH could not itself justify creating as an independent institution. (CX 6305 at 10 (Stearns, Dep.)).

2310. To guarantee HPH’s future, the HPH Board decided to find a partner that would bring in capital, talent and clinical programs that would enhance HPH and its ability to serve the community. (CX 6305 at 7 (Stearns, Dep.)).

2311. The HPH Board considered divesting the hospital to a for-profit provider, but ultimately rejected that option because it would require changing the culture of a not-for-profit hospital to a for-profit corporation. (Kaufman, Tr. 5822). The for-profit option conflicted with the Board’s criteria to retain local control over the hospital because a sale to a for-profit would mean that “local control is completely lost.” (Kaufman, Tr. 5822).

2312. Kaufman Hall, in cooperation with the HPH Board, evaluated a number of other options for the future of the hospital – including developing relationships or possible mergers with Northwestern Memorial Hospital, Advocate Healthcare and the Mayo Clinic. (Kaufman, Tr. 5823). Each of the parties HPH contacted were not interested in pursuing possible merger options. (Kaufman, Tr. 5823-24; CX 6305 at 12 (Stearns, Dep.)).

2313. The HPH Board also considered joint ventures, but that option was not recommended by Kaufman Hall. (Kaufman, Tr. 5823). Kaufman Hall did not recommend joint ventures because they would not solve HPH’s main problem of capital capacity. (Kaufman, Tr. 5823). A joint venture may be successful in bringing additional services, but it does not add capital capacity to an organization. (Kaufman, Tr. 5823).

2314. After reviewing all of HPH’s strategic options, Kaufman Hall recommended to the HPH Board that the hospital pursue a merger with Evanston Hospital. (Kaufman, Tr. 5824). A merger between HPH and Evanston Hospital was the best option because it met the three criteria established by the HPH Board for the future of HPH – capital capacity, increased quality and local control. (Kaufman, Tr. 5824).

2315. Kaufman Hall recommended that HPH merge with Evanston Hospital because Kaufman Hall’s strategic analysis of the hospital revealed that HPH could not maintain its capital capacity, improve its quality and improve its level of services on its own. (Kaufman, Tr. 5828-29).

2316. As the 1990s progressed, the HPH Board's principal concern became whether a community hospital like HPH could long exist. (CX 6305 at 7 (Stearns, Dep.)). Some Board members did not believe that HPH had a future. (CX 6305 at 7 (Stearns, Dep.)). In the mid to late 1990s, HPH's existing volume of business was not sufficient to sustain the hospital. (CX 6305 at 5 (Stearns, Dep.)).

2317. The HPH Board had a fiduciary duty to the hospital and the community to insure that the best possible and highest quality care was made available to the Highland Park community. (Kaufman, Tr. 5829). The Board consisted of very sophisticated business people from companies throughout Chicago who had a deep experience with asset mergers from their professional businesses. (Kaufman, Tr. 5821).

2318. As it turned out, the Merger between HPH and Evanston Hospital best met the fiduciary duty of the Board, as well as the HPH Board's three criteria discussed above. (Kaufman, Tr. 5824, 5829). First, Evanston Hospital was able to bring very significant capital capacity to HPH. (Kaufman, Tr. 5824). Second, Evanston Hospital also had a very good reputation for quality in the Chicago area and, through its connection with Northwestern Medical School, was able to bring quality and an academic link to HPH. (Kaufman, Tr. 5824). Finally, a merger between HPH and Evanston Hospital met the third criteria of the Board because HPH could maintain a good level of local control due to the fact that there is some overlap in the Evanston and Highland Park communities. (Kaufman, Tr. 5824).

3. HPH's Financial Condition Was Rapidly Declining

2319. As the 1990s progressed, HPH's operating income declined. (CX 6305 at 2-3 (Stearns, Dep.)). HPH began to lose money in the mid to late 1990s. (CX 6305 at 5, 10 (Stearns, Dep.)).

2320. From 1996 to 1999, HPH was not making money from operations on a year-to-year basis. (Kaufman, Tr. 5811). In 1996, HPH's operating margin was \$3.889 million, but by 1999, its operating margin hovered near losses of over \$3 million. (RX 609 at EY 236). In 1999, HPH's audited financials reported an \$11 million loss. (Spaeth, Tr. 2307; CX 1732 at 4).

2321. From 1997 to 1998, HPH's operating revenue was steadily decreasing. (Kaufman, Tr. 5793-94; RX 1979 at FTC KHA 2167). Despite experiencing a slight increase in total revenue in 1998, HPH was having more and more trouble turning a dollar of revenue into any type of profit. (Kaufman, Tr. 5794).

2322. From 1997 to 1998, HPH's operating margin "deteriorated significantly." (Kaufman, Tr. 5798; RX 1979 at FTC KHA 2172). From 1997 to 1998, HPH's operating margin dropped by half of its value the prior year. (Kaufman, Tr. 5798; RX 1979 at FTC KHA 2172). The declining operating margin was significant because HPH's financial momentum was trending downward. (Kaufman, Tr. 5798-99).

2323. In the late 1990s, the Balanced Budget Act of 1997 ("Balanced Budget Act") had an impact on HPH. (Spaeth, Tr. 2260). In the 1990s, HPH's operating revenues were being reduced by the Balanced Budget Act. (Spaeth, Tr. 2263). According to the April 1998 Lakeland Finance Committee meeting minutes, HPH projected a \$1.3 million loss in 1998 because of the

Balanced Budget Act. (RX 327 at ENH DR 3695). HPH further projected a \$4-6 million loss due to the Balanced Budget Act in the years after 1998. (RX 327 at ENH DR 3695).

2324. HPH's operating income came under pressure in the late 1990s because of the Balanced Budget Act and because of a decline in HPH's inpatient admissions. (CX 6305 at 3 (Stearns, Dep.)). HPH financial health was also negatively affected by reduced reimbursements from MCOs. (CX 6305 at 10 (Stearns, Dep.)).

2325.

(REDACTED)

(RX 349 at ENH RS 3440, *in camera*).

2326. The 1999-2002 Lakeland Strategic Plan, written in August 1998, also concluded that the Balanced Budget Act would have a "significant impact on [Lakeland] and Highland Park Hospital." Specifically, the 1999-2002 Lakeland Strategic Plan also predicted that the Balanced Budget Act would decrease HPH's Medicare payments by \$3.6 million in fiscal year 1999. (RX 363 at FTC-KHA 2350).

2327. HPH's operating margin in 1998 was considerably lower than the comparative universe of hospitals in the United States at that time. (Kaufman, Tr. 5804-05; RX 465 at FTC-KHA 280). HPH's operating margin in 1998 was 2.6 whereas the margin for an A-rated hospital in 1997 was 4.4. (Kaufman, Tr. 5804-05; RX 465 at FTC-KHA 2179-80). HPH's low operating margin was very significant because the hospital was going to need a significant amount of investment into its facilities, services and plant to compete in the marketplace. (Kaufman, Tr. 5804-05; RX 465 at FTC-KHA 2180).

2328. HPH's excess margin was considerably lower at 3% in 1998, while an A-rated hospital in 1997 had 7% excess margin. (Kaufman, Tr. 5804-05; RX 465 at FTC-KHA 2179-80). Despite taking into account HPH's strong investment income in 1998, HPH's excess margin was still less than half of the excess margin that was being shown by A-rated hospitals. (Kaufman, Tr. 5804-05; RX 465 at FTC-KHA 2179-80).

2329. HPH's negative operating revenue trend-line continued into 1999 (Kaufman, Tr. 5795-96). In June of 1999, HPH's declining financial performance accelerated even faster. (H. Jones, Tr. 4093). HPH reported a negative net margin of approximately \$2 million for the first 6 months of 1999, approximately \$4.7 million lower than what HPH had budgeted to achieve during the same time period. (RX 609 at EY 19; H. Jones, Tr. 4121).

2330. In September 1999, HPH's Chief Financial Officer reported to the HPH Board "significant operating shortfalls relative to budget reflected in June and preliminary July 1999 income statements." (RX 592A at ENH RS 880; Spaeth, Tr. 2305; Newton, Tr. 443-44). The June 1999 financial statements reflected a consolidated year-to date operating loss of \$2,235,000 compared to a budgeted loss of \$196,000. (RX 592A at ENH RS 882; Newton, Tr. 444).

2331. Other area hospitals such as Condell recognized that HPH was experiencing financial difficulties. (RX 1764 at CMC 19916-17, 19927). Internal Condell documents further

show the explosive growth Condell enjoyed while HPH struggled to get by in 1999. For example, in 1999, Condell's \$155,832,106 in gross revenue more than doubled HPH's \$70,949,405. (RX 1764 at CMC 19920).

2332. As early as January 31, 1999, HPH faced a year-to-date net margin loss of over \$3.5 million. (RX 449 at ENH HJ 1945). When taking into account adjustments for bad debt, necessary merger accruals and other year-end adjustments related to the Merger, as of January 1999, HPH stood to lose over \$11.7 million. (RX 449 at ENH HJ 1945). HPH's audited financial for 1999 showed an \$11 million operating loss. (Spaeth, Tr. 2307).

2333. In response to the significant financial losses in the late 1990s, HPH attempted to enact cost containment programs. (Spaeth, Tr. 2263, 2305; RX 592A at ENH RS 880; Newton, Tr. 444). Initially, HPH was able to reduce overhead costs. But, as time progressed, HPH started to look into cutting patient services such as nursing and radiology. (Spaeth, Tr. 2263-64). HPH successfully reduced costs only to a certain extent. (CX 6305 at 4 (Stearns, Dep.)).

2334. In December 1999, the CEO of HPH told the Board that HPH did not have a rosy financial future. (Spaeth, Tr. 2307-8). HPH's "Financial Statement Highlights for the 10 Months Ended October 31, 1999" stated that the "Hospital's operating margin for the 10 months ended October 31, 1999 was (\$5,050,000) which is 455.6% unfavorable to budget." (RX 2013 at ENH RS 6102; Newton, Tr. 447).

2335. In December of 1999 a member of HPH's financial team "reported on the October 1999 financial statements (excluding the Merger-related accruals noted above) which show a consolidated year-to-date operating loss of \$4,686,000 compared to a break-even budget. Operating loss of the Hospital was \$2,740,000, which was \$4,160,000 under budget. Operating income of the Foundation was \$392,000 or \$209,000 under budget. Operating loss of Lakeland Health Ventures was \$2,062,000 compared to a budgeted loss of \$1,738,000." (RX 2013 at ENH RS 6097; Spaeth, Tr. 2306-07; Newton, Tr. 446).

4. Evanston Hospital's Due Diligence Revealed That HPH's Financials Were On A "Downward Spiral"

2336. The Merger due diligence process revealed that HPH was on a financial "downward spiral." (H. Jones, Tr. 4157). In 1999, the financial condition of HPH was deteriorating and continuing to get worse. (Kaufman, Tr. 5816-17; H. Jones, Tr. 4157-58). HPH's finances were described as a "deteriorating financial trend." (H. Jones, Tr. 4093).

2337. Evanston Hospital's pre-Merger due diligence revealed problems with HPH's financial condition. (CX 6304 at 4 (Livingston, Dep.)). ENH's pre-Merger due diligence further revealed that the perception that HPH was a "strong community hospital" was not accurate. (CX 6304 at 4 (Livingston, Dep.)). To the contrary, HPH was not "strong." (CX 6034 at 5 (Livingston, Dep.)).

2338. Preliminary due diligence meetings between Evanston Hospital and HPH occurred in March and April of 1999. (H. Jones, Tr. 4091-92). After the Merger was approved by the Board of Directors for each hospital in June 1999, the due diligence process began in earnest. (H. Jones, Tr. 4092). The heavy lifting of the due diligence process occurred primarily

during July through September of 1999. (H. Jones, Tr. 4091-92). The due diligence process ended on or about September 15, 1999, with a report to Evanston Hospital's Board of Directors. (H. Jones, Tr. 4092).

2339. The primary players in the financial due diligence were Harry Jones and Larry Damron from Evanston Hospital, Jack Gilbert and Steve Berger from HPH, as well as Ken Kaufman and Jason Sussman from Kaufman Hall & Associates. (H. Jones, Tr. 4103-04; RX 514 at FTC-KHA 1658). Mark Newton, who testified at trial for Complaint Counsel, was not involved in the financial due diligence and was not a finance person at HPH. (H. Jones, Tr. 4104; Spaeth, Tr. 2282-83). Soon after the Merger, Newton left ENH to assume a position at Swedish Covenant Hospital, one of ENH's competitors. (Hillebrand, Tr. 2028-29; Newton, Tr. 279).

2340. At the conclusion of the due diligence process, Evanston Hospital created a full due diligence report in coordination with various consultants that Evanston Hospital hired to assist with the process. (RX 609; H. Jones, Tr. 4117-18; Hillebrand, Tr. 1903; RX 635 at ENH JH 3979). The due diligence discovered three major issues with respect to HPH: (1) Results from operations in 1999; (2) Facility Code Compliance and Life Safety Issues; (3) Executive Compensation. (RX 609 at EY 8; H. Jones, Tr. 4119; RX 635 at ENH JH 3978).

2341. The due diligence team determined that the overall financial situation of HPH was "High Risk." (H. Jones, Tr. 4120-21; RX 609 at EY 19; RX 635 at ENH JH 3989; Hillebrand, Tr. 1905). At the time of the due diligence in the Summer of 1999, HPH's earnings were negative and were continuing to trend to greater negative earnings. (H. Jones, Tr. 4093; Kaufman, Tr. 5798-99). HPH's downward financial trend was a problem that needed to be addressed in the Merger transaction discussion process. (Kaufman, Tr. 5798-99).

2342. During the due diligence, ENH discovered several "materially adverse results" with respect to the condition of HPH. (RX 569 at ENH JH 1215). HPH's 1999 operating results showed that HPH lost \$1,584,000 during the first six months of 1999. (RX 569 at ENH JH 1215). In addition, Lakeland posted non-operating losses of \$405,000 in the first six months of 1999. (RX 569 at ENH JH 1215). Further, expenses were \$3,753,000 unfavorable to budget. (RX 569 at ENH JH 1215).

2343. Evanston Hospital was concerned that HPH did not have sufficient financial reserves to sustain itself in light of the declining financial situation it was experiencing. (H. Jones, Tr. 4101). In June 1999, Neaman informed the Evanston Hospital Board that "Highland Park must be viewed as a significant turnaround effort with some risks." (RX 557 at ENH GW 4253). Adding HPH's financial condition to the already declining financial condition of Evanston Hospital would be a "tremendous strain" on Evanston Hospital's ability to turn the organization around. (H. Jones, Tr. 4101).

2344. The HPH financial statements prepared during the due diligence process identified a number of "nonrecurring costs." (H. Jones, Tr. 4181; CX 517 at 4). While a portion of these costs related to Merger-specific items, the majority of the nonrecurring costs identified in the due diligence process were year-end adjustments that needed to be accounted for regardless whether the Merger proceeded. (H. Jones, Tr. 4181). For example, due diligence

revealed that the HPH Board passed a new compensation plan in 1999 for its executives that had not been accrued within HPH's financial statements. (H. Jones, Tr. 4119-20).

2345. The financial results reported in due diligence expressly excluded \$100 million from HPH's financial statements because that money was going to be used to establish an independent private foundation for the city of Highland Park. (H. Jones, Tr. 4122). The ENH due diligence team excluded the \$100 million because it was not going to become part of the combined entity. (H. Jones, Tr. 4122).

2346. HPH's financial and facility problems were getting progressively worse. (CX 6304 at 4-5 (Livingston, Dep.)). As the due diligence progressed, ENH learned that HPH's financial and quality problems were more serious than first thought. (CX 6304 at 9 (Livingston, Dep.)).

a. HPH Was Losing Money And Being Supported With Investment Income

2347. HPH's financial statements appeared to show that the hospital was making money from operations because the hospital was including investment income into operations. (Kaufman, Tr. 5811). But when HPH's investment income was subtracted from its operating revenue, it shows that the hospital was showing a "significant operating loss." (Kaufman, Tr. 5811).

2348. The due diligence process revealed that HPH was losing money and was utilizing investment earnings in an attempt to bolster its operating performance. (H. Jones, Tr. 4093, RX 408 at ENHL TH 1509). HPH's financial statements reported investment income "above the operating line," or as part of operating income. (Kaufman, Tr. 5796).

2349. Hospital accounting methods and the Hospital Audit Guide suggest that investment income should not have been reported as operating revenue, but rather as nonoperating revenue because investment income is not part of the delivery of patient care services. (H. Jones, Tr. 4093-94). Investment earnings should not have appeared as operating revenue because investment funds are intended to be set aside and reinvested into the hospital. (H. Jones, Tr. 4095-96).

2350. The capital lending markets in the healthcare industry do not accept the inclusion of investment income in operating income as a legitimate practice. (Kaufman, Tr. 5811). The practice of reporting investment income as part of operating income was not done in other parts of the healthcare industry. (Kaufman, Tr. 5796).

2351. To really determine the profit and loss from HPH, the investment income had to be removed from the operating income. (Kaufman, Tr. 5796). Once investment income is removed from the operating income for 1998, it shows that HPH actually lost money from operations. (Kaufman, Tr. 5796; RX 1979 at FTC KHA 2167). The audited financials for HPH show an operating income loss in excess of \$1 million for 1997, and a loss of over \$7 million in 1998 – once investment income is removed from HPH's operating revenue. (RX 408 at ENHL TH 1509, H. Jones, Tr. 4095-96).

2352. Pre-Merger Evanston Hospital and post-Merger ENH did not report investment income as part of operating revenue. (H. Jones, Tr. 4096). Instead, ENH reports investment income “below the line” – as part of nonoperating income. (H. Jones, Tr. 4096).

2353. Accordingly, the due diligence team requested that Kaufman Hall present HPH’s financial information with the investment income reported “below the line,” *i.e.* not as part of operating revenue, in an effort to be consistent with Evanston Hospital’s financial statements and allow for a more consistent comparison of the two entities’ financial statements. (H. Jones, Tr. 4111-12; RX 514 at FTC-KHA 1669).

b. HPH’s Debt Capacity Was Severely Constrained

2354. Kaufman Hall determined that HPH’s capital capacity was “insufficient to compete in the changing Chicago marketplace.” (Kaufman, Tr. 5789-90). HPH had not been making money from operations for a long period of time. (Kaufman, Tr. 5789-90). Since capital capacity in the non-profit area is developed almost entirely from success in operations, HPH never made enough money to develop any excess capital capacity. (Kaufman, Tr. 5789-90).

2355. In 1998, HPH had a total of \$120 million in long-term debt, which was considered to be a large amount of debt for the hospital. (Kaufman, Tr. 5816; H. Jones, Tr. 4137; Newton, Tr. 441-42; Spaeth, Tr. 2260-61; RX 465 at FTC-KHA 2179). HPH’s debt in 1998 exceeded its cash and unrestricted investments by \$3 million. (Kaufman, Tr. 5816; RX 465 at FTC-KHA 2179). During the same time period in 1998, Evanston Hospital, by comparison, had no debt. (RX 518 at ENH GW 2054).

2356. HPH’s large amount of long-term debt “was a big problem.” (Kaufman, Tr. 5816). HPH’s long-term debt and its debt-to-capitalization ratio meant that HPH’s “ability to borrow significant dollars into the future was limited.” (Kaufman, Tr. 5816).

2357. For not-for-profit hospitals such as HPH, there are really only two sources of investable funds: (1) the money that the hospital makes; and (2) the money that the hospital borrows. (Kaufman, Tr. 5801-02). HPH’s revenues were declining significantly as well as the hospital’s ability to borrow funds. (H. Jones, Tr. 4093; Kaufman, Tr. 5798-99, 5801-02; RX 1979).

2358. HPH had borrowed money heavily through the 1980s and 1990s in an effort to compete in its service area and as a result had a very high debt/capitalization ratio. (Kaufman, Tr. 5802; RX 1979 at FTC KHA 2172). In 1991, HPH issued \$61.7 million in bonds. (CX 6320 at 1). In 1992, HPH issued bonds for an additional \$30 million that were insured by a financial guaranty insurance company. (CX 6319 at 1, 6). In 1997, HPH issued another \$40 million in bonds, which were again insured by a financial guaranty insurance company. (CX 6321 at 1, 9-10, 36).

2359. HPH’s debt-to-capitalization in 1998 was 61%, as compared to 33% for A-rated hospitals in 1997. (Kaufman, Tr. 5806; RX 465 at FTC KHA 2179-80). HPH’s high debt-to-capitalization percentage was “very high” and is evidence that, by any measure, HPH was “significantly over-leveraged.” (Kaufman, Tr. 5802, 5806; RX 465 at FTC-KHA 2179; RX 1979 at FTC KHA 2172).

2360. HPH's decreasing debt service coverage ratio was an indication of the decreasing capital capacity of the hospital. (Kaufman, Tr. 5801-02). The decreasing capital capacity of the hospital was a very important issue for the HPH Board in evaluating the future of the hospital. (Kaufman, Tr. 5801-02).

2361. HPH's debt service coverage in 1998 was 1.8 as compared to 3.8 for A-rated hospitals in 1997. (Kaufman, Tr. 5805-06; RX 465 at FTC-KHA 2179-80). HPH's debt service coverage ratio in 1997 was "very weak." (Kaufman, Tr. 5805-06; RX 465 at FTC-KHA 2179). The capital markets in the healthcare industry believe that a debt service coverage below 2 is a "significant warning signal" (Kaufman, Tr. 5805-06; RX 465 at FTC-KHA 2179). Debt service coverage is a primary indicator of capital capacity in the healthcare business, and HPH's ratio was trending in the "wrong direction." (Kaufman, Tr. 5801-02; RX 1979 at FTC KHA 2172).

2362. The due diligence process revealed that HPH did not issue its own debt based on its credit rating, but rather purchased bond insurance to obtain better rates and guarantee payment to the bond holders. (H. Jones, Tr. 4099). The due diligence discovered that HPH was paying its outstanding debt at interest rates that were 120-230 basis points (1.2% - 2.3%) higher than Evanston Hospital was able to receive. (RX 609 at EY 23; H. Jones, Tr. 4125-26). The higher interest rates translated to approximately \$1-2 million per year in interest payments. (H. Jones, Tr. 4125-26).

2363. Due to its precarious financial situation, HPH was unable to receive interest rates on its debt similar to what Evanston Hospital was able to achieve. (H. Jones, Tr. 4125-26; RX 609 at EY 23). Lakeland's \$120 million in outstanding debt was "credit enhanced by bond issuers" to AAA rating. (RX 518 at ENH GW 2077). If the debt were held by Lakeland standing alone, the rating would have been lower. (RX 518 at ENH GW 2077).

2364. To account for the "medium risk" associated with HPH's accounts receivables, the due diligence team recommended refinancing HPH's debt to take advantage of the lower interest rates that Evanston Hospital was able to receive as compared to HPH. (RX 609 at EY 23; H. Jones, Tr. 4126). After the Merger, Evanston Hospital was able to refinance all of HPH's debt and obtain a lower interest rate. (H. Jones, Tr. 4126).

c. HPH's Cash And Investments Were Insufficient To Compete In The Marketplace

2365. HPH had "very weak capital capacity on the operating side," however they shored up their credit by maintaining significant cash balances. (Kaufman, Tr. 5806; RX 465 at FTC-KHA 2180). In 1998, HPH had 444 days cash on hand, as compared to the median of 186 days cash on hand for A-rated hospitals. (Kaufman, Tr. 5806; RX 465 at FTC-KHA 2180). HPH's 444 days of cash on hand would translate to \$177 million in actual dollars. (Kaufman, Tr. 5807; RX 465 at FTC-KHA 2180).

2366. Despite HPH's cash on hand and additional investment money, HPH's funds were still insufficient to meet the competitive challenges of the Chicago marketplace. (Kaufman, Tr. 5806-07; RX 465 at FTC-KHA 2179-80). Although HPH had a considerable amount of money,

on a relative basis it in fact was not a lot of money. (Kaufman, Tr. 5806-07; RX 465 at FTC-KHA 2179-80).

2367. HPH's bondholders required that the hospital have cash on hand to secure the bonds. (Spaeth, Tr. 2261). During the 1990s, other than its cash on hand, HPH did not have access to other sources of cash. (Spaeth, Tr. 2261).

2368. Kaufman Hall did not recommend that HPH spend its cash on hand or investment dollars because the existence of those funds on the balance sheet was "the only thing that was providing a financial cushion for the hospital to operate in what was becoming an increasingly competitive market." (Kaufman, Tr. 5809). If HPH would have spent either its cash on hand or investment dollars, the hospital "would have nothing at all, because they had no [revenue from] operations." (Kaufman, Tr. 5809). The cash on the HPH balance sheet was the only thing keeping the hospital from mere survival because spending the funds would have removed all financial flexibility from the hospital. (Kaufman, Tr. 5809).

2369. If HPH had spent down their cash and investments, the hospital's operating results would have declined at an even faster rate because the investment income that was being used by HPH to prop-up the operations at the hospital would no longer be available. (Kaufman, Tr. 5813). HPH was reporting investment income as part of operating revenue in an attempt to bolster its operating performance. (H. Jones, Tr. 4093-94; Kaufman, Tr. 5796; RX 408 at ENHL TH 1509). Using the cash and investments to pay off debt or invest into the hospital would actually have resulted in a deterioration of the balance sheet because there would be significantly less cash available. (Kaufman, Tr. 5876-77).

2370. HPH could have lived off the cash on its balance sheet for a while. But merely surviving was inconsistent with the goals of the HPH Board and management. (Kaufman, Tr. 5875-76). The HPH Board and management believed that they were no longer able to produce the type of hospital they wanted for the Highland Park community. (Kaufman, Tr. 5875).

d. HPH's Joint Ventures Were Losing Money

2371. The due diligence process also revealed that HPH's joint ventures were a "medium risk" assessment. (RX 609 at EY 25; H. Jones, Tr. 4127). HPH's joint ventures had a projected loss of \$2.5 million for 1999. (RX 609 at EY 25; H. Jones, Tr. 4127).

2372. Evanston Hospital did not get involved in many joint ventures because it was outside of Evanston Hospital's core competencies. (H. Jones, Tr. 4127-28).

2373. HPH, in contrast, became involved in numerous joint ventures and failed to demonstrate that they could successfully and profitably operate the ventures. (H. Jones, Tr. 4127-28; RX 609 at EY 25).

2374. In 1999, Newton was the chief operating officer of HPH's joint ventures, or Lakeland Health Ventures, Inc. (Newton, Tr. 444-45). At the Lakeland Health Services Board of Directors meeting on August 23, 1999, Jack Gilbert (HPH's former CFO) reported that "[o]perating loss of Lakeland Health Ventures, Inc. was \$1,235,000 compared to a budgeted loss of \$1,114,000." (RX 592A at ENH RS 882; Newton, Tr. 445).

2375. Lakeland Health Ventures had a projected net loss of \$2.5 million in 1999. (RX 569 at ENH JH 1218; RX 609 at EY 25). Lakeland Health Ventures, lost an additional \$2 million in 1999. (Neaman, Tr. 1335).

e. HPH Made Insufficient Capital Expenditures

2376. Evanston Hospital's due diligence process included an architectural review of HPH. (H. Jones, Tr. 4097-98). The due diligence discovered that HPH immediately required \$15-19 million in "critical facility improvements in order to maintain code compliance, provide for critical life safety measures, mechanical, and electrical requirements." (RX 569 at ENH JH 1215, 1225-26; H. Jones, Tr. 4097-98, 4119). In addition to the numerous critical facility upgrades, there were dozens of "priority facility upgrades" as well. (RX 569 at ENH JH 1225-29).

2377. A notice of intent to terminate HPH's Medicare participation was received from HCFA as a result of its deficiencies in facilities. (RX 609 at EY 12).

2378. Before the Merger, HPH was tired and old. (Styer, Tr. 4970). HPH had significant deficiencies in its physical plant that limited HPH's capacity to render adequate care and ensure the health and safety of its patients. (Chassin, Tr. 5285-86; RX 545 at ENH JH 11578). Additionally, the equipment in several service areas such as radiology and pathology was old and outdated and in need of replacement. (O'Brien, Tr. 3491, 3508; Chassin, Tr. 5359; Victor, Tr. 3614).

2379. Before the Merger, HPH was investing in its capital expenditures at an amount equal to its depreciation expense. (H. Jones, Tr. 4098; Kaufman, Tr. 5814). HPH's low level of capital expenditure investment was an indication of insufficient cash flow and reserve assets. (H. Jones, Tr. 4098-99). Reinvesting an amount equal to historical depreciation was insufficient to improve patient care and grow services at HPH and was insufficient to sustain HPH's competitive position over the next five to fifteen years. (H. Jones, Tr. 4099; Kaufman, Tr. 5814-15).

2380. A HPH Investment Committee report from 1998 revealed that the hospital was forced to reduce its spending on capital expenditures because of financial pressures from various sources, including the Balanced Budget Act. (RX 400 at ENH RS 6702).

2381. HPH's five year capital expenditure plan anticipated spending an amount equal to the hospital's depreciation expense on an annual basis for the coming years. (H. Jones, Tr. 4134, 4138; RX 609 at EY 251). HPH's 1997-2001 strategic financial plan anticipated capital expenditures in excess of \$75 million. (Kaufman, Tr. 5825-26; CX 1868 at FTC-KHA 2357). HPH's capital expenditure plan of \$75 million "wasn't going to begin to get at the problems" that were occurring at HPH. (Kaufman, Tr. 5826).

2382. The 1999-2003 HPH strategic plan included \$65 million in capital expenditures. (CX 96 at 4; Styer, Tr. 5019). The passage of the 1999-2003 strategic plan did not change HPH's need to merge with Evanston Hospital because HPH's capital expenditure needs were far beyond what the 1999-2003 strategic plan could provide and because those needs were immediate in 1999. (Styer, Tr. 5029). Further, the \$65 million included in the 1999-2003

strategic plan was not sufficient to ensure the healthcare needs of the Highland Park community. (Styer, Tr. 5029).

2383. During the same time period, ENH was in the midst of a \$350 million capital expenditure plan, which equaled two to three times its depreciation expense. (H. Jones, Tr. 4098, 4138). And HPH's primary competitors, Lake Forest Hospital and Condell, had major expansion plans of their own. (RX 1206 at FTC-LFH 2171).

2384. The due diligence team thus projected that the investment funds at HPH were insufficient to cover the cost of the work that was needed on the hospital facilities and plant. (H. Jones, Tr. 4137-38). The HPH capital expenditure plan, if carried out, would have nearly depleted HPH's investments by the end of 2003. (H. Jones, Tr. 4133; RX 609 at EY 251).

2385. The due diligence team prepared projections that illustrated the effect of the HPH capital expenditure plan on HPH's investments. (H. Jones, Tr. 4136-38; RX 603 at KHA 32). The financial projections showed that the HPH capital plan, or "Board Designated Investments," decreased the HPH investments to a balance of \$15 million in 2004 and would have been entirely depleted if projected out one additional year. (H. Jones, Tr. 4136-37; RX 603 at KHA 32). The due diligence team concluded that if there were not significant changes made to HPH's operations, the HPH capital expenditure plan would have driven the hospital out of business. (H. Jones, Tr. 4137).

2386. If HPH had depleted their investments, as was anticipated through their five year capital expenditure plan, the hospital's investment earnings would have decreased significantly, and the hospital would no longer be able to subsidize its operations with investment earnings. (H. Jones, Tr. 4139). HPH was utilizing its investment earnings to subsidize its operations. (H. Jones, Tr. 4139).

f. HPH's Collection Rates/Accounts Receivable Were Declining

2387. The due diligence team also reviewed the accounts receivable performance at HPH and determined it to be a "medium risk" area. (RX 609 at EY 23; H. Jones, Tr. 4123-24). The due diligence process discovered that HPH's cash position was "substantially overstated." (RX 429 at FTC-KHA 995). HPH had credit balances of \$2.6 million over 270 days and may have had "legal issues" associated with the long-standing credit balances. (RX 429 at FTC-KHA 995). Evanston Hospital interpreted those numbers to mean that there was not enough attention or resources available to collect on HPH's accounts. (RX 429 at FTC-KHA 996).

2388. The due diligence report highlighted that HPH's gross collection rates decreased from 64.6% in 1996 to 55.1% through June of 1999. (RX 609 at EY 19). The Evanston Hospital due diligence team observed a downward trend in the amount of money HPH was collecting from MCOs. (H. Jones, Tr. 4123).

2389. The due diligence found that gross unbilled charges at HPH had increased from \$5.3 million in 1997 to \$8.6 million in June of 1999. (RX 609 at EY 23; H. Jones, Tr. 4124). In conjunction with HPH's change to the Meditech billing system, the hospitals unbilled charges had increased from \$5.3 million in 1997 to \$8.6 million in 1999. (H. Jones, Tr. 4124; RX 609 at EY 23; RX 569 at ENH JH 1218). HPH's unbilled charges was determined to be a risk because

the longer it took for a bill to be processed, the likelihood that the bill will be paid decreases. (H. Jones, Tr. 4124-25).

2390. HPH's financial condition was affected by administrative matters that required "immediate attention." (RX 569 at ENH JH 1218). Provision for bad debt at HPH increased by \$1.6 million in the first six months of 1999. (RX 569 at ENH JH 1218).

2391. HPH's accounts receivable was a cause for concern as Evanston Hospital weighed the Merger. (RX 429 at FTC-KHA 996). HPH's inpatient unbilled charges of \$3.2 million was "unusually high." (RX 429 at FTC-KHA 996). At the time, Evanston and Glenbrook Hospitals' accounts receivables totaled only \$1.3 million. (RX 429 at FTC-KHA 996). HPH's accounts receivable days were "high and rising" from 88 days at HPH, as compared to 50 days at ENH. (RX 569 at ENH JH 1219).

2392. The due diligence also discovered that HPH's credit balances increased from \$1 million in 1997 to \$3.1 million in June of 1999, meaning that HPH owed Medicare and patients \$3.1 million in refunds for duplicate payments. (RX 609 at EY 23; H. Jones, Tr. 4125). The amount that HPH owed for duplicate payments tripled from 1997 to 1999. (H. Jones, Tr. 4125).

g. Due Diligence Revealed That HPH's Future Financial Projections Were Unrealistic

2393. HPH's future financial projections were inconsistent with HPH's historical trend line. (H. Jones, Tr. 4112; RX 514 at FTC-KHA 1669). Despite HPH's declining trend line, HPH "thought that somehow they were going to reverse that trend." (H. Jones, Tr. 4112; RX 514 at FTC-KHA 1669). But the HPH future financial projections were unrealistic. (H. Jones, Tr. 4097).

2394. The HPH due diligence financial projections prepared in coordination with Kaufman Hall showed that HPH's "Excess of Revenue over Expenses from Operations," or operating revenue, decreased from \$4 million in 1997, to approximately \$317 thousand in 1998. (RX 514 at FTC-KHA 1669; Kaufman, Tr. 5834-35). HPH's financials projected a loss of \$793,000 in 1999, a loss of \$868,000 in 2000, and a slow but gradual return to profitability in 2001-2004. (RX 514 at FTC-KHA 1669; Kaufman, Tr. 5834-35). The actual financial results of HPH, however, were not supporting the hospital's projections that the financial situation was going to turn around in the future. (H. Jones, Tr. 4121).

2395. HPH, in coordination with Kaufman Hall, projected a "downward trend" and "on a going forward basis, [HPH] just didn't expect to be doing very well." (RX 514; Kaufman, Tr. 5834-35).

2396. As the due diligence process continued into the Summer of 1999, HPH's actual financial results were significantly below what the HPH projections illustrated. (H. Jones, Tr. 4113). In addition, the due diligence process identified capital costs required for critical improvements to the HPH facility as well as unrecorded executive compensation packages that were not taken into account within HPH's financial projections. (H. Jones, Tr. 4113).

2397. As the due diligence process continued, the due diligence team worked to revise the initial financial projections and create a set of more “realistic” projections for the combined organizations. (H. Jones, Tr. 4113-14, 4116; RX 514; RX 603). The revised financial projections for HPH show the hospital’s operating revenue declining from approximately \$1.8 million in 1997, to negative \$3.4 million in 1998, negative \$19 million in 1999 and remaining in the negative for the foreseeable future with a negative \$37 million in 2004. (RX 603 at KHA 31).

2398. HPH’s financial projections were based on a set of assumptions that were more aggressive than its actual historical performance. (RX 539 at DC 7657). For instance, HPH’s actual 1996 to 1998 volume as measured by discharges decreased by 1%, yet HPH’s 1999 to 2004 projections assumed 1.2% growth. (RX 539 at DC 7657). While HPH’s actual 1996 to 1998 average length of stay was 1.2%, its projections assumed only .7%. (RX 539 at DC 7657). Similarly, while net revenue per patient day decreased by .2% from 1996 to 1998, HPH projected that it would increase 1.7% from 1999 to 2004. (RX 539 at DC 7657).

2399. Astoundingly, while HPH’s operating income was actually decreasing by 45% from 1996 to 1998, HPH projected that it would increase 34% from 1999 to 2004. (RX 539 at DC 7657).

2400. As a result, ENH re-calibrated HPH’s projections using “more reasonable” assumptions as to HPH’s financial position in light of its historical experience. (RX 539 at DC 7658; RX 609 at EY 37). Using the more reasonable assumptions, ENH projected that HPH was on a downward trend in operating income that would continue to worsen as time passed. (RX 539 at DC 7659). While losses would be \$.6 million in 2000, by 2004 the losses would be \$9.1 million in operations. (RX 539 at DC 7659). The due diligence document projected that operating losses could exceed \$20.9 million by 2002. (RX 609 at EY 38).

2401. The 1999-2002 Lakeland Strategic Plan stated that HPH’s “long range financial plan anticipates operating margins to decrease over the next several years.” (RX 363 at FTC-KHA 2357). The Plan also stated that HPH’s cash flows would be positive between 1997 and 2001, but primarily because of returns from investments. (RX 363 at FTC-KHA 2357). Moreover, the Plan stated that “[g]reater returns must be achieved through operations.” (RX 363 at FTC-KHA 2357). Finally, the Plan concluded that, for HPH to survive, it had “to continue to expand its revenue base and develop current product lines while maintaining cost control.” (RX 363 at FTC-KHA 2357). Lakeland’s 1999-2002 Strategic Plan itself stated that it was “linked to the organization’s long term financial plan and annual operating and capital budgets.”(RX 363 at FTC-KHA 2349).

2402. In 1999, HPH was budgeted to make an operating gain but, in reality, was headed for an operating loss. (Neaman, Tr. 1257). HPH’s operating finances deteriorated substantially in 1999, despite HPH having predicted a profit. (Neaman, Tr. 1332-33). HPH had a very high accounts receivable along with rising debt and strained credit. (Neaman, Tr. 1333).

2403. During the due diligence period, ENH concluded that “[i]f LHS [*i.e.*, Lakeland] continues to operate as it historically has, ENH management expects LHS to experience operating losses over the next several years.” (RX 435 at DC 7498). In fact, the due diligence

showed that ENH management expected that LHS would experience operating losses of \$.6 million in 2000, \$2.5 million in 2001, \$4.5 million in 2002, \$6.6 million in 2003 and \$9.1 million in 2004. (RX 435 at DC 7498).

2404. ENH management also concluded that “[u]nder [ENH’s] Baseline Scenario, LHS would be expected to have negative cash from operations, thus requiring significant investment income to maintain liquidity.” (RX 435 at DC 7499).

5. Expert Testimony Confirms The Significance Of HPH’s Declining Financial Condition

2405. Based on an independent review of HPH’s financial statements and a review of the record evidence, Dr. Noether concluded that HPH was in substantially weakened financial condition after the Merger and that had it remained independent, such a scenario would have limited its competitive significance in the market. (Noether, Tr. 5902, 6027).

2406. HPH’s cash flow before the Merger fluctuated somewhat from year-to-year, but “in general, it was not generating substantial cash flow.” (Noether, Tr. 6034). Given the \$100 to \$200 million of capital investments that HPH needed to make, it was not generating sufficient cash to be able to make the necessary investments. (Noether, Tr. 6033-34).

2407. Particularly given the expansion effort and capital expenditures that were being made by neighboring hospitals, HPH’s financial condition would not have allowed it to “keep up” with what the competition was doing. (Noether, Tr. 6026-27).

2408. HPH had negative \$11.3 million in operating income in 1999. (Noether, Tr. 6179-80). Any suggestion that certain costs characterized as Merger-related costs were the cause of the downturn in HPH’s operating income is misguided because evidence suggests that many of these costs would have been incurred even absent the Merger. (Noether, Tr. 6031, 6180-81, 6207). Even if these costs were excluded from the analysis, HPH still would have reported an operating loss of around \$3 million. (Noether, Tr. 6207).

2409. Although HPH had made some projections that suggested it would be able to reverse the downward operating income trend, the Merger due diligence team concluded that these projections were unrealistic in light of the passage and impact of the Balanced Budget Act and the stock market decline in 2000. (Noether, Tr. 6031).

2410. Dr. Noether weighed HPH’s future cash needs against its sources of cash. (Noether, Tr. 6028). HPH needed cash for three primary reasons: (1) to fund operations; (2) to make necessary capital expenditures in the range of \$100 to \$200 million; and, (3) to pay off its debt of \$115 million. (Noether, Tr. 6035). Although HPH had a significant amount of cash on its balance sheet, it had only enough cash to meet two of its three pressing needs for cash. (Noether, Tr. 6035).

2411. HPH also had a “substantial” amount of debt, approximately \$115 million in 1999. (Noether, Tr. 6034). HPH needed cash to service that debt. (Noether, Tr. 6034). HPH’s precarious financial condition is further evidenced by the fact that HPH took out debt insurance to lower the interest rate that it had to pay on its debt. (Noether, Tr. 6036).

2412. Dr. Noether's analysis concluded that HPH was likely to get even weaker without the Merger and that, in the long run, HPH would have a hard time meeting its cash needs. (Noether, Tr. 6028-29).

2413. Dr. Haas-Wilson did not undertake an analysis of the financial condition of HPH before the Merger. (Haas-Wilson, Tr. 2441; Noether, Tr. 6027). As a result, Dr. Haas-Wilson did not offer an opinion on the pre-Merger financial condition of HPH. (Haas-Wilson, Tr. 2441).

C. ENH's Not-For-Profit Status Is Relevant To The Competitive Effects Analysis

1. Not-For-Profit Status Plays A Role In Hospital Pricing

2414. Not-for-profit hospitals, like ENH, reinvest their revenue into the hospitals. (CX 6304 at 11 (Livingston, Dep.)). Revenue earned by a not-for-profit hospital, like ENH, does not leak out of the hospital system in any way at all. (CX 6304 at 12 (Livingston, Dep.)).

2415. For example, HPH's management and its Board took the hospital's not-for-profit status into account when determining its pricing and profit approaches. (Newton, Tr. 473). HPH's management philosophy was to be careful about not overcharging the community for healthcare because HPH was responsible for healthcare in the community. (Newton, Tr. 473). As a not-for-profit hospital, and as an asset of the community, HPH kept its price increases appropriate to give the community a level of care that the community appeared to need. (Spaeth, Tr. 2180-81).

2. The Opinions Of Complaint Counsel's Not-For-Profit Expert Support The Fact That ENH, As A Not-For-Profit Entity, Acts Differently Than A For-Profit Entity

2416. Economic theory does not necessarily predict that a not-for-profit hospital would try to maximize profits. (Simpson, Tr. 1646).

2417. The decision to open a new service not in the hospital where it would be most profitable, but in the hospital that would best benefit the community, is evidence that the hospital system is not acting like a profit-maximizing firm. (Simpson, Tr. 1633).

2418. After the Merger, ENH elected to open a comprehensive adolescent psychiatry center at HPH, not because it was profitable, but because it would benefit the community. (RX 1754 at ENH RS 3091; Neaman, Tr. 1358). Before the Merger, adolescent patients at HPH in need of psychiatric services were treated in a "mixed adult and adolescent facility." (RX 1754 at ENH RS 3086; Neaman, Tr. 1358). Treating adolescents in such an environment with adult psychiatric patients did not meet minimal Medicare standards. (RX 1754 at ENH RS 3085; Neaman, Tr. 1358-59). Rather than consolidate all psychiatric services at Evanston Hospital, a consolidation that would have been more profitable, ENH elected to create dedicated adolescent and adult psychiatric centers that benefit both patients and the community. (RX 1754 at ENH RS 3091; Neaman, Tr. 1358-59).

2419. Moreover, the provision of more charity care would benefit the community and is an example of how a not-for-profit hospital provides benefits to the community that a for-profit hospital might not. (Simpson, Tr. 1633).

2420. ENH uses funds it receives from the Highland Park Healthcare Foundation to offset the cost of charity care that is provided at HPH. (RX 2037 at HFHP 1362; Styer, Tr. 4981; Neaman, Tr. 1312). The cost of charity care at HPH exceeds the annual payment that ENH receives from the Foundation. (H. Jones, Tr. 4179-80).

2421. Complaint Counsel's expert further explained the existence of a theory by Dr. William Lynk "that non-profit hospitals tended not to exploit market power; specifically, he found that non-profit hospitals – that the prices of non-profit hospitals in more concentrated markets were not higher than the prices of non-profit hospitals in less concentrated markets." (Simpson, Tr. 1625). A subsequent study by Dr. Lynk and Lynette Neumann "also found that non-profit hospitals tended not to exploit market power." (Simpson, Tr. 1626).

2422. Complaint Counsel's expert also explained that Dr. William Lynk's theory goes on to state "that if you have a non-profit hospital with community representatives on the board of directors, these community representatives will use their influence on the board and the non-profit hospital to ensure that the non-profit hospital basically sets the competitive price." (Simpson, Tr. 1622).

2423. ENH's Board contains community representatives who provide oversight to the organization. (Simpson, Tr. 1639). Approximately three-quarters of ENH's Board are outside directors chosen from the community. (Simpson, Tr. 1639). In addition to the ENH Board, the Healthcare Foundation of Highland Park also monitors ENH's activities, specifically its commitments to HPH and the Highland Park Community. (RX 2037 at HFHP 1364; Styer, Tr. 4971, 4985).

2424. Complaint Counsel's expert did not testify that ENH used surplus funds in a wasteful manner. (Simpson, Tr. 1648, 1650). He also did not testify that ENH's managers tried to build a prestigious facility that the community might not otherwise need. (Simpson, Tr. 1635).

3. The Pre-Merger HPH Foundation Is Evidence Of How A Not-For-Profit Hospital Benefits The Community

2425. HPH had a Foundation that was part of the hospital pre-Merger. (Styer, Tr. 5001-2). The HPH Foundation Board consisted of many members of the Highland Park community, including the Mayor of Highland Park and the CEO of the hospital. (Styer, Tr. 4957-58, 5008).

2426. The HPH Foundation's bylaws required that the Foundation raise funds exclusively for Lakeland Health Services and HPH. (Styer, Tr. 5001-2). The funds the HPH Foundation raised went to HPH in an attempt to fulfill the hospital's needs. (Styer, Tr. 4954). The funds from the HPH Foundation were never used to support causes outside of HPH. (Styer, Tr. 4954).

2427. Pre-Merger HPH was able to raise \$1-1.2 million per year through fundraising efforts. (Spaeth, Tr. 2294-95; Styer, Tr. 5005). However, HPH could not have survived alone on its fundraising income. (Spaeth, Tr. 2295-96). Specifically, the \$1 million annually raised was not close to being sufficient to cover pre-Merger HPH's requests to the Foundation. (Styer, Tr. 4959-60, 5028).

2428. As HPH started to suffer operating income losses in the late 1990s, the HPH Foundation's funds were used to help offset HPH's operating losses. (Styer, Tr. 4961; RX 400 at ENH RS 6692). The HPH Foundation's funds were used to offset HPH's operating losses because HPH management was concerned about maintaining the hospital's bond ratings and the hospital's future viability. (Styer, Tr. 4961-62).

4. The Creation Of The Independent Highland Park Healthcare Foundation As A Result Of The Merger Demonstrates How ENH Acts To Benefit The Community As A Not-For-Profit

2429. In December 1999, Evanston Hospital and the HPH Foundation signed the agreement creating the Healthcare Foundation of Highland Park. (RX 2037; Styer, Tr. 4977-78). The Healthcare Foundation of Highland Park came into being on January 1, 2000, as a result of the Merger. (Styer, Tr. 4951, 4971; Belsky, Tr. 4894; Spaeth, Tr. 2281).

2430. The Healthcare Foundation of Highland Park started with a corpus of roughly \$100 million. (Neaman, Tr. 1260). As of March 2005, the Healthcare Foundation had a \$85 million corpus, down from its original \$100 million due to poor performance of investments in 2000 and 2001 and because the Foundation has given away more than \$28 million. (Styer, Tr. 4979-80).

2431. The Healthcare Foundation of Highland Park has a significantly different mission than the pre-Merger HPH Foundation in that the post-Merger Foundation dispenses money instead of raising money. (Styer, Tr. 4972). The Healthcare Foundation of Highland Park also supports causes beyond HPH. (Styer, Tr. 4972-73).

2432. The creation of the Healthcare Foundation of Highland Park was another means of fulfilling HPH's primary Merger goal of benefiting the Highland Park community. (CX 6305 at 16 (Stearns, Dep.); Neaman, Tr. 1373). The Foundation Agreement establishing the Healthcare Foundation of Highland Park describes the Foundation's mission to support HPH and healthcare in the general Highland Park community. (RX 2037 at HFHP 1356; Styer, Tr. 4951, 4979; Neaman, Tr. 1373).

2433. The Bylaws of the Healthcare Foundation detail the Foundation's main purposes as: (1) to foster, promote, develop, and support HPH and other community benefit charities which provide or support healthcare or other similar services in Highland Park and the surrounding communities; and (2) to monitor and enforce the obligations of ENH set forth in the Agreement and Plan of Merger to the extent provided in the Foundation Agreement between the Healthcare Foundation and ENH. (RX 1409 at HFHP 1071; Styer, Tr. 4971).

2434. The Healthcare Foundation of Highland Park is not legally connected to HPH and is separate and independent of ENH. (Styer, Tr. 4972; Belsky, Tr. 4916; Neaman, Tr. 1373; CX 6304 at 7 (Livingston, Dep.); Hillebrand, Tr. 1784).

a. The Healthcare Foundation of Highland Park is Required to Monitor the Commitments ENH Made to the Community

2435. The Foundation Agreement gives the Healthcare Foundation the power to notify the Illinois Attorney General of “a material breach by ENH of any of its obligations under the Merger Agreement which substantially undermines or adversely affects the Highland Park community” if ENH and the Healthcare Foundation cannot themselves resolve ENH’s alleged breaches within 90 days. (RX 2037 at HFHP 1364; Styer, Tr. 4971, 4985).

2436. The Healthcare Foundation is able to monitor whether ENH is fulfilling its commitments under the Merger Agreement through the regular reports it receives from Spaeth at board meetings and through a visual inspection of the physical improvements at HPH. (Styer, Tr. 4986; RX 926 at HFHP 2044; RX 990 at HFHP 2041; RX 1055 at HFHP 2037-39; RX 1102 at HFHP 2034-35; RX 1151 at HFHP 2021; RX 1408 at HFHP 2005; RX 1442 at HFHP 10762-63; RX 1546 at HFHP 1997-98; RX 1573 at HFHP 1994; RX 1691 at HFHP 2454).

2437. As of March 2005, the Healthcare Foundation has not found ENH to be in breach of the Merger Agreement. (Styer, Tr. 4985). In fact, Styer believes that ENH far exceeded the commitments it made to HPH and the Highland Park community in the Merger Agreement. (Styer, Tr. 4986).

2438. As chairman of the Healthcare Foundation of Highland Park, Styer believes that the Merger has unequivocally improved HPH and the patient’s experience from the time the patient enters to when the patient exists the hospital. (Styer, Tr. 4986-87; RX 1359). The Healthcare Foundation of Highland Park, again another product of the Merger, has been “absolutely” beneficial to the Highland Park community. (Spaeth, Tr. 2282).

b. The Highland Park Healthcare Foundation Contributes Funds to HPH for the Benefit of the Community

2439. The Foundation Agreement creating the Healthcare Foundation of Highland Park obliged the Foundation to send to ENH the greater of 100% of its investment earnings or \$8 million in 2000, the greater of 75% of its investment earnings or \$6 million in 2001 and 2002, and the greater of 50% of its investment earnings or \$4 million for every year thereafter. (RX 2037 at HFHP 1362; Styer, 4980-81; Spaeth, Tr. 2281; Neaman, Tr. 1261; Belsky, Tr. 4898). The Foundation Agreement, in turn, obliges ENH to use the money it gets from the Healthcare Foundation to offset the costs of uncompensated care and other clinical programs at HPH selected at ENH’s discretion. (RX 2037 at HFHP 1362; Styer, Tr. 4981).

2440. The majority of the Healthcare Foundation’s funds sent to ENH are used to support indigent or uncompensated care at HPH. (Styer, Tr. 4981; H. Jones, Tr. 4179-80). Even though Highland Park is a wealthy community, it has a large number of seniors and minority groups who cannot pay for healthcare. (Styer, Tr. 4981). Consequently, the cost of charity care

at HPH exceeds the annual payment that ENH receives from the Foundation. (H. Jones, Tr. 4179-80).

2441. The HPH team that negotiated the Foundation Agreement agreed to the annual contribution to ENH because: (1) they wanted the Highland Park community to know that the money raised by the community for the old HPH Foundation would still support HPH; and (2) to assure that that money would be spent at HPH. (Styer, Tr. 4982).

2442. Styer believes that the annual payment from the Healthcare Foundation to ENH is a very fair arrangement because it is a “drop in the bucket” compared to the over \$100 million ENH has spent on improving the HPH campus since 2000. (Styer, Tr. 4982; Kaufman, Tr. 5833-34). In addition, Styer believes that the annual payment from the Healthcare Foundation to ENH is a very fair arrangement because the annual contributions demonstrate to the Highland Park community and ENH the desire to continue to support the HPH campus. (Styer, Tr. 4983; Kaufman, Tr. 5833-34).

c. The Highland Park Healthcare Foundation Provides Grants To Community Organizations

2443. The Healthcare Foundation of Highland Park also dispenses grants to charities in the Highland Park area. (Styer, Tr. 4987-88). Since its creation, the Healthcare Foundation of Highland Park has given roughly \$26 million back to HPH and another \$3-4 million to organizations within the greater Highland Park community. (Styer, Tr. 4974).

2444. In 2002, the Healthcare Foundation awarded \$500,000 to the Lake County Health Department to establish a community healthcare clinic in the Highland Park/Highwood area to improve access to healthcare for underserved populations in southeast Lake County. (RX 1238 at HFHP 2565).

2445. Groups interested in receiving funding from the Healthcare Foundation must then submit an application to the Foundation which the allocation subcommittee will first review. (Belsky, Tr. 4896). The allocation subcommittee will vote on applications for funding and will decide how much money should be allocated to which groups before passing their recommendations on to the full board. (Belsky, Tr. 4896).

X. REMEDY

A. Divestiture Is Not A Proper Remedy Because The Merger Was Necessary To Achieve Quality Improvements At HPH

2446. Overall, ENH spent \$120 million on capital improvements at HPH after the Merger. (Hillebrand, Tr. 1977; Neaman, Tr. 1250). HPH could not have made comparable investments in HPH on its own. (Spaeth, Tr. 2280-81).

2447. The quality improvements ENH made after the Merger enabled HPH to offer services not typically offered by community hospitals. (Wagner, Tr. 3999-4000; Romano, Tr. 3334; Neaman, Tr. 1352; Dragon, Tr. 4325, 4344-48, 4370-71; Chassin, Tr. 5329; RX 1341 at ENHE TH 975).

2448. There was no evidence that, before the Merger, HPH had the plans or the capacity to implement the quality changes that occurred after the Merger, or that HPH could have accomplished similar improvements through a joint venture. (Chassin, Tr. 5390-93).

2449. Accordingly, the Merger was necessary to bring about the vast majority of the quality improvements made at HPH, thus improving patient care. (Chassin, Tr. 5381).

1. HPH Was Not Capable Of Remediating Its Quality Problems, Implementing New Services, Or Improving Old Ones Without The Merger

a. HPH Lacked The Financial Capacity To Implement Necessary Quality Improvements

2450. Before the Merger, HPH had significant deficiencies in its physical plant that limited HPH's capacity to render adequate care and ensure the health and safety of its patients. (Chassin, Tr. 5285-86; RX 545 at ENH JH 11578). Additionally, the equipment in several service areas such as radiology and pathology was old and outdated and in need of replacement. (O'Brien, Tr. 3491, 3508; Chassin, Tr. 5359; Victor, Tr. 3614).

2451. HPH also lacked the money to improve patient care and grow services before the Merger. (H. Jones, Tr. 4098-99; Kaufman, Tr. 5814-15). The capital expenditures proposed in its 1997-2001 strategic plan were not "going to begin to get at the problems" occurring at HPH. (Kaufman, Tr. 5826).

2452. Due to HPH's declining financial condition, it lacked the capacity or resources to make the \$120 million in capital investments that was made by ENH. (Neaman, Tr. 1353). Capital expenditures similar to ENH's investment would have "tanked" the organization. (Neaman, Tr. 1353). Thus, HPH's declining financial condition prevented it from making the necessary capital expenditures to remedy its quality problems, improve the services it already provided, or add new services. *See* Section IX.B If HPH had merged with a hospital other than Evanston Hospital, it could have achieved the same quality improvements that resulted from the

Merger only if that other hospital had the capacity to make the same level of investment in HPH that Evanston Hospital did. (Chassin, Tr. 5395).

b. HPH Lacked The Capacity To Effect Organizational Change

2453. Before the Merger, HPH also lacked the capacity to implement the quality changes that occurred post-Merger. (Chassin, Tr. 5390-91).

2454. As discussed in Section VIII.D, ENH improved the quality at HPH after the Merger in 16 different areas. (Chassin, Tr. 5381-82; RX 2045). It accomplished this improvement in three ways: (1) by integrating the clinical and administrative systems of management and oversight between Evanston Hospital and HPH, an integration that required merging all of the clinical departments, service departments and management structures; (2) by immediately and broadly exporting Evanston Hospital's collaborative and multidisciplinary culture to HPH; and (3) by investing in either expanding clinical services, upgrading equipment, or changing the physical plant. (Chassin, Tr. 5382).

2455. Clinical integration and ENH's collaborative culture were necessary to achieving the vast majority of the improvements. (Chassin, Tr. 5388; RX 2045). For example, a complete transformation of leadership was required to bring about changes in quality assurance. (Chassin, Tr. 5389). Before the Merger, there was no effective physician discipline, and the physician leaders were unable to address physician behavior. (Chassin, Tr. 5389-90). The integration of the clinical departments at Evanston Hospital and HPH gave full-time Evanston Hospital clinical chairs the ability to implement quality assurance systems already in place at Evanston Hospital. (Chassin, Tr. 5389-90). Thus, the Merger was necessary to achieving meaningful improvement in quality assurance at HPH. (Chassin, Tr. 5389).

2456. The HPH nursing issues also could not have been solved before the Merger because HPH lacked a culture – throughout the hospital, through administration, or through physician leadership – that promoted positive nurse/physician relationships. (Krasner Tr. 3739). Solving the cultural issues at HPH with respect to nursing required a change of the hospital systems, administration and physician leadership. (Krasner, Tr. 3739). Support for cultural change had to be pervasive throughout the organization. (Krasner, Tr. 3739). Without the cultural change that ENH brought to HPH, nursing services would not have improved. (Chassin, Tr. 5388). Thus, HPH could have achieved similar improvements by merging with a hospital other than Evanston Hospital only if that hospital had the same kind of collaborative culture. (Chassin, Tr. 5395).

2457. Indeed, even though HPH could have hired a consulting firm to identify problems in nursing, HPH needed the expertise and experience that Evanston Hospital brought to the Merger to change the culture and organizational style of the hospital. (Chassin, Tr. 5389). HPH could not have made those same changes on its own. (Chassin, Tr. 5389).

2458.

(REDACTED)

(Silver, Tr. 3924-25, *in camera*).

(REDACTED)

camera).

(REDACTED)

(Silver, Tr. 3925, *in camera*).

2. The Improvements Made By ENH Could Not Have Been Achieved Through Joint Ventures

2459. The Merger was necessary to produce the extremely high quality cardiac surgery program at HPH today. Cardiac surgery is a highly complex and team-dependant service. In fact, cardiac surgery is probably the most complex and team-dependant service that exists at HPH post-Merger. The close collaboration of all team members – from the perfusionist, to the surgeon, to the physician’s assistant, to the ICU and OR nurses – is absolutely necessary to the performance of high quality cardiac surgery. This collaborative culture did not exist at HPH before the Merger. (Chassin, Tr. 5392).

2460. If the cardiac surgery program at HPH had been launched through an affiliation or joint venture, the program would have been of significantly lesser quality, similar to the programs at Weiss Hospital or Swedish Covenant Hospital. (Chassin, Tr. 5392-93).

2461. Neither Weiss Hospital nor Swedish Covenant Hospital is owned or operated by ENH. (Rosengart, Tr. 4443). Rather, ENH cardiac surgeons practice at these two sites only through an affiliation agreement. (Rosengart, Tr. 4443). As a result, both cardiac programs function independently of ENH. (Rosengart, Tr. 4444, 4489, 4500-01).

2462. Due to this lack of integration, the quality of cardiac surgery performed at HPH is higher than the quality of cardiac surgery performed at the affiliated sites. (Rosengart, Tr. 4504).

2463. The complete integration between Evanston and HPH allows certain cutting edge procedures to be performed at HPH that otherwise would not be performed at an affiliated hospital. (Rosengart, Tr. 4492-93). For example, vein harvesting techniques using periscopes through a one inch incision and bloodless surgery, which is performed only at a handful of hospitals in the country, are performed at HPH but not at Swedish Covenant or Weiss Hospital. (Rosengart, Tr. 4494-96). Dr. Rosengart explained: “We are not doing [advanced surgical techniques] at either Swedish or Weiss. I wouldn’t feel comfortable. It really involves a lot of integration of anesthesia and nursing, equipment, resources and things like that, and by virtue of not having that sort of commonality of the team, probably would not – certainly no in – not in the near future do it at either of those sites.” (Rosengart, Tr. 4493).

2464. New technology is also adopted more quickly at HPH because of the common leadership and structure at Evanston Hospital and HPH. For example, when a new stenting technology came out two years ago, Evanston and HPH simultaneously adopted it well ahead of other cardiac programs in the Chicago area. (Rosengart, Tr. 4496-97).

2465. Additionally, more private and government funded research takes place at HPH than at affiliated hospitals because the affiliated hospitals maintain separate infrastructure, separate Institutional Review Boards and separate contracting practices. (Rosengart, Tr. 4496).

2466. The integration from the Merger also affords HPH's cardiac surgery program staff access to ENH's state-of-the-art medical technology. (Rosengart, Tr. 4566).

2467. An affiliation agreement does not afford sufficient control of the cardiac surgery program to ensure quality. For example, HPH is subject to ENH's quality assurance program, but Weiss Hospital and Swedish Covenant Hospital are not. (Rosengart, Tr. 4467-68, 4550).

2468. Further, ENH has not been able to resolve issues with the administration, resources and the ability to obtain necessary upgrades at Weiss Hospital. Consequently, surgeries performed at Weiss Hospital are kept more basic, and patients with complex cases are transferred to Evanston Hospital. (Rosengart, Tr. 4503-04).

2469. Outcome data confirms that the quality of cardiac surgery performed at HPH since the Merger is of a higher quality than that done by hospitals with cardiac surgery programs opened through affiliation with ENH. (Rosengart, Tr. 4502-05). Moreover, the length of stay for cardiac surgery patients is longer at Swedish Covenant Hospital than at HPH. (Rosengart, Tr. 4501).

3. The Geographic Proximity Of Evanston Hospital To HPH Was Essential To Improving The Quality At HPH

2470. HPH could not have achieved similar improvements by merging with a hospital that was not in close geographic proximity to HPH. (Chassin, Tr. 5395).

2471. The relatively close geographic proximity of Evanston Hospital to HPH enables physicians to rotate between the HPH and Evanston Hospital campuses – as occurs in the pathology, radiology, emergency and cardiac surgery departments. (Chassin, Tr. 5395-96). It also allows specialists to move back and forth between the HPH and Evanston Hospital campuses. (Chassin, Tr. 5395-96).

4. The Merger Enabled HPH To Make Quality Improvements And Offer Services That Are Not Generally Offered By, And/Or Not Feasible For, Community Hospitals

2472. Some, but certainly not all, of the HPH quality improvements that would not have occurred absent the Merger are summarized below.

a. ENH Upgraded HPH To The Epic System

2473.

(REDACTED)

(Romano, Tr. 3162, *in camera*).

2474. Indeed, no community hospital has deployed an enterprise grade electronic medical record system such as Epic. (Wagner, Tr. 3999-4000). Those hospitals smaller than HPH that are installing Epic are part of a larger hospital system. (Wagner, Tr. 4000).

2475. Moreover, the majority of community hospitals today do not have an electronic medical record that includes CPOE systems. (Romano, Tr. 3334).

b. ENH Vastly Improved HPH's Oncology Services

2476. The Merger allowed HPH's oncology department to offer facilities, oncology services, research trials and new equipment that typically are not found in community hospitals. (Chassin, Tr. 5369, 5371; Dragon, Tr. 4370-71; RX 1723). *See*, Section VIII.D.2.d., *supra*.

2477. Community hospitals typically do not: (1) have centers similar to the Kellogg Cancer Care Center; (2) have multidisciplinary site-specific oncology conferences to discuss patient treatment; (3) offer coordinated ancillary and support services, such as psycho-social support, oncology pharmacy services and dietary services – directly on-site; (4) offer the range of sub-specialty care that ENH brought to HPH after the Merger; (5) perform the level of research that is required to receive funding from the National Cancer Institute for clinical and cancer prevention research; or (6) have CT/PET scan machines, which are latest generation of positive emission tomography scanning devices. (Neaman, Tr. 1352; Dragon, Tr. 4325, 4344-48, 4370-71; RX 1341 at ENHE TH 975). Many of these services are offered only in academic teaching hospitals. (Dragon, Tr. 4322-23; Chassin, Tr. 5371).

2478. After the Merger, HPH was able to: open the Kellogg Cancer Care center, have its patients included in weekly multidisciplinary site-specific care conferences, offer coordinated ancillary and support services on-site, offer access to a broad range of sub-specialists, receive additional funding from the National Cancer Institute that gave HPH patients access to a broader range of treatment and prevention research trials, and purchase a CT/PET scan machine. (Chassin, Tr. 5369, 5371; Dragon, Tr. 4370-71; RX 1723). *See* Section VIII.D.2.d., *supra*.

2479. All of the improvements made by ENH to oncology services at HPH post-Merger caused the American College of Surgeons to change its designation of HPH's oncology program from a community oncology program to an academic hospital cancer center. (Dragon, Tr. 4360-61).

c. ENH Improved HPH's ICU Services By Adding The Services Of Intensivists

2480. Intensivist programs such as the one instituted at HPH after the Merger are not common in community hospitals (such as HPH before the Merger). (Chassin, Tr. 5329).

2481. The Leapfrog Group conducted a survey that tallied the number of hospitals reporting intensivist programs. (Chassin, Tr. 5329-30). Only 6 out of 37 hospitals reporting to LeapFrog in Illinois had intensivist programs, and three of those six hospitals were the ENH hospitals. (Chassin, Tr. 5330; Romano, Tr. 3324).

d. ENH Provided Much-Needed Improvements To HPH's Ob/Gyn Services

2482. (REDACTED)
(Silver, Tr. 3889-90, *in camera*). (REDACTED)
(Silver, Tr. 3890, *in camera*).

B. Divestiture Is Not A Proper Remedy Because It Would Erode Quality Of Care Improvements Resulting From The Merger And Thus Harm Consumers

2483. The divestiture of HPH would likely erode a number of the improved quality and increased services achieved as a result of the Merger. (Chassin, Tr. 5139, 5397). Accordingly, the proposed remedy of divestiture, if imposed, would harm – *not* benefit – consumers. (Noether, Tr. 6037). There could not be divestiture in the inpatient market without harming outpatient quality as well. (Baker, Tr. 4609).

2484. The maintenance of changes in quality improvements at HPH depend on the continued benefits of the relationship derived from ENH. (Chassin, Tr. 5402-03). Maintaining quality improvement is a continuous process that requires a large amount of input from a variety of different skills. (Chassin, Tr. 5403). For example, exposure to subspecialists with knowledge of clinical advancements and the continual monitoring and updating of protocols are quality improvement areas that are constantly changing. (Chassin, Tr. 5403).

2485. Further, clinical protocols are mechanisms for resolving problems in health care treatment that similarly need to be constantly updated and modified pursuant to current knowledge. (Rosengart, Tr. 4560). Using a protocol developed in the past without constant minding and attention likely will decrease the quality of care provided. (Rosengart, Tr. 4560). If HPH were divested from ENH and HPH retained the protocols extended to the hospital after the Merger, this would adversely affect the facility. (Rosengart, Tr. 4560-61).

2486. ENH, which has substantial subspecialty clinical expertise that was brought to HPH after the Merger, is the source of HPH's quality improvements. (Chassin, Tr. 5403). If one were to cut off HPH's continuous exposure to ENH's subspecialists and its continual monitoring and updating of protocols, HPH quality would begin to atrophy, thus adversely affecting consumers. (Chassin, Tr. 5403).

2487. Like all communities, healthcare is very important to Highland Park residents. (Belsky, Tr. 4899). Accordingly, the Mayor of Highland Park, Michael Belsky, agreed to represent the Highland Park community before the FTC in this action. He wanted to do his part to assure that the major investments made in the community by ENH were successfully completed. (Belsky, Tr. 4899, 4923). Mayor Belsky believes that the Merger benefited HPH with an improved physical plant and has improved HPH's services. (Belsky, Tr. 4905). He is concerned that a possible divestiture of HPH by ENH would make continued improvements to HPH's facilities and services more uncertain. (Belsky, Tr. 4912-13). As mayor, Belsky believes that the Highland Park community wants certainty as to the continued improvement of HPH. (Belsky, Tr. 4913).

2488. Also, as discussed in Section IV.E, the Healthcare Foundation was established as a result of the Merger to support HPH and to enhance healthcare in other areas of the community. (Tr. 4969-70). As the Chairman of the Healthcare Foundation, James Styer, who testified at the hearing, believes that if ENH were forced to divest HPH it would be a "tragedy" because the Foundation has transformed HPH into a "wonderful" facility. (Styer, Tr. 4995).

2489. The Healthcare Foundation took formal action to express its concerns about a possible divestiture of HPH as a result of this litigation by sending ENH's Chairman of the Board, Homer Livingston, a letter in August 2004. (RX 1714 at HFHP 105-06; Styer, Tr. 4996; Livingston, Tr. 4905-06). The letter expressed the Healthcare Foundation's concern that the divestiture might unravel all of the improvements the Merger brought to HPH, including the construction of a new ambulatory care center, creation of a picture archiving system as well as the implementation of an expensive electronic medical record system. ENH also enhanced the emergency department, catheterization labs and radiology equipment, among other improvements. (RX 1714 at HFHP 105; Styer, Tr. 4996; Belsky, Tr. 4907-08). Mayor Belsky, who serves on the Healthcare Foundation's Board of Directors, gave Styer his approval to send a letter expressing concern about this litigation. (RX 1714 at HFHP 110; Belsky, Tr. 4907).

1. Divestiture Would Have Adverse Quality Of Care Consequences Pertaining To Cardiac Procedures At HPH

a. Divestiture Would Result In The Loss Of Cardiac Surgery At HPH

2490. Divestiture would have an adverse affect on HPH's post-Merger cardiac surgery program. If HPH were divested from ENH, the knowledge retained by the operating room team, the ICU team, and all the various personnel involved in the provision of cardiac surgery would not be retained. (Rosengart, Tr. at 4560).

2491. As Commissioner of Health in New York State, Dr. Chassin reviewed the proposals for open heart surgery programs at community hospitals desiring to be affiliated with academic hospitals. (Chassin, Tr. 5614). Based upon Dr. Chassin's review of the volumes of surgeries and those expected to be performed at HPH as a freestanding entity, he concluded that it would be nearly impossible for HPH to maintain a cardiac surgery program as a stand-alone hospital with any reasonable quality if it were cut off from its relationship with ENH. (Chassin, Tr. 5607-08). In addition, if HPH were a freestanding hospital, it would not have the volumes to support having sub-specialists work solely at HPH. (Chassin, Tr. 5599).

2492. Certain minimum volume requirements should be met to operate a high quality cardiac surgery program. HPH's cardiac surgery program does not function as a stand-alone program and is integrated with Evanston Hospital's program and, as a result, HPH does not suffer from concerns about low volume in the practice of cardiac surgery. But if HPH were not integrated into ENH and operated as a stand-alone program, this would raise concerns about whether the volume of cardiac surgery patients at HPH adversely affects the quality of the program. (Rosengart, Tr. at 4518-21).

er is
as a
eiss
lity
vel

at
r.
is
r.

|

c. Divestiture Would Result In Loss Of Nursing Improvements Resulting From Improved Cardiac Care At HPH After The Merger

2500. There is a strong relationship between the cardiac surgery program and the skill level of nursing. To maintain a high quality cardiac surgery program, the hospital must employ an intensive nurse training program. (Chassin, Tr. 5603-04; Ankin, Tr. 5068-70).

2501. Cardiac surgery is one of the most complex set of procedures performed at HPH, and it requires constant updating of everyone's skills – from the surgeon to the physician assistant and all of the different levels of nursing that are involved in providing care to those patients. (Chassin, Tr. 5603).

d. Divestiture Would Result In Loss Of ICU Nurse Acuity Gained From The Cardiac Surgery Program

2502. There is a relationship between the quality of ICU services and the maintenance of a cardiac surgery program because the ICU services the joint cardiac surgery and other critical care area for the hospital. (Chassin, Tr. 5604).

2503. Once the ICU nurses are trained to handle the very sick and complicated cardiac surgery patients, those skills spill over into improving their ability to take care of many other critically ill patients who are in the ICU for other reasons. (Chassin, Tr. 5604; Ankin, Tr. 5068-70).

e. Divestiture Would Result In A Decline In Quality Of Care For Patients With AMI

i. HPH Would Lose Its Capacity To Treat AMI Patients

2504. Acute myocardial infarction (“AMI”) is more commonly known as a heart attack. (O'Brien, Tr. 3528). If HPH lost its cardiac surgery program, HPH would lose its capacity to provide immediate life-saving cardiac surgical interventions in cardiac surgical emergencies. (Chassin, Tr. 5609). As a result, HPH patients with those kinds of emergencies would no longer be able to receive care, and their immediate survival would be threatened by the lack of a cardiac surgery program. (Chassin, Tr. 5609-10).

2505. Generally, ambulances take patients with critical emergencies to the nearest hospital and the specific diagnosis of a cardiac surgical emergency – such as a tear in the aorta – would not be apparent to an ambulance or paramedic personnel. (Chassin, Tr. 5613).

ii. There Would Be An Increase In Transfers Of Patients With AMI From HPH To Other Hospitals

2506. Without a cardiac surgery program, and without a PCI program, the pattern of increasing transfers *into* HPH of patients with a heart attack would start to be reversed because

patients would know that they cannot get their heart attack treated by revascularization at HPH and they would begin to go elsewhere. (Chassin, Tr. 5612).

2507. Indeed, one should expect to see a re-emergence of heart attack patients being transferred *from* HPH to receive the interventional treatment that they previously could have received, but no longer were able to receive, from the hospital. (Chassin, Tr. 5612-13). See Section VIII.D.2.b.ii.

iii. Delays In Transfer Would Harm Patients

2508. A patient with a problem with his aorta who is admitted to a divested HPH with no PCI program would require much more time to be transferred to another hospital than the mere length of the ambulance ride. (Chassin, Tr. 5623).

2509. The patient first would need to be evaluated in the HPH ED, a correct diagnosis would have to be made, the physician would have to correctly determine the necessary treatment, arrangements then would have to be made for an ambulance transfer, the ambulance would have to arrive, the ambulance then would have to take the patient to another hospital, the patient would have to be re-evaluated by that hospital, and a new team would have to be assembled to perform the procedure. (Chassin, Tr. 5623).

2510. Accordingly, it is not merely the matter of the ambulance ride as the total time delay between the diagnosis of the emergent condition and the actual implementation of treatment. (Chassin, Tr. 5623-24). This delay would harm patients. (Chassin, Tr. 5623-24).

2. Divestiture Would Result In HPH Returning To A Community Hospital Governance Model

2511. Hospital governance places a critical role, at all levels, in providing a structure for effective peer review and quality assurance. (Chassin, Tr. 5211).

2512. From the top down, the hospital's trustees must have a role in hearing about and then enforcing discipline. A devotion to such a practice must be reflected in the hospital's leadership – including the administrative leadership as well as the nursing and physician leadership. Such leadership is necessary to make peer review and quality assurance work well. (Chassin, Tr. 5211).

2513. If divestiture were awarded, these administrative functions would have to be recreated. (Noether, Tr. 6038). It had a very weak structure within each of the clinical departments for performing effective peer review and identifying problem physicians, and it lacked an adequate process to discipline those physicians. (Chassin, Tr. 5210-11).

a. Loss Of Integrated Medical Staffs Would Deprive HPH of Clinical, Academic and Research Activities

i. Divestiture Would Result In HPH's Loss Of Academic Involvement By HPH Physicians At Evanston Hospital Campus

2514. If the HPH physicians were to lose the continuous influx of exposure to an academic medical center, including academic teaching, their learning would become impaired because they would no longer be participating in activities that would improve their clinical skills. Those skills, therefore, would begin to stagnate. (Chassin, Tr. 5400-01).

ii. Divestiture Would Result In HPH's Loss Of Research Partnerships With Physicians At Evanston Hospital

2515. If HPH were to be returned to a stand-alone hospital, it would lose the kinds of conferences and partnerships among physicians at the three hospitals. These conferences and partnerships focus on the development of multidisciplinary treatment plans for individual patients and, on the quality assurance side, look at individual complications and individual difficult cases to make decisions that could never be made at a free-standing community hospital. (Chassin, Tr. 5598-99; Ankin, Tr. 5053-54).

2516. These types of multidisciplinary discussions cannot be accessed through regular educational conferences because those types of conferences tend to be straightforward lectures and didactic seminars. (Chassin, Tr. 5598-99).

iii. Divestiture Would Result In HPH's Loss Of Department Conferences And Case Consultation

2517. More information can be shared among physicians at department conferences within the same hospital than if physicians merely attend the conference as a visitor from another hospital. (Chassin, Tr. 5598-99). The conferences that are held in which medical staff members of many, unaffiliated hospitals attend are pretty much straightforward lectures. (Chassin, Tr. 5599).

2518. In contrast, the kinds of conferences that are routinely held now involving physicians from HPH and Evanston and Glenbrook Hospitals are multi-disciplinary, patient care-focused conferences to develop treatment plans for individual patients. (Chassin, Tr. 5599). With respect to quality assurance, these conferences within ENH are multidisciplinary quality assurance conferences that look at individual complications and difficult cases to make decisions that would never be made in conferences involving separate institutions. (Chassin, Tr. 5599).

3. Divestiture Would Result In HPH's Loss Of ENH Quality Improvement And Quality Assurance Programs

2519. Upon divestiture, it would be likely that the cardiac surgery team at HPH would not be able to perform at the high level it does today. (Chassin, Tr. 5401).

2520. The integrated nature of the cardiac surgery program between ENH and HPH that was created after the Merger requires that every member of the cardiac surgery team continuously interact with every other member of the team. (Chassin, Tr. 5401). This involves continuous participation in learning and developing new protocols, new evidence-based methods of taking care of patients. (Chassin, Tr. 5401).

2521. If that close relationship were severed, the skills of the combined group, ENH and HPH, would start to atrophy at the HPH site. (Chassin, Tr. 5401).

2522. Moreover, if HPH were to return to a stand-alone hospital, it would not be able to continue the preoperative gynecologic surgical review program because it would not have the department leadership provided by ENH. (Silver, Tr. 3861-62).

4. Divestiture Would Result In HPH's Loss Of The Benefits Of Epic

2523. As discussed in Section VIII.D.2.h, the community served by the ENH hospitals benefits from the use and deployment of Epic at those hospitals. (Wagner, Tr. 3989). The value of Epic to the community is enhanced and improved by greater participation in the system. That is, the more institutions, the more physicians and the more caregivers looking at the same data and having access to patients' electronic records, with the system's safety features, the better the outcomes for the patients. (Wagner, Tr. 3989-90).

2524. The value of Epic to the community is diminished when physicians and hospitals cease to use the same Epic database. (Wagner, Tr. 3990).

2525. The Merger increased the value of ENH's implementation of Epic by increasing the number of participants, sites of care, and providers of care. (Wagner, Tr. 3961-62). ENH's deployment and use of Epic at HPH benefited patients in the Highland Park community as well as other communities. (Wagner, Tr. 3990-91).

2526. ENH owns the license to use Epic, which is non-assignable. This means that the license could not be assigned to HPH if it were divested from ENH. (Wagner, Tr. 3991). Thus, HPH would not be able access the data stored in ENH's Epic database through any sort of cost-sharing arrangement in the event that divestiture were ordered. (Wagner, Tr. 4080). If HPH were no longer part of the ENH system, it would need to purchase a separate license to use Epic. (Wagner, Tr. 3991).

2527. There are numerous barriers preventing HPH from maintaining Epic post-divestiture. (Wagner, Tr. 3991-95). First, if any part of the hospital environment were changed, the workflows in Epic must be rebuilt. (Wagner, Tr. 3992-93).

2528. Second, to maintain Epic if divestiture were ordered, HPH also would have to purchase a data center, hire an information services department to manage and run Epic, develop its own training division and develop their own support team. (Wagner, Tr. 3993-94).

2529. Third, HPH currently does not have the infrastructure to run Epic on its own. (Wagner, Tr. 4073). If divestiture were ordered, it would take HPH three to five years to get up and running with Epic on its own. (Wagner, Tr. 3994).

2530. Finally, if HPH were bought by another hospital system that used Epic, there currently is no way for the two Epic systems to communicate. (Wagner, Tr. 3994-95). Currently, hospitals that use Epic but are in different hospital systems cannot share information that is in their respective Epic databases. (Wagner, Tr. 3994).

5. Divestiture Would Result In A Diminished Ability By HPH To Recruit High-Caliber Physicians And Hospital Administrators

2531. A hospital's status as an academic medical center, or being affiliated with an academic medical center, has a substantial positive impact on the hospital's ability to recruit the highest quality physicians and hospital administrators. (Chassin, Tr. 5600).

2532. The impact of being an academic medical center, or being affiliated with one, on recruiting high-caliber physician leaders is that when most academic hospitals seek to fill leadership positions, they endeavor to find someone interested in staying as current as possible and, in fact, establishing what the new standards of practice will be. (Chassin, Tr. 5600-01). Thus, academic hospitals attract physicians who are interested in research connections with respect to their field, physicians who are interested in establishing the latest and most effective best practices in patient care, and physicians who are interested in establishing the latest and most effective best practices in patient care and in establishing the ongoing process of maintaining those best practices and providing the best quality care. (Chassin, Tr. 5601).

C. Divestiture Is Not A Proper Remedy Because ENH Cannot "Unlearn" About Its Demand

2533. (REDACTED)

(Baker, Tr. 4655-56, *in camera*). (REDACTED)
(Baker, Tr. 4656, *in camera*).

2534. (REDACTED)

(Baker, Tr. 4656, *in camera*).

D. Divestiture Is Not A Proper Remedy Because The Merger Was Between Two Members Of An Approved Network

2535. As discussed in Section III.A, Evanston Hospital and HPH were both part of the Network, which received Hart-Scott-Rodino approval in 1993. (Neaman, Tr. 1360).

2536. In August 1999, before the Merger, the FTC Pre-Merger Notification Office notified the Network, Evanston Hospital, and Lakeland, the parent company of HPH, that it

viewed the Network as already holding the assets of both Evanston Hospital and Lakeland. (RX 586 at 2).

2537. As such, the FTC Pre-Merger Notification Office did not view the Merger between Evanston Hospital and HPH as an acquisition of assets under the HSR Act. (RX 586 at 2). “This conclusion is not altered by the fact that [the Network] will be dissolved and removed as a member of [ENH] following the effective date of the merger. . . . [A]s long as [the Network] exists and holds the reserved power over appointments to the boards of [ENH] and [Lakeland Health Services] at the time of the merger, the merger will not be reportable.” (RX 586 at 2).

E. Divestiture Is Not A Proper Remedy Because It Would Undo Efficiencies Of The Merger

2538. Harry Jones, as head of the finance department at ENH, was given the responsibility to track the cost savings and revenue enhancements that were achieved after the Merger. (H. Jones, Tr. 4130-31). The various departments at ENH would report their savings to the finance department, which would challenge the expected savings and compile them into a monthly report. (H. Jones, Tr. 4130-31; RX 883). The list prepared by the finance department was not an exact calculation, but rather a “best estimate” of what was achieved. (H. Jones, Tr. 4131; RX 883).

2539. The finance department tracked approximately \$36 million in enhancements and savings that were achieved after the Merger. (H. Jones, Tr. 4131). Approximately \$12 million of the total amount was directly tied to savings after the Merger. (H. Jones, Tr. 4131).

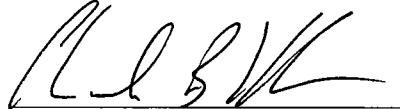
2540. Several Merger efficiencies contributed to the cost savings of the Merger. (RX 967 at ENH GW 1147-50). ENH saved \$2 million by phasing-out seven senior management positions and twenty-five corporate staff. (RX 967 at ENH GW 1147). The unified pricing structure of the three hospitals resulted in a \$5 million cost improvement. (RX 967 at ENH GW 1147). Another \$2 million was saved by combining advertising and other corporate functions. (RX 967 at ENH GW 1148). ENH also achieved \$400,000 savings by merging human resource benefits and \$900,000 by consolidating information systems staffing. (RX 967 at ENH GW 1148-49).

2541. By adding HPH to a single Medicare provider status after the Merger, ENH realized \$200,000 in cost savings. (RX 967 at ENH GW 1150).

2542. “One needs to evaluate the benefits and costs associated with a remedy.” (Noether, Tr. 6037). Complaint Counsel's chief economic expert witness, Dr. Haas-Wilson, testified plainly that she offered no opinion on the proper remedy in this case. (Haas-Wilson, Tr. 2441).

Dated: May 27, 2005

Respectfully Submitted,



Duane M. Kelley
WINSTON & STRAWN LLP
35 West Wacker Dr.
Chicago, IL 60601-9703
(312) 558-5764
Fax: (312) 558-5700
Email: dkelley@winston.com

Michael L. Sibarium
Charles B. Klein
WINSTON & STRAWN LLP
1700 K Street, NW
Washington, DC 20006
(202) 282-5777
Fax: (202) 282-5100
Email: msibarium@winston.com
Email: cklein@winston.com

Attorneys for Respondent

CERTIFICATE OF SERVICE

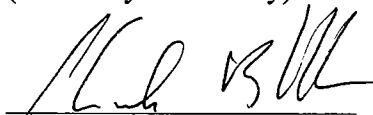
I hereby certify that on May 27, 2005, copies of the foregoing **Respondent's Proposed Findings of Fact, Exhibit List and Witness List (Public Version)** was served (unless otherwise indicated) by messenger on:

The Honorable Stephen J. McGuire
Chief Administrative Law Judge
Federal Trade Commission
600 Pennsylvania Ave. NW (H-106)
Washington, DC 20580
(two courtesy copies delivered by messenger only)

Thomas H. Brock, Esq.
Federal Trade Commission
600 Pennsylvania, Ave. NW (H-374)
Washington, DC 20580
tbrock@ftc.gov

Philip M. Eisenstat, Esq.
Federal Trade Commission
601 New Jersey Avenue, N.W.
Room NJ-5235
Washington, DC 20580
peisenstat@ftc.gov

Chul Pak, Esq.
Assistant Director Mergers IV
Federal Trade Commission
601 New Jersey Avenue, N.W.
Washington, DC 20580
cpak@ftc.gov
(served by email only)



Charles B. Klein, Esq.

